Housing First Charlotte-Mecklenburg Research & Evaluation Project

Process Evaluation Final Report / September 2020

Funded by Roof Above, Mecklenburg County &
UNC Charlotte - College of Health & Human Services, School of Social Work, Urban Institute

In Honor of HFCM research participants
In Memory of Nancy Crown & John Yaeger

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MECKLENBURG COUNTY NORTH CAROLINA

UNC CHARLOTTE

HOUSING FIRST
Charlotte–Mecklenburg
Ending Chronic Homelessness in 2016

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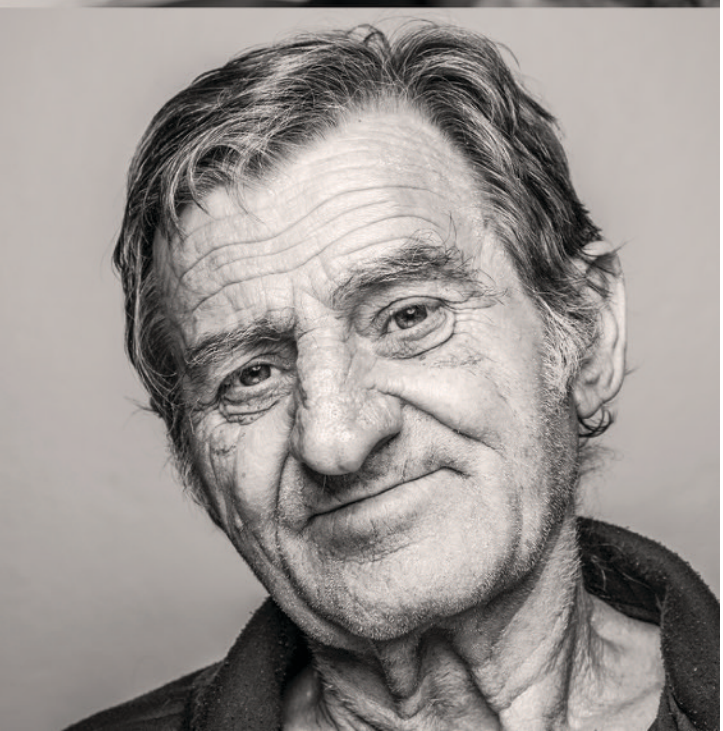

Housing First Charlotte-Mecklenburg Process Evaluation Final Report

Key Findings

Housing First Charlotte-Mecklenburg (HFCM) is a multi-sector collaboration to end chronic homelessness by scaling housing first, and particularly the housing first permanent supportive housing model. Housing first programs prioritize housing as an early step in service delivery, have low barrier admissions policies with minimal eligibility criteria, maximize client choice in housing and services, use a harm reduction approach to substance use and other personal challenges, and do not require service compliance or success in order for a tenant to maintain housing.

The Housing First Charlotte-Mecklenburg Research & Evaluation Project examined the implementation and outcomes of the effort. This report focuses on the process evaluation of effort implementation. The study was funded by Roof Above (formerly the Urban Ministry Center), UNC Charlotte College of Health and Human Services, School of Social Work, and the UNC Charlotte Urban Institute. The study suggests evidence of positive impact and opportunities for improvement at program and community levels.

Key Findings

Over 1000 Individuals Housed

As of January 2020, 1011 individuals experiencing chronic homelessness were housed. Evaluation of the By-Name List from 2015-2018 suggests low rates of return to emergency shelter and a more extensive recidivism analysis in the outcomes and utilization evaluation study suggests high housing retention rates, particularly for those in housing first permanent supportive housing.

Multi Sector Collaboration

HFCM brought together diverse community partners for a new collective purpose. The multi-sector collaboration allowed the services sector to extend its reach beyond typical and often fragmented resources and accelerate the rate at which individuals were housed. As one service provider noted, "I'm a very strong believer in collaboration, and I think whenever people in a community get together around a common goal that it matters. It changes things" (A-16:25).

Orientation toward Permanent Solutions

Housing First Charlotte-Mecklenburg facilitated a reorientation of chronic homeless services from crisis management to permanent housing solutions, particularly through the use of housing first permanent supportive housing, an evidence-based practice. As one effort leader stated, "I think there was generally this accepted, assumed reality that homelessness was this huge, monolithic social problem for which there was no answer. And I think we have changed the conversation to, 'Yes, there is an answer'" (A-17:19).

Initiative Infrastructure

HFCM developed a project infrastructure to support the effort that did not rely solely on already over-extended resources and services. Collaborators brought over $1 million to the effort stimulating additional financial and in-kind investments from Charlotte Housing Authority (now Inlivian), Crisis Assistance Ministry, Mecklenburg County, and UNC Charlotte. Funding was used to develop a project management infrastructure that propelled early housing success. The infrastructure facilitated several factors that led to success including:

- A clear goal and way to monitor ongoing progress toward it through the By-Name List.
- Scaling what works using housing first permanent supportive housing, an evidence-based practice.
- Creative problem solving as the cost of available housing rapidly increased.
- Effective communication early in the effort.
- Training for direct service providers.

Implementation Lessons

Examine the Racial Equity Implications of the Prioritization Tool

Analysis of the VI-SPDAT scores of those on the By-Name List between 2015-2018 suggests that on average, the prioritization tool scores White individuals higher than Black individuals. In addition, a greater percentage of White individuals were housed in permanent supportive housing than were Black individuals, an outcome likely related to the VI-SPDAT. These findings are similar to a study of three Pacific Northwest Continuum of Care communities that found that the instrument better predicted White vulnerability than Black vulnerability and thus prioritized more extensive housing supports for White people. The CoC should examine and review use of the tool and develop a prioritization process that is more sensitive to vulnerabilities that may vary by race and ethnicity.

Address Initiative Improvements

Like any initiative, HFCM faced a number of internal and external challenges as the effort unfolded. HFCM stakeholders noted several lessons learned about the initiative including:

- Ensure representation of related sectors, direct service providers, and people with lived experience.
- Engage stakeholders in strategic and operational decision-making.
- Sustain project management across the initiative and ensure its capacity.
- Sustain communication especially in the case of initiative setbacks.
- Plan in advance for mechanisms to adjust and recalibrate management when the effort faces challenges.

Support the Philosophical Shift

Housing first is a significant departure from traditional homeless service delivery and shifting people's perspectives from the front-line to the board room can be challenging. In the housing first model, housing is a foundation not a reward, people are born housing-ready, and services begin with the person instead of a threshold of eligibility criteria. Stakeholders suggested that multiple layers of support are needed to facilitate and sustain a lasting change in philosophy even among organizations that are housing first proponents.

Connect to the Systems Context

Findings suggest the importance of connecting chronic homelessness to larger community issues like the overall homelessness problem, the cost of housing, and limited economic mobility. The broader homelessness problem, particularly among single adults, impacted the inflow of people into chronic homelessness. The cost of housing impacted both the inflow of people into homelessness and the outflow of people into permanent, safe housing. Chronic homelessness is a life course outcome of the same system dynamics that create barriers to economic mobility. For longevity and effectiveness, defining and understanding how a problem connects to systems and issues around it should be an early and ongoing part of any change initiative, even if solutions are focused more narrowly.

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Housing First Charlotte-Mecklenburg (HFCM) is a multi-sector collaboration in Charlotte, North Carolina (NC) to end chronic homelessness by taking housing first to scale. The process evaluation examined the implementation of the HFCM effort, which by January 2020 had housed 1011 individuals.

Housing First Charlotte-Mecklenburg (HFCM) is a multi-sector collaboration to end chronic homelessness in Charlotte, North Carolina through the community-wide implementation of the housing first model. Nationally, HFCM is affiliated with the Community Solutions Built for Zero campaign (then Zero:2016) that mobilizes communities to end chronic and veteran homelessness. HFCM began formally in January 2015 during the annual point-in-time count, a federally mandated one-day census of all individuals who meet the federal definition of homeless. The census efforts included a vulnerability assessment of those who met the federal chronically homeless definition. Over 250 volunteers joined the count and extended it for two additional days to create a chronic homeless registry, now called the By-Name List. The 516 placed on the registry during those three days became the starting point for the housing and supportive services efforts of HFCM. As additional individuals were identified as chronically homeless through Coordinated Entry they were added to the By-Name List. As housing became available, it was offered to individuals on the registry prioritized by vulnerability and length of time homeless. HFCM developed eight strategies to facilitate this process, including evaluation. Table 1 lists the eight original strategies to end chronic homelessness.

Table 1. HFCM Strategies

1	Create and maintain a chronic homeless registry
2	Expand outreach efforts
3	Create 250 new permanent supportive housing units, including at least one new single site building
4	Coordinate moves into housing for those experiencing chronic homelessness
5	Train organizations and staff in the housing first model
6	Engage the community to be a part of the solution
7	Ensure adequate leadership and staff
8	Evaluate the effort to end chronic homelessness

HFCM seeks to end chronic homelessness by scaling up housing first and particularly, the housing first permanent supportive housing model (HF PSH), an evidence-based model with local, national, and international evidence of effectiveness (Busch-Geertsema, 2014; Padgett et al., 2016; Thomas. Priester, Shears, & Pate, 2015). HF PSH secures permanent, independent housing for tenants and ensures access to necessary supportive services. It emphasizes housing as an early step in service delivery, maximizes client choice in housing and services, has low barrier admissions policies with minimal eligibility criteria, uses a harm reduction approach to substance use and other personal challenges, and does not require service compliance or success in order for a tenant to maintain housing. HF PSH effectively ends homelessness, reduces the cost of emergency and crisis services, and provides a foundation for wellness and recovery. Effective HF PSH programs maintain fidelity criteria established by research (Stefancic, Tsemberis, Messeri, Drake, & Goering, 2013) and described below in Table 2. Together, the implementation strategies and fidelity criteria form the HFCM theory of change.The logic model and theory of change are detailed in Appendix A.

Table 2. Housing First Permanent Supportive Housing Fidelity Criteria

Housing Choice & Structure	Tenants have a choice of neighborhood, unit, & living environment.
Separation of Housing & Services	Housing is not dependent on service success or compliance. Tenant has same rights and responsibilities as those with a standard lease.
Service Philosophy	Services are voluntary & client-driven. Services utilize a harm-reduction approach and active, person-centered, non-coercive engagement.
Service Array	A range of necessary services are provided directly or brokered. Crisis response is available 24/7.
Program Structure	Programs prioritize those with severe and complex needs. Programs maintain low staff to client ratios. Structure supports above characteristics.

The HFCM Research & Evaluation Project (project) included three components – a process evaluation, an outcomes evaluation, and a service utilization study. The process evaluation component examined how HFCM was implemented and how implementation was related to HFCM outcomes. The outcomes evaluation component examined individual housing, quality of life, health, and mental health outcomes of HFCM. The service utilization component examined the community impact of HFCM, including the utilization of health and human services. Together the three components evaluated the implementation and effectiveness of Charlotte's effort to end chronic homelessness.

This final report describes findings from the process evaluation, which covered the study period between 2015-2018. Findings from the outcomes evaluation and service utilization study are presented in a separate report and a subsequent brief report will describe the findings of a HF PSH cost analysis. This and companion reports provide evidence of positive impact and opportunities for improvement at program and community levels. The reports should be approached as living, learning documents that can support ongoing personnel, program, and system development to effectively address chronic homelessness.

HFCM History

Charles Bowman, Bank of America Market President for North Carolina and Charlotte and HFCM Steering Committee Member, participates in the media event on January 6, 2015 announcing the community's effort to end chronic homelessness. *Photo: Charlotte Center City Partners*

HFCM began as a multi-sector response to homelessness in uptown Charlotte.

HFCM officially kicked-off in January 2015 with an extended point-in-time count of homelessness to identify individuals experiencing chronic homelessness and include them on a By-Name List for housing as it became available. While the goal of the effort was to end chronic homelessness by the end of 2016, the effort was extended and it continues in order to address the ongoing inflow of chronically homeless individuals. In May 2018, the initiative consolidated and transitioned to the Charlotte-Mecklenburg Continuum of Care. By the end of 2018, the effort had housed 814 individuals, 58% more than the 516 effort leaders thought they would be housing when the By-Name List was created in 2015. Of those housed, 18.9% did not return to emergency shelter during the study period. By January 2020, 1011 people from the By-Name List had been housed. Figure 1 describes key events and milestones in HFCM history.

2014

Work to build the initiative began prior to the January 2015 PIT count. In response to a rise in visible street homelessness in uptown Charlotte, Charlotte Center City Partners (CCCP) convened an ad hoc group of homeless service providers, uptown business representatives, and Charlotte-Mecklenburg police officers to discuss and better understand the problem. The effort included pre-dawn walks with community leaders and a summer count of street homelessness to better understand the extent of the problem. On July 31, 2014, the Charlotte Observer published an article describing proposed plans to remove the uptown benches for 30 days as a deterrent to street homelessness. Several homeless service providers objected. The ad hoc group rejected the proposal and began the formalization of HFCM, a long-term solution to the problem. The group initially rallied around Charlotte Housing Authority's (now Inlivian) plans to open the Housing Choice Voucher waitlist for the first time since 2007 and their willingness to prioritize vouchers for homeless households. Homeless service providers mobilized to get as many chronically homeless individuals on the waitlist as possible and Mecklenburg County Community Support Services (CSS) agreed to provide wrap around services for those who received vouchers. When vouchers became available in 2015, the collaboration had laid the groundwork to expand the availability of permanent supportive housing.

2015

Taking advantage of the momentum from housing over 100 individuals during the 2013 100,000 Homes campaign (the precursor to Zero:2016 and Built for Zero), Urban Ministry Center proposed that the community scale up housing first permanent supportive housing to end chronic homelessness. Other homeless service providers agreed. CCCP and uptown business leaders were drawn to local and national evidence supporting the model. The effort launched formally in January 2015 with CCCP serving as project sponsors and Urban Ministry Center as project managers, and supported by a "broad coalition" of business, government, and nonprofit leaders.

Housed in 2016, Ricky Duncan holds the keys to his new apartment. *Photo: Housing First Charlotte-Mecklenburg*

2016

By the end of 2016, the group had nearly reached the original numerical goal, housing 445 individuals, but the number of additional homeless individuals added to the By-Name List since the PIT count meant that there were an additional 336 individuals to house. The effort also faced other transitions and setbacks in 2016. Liz Clasen-Kelly, the co-project manager of the effort accepted the Executive Director position at the Men's Shelter of Charlotte. Her job duties were assumed by three people: the other co-project manager, Dale Mullennix; the new Urban Ministry Center Outreach Director, Allison Winston; and, a new lead on By-Name List management, Courtney LaCaria at Mecklenburg County Community Support Services (CSS). Amidst the transition of these key positions, a new 120 unit single site development was tabled when Westerly Hills residents and elected officials objected to its placement in their neighborhood. The Charlotte Housing Authority agreed to convert the 120 single site project-based vouchers to tenant-based rental assistance for Urban Ministry Center, who partnered with Mecklenburg County CSS to hire a scattered site PSH team to begin immediately housing individuals from the By-Name List, avoiding the housing delay that would have been required because of single site construction. Nevertheless, the sudden change in strategy took many effort insiders by surprise and leaders expressed concern that the effort had lost critical momentum.

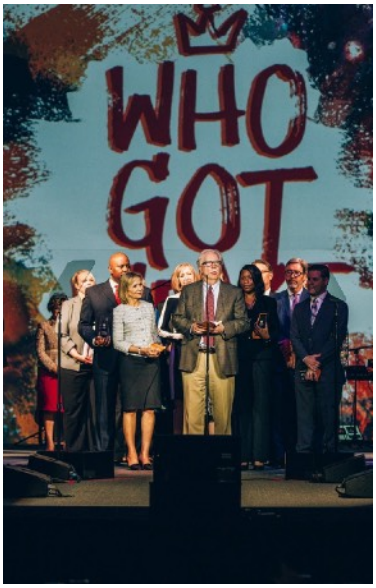
The larger community context of 2016 also threatened the momentum of the HFCM effort. The initial report of the Opportunity Task Force and the multifaceted work that would flow from it was anticipated by the beginning of 2017 and involved many of the same people leading HFCM. The focus on the report and the work of the Task Force became even more pronounced when Charlotte erupted into nearly a week of protests after the police shooting of Keith Lamont Scott. Numerous public forums and individual complaints in the wake of the protests confirmed what many Charlotteans, including those experiencing homelessness, knew well: The prosperity and growth of the Queen City was not shared by all its citizens and issues like affordable housing, access to good jobs, and structural racism and inequality fueled the social unrest. For many community leaders, however, the extent of the problems and the discontent was surprising and it redoubled the focus on the Opportunity Task Force. Despite concerns about momentum, HFCM extended its timeline through 2017 to house the remaining individuals on the By-Name List.

Man sleeping outside the Charlotte-Mecklenburg Library in uptown Charlotte during the 2017 Point-in-Time Count. *Photo: Peter Safir*

2017

By the end of 2017, HFCM had housed 617 people but over 300 still remained on the By-Name List. During the year, a new co-project manager, Caroline Chambre Hammock, led the merging of two key HFCM subcommittees - the Data committee and the 250 PSH committee. A new key task of the committee was to make sense of the inflow of new individuals into chronic homelessness. In addition, the committee was tasked with identifying housing for those who qualified as chronically homelessness but were not as vulnerable according to the assessment tool. In October, Hammock resigned as the day-to-day project manager of the effort and her position was not replaced.

Her transition report noted the successes of the effort, but also the continued challenges of inflow, persistent visible street homelessness, and housing solutions for a chronically homeless population that was somewhat different than the population anticipated at the beginning of the effort. The report's closing paragraph noted HFCM as "another example of Charlotte-Mecklenburg's tendency towards project-based



Dale Mullennix accepts the 2018 Charlotte City Center Partners Vision Award on behalf of HFCM partners. *Photo: Housing First Charlotte-Mecklenburg*

initiatives that, while wonderfully intentioned and collaborative, often lack the policy muscle to drive long-lasting change" (K-11) and recommended a systems-approach to ending chronic homelessness. Late in 2017, Michael Smith and Moira Quinn of CCCP, assured the Homeless Services Network that they would remain engaged in the effort to end chronic homelessness and that the steering and working committees would continue to meet to discuss the future of the effort, even as the subcommittees evolved to better meet the needs identified through the effort.

2018

Questions about the future of HFCM remained as the stated 2017 end of the effort passed. The last HFCM steering committee meeting was held in March 2018. The committee members discussed initial findings from the process evaluation of the effort and discussed how to integrate learnings from the first years of the effort into an ongoing system approach to address chronic homelessness. In April, CCCP presented one of the 2018 Vision Awards to HFCM and the organizations that comprised it, in many ways signaling the end of the project-oriented campaign. The future of the working and subcommittees, however, was still unclear. In May, the Continuum of Care approved the addition of a new committee focused on chronic homelessness where the work of ending chronic homelessness moved and continues. The Continuum has since moved from City to County management. By the end of 2018, 814 chronically homeless individuals had been housed, but 417 still remained on the By-Name List.

Housing First Charlotte-Mecklenburg

Timeline

2014

AD HOC CONVENING
Charlotte Center City Partners convenes homeless services providers and Charlotte-Mecklenburg police officers to address street homelessness

OBSERVER ARTICLE
Article reporting proposal to remove Uptown benches to address street homelessness

DAWN WALKS
Charlotte Center City Partners convenes homeless services providers and Charlotte-Mecklenburg police officers to address street homelessness

HFCM FORMALIZES
Ad hoc group becomes Housing First Charlotte-Mecklenburg Working Committee and Steering Committee is recruited

ANNOUNCEMENT
Broad HFCM Coalition holds media event announcing public goal to end chronic homelessness by the end of 2016

BY-NAME REGISTRY
Over 250 volunteers assist in extended Point-In-Time count to create By-Name List of 516 individuals experiencing chronic homelessness

2015

OUTREACH GROWS
Outreach team expands from 3 to 12 staff and PATH team members are added to the Urban Ministry Center outreach staff

PATHWAYS
Dr. Sam Tsemberis and Pathways Housing First begin technical assistance for the community, aimed toward direct service providers

200+ HOUSED
HFCM houses 214 by end of 2015

EVALUATION
Contracts completed between UNC Charlotte and Mecklenburg County for the Outcomes & Utilization Evaluation, & with Urban Ministry Center for Process Evaluation

2016

EXPANSION
Moore Place Expansion opens, providing 35 efficiency apartments for veterans experiencing chronic homelessness

TRANSFERS
Service providers establish practices that allow housed individuals to transfer between programs

SITE STALLS
New single site facility tabled when neighborhood resists its planned placement.

MANAGEMENT
Urban Ministry Center names new project manager

440+ HOUSED
HFCM houses 445 by end of 2016. Effort extended to meet goal

GROUPS MERGE
Data and 250 PSH committees combine to better address inflow and need for additional units

2017

CONSORTIUM
Housing CLT Landlord Consortium established

MANAGEMENT
Project manager leaves and is not replaced

600+ HOUSED
HFCM houses 617 by end of 2017

CONSOLIDATION
Operational effort to end chronic homelessness becomes a committee of the Continuum of Care

AWARD
Charlotte Center City Partners presents HFCM with a 2018 Vision Award

2018

800+ HOUSED
HFCM houses 814 by end of 2018

1000+ HOUSED
HFCM houses 1011 by January 2020

Study Methods

The Housing First Charlotte-Mecklenburg (HFCM) Research and Evaluation Project examined two interrelated processes: the implementation of a multi-sector collaboration to end chronic homelessness as well as the implementation of an evidence-based practice to meet that goal. This section briefly describes the research methodology of the process evaluation. Appendix B provides more detailed information on the study methodology guiding the project.

Process evaluations examine how an intervention, program, or community-wide effort happens and the extent to which the effort was carried out as it was intended (Newcomer, Hatry & Wholey, 2015). They also help stakeholders understand how the implementation of an effort is related to its outcomes and identifies opportunities to replicate successes and address challenges and disappointing outcomes as the effort continues (Rossi, Lipsey, & Freeman, 2004). This portion of the evaluation was guided by the following research questions:

Process Evaluation Research Questions

- Was the effort implemented as intended?
- Who was served and how did each program deliver services?
- How did the project structure and management impact implementation and outcomes?
- What was the nature and role of collaboration?
- What problems were encountered and how were they addressed?

Research Design

In order to address the research questions, the research team used a variety of qualitative and quantitative research approaches in a mixed methods design. Most process evaluations begin by mapping out the specific theory of change and logic model that stakeholders believe guide their efforts. The theory of change and logic model show how the resources and strategies associated with a program or intervention will lead to a sequence of expected outcomes (McLaughlin & Jordan, 1999). The research team worked with HFCM leaders and members of the HFCM working committee to describe the theory of change and create a logic model, which incorporate both the multi-sector community and program level processes. See Figure 2 for brief HFCM Theory of Change. See Appendix A for the full HFCM Theory of Change and Logic Model.

Figure 2. Brief HFCM Theory of Change

Implementation Strategies:

1. Registry
2. Outreach
3. PSH Housing Units
4. Coordinate Moves
5. Housing First Training
6. Community Engagement
7. Leadership & Staffing
8. Evaluation

Housing First Fidelity Criteria:

- Maximize Choice in Housing
- Separate Housing from Service Compliance
- Ensure Voluntary & Person-Centered Services
- Provide a Range of Necessary Services
- Maintain a Program Structure to Support Above

End Chronic Homelessness

Data Collection

In order to answer the research questions and understand if the implementation of HFCM matched its theory of change and logic model, the research team reviewed and gathered existing effort and program-related data, and collected additional data through interviews, observations, and document reviews (Mulroy & Lauber, 2004; Nightingale & Rossman, 2015). The study used HMIS data deposited in the Institute for Social Capital integrated data system for de-identified information about the individuals on the By-Name List to understand the population served by the initiative from the beginning in 2015 through year end 2018. Key stakeholders participated in individual and/or focus group interviews.The research team also observed HFCM steering committee meetings, working committee meetings, subcommittee meetings, and other events sponsored by HFCM. In addition, the team collected HFCM documents and formal communications including meeting minutes and email communications regarding the project. Surveys were conducted with direct service providers, program leaders, and service recipients. Finally, the research team followed up with stakeholders as needed in a member checking process to ask questions and clarify the interpretation of findings. Table 3 summarizes process evaluation data collection methods.

Table 3: Description of Data Collection Methods

Data Collection Method		Number	Timing/Description
	**Administrative Data**	De-identified data on 1660 individuals on the By-Name List from 2015-2018	Data Deposit into the ISC integrated data system (Summer 2019)
	**Interviews**	29 interviews with 33 individuals completed	HFCM and community Leaders (late 2016)
	**Focus Group Interviews**	21 focus groups with 103 people	Training focus groups (late 2015); Service Providers & Working Committees (late 2017); Service Recipients (Summer 2018)
	**Observations**	35 Observations	Throughout the initiative
	**Artifacts**	Project management files, project emails, initial fidelity documents	From initiative development in 2014 through end of data collection in 2018
	**Surveys**	3 surveys conducted with 377 individuals.	Program Directors & Service Providers (Fall 2018); Individuals experiencing chronic homelessness (2016-2018)
	**Member Checking**	Not applicable	As needed and at end of effort to address unclear and ambiguous findings

The research team used purposive sampling from a sampling frame that included the groups described in Table 4. All HFCM stakeholder organizations are listed in Appendix C. The final sample consisted of 155 unduplicated individuals who participated in the individual interviews, focus group interviews, and/or electronic surveys and the 330 individuals from the By-Name List who participated in the Outcomes and Service Utilization Study.

Table 4. HFCM Stakeholder Groups

Individuals Experiencing Chronic Homelessness	Individuals on By-Name List Housed in Housing First PSH Individuals on By-Name List Housed in Other Housing Individuals on By-Name List Not Yet Housed
HFCM Infrastructure	Project Sponsors, Center City Partners Project Managers, Urban Ministry Center Steering Committee Members Working Committee & Subcommittee Members Funders
Housing First PSH Partners	Community Care Partnership Community Link HUD VASH Mecklenburg County Shelter Plus Care Supportive Housing Communities Urban Ministry Center
Service & Planning Partners	Charlotte Housing Authority Charlotte Neighborhood and Business Services Charlotte-Mecklenburg Coordinated Assessment Crisis Assistance Ministry Mecklenburg County Community Support Services Men's Shelter of Charlotte Pathways to Housing National Salvation Army Center of Hope UNC Charlotte, CHHS, Urban Institute/ISC
Community Leadership on Homelessness	Homeless Services Network Housing Advisory Board of Charlotte-Mecklenburg

Characteristics of the participants in interviews and/or focus groups are described in Table 5. Surveys were also conducted to understand frontline service providers and service recipients' experiences of HFCM and related programs and to gather descriptive information about programs. The characteristics of frontline service providers who participated in an electronic survey of their programs and HFCM are described in Table 6. Program related questions were also added to the outcomes survey conducted with individuals experiencing chronic homelessness. The demographic characteristics of the participants are also available in Table 6. Demographic information was not collected from the individuals who completed general program description surveys for their organizations.

Table 5: Interview and Focus Group Demographic Characteristics

		Frontline Service Provider Surveys (n=40)	Service Recipient Surveys (n=330)
Gender	Female Male	26 (65.0%) 14 (35.0%)	84 (25.6%) 244 (74.4%)
Race	Black White Other/Multi	28 (60.0%) 12 (30.0%)	232 (70.3%) 98 (29.7%)
Ethnicity	LatinX	< 5	9 (2.7%)
Age	Median Years 18-49 50+	43 26 (65.0%) 14 (35.0%)	53.3 124 (36.7%) 206 (62.4%)
Highest Level of Education	Bachelors or above	39 (97.5%)	14 (4.2%)
Primary Role	Direct Service Provider Supervisor No Response	28 (70.0%) 9 (22.5%) 3 (7.5%)	——
Organization Tenure	Mean Years	2.7	——
Years Homeless	Mean Min Max	——	8 1 40

Table 6. Survey Participant Characteristics

		HFCM Leaders - Interviews (n=33)	Working Committees (n=9)	Frontline Service Providers* (n=43)	Training (n=35)**	Service Recipients+ (n=24)
Gender	Female	22 (66.7%)	6 (66.7%)	25 (59.5%)	27 (77.1%)	12 (50.0%)
	Male	11 (33.3%)	3 (33.3%)	17 (40.5%)	8 (22.9%)	12 (50.0%)
Race	BIPOC	8 (24.2%)	2 (22.2%)	25 (59.5%)	24 (68.6%)	18 (75.0%)
	White	25 (75.%)	7 (77.8%)	17 (40.5%)	11 (31.4%)	6 (25.0%)
Ethnicity	LatinX	0 (0%)	0 (0%)	6 (14.3%)	3 (8.6%)	< 5
Age	Median	47	45.5	41.5	39.5	52
	18-49	23 (69.7%)	6 (66.6%)	31 (73.8%)	32 (91.4%)	9 (39.1%)
	50+	10 (30.3%)	3 (33.3%)	11 (26.2%)	3 (8.6%)	14 (60.9%)
Highest Level of Education	Bachelors or above	32 (100%)	7 (77.8%)	38 (90.5%)	33 (94.3%)	< 5
	Missing	1	0	0	2	0
Empl Status	Full-Time	29 (87.9%)	7 (77.8%)	39 (92.9%)	32 (91.4%)	——
Org Tenure	Mean Years	9.7	5.3	3.6	2.6	——
Years Homeless	Mean Years	——	——	——	——	11.3
Housed thru HFCM	Number	——	——	——	——	18 (75.0%)
	Mean Yrs					1 year

*Missing one demographic form for frontline service providers . ** Missing 2 responses for education for training focus groups.
+ Missing one respondent for age for service recipients..

Data Analysis

The research team used several techniques to analyze data for the process portion evaluation. The interviews were digitally recorded and transcribed verbatim. In the first phase of qualitative analysis, the data were segmented into units. Units or segments of data were then compared to other segments of data to identify similarities and differences and determine categories and subcategories that describe the data. Atlas-ti qualitative data analysis software was used for unitizing, coding, and analyzing the data. In the second phase of analysis, the research team examined all data sources - interview codes, documents, and observations - for patterns describing the eight implementation strategies and five fidelity criteria that comprise the theory of change. Univariate and bivariate statistics were used to describe the characteristics of people who participated in the study. Differences among groups were determined by t-tests or Chi-Square analyses.

Who Was Served

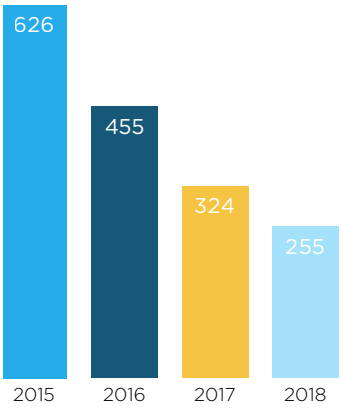
Understanding who was served by the Housing First Charlotte-Mecklenburg (HFCM) effort and if those actually served by the effort were the intended target population were key process evaluation objectives. This section examines the general characteristics of who was served by HFCM between 2015-2018. A sample of these individuals was followed more extensively through the outcomes and service utilization portion of the research project.

Chronic Homelessness. HFCM serves individuals who meet the federal definition of chronic homelessness, a definition that evolved during the course of the evaluation. The federal definition of chronic homelessness prior to the point-in-time count in January 2016 was an individual or head of household that has a disabling condition and has been homeless (sleeping in a shelter, Safe Haven, or place not meant for human habitation) over one year or four or more times in 3 years. The new definition, effective January 15, 2016, added that:

1. the four episodes in three years must total at least 12 months,
2. stays less than 90 days in institutional care (jails, hospitals, psychiatric centers) will count toward time homeless,
3. the time between homeless episodes must be at least 7 days to be considered two separate episodes, and
4. the procedures to verify homelessness align with use of Homeless Management Information Systems (HMIS) and don't require documentation of each day homeless (24 CFR § 578.3).

Individuals experiencing chronic homelessness are a small portion of the overall homeless population. The initial research that identified chronic homelessness as a subgroup of the general homeless population found that this small part of the single adult homeless population used a disproportionate amount of shelter resources in part because they were not eligible for other services in the homeless continuum-of-care (Kuhn & Culhane, 1998). They thus cycled in and out of emergency shelter more than most homeless individuals who were typically homeless only once and for a shorter period of time. These individuals were more likely to have a disability, often mental health and substance use disorders, and other continuum programs typically required a period of sobriety, continued abstinence, and compliance with psychiatric medication regimens before they were eligible for programs beyond emergency shelter. The housing first permanent supportive housing (HF PSH) intervention was developed around the same time to serve individuals experiencing chronic homelessness. The low barrier nature of HF PSH addressed the barriers of the traditional continuum-of-care and research demonstrated that it more effectively ended homelessness than traditional continuum services (e.g., Padgett, Henwood, Tsemberis, 2016). The effort to address and end chronic homelessness in the 2000s was a response to the lack of continuum services for the population, the resulting disproportionate use of emergency shelter, and the emergence of an evidence-based intervention that effectively addressed the problem.

Figure 3. Number of People Added to the By-Name List by Year, 2015-2018 (N=1660)



The By-Name List. Formerly called the Chronic Homeless Registry, the initial By-Name List was developed during the point-in-time count in January 2015. The list was developed to identify and monitor the number of individuals experiencing chronic homelessness who still need permanent housing in Charlotte-Mecklenburg. Its development and use are discussed more extensively in the implementation strategies portion of this report. The following description of individuals served by HFCM is derived from the By-Name List integrated with HMIS data, and includes a description of individuals who are or have been on the active By-Name List (housed and unhoused) between its creation in January 2015 through December 2018, the study period. Between 2015 and 2018, 1660 individuals were added to the By-Name List. The majority of individuals (38%, n=626) were added to the list the first year of HFCM, with subsequently smaller numbers in the three years following the list's development. In 2018, 255 individuals were added to the By-Name List, only 15% of those added to the list during the study period. Figure 3 describes the number of individuals added to the By-Name List by year from 2015 to 2018 (See Table 1 in Appendix D for the related data table). Note: In 2019, the method of counting the By-Name List was changed resulting in a large increase in the number of people on it.

By-Name list Demographic Characteristics. The majority of individuals on the By-Name List and eligible for housing through HFCM during the study period were Men (75%, n=1250), Black and Indigenous People/Persons of Color (BIPOC) 73%, (n=1205), Non-LatinX (98%, n=1616), and between the ages of 51-64 (46%, n=757). Approximately 10% (n=167) of individuals on the By-Name List during the study period were veterans, who were also eligible for housing through the Continuum-of-Care and Veteran's Administration's Housing our Heroes initiative. Figure 4 below describes the demographics of individuals on the By-Name List between 2015-2018. Sample sizes differ because of missing values (See Table 2 in Appendix D for the related data table).

Figure 4. Demographic Characteristics of Individuals on the By-Name List, 2015-2018 (N=1660)

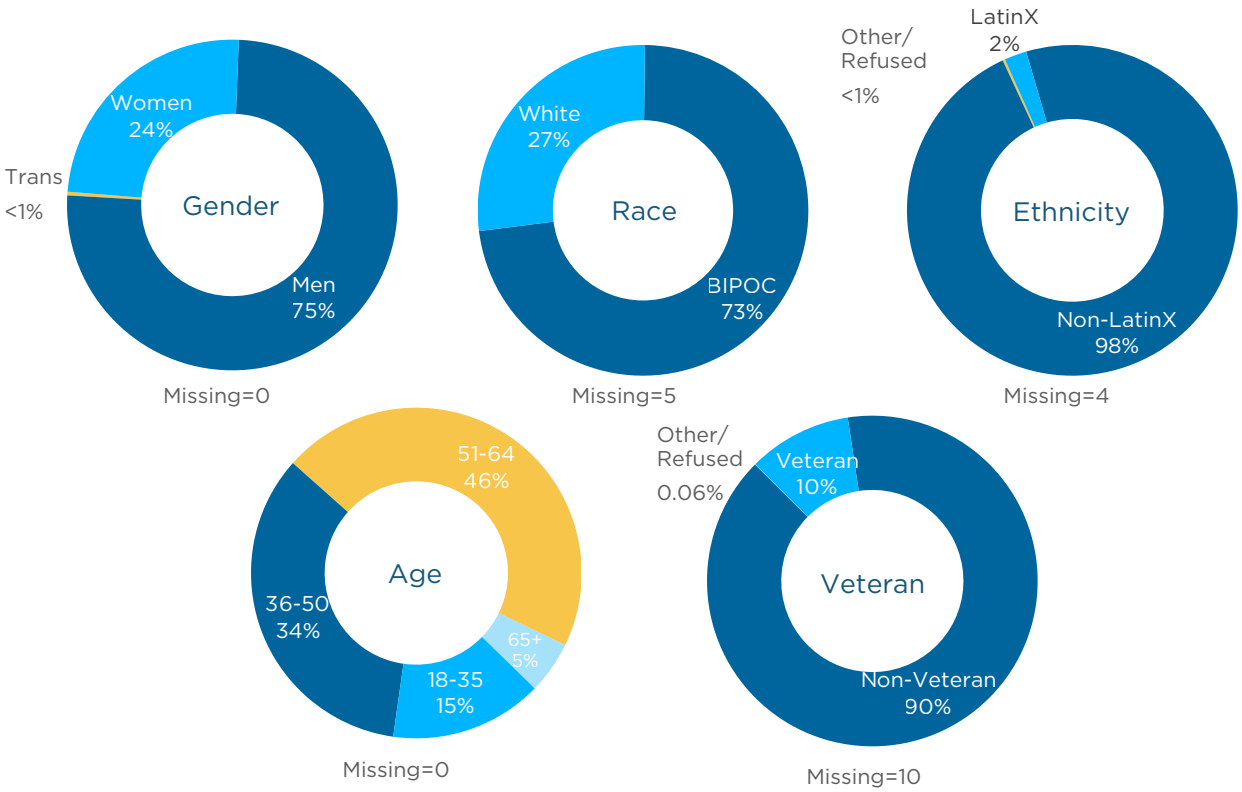
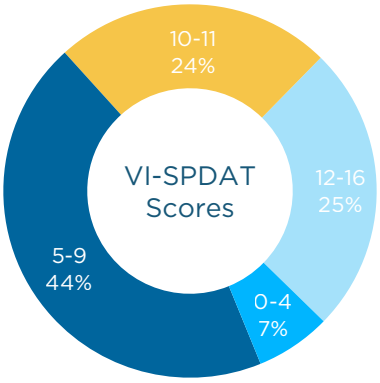


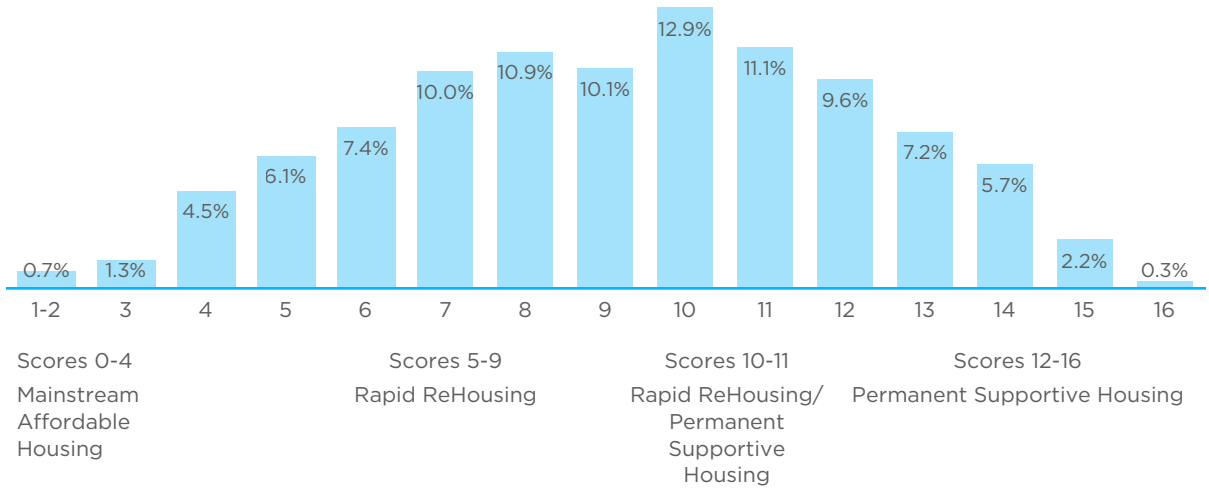
Figure 5. Percentage of Initial VI-SPDAT Scores by Scoring Range, 2015-2018 (N=1563)



VI-SPDAT scores. The Vulnerability Index - Service Prioritization and Decision Assistance Tool (VI-SPDAT) was introduced by HFCM to assist in the prioritization of individuals on the By-Name List for permanent housing. Higher scores were prioritized for housing. According to instrument developers, higher scores suggest greater vulnerability and a triage system for housing options for single adults: Individuals scoring 0-4 should be directed to mainstream affordable housing, individuals scoring 5-9 should be prioritized for rapid rehousing, and those scoring 10 and over should be prioritized for permanent supportive housing (OrgCode, n,.d.). As inflow into chronic homelessness increased but access to affordable housing decreased, the combined HFCM data and 250 unit committee considered various cut-points to prioritize housing, and recognized that individuals scoring 10-11 may or may not need permanent supportive housing, but scores under 10 would not likely be housed because of the lack of available housing. A number of direct service providers were concerned that the VI-SPDAT wasn't accurately measuring the vulnerability they observed, leading to a vulnerability review process and potentially multiple VI-SPDAT administrations. Approximately 26% of the individuals on the By-Name List between 2015 and 2018 had more than one VI-SPDAT score. For consistency, the initial scores are reported here. Concerns about the validity of the VI-SPDAT are discussed in other sections of the report.

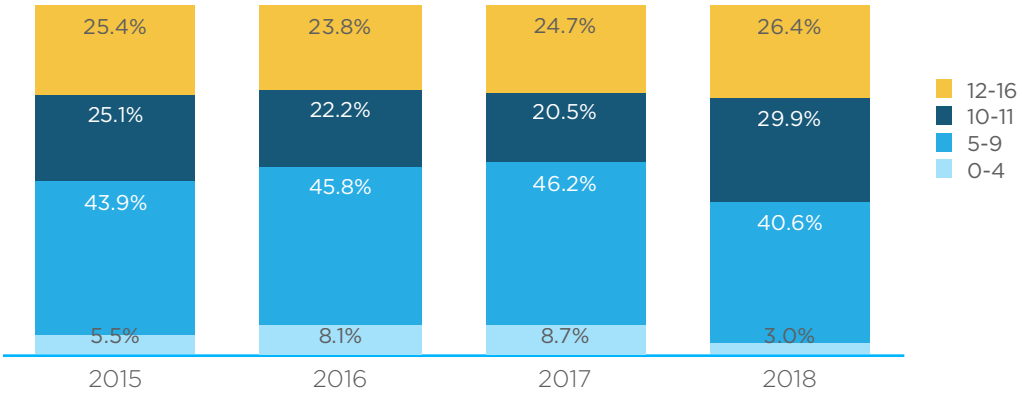
Among those who had VI-SPDAT scores in HMIS (n=1563), 25% (n=390) scored 12-16 on the VI-SPDAT, 24% (n=376) scored 10-11, and 51% (n=797) scored under 10 on the VI-SPDAT. Figure 5 above describes the percentage of individuals in VI-SPDAT scoring ranges and Figure 6 below describes the distribution of all VI-SPDAT scores (See Tables 3 and 4 in Appendix D for the related data tables, respectively). Note: VI-SPDAT scores were missing for 97 individuals.

Figure 6. Distribution of Initial VI-SPDAT Scores, 2015-2018 (N=1563; Missing=97)



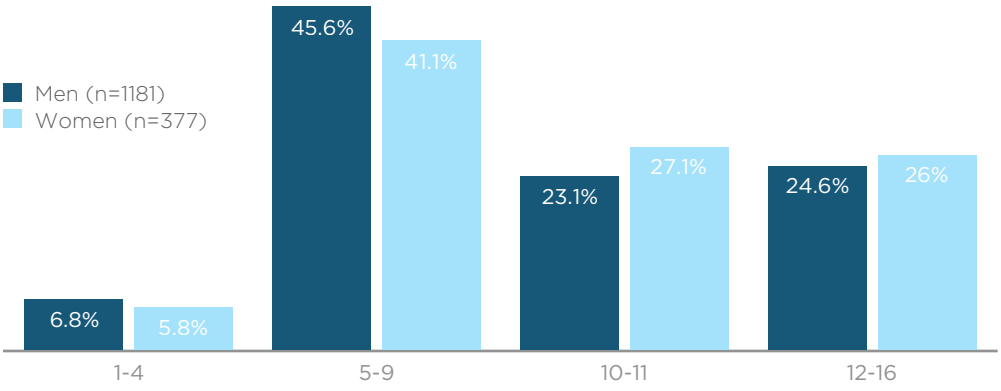
VI-SPDAT Scores by Year Added to By-Name List. The majority of individuals were added to the By-Name List in its first year and the number added went down each subsequent year during the study. The VI-SPDAT score ranges of those added to the By-Name List remained similar each year. The majority of individuals added to the list each year scored in the 5-9 range. Approximately half of individuals added to the By-Name List each year scored under 10 on the VI-SPDAT, suggesting they were low priority for housing. Roughly a quarter of individuals added to the By-Name List each year scored in the 12-16 range. Figure 7 below describes the percentage of VISPDAT scores by scoring ranges and year added from 2015 to 2018 (See Table 5 in Appendix D for the related data table). Note: The method for creating the By-Name List was modified in October 2019 resulting in larger numbers of individuals on the list.

Figure 7. VI-SPDAT Score Ranges by Year Added to By-Name List, 2015-2018 (n=1563, missing=97)



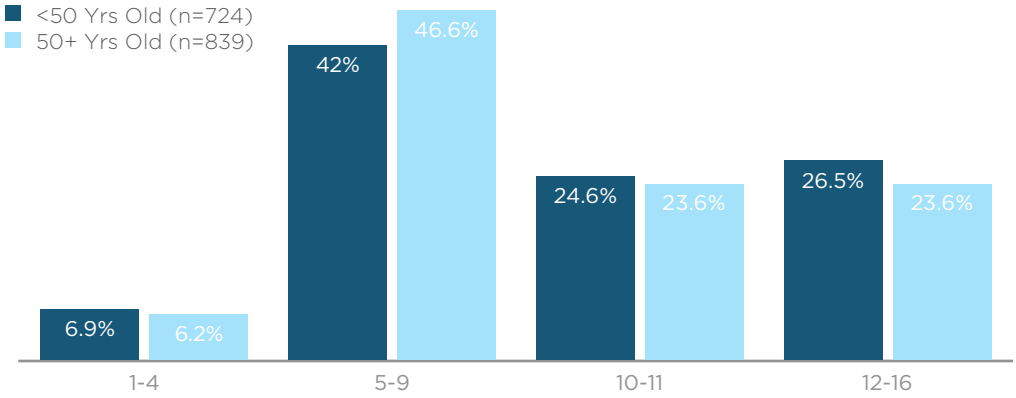
VI-SPDAT Scores by Gender. The distribution of VI-SPDAT scores was similar between men and women. The majority of each group scored in the 5-9 range (Men-46%, n=538; Women-41%, n=155). Roughly a quarter of each group scored in the 12-16 range (Men-25%, n=290); Women-26%, n=98), which were priority scores for housing. The average VI-SPDAT scores of men (M=9.2, SD=3.03) and women (M=9.4, SD=2.92) were not statistically different (p=0.1936). Figure 8 below describes the percentage of initial VI-SPDAT scores by scoring ranges and gender from 2015 to 2018 (See Table 6 in Appendix D for the related data table).

Figure 8. Percentage of Initial VI-SPDAT Scores 2015-2018 by Gender (n=1588, missing=102)



VI-SPDAT Scores by Age. The distribution of VI-SPDAT scores was similar between individuals under the age of 50 and those who were 50 and older. The majority of each group scored in the 5-9 range (<50-42%, n=304; 50+-47%, n=391). Roughly a quarter of each group scored in the 12-16 range (<50-27%, n=192; 50+-24%, n=198), which were priority scores for housing. The average VI-SPDAT scores of individuals under 50 years of age (M=9.3, SD=3.06) and those 50 and older (M=9.1, SD=2.96) were not statistically different (p=0.2285). Figure 9 below describes the percentage of initial VI-SPDAT scores by scoring ranges and age from 2015 to 2018 (See Table 7 in Appendix D for the related data table).

Figure 9. Percentage of Initial VI-SPDAT Scores 2015-2018 by Age (n=1563, missing=97)



VI-SPDAT Scores by Race. The distribution of initial VI-SPDAT scores by race demonstrates a different pattern than the distribution by gender and age. Note that 98% of individuals in the BIPOC category identify as Black or African-American. The majority of BIPOC individuals scored in the 5-9 range (48%, n=536). However, about equal proportions of White individuals scored in the 5-9 range (36%, n=156) and the 12-16 range (36%, n=158), while only 21% (n=231) of BIPOC individuals scored in the 12-16 range, which is the priority range for housing. Further, only 45% (n=502) of BIPOC individuals scored in the general range to be considered for permanent supportive housing, while 60% (n=263) of White individuals scored in the PSH range. The majority of BIPOC individuals scored under 10 (55%), while the majority of White individuals scored 10 or over (60%). BIPOC individuals scored an average of 1.1 points lower on the VI-SPDAT than White individuals and the scores were statistically different (M=8.9, SD=2.94; M=10.0, SD=3.03; p<.0001) suggesting, on average, a lower priority score for housing. Figure 10 describes the percentage of BIPOC and White individuals in VI-SPDAT scoring ranges in their first administration of the assessment, and Figure 11 presents the distribution of all VI-SPDAT scores by racial group (See Tables 8 and 9 in Appendix D for the related data tables, respectively).

Figure 10. Percentage of Initial VI-SPDAT Scores 2015-2018 by Race (n=1559, missing=101)

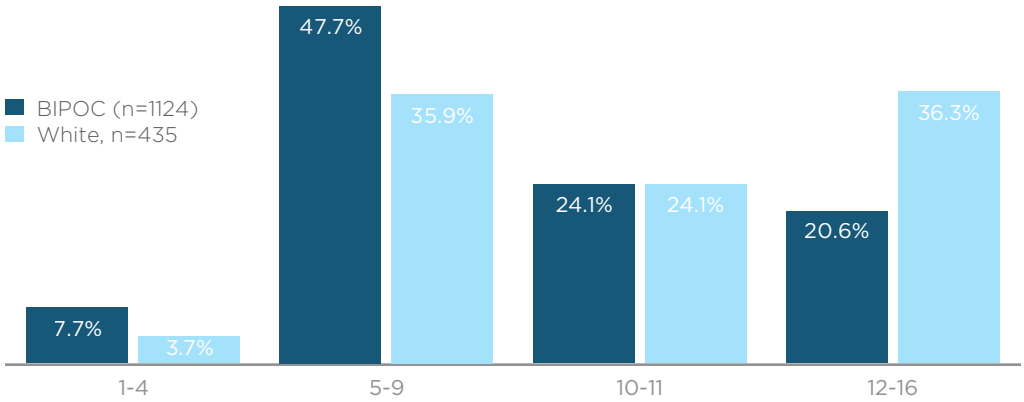
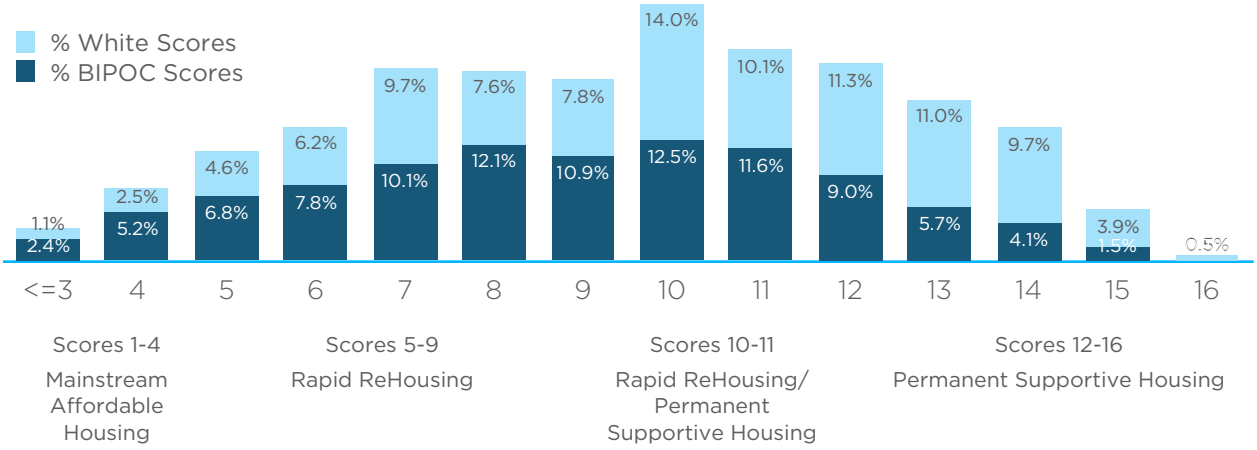


Figure 11. Frequencies of Initial VI-SPDAT Scores 2015-2018 by Race (n=1559, missing=101)



Housed Individuals. As of December 31, 2018, HMIS recorded that 769 individuals experiencing chronic homelessness had been housed from the By-Name List. A quarter (n=195) of the individuals housed by HFCM were housed in the first year of the effort and 32% (n=242) of individuals housed were housed in 2016. Individuals were housed in permanent supportive housing (PSH), rapid re-housing (RRH), permanent placements with family or friends, and other housing placements. Other placements included rental by client with no ongoing subsidy or with a subsidy but without supportive services; ownership by client, with or without subsidy; and, permanent placements in long-term care. Each year, the majority of individuals were housed in PSH and smallest percentage of individuals were housed in RRH. Figure 12 describes the percentage of individuals from the By-Name List housed by year housed from 2015 to 2018, and Figure 13 presents the percentage of individuals from the By-Name List housed by housing type from 2015 to 2018 (See Tables 10 and 11 in Appendix D for the related data tables, respectively).

Figure 12. Percentage of Housed Individuals From By-Name List by Year Housed, 2015-2018 (n=769)

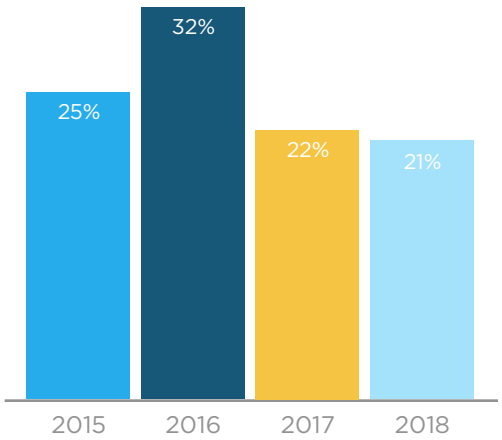
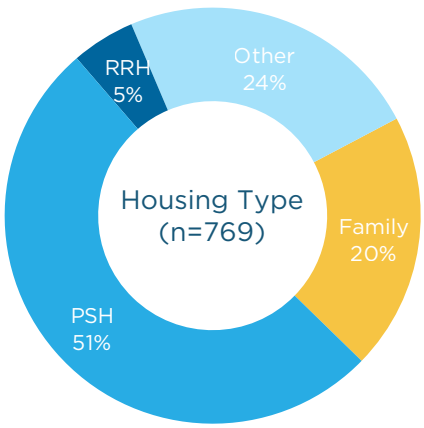


Figure 13. Percentage of Individuals From By-Name List Housed by Housing Type, 2015-2018 (n=769)



Characteristics of Housed and Unhoused Individuals. Housed individuals were similar to unhoused individuals in terms of race, ethnicity, and age, with similar percentages of people from each group represented among those housed and unhoused. However, more women were represented among the housed than they were among the unhoused. And a greater percentage of individuals with higher VI-SPDAT scores were housed than unhoused. Both are likely indicators of prioritization. Figure 14 describes the percentage of individuals from the By-Name List housed by housing placement type and year housed from 2015 to 2018, and Figure 15 presents demographic characteristics of housed and unhoused individuals on the By-Name List from 2015 to 2018 (See Tables 12 and 13 Appendix D for the related data tables, respectively).

Figure 14. Percent of Housing Placement Type by Year, 2015-2018 (n=769)

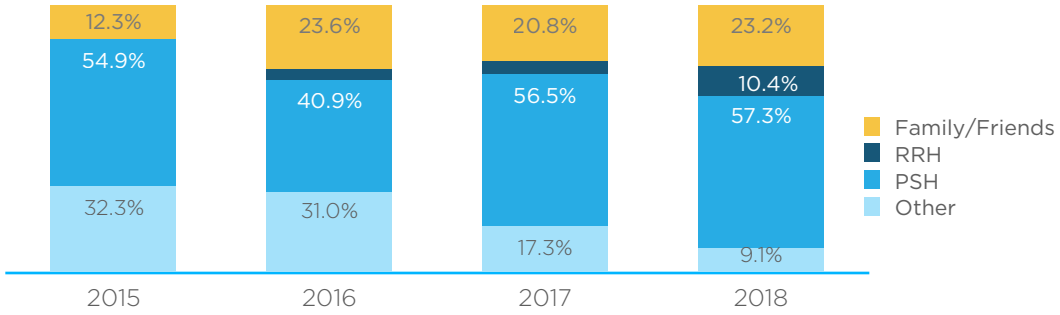
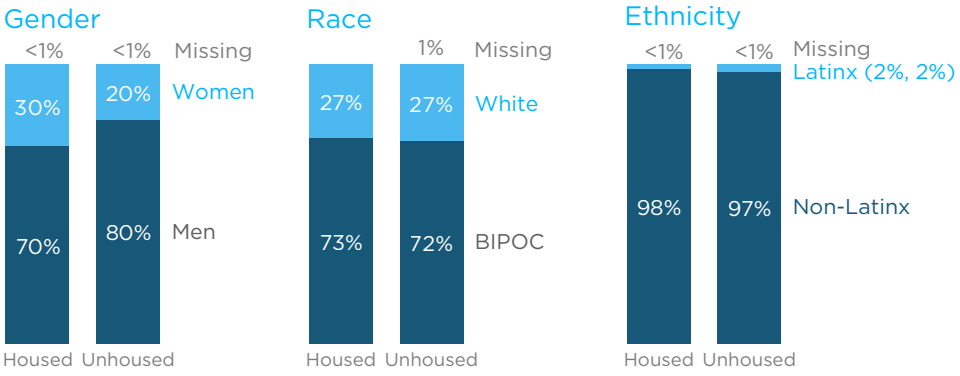
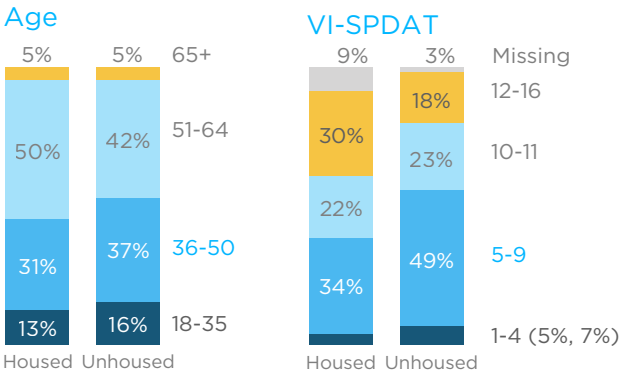


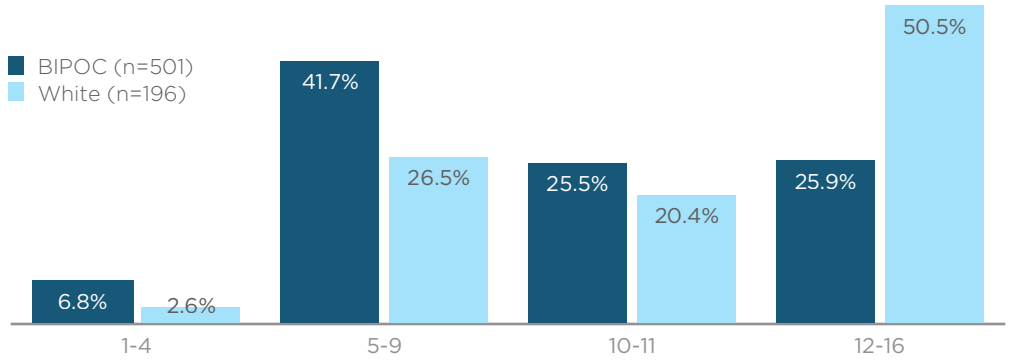
Figure 15. Demographic Characteristics of Housed (n=769) and Unhoused (n=891) Individuals on the by-Name List, 2015-2018





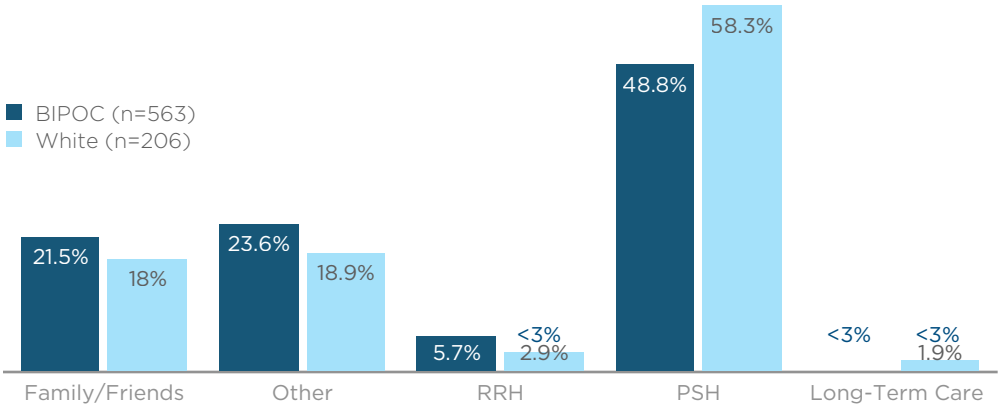
Race and Housing Placements. Like the VI-SPDAT scores for all individuals on the By-Name List between 2015-2018, scores for individuals who were housed reflect a similar disproportionate pattern. The largest group of Black, Indigenous People/Persons of Color score in the 5-9 range on the VI-SPDAT (42%, n=209), while the largest group of White individuals score in the 12-16 range (51%, n=99). White individuals scored in the 12-16 range at twice the rate of BIPOC individuals, meaning they scored in the range more likely to receive permanent supportive housing, which includes a permanent housing subsidy and wrap around supportive services. BIPOC individuals were over approximately two times more likely (OR=1.97) to score in the 1-9 range (95% CI [1.581-2.453]), meaning they scored in the range unlikely to receive a housing subsidy either through rapid rehousing or permanent supportive housing. Average scores reflect the pattern, BIPOC individuals scored an average of 1.6 points lower on the VI-SPDAT than White individuals and the scores were statistically different (M=9.3, SD=3.03; M=10.9, SD=3.00; p<.0001). Figure 16 describes the percentage of housed BIPOC and White individuals in VI-SPDAT scoring ranges in their first administration of the assessment (See Table 14 in Appendix D for the related data table).

Figure 16. Percentage of Initial VI-SPDAT Scores of Housed Individuals by Race (n=697, missing=72)



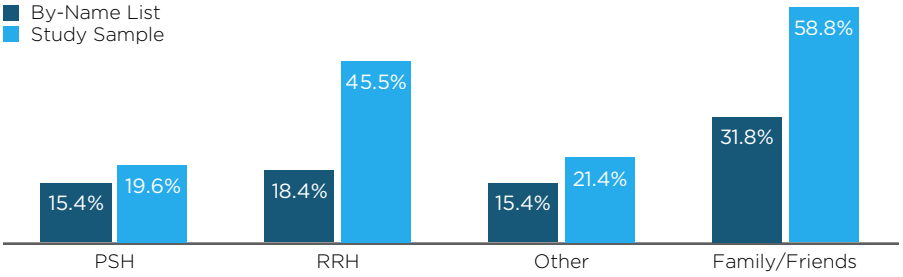
Actual housing placements suggest a less pronounced difference between housing placements for White and BIPOC individuals than one would expect by VI-SPDAT scores alone. Despite the majority of BIPOC individuals scoring in the 5-9 range, the largest group of BIPOC were housed in permanent supportive housing (49%, n=275). The percentage of BIPOC individuals who were housed in the PSH was less, however, than White individuals housed in PSH (58%, n=120), and the difference was statistically significant (X^2=5.34, p<.05). Figure 17 describes the percentage of housed BIPOC and White individuals by housing placement (See Table 15 in Appendix D for the related data table).

Figure 17. Percentage of Race by Housing Placement (BIPOC, n=563; White, n=206)



Returns to Shelter. While specific intervention outcomes are reported in the final outcomes and utilization report, one indicator of the successful implementation of the project is the percent of those housed through the effort that did not return to emergency shelter after they were housed. Returns to emergency shelter were relatively low among all housed groups and lowest among individuals housed in PSH and in other housing placements. Returns to shelter were highest among individuals who were placed with family or friends, nearly 32% of whom touched the shelter after their housing date but before the end of 2018. The pattern of returns is similar to the pattern the research team observed in the outcomes and utilization study, however, while the pattern is similar, the rate of return is greater in the outcomes study, particularly for those placed with family and friends. The research team was able to complete a far more thorough review of housing trajectories for the study sample in the outcomes report. The pattern persists in both analyses, however. Returns to shelter are lowest among those placed in PSH and highest among those placed with family or friends. Figure 18 describes rates of return to shelter by housing type for those housed from the By-Name List between 2015-2018 compared to those in the outcomes study sample who had negative housing exits (returned to shelter, street, jail, hotel, etc.) (See Table 16 in Appendix D for the related data table).

Figure 18. Rates of Return to Shelter by Housing Type (n=769) Compared to Negative Exits in Outcomes Study (n=165)



Summary

Serving Individuals Experiencing Chronic Homelessness

Data from the By-Name List in the Homeless Management Information System (HMIS) suggests that HFCM served individuals experiencing chronic homelessness as intended. Further, the VI-SPDAT scores of individuals served during the study period (2015-2018) show that a greater percentage of higher scoring individuals were housed than those who scored lower on the instrument. This suggests that housing was prioritized for those who were considered most vulnerable by the instrument.

Housing Destinations

Of those housed during the study period, the majority (51%, n=395) were housed in housing first permanent supportive housing (HF PSH) provided by six different homeless service providers. HF PSH programs had the lowest returns to emergency shelter alongside those in the "other housing" category. The low rates of return to emergency shelter are congruent with extensive research that finds that HF PSH effectively ends homelessness and the use of emergency shelter for most individuals experiencing chronic homelessness (e.g., Tsemberis, Kent, & Respress, 2012). While this project only documented returns to shelter for a year, evidence suggests high housing retention rates over time for individuals housed in HF PSH.

Nearly a quarter (23.7%, n=182) of those housed were housed in "other housing," which included individuals who owned their home (2%), individuals who found their own housing on the rental market without a subsidy (39%), individuals who found housing on the rental market with a subsidy but with no supportive services (55%), and those who were placed in long-term care (3%). Other housing was the second largest housing category. Further research is needed to understand the long-term effectiveness and implications of housing in these categories, particularly among those who found housing on the rental market and sustained it without the wrap around services of HF PSH.

Only 5% (n=38) of individuals on the By-Name List were placed in rapid re-housing according to HMIS data, but just 18.4% (n=8) of them returned to shelter. The rate of return for the outcomes sample, which more extensively examined housing trajectories, was more than double this figure (45.5%, n=13). RRH was initially tried during the early part of HFCM with individuals with high VI-SPDAT scores with the understanding that if they did not succeed in RRH with limited supportive services, they could be moved into PSH. According to observation notes, the majority of high scoring individuals were moved to PSH. Later in the effort, RRH was used for individuals who scored lower on the VI-SPDAT. Since few individuals placed in RRH participated in the outcomes portion of the study, additional research is needed to examine the ongoing effectiveness of RRH for individuals experiencing chronic homelessness.

Permanent placements with family or friends had the most returns to shelter among those housed from the By-Name List between 2015 and 2018 (31.8%, n=49). In the outcomes portion of the study, where the housing trajectories were examined in more detail, the recidivism rate of those placed with family or friends was almost double (58.8%, n=18). As noted in the outcomes and utilization report, further study of this placement type is warranted as is testing innovations that may increase its effectiveness. For example, would a permanent placement with family or friends work better if the households were provided economic (i.e., a shallow rent subsidy) and case management support?

Race, the VI-SPDAT, & Housing Placements

White individuals score higher on average than Black individuals on the VI-SPDAT (M=10.0, SD=3.03; M=8.9, SD=2.94; respectively) suggesting that White individuals receive, on average, higher prioritization scores for housing, particularly in the range for HF PSH. These findings are similar to a recent study of three continuum-of-care communities in the Pacific Northwest that found that Whites scored higher than Black and Indigenous People/ Persons of Color (BIPOC) on the VI-SPDAT (M=9.19, SD=3.87; M=8.71, SD=3.90; respectively) (Wilkey, Donegan, Yampolskaya, & Cannon, 2019). The study further found that VI-SPDAT sub-scale scores are also predicted by race, with 8 out of 11 sub-scales predicting higher scores for White individuals including sub-scales measuring if a person sleeps more frequently outdoors, if they are unable to take care of basic needs, if their current homelessness is caused by social relationships, and if they have more issues with substance use that caused their homelessness or prevent them from leaving it (Wilkey et al., 2019). At least among single individuals experiencing homelessness, the study suggests that White individuals are more likely to experience key vulnerabilities that drive the VI-SPDAT score higher and into a range to prioritize permanent supportive housing and that the instrument doesn't accurately

assess the vulnerability factors of BIPOC individuals. Given the more pronounced difference among the average scores of White and BIPOC individuals on the By-Name List in Charlotte-Mecklenburg, the concerns voiced by Wilkey and colleagues should also be considered here.

HFCM placed White and BIPOC individuals in housing at rates proportionate to their rates of chronic homelessness. Approximately 72% of individuals experiencing chronic homelessness between 2015-2018 were BIPOC and approximately 73% of individuals housed through HFCM between 2015-2018 were BIPOC. However, housing placements of racial groups show that a greater percentage of White individuals were housed in PSH than were BIPOC individuals, an outcome likely related to the VI-SPDAT. Had the homeless services sector only relied on the VI-SPDAT for housing placement decisions, the outcome would have been more disproportionate. Other mechanisms like the vulnerability review that allowed direct service providers to make a case for higher prioritization of an individual outside of the VI-SPDAT may have served an important racial equity function, and in this case may have prevented further disproportionate housing outcomes. The use of the VI-SPDAT as the primary prioritization tool for individuals experiencing chronic homelessness in Charlotte-Mecklenburg should be examined. As Wilkey and colleagues (2019) note, communities need a prioritization tool that is sensitive to the vulnerabilities that may vary by race and ethnicity.

Inflow

When HFCM mobilized over 250 volunteers to conduct an extended point-in-time count in January 2015, stakeholders assumed that the 516 individuals added to the chronic homeless registry represented a realistic estimate of the number of individuals experiencing chronic homelessness in Charlotte. After all, the number was over three times that of the annual point-in-time count. As the community incorporated the By-Name List as a new method of understanding the scope of chronic homelessness, what became clear was the number of people added to the list on a monthly basis was much higher than anticipated. By the end of 2015, many other communities that were a part of the Built for Zero network were discovering similar patterns - inflows of people threatened to erase any forward progress in ending chronic homelessness (Community Solutions, 2018).

While in many ways this surprised advocates, it also demonstrated the importance of the new tool to understand the scope of the issue. As one community stakeholder noted, “I think that we are now on the cusp of having a better understanding of this inflow, outflow, there's all these new aspects. We didn't, 15 years ago, 20 years ago when we started some of this stuff, we didn't have all of these things or all of these tools or methods that we have now and I think that I have a better understanding of where we're at and how you can see that you can reach a goal.” And importantly, it also pointed to the way chronic homelessness was connected to the larger issue of single adult homelessness and the concern that folks were “aging-in” (A-28:29). One community stakeholder noted this issue when asked what concerned them about HFCM, “…the initiative has been so laser focused on the chronically homeless that it has failed to take stock of those who are at risk for chronic homelessness and are aging in – that’s actually a community issue, not even a HFCM issue” (A-30:18).

Inflows into chronic homelessness primarily are defined as people who are newly identified and aging into chronic homelessness and those who are returning to homelessness from housing. The majority of individuals are aging in, meaning that they have been homeless long enough to meet the time requirement in the federal definition of chronic homelessness (at least one continuous year or 4 or more times in a 3 year period that equal at least 12 months). Most of these individuals come from the ranks of single adult homelessness for which there are few permanent housing options. Until recently, single homeless adults had few supportive services beyond emergency shelter despite the fact that they comprise 67% (n=2,137) of the homeless population in Mecklenburg County (Anderson, 2020) and 70% nationally (Henry et al., 2020). In Charlotte-Mecklenburg, the lack of solutions disproportionately impacts Black men. In many ways, it is not surprising that without permanent solutions, some of these individuals are becoming chronically homeless.

The effort to end veteran homelessness may provide an important cue for ending chronic homelessness, particularly as it relates to inflow. Recent research describes the effectiveness of HF PSH in reducing both veteran and chronic homelessness (Evans, Kroeger, Palmer, & Pohl, 2019; Byrne, Fargo, Montgomery, Munley, & Culhane, 2014). However, the impact of the HUD Veterans Affairs Supportive Housing (HUD-VASH) program is more pronounced. For every one HUD-VASH voucher, veteran homelessness decreased by 1 person. By increasing the availability of HUD-VASH vouchers, the program prevented the increase of nearly 90,000 homeless veterans (Evans et al., 2019). The provision of PSH units was associated with a decrease in chronic homelessness, but slower than the rate that PSH is provided (Byrne et al., 2014). As Batko (2020) notes, this slower rate may be explained by the inconsistent quality of housing first programs and the lack of effective prioritization for HF PSH. But primarily she notes that the slower

rate is a problem of inflow and a lack of interventions to prevent chronic homelessness, interventions that veterans have access to. Specifically, in addition to HUD-VASH (PSH) for chronically homeless veterans, veterans have access to the Supportive Services for Veteran Families (SSVF) program which provides RRH and other preventive and supportive services to homeless veterans *before* they become chronically homeless. SSVF effectively reduces the inflow of veterans into chronic homelessness.

During the study period, Charlotte-Mecklenburg had few interventions to address the "aging" of individuals into chronic homelessness. In 2019 however, Mecklenburg County invested over $8 million in two programs to address the housing shortage for households earning less than 30% of area median income ($16,600 year for a single adult) including rapid re-housing subsidies and bridge housing for individuals likely to age into chronic homelessness. The deployment of interventions further upstream with individuals experiencing non-chronic homeless could reduce inflow, particularly single adults who comprise the largest segment of the homeless population. As one housed participant stated, "This ministry was walking up and down the street handing out blankets and gloves when it got cold these last few months. To me, all the things that has been done to help homelessness is really good, but I think if people could put more focus on addressing it before it becomes chronic that would be better" (E-903:7).

It is also important to note, however, that going too far upstream will likely not impact single adult and chronic homelessness (Culhane, Metraux, & Byrne, 2011). Although the monthly math to pay for housing and other life necessities may be a continuous and often impossible challenge, the vast majority of the 32,000 households earning 30% or less of the area median income will *not* become homeless. If housing resources to prevent homelessness are directed generally to households in this larger category, the resources will meet a pressing need, but will likely not prevent actual homelessness since few of those households would become homeless otherwise. Resources to prevent homelessness must be more focused to be effective (e.g., Culhane et al., 2011; Gaetz & Dej, 2017).

Despite the concern about inflow, the number of individuals added to the By-Name List decreased in the years following the launch of HFCM until the end of 2019. While the numbers on the By-Name List indicate that there is still work to be done, it also indicates that HFCM was working during the study period and resulted in meaningful reductions in chronic homelessness.

Implementation Strategies

The HFCM implementation strategies were drafted by the project managers and sponsors, Urban Ministry Center and Charlotte Center City Partners (CCCP), respectively. The strategies were then presented to the steering committee for discussion and revision. Leaders among homeless services and other community stakeholders were recruited for each of the strategies and an initial subcommittee was formed to guide implementation of the strategy. The leaders of each of these strategies formed the working committee, along with other key stakeholders. This section provides the original strategy language (in blue boxes), describes implementation of each strategy, describes themes that emerged about the strategy across data sources, and provides a brief description of the current status of the strategy work.

Original Strategy

Strategy 1: Create and Maintain Chronically Homeless Registry

Following the best practices of other communities, Charlotte would create a "registry" of all individuals experiencing chronic homelessness. This registry would be the key in monitoring the progress made towards ending chronic homelessness. Building upon the success of the Vulnerability Index, completed in 2010, we would mobilize Outreach staff and volunteers to canvas the community for one week in January, 2015, identifying chronically homeless individuals. These individuals would be assessed through the **coordinated intake process** in order to be placed in the **queue for Permanent Supportive Housing units**. Project Management staff and UNCC's Urban Institute would be responsible for managing the registry, adding individuals as they are identified and tracking housing placements.

Budget: $10,000 ($2,500 to create registry & $7,500 for maintenance)
Timeline: Complete by February 2015
Staffing: Project Management Staff and Contract with UNCC's Urban Institute

Registry

Strategy Implementation

Developing and maintaining the chronic homeless registry, now called the By-Name List, was a central and early organizing strategy of the HFCM effort and widely considered a key success of the effort. The goal of the By-Name List was to identify every individual in Charlotte-Mecklenburg experiencing chronic homelessness in order to understand the overall need for housing, assist in prioritization of who should receive housing, and monitor the progress the effort made in achieving the goal of ending homelessness. Initial funding for the By-Name List was provided by Bank of America. Initially, organizational leadership for this strategy was provided by project co-manager, Liz Clasen-Kelly and Pamela Jefsen, Executive Director of Supportive Housing Communities. It included a contract with the UNC Charlotte Urban Institute for reporting monthly By-Name List trends and monitoring housing progress. The data subcommittee met monthly to monitor and discuss data trends related to the By-Name List until September 2016 when the subcommittee alternated meeting months with the 250 PSH Units subcommittee. Eventually, Mecklenburg County Community Support Services assumed responsibility for maintaining and monitoring the By-Name List.

The creation of the chronic homelessness registry was a recommended practice of Built for Zero, an initiative of Community Solutions, a technical assistance organization that focuses on homelessness and housing solutions in the United States and Canada. Built for Zero describes the By-Name List as the "gospel tenet" of their work and is the "essential compass every community needs in order to make decisions at the speed of homelessness" (Community Solutions, 2018, p.9). As of May 2019, By-Name Lists are now used in more than 70 communities across the country (Community Solutions, n.d.)

The initial By-Name List in Charlotte-Mecklenburg was developed in January 2015 as a part of an extended annual point-in-time count of community homelessness. Approximately 250 volunteers joined homeless service providers in a three day count and initial assessment of individuals experiencing chronic homelessness. The count identified an initial list of 516 individuals, exceeding the 169 reported to HUD using the PIT methodology, which only included the individuals identified in one day. The larger number was considered a more accurate assessment of chronic homelessness and became the starting number for the HFCM effort. While some stakeholders believed the By-Name List total to be more finite, the monitoring process proved it a more fluid and an approximate benchmark. Monthly monitoring reports and related meetings soon identified a troubling trend - the housing gains were often matched or exceeded by individuals entering chronic homelessness. By July of 2017, the steering committee recognized that HFCM had "failed to look behind us…at who was at risk for becoming chronically homeless" (K-12).

By mid 2016, the topic of By-Name List inflow and outflow was a primary focus of the working committee and the data subcommittee meetings and the trends convinced effort leaders and committee members that the timeline to end chronic homelessness needed to be extended through 2017. The steady inflows were also evident to frontline workers and service recipients as well, and reported to researchers as a key concern about the effort. Eventually, the By-Name List trends suggested to HFCM leaders that the effort to end chronic homelessness was a longer term objective. In 2017, the data subcommittee and PSH subcommittee merged and turned their joint focus to understand the By-Name List numbers and to address the inflows (D-02:05).

Strategy Findings

Modified Service Sector. Several service sector processes were developed or refined throughout the HFCM effort to ensure effective implementation of the By-Name List. A cleaning process was developed to ensure list accuracy. Initially, project co-manager Liz Clasen-Kelly and the Urban Ministry Center Outreach team led the cleaning process that included multiple steps to locate individuals on the By-Name List and confirm their homeless status (A-09:16). The process was then managed by Outreach at Urban Ministry Center in partnership with Mecklenburg County Community Support Services. Subsequently, the cleaning process evolved into a monthly case conferencing meeting, which reviewed the entire By-Name List. The By-Name List was eventually integrated into the homeless management information system (HMIS) and became a part of County HMIS staff responsibilities.

Through the HFCM effort, the Coordinated Entry process that began in 2014 was modified to include the VI-SPDAT (Vulnerability Index-Service Prioritization and Decision Assistance Tool) as an objective prioritization tool for families and chronically homeless individuals going through the Coordinated Entry process. Feedback from the data committee and guidance from Community Solutions led to VI-SPDAT administration only to individuals who meet the

federal definition of chronic homelessness and only after an initial period to ensure accuracy as some individuals may self-resolve and not require initial placement on the By-Name List. As one service provider stated, "I just feel like that doing it right off the bat is not really going to get you the best answers…" (B-10:127). As one coordinated assessor noted, the community is "…making good strides on making it good quality data" (B-08:31). These By-Name List-related modifications shaped ongoing homeless services processes and practices.

LImited Initial Access. The By-Name List was created separately from HMIS at the beginning of the effort because of limited data sharing within the HMIS system. To ensure privacy and data security, initial access of the By-Name List was limited to project management and those charged with cleaning the list. During focus group interviews, however, several providers mentioned the difficulty sharing and viewing By-Name List-related data (I-07). For example, one provider defined By-Name List access as "a major challenge in just making sure that you're keeping up the data and keeping it accurate" (D-01:42). Frontline workers then explained that "it's not as efficient as necessarily it could be" and suggested making it "something that everyone has access to" (D-01:42). Since initial implementation, the By-Name List has been more integrated into the ongoing operation of HMIS, which has since created additional capacity to share data between partnering organizations. The HMIS administrator works closely with COC By-Name List point persons to ensure list accuracy.

Concerns about the VI-SPDAT. While service sector leaders noted the importance of an objective tool to guide prioritization of scarce housing resources and ensure fairness, frontline service workers and individuals who were on the By-Name List raised concerns about the validity of the scores. As one service provider stated, "…75-80% of the time it's pretty accurate, but there are definitely some times when somebody is in a very vulnerable state and they're scoring low" (B-06:121). Concerns about the accuracy of the VI-SPDAT were frequently voiced by both frontline workers and service recipients since someone's VI-SPDAT score was directly related to their ability to access housing (higher scores prioritized for housing). As one coordinated entry worker stated, "It's all driven by the VI-SPDAT" (B-08:11). Some providers were particularly concerned that individuals would present themselves positively because they were accustomed to doing so in order to receive services: "I think people - everybody - wants to present themselves in the best light so that negative information, we don't share because then you'll be - you're already labeled as homeless, chronically homeless, and then a frequent user of the medical system, or a criminal. So people try to avoid that so they don't tell you the best part of the story" (B-08:15). Eventually, a vulnerability review process was initiated to address concerns about the potential inaccuracy of VI-SPDAT scores. The case conferencing led in turn to greater discussion of vulnerable individuals and their connection to resources. However, findings discussed earlier in this report suggest reason for ongoing concerns with the VI-SPDAT, especially in terms of racial equity.

A Key HFCM Accomplishment. Overall, the creation of the By-Name List is considered a key accomplishment of the HFCM initiative. As one community stakeholder stated, "I think the creation of the binding registry has been huge for us as a community because we're not only doing that with our chronically homeless, but we're doing that with veterans as well. And it has created a framework for us, almost a best practice that we can take on to the youth and family homelessness as we move on so I think that's huge" (A-11:33). The establishment of the By-Name List and related processes allowed for a better understanding of the extent of chronic homelessness in the community and a better measure of success in addressing it. As of June 2019, monthly progress on ending chronic homelessness has been tracked on the Housing Data Snapshot page of the Charlotte-Mecklenburg Housing & Homelessness Dashboard.

Moving Forward

A number of concerns that emerged during the implementation of the By-Name List have been addressed through the community structures now tasked with addressing chronic homelessness. Specifically, the By-Name List is now an integrated part of the Continuum of Care and its monthly data are now more widely available to providers and the broader community through the Mecklenburg County Housing and Homelessness Dashboard. Questions and concerns remain, however, about the inflow of individuals that continues to offset housing gains as well as about the validity of the VI-SPDAT, a central tool in the prioritization of housing for individuals experiencing chronic homelessness.

Original Strategy

Strategy 2: Expand Outreach Efforts

While a portion of chronically homeless individuals reside in emergency shelters, many live on the street and other places unfit for human habitation. For those on the street, there is often a reluctance to engage in services. Street outreach workers can play a vital role in identifying individuals, building a trusting relationship, and helping navigate through the housing process. For a city the size of Charlotte, our community has extremely limited street outreach resources. Currently, Urban Ministry Center hosts a team of 2.5 outreach workers. To end chronic homelessness, we recommend adding three street outreach workers: a SOAR specialist, who would assist individuals in securing disability income and Medicaid insurance; a peer support specialist, a formerly homeless individual focused on building rapport with service-resistant individuals; and an additional outreach worker, who would focus on building relationships and connecting people with housing.

Budget: $302,000
Timeline: Hire by January 2015
Staffing: 3 FTEs for two years

Outreach

Strategy Implementation

The second strategy presented to the steering committee to end chronic homelessness in Charlotte-Mecklenburg was to expand the community's capacity to conduct outreach to engage the individuals on the By-Name List, particularly those sleeping on the streets and in camps. Leadership for this strategy was initially provided by the project managers, Dale Mullennix and Liz Clasen-Kelly, then serving in a dual role as the Director of Outreach for Urban Ministry Center. Funding was provided locally by Wells Fargo and nationally through a PATH (Projects for Assistance in Transition from Homelessness) grant from Cardinal Innovations through the Substance Abuse and Mental Health Services Administration, a division of the U.S. Department of Health and Human Services.

By mid-2015, the Outreach team at Urban Ministry Center had expanded from 3 (2 staff and one director) to 11, including the three Outreach team members as outlined in the strategy and an additional PATH team of 5, including two SOAR (SSI/SSDI, Outreach, Access, and Recovery) specialists focused on disability documentation and benefits enrollment. The rapid increase in outreach workers was short-lived. By mid-2016, Urban Ministry Center had elected not to continue the PATH partnership with Cardinal Innovations while another outreach worker left around the same time and the position was not replaced. Outreach capacity fell from 11 back to 3 outreach workers, in practice 2.5 FTEs since the director of Outreach was also an administrator. Focus group interviews suggested the outreach workers' distress about this decision. Cardinal Innovations reposted the RFP for a community partner in October 2016 and Supportive Housing Communities was selected to continue the PATH program, which began again in mid-2017 with 6 team members.

Strategy Findings

Outreach played the obvious and essential role of engaging, connecting, and guiding individuals experiencing chronic homelessness through the process of securing permanent housing. Beyond the one-on-one interactions, however, the Outreach team members also facilitated many aspects of the larger community effort to end chronic homelessness. Several key roles demonstrate the importance of outreach for both individual and the larger HFCM initiative.

Front Door to Housing. For many individuals experiencing chronic homelessness, the Outreach teams served as the front door to housing, from engaging individuals yet to be identified through Coordinated Entry to finding individuals and helping them complete housing applications when units/subsidies became available to providing support during move-ins. As one program director stated, "Primarily it is…Outreach and engagement that does the application, the housing applications, that does the handoff from homelessness to housing" (A-07:13). The housing process could be quite lengthy and, during that time period, Outreach team members served as an important touchpoint and source of hope for those who were waiting. As one Outreach team member stated, "I think another part of it is the ability to

create hope and the sense that beyond just housing people, like a lot of the people that I think we're seeing now understand that there's a bit of a gap or a pause in actually getting housed. But, at the end of the day, I feel like no one is stopping from coming in, because they still want to get their application because they know there's that better hope that 'sooner or later, I'm going to actually have a better time and actually being housed.' It's not a question of if, it's a question of when" (B-06:56). Service recipients appreciation for the Outreach team was evident during the service recipient focus groups and during individual interviews. Outreach team members were frequently cited when participants were asked what strengths and resources they have to help them leave homelessness. Referring to one Outreach team member, one man who was housed through HFCM stated, "He is more than a case worker. I will never forget him" (E-42:04).

Connected Service Sectors. Outreach team members created and maintained working relationships with key community institutions to help individuals access housing and eliminate barriers as they were identified. Outreach workers engaged with the Charlotte-Mecklenburg Police Department (CMPD) and area hospitals to identify and divert frequent users of both the medical and judicial systems to the HFCM initiative. The team also worked with CMPD to create an incident referral form that CMPD officers could submit to Outreach for individual follow-up. They worked with Charlotte Housing Authority to track when individuals on the Housing Choice Voucher waitlist were approaching availability. Notably, the Outreach team developed a monthly disability clinic to identify and document an individual's disability and worked with CMPD to confirm individuals' length of homelessness, both of which were required documentation for the housing application. Outreach became a key thread that connected the effort to end chronic homelessness.

Other Duties as Assigned. The Outreach team completed key HFCM administrative tasks, including cleaning the By-Name List, assisting the HFCM research team at UNC Charlotte, and facilitating the development and distribution of Welcome Home Kits (housing and housekeeping supplies for newly housed individuals). They also took on leadership roles in the annual point-in-time Count and attended HFCM committee meetings (working committee, steering committee, Data, 250 PSH, and Community Engagement sub-committees). While a number of these roles likely emerged because Liz Clasen-Kelly, the initial Director of Outreach at Urban Ministry Center, was also an HFCM project co-manager, this role persisted after her departure to serve as the Executive Director of the Men's Shelter of Charlotte. As one team member noted about the non-outreach administrative tasks: "This is not our job, but we are doing it" (B-06:43).

Early Warning System. Importantly, the Outreach teams also served as an early warning system for HFCM and, in many ways, helped usher in needed changes across the homeless services sector. Outreach members cited the ability for individuals to transfer to a different housing placement as an important change they helped draw attention to through their interactions with individuals experiencing chronic homelessness. As one Outreach member stated, "We do a lot of advocating for our clients that results in system wide change. When I think of the PSH transfers, like a lot of that stems from us saying, 'hold on. We're seeing all of our clients come back to us after they've been evicted,' like 'we need to do something about this,' and now there's a whole process…"(B-06:36). This change across programs enabled all local PSH programs to operate in closer alignment with the evidence-based housing first permanent supportive housing fidelity criteria associated with program effectiveness. Outreach also helped establish the vulnerability review to ensure that there was a process to address cases where the VI-SPDAT score did not match the vulnerability of the individual experiencing chronic homelessness.

Insufficient Capacity. During a key time in the HFCM initiative, the capacity to conduct outreach was significantly reduced. Notes from the working committee and some subcommittees reflect the rationing of services that had to occur to adjust to the availability of Outreach personnel. Outreach began to focus its efforts on those who were considered most vulnerable and thus prioritized for housing. As a committee member stated regarding VI-SPDAT prioritization scores during a subcommittee meeting, "Outreach has to focus on 10 or higher, they are tapped out" (I-02). Those assumed less vulnerable because of their lower VI-SPDAT scores are no longer a primary focus for the Outreach teams. The lack of resources to focus on individuals with lower scores may explain the distress and frustration reflected in focus groups with individuals experiencing chronic homelessness. One woman stated, "It seems like I have nobody to really listen to me to understand where I'm coming from. And it just seems like I'm just on the back burner like I'm just not really getting nowhere" (C-04:124). Comments from focus groups and individual interviews with those on the By-Name List suggest the persistent challenge of navigating a fragmented service and housing system. While the needs may be more pronounced and fundamental for individuals who score as more vulnerable on the VI-SPDAT, the process to housing has no fewer hoops and is no easier to navigate for individuals who score as less vulnerable on the VI-SPDAT. Engagement with these individuals as well as those approaching homeless chronicity status has emerged as an important community priority to end chronic homelessness and prevent greater levels of vulnerability among those who are chronically homeless and those at-risk.

Lack of Peer Support. The original strategy also suggested using peer support specialist(s) to help engage individuals experiencing chronic homelessness. Peer support is provided by individuals with lived experience in homelessness who are trained and paid to provide outreach and engagement services, alongside traditional outreach and other frontline workers. Peer support is widely recognized as an effective and necessary practice working with individuals with mental health and substance use disorders (Davidson, Bellamy, Guy, & Miller, 2012) and a key aspect of the Pathways to Housing PSH model (Stefancic et al., 2013). Peers are able to empathize, connect, and build trust with clients often more easily than other professionals because of a shared lived experience. In research, peer support is associated with increased perceptions of control to create change, higher self-esteem and empowerment scores, and a belief that their program is working to meet their needs (e.g., Davidson et al., 2012). A peer outreach specialist was hired on the Outreach team for a brief time during 2016 and on the PATH team, but peer support wasn't sustained during the HFCM initiative. While some PSH programs employ peer support specialists, it isn't a widely implemented feature of services addressing chronic homelessness, particularly in outreach and engagement efforts. For the most part, peer support remains an untapped opportunity to address chronic homelessness in Charlotte-Mecklenburg.

Moving Forward

The Outreach teams continue to serve as the front door for many individuals experiencing chronic homelessness in the Charlotte-Mecklenburg community. As of April 2019, the Urban Ministry Center has been operating a team of five and Supportive Housing Communities has been operating a team of six, which has returned outreach to its staffing levels of 2016.

Original Strategy

Strategy 3: Create 250 New Permanent Supportive Housing (PSH) Units

Create 250 New PSH Units, including at least one new single-site building. Even with the current plan for 195-225 upcoming PSH units, an estimated 250 additional PSH units are needed to end chronic homelessness by 2016. In order to create the additional PSH units, three components are needed:

- the physical housing unit (either through capital construction or an existing landlord);
- the subsidy to make the rent affordable;
- the support services to promote housing stability for this vulnerable population.

Units are most commonly created through a scattered-site approach, using subsidy to rent existing units from landlords, but some of the chronically homeless population may benefit from a single-site, such as Moore Place. For this reason, we recommend an additional single-site housing to reach the goal of ending chronic homelessness. Given the special needs of this population and the long-term need for services, these rent subsidy and support services are best funded through public resources.

Budget: TBD by housing plans. Estimated $9.5 million for capital and sustainability of new building. $50,000 in flexible funding for scattered-site programs
Timeline: Planning begins Winter 2014. Units created throughout the course of the project
Staffing: TBD by housing plans. Estimated 17 case managers and 6 support staff

PSH Units

Strategy Implementation

Another key strategy to end chronic homelessness in Charlotte-Mecklenburg was to ensure a sufficient number of housing units and supportive services. Project management, PSH providers, and community leaders in the homeless services sector estimated that, in addition to currently available units and units available in the near future, another 250 units of affordable housing would need to be built or otherwise identified to meet demand. Initially, leadership for this strategy was provided by Stacy Lowry, Mecklenburg County Director of Community Support Services, and Pamela Wideman, Director of Housing and Neighborhood Services for the City of Charlotte; their staff designees, Karen Pelletier of Mecklenburg County and Zeleka Bierman of the City of Charlotte, assumed ongoing leadership of the group. A subcommittee met monthly to move the strategy forward. By September 2016, the subcommittee was alternating with the data committee and meeting every other month. Both Inlivian and Mecklenburg County contributed to this strategy by providing housing subsidies and supportive services, respectively. Additional funding for this strategy was to be raised according to specific housing plans.

In late 2014, HFCM project managers worked with area permanent supportive housing providers to identify 190-225 units estimated to become available by the end of 2016. These units included, among others, additional HUD-VASH (HUD-Veteran Affairs Supportive Housing) Vouchers, a new permanent housing program through Carolinas Care Partners housing individuals experiencing chronic homelessness and HIV/AIDS, Housing Choice Vouchers, as well as expected additions and attrition in existing PSH programs (See Table 7 below).

Table 7. Sources of Initial Permanent Supportive Housing Units

Source	Description	Number of Initial Subsidies/Units
HUD-VASH	PSH through local housing authority and services by local VA	40
Carolinas Care Partnership	New PSH program using HOPWA for subsidies and Mecklenburg County supportive services fund	30

Community Link	New PSH program using Continuum of Care funding	10
Housing Choice Vouchers	Units prioritized for homeless households, require supportive service to remain a priority	45-75
Moore Place Expansion	Addition to original Moore Place single site PSH apartment building	35
Supportive Housing Communities	Expansion of scattered site PSH program	5
Attrition from Existing PSH	Occupied PSH units that become available due to housing exits	30

To meet the goal of identifying the additional 250 units necessary to end chronic homelessness, Urban Ministry Center was to raise money to develop an additional single site facility to house 120 individuals, as it had done for Moore Place at the height of the Great Recession. Some funding and a site had been identified and the staff of Urban Ministry Center pursued this path to create 120 units by 2017. The 250 PSH Unit subcommittee thus focused most of its work on identifying the remaining 130 units of housing, which increased when the initial By-Name List suggested a need for housing for 519 individuals. As one committee member stated, "we've had to morph into other things because we need more than 250 units and we haven't really gotten there yet" (A-28:21).

The 250 PSH group sought to identify opportunities where they had leverage and power to effect change. The group turned their focus toward understanding new additions to the By-Name List and, related, how to effectively clean the By-Name List and best match individuals on the By-Name List with the appropriate resources. This led initially to dividing the list based on individuals' vulnerability levels, using VI-SPDAT scores. The high vulnerability group was connected with housing resources, while alternative resources were directed to the lower vulnerability group in an effort to keep these individuals connected and to understand when individuals self-resolved to improve the reliability of the By-Name List. After initially attempting to house the most vulnerable individuals from the By-Name List as quickly as possible, it became apparent that Rapid Re-Housing (RRH) was not well suited for individuals with higher vulnerability scores. The group switched strategies, housing less vulnerable individuals in RRH, and waiting for PSH units to become available for individuals with greater needs. In addition, a group was established to facilitate transfers from one program or unit to another to prevent housing loss if the current housing situation was problematic.

Strategy Findings

Creativity. Committee members and project managers described the resourcefulness and creativity of the subcommittee to identify housing, particularly while the rental housing market was tightening in the Charlotte area. The creativity began at the earliest stages of the initiative 2014 before the formal launch. Mecklenburg County CSS and homeless service providers mobilized to take advantage of the Section 8 waitlist, which was open for one week in September 2014. Combining a mainstream affordable housing resource with homeless services resources led to early housing successes in 2015. This creativity also comprised previously untapped programs including the Key Program and the Transition to Community Living Initiative, state programs to address the housing needs of low-income individuals with disabilities. The Key program is administered by the NC Housing Finance Agency and the NC Department of Health and Human Services and subsidizes the cost of rent and security deposits. No supportive services are provided by the program. The Transition to Community Living Initiative is administered by the NC Department of Heath and Human Services and is a condition of the settlement between North Carolina and the US Department of Justice requiring the transition of individuals who have been or could be institutionalized because of their disability into independent community living. This work also included working with the Housing Advisory Board of Charlotte-Mecklenburg and eventually Socialserve.com to establish a landlord consortium and "a unified collaborative approach among housing providers, service providers, and tenants" (Socialserve, n.d.), now named HousingCLT, to help locate affordable housing. In addition, the committee regularly examined the models other communities were using to find affordable housing, including a Nashville model where developers donate apartments in a larger development.

Sudden Shift in Strategy. HFCM faced a number of challenges in Fall 2016 that threatened to derail progress and ultimately resulted in the extension of the initiative through 2017 and a shift in committee structure. Residents in

Westerly Hills, the neighborhood sited for the development of the new single site building, registered vocal objections to the plan to build a "new Moore Place" as did elected officials from the district. The proposal for the new building was withdrawn and CHA agreed to provide the vouchers for scattered site housing instead. While the housing units were preserved, the loss of the single site project discouraged and frustrated a number of stakeholders, who were concerned about how the effort had been planned and communicated. One steering committee member noted that she could have assisted in the planning and siting of the new single site development, but she wasn't made aware of it until after objections were registered. Other steering and working committee members described the lack of communication about such a key shift in strategy from single site to scattered site.

Unexpected External Challenges. The number of new additions to the By-Name List (inflow) continued to offset gains made in housing placements (outflow), slowing efforts to reduce chronic homelessness. In addition, larger issues and events in Charlotte were shaping the landscape and competing for the attention of community leaders who had provided initial support for HFCM. The Charlotte community was facing an increasingly pronounced housing affordability crisis, the social uprising in the wake of the Keith Lamont Scott shooting, and a related and growing concern about economic mobility among the community's poor households. Frontline workers reported that viable housing options for individuals experiencing chronic homelessness decreased as available affordable units were either torn down or renovated to attract higher rents. As one service provider noted, "We're running out of housing in the community, first of all. We are running out of options, there aren't many choices" (B-04:62).

Missing Stakeholders. In addition, there was a sense that the decision-makers necessary to construct new housing units were not involved in the 250 PSH subcommittee, including developers and property managers. Perhaps related, steering committee members expressed concerns that, among project management, there was some resistance to approach problem-solving around additional units in new ways, utilizing the development capacity of the banking and financial sector. One committee member noted missed opportunities to pursue tax credits to support building new supportive housing and stated about the challenge, "I think one is it [tax credits] is hard before you find a space to pursue it. I know that information was held pretty close to the chest of where all they were looking. So some of it is just logistics. And then I think others is it's because, again, it's not the way things have been done in the past. And because Moore Place was built during the financial downturn, I think there was a belief that that would hold true again" (A-06:19).

Less Emphasis on Services. The inflow numbers and difficulties in finding housing took top priority with less discussion concerning support services for housed individuals. While support services are included as one of three items integral to the housing effort, the topic rarely came up during committee meetings. The challenges of housing and inflows were the main concerns. However, frontline workers conveyed the need for more support services. "So [some households] do not have case management services…So those are calls I get, my colleagues get, when they have issues come up, when they need a food referral, need a furniture referral, landlords call the internal staff with any issues they see. I mean we try to address it the best we can, if they don't have an attached social worker, or a case manager" (B-04:52). One survey comment noted, "Overall, we do very well with the resources we have, but would still benefit from more supportive services as we have seen a shift in the population coming into the program. New referrals seem much more vulnerable and need much more support" (J-01).

Moving Forward

Since the 250 PSH subcommittee began, it has transitioned twice, first merging with the data subcommittee in 2017 and in May 2018 becoming the chronic work group under the Continuum of Care structure of the Housing Advisory Board of Charlotte-Mecklenburg, a structure suggested by Community Solutions. In 2019, the Continuum of Care structure shifted to Mecklenburg County. The current subcommittee functions not only to identify and create housing for individuals experiencing chronic homelessness, but has taken over the project management functions of Charlotte's current efforts to end chronic homelessness.

Original Strategy

Strategy 4: Coordinate Moves

Early in the process, HFCM leadership decided that the strategy "Coordinate Moves" should not be a separate subcommittee but the responsibilities should be assumed by current service providers, and particularly Crisis Assistance Ministry and Urban Ministry Center.

TJ MAXX volunteers help move in furniture Thomas chose for his new apartment in 2018. Photo: Crisis Assistance Ministry

Coordinate Moves

Strategy Implementation

Coordinating moves into housing was not initially suggested as a key strategy to end chronic homelessness, but was quickly recognized in 2015 as a key task of the effort. Leadership for the strategy fell primarily on two partner organizations, Crisis Assistance Ministry and Urban Ministry Center. Coordinating moves into housing involved mobilizing a range of community partners to assist with the logistics of moving individuals who had few or no personal belongings, including furniture, household goods, and food. Leadership for this strategy was provided initially by Joy Crosby, formerly of Crisis Assistance Ministry and Liz Clasen-Kelly as the Director of Outreach at Urban Ministry Center.

Crisis Assistance Ministry provided access to financial assistance and furniture from their furniture bank, including "essential" items such as beds, dressers, sofas, chairs, tables and kitchen chairs and "non-essential" items, such as televisions, pieces of art, end tables, coffee tables, lamps, and rugs. Assistance was also provided after the initial moves, such as additional furniture, furnishings, rent, and utility assistance. The organization signed a Memorandum of Understanding with HFCM (represented by one of the two project co-managers, Dale Mullennix) to provide emergency financial assistance, furniture, appliances, and other material goods, as well as coordinate the relocation of HFCM individuals. Crisis Assistance Ministry typically works with individuals who are unstably housed (e.g., due to abatement, foreclosure, fire and flood, or domestic violence). Working with individuals who are chronically homeless was a bit of a departure for the agency. Yet, agency stakeholders described how they believed in the mission of HFCM and stepped up to serve as a "partner" with a "service" and "transactional" role (A-02:05 and A-02:07, respectively). From March 1, 2015 to December 31, 2018, Crisis Assistance Ministry reported providing services to 565 unique households through HFCM. They reported providing $205,403 in financial assistance (e.g., security deposits and rental assistance), $31,456 in utility guarantee assistance, 3,391 appliances and furniture items, and assisted with 150 relocations. According to the agency, they were able to accomplish this with 2,250 volunteer hours and without additional staff.

In addition, Urban Ministry Center managed a Reducing Barriers Fund of $50,000 provided by an anonymous donor that helped address financial barriers that could prevent a person from moving into housing, including back-owed

utility bills, application fees, security deposits, identifying documents required by housing providers (for example, a birth certificate is required for Charlotte Housing Authority), and renters insurance. Urban Ministry Center also worked with the Engagement committee and community partners to develop Welcome Home Kits to provide dishes, linens, kitchenware, and other household necessities for individuals moving into housing. A number of community partners also participated in Welcome Home Kits, including Elevation and other local congregations, Bank of America, Charlotte-Mecklenburg Police Department, and Community & 4th Ward Neighbors, but the job of coordinating Welcome Home Kits largely fell on Urban Ministry Center staff, including Outreach staff.

Strategy Findings

Extended Existing Infrastructure. The effort to coordinate moves into housing is a key example of HFCM's ability to extend existing infrastructure and the willingness of community partners to contribute to the overall effort. One stakeholder described how Crisis Assistance Ministry was "uniquely positioned" to offer furniture and financial assistance to HFCM individuals, to "use their resources, their infrastructure, and processes to do the actual difficult and financial moving of people from homelessness" (A-02:05). Another stakeholder echoed the importance of this contribution by saying "Crisis came onboard in this major way" (A-09:10). The Reducing Barriers Fund and Welcome Home Kits similarly made use of existing infrastructure at the Urban Ministry Center, including staff and processes to manage the funds and donations as well as recruitment of funders and volunteers to support the two initiatives. Extending existing infrastructure and collaborating to serve this community purpose was celebrated in stakeholder interviews.

New Patterns of Collaboration. Coordinating the moves required that organizations and volunteers work together in new and different ways. For example, Crisis Assistance Ministry rearranged schedules to help make staff available when needed and they began offering Saturday hours. Inspections needed to happen in a timely manner, and volunteers with trucks needed to be recruited to pick up and move furniture during weekdays and weekends. One stakeholder who was interviewed remarked, "It's been good to see new infrastructure, new people…. new processes, take flight. It's been very exciting. I mean, it's completely out of the box of us to go and recruit volunteers who will physically move stuff on their own and have connections to customers in a whole new role, everything from new liability insurance to recruitment methods" (A-02:11).

Sustainability Concerns. Several stakeholders also recognized a downside of these celebrated effort successes, particularly the sustainability of extra effort and resources. Much of the effort dedicated to coordinating moves was performed with existing agency staff and volunteers from the community. During the interviews, some stakeholders questioned the sustainability of this approach, describing concerns about the capacity of key organizations to maintain the increased work, increased expense, and increased fundraising burden. When the inflow numbers grew and the single site strategy shifted, one HFCM committee member noted, "When they said they weren't going to build the building, we didn't have a plan …. that's a whole lot more electric bills and furniture and moves….I can't keep raising additional dollars and putting additional work on existing staff" (A-03:09). Another said, "We've all agreed to a time-bound project" (A-21:47) expressing concerns about the potential for additional extensions. These comments and observations highlight the importance of documenting not only the contributions of the different collaborative partners, but also the hidden costs of collaboration.

Moving Forward

The coordinated effort around moving continues through the work of Crisis Assistance Ministry staff, volunteers, and various organizations' housing case managers working to move their clients into housing.

Welcome Home Kits from West End Advisors in 2018. *Photo: Housing First Charlotte-Mecklenburg*

Original Strategy

Strategy 5: Train Organizations and Staff in the Housing First Model

The Housing First approach, a low-barrier housing approach with minimal eligibility requirements, differs dramatically from the traditional service provision practiced for years. Having organizations and staff that embrace the Housing First approach is vital to the success of any housing targeting the chronically homeless. Since our community has limited Housing First programming and many organizations are shifting from a traditional approach to a Housing First approach, quality training and support is necessary to ensure the long-term success of this initiative. Our community has local resources that can serve as a training resource, though a national provider, such as Corporation for Supportive Housing or Community Solutions, could be helpful in providing community-based trainings on implementing a Housing First approach.

Budget: $20,000
Timeline: Select training partner by Fall 2014. Provide trainings in conjunction with the opening of new PSH units
Staffing: Contract with a training partner

Housing First Training

Strategy Implementation

Early leadership of the HFCM effort identified training in the Housing First model as a requirement for ensuring the success of the initiative. Funding for the training strategy was provided by Wells Fargo. Caroline Chambre Hammock and Lori Thomas were initially tasked to determine the scope and nature of training efforts and were joined by Karen Pelletier of Mecklenburg County CSS and John Yaeger of Urban Ministry Center to make initial training decisions. Leadership of the training strategy shifted to Pelletier and Yaeger as Hammock and Thomas assumed additional responsibilities in the effort, although they remained engaged in training efforts. In September 2016, the Mecklenburg County CSS created a new training position and dedicated a portion of that position to staffing the HFCM training effort.

The initial training team decided to conduct focus groups in early 2015 to identify the most pressing training needs. Six focus groups were conducted with 35 service providers from eight agencies. Most attendees were direct service providers, although executive leadership and board members were also invited to participate in focus groups. Focus group participants raised concerns about implementing housing first with "dwindling" available affordable housing and overcoming barriers working with the landlords and property managers of existing affordable housing. Most of these barriers were related to the larger negative public perception of individuals experiencing homelessness. Participants also identified organizational and staff level barriers, many related to the challenge of implementing a model that was such a "drastic" change from existing models. Focus group themes and quotation examples are listed in Appendix E.

While conducting the focus groups, the training committee was also considering two potential national assistance providers who could help the community address training and education needs. The Corporation for Supportive Housing was identified as a technical assistance provider whose key strength was helping communities shift their homeless service systems and organizations to housing-based solutions. Pathways Housing First (Pathways; at the time named Pathways National) was identified as a provider whose strengths were maintaining model fidelity and addressing the daily challenges direct service providers may encounter as their organizations implement the housing first model. Based on the feedback of the focus groups and since a number of key homeless network leaders were already supporting the HFCM effort, the committee decided that Pathways was most needed in the community at the time.

The committee decided on a multifaceted training approach and facilitated the following activities with Pathways Housing First:

1. **Kick-Off Training** - Dr. Sam Tsemberis, a founding father of housing first and the lead trainer for Pathways Housing First, and a Pathways staff member conducted a day-long community training event that would introduce housing first permanent supportive housing fidelity criteria and the organizational assessment process. The training event

was held on September 29, 2015 and was open to interested homeless service providers. Over 150 people attended the kick-off training event.

2. **Site Visits** - Dr. Sam Tsemberis, a member of his staff, and Lori Thomas, who had previously implemented a housing first PSH program in Richmond, Virginia, conducted site visits with all participating programs including Carolinas CARE Partnership (CCP), Community Link, Shelter Plus Care, Supportive Housing Communities, and Urban Ministry Center. A Q&A session with Dr. Tsemberis was provided for HUD VASH staff at Mecklenburg County CSS, but a site visit was not conducted since a visit and fidelity assessment had not been officially approved by the local Veterans Administration. The extent of the site visits varied based on the size and age of the programs. Newer programs, like CCP, had a meeting with the site visitors and a case records review. Reviews of more established programs like the Urban Ministry Center also included observations of team meetings and interviews with leadership, staff, and clients. Visits were followed by a draft report to each agency and phone conference with Tsemberis to discuss and adjust scores if needed and identify areas for improvement and growth. Site visits were conducted through December of 2015 and concluded with a joint meeting of all PSH service providers at the Hal Marshall Center that identified webinar and training topics.

3. **Monthly Training Calls** - Following the site visits, John Yeager facilitated monthly community calls with Dr. Sam Tsemberis and participating PSH sites to discuss training topics and review challenging cases. Calls began in February 2016 and occurred monthly for one year until transitioning to bimonthly conference calls. In the intervening months through the end of 2017, the training committee held calls with Dr. Tsemberis to develop a Housing First 101 training and transition strategy to take over monthly phone calls.

4. **Webinars** - The training committee originally contracted with Pathways to conduct up to 6 workshops on training themes identified during the site visits. The webinars did not occur due to a lack of Pathways staff capacity to provide them (a Pathways trainer that originally worked with Charlotte transitioned out of a full-time role with the organization).

In the Fall of 2016, Mecklenburg County CSS hired Savanah Warren as a Senior Quality and Training Specialist and included HFCM training as one of her responsibilities. Warren began to facilitate training committee meetings and developed the HFCM Training Consortium. The Consortium, which started in February 2017, included the HFCM training committee, and recruited trainers from established PSH programs to work with the committee to develop an ongoing Housing First 101 training and eventually take over the monthly calls that Dr. Tsemberis was then conducting. The Consortium used bimonthly training calls with Dr. Tsemberis to "train-the-trainer," discussing the Housing First 101 training and building trainer capacity to facilitate monthly calls with the community including: how to provide supervision to staff providing housing first services, how to staff cases in a non-judgmental and strengths-based manner, and how to handle value conflicts (for example, housing first fidelity criteria versus more traditional program-compliance expectations). The Consortium trainers began co-staffing calls with Dr. Tsemberis in July 2017, conducted a "dress rehearsal" of the first Housing First 101 training in August 2017, launched the bi-annual Housing First 101 training in September 2017, and took over staffing community phone calls in January 2018.

Strategy Findings

Dedicated Staff. In addition to committee volunteers, two organizations' staff members were assigned to the training effort as an ongoing part of their ongoing job responsibilities. Warren, the County's Senior Quality and Training Specialist, facilitated ongoing committee meetings, developed a sustainable training model with little funding, and ensured the Housing First 101 training was developed, piloted, and evaluated. Yaeger, the Director of Scattered Site Housing at Urban Ministry Center, facilitated monthly phone calls and coordinated with Dr. Tsemberis and later with local trainers to staff calls. Assigned staffing provided project management and support to enable the implementation of training committee ideas. Warren's position, in particular, ensured that there was a structure to support ongoing training and monitoring.

National and Local Expertise. The training committee incorporated technical assistance into a larger process of community engagement that utilized both national and local expertise. Early focus groups with service providers identified key training needs and helped identify a national training partner. The HFCM Training Consortium identified local expertise and supported their development into community training facilitators. The Housing First 101 training incorporated individuals with lived experience in the development of the training as well as a key feature of the training. All of these efforts integrated local and national expertise, as Dr. Tsemberis provided feedback on locally developed training materials and participated in training-the-trainers.

Beyond the Frontline. Finally, HFCM training focused predominantly on direct service provider practice as requested by providers and indicated in training focus groups. The larger implementation of HFCM suggests the importance of multilevel training and capacity building to assist programs, organizations, and larger community networks implement and maintain new evidence-based and evidence-informed practices. Without attention to the multilevel implications of implementing significant changes in a community, the pressure to successfully transition practices and achieve outcomes falls primarily on direct service providers who may have little to no control over organizational or network practices. In retrospect, the training committee's focus on training direct service providers was necessary, yet incomplete. Implementing an evidence-based practice requires commitment and often altered practices from the front line to the board room to the service network.

Moving Forward

In late 2017, two personnel transitions occurred toward the close of the HFCM effort, and impacted ongoing and future HFCM training efforts. First, Savanah Warren left Mecklenburg County. While she left detailed transition plans in place, a new Quality and Training Specialist wasn't hired until later in 2018, when energy concerning the HFCM effort had waned. Second, John Yaeger unexpectedly died in late March 2018. Urban Ministry Center continued to host monthly calls and training partners continued to facilitate them, but community participation declined and the calls ended in 2018. Both Warren and Yaeger were key facilitators in HFCM training efforts and their absence coupled with transition of the HFCM effort back to existing homeless service structures impacted ongoing training activity. Semi-annual Housing First 101 training is the only ongoing HFCM training activity that remains, although Mecklenburg County CSS continues to support targeted training on techniques that inform and complement housing first permanent supportive housing.

Housing first founder Dr. Sam Tsemberis meets with Charlotte housing first providers. *Photo: Lori Thomas*

Original Strategy

Strategy 6: Engage the Community to be Part of the Solution

No doubt large public and private investments will be necessary to end chronic homelessness, but there are countless ways average citizens can play a role. Through building web-based and social media tools that invite the community to take part in this initiative, citizens can be connected with existing programs and participate in ending chronic homelessness in this community. For example, landlords can offer to rent their units through programs serving the chronically homeless; congregations can help move furniture into someone's new home; a scout troop can pull together a "Welcome Home" box of household goods; a family can alert outreach workers when they see someone sleeping outside. Through a concerted community engagement effort, we can create the community momentum needed to get to zero.

Budget: $5,000 for technology tools
Timeline: Winter 2014-2015
Staffing: Filled by existing Center City Partners staff

Community Engagement

Strategy Implementation

The Engagement Strategy was one of the first strategies put into action in late 2014 to educate and engage the community in the HFCM effort. CCCP worked closely with Urban Ministry Center to activate an engagement committee. The committee began working in late Fall 2014 to establish and refine the mission of HFCM and plan the January 2015 kick-off event. In addition, they began focusing on longer term engagement efforts to develop tools to educate the public about the problem and solution, identify and acquire resources (from volunteers to major funding partners), and build excitement and tell the story of HFCM. As one community leader noted, "the [committee] purpose was to really engage the public in ending chronic homelessness" (D-02:01). Leadership for the committee was provided by Moira Quinn of CCCP, Emily Crow of Bank of America, and Kristi Thomas of Wells Fargo.

CCCP provided in-kind expertise and project management to the initiative's development and community engagement. Early engagement efforts included "getting all of the organizations [...] sitting in a room together" (D-02:01) in order to build the foundation of the effort. CCCP and the committee quickly went to work bringing partners into the initiative. Partners included a broad range of organizations from center city businesses and local government to homelessness, health, and human service organizations as well as local foundations. The partners are listed in Appendix C.

Once key partnerships were established, attention quickly turned to public engagement. Public engagement efforts included a speaker's bureau and presentation materials, media engagement, and an online and social media presence (facebook: https://www.facebook.com/HousingFirstCharMeck) and plan. In addition, CCCP and members of the committee maintained regular contact with local neighborhood groups and businesses, who saw or interacted with homeless individuals daily. Friends of Fourth Ward, the local neighborhood association, worked with HFCM engagement leadership to develop a campaign to educate residents and businesses in the Fourth Ward about chronic homelessness and housing first and to engage them in fundraising for, and otherwise participating in, the effort.

Strategy Findings

Early Wins. During interviews with community leaders in Fall of 2016, education and awareness was frequently mentioned as a success of the initiative. Stakeholders cited a greater awareness and understanding of chronic homelessness, explaining how deliberate efforts at the beginning of the initiative proved to be beneficial. For example, some members of the steering committee visited homeless camps and did pre-dawn walks around uptown Charlotte to better understand the extent of chronic homelessness in the city. In addition, extensive efforts were taken to involve stakeholders in the annual point-In-time Count. As one interviewee explained, "Personally this was a great learning experience, it gave me a better understanding of sort[s] of homeless situations, and I think for a lot of us, my

fellow funders and some of the people that weren't as close around the table, it is really great experience for us to really understand the ins and outs and all of the partners that were involved" (A-13:30). New knowledge helped the steering committee better understand the impact chronic homelessness has on individuals and the community. One stakeholder reflected on how this has translated into a broader understanding of the affordable housing issue noting, "we're really becoming educated about all forms of affordable housing and why it's so needed" (A-20:09).

Stakeholders also noted how HFCM built awareness and knowledge in the broader community, beyond the partners of the effort. One provider noted, "I think we've really changed the conversation in much of the broader community about homelessness. I think there was generally this accepted, assumed reality that homelessness was this huge, monolithic social problem for which there was no answer. And I think we have changed the conversation to 'Yes, there is an answer" (A-17:19). Respondents also listed the importance and effectiveness of the Charlotte Observer articles, the attention to the Housing First model, and a better understanding of what distinguishes chronic homelessness from other forms of homelessness.

Lack of Clarity About Ongoing Status. The direction and goals for the community engagement committee were less clear in the second half of the initiative, beginning with the announcement of the neighborhood rejection of a new single site model in the Fall of 2016 and the need to extend the effort through 2017 to meet the goal. The lack of clarity about the state of HFCM was evident in community leader interviews and the committee focus groups. One stakeholder stated, "I think obviously not reaching our goal is always a concern. We made a commitment we were going to do something. So obviously we didn't make it. And so we need to regroup and figure out what's a realistic goal for us. Or are we ever – they talk about the functional zero thing. So is that really where we're headed? So I think we make sure that it's clear where we're going, so we're just – because the other problem that you ultimately have is you just keep going and going, and there's no end game. And we want to make sure we have an end game" (A-05:30). Committee members and other stakeholders were not clear on the role education and engagement were to play as the effort extended beyond the timeframe of the initial goal. Another committee member noted, "…I think after about 18 months the momentum was such that we felt like we'd done a lot. But at the same time, we sort of plateaued and it was like we knew there was a lot more to do but what's next?" (D-02:11).

Sustaining Awareness. Related, in late 2017 during the latter half of the initiative, frontline workers commented on the ongoing need for education and awareness in the community. Workers expressed that increased engagement efforts could assist with landlords and property managers, and generally build support for the initiative. The need for more political support was also mentioned: "I think the political side of it, of going to city council meetings, getting this on the agenda of the politicians, that is not well organized and coordinated in the homeless services world at all, like who is going to these meetings?" (B-06:109). Frontline workers pointed to missed opportunities to elevate the initiative in public forums, but workers and other stakeholders recognized the shift in community attention to other community initiatives such as the Opportunity Task Force and the push to increase affordable housing.

Clarifying Related Issues. Effort stakeholders also raised questions about the ambiguous relationship between HFCM and the overlapping but distinct issues of street homelessness and panhandling, two issues important to the constituents of CCCP. One community leader noted that the distinction between chronically homeless individuals and street homeless individuals was not as clear initially, and yet the distinction was important for center city businesses and residents to understand why there had not been a visible reduction in street homelessness although several hundred individuals had been housed through the effort. Individuals seen as the street homeless may or may not meet the definition of chronically homeless, which requires a documented disability and documented extensive period of homelessness. The leader noted, "So this was originally started because of the uptown homelessness, street homelessness. And I also think there was a belief early on that by tackling chronic homelessness, you would help street homelessness. And I'm learning – and I learned after the fact and I've been at most of the meetings – they're different things" (A-06:25).

The relationship between chronic homelessness, or homelessness in general, to panhandling was similarly ambiguous to some stakeholders. While some community leaders counted it a success that they "…have become more educated as a result of doing all of this which is a very good thing for all of us" (A-12:47), others noted the lack of initial education and clarity on the two distinct issues that led some stakeholders to equate success with the disappearance of individuals panhandling and living on uptown streets. Some direct service providers also expressed questions about the relationship between HFCM and the campaign to discourage panhandling, frequently discussed in engagement committee meetings although not described as an official initiative of the HFCM effort. Frontline workers were particularly concerned about the information the campaign was built upon. As one frontline worker noted, "…it seems like a lot of the responses are based on anecdotal information like, "I talked to one homeless guy and he was faking it, so all of them are faking it." We're like, "No, maybe not" (B-06:135). This service provider and other frontline workers in the same focus group expressed the need to conduct research to develop a more effective response to panhandling and help the public better understand the relationship of homelessness and panhandling.

Moving Forward

The engagement committee continued meeting until Spring 2018. On April 24, 2018, CCCP presented HFCM partners a Vision Award for the work to end chronic homelessness in Charlotte at their annual awards dinner. The award presentation focused on the successes of the effort including the broad collaboration across sectors and the number of people housed. The award presentation served as a conclusion of sorts for the broader HFCM effort and the transition of operational leadership to the Continuum of Care committee on chronic homelessness. Education and engagement activities are now subsumed under the chronic work group of the COC.

Original Strategy

Strategy 7: Ensure Adequate Leadership and Staff

To ensure success, the effort will require the following staffing:

- Project Management: Project Management will be responsible for convening stakeholders, guiding implementation, monitoring progress and building service-provider and community support.
- Community Engagement: Community engagement staff will be dedicated to telling the story of the initiative, reporting out progress, and creating accessible opportunities for the general public to become part of the effort. A staffing need for volunteer coordination could emerge.

In addition to staffing, two volunteer-based groups will be convened to oversee proper implementation of the strategy:

- Working group: Comprised of service providers and public partners, this group will work towards implementing the strategy of the initiative, identifying opportunities for additional permanent supportive housing units, coordinating services, and measuring progress towards ending chronic homelessness. Anticipated meeting schedule is twice per month.
- Steering committee: Comprised of community influencers, this group will advise on overall strategy, secure funding, and assist in opening doors, in order to achieve goal of ending chronic homelessness. Anticipated meeting schedule is quarterly.

Note: The creation of 250 new PSH units will come with significant staffing needs – additional case managers, medical, and administrative staff not outlined here. Those staffing needs will be specific to the type of units created and the target population.

Budget: $250,000 for Project Management
Timeline: December 2014-December 2016
Staffing: Urban Ministry Center will serve as project manager. Center City Partners will serve as community engagement staff.

Leadership and Staffing

Strategy Implementation

In the initial proposal for HFCM, "leadership" was described as being "critical to the overall success of the initiative" (K-11). CCCP and Urban Ministry Center provided early leadership for this strategy, serving as project sponsors and project management, respectively. Specifically, Dale Mullennix and Liz Clasen-Kelly of Urban Ministry Center were chosen and funded to assume responsibility for "convening stakeholders, guiding implementation, monitoring progress and building service-provider and community support" (K-11). The HFCM initiative was designed to be a cross-sector collaboration between public, private, and nonprofit organizations. Thus, the leadership structure also included a steering committee, hosted by Michael Smith of CCCP and managed by Mullennix with assistance from Clasen-Kelly, and a working committee, hosted by Moira Quinn of CCCP and managed by Clasen-Kelly. The working committee also included six initial subcommittees responsible for each of the key strategies (Data monitoring, 250 new PSH units, Coordinate moves, Education and engagement, Training, and Evaluation), each led by at least two community stakeholders and staffed and monitored by Clasen-Kelly. Funding to support project management was provided by Bank of America.

Steering Committee. The initial steering committee consisted of executive leaders representing 21 community business, government, and nonprofit organizations. While members of the committee were engaged in the earlier development of the initiative, the steering committee met for the first time in March 2015. The committee was tasked with setting overall effort strategy and monitoring its ongoing and overall success. Early meeting agendas suggest that the steering committee was initially organized into four subcommittees: 1) Personnel (led by Michael Smith), 2) Funding (led by Ron Carlee), 3) Finance (led by Dena Diorio and Lee Kessler), and 4) Communications (led by Moira Quinn at CCCP). Feedback during stakeholder interviews suggested that these subcommittees met rarely or infrequently.

Initial Steering Committee Members

Charles Bowman, Bank of America

Ron Carlee, City of Charlotte

Mike Clement, Urban Ministry Center

Brian Collier, Foundation for the Carolinas

Carson Dean, Men's Shelter of Charlotte

Dena Diorio, Mecklenburg County

Nancy Fay-Yensan, UNC Charlotte

Sean Garrett, United Way

Carol Hardison, Crisis Assistance Ministry

Lois Ingland, Atrium Health

Lee Kessler, Charlotte-Mecklenburg Library

Fulton Meachum, Charlotte Housing Authority

Deronda Metz, Salvation Army Center of Hope

Bob Morgan, Chamber of Commerce

Dale Mullennix, Urban Ministry Center

Tom Murray, Charlotte Regional Visitors Authority

Dee O'Dell, US Bank

Mike Rizer, Wells Fargo

John Santopietro, CMC Behavioral Health

Ken Szymanski, Housing Advisory Board of Charlotte-Mecklenburg

Michael Smith, Charlotte Center City Partners

Laurie Whitson, Cardinal Innovations

Initial Working Committee Members

Liz Clasen-Kelly, Urban Ministry Center

Mike Campagna, Charlotte-Mecklenburg Police Department

Caroline Chambre Hammock, Urban Ministry Center

Emily Crow, Bank of America

Alan Dodson, CMC Behavioral Health

Mary Gaertner, Housing Advisory Board of Charlotte-Mecklenburg

Carol Hardison, Crisis Assistance Ministry

Pam Jeffsen, Supportive Housing Communities

Stacy Lowry, Mecklenburg County

Deronda Metz, Salvation Army Center of Hope

Carol Morris, Foundation for the Carolinas

Dale Mullenix, Urban Ministry Center

Moira Quinn, Charlotte Center City Partners

Larry Padilla, Charlotte Housing Authority

Ollie Rencher, St. Peter's Episcopal Church

Stephanie Shatto, Men's Shelter of Charlotte

Michael Smith, Charlotte Center City Partners

Kristi Thomas, Wells Fargo

Lori Thomas, UNC Charlotte

Suzanne Storch, Cardinal Innovations

Pam Wideman, City of Charlotte

During the first steering committee meeting, members provided feedback on the proposed strategies and funding mechanisms for ending chronic homelessness. During most subsequent meetings, the project managers would present an update about the initiative's progress and successes to date. The committee would also review the number of housing placements, and they would discuss various projections of inflow to the By-Name List and planned housing placements in order to assess the feasibility of achieving "functional zero" by 2016, then 2017. Anecdotes of specific success stories were also shared. While early HFCM documents suggest that the steering committee was to meet quarterly, records suggest it only met twice a year from 2015 - 2017. The last meeting was held in March 2018. Early meetings were attended by lead organization representatives, but later in the effort, other organizational delegates often attended instead.

Working Committee. The ad hoc group that had been meeting with CCCP to address visible street homelessness uptown formalized in November 2014 as the HFCM Working Committee. The committee, comprised of a number of homeless service providers pushed for the launch of the effort. In addition, the subcommittees that completed much of the work of the initiative were formed from its ranks. The committee met initially on a monthly basis, but at the request of some members, transitioned to bimonthly meetings in 2017. Like the steering committee meetings, working committee meetings largely focused on reporting on progress and barriers, particularly that of the subcommittees.

Strategy Subcommittees. The main work of HFCM took place at the subcommittee level. Initially, a subcommittee was formed for each strategy except for the leadership strategy, and two subcommittee chairs were identified to organize and lead the work in each committee. By mid-2016, four subcommittees continued to meet regularly: the data monitoring subcommittee, the 250 new PSH units subcommittee, the education and engagement subcommittee, and the training subcommittee.

Project Management. Project managers played a range of roles that held the effort together, including scheduling and convening meetings; overseeing the initial efforts to clean and manage the By-Name List providing regular updates on the project's activities and outcomes; and coordinating training, outreach to committee members and to individuals experiencing homelessness, public relations, and fundraising efforts with the help of CCCP. In August of 2016, Clasen-Kelly became the new Executive Director of the Men's Shelter of Charlotte and while she remained engaged in some management activities, the majority of her project management responsibilities shifted to new leaders - Allison Winston took over direction of street outreach at Urban Ministry Center, Courtney LaCaria took over monitoring the By-Name List at Mecklenburg County, and Dale Mullennix assumed overall project management for the effort. Caroline Chambre Hammock, the former Director of Moore Place and then Director of Operations at Urban Ministry Center was hired as a co-project manager from March-October 2017. Her position co-managing the effort was not replaced.

Strategy Findings

Broad Coalition of Stakeholders. Most stakeholders agreed that HFCM had a strong start due to the leadership and management of the initiative. A key success attributed to the project sponsors and managers was the recruitment and involvement of a broad coalition of stakeholders from the business, government, and nonprofit sectors, in addition to the 250 volunteers engaged to build the initial By-Name List in January 2015. As one stakeholder stated, "I think the initial success was just everyone coming together. We were there for the announcement, the press conference, announcing the partners, announcing the effort at Moore Place when it started, and then just all those key organizations and leaders coming together around one issue I think was a success" (A-24:12). Similarly, another committee member said, "I don't know who was in that magic room, pulling all of those people together. But whoever was there, it just proves that we can accomplish a lot" (A-21:33). Despite the wide diversity of stakeholder groups present, individuals with lived experience were not represented in the HFCM structure.

Early and Regular Communication. The success of the project kick-off was also attributed to regular communication by project managers and sponsors. As one community leader noted, "There was a lot of communication, a lot of reporting via either in- person or via email; updates, really, on a regular basis to help folks understand how the initiative is going on. So, that piece, I think, worked really well" (A-11:103). A key part of that communication was regular data on the progress of the effort. Ongoing progress reports suggested careful monitoring of the effort. As another community leader noted, "It really helps to have good data and I think that they're doing a really good job of putting that data together, doing those reports so that we understand. You can't fix the problem until you really understand it and it's very helpful to understand what the problem is" (A-12:24). Another leader noted, "I think the reports that they were putting out were really great. Having that visual perspective, I think that was really good" (A-11:25). One steering committee member noted that the meetings were "well run," stating, "I think we have a good agenda. They are pretty meaty" (A-05:17). Early leadership around the coalition, communication, and data combined to build excitement and buy-in around the effort.

Lack of Sustained Communication. Despite reports of a strong start and a public recognition of the effort's successes at CCCP Annual Vision Awards banquet in 2018, a number of stakeholders also noted a trailing off of the initiative, attributed to a number of project management and contextual challenges. While communication was recognized as a strength early in the initiative, stakeholders reported a lack of communication and discussion on key decision points as the effort evolved.

For example, the decision to change from a single-site to a scattered-site strategy toward the end of 2016 came as a surprise to several stakeholders on the steering and working committees. During the interviews and in various project meetings, some of the committee members questioned this decision and how it was made. One stakeholder noted, "There wasn't a lot of discussion" (A-28:110) about the change in strategy. Another stakeholder described how the project managers had promoted a single site development as a key to the initiative, but then abruptly changed course. The leader remarked, "there was another press conference [Moore Place expansion] to again, reinforce the greatness of single site and how important and how successful this is. So then there's like an offline conversation that comes back to the group and says, 'eh, we're going in a different direction" (A-28:126).

Subcommittee members also voiced frustration at the lack of communication, particularly toward the end of the effort. One committee member noted in a 2017 focus group, "…In the last few months, I feel like we weren't receiving as much information from the other committees and we really didn't know like what's the specific message to the community? What do we need? What do we need them to know? And so, I think if it's just kind of like status quo. You kind of lose the focus of what the …committee can be doing because it's kind of the same old message" (D-02:22). As the deadline approached, committee members expressed confusion over how to acknowledge an ending or ongoing efforts. Another focus group participant stated, "I just think there's mixed messages everywhere. I mean I heard - first I heard yes, we're going to end……and then [one leader] said something different and [another leader] says something different. I mean my impression now is that there are different opinions and that the steering committee is still working on it" (D-02:36).

Lack of Participation in Decision-Making. The concern about communication was closely related to concerns voiced about lack of participation in key decisions. One steering committee member noted about project management: "I get the sense that there's discussions that go on between them and Center City Partners that potentially that we're not always at privy too. So when we come to meetings, a lot of the – it seems like there's stuff that goes on behind the scenes that I'm not particularly aware of. So when I go to a meeting, it's sort of like we've changed direction or we have some new information we didn't have before. So I think they're doing a good job leading us to where they want us to go, which is what good project managers do. I'm not sure they ask us for our input as some of those changes are happening" (A-05:15). The committee member went on to say, "I think sometimes they need to understand how they can tap into our expertise a little bit better" (A-05:14). Regarding the single site project, another steering committee

member stated, “I don't know if they reached out to us or to others to be there with them as they were negotiating with the neighborhood” (A-04:20). Also related, a number of stakeholders commented that the steering and working committees were mainly update-oriented and that the meetings were, perhaps, missed opportunities for more constructive dialogue and structured decision-making about the effort. However, as one committee member noted, “We're there to listen, to provide feedback” (A-24:48). Project managers and sponsors reflected on the balance between engaging and overburdening members of the steering committee, but also reflected that they may have underutilized the expertise on the committee and were at times at a loss of how to engage them. As one effort leader noted, “Because HFCM has brought together so many diverse partners from different sectors, it has sometimes felt challenging to have meaningful roles for everyone. The shelter and housing providers are on the front lines. Then you have the corporate entities, such as the banks and institutions, such as the library, just to name a few. I think it has been hard to maintain the engagement of the latter groups because this work is not their core line of business. So sometimes it has felt like there are partners who are there in name only” (A-30:14).

Decreased Engagement. Related, stakeholders linked the lack of communication and participation to other challenges the effort faced. One stakeholder linked the lack of communication and a lack of regular steering committee meetings to the decrease in engagement from key community leaders. The stakeholder stated, “So the way that [the project manager] would send the working group monthly updates, I think they need to do that with the steering committee. Maybe they don't convene them monthly, but maybe every other month, and for sure monthly updates. 'Cause it fell off of everyone's radar, and I don't think it's coming back. I think the ship has sailed” (A-06:24). Lack of communication and discussion about the decision to focus on scattered-site permanent supportive housing also undermined supporters' belief that ending chronic homelessness was possible. As one leader noted, “I just don't see how we're going to be able to get to functional zero without a single-site of supportive housing” (A-10:62).

Choice of Project Manager. The choice of staff at Urban Ministry Center as the project managers was described as both the right choice because of their local expertise and passion to meet the goal, but also a potential problem. Project managers and stakeholders voiced concern that the effort was perceived “as just an Urban Ministry Center thing” (A-09:59), too closely linked to Urban Ministry Center and not to the broader coalition of providers and community leaders. A few stakeholders raised concerns that the relationship was a “conflict of interest” (A-25:39) since much of the funding for the effort in terms of project management, outreach, and single site housing development was set aside for use by Urban Ministry Center for the overall effort. Concerns about the capacity of individual project managers to do effective project management on top of ongoing responsibilities were also identified.

When the research team asked frontline stakeholders about how project management had assisted them in fulfilling their role in HFCM, a few of the individuals said they were not aware that HFCM had a designated project manager. For example, one individual responded by saying “Project management? What do you mean by that?” (A-19:126) and another responded with “I don't think I've interacted with them…I didn't know there was that or what that would look like” (A-18:24). In contrast, other stakeholders who worked more closely with the project managers responded to this question by describing how specific relationships and personalities contributed to the successes and outcomes of the initiative. Some of these comments praised the work of the project managers, while others were more critical.

Connecting to the Broader Context. Finally, several key stakeholders discussed the need for leaders to connect the problem of chronic homelessness to the broader community context, particularly the work of the Opportunity Task Force and the larger affordable housing problem. As one stakeholder noted, “All those other things also impact homelessness at one point, we're not there yet but we have got to weave in with the Opportunity Task Force and I don't know exactly what I'm going to say but I mean and that all has to be worked together. So we're going to have to somehow have Housing First Charlotte Mecklenburg and have steering committee talk with maybe the chairs of the Opportunity Task Force, there needs to be some connection there” (A-28:151). One stakeholder noted in 2016 in the wake of the protests that the attention of steering committee members and community leadership had already shifted from HFCM and they were becoming disengaged, “I just don't think it's top of mind anymore. I think it's Read Charlotte and the Opportunity Task Force and some stuff coming out of the protests, and Renaissance West” (A-06:37).

Stakeholders noted concern that the growing affordable housing problem and the resulting community meetings and task forces about it were rarely explicitly linked to the problem of chronic homelessness. As one community leader noted, “I also think that we need to point out how we really need permanent supportive housing or subsidized housing with the conversation around affordable housing and that this focus continues 'cause I unfortunately see sometimes…'affordable' housing is really looking at 60 percent [of area median income] and above and that's usually where elected officials feel comfortable, in my opinion” (A-28:153). Stakeholders also noted that the lack of affordable housing may explain the prevalence of street homelessness.

Moving Forward

In Spring 2018, leadership and management of the community's effort to end homelessness reverted back primarily to homeless service providers through the chronic work group of the Continuum of Care (CoC) Committee of the Housing Advisory Board of Charlotte-Mecklenburg. The committee was initially led by Karen Pelletier of Mecklenburg County, as well as inflow/outflow work managed by Robert Nesbit of Mecklenburg County and Allison Winston of Urban Ministry Center. The governance of the CoC transitioned from the City to the County in 2019.

Original Strategy

Strategy 8: Evaluate the Effort to End Chronic Homelessness

An essential component of this effort will be monitoring our progress towards ending chronic homelessness. In addition, we may choose to measure the impact of this effort on the community, as well as the lives of those experiencing homelessness. There are several components of a robust evaluation – from evaluating the process itself to examining the impact of the effort on community costs, such as emergency room bills.

Budget: $45,000 minimum up to $260,000
Timeline: January 2015-TBD
Staffing: Partner with UNCC College of Health and Human Services & Urban Institute

Evaluation

Strategy Implementation

Unlike the other HFCM strategies, evaluation was not initially considered a key strategy of the HFCM effort, but as a menu of options for the steering committee to consider in their first March 2015 meeting. According to interviews with HFCM leaders, committee members, particularly government leaders, insisted on investing in evaluation to understand the implementation of the effort and the impact of such a sizable commitment of public and private resources to address a pressing community problem. Dr. Lori Thomas, a faculty member in the UNC Charlotte School of Social Work who had recently completed a study on the Moore Place housing first program, was asked to prepare a proposal to evaluate HFCM. The proposal to conduct a process evaluation, an individual outcomes evaluation and service utilization study was presented to, and approved by, the steering committee at the June 2015 meeting. An initial evaluation subcommittee led by Thomas and Clasen-Kelly was formed to advise the more detailed development of the evaluation. After institutional contracts were signed and research began in March 2016, an evaluation status meeting was conducted monthly through 2017 and included research team leadership and evaluation funders. Individual and focus group interviews were conducted from March 2016 through December 2018. Administrative data were collected through September 2019.

The outcomes evaluation and utilization study was funded by the county ($200,000) and the process evaluation was funded by private donors through Urban Ministry Center ($30,000). The UNC Charlotte College of Health and Human Services contributed to the community investment ($161,000) primarily to support the costs of graduate students and personnel. When the HFCM deadline was extended to the end of 2017, the County provided an additional $165,000 to support the extension of the evaluation and CHHS invested an additional $31,000 through Research Enhancement Funds to support the project. By the end of the grant period, funders invested $583,000 in the project. Additional details on research design and methodology are provided in the appendices of the final reports.

Strategy Findings

Important Component. The evaluation strategy was not specifically queried in stakeholder interviews, however a number of participants discussed the evaluation as an early success of the effort and an "incredibly important" component of HFCM (A-05:08). The importance of examining outcomes and the value of the data were highlighted in interviews. One stakeholder noted, "All of the information will be really valuable." (I-06). Another stated, "The data makes people believe. Stories make people care" (A-17:20). Another stakeholder noted, "I think that it is the research and the data that comes out of this, and the tracking of the success of the individuals who are housed through this process over the next five years, is really going to help inform how funding is spent and how decisions are made around homelessness programs" (A-04:22).

Beyond Outcomes. While the value of understanding and demonstrating effective outcomes was highlighted as important, a number of stakeholders also noted the importance of the process evaluation and understanding and learning from how the effort was implemented. As one community leader stated, "I think that the work that you guys are doing is really important because it isn't just the goal that matters. It's also what went on to either meet or not meet the goal. I mean, I'm just so pleased that we were able to get this beautiful huge study paid for, and I think that it will serve as a model, good or bad, with its good and bad aspects for other community efforts. Yeah, I think it's just hugely important" (A-16:62). Another leader noted the importance of the process evaluation and how it relates to lessons learned about other major community initiatives, "The way you avoid making decisions and approaching things by the seat of our pants is through serious research and evaluation and trying to connect the successes across the different efforts, like Project L.I.F.T. and economic mobility and Housing First, and understanding what are the variables that really make a difference in helping a collaborative effort be successful and addressing those intentionally during the course of the process in order to really ensure the success" (A-25:57).

Optional or Integral. Project leaders also described the lesson they learned when they proposed evaluation as an optional versus integral strategy to end chronic homelessness in Charlotte-Mecklenburg. When the proposed cost of the evaluation was discussed between project sponsors and managers, leaders were concerned it would "scare people" on the steering committee and project leaders decided to provide a description of possible research options in the appendix of the proposed strategies document. However, as one leader noted, "One of the first questions was, 'What about evaluation?' I was like, 'I have this handout,' and they were like, 'Yes! Let's see it!' And then there was so much energy" (A-09:66). One of the steering committee members that pushed for thorough evaluation noted the integral importance of the evaluation, "What happened here? Is it just idiosyncratic or are there real lessons here that are learned that can be replicated with other challenges and issues that Charlotte or other communities are facing? We don't know that unless we ask those questions and seriously, honestly, and objectively analyze them" (A-25:56).

Strategy Implementation

The final process and outcomes/utilization evaluation reports mark the official end of the HFCM evaluation project. Given the breadth of the data collected, additional knowledge can be gained and shared with local and national audiences. The HFCM research team will continue to analyze and share this information through local stakeholder presentations, national conference presentations such as the Housing First Partners Conference, peer-reviewed literature, and local outlets such as the Charlotte-Mecklenburg Housing and Homelessness Dashboard.

Registry	Modified service sector Limited initial access Concerns about the VI-SPDAT A key accomplishment
Outreach	A front door to housing Connector to institutions Other duties as assigned Early warning system Insufficient capacity Lack of peer support
250 PSH Units	Creativity Sudden shift in strategy Unexpected external challenges Missing stakeholders Less emphasis on services
Coordinate Moves	Extended existing infrastructure New patterns of collaboration Sustainability concerns
Housing First Training	Dedicated staff National and local expertise Beyond the front line
Community Engagement	Early wins Clarity about state of HFCM Ongoing education and awareness Addressing related issues
Leadership & Staffing	Broad coalition Early communication Sustained communication Participation in decisions Decreased engagement Choice of project manager Connect to larger context
Evaluation	Important component Beyond outcomes Optional or integral

Summary

Strong Start

Stakeholders widely agreed that the launch and early years of HFCM were a success and an example for other initiatives to solve pressing community problems. The effort featured multi-sector leadership and participation, a clear plan, a project management structure, a clear goal and related data monitoring, and an evidence-based housing model empirically linked to desired outcomes. The multi-sector buy-in resulted in substantial and diverse financial support, as well as dedicated resources from partner agencies, volunteer efforts, and donated goods. Early media coverage and multiple modes of communication by leaders and a volunteer speakers bureau built support and anticipation. Despite some skepticism about 2016 as a realistic ending point, in general, people believed it was possible to end chronic homelessness. When asked why the effort was a success, one effort stakeholder stated, "I think it's partly because the model has been proven to work, and then I think it's because you have really the agencies that are directly involved with you know housing people and intake and outreach, so the Urban Ministry Centers or Salvation Army or the other organizations – the Men's Shelter – that are directly involved in meeting folks where the needs are I think has been a big component of the success that has happened, because you have organizations who have done this for a while and know what they're doing and do great work, and then the fact that you've been able to bring this collaborative group together and everyone has worked well together I think has made the impact" (A-24:20).

Representation

The multi-sector nature of the effort was widely recognized as a primary success of HFCM. The initiative incorporated business leaders and employees, government leaders and departments, leaders from allied sectors, local foundations, homeless service providers, and uptown neighborhoods. However, stakeholders recognized representation as both a strength and weakness of the effort. There was limited participation from key sectors including housing development, health, and mental health, and elected officials in the ongoing leadership and implementation of the effort. As one stakeholder noted, "The hospitals are technically kind of at the table, but they're not really at the table. I think it's really the nonprofits, city, and county at the table. So I would say the hospitals. You know potentially, a developer, to get some different voices" (A-6:30).

There was also limited participation from direct service providers at the forefront of housing and service delivery. And there was no representation of individuals with lived experience in the structure of the effort. Individuals with lived experience were included in some service delivery and strategy implementation efforts including peer support specialists on the outreach team and in permanent supportive housing, and as a peer research specialist on the research team. But as with direct service providers, there were no formal HFCM mechanisms to provide opportunity for individuals with lived experience to share their concerns and ideas about the effort. As one direct service provider stated, "So there's just a disconnect of, 'We want all this to happen,' okay, but who is actually doing the work, and they're not in the room. Their perspective wasn't even brought in. I feel like I sometimes have to be the voice of the people on the ground, and there are no homeless people, either, that are represented, or people with lived experience, which also I think is missing from the room" (B-06:23).

Finally, as the effort continued into 2017 and beyond, there was less sustained representation by the many sectors that had initially joined the effort to end chronic homelessness. By 2018, the organizations and individuals participating in organization and implementation efforts were often the usual homeless service sector providers who led and shouldered the work prior to HFCM. As one stakeholder noted, "Because HFCM has brought together so many diverse partners from different sectors, it has sometimes felt challenging to have meaningful roles for everyone. The shelter and housing providers are on the front lines. Then you have the corporate entities such as the banks and institutions such as the library, just to name a few. I think it has been hard to maintain the engagement of the latter groups because this work is not their core line of business. So sometimes it has felt like there are partners who are there in name only" (A-30:14).

Clarity and Transparency

Concerns about clarity and transparency were raised as the effort continued into 2016. In the Fall of 2016 as the initial end of the initiative approached, various stakeholders noted that they were not clear about the plan for the end of the initiative since there were still several hundred individuals to house and since inflow of new chronically homeless individuals seemed to be increasing. Stakeholders also described their frustration at the planning, decision-making,

and communication around the "sudden shift" in focus from single site housing and the construction of a second Moore Place to scattered site housing throughout Charlotte neighborhoods. While decision-making in working committees was primarily perceived as shared, decision-making for the overall effort was perceived by a number of stakeholders as an Urban Ministry Center initiative. One community stakeholder noted, "I think that potentially finding a new home that isn't Urban Ministry Center – I mean, they're experts. I love them. They are so good at what they do. But I think potentially finding a home for this at more of an umbrella agency might be helpful, because then it's not just an Urban Ministry Center project. It's really viewed as a community effort" (A-06:43).

In addition, the relationship of street homelessness to the effort to end chronic homelessness was not initially clear. Some steering committee members expressed their frustration that they learned later in the initiative rather than earlier that street homelessness and chronic homelessness were distinct, although overlapping and related, types of homelessness. When the number of individuals visible on uptown streets did not decrease despite significant housing numbers, some questioned the viability of the effort. As one stakeholder noted, "Because if the banks are investing this money, and what their employees are saying is nothing's changed, then you've lost all your credibility" (A-09:39). The lack of information and mixed messages inhibited trust in leaders and belief in the overall effort.

A Broader Context

The overall housing success of HFCM - over 1000 housed at last count - demonstrates the wisdom of narrowly focusing a change effort. It was clear among stakeholders that the purpose of HFCM was to house individuals as a permanent solution to the problem of chronic homelessness and effort results demonstrate the impact of such clarity. As HFCM unfolded however, the lack of connection between the narrow intervention and larger systemic problems became a challenge that impacted the initiative. First, the relationship between chronic homelessness and the broader issue of homelessness in general was not clear. As noted above, the relationship between chronic and street homelessness was not understood early in the initiative. The initial surprise at the substantial inflow of individuals "aging in" to chronic homelessness also suggested the need to better understand how more acute forms of homelessness become chronic in nature. Stakeholders also wondered aloud at the relationship of HFCM to the problem of homelessness among households with children.

Second, while a number of stakeholders and advocates understood the connection between chronic homelessness and affordable housing, several noted that the effort to end chronic homelessness could be more effectively linked to the broader concern around the cost of housing. As housing affordability became a larger community issue in 2016, HFCM was only tangentially linked to it. The challenge of connecting these issues speaks to the pervasive community assumption that chronic homelessness is primarily a problem of particular people, mainly those with extensive health, mental health, and substance use issues, rather than an issue of more structural determinants like the cost of housing and the availability of jobs with sustainable wages. As one effort leader noted, "Most of it is a systems issue. There's not – there's just not enough subsidized housing for everybody to get a house. You know, then we have an affordable housing issue in Charlotte that has to be addressed in order for housing first to be successful" (A-29:19).

Finally, as HFCM developed in 2014 and kicked off in 2015, the Charlotte-Mecklenburg community was also coming to terms with its low public placement in national economic mobility rankings (Chetty et al., 2014). As efforts to address economic mobility ramped up, the effort to end chronic homelessness was rarely discussed as a related issue, despite an inherent connection to the same systemic issues that limit economic mobility and despite HFCM leadership efforts to connect the two. The problem of chronic homelessness in Charlotte is another face of the concerns outlined in the Opportunity Task Force Report including racial exclusion, public transportation, housing affordability, mental health, and financial security among the many other issues raised that are also connected to chronic homelessness. The effort to address economic mobility however, was exclusively focused on children and their families. As one community stakeholder noted, "All those other things also impact homelessness at one point, we're not there yet but we have got to weave in with the Opportunity Task Force and…that all has to be worked together… there needs to be some connection there" (A-28:151).

The lack of an ongoing connection between chronic homelessness and these issues, both internally and externally, left the effort vulnerable to the public attention span that became more focused on housing affordability and economic mobility. In addition, the absence of connection between chronic homelessness and these other pressing issues could reaffirm the "ethos of bootstrapping" (Charlotte-Mecklenburg Opportunity Task Force, 2017), the common assumption that this problem is the fault of individuals making bad choices rather than the same systemic issues that underlie a number of social problems in Charlotte-Mecklenburg.

Sustained Technical Capacity

The implementation strategies emphasized the need to build capacity in multiple arenas including, among others, outreach, available housing units, and supportive services. As the effort continued and extended however, the ability to grow or even maintain capacity was limited. During the heart of the initiative, outreach was limited by a reduction in force and the need to address "other duties as assigned" that were important to the effort, but not necessarily the staff's core function. As demand grew, there were few new additional resources for housing and service providers began to face the rising cost of housing that was displacing those that were already housed. There were also few new additional resources for services and many programs were well over the small client-staff ratio suggested by guidelines for evidence-base models. These limits plus the discontinuity in operational project management challenged HFCM's ability to grow and sustain technical capacity to meet the effort goal. As one stakeholder noted, "I wish we had more capacity everywhere" (A-12:58). The struggle to sustain capacity to continue the effort reflects the effort's development as a finite project instead of an ongoing effort. Most aspects of the effort were built to last only until the end of 2016, when the community was to reach functional zero.

A Tale of Two Initiatives

The early successes and emerging challenges suggest, as one research team member noted, a tale of two initiatives. Stakeholders described, for example, how there was more regular communication at the beginning of the project, with many describing how, over time, they knew less about important HFCM decisions and how they were made and implemented, such as the extension of the project through 2017 and then 2018, the shift away from a single site strategy, and turnover in project management personnel. Adjusting to the substantial challenges within the effort and outside in the broader context strained resources and commitments. One of the key organizers of HFCM described almost too much momentum and interest on the front end and not enough planning to sustain it, "We should've given ourselves six months to get ready to start implementing,...We should've given ourselves time to prepare and then launch the campaign itself, or put the start date – or some way or another, I just think the timing, we were just overly optimistic. It's been more complex than that" (A-17:24).

Services & Program Fidelity

Services Provided

Housing first permanent supportive housing (HF PSH) was the primary service provided by the Housing First Charlotte-Mecklenburg (HFCM) effort and it was, in part, the local and national evidence associated with the model that prompted community leaders from government, nonprofit, and business sectors to form HFCM. In practice, people were housed through a variety of models and the meaning of housing first varied among stakeholders. This section examines the definition of housing first and describes the HFCM housing categories and service providers.

Defining Housing First. Housing first emerged in the early 1990s and referred to specific housing models including Beyond Shelter, a scattered-site rental program developed by Tanya Tull in 1988 for homeless families in Los Angeles (Lanzerotti, 2004) and Pathways to Housing, a scattered-site permanent supportive housing program developed by Sam Tsemberis in 1992 for chronically homeless individuals in New York City (Padgett, Henwood, & Tsemberis, 2016). Two congregate permanent supportive housing models were introduced soon after in 1997 in San Francisco and Seattle for chronically homeless individuals. These initial models were appreciably different but each focused on the early, if not immediate, provision of permanent housing for those experiencing homelessness as well as reducing typical housing eligibility barriers.

Numerous randomized controlled trials were later conducted and demonstrated the intervention's effectiveness in improving mental and physical health, housing stability, community functioning, as well as quality of life among

formerly homeless individuals (Goering et al., 2016; Greenwood, Schaefer-McDaniel, Winkel, & Tsemberis, 2005; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003; Padgett, Gulcur, & Tsemberis, 2006; Stefancic, Schaefer-McDaniel, Davis, & Tsemberis, 2004; Tsemberis, Gulcur, & Nakae, 2004; Tsemberis, Moran, Shinn, Asmussen, & Shern, 2003). More specifically, one of these studies demonstrated the intervention's potential to double housing success rates, in comparison with the treatment first model (Tsemberis et al., 2004). This body of knowledge led the U.S. Department of Housing and Urban Development (HUD) to endorse Housing First as the formal policy and program solution to end chronic homelessness nationwide.

While housing first emerged in specific supportive housing models, the phrase is often used to describe both a specific permanent supportive housing model and a more general philosophy that prioritizes housing and minimizes eligibility and ongoing service requirements. Later usage of the term housing first has become more diffuse as agencies, institutions, and communities around the country apply the term differentially (Padgett et al., 2016).

HFCM Housing Placements. The stated intention of HFCM was to house individuals experiencing chronic homelessness through the evidence-based housing first permanent supportive housing model. Initially the partnership included six local PSH providers and a seventh provider was added. The providers are briefly described in Table 8.

Table 8. HFCM PSH Providers

Organization	Brief Description
Carolinas Care Partnership	Carolinas CARE Partnership works regionally to prevent the spread of HIV/AIDS and to meet the needs of those affected by the disease. The organization provides Permanent Supportive Housing units for HIV Positive funded through the County and national HOPWA funds.
Community Link	Community Link assists working poor individuals and families access and maintain affordable housing. Community Link currently provides housing through rapid re-housing programing. Community link provided PSH housing through Fall of 2016.
HUD VASH	HUD VASH combines Housing and Urban Department vouchers with supportive services from the Veterans Administration to provide PSH for homeless Veterans. The Veterans Administration also provides funding for Rapid Re-Housing through the Supportive Services for Veteran Families (SSVF) program.
Mecklenburg County Shelter Plus Care	Shelter Plus Care is a federally funded permanent supportive housing program that links housing with supportive services to move individuals, and adults with families, who are homeless, have a disability and a low-income, to permanent housing. Care partners include a variety of community service providers.

	**Supportive Housing Communities**	Supportive Housing Communities provides permanent supportive housing for households experiencing homelessness, especially veterans and those with mental illness, substance abuse, or other disabling conditions. SHC also provides Rapid Re-Housing and housing for families experiencing chronic homelessness.
	**Transitions to Community Living**	TCLI is a state initiative coordinated in local communities by the local Managed Care Organization. Through TCLI, eligible participants are provided move-in assistance (deposits), monthly rental subsidy, mental health case management, and housing tenancy supports. TCLI funds can be used to support PSH.
	**Roof Above (Formerly, Urban Ministry Center)**	Roof Above provides housing with case management, basic services, outreach programs, winter shelter, and permanent supportive housing for homeless households. Recently, Urban Ministry Center merged with the Men's Shelter of Charlotte to form Roof Above.

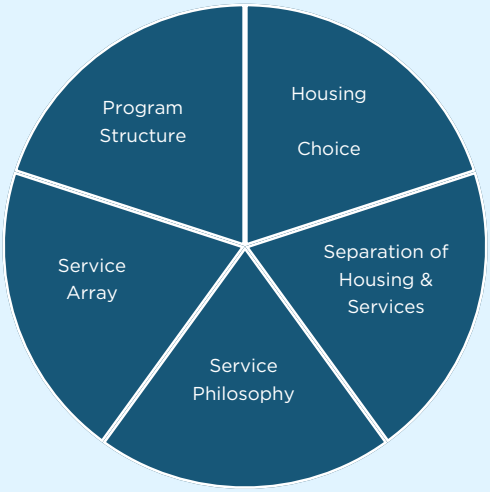
Non-PSH Housing Placements. While PSH was the primary intervention of HFCM, other housing placements were used to end homelessness among those who were on the By-Name List. These placements included rapid re-housing models through Community Link, Roof Above (formerly, Men's Shelter of Charlotte), the Salvation Army Center of Hope, and Supportive Housing Communities. Rapid Re-Housing is a housing intervention that provides low-barrier access to short-term subsidies and short-term housing stability supports for homeless individuals and families.

Other placements included ongoing housing without subsidy, subsidized housing without support, permanent placement with family or friends, and permanent placement in institutions (i.e., long term care facilities). The KEY program is an example of a subsidy program with few supportive services. KEY is a joint program between the Housing Finance Agency and NC Department of Health and Human Services. Any developer who receives funds from the Housing Finance Agency is required to set aside 10% of the units for the KEY program.

Other Services. While the primary focus of HFCM was permanent housing, usual services remained available to individuals while on the By-Name List, including emergency and transitional shelter and supportive services. Ongoing services also included additional outreach workers engaging with homeless individuals, enhanced services to support transition to housing, access to additional services like disability clinics to assist in disability designations, and access to community programs like Atrium's CommunityCareBridge that wraps health and social services around individuals who frequently use emergency medical services.

Fidelity Criteria

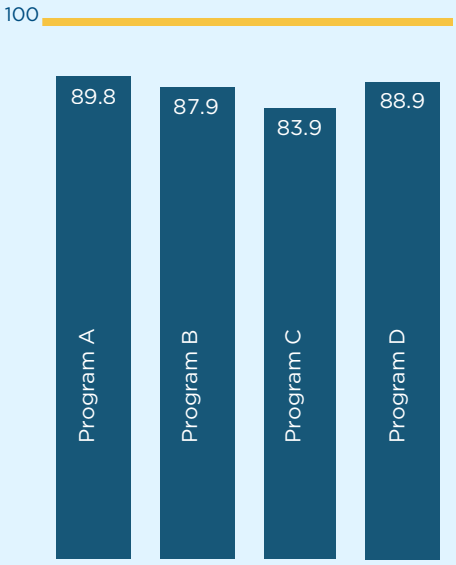
Figure 19. Housing First Permanent Supportive Housing Fidelity Criteria



While additional housing interventions were used to address homelessness, the effort was built around the use of the evidence-base model housing first permanent supportive housing to effectively end homelessness among most chronically homeless individuals and help them begin the path toward stability and recovery. To achieve the outcomes associated with housing first permanent supportive housing, successful programs attend to how services are provided and use research to inform program practices and structure. Program fidelity is the extent to which programs adhere to a program model, and more specifically the extent to which they adhere to the evidence-informed criteria that are associated with desired program outcomes. The most extensive research on program fidelity for housing first permanent supportive housing establishes five criteria for successful programs (Stefancic et al., 2013), listed in Figure 19. When compared to lower fidelity programs, programs with higher fidelity scores on these criteria are associated with higher housing stability, quality of life, and less use of substances and expensive emergency services (Goering et al., 2016).

HFCM examined program fidelity at the beginning (2015/16) of the initiative as well as at the end of evaluation (2018). As a part of the HFCM training strategy, the research team worked with Sam Tsemberis and Pathways Housing First to do site visits in late 2015 and early 2016 with all permanent supportive housing providers to provide initial program fidelity scores. Visits included an initial program survey followed by a meeting with all staff. Depending on access granted and the maturity of the program, site visits also included observations of team meetings, individual interviews with key staff, focus groups or individual interviews with tenants, and review of case files. Initial fidelity scores were presented and discussed with program staff at participating permanent supportive housing programs. The initial fidelity scores were intended to provide program feedback early in the HFCM initiative and allowed programs to identify their strengths and opportunities for improvement.

Figure 20. Average Program Fidelity Scores (n=28)



In Fall 2018, housing first permanent supportive housing frontline service providers and program staff completed a survey that included a fidelity assessment. The program self-assessment was completed by 40 individuals representing eight housing programs, including six permanent supportive housing programs and two rapid rehousing programs. Of the six PSH programs, four had three or more survey participants (n=28). Figure 20 describes the overall fidelity scores on a 100-point scale for each of the four PSH programs.

High fidelity programs should score at least an 87.5 on a 100-point scale on the criteria and sub-criteria (Macnaughton et al., 2015). Scores suggest overall fidelity to the housing first permanent supportive housing model with room for improvement. This section of the report describes each of the fidelity criteria, the average scores for the four programs, and themes from focus group and individual interviews regarding program fidelity criteria. Note that the original 4-point fidelity scale was converted to a 100-point scale for ease of interpretation.

Housing Choice

A key characteristic of Housing first permanent supportive housing (PSH) that distinguishes it from the housing models that preceded it is the central role of choice and individual agency. Maximizing choice in housing includes ensuring that within what is reasonably affordable, clients have choice in neighborhood location, the unit they will live in, and the home environment they will create for themselves. In addition, the housing process and related policies should allow someone to move in to affordable housing as soon as possible and trust that it is non time-limited, setting the stage for community integration and individual investment in a neighborhood (Stefancic et al., 2013). The Housing Choice criterion includes the following criteria:

Housing Choice. Program participants choose the location and other features of their housing.

Housing Availability (Intake to move-in). Extent to which program helps participants move quickly into permanent housing units of their choosing.

Housing Availability (Voucher/subsidy availability to move-in). Extent to which program helps participants move quickly into permanent housing units of their choosing.

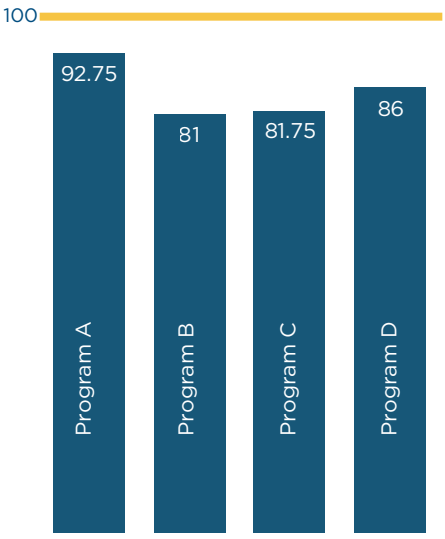
Permanent Housing Tenure. Extent to which housing tenure is assumed to be permanent with no actual or expected time limits, other than those defined under a standard lease or occupancy agreement.

Affordable Housing. Extent to which participants pay a reasonable amount of their income for housing costs.

Integrated Housing (Urban programs). Extent to which program participants live in scatter-site private market housing which is otherwise available to people without psychiatric or other disabilities.

Privacy. Extent to which program participants are expected to share living spaces, such as bathroom, kitchen, or dining room with other tenants (Tsemberis & Stefancic, 2012, pp. 1-2).

Figure 21. Average Housing Choice Program Scores (n=28)

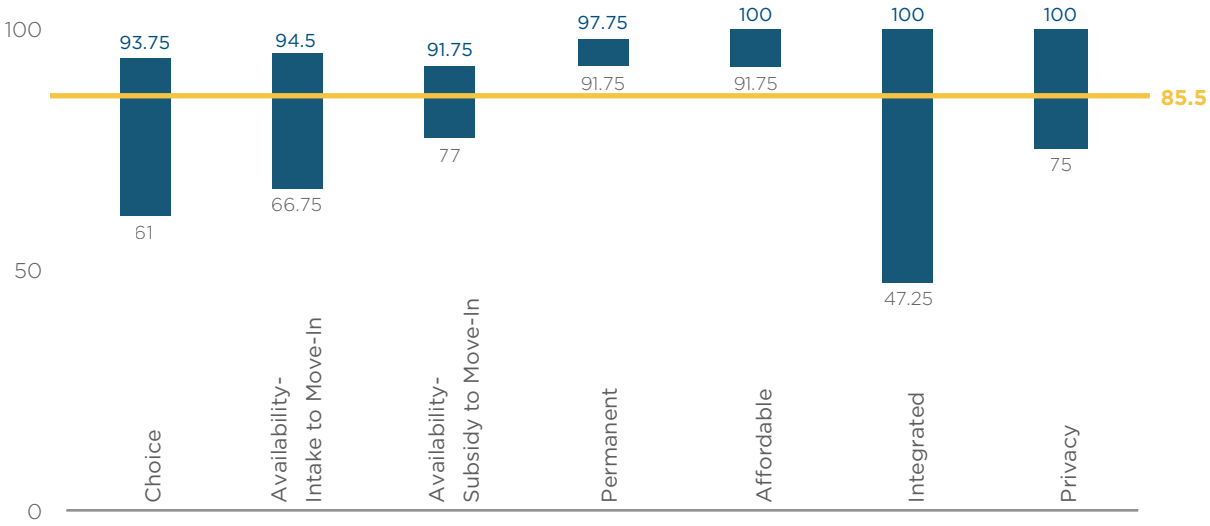


PSH Fidelity Scores

Figure 21 describes the average Housing Choice program scores from service providers' fidelity self-assessments. Overall, three programs fell below the threshold for high fidelity programs (87.5).

Figure 22 below describes the range of average Permanent Supportive Housing (PSH) program scores on the housing choice criteria in relationship to the average housing choice fidelity score across programs (85.5, horizontal line). The top score indicates the highest score in the range and the bottom score indicates the lowest score in the range. Smaller ranges suggest that programs are similar on the criterion; larger ranges suggest more variation across the programs. Programs generally scored high and similarly on the permanent housing tenure (91.75-97.75) and affordable housing (91.75-100) criteria. Programs were more varied in how they assessed their fidelity to the integrated housing criterion, where the average scores varied considerably (47.25-100), as well as the choice criterion, where the average scores varied between 61 and 93.75. This range may reflect the participation of a single site program in the assessment, which by definition requires individuals to live in congregate housing with others who are disabled and not among the general public. However, a number of scattered site service providers

Figure 22. Range of Average Housing Choice Fidelity Scores (n=28; 4 PSH programs)



noted that the lack of affordable housing often required them to house their clients in apartment complexes that were predominantly occupied by other formerly homeless or chronically homeless individuals with disabilities.

Qualitative Insight

Choice. Overall, homeless service providers used the language of housing as a right, central to the Housing First model, and recognized the value of housing choice. As one service provider noted, "It's very empowering, the fact that scattered site, it's still 100 percent [the] client's say. The caseworker can find them an apartment, and they can look at it and say, 'No, I don't want to live here.' That's what I tell all my clients, is that we serve you" (B-06:69). Congruent with the model, clients described being taken to properties, and given the opportunity to view and select the housing unit of their choice. On several occasions, clients reported refusing housing units that were offered to them and being subsequently shown other units. This reflects a collaborative, rather than prescriptive, process that engages clients and encourages individual agency and self-determination.

Living Environment. Choice in housing includes the ability to create a space of one's own, including the ability to choose household items and furniture. Providers and tenants suggested that most program partners gave clients the opportunity to choose furniture and household items. Clients typically spoke positively about the process of furnishing and decorating their home. Several participants explained receiving assistance in this area, yet being given the freedom to furnish their housing units based on their individual tastes and preferences. One client noted: "And one of the other things they [program] allowed me to do in moving into the new apartment was they took us over to a place right down by the women's shelter where you can get free furniture…And that was a beautiful thing…The Furniture Bank. Because you could build your life…You know, and you went in there and you picked and choose and you made your crib. You know? You built your crib" (C-03:99).

Program Constraints. Despite the programs' embrace of housing choice, contextual factors often constrained housing choice, including program practices and requirements. A few clients described not being able to view the inside of the housing units offered to them prior to move-in. In addition, sometimes what a program recognized as a choice, wasn't perceived as choice by the client. For example, agencies that featured scattered site and single site housing gave clients the option to choose between units in both locations. Because scattered site units often took longer to find, however, a client might "choose" the most immediately available option to get off of the street or out of shelter as quickly as possible. As one client described, scattered site was his preference but single site was available, "I was waiting on the scattered thing, but the wait list is so long…Moore Place came up…A little different from here. You got an apartment, a house somewhere. This here is like a joint thing. It's okay with me but you know that was my first preference" (C-01:64).

Housing Constraints. As Tsemberis noted in an initial fidelity site visit report, "Staff identified finding 'safe, decent and affordable housing' as their biggest challenge…as with all cities, the real estate market constrains the range and type of housing available and considerably reduces the choice in housing" (F-02). Two years later, service providers agreed and specifically cited landlords and the disappearance of affordable housing as key constraints on the housing choice they could offer clients. A number of respondents, particularly service providers, described the need for new landlords to meet housing goals. One provider stated: "The community has over 300 more people to house. So, we're probably not going to keep using the same 12 property managers to get all of them…" (A-07:45). Respondents noted the difficulty of finding landlords and property managers to partner with - "supply is still an issue" - and maintaining relationships with landlords and property managers when demand for affordable housing is high (A-20:21).

Several service providers noted that the disappearance of affordable units required them to move their clients. One provider noted, "…,.they're tearing down affordable neighborhoods. I mean, places where you'd have private owners that would maybe work with somebody that had a little more criminal history, they're gone, you know?……we had some people that were on 6th Street that got displaced" (B-05:126). Clients who had been housed in scattered sites through HFCM were aware of the rising cost of rent and the disappearance of affordable units, recounting moves they had to make because of the difference in the rising rents and what their voucher would pay. With nods around the room, one housed individual described the increases in his rent and utilities since he moved in and asked, "Now are we going to be homeless again if our rent increases?" (C-03:219).

Respondents also noted the challenge of working with landlords and property managers who, in a period of high demand, can pick and choose the subsidies and clients they will accept. A service provider described the barriers related to the use of particular subsidies, "Not every property manager will take, say, a Shelter Plus Care voucher, but will say 'Ok, we'll take a Housing Choice voucher', so sometimes you're looking for different property managers as well or landlords….the biggest challenge, is finding landlords and property managers to work with whatever voucher you're trying to house someone with at that moment" (A-07:37). With such high demand, property managers and landlords also could pick and choose the types of clients they wanted to house. A provider described this challenge with clients with a criminal background, "…landlords are saying, 'No, no, no, no, you need – I'm not gonna even going to accept you with X, Y and Z on your history here, you need – to do something about those before I even touch you' and it's the same landlord after landlord after landlord…" (A-19:118).

The tight affordable housing market often meant clients seeking housing had to choose among substandard apartments that were dirty or in disrepair or otherwise unsafe. Numerous service providers spoke to concerns about "the shortage of affordable – not only affordable housing, affordable […] clean and safe housing" (B-07:90) and expressed frustration that "clients are moved into substandard housing at market rate…you wouldn't put your dog in these houses" (B-10:111). As one service provider stated, "Yeah, I've had clients who have told me, 'If this is all the choices I have, I would rather be homeless,'" to which another provider replied, "I heard that today" (B-05:134).

Neighborhood Constraints. Related, the limited availability of affordable housing led to housing choices limited to options only in challenged neighborhoods. This barrier to program fidelity was identified during the 2015-2016 site visits, "The scatter site apartments are described as generally located in difficult, unsafe neighborhoods that are without access to services or transportation" (F-04). Service providers expressed concerns that placing clients in housing and neighborhood environments with heavy drug use was a problem for clients struggling with substance use disorders. As one provider stated, "We have a neighborhood behind us actually that is basically a haven for drug…And putting someone there is almost setting them up for failure, especially if they have drug use" (B-10:114). Housed clients reiterated this concern, "The area of the apartments, I know I have a felony and all, but I've heard of people getting into better places. People will stop me as I'm walking to the store and ask if I want to buy weed" (E-631:04).

Service providers described streets, neighborhoods, and apartment complexes that looked much like the homeless settings that clients were leaving. "I think one of the challenges that comes with only a certain number of landlords working with us is that it's harder to have true community integration when you're in a situation where, you know, half of the people they knew on North Tryon Street live right down the road. And that's an issue" (B-05:154). As another provider noted,"…when you do find a complex that might take someone, you tend to flood it with clients" (B-04:127). Lack of available affordable housing and the neighborhood concentration of the few available units undermine efforts to offer formerly homeless individuals opportunities to join and participate in broader community life, one of the key reasons the housing first PSH model promotes scattered over single site apartments. In practice, however, the concentration of scattered site units fails to provide opportunities for community integration.

While programs demonstrated commitment to housing choice, the contextual constraints service providers and clients faced consistently challenged community and agency capacity to effectively implement the housing first PSH program model. As one provider noted, "the infrastructure is not there" to implement housing first as intended (B-10:141), particularly "as the housing market…keeps getting tighter and tighter" (B-05:173). In order to adjust to these

constraints, providers felt they often had to choose the lesser of evils. As another provider commented, "We are running out of options, and there aren't many choices…It's always a choice between bad and worse" (B-04:63). Considerable contextual constraints limit the nature of choice and the range of options available to individuals leaving chronic homelessness.

Separation of Housing and Services

In addition to ensuring housing choice, the housing first PSH model separates housing from service participation. Housing first programs are low barrier and participants are not required to meet certain eligibility criteria or be enrolled in certain services in order to be housed. Leases, therefore, should provide the same legal protections for individuals who have experienced homelessness as they do for the general public and should list no service participation or adherence requirements. If someone loses housing, supportive services should continue and the program should work with the client to find new housing. In highest fidelity programs, housing and services are not provided at the same location in order to reduce perceptions of institutionalization and to encourage a "sense of home" (Stefancic et al., 2013). The separation of housing and services fidelity assessment measure includes the following criteria:

No Housing Readiness. Extent to which program participants are not required to demonstrate housing readiness to gain access to housing units.

No Program Contingencies of Tenancy. Extent to which continued tenancy is not linked in any way with adherence to clinical, treatment, or service provisions.

Standard Tenant Agreement. Extent to which program participants have legal rights to the unit with no special provisions added to the lease or occupancy agreement.

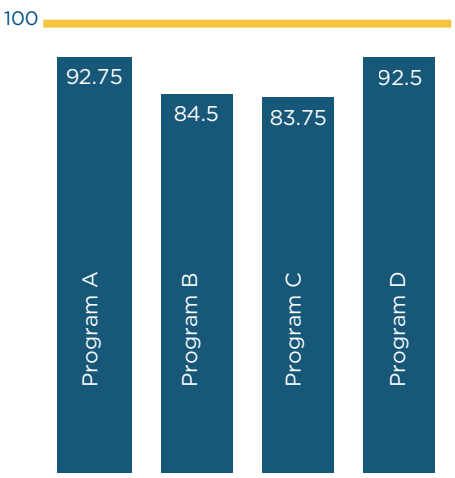
Commitment to Re-House. Extent to which the program offers participants who have lost their housing access to a new housing unit.

Services Continue Through Housing Loss. Extent to which program participants continue receiving services even if they lose housing

Off-site Services. Extent to which social and clinical service providers are not located at participant's residences

Mobile services. Extent to which social and clinical service providers are mobile and can deliver services to locations of participants' choosing (Tsemberis & Stefancic, 2012, pp. 2-4)

Figure 23. Average Separation of Housing & Services Program Scores (n=28)



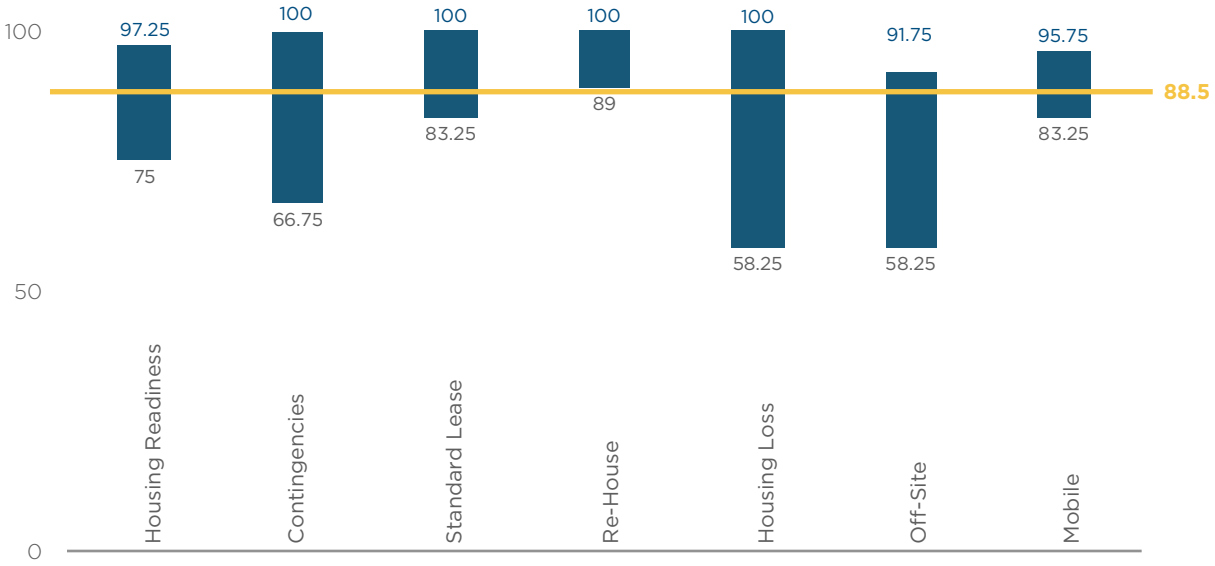
PSH Fidelity Scores

Figure 23 describes the average Separation of Housing and Services program scores from service providers' fidelity self-assessments conducted in 2018. Overall, participating staff from two programs rated themselves as high fidelity programs in terms of housing choice.

Figure 24 below describes the range of average Permanent Supportive Housing (PSH) program scores on the separation of housing and services criteria in relationship to the average separation of housing and services fidelity score across programs (88.5, horizontal line). The top score indicates the highest score in the range and the bottom score indicates the lowest score in the range. Smaller ranges suggest that programs are similar on the criterion; larger ranges suggest more variation across the programs. Programs generally scored high and more similarly on the commitment to re-house sub-criterion (89–100). The range of average scores for off-site services (58.25-91.75)

suggests more variation among programs on the criterion. The lower scores may also reflect the assessments of a single site model, which co-locates housing and services. Programs also assessed extensive variation and low range scores in the services continue through housing loss (58.25-100) and no program contingencies of tenancy criteria (66.75-100).

Figure 24. Range of Average Separation of Housing & Services Program Scores (n=28; 4 PSH programs)



Qualitative Insight

Low Barrier Programs. Overall, service providers and clients reported low barrier programs that do not require clients to meet extensive eligibility criteria to gain housing. One service provider described her interaction with new clients, "I tell them this is housing first, that means we house you with any issues you have right now and once you get housing, we will explore other services you need" (F-01). Clients confirmed that they did not have to agree to sobriety or take medications for mental health conditions in order to get housed. Service provider and client comments were congruent with early fidelity site visit reports. Tsemberis noted of several programs that, "The central premise of not requiring treatment or sobriety as a condition for getting housing or keeping housing is well understood and practiced by staff" and programs had "a clear understanding of the fundamentals of this separation: tenants are not required to participate in treatment or attain sobriety in order to obtain housing" (F-01 and F-06, respectively).

It is important to note that although programs generally self-assessed and demonstrated fidelity to this aspect of the housing first model, there were exceptions. For one program, willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance was a condition to gain access to a permanent, independent scatter-site apartment (G-01). In addition, some providers pointed to the inconsistent use of the criterion during implementation and mentioned that "some [clients] are required to be sober, while other residents are allowed to use" (I-14). Finally, program partners reported "extreme" or "severe and persistent behavioral issues" (J-02 and J-03, respectively) as possible reasons for clients to be discharged from programs.

Departure From Accustomed Services. The separation of housing and services represents a considerable departure from the traditional model of homeless assistance, whose services relied on compliance with eligibility criteria and ongoing participation in mandated services to remain in housing. One service provider described the adjustment required, noting, "With them coming into the housing first model, you know that was something for me to get used to, because of the fact that with those mandated services, there were certain things that had to take place. But this is just totally different" (B-05:45). Clients also suggested that the services were new for them as well and differed from their past experiences with homeless services. Several clients reported concern, and expressed feelings related to the fear of losing their housing. One participant noted, "I'm not doing enough and feeling like I will be kicked out" (E-829:06).

Low Barrier Skeptics. For some service providers, the lack of traditional eligibility requirements was concerning. One provider associated the absence of expectations of housing readiness with housing losses, stating, "So there are

people who are still in McCreesh Place prior to – you know what I mean, been [there] for years, and have never had any issues. They came in sober, because they had to be. You know what I mean? There were those parameters. And I think a lot of those people are still in the program unless they did well, and got jobs, and graduated out. Versus maybe how quickly people are losing places" (B-04:47). Another feared that not requiring more from clients to enter housing was "setting them up for failure" asking, "why would you put somebody in housing, they're going to do the same thing they've been doing?" (B-07:94).

Single Site and Scattered Site Differences. Staff of both single and scattered site programs indicated that adherence to separation of housing and services varied across the two models, even within the same agency. The physical structure of single site programs made fidelity to this criterion challenging. A service provider noted, "All our offices are located right beside property management. So it's hard for someone who's running from property management because they haven't paid their rent. You got to go down the same hallway to get to us" (B-09:57). Another noted concern that tenants couldn't distinguish between their clinical case manager and property management, "the gist is that we are the same as property management. Or if sometimes they tell us something with regard to maybe their drug use or other things I think some of the folks, not everyone but some of the folks feel like, 'We're going to go back and tell property management.' It's a struggle around rapport building and different things that maybe a scattered site wouldn't have those struggles" (B-09:128).

Single site policies regarding guests were different than the standard leases typically used in scattered site and were described by clients as frustrating and problematic. Tenants noted that the "guest policy hinder[ed] [their] social interactions" and held the "conditions of the lease" responsible for this, as they caused them to "feel trapped because you have to register guests and they can't visit for more than 3 days" (E-843:06, E-843:03, respectively). Guest restrictions were particularly difficult to handle for clients when significant others also experiencing homelessness had not yet been housed. As one tenant expressed, "it wasn't like I wanted to leave him in the streets either. I didn't think it was really fair for you to house me, and he still has to go to that tent" (C-02:40). This lease requirement reinforced client perceptions that their continued tenancy was dependent on adhering to a set of rules that weren't applicable to most renters. As one tenant noted, "there are a lot of rules here" (E-821:03).

Several service providers also described variations in eviction and housing loss patterns between single and scattered site housing types. Single site providers described their ability to be more flexible with tenants compared to community landlords and project managers. One provider noted, "I think if you're a scattered site you're having the same – you could easily be evicted from a scattered site model, maybe more easily get evicted because of your behavior like that" (B-09:50). Another agreed," Oh for sure. I think that our guys get a lot more chances at plate" (B-09:50). Other service providers, however, expressed concern that there was a lower threshold for behavioral issues at a single site program since disruptive behavior impacted other residents.

Housing Loss and Service Continuity. Several early fidelity site visit reports noted concern that once a person lost their housing, they were discharged from services as well and noted the need to address practices around housing loss and program discharge. Early training calls tackled this issue as service providers sought to prevent returns to homelessness. This early concern led to a change in the ability to move individuals among various housing programs within and across agencies in order to preserve housing. Overall, partnering agencies made clear efforts to rehouse participants upon housing loss.

Service Philosophy

High fidelity housing first PSH programs provide services that are voluntary in nature and do not demand service compliance or success. Instead of focusing on compliance to a prescribed list of services, service providers instead focus on person-centered and harm reduction services. This does not mean, however, that housing first is housing only or that services are unimportant. Rather the criterion recognizes what evidence underscores; services are more effective when they are client-chosen and client-directed (Greenwood et al., 2005; Greenwood & Manning, 2017). For a variety of reasons including long histories with and distrust of service systems, as well as the impact of mental illness and substance use disorders, service providers will encounter program participants that are reluctant to engage in services. Thus, successful programs will use effective techniques to engage with them including motivational interviewing, assertive engagement, and person-centered planning rather than holding all clients to a set list of participation requirements. The housing first PSH service philosophy recognizes the uniqueness of each client situation and commits to start where the client is initially and on an ongoing basis. The service philosophy fidelity assessment measure includes the criteria described below.

Service choice. Extent to which program participants choose the type, sequence, and intensity of services on an ongoing basis.

No requirements for participation in psychiatric treatment. Extent to which program participants with psychiatric disabilities are not required to take medication or participate in psychiatric treatment.

No requirements for participation in substance use treatment. Extent to which participants with substance use disorders are not required to participate in treatment.

Harm Reduction Approach. Extent to which program utilizes a harm reduction approach to substance use.

Motivational Interviewing. Extent to which program staff use principles of motivational interviewing in all aspects of interaction with program participants.

Assertive Engagement. Program uses an array of techniques to engage consumers who are difficult to engage, including (1) motivational interventions to engage consumers in a more collaborative manner, and (2) therapeutic limit-setting interventions where necessary, with a focus on instilling autonomy as quickly as possible. In addition to applying this range of interventions, (3) the program has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of these techniques, and modifying approach where necessary.

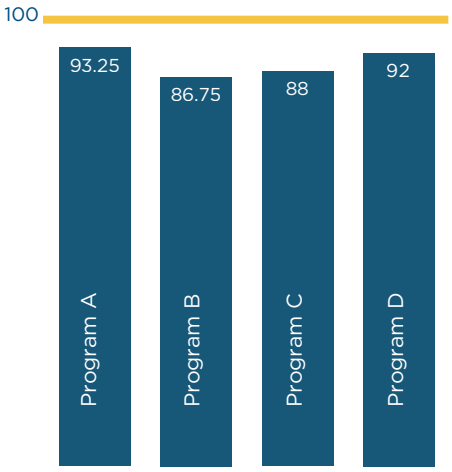
Absence of Coercion. Extent to which the program does not engage in coercive activities towards participants.

Person-Centered Planning. Extent to which program conducts person-centered planning, including: 1) development of formative treatment plan ideas based on discussions driven by the participant's goals and preferences, 2) conducting regularly scheduled treatment planning meetings, 3) actual practices reflect strengths and resources identified in the assessment.

Interventions Target a Broad Range of Life Goals. Extent to which program systematically delivers specific interventions to address a range of life areas (e.g., physical health, employment, education, housing satisfaction, social support, spirituality, recreation & leisure, etc).

Participant Self-Determination and Independence. Extent to which program increases participants' independence and self-determination by giving them choices and honoring day-to-day choices as much as possible (i.e., there is a recognition of the varying needs and functioning levels of participants, but level of oversight and care is commensurate with need, in light of the goal of enhancing self-determination) (Tsemberis & Stefancic, 2012, pp. 4-7).

Figure 25. Average Service Philosophy Program Scores (n=28)

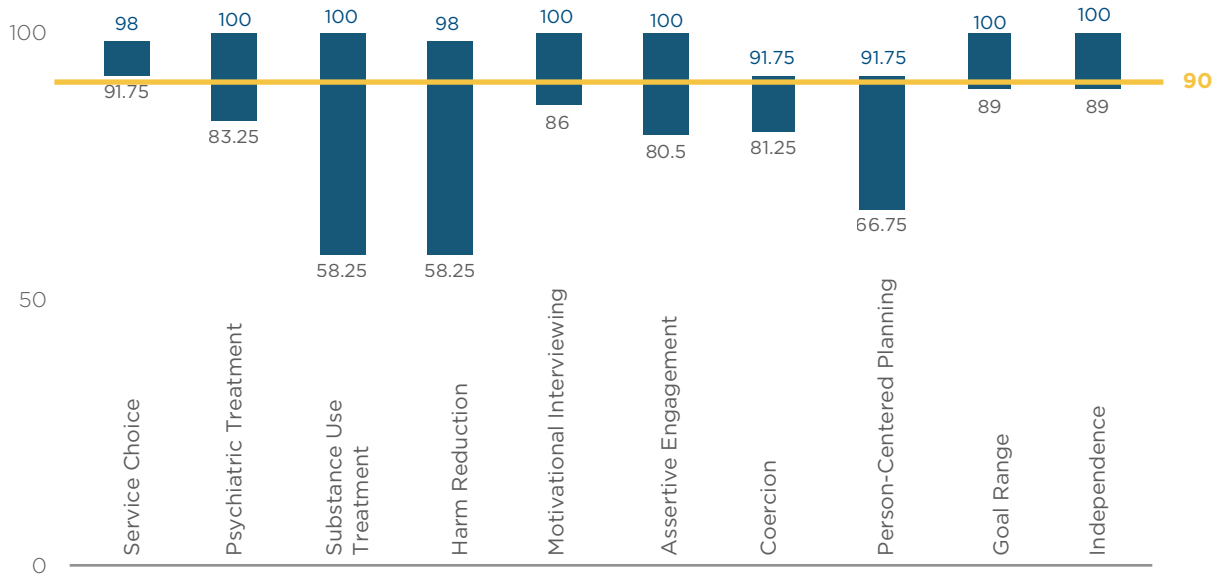


PSH Fidelity Scores

Figure 25 describes the average Service Philosophy program scores from service providers' fidelity self-assessments conducted in 2018. Overall, participating staff from three out of four programs rated themselves as high fidelity programs in terms of service philosophy.

Figure 26 below describes the range of average PSH program scores on the service philosophy criteria in relationship to the average service philosophy fidelity score across programs (90, horizontal line). The top score indicates the highest score in the range and the bottom score indicates the lowest score in the range. Smaller ranges suggest that programs are similar on the criterion; larger ranges suggest more variation across the programs. Programs consistently scored themselves high on the sub-criteria service choice, goal range, and independence. In contrast, score ranges suggest greater variation across person-centered planning, no requirements for participation in substance use treatment, and harm reduction, suggesting different levels of integration across programs. These criteria differentiate the housing first service philosophy from the traditional model and require a fundamental shift from deeply rooted approaches to homeless assistance services.

Figure 26. Range of Average Service Philosophy Program Scores (n=28; 4 PSH programs)



Qualitative Insight

Buy-in. Leaders and providers reported their personal belief in the service philosophy and in the housing first model's ability to work for individuals experiencing chronic homelessness. As one community leader stated, "And so for me being on the streets and [seeing] people who have addiction issues, have mental health issues, where there's alcohol. Sometimes it's just purely financial but lots of times there are these severe debilitating factors. You can't fix those things on the street. So the best case is, sure, let's get clean and sober and get housing, we're going to have a fairytale happy ending. But the reality is if we get them off the street first, the chances of being able to overcome some of these other things or at least get them to where we can manage them – there's a lot of housed people that suffer these same things all over Charlotte, right?" (A-10:87). Service providers voiced similar personal and professional belief in the model's ability to realistically address the problems individuals experiencing chronic homelessness face. One provider stated, "In homelessness, you've got to have housing first [...]. Because everybody is not going to go to drug treatment and get clean and then be ready for housing" (B-07:64). In addition, stakeholders described the importance of community buy-in since, as one service provider noted, "...it's not just putting someone into an apartment. You've got to have the community buy-in...there's funding needs that are there. It's not just the housing, but healthcare, it's getting communities to be accepting of having our people, it truly takes a village. You need to have people from all of these different groups backing the effort, saying "Yes we're willing to help you to make this successful" (A-07:49).

Agency Trust and Courage. Buy-in beyond service providers was also important for homeless service agencies who had previously been heralded and funded for traditional homeless service models. Agencies had only recently been asked to embrace the housing first model, which ran counter to prior common practice. Programs needed to hear from and trust leaders and funders that they would not be penalized for implementing a model that according to previous "treatment first" training and experience was counter-intuitive and that many feared would result in lower housing stability rates. One community leader and funder described the importance of building trust for successful implementation, "So helping agencies understand we're more concerned about using Housing First than having 100 percent of the people that you get into housing maintain their housing and so it's, I think, building that trust with agencies" (A-28:56). Another community leader noted the courage it took for agencies to adopt a new service model, "It was great to see some agencies who had a more traditional methodology say, 'We'll try the housing first strategy', which really was stretching, and took courage to get out of their comfort zone of their normal way they did things. And so that was huge that now five different organizations used housing first" (A-17:17).

Harm Reduction Concerns. Providers generally appeared to follow the guidelines implied by the adoption of a harm reduction approach. As one provider explained, "Total abstinence works for some people. Some people aren't ready for that yet. You know, so you've got to meet them where they're at, and then you've got to hold their hand and try to walk them through it" (B-07:70). However, the harm reduction approach was a concern for some service providers who felt as if they were "encouraging" clients to use substances or as noted earlier, "setting them up for failure" (B-10:114). As one of the initial program fidelity reports noted, "Some staff members struggle with questions about how much they should be doing for clients and at what point does 'doing for clients' become a form of enabling. There are other staff that understand client driven services" (F-04). One provider suggested the greatest challenge with the model was "no requirement for a recovery process" (B-10:55). Another provider noted professional and ethical concerns, "It's incredibly stressful, too, because you're having to put in your notes, our plan is they're going to continue smoking crack" (B-04:123).

Choice Versus Engagement. The concerns raised about harm reduction pointed to a broader insight about the perceived relationship between choice and engagement among service providers. Service provider comments suggest that a number of frontline workers felt the model forced them to uphold choice at the expense of supportive services, particularly if the client did not want to engage in services. As one provider expressed, "It seems the piece that's missing – that housing first is a good model to get people into a program. But then the program should have some – I think sometimes it's the teeth that are missing to help people. So client choice, it's not about taking away people's opportunity to choose. But the choice might be – this is what it takes to be successful in housing. And with knowing that, these are some of the expectations" (B-04:158). Another noted, "I feel like we do a disservice to the clients by taking them off the streets, putting them into housing, and that's all they get. They don't know how to take a shower. They don't know how to wash clothes. They don't know how to clean a house. So when inspection time comes, it's like major league dirty that they've got to do some – that fails the inspection. So I mean we can't require them to do any of these things. Sit for this orientation on how to do housekeeping, or bathe, or whatever. I mean none of that. They don't know how to – a lot of them don't know how to keep a place" (B-04:169). These and similar comments suggest a common difficulty managing the tension between service choice and lack of client engagement, or that choice means anything goes.

Assumptions About Single Site and Scattered Site Models. Service providers' concerns about client choice were sometimes related to concerns about client capacity for independence and, specifically, the type of program best suited for those that were assumed to have less capacity for self-sufficiency. Fidelity to the independence criterion seemed hindered by local assumptions that some clients weren't capable of living independently, and that the "most challenged clients need the structured environment," provided by a single site model or higher levels of institutional care (A-27:25). Service providers reflected the assumption that single site programs were programs for those with the most severe needs, often referring to the proximity and intensiveness of available services at a single site location. As one service provider stated, "And sometimes the right housing, the affordable housing you have might not be right for a client..should have been better suited at Moore Place where they had wraparound supports for her, than to put her out in the community where you going to risk a landlord [relationship]...And yet maybe she'll graduate out of Moore Place into the Scattered Site program, because she's gotten all those skills at Moore Place to actually now go out into the community, into her own place" (B-04:148).

Another provider noted her perception of prospective client differences between scattered site and single site, "Now, if you need something like Moore Place because you may not have the mental capacity, you know what I mean, or you may not have the ability, that's really perfect for someone. But for someone who maybe does have more, and the ability to learn, giving them some more personal responsibility as mistakes are made" (B-04:183). Single site providers also noted this prevalent misunderstanding of the role of single site PSH models, noting that scattered site workers as well as other service providers assume that single site workers provide more intense services and a residential level of care, "They think it's like a PRTF, a Psychiatric Residential Treatment Facility. And that's just not something we do. We're an amenity, like a pool. Like if this were an apartment complex and say our offices were across the street, that's the separation as far as what we can and can't do" (B-09:79). Single site providers noted that various physicians and even adult protective service (APS) workers assumed that once someone was housed at Moore Place, they had the institutional care typically expected of a nursing home.

Relational Nature of the Work. Despite challenges and varying assumptions about the model, most service providers described their appreciation for the model and the nature of their jobs. Frontline workers identified the relational nature of services as one of the aspects of housing first they appreciated and one of the model's features that differentiated it from the traditional service provision model. Service choice, the harm-reduction approach, person-centered planning, and focus on self-determination allowed clients to start "where they are" (B-05:42). As one service provider stated, "everyone doesn't speak to that same rhythm and you have to change your tune and change yourself to make it work" (B-10:27). Another noted that the model enabled her to adhere to her professional ethics as a social worker, "This is what makes it really true social work, is that you let the client dictate where they want to go, and you also really have so many opportunities to empower the client. [...] In Housing First, I think that we really do walk with, beside our client" (B-05:85).

Service Array

While services are voluntary, a range of services are needed to support individuals who have experienced chronic homelessness. As program participants are engaged, they need access to services to meet their goals and facilitate recovery. Programs can provide services themselves or formally or informally broker them with other providers, but an array of services should be accessible to tenants regardless. In addition, given the tenuous nature of recovery, crisis services should be available to tenants every day, including after hours, and the program should help facilitate and ease transitions before and after any in-patient treatment the client chooses to enter. The service array criterion includes the following specific criteria:

Housing Support. Extent to which program offers services to help participants maintain housing, such as offering assistance with neighborhood orientation, landlord relations, budgeting and shopping.

Psychiatric Services. Extent to which the program has strong linkages, provides active referrals and conducts follow-up for the provision of psychiatric services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/ providing consultation with other providers regarding services on a regular basis and coordinating care.

Substance Use Treatment. Extent to which the program has strong linkages, provides active referrals and conducts follow-up for the provision of substance abuse services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.

Employment & Educational Services. Extent to which the program has strong linkages, provides active referrals and conducts follow-up for the provision of employment and educational services. Specifically, the program: 1) has established formal and informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, and directly introducing participants to providers, and 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis and coordinating care.

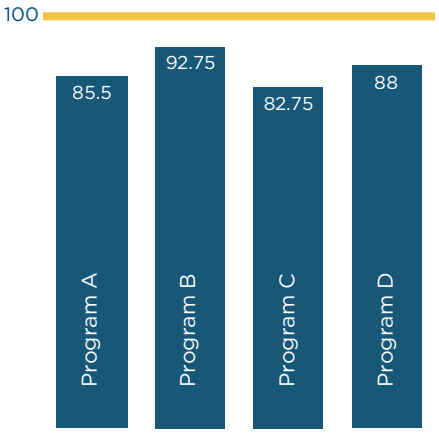
Nursing/Medical Services. Extent to which the program has strong linkages, provides active referrals and conducts follow-up for the provision of nursing/medical services. Specifically, the program: 1) has established formal & informal links with several providers, 2) assesses participants to match needs & preferences to providers, 3) assists participants in locating, obtaining, & directly introducing participants to providers, & 4) conducts follow-up including communicating/providing consultation with other providers regarding services on a regular basis & coordinating care.

Social Integration. Extent to which services supporting social integration are provided directly by the program. 1) Facilitating access to and helping participants develop valued social roles and networks within and outside the program, 2) helping participants develop social competencies to successfully negotiate social relationships, 3) enhancing citizenship and participation in social and political venues.

24-hour Coverage. Extent to which program responds to psychiatric or other crises 24-hours a day.

Involved in In-Patient Treatment. Program is involved in inpatient treatment admissions and works with inpatient staff to ensure proper discharge as follows: 1) program initiates admissions as necessary, 2) program consults with inpatient staff regarding need for admissions, 3) program consults with inpatient staff regarding participant's treatment, 4) program consults with inpatient staff regarding discharge planning, and 5) program is aware of participant's discharge from treatment (Tsemberis & Stefancic, 2012, pp. 8-12).

Figure 27. Average Service Array Program Scores (n=28)

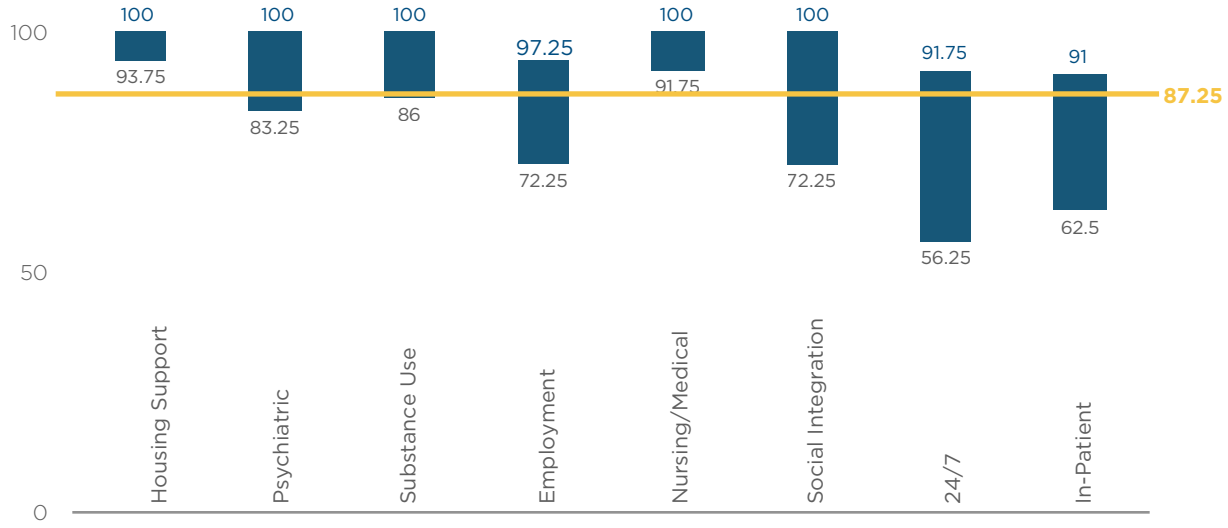


PSH Fidelity Scores

Figure 27 describes the average Service Array program scores from service providers' fidelity self-assessments. Overall, participating staff from two programs rated themselves as high fidelity programs in terms of service array.

Figure 28 describes the range of average PSH program scores on the service array criteria in relationship to the average service array fidelity scores across programs (87.25, horizontal line). The top score indicates the highest score in the range and the bottom score indicates the lowest score in the range. Smaller ranges suggest that programs are similar on the criterion; larger ranges suggest more variation across the programs. On two sub-criteria scores, housing support and nursing or medical services, programs scored themselves similarly high. In contrast, the range of scores across the other sub-criteria demonstrate greater variability, suggesting different levels of integration across programs, particularly among employment, social integration, crisis intervention, and in-patient engagement services.

Figure 28. Range of Average Service Array Program Scores (n=28; 4 PSH programs)



Qualitative Insight

Extensive Housing Location Efforts. Congruent with the fidelity self-assessments, service providers noted that they were consistently providing housing-related services to individuals as they transitioned into the program, often using most of their time to do so and limiting their extent to provide or connect individuals to other needed services. Scattered site service providers reported feeling "desperate" to provide housing for their clients (B-05:172) and expressed worry that their housing subsidy would expire before they could help their client locate housing. Clients echoed this concern. One person stated, "It takes too long because of the amount of people they are dealing with and trying to find a place where they can live and afford. It took me a year to find housing through the men's shelter and I would like to see that process be shorter for my sake and theirs" (E-850:05). A few clients expressed the same concern but also felt like housing location was mainly left up to them and they needed help. The frontline focus on finding housing often came at the expense of other stabilizing services that assist in the transition to housing and recovery.

Inconsistency Across Programs. Some service providers reported not having regular access to health care providers and few formal connections that they could rely on to support their clients. Other programs had a nurse on staff and

formal agreements with clinics and physicians, including psychiatrists. This unevenness across programs was reflected in focus groups with program participants who had been housed. When asked what services she received regularly, one client noted, "I get transported to and from my doctor's appointment" (C-02:59). However, several housed participant noted their struggle to get health care. "Yeah, and I'm not really getting good care, like, this is a giant bureaucracy, like, a government program and it's giant. The healthcare is – it's a hard dance. You've gotta get primary and all that – you can't just go get healthcare" (C-05:74).

In one program, service recipients were not aware they were receiving case management. When the interviewer asked if a client had a case manager, the client stated, "They don't give you one. Yeah, put you in the housing and then after that it's like you're on your own" (C-03:110). A service provider at the program confirmed this in a service provider focus group, stating, "So we lack case management services in this program. So those are the calls I get, my colleagues get, when they have issues come up, when they need a food referral, need a furniture referral, landlords call the internal staff with any issues they see. I mean we try to address it the best we can, if they don't have an attached social worker, or a case manager. If they do, then we do engage that person to say 'hey, this is what I've been notified of, can you look into it?' " (B-04:51).

Substance Use Treatment Options. Service providers discussed a variety of perspectives on substance use treatment and a harm reduction philosophy. The shift to a harm reduction service philosophy from an abstinence and "tough love" philosophy was a struggle, or even viewed as a mistake by some providers. Some providers seemed to take a hands off approach to engagement if a client made a "choice" to continue using substances. As one provider noted, "I mean all we can do is offer what we have. But it's up to them to engage. So if they're still not engaging, it's still going to be the same outcome of losing housing, ultimately" (B-04:96). Several providers noted with exasperation that there was only so much they could do. Others noted that they were nervous about supporting harm-reduction, particularly when they may be aware of continued use and don't want to appear to condone it, "we shouldn't be encouraging this" (B-04:123). These perspectives contributed to a lack of options for harm-reduction oriented substance use services.

Other providers, however, seemed more comfortable with the philosophical shift. One frontline worker stated, "But then you kind of alluded that second piece is accepting them where they are, this barrier free approach that we don't expect anything – you don't have to change anything. You don't have to change anything. We would love for you to change, you know, taking medication or stop using drugs or alcohol or whatever the case may be, but starting that because I think they hear a lot – I think they're judged a lot by people, by service providers for whatever their situation is" (A-10:37). Providers also noted the creativity and persistence it took to use a harm reduction approach to help a person recover which led to the development of a harm reduction support group, one of the few mechanisms in the Larger Community To Support the Frontline and Their Clients in a Harm Reduction Based Recovery Journey.

No Formal 24/7 Services. No PSH program in Charlotte reported the availability of formal 24/7 services beyond 911 or mobile crisis for either scattered and single site clients, and a front-desk security guard at Moore Place. A number of service providers reported their concern about their clients after business hours. As one provider stated, "That's where we have the most problems is when we leave at five o'clock it's completely out of our control. And that is when -- sex work, the drug dealing, and just the excessive drinking. You just never know what you're going to come into the next day. We joke, when people interview for this job, one of our scenarios is: 'Okay, you walk in at eight o'clock in the morning and there's a blood trail from the front door to one of your tenant's apartments" (B-09:44). Some providers reported remaining available informally to their clients by phone and the availability of some supervisors in case of emergency, but no program utilized a formalized on call program that rotates service providers in order to address crises and provide services after hours. A formal 24/7 program connects clients in crisis to someone they know and potentially reduces utilization of emergency services.

Need for Higher Levels of Care. Several service providers also expressed concern that some clients were too chronically ill for PSH and needed higher levels of residential care. One service provider noted, "I've had a few folks who have needed higher levels of care, if there could be a streamlining kind of way to get connected to one, assisted living that takes folks that have substance abuse behavioral challenges that would be awesome" (B-09:70). Another frontline worker noted, "we get a lot of people…that should not be in our program. They're ideal on paper, but once you put them in that place you notice they do need a higher level—they need support housing, or this is what they need, more care--more care, assisted living. Whatever happening, they need extra care" (B-10:119). Another provider questioned if the highest VI-SPDAT scores sometimes correspond to people who could and should not live independently.

Transition Support. Several research participants with lived experience discussed the difficulty they had transitioning from homelessness to their own apartment. One person stated, "You know, those ten years, it took a toll, and I didn't know it. I thought when I moved into the apartment I was going to hit the ground running, I was going to get back to working and, you know, get back into my daughter's life, save some money. It didn't turn out like that, you

know?" (C-03:44). Another person stated, "It's been difficult, 'cause I had these moments—I had the moments where I didn't want to go outside. I was depressed or something. Need some help to get well. Something to kickstart" (C-03:184). Service providers also recognized this as a potentially vulnerable period. As one frontline worker noted, "So sometimes we're juggling trying to meet with all of our clients, but then there's other clients that take up a lot of our time and have really complex medical issues, especially when they're first transitioning living at Moore Place I think sometimes a lot of our time might be spent on helping them with that transition period" (B-09:19).

Community Integration. Housed participants expressed concerns about social isolation. As one person in a scattered site apartment stated, "I've felt more isolated and socially anxious since leaving my camp and being away from my social network" (E-846:01). Similar concerns were echoed by service providers. During initial fidelity visits, one service provider expressed concerns about "loneliness once [clients] are in housing" and foresaw "social isolation" as an upcoming challenge among housed clients (H-03). During focus group interviews, another case manager emphasized the importance of providing social integration services, specifically early on after a client had been housed: "I find that as time goes on, I've had that with a few people, it [social integration] wasn't needed as much. But at the beginning, when somebody gets in there, and you know they were around people constantly, and then there's just like these four walls, and it's just silent, I think, you know, having some social connections" (B-05:157).

Program Structure

Housing first permanent supportive housing, like other evidence-based practices, requires a program structure to facilitate and maintain effectiveness. This is particularly important for a program like housing first that is a significant departure from traditional homeless services. Structural elements have been linked to a program's capacity to maintain the above fidelity criteria and the overall housing first philosophy (Kertesz et al., 2017). For example, scarce resources often prevent the low client to staff ratio linked to positive program outcomes (Gilmer et al., 2013; Keller et al., 2013) .The program structure criterion includes the following specific criteria:

Priority Enrollment for Individuals with Obstacles to Housing Stability. Extent to which program prioritizes enrollment for individuals who experience multiple obstacles to housing stability.

Contact with Participants. Extent to which program has a minimal threshold of non-treatment related contact with participants.

Low Participant/Staff Ratio. Extent to which program consistently maintains a low participant/staff ratio, excluding the psychiatrist & administrative support.

Frequent Meetings. Extent to which program staff meet as a team to plan and review services for program participants.

Weekly Meeting/Case Review (Quality): Serves the following functions:

1) Conduct a brief but clinically relevant review of ½ caseload

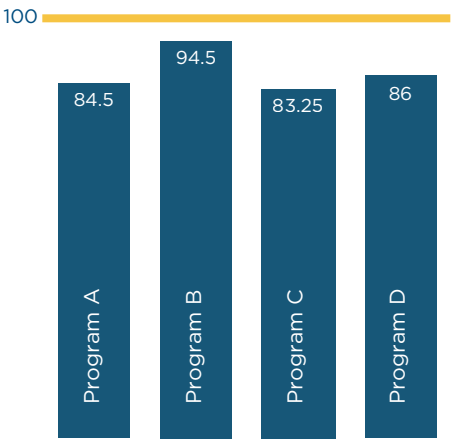
2) Discuss participants with high priority emerging issues in depth to collectively identify potentially effective strategies and approaches

3) Identify new resources within & outside the program for staff or participants

4) Discuss program-related issues such as scheduling, policies, procedures, etc.

Participant Representation in Program. Extent to which participants are represented in program operations and have input into policy (Tsemberis & Stefancic, 2012, pp. 12-13).

Figure 29. Average Program Structure Program Scores (n=28)

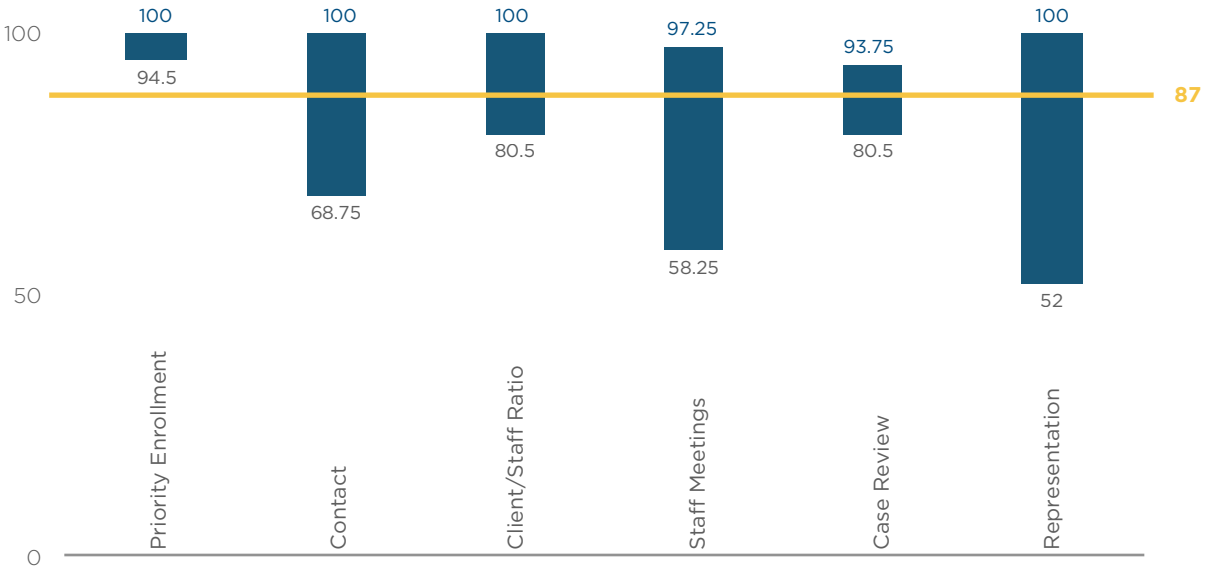


PSH Fidelity Scores

Figure 29 describes the average program structure scores from service providers' fidelity self-assessments. Overall, participating staff from one program rated themselves as high fidelity programs in terms of program structure.

Figure 30 below describes the range of average PSH program scores on the service array criteria in relationship to the average service array fidelity scores across programs (87, horizontal line). The top score indicates the highest score in the range and the bottom score indicates the lowest score in the range. Smaller ranges suggest that programs are similar on the criterion; larger ranges suggest more variation across the programs. On the priority enrollment, programs scored themselves high and similarly (94.5-100). In contrast, the range of scores across three of the other criteria demonstrate greater ranges of variability, suggesting different levels of integration across programs, particularly contact with participants, staff meetings, and consumer representation.

Figure 31. Range of Average Program Structure Scores (n=28; 4 PSH programs)

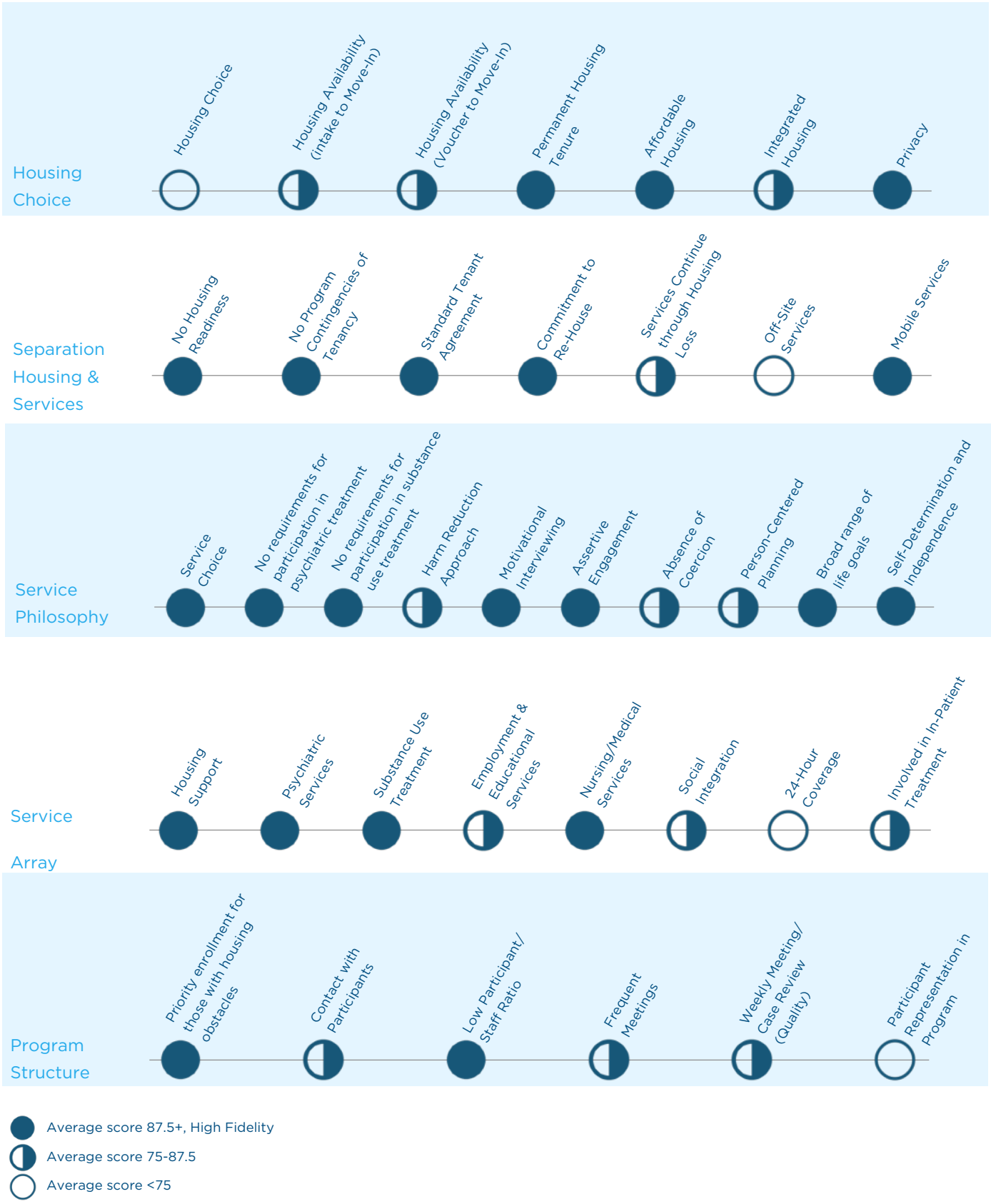


Qualitative Insight

Regular Contact Varies. Programs varied in how they implemented aspects of the program structure. While the fidelity standard is approximately 3 meetings per month, a couple of programs reported no requirements for regular client check-ins, one provider reported a monthly requirement, and one reported a weekly requirement. "I thought that was housing first, is that there is nothing that's a requirement" (B-04:73), stated one service provider, while another noted: "Housing first is I think a home visit weekly or something? But we don't have the staff to implement that" (B-04:184). Other staff noted that contact depends on the functioning level of the client, as illustrated by the comment made by a service provider in the same focus group: "But you still see them at least twice a month, or more than that maybe. There's clients I see three four times a week. There's some clients I might only see once a week. There's some clients I see biweekly. Depends on what's going on, and how the client is" (B-04:185). In some cases, low contact is also an issue of high client:staff ratios, which in most programs exceeded recommended ratios.

Incorporating Lived Experience. Most programs reported having some staff with lived experience, trained as peer support, but those workers were not available for everyone and were not available for all services or programming. As one housed participant noted, "They were doing anger management and I think they need to do it again. But they need to get a different instructor. Because how can you talk about being angry if you never been angry? And some instructors look like they're sweet as pie and have never had an altercation in their life. And it's like, no, you have a lot of anger from being homeless. Like she [another focus group member] said, you feel like somebody owes you something because you're out here and you're invisible" (C-02:83). Another woman noted, "Yeah, I can't explain what it is or how it feels. I can tell you how I'm feeling but if you never been there you'll never understand" (C-02:90). Another expressed, "Workers dealing with the homeless population should be able to relate to them" (E-776:02). While working with people with lived experience was valued by housed participants, service providers and participants noted that some housed individuals only had a peer support case manager with a very high caseload. All programs except one reported mechanisms to solicit client input on program policies and practices. Only one organization included clients or persons with lived experience on governing bodies.

Figure 32. Summary of Fidelity Criteria Self-Assessment Scores (n=28; 4 PSH Programs)



Summary

When created in the late 1990s, housing first permanent supportive housing was a significant departure from traditional service delivery for individuals experiencing chronic homelessness. It challenged assumptions about the appropriate role of housing. It challenged assumptions about who was most appropriate for housing. And, it challenged assumptions about how services needed to be delivered to those who were homeless. In the new housing first model, housing was a foundation not a reward, people were born housing-ready, and services began with the person instead of a threshold of eligibility criteria.

Initially, there were more detractors than supporters and the sector generally challenged the wisdom of housing first until evidence began to suggest it was much more likely to keep a person stably housed and individuals experiencing homelessness preferred it. Once evidence began to accumulate about its effectiveness and funders, including the federal government, started to expect providers to use the model, housing first began to spread and communities adapted it in various settings and contexts. The model was often adapted in contexts that adopted some of its elements while de-emphasizing or questioning others or in contexts that remained resistant to its non-traditional assumptions. Fidelity criteria were developed from and tested with evidence-supported models to help adopting communities replicate the elements that are tied to effectiveness.

HFCM faced the same challenges other communities have faced implementing a major change in a service sector that for years has operated under different assumptions and in large part is staffed by providers who were trained in more traditional models of service delivery for homeless populations. The fidelity self-assessments and qualitative data suggest a number of areas where that transition has been successful: direct service providers believe in the importance of housing as a foundation and they generally believe that low barrier programs allow people to access services more effectively. The data also suggest areas, however, where programs can improve. Figure 29 above suggests areas that programs can focus on for improvements. In addition, interviews and self-assessments suggest the following areas may be instructive for programs and for service sector leaders.

Housing Market Constraints

Direct service providers repeatedly noted in interviews the challenge of finding housing and how the housing search consumed much of their time. While providers were doing their best to meet the needs of individuals before they found housing, some services were necessarily delayed until housing could be located. Although some programs include housing specialists on staff, this finding points to the potential usefulness of having staff dedicated to landlord relationships. As Sam Tsemberis noted in a training event, it may be useful to bring on a team member whose caseload is landlords and whose primary job is to develop and maintain those relationships. In addition, given the increased scarcity of housing in the Charlotte-Mecklenburg area, individual programs and the sector need to understand how ongoing shortages may impact the effort to end chronic homelessness. Scarce housing resources may force rationing, which tends to be applied using principles of service compliance and merit-related eligibility inherent to the treatment first model that previously dominated homeless assistance services. Ultimately, these challenges shed light upon the need for sustainable policy solutions that ensure housing that is affordable at all levels, without which the burden of housing affordability is born most acutely by the front line and by the homeless individuals they seek to house and serve.

Site Assumptions

Single site PSH, aside from a small scattered site pilot program, was the first HF PSH program in Charlotte-Mecklenburg and in many ways set the standard for housing first permanent supportive housing in the community. Focus group and interview data with direct service providers and community leaders suggest prevailing assumptions that the single site model is the best form of housing for individuals experiencing chronic homelessness and that single site and scattered site programs serve different populations. Specifically, the qualitative data suggested assumptions that the “more difficult to serve” because of health, mental health, or substance use challenges should be in single site programs like Moore Place and those with fewer support needs should be in scattered site programs where services aren’t as readily available.

Research on HF PSH *does not* support this division in terms of acuity and most empirical evidence suggests the effectiveness of scattered site HF PSH with acute symptoms of a serious and persistent mental illness and co-occurring disorders (e.g., Stefancic, Schaefer-McDaniel, Davis, & Tsemberis, 2004). HF PSH was developed to integrate individuals experiencing chronic homelessness into apartments in the community “otherwise available to people without psychiatric or other disabilities” where they were wrapped with an array of service supports depending on

their unique needs, including 24/7 access to an on-call case manager. All housing first permanent supportive housing should provide permanent housing and wrap-around services whether in a scattered or single-site location. Individuals with acute symptoms are appropriate for either setting and if programs are providing HF PSH as designed, the primary question should be where they choose to live, within the constraints of what is available.

Housing first or Housing Only?

Some interpretations of choice and voluntary services could result in limited supportive services. This was particularly true of approaches to substance use disorders but evident across multiple types of tenant needs. As noted in the discussion above, when clients refused services, several service providers noted there was little they could do to change the tenants outcome and in many cases seemed resigned to label the tenants as service resistant and let them be. However, the model incorporates elements to address this. First, while there are very few requirements to access housing in housing first permanent supportive housing, agreeing to regular visits, often weekly visits from a case manager is necessary. Prospective tenants should be informed before they move-in that they are required to meet with a case manager even if they choose not to engage in any of the services the case manager or program offers. The regular contact allows for further relationship development through periods of service resistance and allows for assertive engagement around behaviors that may be harmful to the tenant or others. This should be structured into the program so it is an expectation of service providers and tenants from the beginning of the relationship. Second, peer support can be an effective way to address the needs of tenants who are reluctant to engage in services. Working with someone whose life experience is more similar to yours may reduce perceived barriers to services. Finally, with very few harm reduction services available in the Charlotte-Mecklenburg community, ensuring that tenants have access to support beyond the case manager relationship can provide additional options for tenants who are not immediately willing or able to engage in services.

Based on focus group interviews with direct service providers, some scattered site programs did not provide an array of services to support the needs of individuals in scattered site apartments and were not appropriately structured to do so. Large caseloads, infrequent contact, and in some cases no assigned case manager led to concerns from both those providing and receiving services about the ability of the model to actually meet the needs of individuals once they were housed. Describing programs as housing first permanent supportive housing when they don't meet program criteria undermines direct service provider and recipient trust in the model. To call something housing first permanent housing when people receive few if any services perpetuates assumptions that housing first is housing only.

This leads to a larger homeless services system question of how to understand and apply housing first outside of permanent supportive housing. The fidelity criteria to support the replication of housing first permanent supportive housing programs is readily available and clear, but far less is known and understood about the application of housing first beyond PSH. How does the philosophy of housing first apply in rapid-rehousing when you can't secure housing long enough for someone to recover from a substance use disorder? How does a housing first philosophy apply to coordinated entry, when the early forms of HF PSH was built around first come first served. How do you incorporate a housing first philosophy in emergency shelter? What does it mean to be a housing first system? Many of these questions have not yet been asked or answered and are left up to local contexts to interpret and these interpretations can impact how individuals feel about housing first.

Self-Assessment Limitations

As with any self-assessment, there are limitations. A direct service provider may feel the need to score their program high because of concerns that a low score may hurt their organization or may even personally impact some aspect of their job. When Pathways Housing First conducts assessments, they also conduct site visits that consist of interviews and observations of program practices and then combine scoring to have both external and internal feedback, as they did at the beginning of the HFCM effort. Nevertheless, toward the end of the study period, qualitative and quantitative findings suggest areas across programs where programs are stronger and areas that could use improvement. Self-assessments are learning tools for individual programs and the community. Individual programs can also use the fidelity self-assessments themselves as an annual or regular exercise to assess themselves and involve staff and stakeholders in continuous quality improvement efforts.

The self-assessment instruments were developed based on the scattered site model, the most empirically tested and supported model of housing first permanent supportive housing. While most of the self-assessment items apply regardless of housing location, single site presents a considerable challenge for some criteria around housing choice, integrated housing, and privacy, as well as the on-site challenges of philosophically and logistically separating housing and services (i.e., property management and case management) - a challenge observed in single site qualitative data.

More extensive research needs to be conducted on single site models, and single site versus scattered site models to develop more specific criteria for single site programs. To date, only one randomized control trial has been conducted comparing the two models (Somers et al., 2017). Key questions remain for single site housing first models - how do they emphasize choice and distance themselves from the institutional characteristics and concerns about warehousing individuals with disabilities that housing first permanent supportive housing was developed to challenge? How do they separate services in housing when property managers and case managers have offices in the same building? The current self-assessment instruments may remind single site programs of the importance of these components, but they are not designed to help single site programs examine how they are managing those key places of tension in single site programs. This and further research may help adapt the self-assessment instrument for more specific single site use.

Discussion

Key Accomplishments

The key accomplishment of Housing First Charlotte-Mecklenburg is tangible - 1011 housed according to the January 2020 Chronic and Veteran Homelessness Summary. A basic examination of recidivism rates during the study period (2015-2018) suggests that the majority of individuals housed did not return to emergency shelter. This was accomplished despite the tightening of the housing market that accelerated during the launch of the initiative. As one community leader stated, "We feel very good about the number of people who've been housed. We feel really good about that" (A-12:46). This accomplishment had ripple effects to individual lives and the larger community as discussed in more detail in the outcomes and utilization report.

> "We feel very good about the number of people who've been housed. We feel really good about that"

The initiative also facilitated a reorientation of the chronic homelessness service sector beyond crisis management toward the permanence of housing. The effort led to the broad adoption of an evidence-based practice, the establishment of the By-Name List, an increased emphasis on outreach, new housing relationships and a landlord consortium, a concerted training effort that continues under Mecklenburg County and service provider leadership, extended service collaboration that helps literally move people from homelessness to housing, and overall, a new creativity toward solving the problem with limited resources. As one effort leader stated, "I think there was generally this accepted, assumed rather reality that homelessness was this huge, monolithic social problem for which there was no answer. And I think we have changed the conversation to, 'Yes, there is an answer' " (A-17:19).

HFCM brought together diverse community partners for a new collective purpose. The multi-sector collaboration allowed the services sector to extend its reach beyond typical and often fragmented resources and accelerate the rate at which individuals were housed. As one service provider noted, "I'm a very strong believer in collaboration, and I think whenever people in a community get together around a common goal that it matters. It changes things" (A-16:25). While the partners did not meet the initial goal to end chronic homelessness by the end of 2016, they did set a new path to more permanently address versus simply manage the problem of chronic homelessness. The collaboration spurred greater awareness of chronic homelessness and actions to address it.

Finally, HFCM developed a project infrastructure to support the effort that did not rely solely on already over-extended resources and services. Collaborators brought over $1 million to the effort stimulating additional financial investments from Mecklenburg County, Charlotte Housing Authority (now Inlivian), Crisis Assistance Ministry, and UNC Charlotte. Funding was used to develop a project management infrastructure that propelled early housing success including regular data monitoring, creative problem solving as the cost of available housing rapidly increased, effective communication, and training for direct service providers. The effort also invested in evaluation, to understand its own process and impact and provide information for future work.

Examine Racial Equity Implications of Prioritization

While the accomplishments above suggest successes to celebrate, the process evaluation also provides opportunities to improve the community response to chronic homelessness and other pressing community issues. First, findings suggest the importance of examining the implications of the VI-SPDAT on equitable housing prioritization. Analysis of the VI-SPDAT scores of those on the By-Name List between 2015-2018 suggests that on average, the prioritization tool scores White individuals higher than Black individuals. In addition, a greater percentage of White individuals were housed in permanent supportive housing than were Black individuals, an outcome likely related to VI-SPDAT scoring. Qualitative findings from direct workers and individuals experiencing homelessness further raise concerns about the validity of the VI-SPDAT. Local findings are similar to a study of three Pacific Northwest Continuum of Care communities that found that the instrument better predicted White vulnerability than Black vulnerability and thus prioritized more extensive housing supports for White people. The Continuum of Care should examine use of the VI-SPDAT to address the scoring concerns discussed by frontline workers and the racial equity implications suggested in

the By-Name List patterns. The prioritization tool has been widely adopted nationally and internationally, but findings from this and other studies suggest the importance of modifying or reconsidering it as a primary tool for housing prioritization.

Initiative Improvements

In addition, stakeholders noted several practical lessons learned that can inform future initiatives to address community challenges. First, ensure ongoing representation of related sectors like in this case, the health, mental health, political leaders, and housing development sectors, as well as direct service providers, and people with lived experience. Second, engage stakeholders in decision-making. Steering committee members noted that they were not included in some strategic and operational decisions that they could have assisted with. Working committee members noted that they were not included in the strategic decision-making of the overall effort. Third, sustain project management across the initiative and ensure capacity. In addition, although it's difficult to please everyone, continually work to ensure that stakeholders view project managers as working for all stakeholders and not their own interests. Fourth, sustain communication to stakeholders and the public, especially in the case of setbacks. Finally, because all efforts face challenges, plan in advance for mechanisms to adjust and recalibrate management accordingly. HFCM lost momentum in 2016 when it struggled to adjust to internal and external challenges.

Supporting a Philosophical Shift

Findings suggest that the work of shifting an underlying philosophy is hard and multiple layers of support are needed to create and sustain it. While many service workers noted how they appreciated the housing first permanent supportive housing model, many also suggested that it was challenging to figure out how to work with tenants with the different set of service tools that a housing first philosophy required. As one direct service provider noted about the inability to use loss of housing as tool to "encourage" change, "We have one stick and we can use it one time" (B-09:12). While HFCM provided training, direct service providers discussed the importance of ongoing support for programs shifting from engrained practices to new evidence-based and informed practices.

Tensions inherent and necessary in the model can result in housing *only* instead of housing *first* if the philosophical shift is not supported or sustained.

There are tensions inherent in the HF PSH model that are difficult to navigate as a direct service provider. While housing first prescribes absence of coercion in service provision and no requirements for participation in psychiatric treatment and substance use treatment, the model also calls for regular meetings with clients and assertive engagement and motivational interviewing techniques to engage clients who lack motivation or otherwise don't participate in the services offered. Service providers described a high degree of fidelity to service choice and no requirements for participation in psychiatric treatment and substance use treatment. However, providers frequently described concern that in order to protect choice, they couldn't proactively and directly engage clients to change problematic behaviors or address mental health and substance use problems. While service providers scored themselves pretty high on the fidelity self-assessments regarding the incorporation of assertive engagement and motivational interviewing techniques, qualitative data suggest a lack of integration of the techniques and sometimes the assumption that housing first programs didn't allow proactive engagement because it violated a client's choice to continue substance use or other potentially detrimental behaviors. Such assumptions often translate to housing only programs (rather than housing first programs) that don't provide clients necessary services. Tensions inherent and necessary in the HF PSH model can result in housing only instead of housing first if the philosophical shift is not adequately supported or sustained.

Beyond the client-worker interaction, while the literature provides extensive information about HF PSH, it provides limited information on how housing first applies beyond it. Some research is available about rapid re-housing for individuals with fewer extensive needs, but there is no research on a "missing middle" of services for those who need more extensive housing subsidies and/or more extensive services than RRH but also don't need the longer term support of HF PSH. How does a housing first philosophy apply in these cases? In a context of limited resources and pressing human need, there is room and demand for innovation here but also well worn paths that make more

traditional service models attractive and easy to implement. How do more improvised model adaptations support or undermine a housing first philosophy? How can an effort like HFCM support this exploration and innovation while meeting immediate needs? The HFCM training efforts focused on the clinical skills of direct service providers. While this was necessary, it was also probably insufficient to address the various changes and challenges a significant philosophical shift in service delivery required.

Integrating the Larger Context

Finally, findings suggest the importance of connecting chronic homelessness to larger community issues like the overall homelessness problem, the cost of housing, limited economic mobility, and the patterns of racial exclusion that undergird all three. Each of these pressing challenges are related structurally to the issue of chronic homelessness. The broader homelessness problem, particularly among single adults, impacted the inflow of people into chronic homelessness. As one community leader noted, "I think unless we're going to have to come to the table and look at the continuum, I'm not sure that this effort will impact future efforts. I just think it's important that we look at homelessness on a continuum. And we're not doing that yet. So hopefully this will help that. I don't see that happening right now, but we'll see" (A-05:31). The cost of housing impacted both the inflow of people into homelessness and the outflow of people into permanent, safe housing. Homelessness increases in communities where on average the cost of housing exceeds 22% of income (Glynn, Byrne, & Culhane, 2018). In Charlotte-Mecklenburg, the average cost of housing is 24.3% of income (Glynn & Casey, 2018). Homelessness, including chronic homelessness, is directly related to the cost of housing. Chronic homelessness is a life course outcome of the same system dynamics that create barriers to economic mobility, including structural racism and segregation that also shaped the social uprising of 2016 (Charlotte Opportunity Task Force, 2017). In the effort to narrowly focus on the goal of HFCM, these connections were often excluded from consideration, planning, and publicity.

> "I think unless we're going to have to come to the table and look at the continuum, I'm not sure that this effort will impact future efforts"

It is important to note that some participants expressed frustration that they had tried to connect the problem of chronic homelessness more purposefully to larger system issues like affordable housing and economic mobility but did not always find other sectors receptive. Homeless service providers must define their work in terms of other sectors such as housing, mental health, criminal justice, and employment, however, the reverse is not true. Homelessness is often considered a problem apart from these other issues instead of a direct reflection of them (Culhane & Metraux, 2008). Had HFCM proponents waited until other initiative advocates were on board, the effort may have never happened.

The wisdom of successful initiatives depends on the identification of discrete and feasible objectives and prescribed wisdom suggests that a narrow and limited focus gets a job done efficiently and effectively (Mayne, 2015; Philliber, 1998; Weiss, 1995). However, the nature of wicked problems (Buchanan, 1992) requires a larger system understanding. Those who lead and implement efforts like HFCM must balance narrow focus and broader connection - every problem can't be solved by one effort at the same time, but there are particular risks in not connecting problems to the broader environment in describing a problem/population as particularly distinct (Fredericks, Deegan, & Carman, 2008; Maini, Mournier-Jack, & Borghi, 2018). In the case of HFCM, the lack of connection to larger, systemic issues led to waning stakeholder interest and communication, diminished resources, and notable challenges on the frontline of services including longer periods until housing, prolonged focus on housing above other needs, competition among providers for scarce housing resources, and a growing concern that despite the progress, the gains weren't sustainable. As one direct service provider noted, "And I was just going to say, not to take away at all from the success of Housing First Charlotte Mecklenburg, and I think it's been an incredible success, and I think we do have the chance to make the final push to functional zero. My only concern is that as the housing market is, it just keeps getting tighter and tighter, is just that if the shift is taken away at all, or if any energy is taken away, then a lot of our progress could be quickly lost. " (B-05:172).

In addition, in a context of scarce resources to support an expansive range of human disadvantage and need, the absence of connection to the systemic factors at the root of chronic homelessness tends to point both the sympathetic and unsympathetic to focus on the people experiencing the problem. For those sympathetic to individuals experiencing chronic homelessness, this often takes the form of empathy or pity for those who are disabled

or otherwise vulnerable. For those less sympathetic to people experiencing chronic homelessness, it may take the form of questioning the use of resources when another population may be more vulnerable or deserving of care. Both responses are arguments about value and worth and are a unidimensional individual approach to a multidimensional issue. Homelessness is often framed in terms of individuals - their behavior, their disabilities, their motivation, their choices. Without a more informed and systems level understanding of an issue, proponents and opponents are likely to revert to these unidimensional explanations of complex community issues like chronic homelessness. As one community leader stated, "One barrier is the assumption we have to choose between chronically homeless individuals and children" (A-20:19). For longevity and effectiveness, defining and understanding how a problem connects to systems and issues around it should be an early and ongoing part of any change initiative even if the solution is and should be focused more narrowly (Culhane et al., 2011; Mayne, 2017; Vogel, 2012).

While several stakeholders noted the relationship of chronic homelessness to the cost of housing, intentionally connecting an effort like HFCM more closely to the multiple systemic factors that shape it is key. As one community leader noted, "Because once we get to policy decisions that can actually help all people all of the time, there'd be less of a need I think for these one-off type programs" (A-20:11). As Caroline Chambre Hammock, one of the HFCM project co-managers noted in her final report, "While HFCM has indeed much to be proud of, it is yet another example of Charlotte-Mecklenburg's tendency towards project-based initiatives that, while wonderfully intentioned and collaborative, often lack the policy muscle to drive long-lasting change. It is strongly recommended that our community implement a systems-based approach to cross the finish line in ending chronic homelessness" (Chambre Hammock, 2017).

"It is strongly recommended that our community implement a systems-based approach to cross the finish line in ending chronic homelessness"

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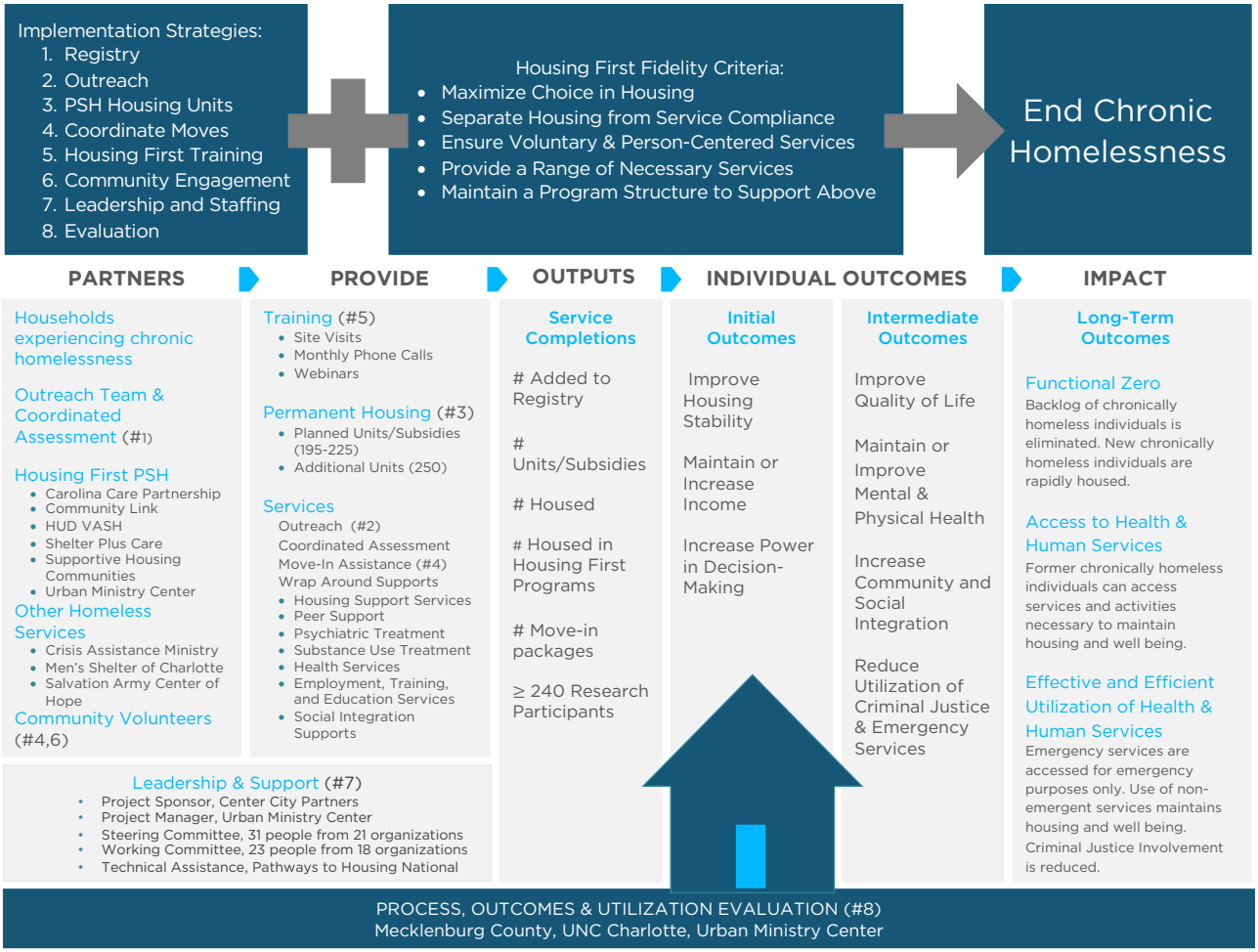
APPENDICES

Appendix A:
Theory of Change & Logic Model

Housing First Charlotte-Mecklenburg Theory of Change & Logic Model

The Housing First Charlotte-Mecklenburg theory of change includes the implementation strategies developed by community stakeholders and the fidelity criteria for effective housing first programs established by research.



Appendix B: Study Methodology
Study Methods

The Housing First Charlotte-Mecklenburg (HFCM) Research and Evaluation Project examined two interrelated processes: the implementation of a multi-sector collaboration to end chronic homelessness as well as the implementation of an evidence-based practice to meet that goal. This section briefly describes the research methodology of the process evaluation.

Process evaluations examine how an intervention, program, or community-wide effort happens and the extent to which the effort was carried out as it was intended (Newcomer, Hatry & Wholey, 2015). They also help stakeholders understand how the implementation of an effort is related to its outcomes and identifies opportunities to replicate successes and address challenges and disappointing outcomes as the effort continues (Rossi, Lipsey, & Freeman, 2004). This portion of the evaluation was guided by the following research questions:

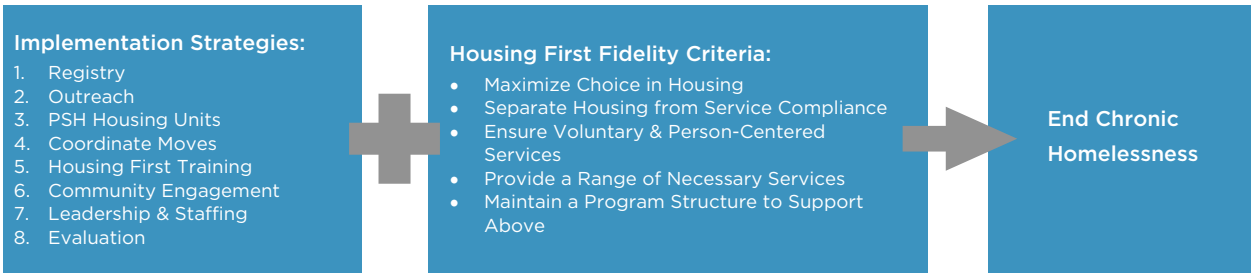
Process Evaluation

- Was the effort implemented as intended?
- Who was served and how did each program deliver services?
- How did the project structure and management impact implementation and outcomes?
- What was the nature and role of collaboration?
- What problems were encountered and how were they addressed?

Research Design

In order to address the research questions, the research team used a variety of qualitative and quantitative research approaches in a mixed methods design. Most process evaluations begin by mapping out the specific theory of change and logic model that stakeholders believe guide their efforts. The theory of change and logic model show how the resources and strategies associated with a program or intervention will lead to a hierarchy of expected outcomes (McLaughlin & Jordan, 1999). The research team worked with HFCM leaders and members of the HFCM Working committee to develop a theory of change and a logic model, which incorporate both the multi-sector community and program level processes. See Figure 1 for brief HFCM Theory of Change. See Appendix A for the full HFCM Theory of Change and Logic Model.

Figure 1. Brief HFCM Theory of Change



Data Collection

In order to answer the research questions and understand if the implementation of HFCM matched its theory of change and logic model, we reviewed and gathered existing effort and program-related data, and collected additional data through interviews, observations, and document reviews (Mulroy & Lauber, 2004; Nightingale & Rossman, 2015). HFCM and community leaders participated in individual and/or focus group interviews. The research team also observed HFCM steering committee meetings, working committee meetings, subcommittee meetings, and other events sponsored by HFCM. In addition, the team collected HFCM documents and formal communications including meeting minutes and email communications regarding the project. Surveys were conducted with direct service providers, program leaders, and service recipients. Finally, the research team followed up with stakeholders as needed to ask questions and clarify the interpretation of findings. Table 1 summarizes process evaluation data collection methods.

Table 1: Description of data collection methods

Data Collection Method		Number	Timing/Description
	Administrative Data	De-identified data on 1660 individuals on the By-Name List from 2015-2018	Data Deposit into the ISC integrated data system (Summer 2019)
	Interviews	29 interviews with 33 individuals completed	HFCM and community Leaders (late 2016)
	Focus Group Interviews	21 focus groups with 103 people	Training focus groups (late 2015); Service Providers & Working Committees (late 2017); Service Recipients (Summer 2018)

	**Observations**	35 Observations	Throughout the initiative
	**Artifacts**	Project management files, project emails, initial fidelity documents	From initiative development in 2014 through end of data collection in 2018
	**Surveys**	3 surveys conducted with 377 individuals.	Program Directors & Service Providers (Fall 2018); Individuals experiencing chronic homelessness (2016-2018)
	**Member Checking**	Not applicable	As needed and at end of effort to address unclear and ambiguous findings

Data collection for the process evaluation began in the fall of 2015 with training focus groups and continued through Spring of 2019, in order to capture post-study period HFCM processes Some follow up and member checking occurred in 2019 and 2020. The specific methods of data collection from the various stakeholder groups (see table 2) are described below.

Table 2. HFCM stakeholder groups

Individuals Experiencing Chronic Homelessness	Individuals on By-Name List Housed in Housing First PSH Individuals on By-Name List Housed in Other Housing Individuals on By-Name List Not Yet Housed
HFCM Infrastructure	Project Sponsors, Center City Partners Project Managers, Urban Ministry Center Steering Committee Members Working Committee Members Funders
Housing First PSH Partners	Community Care Partnership Community Link HUD VASH Mecklenburg County Shelter Plus Care Supportive Housing Communities Urban Ministry Center
Service & Planning Partners	Charlotte Housing Authority Charlotte Neighborhood and Business Services Charlotte-Mecklenburg Coordinated Assessment Crisis Assistance Ministries Mecklenburg County Community Support Services Men's Shelter of Charlotte Pathways to Housing National Salvation Army Center of Hope UNC Charlotte, CHHS, Urban Institute/ISC
Community Leadership on Homelessness	Homeless Services Network Housing Advisory Board of Charlotte-Mecklenburg

Observations. Research team members observed 30 HFCM committee meetings from March 2016 through Spring 2019 as part of the process evaluation. These included three steering committee meetings and five working committee meetings, as well as 22 working group meetings (six permanent supportive housing meetings, five alternative strategies meetings, seven engagement meetings, three data group meetings, and one training committee meeting). In addition, observations were conducted at a Homeless Services Network meeting, Board of County Commissioners meeting, and work groups that were created when the effort moved back to the County (Case Conferencing, Work Group, and Transfers). During these meetings, a team member would record attendance, take notes, and complete an observation form describing the substance and process of the meeting, as well as communication patterns and nonverbal cues.

Artifacts. Research team members assembled artifacts relating to the HFCM project. These included: initiative planning documents, training materials, fidelity assessments, monthly update reports, meeting minutes, emails, media coverage, and other program related information (e.g., IRS Form 990 data, HFCM promotional materials, etc.). While most of the artifacts were provided to the research team by the project managers and various stakeholders, some artifacts were collected by the research team during project meetings, emails, or online.

Individual Interviews. Research team members conducted 29 interviews with 33 HFCM key stakeholders in April and May 2017. These interviews included representatives from HFCM's project management team, steering committee members, working committee members, working group members, supportive housing and rapid rehousing agencies' personnel, and other community leaders. The interviews were recorded, and the audio-recordings were transcribed verbatim by an external transcription company. The transcripts were de-identified and reviewed for accuracy by research team members. Table 6 in the main report provides demographic information for the participants in the individual interviews.

Focus Groups. The initial focus groups, held in the fall of 2015, were conducted to plan the training strategy for the initiative (6 focus groups, n=35; 8 agencies represented). Thereafter, the focus groups gathered feedback on the

progress of the HFCM initiative from various stakeholder groups. There were 14 focus groups with stakeholder groups consisting of front line service providers (n=43), work group members (n=9), and service recipients who had been on the By-Name List (n=24). For each focus group, the research team followed a pre-determined protocol, which included obtaining informed consent from the focus group participants, audio-recording the focus group sessions, and providing $20 gift cards to the focus group participants. The audio-recordings were transcribed verbatim by an external transcription company. The transcripts were de-identified and reviewed for accuracy by research team members and adjusted as needed. Demographic information for individuals participating in the focus groups are included in Table 3 in the main report. Recruitment for the focus groups varied. For the frontline service providers, the research team worked with agency executives to assemble a list of the names and email addresses for the case managers, peer support specialists, coordinated assessment workers, and outreach workers. The research team sent emails inviting everyone on the list to participate in a focus group at Moore Place or the Hal Marshal Building. Seven focus groups were held; four with case managers, one with peer support specialists, one with coordinated assessment workers, and one with outreach workers. While the size of the focus groups ranged from two to eight participants, the average size of these focus groups was five participants.

Focus group participants representing the working subcommittees were identified from the meeting attendance sheets. The research team sent emails to the work group members inviting them to participate in a focus group held at Charlotte Center City Partners. Two focus groups were held with work group members. Four work group members participated in one focus group. Five work group members participated a second focus group.

The research team recruited a purposive sample of service recipients who had participated in the research study and were interested in participating in the focus groups. Six focus groups were conducted, representing men living in scattered site housing, women living in scattered site housing, men living at Moore Place, women living at Moore Place, men who had not yet been housed, and women who had not yet been housed. Efforts were made to ensure that the service recipient focus group participants were diverse in terms of age (40 and younger; 41 to 55 years; and over 55 years) and race (black, white). While the size of the focus groups ranged from three to five participants, the average size of these focus groups was four participants. In addition to $20 gift cards, the service recipient focus group participants received two bus passes.

Surveys and Site Visits. Pathways Housing First conducted an initial fidelity assessment in November and December 2015 based upon data gathered through a four-page paper survey completed by the directors of the seven service providers. The survey questions focused on describing the nature of the housing and supportive services being offered through HFCM. Site visits were also conducted by Pathways Housing First and the research team to triangulate the findings from the survey.

Two online surveys were created in Qualtrics during the summer of 2018; one was for the directors of the seven service providing agencies and the other was for the HFCM case managers. The questions on these surveys were related to gathering follow up information about the implementation of HFCM and fidelity to the Housing First model, and were used as the basis for the program fidelity scores. These surveys also contained questions about the case manager quality of life and work place stress. Forty individuals from the seven service providing agencies completed these surveys. To be included in the fidelity assessment the case manager had to work for a permanent supportive housing program, and the program had to have at least three individuals complete the survey (n=28). All of the survey participants received a $5 Starbucks gift card, and the case managers were entered into a drawing to receive one of eight $20 gift cards.

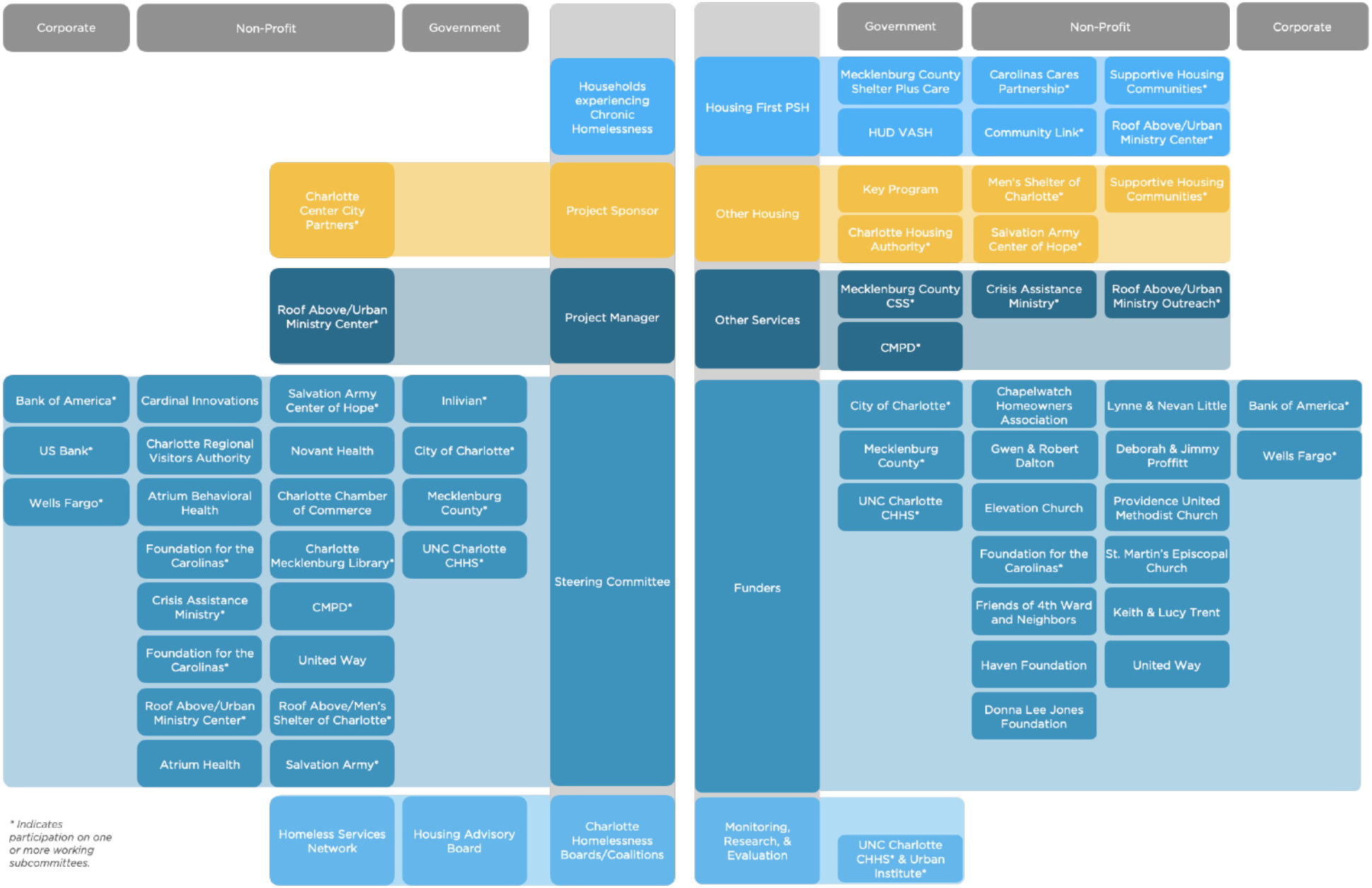
Finally, all participants enrolled in the Outcomes evaluation study (n=330) were asked open-ended interview questions at different times during the program (at baseline, 6 months, 12 months, and 24 months; n=605 surveys). Specifically, they were asked to identify the biggest changes in their daily life since they moved into housing, as well as to describe what their housing program does well and what their housing program could improve. Demographic information for both the study participants and service providers who completed surveys are listed in Table 6 in the main report.

By-name list. Lastly, the study utilized the County's regular deposits of data from HMIS to the Institute for Social Capital for de-identified information about the individuals on the By-Name List to understand the population served by the initiative from the beginning in 2015 through the end of 2018.

Data Analysis

The research team used several techniques to analyzed data for the process portion of the study. The interviews were digitally recorded and transcribed verbatim. In the first phase of analysis, the research team segmented the data into units. Units or segments of data were then compared to other segments of data to identify similarities and differences and determine categories and subcategories that describe the data. Coding was an iterative and collaborative process. The research team members used a combination of pre-determined codes (codes that emerge from the literature and program theory) and inductive codes (codes that emerge from the data). Observations about the patterns and findings in the data were captured through memos. A detailed timeline chronicling the initiative was created using the artifact and observation data. Atlas-ti qualitative data analysis software was used for unitizing, coding, and analyzing the data. In the second phase of analysis, the research team examined all data sources - interview codes, documents, and observations - for patterns describing the eight implementation strategies and five fidelity criteria that comprise the theory of change. For quantitative data, univariate and bivariate statistics were used to describe the characteristics of people who participated in the study. Differences among groups were determined by t-tests or Chi-Square analyses.

Appendix C: HFCM Stakeholders



Appendix D: Data tables

Table 1: Number added to the BNL by year (n= 1660)

BNL entry year	#	%
2015	626	37.7%
2016	455	27.4%
2017	324	19.5%
2018	255	15.4%
Total	1660	100.0%

Table 2: Demographic characteristics of the BNL (n=1660)

	#	%
Gender		
Male	1250	75.3%
Female	404	24.3%
Trans	6	0.4%
Missing	0	0.0%
Race		
White	450	27.1%
BIPOC	1205	72.6%
Missing	5	0.3%
Ethnicity		
LatinX	36	2.2%
Non-LatinX	1616	97.6%
Other/Refused	4	0.2%
Missing	4	0.2%
Age		
Median	51	
18 - 35	248	14.9%
36 - 50	570	34.3%
51 -64	757	45.6%
65	85	5.1%

Missing	0	0%
Veteran Status		
Veteran	167	10.1%
Non-Veteran	1482	89.3%
Other/Refused	1	0.1%
Missing	10	0.6%

Table 3: VISPDAT score by range (n=1563; missing = 97)

VISPDAT	#	%
0 to 4	102	6.5%
5 to 9	695	44.5%
10 to 11	376	24.1%
12 to 16	390	25.0%

Table 4: VISPDAT score by initial VISPDAT n=1563; missing = 97)

VISPDAT Score	#	%
<=2	11	0.7%
3	21	1.3%
4	70	4.5%
5	96	6.1%
6	115	7.4%
7	156	10.0%
8	170	10.9%
9	158	10.1%
10	202	12.9%
11	174	11.1%
12	150	9.6%
13	112	7.2%
14	89	5.7%
15	34	2.2%
16	5	0.3%

Table 5: VISPDAT by range and year added (n=1563; missing = 97)

	2015 (n=633)		2016 (n=445)		2017 (n=288)		2018 (n=197)	
	#	%	#	%	#	%	#	%
0 to 4	35	5.53%	36	8.1%	25	8.7%	6	3.0%
5 to 9	278	43.92%	204	45.8%	133	46.2%	80	40.6%
10 to 11	159	25.12%	99	22.2%	59	20.5%	59	29.9%
12 to 16	161	25.43%	106	23.8%	71	24.7%	52	26.4%

Table 6: VISPDAT range by gender (n=1558; missing 102)

	Men (n=1181)		Women (n=377)	
	#	%	#	%
0 to 4	80	6.8%	22	5.8%
5 to 9	538	45.6%	155	41.1%
10 to 11	273	23.1%	102	27.1%
12 to 16	290	24.6%	98	26.0%

Table 7: VISPDAT range by 50+ and below 50 (n=1563; missing= 97)

	50 + (n= 839)		Under 50 (n=724)	
	#	%	#	%
0 to 4	52	6.2%	50	6.9%
5 to 9	391	46.6%	304	42.0%
10 to 11	198	23.6%	178	24.6%
12 to 16	198	23.6%	192	26.5%

Table 8: VISPDAT range by BIPOC and White (n=1559; missing=101)

	BIPOC (n=1124)		White (n=435)	
VISPDAT Score range	#	%	#	%
0 to 4	86	7.7%	16	3.7%
5 to 9	536	47.7%	156	35.9%
10 to 11	271	24.1%	105	24.1%
12 to 16	231	20.6%	158	36.3%

Table 9: VIPSDAT score by BIPOC and White (n=1559; missing = 101)

	BIPOC (n=1124)		White (n=435)	
	#	%	#	%
<=3	27	2.4%	5	1.1%
4	59	5.2%	11	2.5%
5	76	6.8%	20	4.6%
6	88	7.8%	27	6.2%
7	113	10.1%	42	9.7%
8	136	12.1%	33	7.6%
9	123	10.9%	34	7.8%
10	141	12.5%	61	14.0%
11	130	11.6%	44	10.1%
12	101	9.0%	49	11.3%
13	64	5.7%	48	11.0%
14	46	4.1%	42	9.7%
15	17	1.5%	17	3.9%
16	3	0.3%	2	0.5%

Table 10: Housed participants by year housed (n= 769)

Housed Individuals	#	%
2015	195	25.4%
2016	242	31.5%
2017	168	21.8%
2018	164	21.3%

Table 11: Housed participants by housing Type (n=769)

Housing Type	#	%
PSH	395	51.4%
RRH	38	4.9%
Other	182	23.7%
Family	154	20.0%

Table 12: Housing Placements by type and year (n=769)

	2015 (n=195)		2016 (n=242)		2017 (n=168)		2018 (n=164)	
	#	%	#	%	#	%	#	%
PSH	107	54.9%	99	40.9%	95	56.5%	94	57.3%
RRH	1	0.5%	11	4.5%	9	5.4%	17	10.4%
Other	63	32.3%	75	31.0%	29	17.3%	15	9.1%
Family	24	12.3%	57	23.6%	35	20.8%	38	23.2%

Table 13: Demographics by housed and unhoused individuals on By-Name List

	Housed (n=769)		unhoused (n=891)	
	#	%	#	%
Gender				
Female	227	30%	177	19.90%
Male	538	70%	712	79.90%
Race				
BIPOC	563	73.2%	642	72.5%
White	206	26.8%	244	27.5%
Missing/Refused	0		5	
Ethnicity				
LatinX	15	2.0%	21	2.4%
Non-LatinX	750	98.0%	866	97.6%
Missing/Refused	4		4	
Age				
Median	52		50	
18 to 35	103	13.4%	145	16.3%
36 to 50	242	31.5%	328	36.8%
51 to 64	385	50.1%	372	41.8%
65	39	5.1%	46	5.2%
Missing	0		0	
VISPDAT Score				
1 to 4	39	5.6%	63	7.3%
5 to 9	261	37.4%	434	50.1%

10 to 11	168	24.1%	208	24.0%
12 to 16	229	32.9%	161	18.6%
Missing	72		25	

Table 14:. Percentage of initial VI-SPDAT scores of housed individuals by race (n=697; missing=72)

	BIPOC (n=501)		White (n=196)	
	#	%	#	%
1 to 4	34	6.8%	5	2.6%
5 to 9	209	41.7%	52	26.5%
10 to 11	128	25.5%	40	20.4%
12 to 16	130	25.9%	99	50.5%

Table 15: Percentage of race by housing placement (BIPOC, n=563; White, n=206)

	BIPOC (n=563)		White (n=206)	
	#	%	#	%
PSH	275	48.8%	120	58.3%
RRH	32	5.7%	6	2.9%
Long-term care	2	0.4%	4	1.9%
Family/Friends	121	21.5%	37	18.0%
Other	133	23.6%	39	18.9%

Table 16: Rates of return to shelter by housing type - placements and returns from 2015 through 2018

	Placements	Return to Shelter	Rate of Returns
PSH	395	61	15.4%
RRH	38	7	18.4%
Other	182	28	15.4%
Family/Friends	154	49	31.8%
Total	769	145	18.9%

Appendix E:
Training Focus Group Code Categories

Categories	Exemplar Quotations
Housing	**Affordability & Availability** "affordable housing is dwindling fast in Charlotte. So, you know, a lot of areas have changed over the time." (L-03:21) "We are all fighting for the same housing opportunities, so it's very limited." (L-03:81) "Where you gonna put 'em? It's the biggest barrier, I think." (L-05:32)
	Redevelopment & Gentrification "I think with Charlotte, we, we're changing, we are growing, and we are growing in an upward movement in a sense, to where we had public housing, where we had low income housing, they are tearing that down, they are building housing that our lower income cannot afford, so I mean, we just don't have that housing that our community want to embrace and have someone of lower income come in and move beside them or in that neighborhood, and that kinda thing, so, I mean, I hear Charlotte saying, you know we want to end homeless', but we are taking away a lot of the housing that could actually be available for our homeless population, it's just not there anymore." (L-02:34)
Landlords	**Client Background** "I think with us …following along with the landlord piece, is that we deal with a lot of people that have criminal records and past rental histories, so a lot of them have multiple evictions. So where we get a landlord that might be willing to work with someone that has evictions they don't wanna work with someone that has a criminal record and vice versa." (L-01:28]
	Income Expectations "A lot of landlords want the tenants to make three times the rent. I don't even make three times my rent [laughter]…. I don't know about you all, but I don't make three times my rent. So I mean it's just that much more difficult to find for…housing for our clients when they have all these stipulations to go along with the housing." (L-01:30)
	Inspections "Some of the landlords are not wanting to go through the inspection. That's a barrier, now, because most of them know that they're not gonna pass." (L-03:30)
	Perceptions of homeless population "There's a certain stereotype that goes around, not even just associated with homeless… poor, poverty, section 8. Those people ….there's all this stereotype. And even when you try to educate, it's like this is already… this is what I've always been told, this is my one experience that I had, it must be that way for everyone. So there is not even a door, in my opinion, you can't even walk through the door, if you're associated with some type of housing program. They won't even entertain it." (L-05:35)

Public Perceptions	**Perceptions of homeless population** "I think also maybe, um, and not everyone in Charlotte is like this, it's not the entire community, but some of the community, um…I worked a lot with the homeless population in Asheville, um, and it just seemed almost, that they were a little bit more friendly to the homeless, they had a little bit more resources, …but it just seems a little more down here, like well, "they can get it together", and "they can do it themselves" type of thing." (L-02:30) "That they are homeless because of drugs…that they just need to work harder" (L-02:31)
	Perceptions of housing first "The biggest community barrier is just a lot of people not understanding what housing first is, and then still NIMBY-ism that goes along with that. People fighting…'We don't want these people messing up our community'." (L-03:80)
Organizational Barriers	**Assumptions** "I guess I can say at my organization…those individuals that aren't directly connected to housing don't quite get the housing first model 'cause they are like "let's heal them first and then they can deserve housing." And I think a lot of people that have been in this community and in this field, gear more toward that. So more of the older staff members are just like "let's heal them first. Let's make sure that they're where they need to be and then they will earn their housing", and they don't quite get the no one earns their housing, everyone deserves housing. So I think that would be one of the barriers of my organization, at least." (L-01:54)
	Changing Models "I look at it as being akin to like moving from a medical model to a recovery model, where you are accustomed to saying, "I/we needed to do this thing, in order to {to} get this carrot", like you said you get the carrot in the beginning now, and it's kinda like you're telling me what you need, or how can I assist you to get where you want to go. As a case manager, when you don't hear "I want", "I wanna do this", "I wanna do that"; there are no goals that are verbalized that you feel that they can achieve. It's always gonna be, like you said, it's a sea change. It's something that takes a while to adjust to." (L-01:55)
	Communication "A lot of times, like […] said that conversation happens here but it doesn't get down to us, and so we may do something that was discussed -you know- at this level and decided that -you know- "we don't want you to do that anymore" but we didn't know that, so, -you know- we'll do it anyway just because we didn't know.. um..so I think just communication is key, even with just us little peons that are just -you know- case managers. I think it's important to involve everybody in that conversation so everyone has understanding." (L-01:59)
	Coordination "Um, number one we did not know, ah that this person went through coordinated entry ah, with child welfare. We didn't know the child welfare part. So had we known that piece upfront, um, we could have gotten a little more pieces to that puzzle, from the child welfare social worker." (L-02:46)

	Policies/Practices – Internal Program Requirements "Because of liability, we cannot transport customers in our vehicles. So finding those other means of transportation." (L-03:90) "But coming in, I ended up, after coordinated assessment, with a caseload of 30. And I was only supposed to have 15. So I know that that's an issue for a lot of agencies is the caseload. And then also, going back to your statement earlier about the documentation. It's all the paperwork, and finding the time to be able to do it, particularly when you're looking at your caseload and all it demands." (L-03:66)
	Policies/Practices – External Funder Requirements "There are funds in the community yet so many barriers to have to jump through to get this that or the other…. from an application fee to, you need to buy some pots and pans, you have some the old energy bills or what-have-you…just those kinds of things. They are not always huge, but to go through the 501 different channels to try to get at it…" (L-01:42)
Staff	**Learning Curve** "I think a lot of times, if staff doesn't really understand a program or, it's always difficult when it's a new transition. And it's just learning. And I think that's all it really it's. It's just really learning. If you've never worked with individuals who were homeless or, if you've never worked in the housing field. I think it just takes some time to kinda learn that whole process or program." (L-03:63)
	Attitudes "I think when you get set in your ways in doing some things a certain way and you're proving "MY WAY WORKS!" then why try something different? …And like, the change is so drastic…like housing first is so different from transitional housing. So, I think there's resistance to…well… what was the middle ground? Like where can we meet in the middle of transitional housing and housing first?" (L-05:27)
	Judgment "Well, one, one part could be… maybe just some judgment, like maybe someone's not as deserving of housing. If they're coming in with actively using or something like that or not working, because the not able to find a job because of substance abuse. So maybe some, some judgment. A lot of us are trained not to show that. But it can be difference, may be a perception of not as deserving, or something… " (L-05:25)
	Training "There's this philosophy – what I notice and what I see, is that we have all these institutions - DSS has one set of social workers having different 'investigate- report', when you cross transfer to a "take people where they are"….uh!! that's a clash! You can't take people where they are if I'm trained and programmed to investigate and report." (L-01:61)

Appendix F:
Service Recipient Perspectives

The perspectives of individuals with lived experience were incorporated into the evaluation in three primary ways: First, 6 in-depth focus group interviews were completed with 24 individuals who had participated in the Housing First Charlotte-Mecklenburg (HFCM) research project. To protect participant confidentiality, focus groups were not transcribed by named participant rather by the generic, *respondent 1, respondent 2,* and so on. Therefore, unlike individual interviews, we cannot count the number of times unique individuals responded in each of the categories and sub-categories.

Second, individuals who participated in the outcomes portion of the HFCM research and evaluation project (n=330) were asked open-ended questions at the end of their interviews (baseline, 6 months, 12 months) about their experiences while on the By-Name List and, if applicable, through the housing process. Finally, a peer research specialist with lived experience in chronic homelessness was hired to help with participant recruitment and retention, inform team meetings, and participate in the review of research reports. This section reports on focus group findings and the findings from the open-ended questions from study participants who were housed at 6 and 12 months.

Focus Group Findings

Experiences of Homelessness

Focus group participants, both those who were still waiting for housing and those who were housed, described their experiences of homelessness in detail. Participants' responses are organized into six categories. First, participants reflected on experiences of safety describing particular risks for women and more general concerns of interpersonal violence and sleeping conditions. Participants also discussed the difficulty addressing basic needs and health while homeless, including simply a place to keep their belongings and escape the elements and weather to accessing health services. Third, participants discussed the mental and emotional toll of homelessness, describing a range of emotions and their impact. Fourth, participants discussed their service and shelter experiences while homeless, describing a wide range of services they were able to access including educational/ employment-related services, mental health and substance use, food, health care, housing, hygiene-related services such as laundry and showers, mobile crisis, 211, and transportation. However, they also described fragmented service delivery and difficult experiences with emergency shelter. Finally, participants discussed the positive experiences they recognized about their homeless experience including freedom, their own personal growth because of the experience, and the social networks they had developed. Table 1 summarizes the major categories and subcategories from the analysis along with exemplar quotations from the participants' responses.

Table 1: Experiences of Homelessness Prior to Housing (n=24)

Category	Examples of Participant Responses
Safety	**Risks for women** "But what I hate is I hate men's call themselves being in the same shoes you in and they're out to help you. And then once they get you in there they want to abuse you and watch you have sex and all this good stuff. And if you don't you've got to fight. Well, I didn't have to fight to come in the door. Why should I have to fight to go out the door?" (C-04:84) "Just like these women here are. They're scared for their lives." (C-04:18)

	Interpersonal violence "But not knowing the things, the stress that we go through, sometimes it's not conducive for us to go every night, because there was drama, people fall out with people, people fight, people—sometimes you just need to get away from everything and come back." (C-03:79)
	Sleeping conditions "we literally slept in front of PRN because we couldn't think of any place safe. So, we slept under the tree at PRN just so we can be close to people we knew. We figured nobody's going to come down here – they probably didn't even see us because we're laying down. So, it was really more of a safety necessity thing" (C-02:29)
Basic Needs & Health	**Belongings** "And it [homelessness] will kill you. Like you get to a certain age, the walking, all of that stuff. [...] Like right now I have no cartilage [pointing to his shoulder]. [...] By me carrying my stuff all the time. [...] I mean I had two big full suitcases, two bookbags. I used to wear all my stuff on me. I have no cartilage whatsoever." (C-06:54)
	Eat, sleep, water, hygiene, electricity "But I mean when you're hungry and you haven't had nothing to eat for three or four days, you know, and you're homeless and you're living under a tree or you're living on a park bench downtown, that is like miserable." (C-03:125)
	Weather "Yeah, and being out of the weather, when it rains or the heat. The cold didn't really bother me that much, just the rain. I go and open the door and stand at the door and watch it pour down rain and I'm still thinking about the homeless, the ones that are still homeless out there in the pouring rain or in the heat." (C-03:04)
	Health care "That [health care]'s what I need to work on, bad. [...] I don't even have no health, no connections. Right now, I'm gonna go up here to the [agency name], get with this nurse they got there." (C-05:73)
Emotional toll	**Mental health** "It depresses you. You know, it will literally make you look out the window and cry because you feel like you're going back there." (C-03:253) "It will break you down. It will break you down." (C-03:12)
	Hard "It's a struggle. It's been really a struggle. I'm just tired. I'm so tired." (C-04:43)
	Hopeless "Sometimes you just walk around. You be just hopeless. [...] And I think I was blank. I hurt so bad I was blank. [...] Like the tunnel is too long. [...] I couldn't hurt no more. I had hurt so bad I couldn't hurt no more. Like I was numb." (C-04:108)
	Embarrassing "I was sleeping in a lot of parks, last year, and I didn't mind, except for, I didn't want people to see me, you know, I wanted to be, like, isolated, to some degree." (C-05:119)
	Helpless "It seems like I have nobody to really listen to me to understand where I'm coming from. And it just seems like I'm just on the back burner like I'm just not really getting nowhere. [...]I feel like I'm helpless." (C-04:124)
	Unpredictable "From here to there to there to there. [...] Night by night. When I get my check, I get a room sometimes. I can't stay but so much because they will take all my check and I've got to eat and live for the whole month. [...] So I'm from place to place, room to room, night to night, sometimes under the stars. [...] And very scared and wary." (C-04:15)

	Stigma "And 945 College Street can be a hindrance. Putting that down on your license, putting that down as your ID, you can't get a hotel room." (C-02:102)
	Anger "We're very angry. [...] We are. We feel like the world owes us something, to a certain extent because we put in our time here just like everyone else. So why end up with the short end of the stick?" (C-02:16)
Shelter & Services	**Services, Types** "211 it's all over the United States. You can call 211 and say, "Listen, I'm homeless, I need this, or I need this," and they've got this list" (C-05:105) "Me and [provider name] supposed to be getting together and getting me a case manager and start working on me. " (C-05:46) "Yeah, here's how I got – the men's shelter is the one who – they had a job fair, and I followed up on it and talked to everybody, and this hospitality company called and interviewed me for work, and I went to everything. Went and got hired at Amazon, and then it came back that I was on parole, I'm, like, "I'm not on parole," and it took me two months to get that ticket off." (C-05:29) "I know at [program name] they'll feed you well. You don't go hungry here in Charlotte. Now they will feed you. You can go a lot of places and get food here. The problem is, we don't have shelter." (C-04:75) "You've got social workers out at the hospital, if you get engaged in that, and they can set you up with a primary doctor through family services and stuff like that, down through CMC. They have those type of places that you can apply where they will set you up with a doctor, a primary doctor through being homeless and being in that, so that's a plus." (C-03:159)
	Services, fragmented "I did talk to them people going through a lot of that, and it gets confusing. There's a lot to that, you know, like, "That's not what to do. Who gave you this number?" I'm, like, "The other people the other people told me to call you," and, like, "Nah, that's not how this works." And so, there's a lot of inaccurate information in the whole, like, the 211 and all that. It's hard because then you're, like, "Man, this is screwed, I don't' even wanna do this," you know?" (C-05:87)
	Services, Treated unfairly "That's how they treat homeless people. [...] I was out on the streets. I got kicked out of the program from 2017, 2018. [...] Because I had a disagreement with [another resident] and it was her word against my word. So they told me when I got ready to check into the line, they told me that I was banned from 2017, 2018. I couldn't go out. So therefore, I'm on the streets again. I'm out here again." (C-04:77) "They put me out two days before my knee surgery. This lady hit me with a tray and three a drink on me and they put me out. And all I did was like that and walked out and they put me out." (C-04:150)
	Shelters, no capacity "That's like a main shelter what we got here in Charlotte and that's the only place and they're full all the time [...]. I mean it should be – I don't think it should be any woman or child on the street at all, nowhere. It shouldn't be a woman or a child" (C-04:153)
	Shelter, not safe "They were trying to get me off the streets so long they try and give me the option to go down to the [shelter], I said oh no I'm not fooling with that. Because that's open war [...] that fighting [...] They got too many activities going on. [...] Yeah, streets better than the shelter any day." (C-01:74)

	Shelters, regulations "They're very strict. You can't have people to come and visit you and you've got to do things their way or you hit the highway. [...] They take part of your belongings. [...] You have to have what they say. [...] No clothes. [...] You can't buy your own stuff and stuff like that. (C-04:31)
Positive Aspects	**Freedom** "They'd rather be on the street than be in these places, because, you know, one thing: you have freedom on the streets." (C-05:41)
	Growth "I think it makes you stronger." (C-03:134)
	Network/ solidarity "Other homeless say, "I got this spot. Come stay there. It's safe. It's clean. It's whatever it may be that you might need." [...] That's how I had to make it out there: I followed the others. The long timers, like the ones who's been out there and are comfortable and content, those are the ones you follow because they got everything under control. They learned the procedures and where to be when and how you get there. So, you just follow them. And you take one and you jump up under their wing and you just stick to them like glue and you learn the process. You learn how to survive out there." (C-02:58)

Housing Process

Focus group participants who had been housed through HFCM described their experiences of the housing process in five categories from access to housing to moving into their own apartment. First, they described the barriers they faced to housing access including criminal records, health, and income. They also described not having case manager support and perceptions of favoritism among case managers as well as a preference to house families over single adults without children. Second, participants discussed concerns and questions regarding Coordinated Entry and confusion about the VI-SPDAT scores. Third, participants described the typically long waiting period to wait for available housing and find a unit. They also discussed their choices around housing including not being able to see the inside of apartments before they could move in, not having a lot of choice in location, and more positively, the important ability to choose furniture and household goods making housing choice, and move-in. Finally, participants described several positive aspects of the move-in process including flexibility and assistance provided. Table 2 summarizes the major categories and subcategories from the analysis along with exemplar quotations from the participants' responses.

Table 2: Housing process (n=24)

Category	Examples of Participant Responses
Housing access	**Criminal records** "Nobody wants to house you – you're a criminal. [...] it's tough." (C-05:113)
	Health/ disability "Mine [housing] took longer due to the fact that my medical history—my left foot has been amputated through diabetes. So in the process of—I would end up at the [shelter]. The [shelter] did everything for me. But I'd get right to that point where I could get housing and then something would happen with my foot and then I would end up spending six months in the hospital." (C-03:70)
	Income/ financial means "Yeah, you make enough money so you can either eat or have an apartment. Well, what are you going to do? You're going to eat." (C-03:217)
	No case manager "I need a case worker, somebody that can lead me to get me leeway to a place." (C-04:122)

	Favoritism "Yeah, that's the one thing I wanted to say about that, too. You got caseworkers out here who drip-drop that they can help you in a cup and it's gonna take a while. And instead of just pointing you in the right direction, you got to deal with them for days, maybe weeks, maybe months, just to find out you could've been already on housing and all they had to do was just tell you, "Hey, all you have to do is right here. Here's this program." What? Then they'll put your best friend in there, they get in this program, and everybody with the hush, everybody got a special person they wanna give this program to, and I'm, like, goodness gracious, you know, this favoritism is off the chain." (C-05:85)
	Criteria "Because some people, like me, they told me I didn't qualify. And I was like—it had to be the worst-case scenario; you had to be on drugs, you had to be suicidal [...] Or disabled. You had to qualify. And for years they kept telling me [...] "You might as well hold your breath if you think you're going to qualify for housing." [...] So I only did the assessments just to go to rooms and inn. And then this last time me and a certain lady talked and we had a heart-to-heart and we were talking about she had a 15-year-old, I had a 15-year-old. And she said, "You know what, you've been through enough." And I qualified. I mean this was last year. And I'm like, for seven years I never qualified at all, they just looked at me and laughed. They were like, "Well, you don't have any problems." (C-03:52) "So it's nothing there for a person that's single. It's nothing. [...] If you don't have any children or dependents or somebody you are [...] Nobody. [...] You don't belong to earth but you don't believe in sky. [...] You're nobody." (C-04:70)
Coordinated Entry/ VI-SPDAT	**General lack of understanding** "Well, actually, what it was is every time I popped up at the [agency name] they would do an assessment. So I didn't know what qualifications was or anything. I didn't know—I just went, said what I had to say and I never checked back with it or anything." (C-03:257)
	Client transparency "If you go in there and you're holding something back, you do a certain drug you don't want them to know and you drinking they can't help you. Because there are so many programs you may fall under just based on what comes out of your mouth but if you're not telling the truth you're going to miss a lot of programs." (C-02:54)
	Scores "When I first did my assessment, I kept scoring low. And I couldn't figure out why. Part of it was because I wasn't being honest" (C-02:111)
	Stereotypes "And how long I've been homeless has been like three or four years. I just moved into my apartment last year, in November. Don't have any problems, you know, just grateful and thankful to be in a place. Had a little animosity to get where I'm at ...as far as who I am, because I felt discriminated, because I didn't have a record, I wasn't carrying bags around, you know, and they said I didn't meet the criteria. And I wanted to know what was the criteria, you know. "Well, you know, you've got to do this and you've got to do that." I mean what else is there for me to do when I said I'm homeless?" (C-06:03)
	Transparency about the meaning of VI-SPDAT scores "People don't know that if you get a score of 15 and somebody scores a 17 like they're going to get it before you get it. Like the lower your number is, the longer it's going to take you to get housed. The higher your number is, the more quicker you're going to – and I had to learn all this. Nobody told me this stuff." (C-04:178)
Waiting for Housing	**Duration** "It took about five to six months, shorter than most, to get in. We had to go get our assessments. And according to which number we got is how we got in, so it's three of us, so one of us went in August, I came in July and the last of us showed up in August. So, it was June, July and August and we went." (C-02:11)

	Finding unit "First my caseworker took me around to different apartments and I found an apartment that I liked, 'cause I told her that I needed to be on the bus line. You know, and I didn't want to walk so far, and excuse me, but I didn't want to be around nowhere where a bunch of chaps was at, children." (C-06:67)
Housing Choice	**Viewing housing unit inside** "'Cause they would not let us in our program, let us see what the apartment looked like. All you could do is go to the exterior and look at it and say, "This is what I want." And I was like, "Why we can't look at it?" It was like, "It's either yes or no." And that's why I said no on the second one. And I ended up going back and I ended up somebody opened the door and it's like you have to have a code to go in our apartment, I mean to get in our glass doors. And I walked through the hallways and I smelled the hallways. But we could not look in. But there was one guy, he was working on—a Hispanic guy, he was working on an apartment. I said, "Please, can I come in and see it?" (C-03:92)
	Housing location "You know, I didn't take that one 'cause the closest grocery store, it was on Scaleybark, the first one that was off Scaleybark and South Boulevard. […] There's no Food Lion? […] Harris Teeter? […] No. Not walking distance. If you didn't have bus fare or something. And even if you took the bus it was just too far." (C-03:97)
	Housing unit Focus Group Participant: "They called in, "There's a place available, but there's a guy, he died there. Would that bother you?" I said, "No, as long as there ain't no blood or guts on the wall or ceiling." […] Focus Group Participant: Same thing happened to me. I said, "No, I don't want that." (C-03:66)
	Single/ scattered site "But see [provider's name] asked me if I wanted a scattered site or if I just wanted Moore Place. And so I requested Moore Place specifically because then I said I would wait for it." (C-01:23)
	Furniture/ decoration "I chose my own furniture. […] And then they took me to pick out my own furniture and I was able to get some nice furniture." (C-06:67)
Moving in	**Furniture & Household Items** "And one of the other things they allowed me to do in moving into the new apartment was they took us over to a place right down by the women's shelter where you can get free furniture. […] And that was a beautiful thing. […] The Furniture Bank. […] Because you could build your life. […] Pick. […] You know, build a bed. You know what I mean? One that's wider than the single one that you were used to, you know, with the mattress that big, you know? A dining room table, you know? Heck, a TV. Whatever they had. You know, and you went in there and you picked and choose and you made your crib. You know? You built your crib." (C-03:99)
	Move-in Assistance "[shelter name] […] were very open to help you relocate with your stuff and whatnot." (C-03:98)
	Flexibility "Well, they let me move in with [name] early 'cause I was so sick. So, I moved into [name]'s place in October and then moved into my place in November, and then had to move out of there because of the home invasion…And so that day they moved us into Moore Place temporarily with a friend until the new place was ready." (C-06:62)

Experiences of Housing

Focus group participants who were housed through HFCM also discussed their experiences of housing. First, they discussed the benefits of being housed and successes associated with housing including privacy and safety as well as a new outlook on life. Second, they discussed the challenges associated with being housed, including the adjustment period after they moved into housing, namely the feeling of being "institutionalized", the financial challenges of maintaining housing, and some of the safety, privacy, and service restriction concerns that persisted upon housing. Participants also suggested perceived differences between scattered site and single site models. Finally, participants discussed reasons for relocation and moves. Table 3 summarizes the major categories and subcategories from the analysis along with exemplar quotations from the participant responses.

Table 3: Experiences of Housing (n=24)

Category	Examples of Participant Responses
Benefits & successes	**Amenities** "And I like my apartment because when I moved in everything in there was new. They had new comforter set for my bed, they had new dishes in my kitchen, new household appliances, […] mop. And so that's why I like it" (C-01:04)
	Outlook "I said I wanted to be a successful story, you know, have a successful life. Because I lost one due to medical conditions and stuff like that. So regaining, for me the best thing when I got relocated, finally situated, I regained some similarity to a life I had. Because I don't think you have a life, a true life when you're homeless. You are more or less a day-to-day person. You don't know what you're going to get, you don't know what harm you're going to come across. There are so many things, so many challenges that you don't have control over. So once you become back into housing you now have control. You know? I have control now." (C-03:29)
	Privacy "And the best thing is [rattling keys]. […] Having the key. Someone asked me that, having a key and locking—you know, you can go and lock the door and you know you've got private—[…] You can cook your own food when you want to, what you want, take a shower every night when you want to. And the first night I was—actually the second night I was there I took a shower, 'cause I had to get a shower curtain. And I was used to going to the [agency name], taking a shower and wearing flip-flops. And the first night I got in the tub with flip-flops on." (C-03:02)
	Safety "To be able to lock—and I think one of the first things, and all these gentlemen will admit to, is the security factor when you're at your own place." (C-03:32)
	Sense of home "I've made my home, home. Anyone that comes in they're like, "Dang, this place is homey." It's nice and toasty – you've been in there – it's toasty. And warm." (C-02:33)
	Services "I think they doing a great job. They got everything covered for me, every angle. " (C-01:57)

Challenges	**Adjustment** "You know, those ten years, it took a toll, and I didn't know it. I thought when I moved into the apartment I was going to hit the ground running, I was going to get back to working and, you know, get back into my daughter's life, save some money. It didn't turn out like that, you know? [...] It's like I just thought things were going to be smoother because I thought I'm back to who I was ten years ago. Them ten years took a toll, and my caseworker always reminds me, she says, "Them ten years you were surviving. You was able to get up and go and do what you had to do and make it happen. You were surviving. It was survival. Now you have a place, you're kind of like relaxed in a sense and you're recovering from all that trauma" or whatever that done did to my psychological, who I felt I was, who I believed I was, what people thought I was. And the lady, the landlord, she was telling me, she said, "Ten years, that's a long time. It was almost like you was incarcerated in a sense. You were doing a sentence and now you're free. And it's like now you've got to start all over again." (C-03:44)
	Feeling "institutionalized" "And some people can't handle four walls and a ceiling. They cannot handle it. [...] There are people who have been housed here that chose to go back because they couldn't handle it. Just like once you've gotten used to that open space it's like they're institutionalized sometimes [...] they can't deal with the laws and restrictions, and not being able to do what they want to do at that very moment without some type of effort being made to do whatever it is. So, they just choose to go back out there and live on the street." (C-02:28)
	Maintaining housing "Now are we going to be homeless again if our rent increases? [...] I mean if our rent goes up to the $750.00 voucher does that mean we have to get out of that spot? [...] Are they going to help us to move? Are you going to put us back on the street? I mean it's—you know, I had a feeling that it was going to go up. I did have that feeling. And it did, it went up $25.00. So, you know, and it's like being that I don't have any income, you know, it pisses me off because it's like if I go over my lights, and now they're charging me for water. So I don't know how they're going to put that in there. " (C-03:219)
	Privacy "A little different from here [Moore Place]. You got an apartment, a house somewhere. This here is like a joint thing. It's okay with me but you know that was my first preference. [...] The list was so long. [...] A house would be better. You got the house to go in and come as you please. You can get whoever you want for company. It's maybe a little quieter." (C-01:67)
	Restrictions/ requirements "And that's the real issue: so many people out here who are not married by law, but common law. And we have kids. And then we can't come together. He has to be over there; I have to be here. How does that work? You been together 13 years and you have three little boys – my mom, my aunt and his niece. We had to split them, all the boys, together?" (C-02:127)
	Safety "They put me in a bad area. [...] They put me on Rachel Street. I had signed the papers to come here. Somehow Rachel street- they put me on Rachel Street, right there in a drug home. [...] Everybody _____ got shot up in there. I could have died. [...] But they came, the police officers, they helped [...], and got me over here. " (C-01:21)
	Services "[When asked about having a permanent case manager]. They don't give you one. Yeah, put you in the housing and then after that it's like you're on your own" (C-03:111)
Differences between Scattered and Single Site	**Privacy** "And the walls, thin, like everybody and they be arguing over there [...] You just in the middle. Somebody might be fighting and everything, you hear some thumping. [...] You have an apartment a house [...] You don't have to deal with other tenants' issues. Like one day you might – when we come home we don't know who we going to be seeing out there, like come out and police out there. You never know. Here you never know. Or you might come around and ambulance out here. You never know." (C-01:71)

	Resources "We [Moore Place tenants] got – well first we got a laundry room, computer room, community room, and we have rooms for various resources, and we got our caseworker. […] But we got caseworkers and we got staff and they're really good, caring people. And not only do we have all these great resources" (C-01:29)
	Security "[when asked if ever afraid] Not really because they get past security […] that's one good thing. They do their job and everything should be all right. They got the camera." (C-01:72)
Relocation & Moves	"They put me in a housing with another person and the problem with some of that is, you know, the other person's got their own idea of what life is. […] But the gentleman they sent me, I started down, "Okay, this will work." I wanted it to work. Well, he was an alcoholic. He became a rude, angry drunk. So that became a very bad situation and that broke up. So it was the second try that they finally, through [provider's name], that they were able to get me into a place where it's actually an apartment building that is set up for individual room rentals type deal. And that works good because you have your own room. But it's the same; it could be problematic if you have who you've got. I got lucky and found another gentleman that is square, straight, you know?" (C-03:38)

Strengths & Resources

Focus group participants mentioned the strengths and resources they were able to draw from to meet the challenges they faced while homeless and trying to find housing, as well as while transitioning into their new lives upon housing. Participants' responses were categorized in seven areas. First, participants described their attitude toward their situation and their outlook on life as strengths. Second, numerous participants, at different stages of the housing process, talked about their case managers as an important source of strength in their lives. Although some of the experiences participants reflected on when discussing the strengthening aspect of their relationship to their case manager were related to housing, others touched on other areas of life, such as emotional well-being, empowerment, family reunification, and healthcare. Third, they mentioned the helpful aspect of certain resources organized through donations within the Charlotte community, such as food, and expressed gratitude for those who participate in these local initiatives. Faith and spirituality were often discussed by participants as a source of strength. More specifically, participants spoke about their trust in God to help them leave homelessness, which allowed them to remain hopeful despite feeling powerless at times. Putting control in God' hands strengthened participants until they reached a point where they felt empowered enough to hold this perceived control in their own hands. This theme was sometimes framed in relation to the experience of homelessness, but also emerged through participants' discussion of their journey to overcome substance addiction. In addition, faith helped participants overcome feelings of fear related to the experience of homelessness. Through prayer, participants felt connected to God, they could "talk to him" and felt like "God had been there with [them]". This presence seemed especially important to some participants who otherwise felt alone; it helped them survive. Next, family and friends seemed to be especially important strengths to focus group participants. Participants who received peer support often underlined the valuable aspect of this resource as they transitioned into housing. Peer support specialists were often portrayed as friends and associated with high levels of trust. The helpful role of peer support specialists was not only framed in relation to housing, but also touched many other facets of the participants' lives, ranging from healthcare, grocery shopping, transportation and emotional support. Finally, participants also discussed their own perseverance as a strength. Participants discussed the willingness to do whatever was necessary to help themselves, even when it meant accepting the present circumstances as something they had to go through at this time in their lives. Table 4 summarizes the major categories and subcategories from the analysis along with exemplar quotations from the participants' responses.

Table 4: Strengths & Resources (n=24)

Category	Examples of Participant Responses
Attitude & outlook	"I have nice clothes but I want to look nice. I want my hair to look nice. […] You're homeless. […] You don't have to look bad. You don't have to walk around looking down and feeling sorry for yourself because you're homeless. There's ways you can pick yourself up." (C-04:72)

Case managers	**Emotional support** "I feel I can always go down there and talk. And get support. I have some real strong positive people in my corner today. That's a real big plus for me. That's really it for me." (C-02:60) "Not only did they help us get in here, but they helped us with our anger problems and issues we had. We took the classes. So, it really helped a lot with the process because we're angry." (C-02:15) "Somebody is always there. When I'm going through a crisis somebody is always [...]- I got like four people that I can pick up the phone and call any time of the day. I wouldn't say night but any time of the day during office hours and I can get some help. And if don't nobody answer within 10 or 15 minutes somebody is calling me back.That's working for me. Just to know that somebody is going to help me, helping me a little easier. Because I can do it. I just need to know that somebody is going to help me if I can't. (C-04:171)
	Empowerment "what I love about my caseworker, they have faith in me. They know me, and they know that they can depend on me like I depend on them. And they know if I call them it's because I need to call them. Because everything I can do on my own I try to do. [...] So, I love that attitude with them that they believe—not the attitude, but the faith that they have in me. And so as long as we have that faith between one another is what matters to me. You know, we had that belief and that honesty, you know, 'cause I won't share nothing out." (C-06:92)
	Family reunification "To be honest with you, you know, I think they doing good with me. She [case manager]'s doing good for me. They got me in contact with my family. My mom's still living. She's 72 years old but – they got in contact with her." (C-01:56)
	Healthcare (including transportation to medical appointments) "I got a case manager now, he's staying on top of me with my meds and make sure I go to my appointments and stuff." (C-01:11) "My radiation. I have to be there every single day for 10-15 minutes a day. I didn't miss one day, except when I chose to stay in the bed pretending like I didn't hear the knock on the door. There was always somebody ready to take me. And after you get burnt a couple times you just like, "What? I ain't going there." I can't take it. [...] I know [case manager] was really feeling some kind of way because he was banging on my door every day." (C-02:71)
	Housing support "I wouldn't ever be in this place if she [case manager] – I've talked to her, I was able to have a conversation with her about my real fears [...], You know, it's the invisible hand theory, a little bit, in some of that: she's gonna go and she's gonna tell them any kind of thing in order to help save my dignity – supposedly, or whatever you wanna call it."; "it would not have worked if it hadn't been for her [case manager]. " (C-05:65; C-05:85, respectively) "She fights hard for me. She fought hard for me, to the point that this woman stood in front of these people [...] like, "This girl don't need to be out there. She has health issues." 'Cause I have a history—I'm a diabetic, I have history of blood clots, cellulitis, asthma, bronchitis, anemia, hypertension. [...] I'm handling my health issues. You know what I'm saying? Thanks to [case manager] because then I didn't care." (C-06:89) "They trying to speed the process for me. [...] It got to the point where I was [...] I can't keep up with it." (C-01:56)
Donors	"They just take care of you. They take care of you all through the night. You know what I'm saying? They are good people, good people at churches and inns all around Charlotte that donate food and stuff to us. [...] Time. [...] Their time and whatever." (C-04:75) "the pantry was a very successful thing and it was profitable towards my becoming somebody, a helping hand, to allow me to reengage in my own life and like I said, cook my own meals and whatnot." (C-03:123)

Faith & spirituality	**To overcome hopelessness** "I mean I trust God. I have no doubt in God. God said take no doubt for your life, what you should eat or drink. I trust in God and I feel like he's going to fix the situation. Not only mine, yours, yours, yours. Fixed yours. Keep trusting. They're going to do more than that for you." (C-04:129)
	To overcome addiction "Me, personally, on the drugs – cocaine – hard. I did that [achieving sobriety] years ago – I did the prison with the rehab, I did NA, AA, I did the Bible, I also put it in God's hands. And then now, I put it in my hand: when I say no, I mean no." (C-05:76)
	To overcome fear, overall and though prayers "I'm not afraid because I know God is with me." (C-04:20) "And staying up in the woods and stuff. I pray and I may with my little tent in the woods and I just pray. And when I close my eyes I should thank the lord for waking me. [...] And then I don't sleep very good because I hear something crawling and I think of snakes and I just sit there. [...] Think and pray and talk to God." (C-04:65)
	To survive "I've survived through, I believe in prayer. And I pray every day to God. I don't miss a day of prayer. [...] And I trust in God and that's how I do it. Otherwise I would have had a nervous breakdown or something, depression attack or lost my mind or something. God's been there with me. [...] he has been there." (C-04:189)
Family & friends	"So I later found my cousin this year. [...] She's been helping me out. She's been good because it's been a struggle." (C-04:78)
Peer support	"my peer support person. And without her I never could have transitioned into a, you know, into the housing. She was a friend. Yeah, a friend. I could call her anytime and she'd—then I was able to get sort of like insurance or healthcare through [program] and she would take me to my appointments and go into the room with the doctor, you know, and the doctor would explain something I didn't know what they were really talking about and she'd help explain it. She would go to [agency] with me. I needed to go grocery shopping, she would take me. Take me anywhere I had an appointment. And she would come visit me every week. Every Wednesday she would come for like four hours and we would do whatever I needed to do or we would sit there and talk. See, there's a certain comfort level that comes with that, knowing that it's somebody you can talk to." (C-03:161)
Perseverance	"You know, the existence that you're in is not conducive to life. You know, it's challenge after challenge that you don't have an answer to and you can't—you have to humble yourself and be able to accept help. You know, or good people. And you have to—as the gentleman had said, you have to do for yourself. Because if you don't do for yourself you'll never get—you know, you have to have goals. Your wants and desires, I would think, and that's how I thought about it. To be able to get past this, "I don't want to be in a shelter, it's not a good place, but it is a place I have to be." (C-03:81)

Suggestions

Focus group participants offered a number of suggestions based on their experience of chronic homelessness. Suggestions fit into four categories. First, participants offered advice to others who were experiencing homelessness including doing the footwork, keep faith and hope, perseverance, seeking help, being transparent with service providers, and working multiple angles. Second, some participants offered suggestions to the public, including addressing the growing problem of young adult homelessness, an issue pointed out by several older adults who participated in the study. Third, participants offered advice to service providers including addressing their own stereotypes and developing greater empathy and understanding for those experiencing homelessness. Finally, participants suggested several improvements to housing and services. Table 5 summarizes the major categories and subcategories from the analysis along with exemplar quotations from the participants' responses.

Table 5: Suggestions (n=24)

Category	Examples of Participant Responses
Advice to others experiencing homelessness	**Do the footwork** "You've got to do a lot of footwork, a lot of mind work, phone work, going from place to place." (C-04:114) "Well, I also, I performed the actions, [...] she gave me good – not advice, she said, "You'd better do this." [...] They call that the footwork. You gotta do the footwork. (C-05:85) " have a strong sense of spirituality and faith and I place God first in everything I do. I place God first in everything I do and I hear you speak a lot about your spirituality. And what I want to share with you is that God's there. He doesn't forget about us but he puts people in our lives that we can use, that we can talk to, that we can call, that we can work with. And whether you feel like you need it or not like you just got to do it. Like I did a lot of stuff that I wouldn't have done just because I wanted to get off the street. Like I talked to people I didn't want to talk to. I said stuff I didn't want to say. Just praying is not good enough. You've got to do your own legwork too. You can't count on anybody." (C-04:136)
	Faith & hope "And just keep your faith and hold your head up because hope is here. Hope is here." (C-04:188)
	Perseverance "Guys, just don't give up and just put your stuff out there with everybody and somebody is going to connect." (C-04:10)
	Seek help "I kept telling somebody please help me. Can somebody listen to me? Can somebody please help me? 'Cause I'm not going nowhere. And just so happened like I just threw it out there one day. And the lady that I spoke about knew the lady that I was talking about. And they were different agencies. Like they do the same thing but they were – one is a shelter and one is [...] And it's just like the dots connected. [...] Yeah. I got with another agency and they were connected. Man, it just – and then I just done what they told me to do. I jumped through hoops. I went everywhere they told me to go. I met every place they told me to meet, dripping wet, soaking wet, dirty. Man, it was rough. It was rough." (C-04:104)
	Transparency "And it's worth it. A lot of people are so like angry out there that they don't want to do the footwork themselves. They've kind of given up on themselves. And they feel that no one else is going to help them. [...] Like go to the [agency name], sit in somebody's chair, not even doing too much footwork. Sit in somebody's chair and tell them the truth. A lot of people want to hold things back from shame and guilt. You don't get housed that way. They won't help you if you act like you've got it under control out there. I'll admit, I was able to maintain and to do out there, but I didn't have it under control. And I'm pretty sure anyone else that goes there every single day to eat that lunch and then they hit every other place to make sure that they eat throughout the day, and they have to figure out where they're sleeping, they're not maintaining either. So, it's just – I don't know, some people have to let go of their pride in order to get what you need." (C-02:27)
	Work multiple angles "They say they'll help you and they do. Don't take that credit from them because they do but they can only do so much. And then it goes into somebody else's hands and then they have to do their part. And then the next person got to do their part. You've got to work with several agencies. Like you can't just work with one. And I did that for a long time. I worked with this one agency. I was with Urban Ministries and it just wasn't working." (C-04:100)

Advice to the public	**Recognition of the problem** (when asked what would help Charlotte be successful in its effort to end chronic homelessness) "Well first of all recognize it. We exist. Don't just put up a building and say we're going to put up a building, we're going to throw you in it and that way you're not on my street so I don't have to look at you." (C-02:116)
	Empathy (when asked what would help Charlotte be successful in its effort to end chronic homelessness) "I think Charlotte should just have a little bit more empathy for the people that's out here." (C-02:122) "What I mean is that they really listen to us and feel – if you were in our position how would you feel?" (C: 04:130) "You got to care about these people. You got to care." (C:02:123)
	Employment (mainly targeted at young adult homelessness) (when asked what would help Charlotte be successful in its effort to end chronic homelessness) "I went up to the [agency name] and I mean it's like I don't know anyone up there. They're all young kids now. It's a whole new generation out there. [...] That would be a good organization to set up for the youth that are homeless that are still young enough to be persuaded or educated. Like some sort of [...] program that will allow them to educate and also follow through with employment. You know, and with that being said, you can kind of limit the fluctuation of people coming in to homelessness." (C: 03:259) "I mean I think jobs solve a lot of things." (C-01:81)
	More affordable housing (when asked what would help Charlotte be successful in its effort to end chronic homelessness) "I think another Moore Place would be very helpful." (C: 01:76) "Affordable housing for the people that are homeless. You know, because everybody's—all these apartment complexes, they're raising the rents. You know, and I might be back homeless again because of affordable housing. They keep raising—all these places, they're raising the rent so much. You know, you go to what your voucher's for." (C-03:216)
	Target subgroups (young adult and family homelessness) "But I would imagine you could lower that if you could have a program [...] that was applicable to these people [young adults who are homeless] and interested in these people, to regain society, the definition that society requires of us, that would have to sit there and lower that. And in lowering that you now have the opportunity to spend more time with the people who need it. You know, so it's a double-edged sword there, but it's a benefit if you can cross that fence. If you solve one problem you help solve another problem." (C-03:215) "Then you've got the homeless people like the families. The homeless families I feel as though if we concentrated on that you would get more—you would figure out an easier solution." (C:03:258)
	Use available resources (when asked what would help Charlotte be successful in its effort to end chronic homelessness) "Stop wasting money. [...] This big building, across the street from Lang's, it's open. It's empty. There's actually a spot that looks like it could be divided, women on one end, men on the other. What the hell are they putting over there? That building has been there forever." (C-02:124)

Advice to Service Providers	**Address root cause** "If you're not tackling the root: what was the reason they went out there and picked up in the first place then you can't help them. […] And it's because of those past things that I can't seem to shake. And then it's getting to the point where the disease is progressive, so it gets to the point where you put the stuff in you, your self-medication, you put it in you and it doesn't work on you. And it sends you places that you really don't want to go. But you got so used to that crutch you can't put it down. And it's just- I don't know how to reach out to the help that I need. I don't really know what kind of help I need. […] Some people don't even know what that root is and if they know what that root is if nobody ever asks them about it they can't just sit and have a real conversation about what happened to you as a child then a lot of stuff stems from our childhoods. A lot of us did not have the best upbringing. There was sexual abuse. There was physical abuse. There was a parent that was an addict or a parent that got divorced or you didn't quite understand what was going on because nobody ever explains a damn thing to a kid. You just have to accept it. And that leave scars. Those scars you carry forever. Until somebody tells you, "I can see your scar. Let's talk about it." And you can open your mouth and get it out, it haunts you, and it makes you do stuff that you wouldn't normally have done." (C-02:119)
	Don't stereotype "And don't stereotype everyone that comes in your shelter. Like everyone is not the same. Some of them are there for different reasons." (C-04:157)
	Empathy "There's a criteria for us when we go to a shelter. We have rules and we have things that we have to do every week. We have chores. […] We have certain times for eating. Like if we can do all that, why can't they attend, the workers, like attend once a week a group like this. Like just so they can feel. Like I think some of them like it's their job and it's no feeling anymore. And if you feel what we – I got chills talking about it. If you feel what we tell you, it's not way you're not going to do everything that you can do to help me. If you listen to me and hear the sincerity in my voice, it's no way. My heart would not let me not help someone. […] And I think if they feel – if people in position feel. Forget that it's your job. I mean know that it's your job but feel. Don't just look at us as a piece of paper or a client because you do – I think it should be something added." (C-04:156)
	Transparency "Now you're forcing them into housing, you know, if you're forcing someone to do something make it comfortable, make it to where you're speaking to them in a way to where they understand exactly what you're trying to do for them and because all people see is that you're trying to push them back. You're trying to push them out of the way to make plans for all the good things for Charlotte to come through it. Like a lot of the homeless people that are out here, they say, "Oh, the white people are going to push us all back to the back and all out of the thing" and that makes them feel, you know, makes them feel like […] Less of a person." (C-03:234)
Housing & Housing Process	**Furniture** "[When asked what they would change about their housing] That bed they give you. That thing is hard as a prison. If you ask anybody most of them say sleep on their couch because that baby is so hard." (C-02:43)
	Speed up housing process duration "Charlotte has the money, the resources, the great people like you guys. Charlotte has the resources, but what it is is the homeless, they want to decrease the number of homeless. So since Charlotte has the resources what they need is to go faster to get them off the streets." (C-01:80)
Services	**Client/ case manager fit** "Anything you can think of that you would change? And if you think of it later as we go just bring it up, just so we get it on the record. So let's talk about the supportive services. So I have already heard that it sounds like kind of haphazard if you get any kind of support or that maybe it's available but you don't have to utilize it. Male: You've got to find the right person" (C-03:137)

	Community meetings "Now I'm doing the art thing to revitalize that mile and a half of North Tryon, so I hear quite a few things. But not many people do. It's not like they have a meeting once a month which I think they should. Have community meeting [...] they would have to participate with us because they have all the information. But that would be nice once a month, once every two months. " (C-02:105)
	Connect/ help access "[When asked what they would change about services] You know, I don't think there's anything that you could change with what's there. The accessibility, you know, the ability to find it quickly, if you will. You know, a lot of these gentlemen, you know, you don't have Internet or they may have phone Internet, but, you know, the Internet is supposed to be the answer to all, everybody's questions. But finding it, you know, you may not be Internet-literate or computer literate." (C-03:181)
	"Kickstart" "It's been difficult, 'cause I had these moments—I had the moments where I didn't want to go outside. I was depressed or something. Need some help to get [...] I would say maybe not kickstarted, but at least [...] have some, you know." (C-03:184)
	Health care linkage/ medical "Yeah. So any other services that you think you need that aren't being offered? Male: Dental. [...] Male: Yeah, any type of medical. [...] Male: Vision. [...] Male: Help on your medication. (C-03:178)
	Mediation/ mutual support (congregate setting) "They need something like that where you can write some – you have a problem, put it on a sticky note or whatever and put it in the box. Somebody takes that box and gets you in touch with somebody so you and the other person can sit down in a private setting and discuss it before it escalates. [...] Yeah, you need a mediation type-group here. Because a lot of times people get together yelling and screaming and arguing because two residents have decided they hate one another. And it could be carrying on because this is a little bit like a college campus, so it lingers. And other people get involved in it, it can escalate. It's just safer if they put something in place to squash it." (C-02:108)
	Responsive to individual needs/ family reconnection "They'll give you bus tickets, but they'll only give you a bus ticket for something that they think is important: doctor or hospital. My grandmother lives down there and my grandmother is my heart. I think if I have to see my grandmother or go to the doctor with my grandma I should be able to say, "Look, I get home I need a ride there." And they should say, "That's family." They should want us to stay connected to our family, so they should hand me a bus ticket without giving me a bunch of grief." (C-02:93)
	Staff training "I don't know what I want, make better training. Maybe they should be trained by the people at [agency name] so that they know how to talk. And if they listen to enough stories they'll say, "Okay, so that's why this person or that person does this particular thing." But not – we don't have that type of counseling system." (C-02:89)
	Staff lived experience/ peer support "They were doing anger management and I think they need to do it again. But they need to get a different instructor. Because how can you talk about being angry if you never been angry? And some instructors look like they're sweet as pie and have never had an altercation in their life. And it's like, no, you have a lot of anger from being homeless. Like she said, you feel like somebody owes you something because you're out here and you're invisible." (C-02:83)

Transportation
"The bus pass. Like a One Ride—a couple of One Rides [...] just one way and then have another one to ride, just to go look for a job. Like I got frustrated with that at first, because I had a little bit of money, but I didn't want to spend $2.20 to go ahead and $2.20 to go. [...] now I've got the light rail out there at the university, so I can catch a light rail and get a pass. But before then it was like, "Okay, I've got $2.20 to go here. $2.20 to come back this way. $2.20 to go—that's almost $10.00." (C-03:186)

Outcomes Interview Findings

Interviews were conducted with participants from the chronic homeless By-Name List from 2016-2018. Interviews included standardized outcome measures as well as open-ended questions about participants' experiences. Previous interim reports discussed responses to questions asked at baseline interviews. This report discusses responses to questions for housed individuals 6 and 12 months after they were housed. Of the 330 individuals who participated in interviews, 61% (n=201) were housed.

Housing benefits

Study participants were asked, "What changed the most for you in your daily life since you were housed?" Responses fell into 15 categories detailed below. Study participants completing follow up interviews indicated that housing had helped improve their mental state specifically in terms of their attitude, stress, and happiness. Many discussed how they were better able to address their basic health needs, such as eating better, sleeping and hygiene, as well as accessing healthcare providers. Changes in environment/living conditions were also mentioned by participants. In addition, participants noted a change in activities and the structure of their day. Table 6 summarizes the major categories and subcategories from the analysis along with exemplar quotations from the participants' responses.

Table 6: Follow up interviews with participants who received housing - What has changed the most

Category	Examples of Participant Responses
Everything	"Just about everything." (E-856:01) "Everything. the food, the health, the recovery, more respect for myself and others." (E-607:03)
Nothing	"Nothing." (E-887:01) "Nothing has changed in my daily life.." (E-642:04) "I don't know, but I am alive." (E-934:01)
Activities	**General** "I have things to do, before the only thin I did was panhandle and fly signs." (E-775:03) "Stove to cook on, shower and bathroom, watch TV all the time, play the guitar." (E-636:02)
	Structure "My structure, my day to day. Before everyday I had something to do like job hunting or seeking information and assistance. Now I have more regimented with my job and support group." (E-630:02) "Being able to have a routine is so nice and helps me stay on track." (E-789:02) "I have slowed down more than anything. I'm not in survival mode 24 hours a day anymore." (E-848:03)
	School "Going to school." (E-663:03)
Autonomy	**General** "I can take care of myself." (E-773:02)

	Shopping "Doing my own shopping." (E-643:05)
	Cooking/Eating "We can cook when we want." (E-900:03)
Difficult/Negative	**Time** "Becoming lazy, I don't want to go nowhere." (E-797:03) "Leisure, I have more of it. I have too much of it. When I was homeless I didn't have any of it." (E-774:11)
	Transition "It's been a little bit strange. I 'm just trying to get used to the differences." (E-893:02)
	Food Access "It's not as easy to get to food and everything." (E-907:05)
	Health "Stress levels have increased because of health problems." (E-937:01)
	Fear of losing housing "For the first time in my life I have fear because i'm afraid of losing housing." (E-843:02)
Environment	**A Place to Stay** "I was able to get off the streets, I would have been dead out there, there's too much going on." (E-787:02) "I don't have to worry about being out there." (E-840:03)
	Living Conditions "Don't have to worry about sitting outside all day long." (E-643:04) "I'm more at ease. I finally have a couch and a bed." (E-902:01) "I'm not sleeping in my care anymore. I am more comfortable." (E-939:01)
	Privacy/Own space "Just housing, just getting my own place." (E-772:03) "Not going home to a tent, feels better to go home." (E-657:02) "I have more privacy." (E-833:01)
Financial	**Job/work** "I couldn't get a job before." (E-653:04)

Health	**General** “ Access to a doctor.” (E-940:01) “My physical being . I had a colostomy and eliostomy. My medical situation is more difficult, but having my own place to live makes it better.” (E-933:01)
	Appearance/Hygiene “I’m able to take a shower.” (E-907:05) “Being able to complete hygiene whenever I want.” (E-780:01)
	Nutrition “I am able to eat better.” (E-646:03) “Eating better, more constantly than before.” (E-662:04)
	Sleep/Rest “I don’t have to get up and find a new place to sleep each night.” (E-796:02) “I am able to sleep better.” (E-646:04) “Comfort of not being on guard all the time or anxious from sleeping outside or in storage.” (E-766:03)
Mental Health/Substance Use	“I don’t do drugs or alcohol anymore since I got into housing.” (E-642:05) “I smoke and drink less.” (E-762:02) “My mental health is getting better.” (E-746:03)
Mental State	**Attitude/Outlook** “Mentally, I am in a better place.” (E-633:05) “The way I look at things. My judgement has changed because I have a base so now I don’t have to worry about what’s going to happen to me. It’s like having a new outlook on things.” (E-788:01) “My attitude. I’m calmer than I used to be. Not angry.” (E-840:01)
	Happier “I am actually happier.” (E-638:03)
	Less Stress/Peace “Quietness, relaxation, time to myself, without people walking over you or police stopping you.” (E-628:02) “My worries have subsided.” (E-652:04) “A sense of peace.” (E-777:01) “My ability to stay calm.” (E-904:03)

No Panhandling	"I haven't had to panhandle." (E-652:05)
Relationships	**General** "I don't have to talk to people." (E-790:01) "I feel like I belong here and around a lot of the people here." (E-649:04) "i'm no longer around people getting high." (E-766:05)
	Family "Seeing my kids more often." (E-663:04) "I am able to take care of my baby." (E-908:01)
Security/Safety	"I actually had keys." (E-648:02) "I like Moore Place and how safe I feel here." (E-752:02)
Stability	"Stability, I am able to be stable." (E-645:05)

Program improvement suggestions

Housed participants were also asked during 6 and 12 month interviews what their housing programs could improve. Major categories and exemplar quotes for responses to what the program could improve on are provided in table 7. The most frequently cited response was 'Nothing', indicating that they were satisfied with their housing program. Recommendations for services included discussions of the need for improved access to furniture and supplies for the units, more assistance with and clarity around bill paying, access to healthcare providers and transportation. Participants mentioned the need for more assistance/services. In terms of housing, participants suggested improvements to the actual housing such as better maintenance, improved security, and more choices for housing. Relationships between staff and clients was also cited as an area for improvements by participants.

Table 7: Follow up interviews with participants who received housing - What could your housing program improve

Category	Examples of Participant Responses
Nothing	"Nothing, I feel satisfied." (E-626:05) "I can't think of a thing. I'm content." (E-788:03) "There's always room for improvement, but I can't think of anything at the moment. Everything works and functions at my house right now. I can't complain." (E-850:03)
Assistance/Services	**Additional Services** "They just kind of throw you in housing and don't provide other resources that were easily accessed when I was homeless and close to the downtown area." (E-907:06)

	Access to supplies/furniture "Give more furniture. Been here for six months and haven't been given the furniture I was told I would receive." (E-887:03)
	Financial "More clarity about what bills they are covering and dollar amounts. Some information sessions about what they do and don't cover would be helpful." (E-645:10) "Better record keeping for payments and not losing the paperwork." (E-793:03) "More connections to financial resources." (E-951:03)
	Health "They can improve more by getting more help for mental health and physical needs." (E-833:06) "More support, like more counseling." (E-841:03)
	Transportation "Transportation to doctor's appointments." (E-751:04) "More bus passes." (E-775:06]
Housing	**Maintenance** "My housing could be better insulated." (E-793:02) "Their book keeping, pest control, fire hazards and improve safety features." (E-847:03)
	More Choices "Get more apartments to help more people." (E-663:06) "Having more housing selection of where you're able to be housed." (E-742:05)
	Safety "It's an unsafe environment where I live and we are trying to move." (E-658:06) "The area of the apartments.....People stop me as I'm walking to the store and ask if I want to buy weed. People ride up in their cars and will ask me, and I'm just like wow." (E-631:04)
Lease	**More Requirements** "Do maybe more of a background check on people. Maybe not take people with a violent background." (E-649:05) "If you're a known drug addict, I think you should have to go through a drug program. If you think you have your sobering, this building will break it." (E-638:07)
Relationships w/ Staff	**General** "They are on point, they are real good. Maybe that I don't feel comfortable opening up with my new caseworker. He had me waiting for so long, but when a white dude came up he immediately assisted him." (E-655:06) "Workers dealing with homeless population should be able to relate to them." (E-776:02) "Being honest with their client." (E-946:03)
Relationships w/ Tenants/Landlords	"More of a relationship between tenant and landlord. It's tough to get through to an be respected by landlords." (E-789:03) "Get some of this crazy people out of here." (E-941:03)

Program successes

Housed study participants also answered the question, "What does your housing program do well?" Responses were organized into eight categories. Major categories and exemplar quotes for responses to what the program did well are

provided in table 8. Participants who had received housing commented on the commitment of the staff at the housing programs. They also indicated that the housing was a strength for the programs. Services and assistance provided by the programs, such as connection to specialized services, transportation, and general support, was cited by participants who had received housing. In addition, Financial assistance was mentioned by participants.

Table 8: Follow up interviews with participants who received housing - What does your housing program do well

Category	Examples of Participant Responses
Everything	"Everything. I love them to death, without them I wouldn't have half of what I have now." (E-663:05) "Really everything. They maintain the places effectively. They come fix things in the apartment quickly." (E-848:04)
Nothing	"I don't have a housing program." (E-854:06) "Nothing." (E-651:03)
Activities	"I know they have workshops and I've been to a few and I like them." (E-631:05) "They have different programs scheduled, always something going on. They keep you busy." (E-761:05)
Assistance/Services	**Connection to services** "They connect me with services I need." (E-645:09) "They give me monthly bus passes, and they take me to churches to receive food and other services." (E-642:07)
	Help/Support "Support, moral, spiritually, financially, they do a lot of things and they do it consistently." (E-903:02) "Cater to my needs. They are very attentive and taught me to advocate for myself." (E-837:02)
	Transportation "They take me places." (E-855:02) "Our case manager comes to see us just about every day. I like that. I'll tell him what I need to get done and he'll take me there." (E-900:04)
Financial Assistance	"They pay two third's my rent." (E-755:09) "They pay my bills for me." (E-775:04)
Housing	"They succeed in putting you in housing and getting you off the streets." (E-911:02) "Providing the opportunity to get housing and move forward." (E-780:02)
Security	"Provides a place where you can gather your thoughts and reduces fear of being unsafe or having things taken." (E-761:06)
Staff	"Case worker is very attentive to all my needs and she's there for me." (E-790:02) "They check on me regularly." (E-911:03) "Support. It's like any time I call them whether it has to do with housing or anything I will call them that day and they will get back to me that day." (E-758:05) "They respect my privacy. If I need them, I can call them and they're pretty responsive." (E-949:02)

Strengths & resources to find housing

Finally, participants reflected on what strengths and resources helped them find housing. Of the 14 categories mentioned, two were very prominent: personal qualities and service providers. Many participants who completed

housed follow up interviews mentioned their own personal qualities as a factor in finding housing. Qualities specified included attitude, determination, perseverance, and a willingness to do the work. In addition, participants indicated they had help from service providers dedicated to working with homeless individuals. Some participants mentioned other organizations that had helped them such as a treatment program or a church. Support from family and friends also played a role for the participants Table 9 lists the primary categories and exemplar quotes regarding strengths and resources that participants deemed helpful to find housing.

Table 9: Follow up interviews - Strengths and resources that helped participants become housed

Category	Examples of Participant Responses
Myself	"Myself, can't pinpoint it, but it is myself." (E-632:01) "Just being me. I don't rely on anyone but me." (E-797:04)
None	"None." (E-820:04)
Other Programs	**Churches** "I have a strong support group through my church." (E-928:05)
	Substance Use Treatment "AA was a big help to me." (E-821:04)
Substance Use	"I am alcohol and drug free and still in my house." (E-642:03) "Getting clean." (E-935:04)
Personal Qualities	**Attitude/Outlook** "I had to keep my head up." (E-777:05) "Believing that things can happen." (E-641:01)
	Determination "I was very determined to fulfill everything I needed to do to get housed." [639:2] "I don't give up. I'm motivated. I just kept going." (E-907:01) "I was very motivated. I was in the streets, but didn't let my mind be in the streets." (E-753:02)
	Willingness to work "I just got tired of it. I did the footwork. I wanted to do it." (E-933:04) "I didn't just sit around, I tried to find programs to help get me out of the men's shelter." (E-835:04)
Relationships	**Family/Friends** "When I was outside I had two people the were watching over me, my brother and my friend." (E-646:02) "My family are all behind me, they worry about me and help when they can." (E-821:05) "Good social network." (E-932:04)
	Sharing Information "Had a couple of friends that got housing and told me about it, that helped." (E-754:01)
Religion	"I owe it all to God. I still don't know why they picked me to get off the streets." (E-843:07) "God, faith and perseverance. It was a miracle." (E-937:04)
Service Providers	**General** "A lot of nice social workers." (E-789:04) "Cooperating and following instructions from my case manager." (E-743:02)
	Specific Organizations "Urban Ministries was amazing." (E-638:01)

	"Urban Ministries was amazing." (E-838:01) "I got lots of help from many service organizations, like Urban Ministries." (E-837:04) "I went to Urban Ministries and stuck with it." (E-849:04) "I found the strength to find Shelter Plus Care and Urban Ministry and then they helped me." (E-775:07) "The Men's Shelter helped me a lot." (E-760:01)
Skills	"Good budgeting skills, good planning skills." (E-662:02) "I have lived in an apartment before and know how to pay bills." (E-790:05)
Tired of Homelessness	"I got sick and tired of waking up in the street. The hardest person to help is yourself and I realized I had to finally help myself." (E-829:02)

Appendix G:
Frontline Worker Perspectives

The perspectives of frontline workers were also incorporated into the evaluation through 7 in-depth focus group interviews with 43 individuals from programs partnering under the Housing First Charlotte-Mecklenburg (HFCM) initiative. To protect participant confidentiality, focus groups were not transcribed by named participant rather by the generic, *respondent 1, respondent 2,* and so on. Therefore, unlike individual interviews, we cannot count the number of times unique individuals responded in each of the categories and sub-categories. Frontline worker responses were categorized into three main categories: Advantages of the housing first model, successes, and challenges.

Advantages of the Housing First Model

In the focus groups, the frontline workers described how the Housing First model changed the way they did their work. They described having lower caseloads and more autonomy, and how they were able to be "more effective" (B-04:136). For example, as one frontline worker explained: "I've been around for a while, so I've had many different jobs. But I will say that this job really busted the door open for me to just do social work, and in a way, unlike other jobs where there was a lot of structure, a lot of regulations" (B-05:81). The frontline workers also commented on the relational nature of the work. For example, one frontline worker said, "At the end of the day it's about relational, being able to have that bond where you listen to them and you just sit with them and put in the time" (B-09-27). Another explained how they "really go into people's houses and see how they live and, you know, work with them in their environment" (B-05-84). A third said "I think Housing First is a very free model and it allows you to….build that relational piece because you're listening to their story and you're allowing them the opportunity to share in a safe space their barriers" (B-09:36). Similarly, they described how work is "more client-centered" and built on "trust." As one frontline worker explained, "It's all in the introduction, when you meet with them, and the rapport that you build together. The trust that that client has with you. That's how successful you'll be with that client, and determines how you all move forward together" (B-04:98). Several frontline workers also commented about scope of the work, saying "With this job you work on every issue that comes up" (B-05:82). Another said, "We're doing the case management and the clinical side, and we get to do the housing side too" (B-10:37). Table 1 lists the primary categories and exemplar quotes regarding advantages of the Housing First model as perceived by frontline workers.

Table 1: Advantages of the Housing First Model (n=43)

Category	Examples of Participant Responses
Case management	**Manageable caseload** "It's not bad. I mean some weeks you may not get to somebody because you had other issues with the other folks on your caseload, but it works. It's manageable." (B-04:135)
	Case management approach "Coming from a mandated service where it was always crisis mode. This right here is just like a piece of cake." (B-05:44)

Creativity	**Harm reduction** "I have a guy that I spoke with on a call before, we could not get him in. The only time I could see him was at the hospital. And he would have to—he was bad off on addiction. Prior to addiction I was meeting him and case managing him in jail. So I was going to jail and he had this nice plan. When he got out it went to hell in a hand basket on fire. But we still had that relationship that we established from the beginning that I met him where he was in jail, with no judgment. [...] So even during his addiction I didn't see him, but when he was ready for a break [...] But that wakeup call, you know, and me constantly showing up. And I talk a little junk and still do the professional side. But again, that was my creativity. I met him where he was, I spoke the language that he spoke, but yet still I did my job, and that was being very flexible. You know, sometimes we come with what it should be, and it's not. Everyone doesn't speak to that same rhythm and you have to change your tune and change yourself to make it work. [...] I found his motivation. His motivation is that he didn't want to die. [...] those real conversations kind of awoke him, and with that, being the 4th of November he's 90 days clean. [...] But it's a process, so again, you know, being where he's at, being creative to get them to want to change or even to see the desire why it would be important for their lives. And if you don't want to, hey, you don't have to." (B-10:28)
	Housing adjustment "We have to find them and keep working with them. Some of them, they – it went as far as to say, well, I don't know if I can stay here. It's too quiet. You know, we have to get them a TV." (B-07:15)
	Housing retention "Or with just the housing, a lot of times – well, you're dealing with the individual. And it's hard to find a one bedroom apartment, so a lot of times they're getting two bedroom units. And so like okay, with your second bedroom, let's turn it into a den. Let's put a kitchen table in there. And that way – because your kitchens are usually pretty small. Put a kitchen table in there. It's a den area. Or if they like to draw or paint. Make it your studio. That way you try to keep them from putting another bed in there, and then the friends and cling-ons just come by and say hey, you got another bedroom, I could – no, it's not for you. So try to give them ideas." (B-04:117)
Autonomy	**Regulations** "I've been around for a while, so I've had many different jobs. But I will say that this job really busted the door open for me to just do social work, and in a way, unlike other jobs where there was a lot of structure, a lot of regulations." (B-05:81)
	Client compliance "Yeah, I'm just thinking through the different things I've done [...] and I did case management with them for a couple of years. It was different. It was very – it was pushing them in a way that they didn't necessarily want to be pushed, in some of the cases." (B-09:34)
Nature of services	**Informal** "So, I really like that. The other thing I really like about Housing First is that you don't just work with them until, you know, you get this one goal met. You work with them, you know, it's permanent supportive housing. So, you work with them. And it kind of makes me think back to, like, the roots of social work, the friendly visitors that would go into people's houses, except for without the moral judgement. But, you know, getting to really go into people's houses and see how they live and, you know, work with them in their environment. (B-05:84)

	Rapport and trust building "I think what you—the hardest thing to do is mirror you're the person that you're talking to. You know, and sometimes that means, like you say, meeting them right where they are. You know, one thing that I try to do is mirror the person that I'm talking to, because you don't want to be what they consider authoritarian or you don't want to be thought of as somebody that is a pushover. You know, and you have to set those boundaries with the different people you talk to, because everybody has different boundaries, everybody doesn't look at me the same way. So you establish those boundaries and you establish that rapport, you know, and there's a sense of trust that has to come. The person has to trust you, and once you build that trust then pretty much you can almost guess what that person's next move is going to be, you know." (B-10:30)
	Relational "I think it's a lot more relational than what I did before. Prior to this I was at [agency name] doing walk-in emergency services and then substance abuse like SAIOP treatment. A lot of these folks are so system savvy they could write a book and teach a class on a group. I think any one of our folks is the most acute person on someone else's caseload. I think that's how a lot of our folks get here is they wash out and burn through other services and then they come to us. So the traditional handbook of reflective listening and MI and CBT – you can deploy those all day long. But at the end of the day it's about relational, being able to have that bond where you listen to them and you just sit with them and put in the time. And then when there's a break in the clouds you've got that connection." (B-09:27)
Scope of work	**Quantitatively- breadth of services** "And so with this job you work on every issue that comes up." (B-05:82)
	Qualitatively- flexibility in defining "I think outside of programs like this oftentimes there are certain standards that we set for our clients automatically at the beginning, without really accounting for where they are or what's going on in their lives. And if they aren't able to follow those rules then we, you know, discharge them or tell them unless they can accomplish these things we're not going to be able to work with them. And that's difficult with the needy population, but then you take a population that's on the street, that already doesn't have access to a lot of those things, and unfortunately we're doing the case management and the clinical side and we get to do the housing side too. A lot of other clinicians don't do both and it's all clinical and that's usually what I've done prior to this. I mean you constantly see these people who have all these other barriers; that doesn't take into account what they're going through with us. So I think we forget how many people come through their lives and how many people build that rapport and then break those relationships because they're not meeting certain rules and expectations that agencies or whatever it may be have for them. And, you know, we all still have things that we need to get accomplished with them and there are still goals and things they have to follow, but we have the ability to be flexible and create plans and goals that work for them, opposed to ones that are coming from a bureaucratic, you know, agency or whatever side." (B-10:37)
Housing	**Housing placements and retention** "Many of them now have been housed for years in some of their apartment complexes [...] And they have built rapports with the landlords. " (B-05:164)
	Housing funding "So from a program perspective, we do – we're finding we have the money to have more slots. And so we have given up some more slots for people to be housed." (B-04:173)

Successes

When asked about the success of HFCM, the frontline workers responded with a range of responses. While there were stories about the outcomes associated with specific individuals relating to housing placements, sobriety, employment, volunteering, education, and reconnecting with family members, the frontline workers also reflected on the smaller successes. For example, one frontline worker said: "If you have somebody who comes in. And they're in a lot of pain. And they just need someone to talk to. And need a little bit of direction. Then you could have a successful appointment. Or intake if they leave feeling better, if they leave with some resources. If they walk in with tears and they walk out with a smile, that's a different kind of success" (B-08:32). Another frontline worker said that compared to some other programs, "the change is more incremental but it's more lasting" (B-09:108). Others explained that it was important to understand the "relative" nature of success, and how success depends upon the individual's needs, abilities, and goals (B-05:159). As one frontline worker explained, success for one person could be relating to cleaning the house or doing the dishes, while success for another person might be finding a full-time job (B-05:159). Table 2 delineates the primary categories and exemplar quotes in relation to the successes of the HFCM initiative as perceived by frontline workers.

Table 2: Successes (n=43)

Category	Examples of Participant Responses
Housing	**Housing placements and retention** "Many of them now have been housed for years in some of their apartment complexes [...] And they have built rapports with the landlords." (B-05:164)
	Housing funding "So from a program perspective, we do – we're finding we have the money to have more slots. And so we have given up some more slots for people to be housed." (B-04:173)
Health & Mental Health Improvements	**Addiction** "Single people that are doing well, working and paying their bills on time, and in recovery, you know. That pursued recovery, when probably their addiction was the thing that was holding them back the most. I have a guy that I'm working with now. [...] he came in through the Housing First, and – because he was a – getting out, staggering, falling, passing out drunk. And he cut back, and then he eventually – it took him over a year before he finally just gave it up, you know." (B-07:87)
	Physical health and health care "Some had severe medical issues at the time, you know, when they were housed, homeless. They have done exceedingly well attending medical appointments and hospital visits are almost zero. [...] Their health has improved." (B-05:162)
Engagement	**Employment and volunteering** "There are there some of them in the community, they are all receiving their income. They're volunteering. I have one guy who is working. He actually writes plays. He asked me, he said "really, I don't need to be on the program anymore, so when can I be transitioned?" And so I told him, "Well, let's see what that looks like, and let's work towards that goal." And I have one that he was a Project 36 Street situation where he was displaced and even with the stipend, he decided, "You know what? I like this. I like being able to have money in my pocket, so I'm going to go get me a job." And he's now housed again, and actively looking and seeking employment." (B-05:163)
	Employment among those with specific obstacles "I had one this morning, a guy that's been out of prison for seven years and his records have changed to follow him. So he feels like he's still in prison because every time he goes to job interviews and they run a background check they're still holding his background against him. [...] But anyway, the one client called me back this morning and said, "Thank you, [provider's name]. [...] I went to my interview and she offered me the job and I took it." [...] "I've been out of prison for seven years, trying to find a job," he said, "and I finally got one." He said, "I don't care what it is." So that was one of my successes this morning when I got to the office." (B-10:36)

Reconnect with Family & Friends	"And then for some that are family-wise, they have reconnected with their families from being estranged for so many years due to drug use, mental health issues, that now that they're stabilized and housed, and the families, they've reconnected with their families, and their families have reached out and helped, and assist them with utilities and other things. So, there's a lot of success stories. Female: Yeah, I've seen a lot of reconnection in the families [...] And like I had been trying to get this guy to, like, make some connection with his family for years. And [...] he said, "Well, I want my sister on there." [...] So, I look online and I'm trying to find the sister. And I give him a number, and he calls it, and it wasn't his sister, but it was a little town and he knew her sister, and he knew someone down the street from her sister, so we called them, and then they called them, and now he's reconnected with his 13 siblings, you know. And he's had Thanksgiving dinner at his apartment. They had to take it out into the parking lot. [group laughs] You know, so, you know, there's a lot of different kinds of successes." (B-05:165)
Relative success	**Smaller successes** "I guess if you're looking at other kinds of successes, not data. If you have somebody who comes in. And they're in a lot of pain. And they just need someone to talk to. And need a little bit of direction. Then you could have a successful appointment. Or intake if they leave feeling better, if they leave with some resources. If they walk in with tears and they walk out with a smile, that's a different kind of success." (B-08:32)
	Based on client's pace "It is making a difference having time. [Client name] has been here the longest but we have a second longest right now is we are seeing people stabilize and get themselves in a good place. Having been on both sides in [agency name] where we're like, "You will do this and you will like it," versus this, the change is more incremental but it's more lasting. And so we have seen folks come from homelessness to now signing their first – [client's name] getting her first home. She's a homeowner now. It's big deal. Or just running marathons and working full time. I've got a guy that he's done a full marathon and two half marathons and he's better. So it is evidence-based and it really does work. We see it every day when we see just the tiniest changes in our folks." (B-09:108)
	Based on client's needs, abilities, and goals "I think it's relative, really, depending on who it is. Because some people's success just means, like, I cleaned my house today. Or, I cleaned a room today, you know, or did my dishes, or whatever. And then, you know, other people it's like – I have one guy who got a full-time job, which was his, like, big, and he's not even housed yet. He's still homeless and he found a full-time job, by himself, with no assistance from me. So, yeah, so I mean, you know, it's so dependent on, you know, the person and what their needs are and how, kind of, I don't want to use the word capable, but I guess, I don't know. I guess whatever they feel like is, you know, a goal of theirs, or you know, sometimes it just means that they stayed housed longer than I expected." (B-05:159)

Challenges

Table 3 lists the primary categories and exemplar quotes in relation to the challenges inherent to the HFCM initiative, as perceived by frontline workers. The most frequent comments made by the frontline workers, however, were related to challenges related to working with landlords. There was a consensus that many landlords are simply not willing to work with clients because they may have a mental illness, a substance use problem, or a criminal record. They describe how some landlords have stopped accepting housing vouchers altogether because of a negative previous experience, with one frontline worker going so far as to say "You don't use the v-word; voucher is like a bad word to a landlord" (B-10:76). Others cited safety concerns. One described how the "Landlords that are willing to work with people are going to be in drug-infested neighborhoods," and another said "There are some landlords who will provide housing. But they wouldn't put their dogs in it. And they expect people to accept it. And be grateful" (B-07:88 and B-08:50, respectively). The lack of affordable housing is also a contributing factor in trying to find scattered site housing. Neighborhoods that used to be affordable are no longer affordable. In describing how rising rents is an issue, one frontline worker said "At one point, it was easy to get four or $500 a month rent in Charlotte....but now you're looking at what? $800 a month. And clients only have $735 a month" (B-08:85). Similarly, another frontline worker said "The voucher amounts just do not jive with how quickly these rental units are increasing at just a rapid

rate" (B-06:85). Others focused more on the need to create more permanent supportive housing, saying "We need more housing. We need another Moore Place. We need two or three other Moore Places" and "I mean, to make the Housing First program really viable and work, it's going to take more places like Moore Place and St. John's" (B-09:125 and B-07:81, respectively). Another frontline worker said:

"I would challenge the Housing First initiative to think more creatively about what we're doing, because it's evident to me that the community, they 're in but they're not all the way in. We can't just wait and be like, 'Well, we've got this mayor who says we're going to get affordable housing.' I think we have enough capacity within the agencies to figure out different ways to get people into housing, whether it's buying out a different apartment complex. I mean there have been other ways that have creatively gotten people into housing. I think that is still a barrier, to figure out how to get those pieces together to push that further" (B-06:108).

Frontline workers also identified challenges relating to the reliability of the VISPDAT. For example, some described issues with the way the questions are worded. One of the frontline workers explained that one of the questions is "Do you ever engage in risky behavior?" He went on to explain "People say no, but if you actually talk to them, you'll see, 'You bought drugs. That's a risky behavior,' or, 'You did sell drugs. That's a risky behavior.' But they don't look at it like that because it's not worded how they would see it, how people would understand it" (B-06:116). Others noted the assessment is based on "how they present in that moment" (B-06:117). This was described as a challenge. For example, one frontline worker said, "There are some challenges, like with folks who may be more vulnerable than they present. Or even less vulnerable than they may present" (B-08:61). Another said, "I think it screens some out that probably should be in" (B-08:13). There was also some agreement that the responses to the VISPDAT questions might be different when the person administering it has developed a better rapport. Yet, there was some complexity here. In one of the focus groups, a frontline worker explained: "Everybody wants to present themselves in the best light so that negative information, we don't share because then you'll be – you're already labeled as homeless. Chronically homeless, and then a frequent user of the medical system, or criminal….So people try to avoid that" (B-08:15). Yet, another frontline worker responded by saying: "On the opposite scale of that, as far as people wanting to withhold information, the ones with a case manager get coached up what to say. They come up with high scores because they're told how to answer the questions" (B-08:18). Frontline workers went on to explain "how clients also inform other clients on what to say," suggesting that some "come in with this script prepared" (B-08:19).

The focus groups with the frontline workers created an opportunity for them to reflect on the tensions with implementing the Housing First model. Some of the frontline workers described what it was like to work with clients who have substance abuse issues, alcoholism, and mental illness. For example, one frontline worker explained: "We have a lot of people who present intoxicated from Day One for the lease signing. And I get that that's an artifact of their illness and a product a lot of times of long-term trauma and a system that's failed them, but we are very much on the front line of some very intense and sometimes problematic behaviors" (B-09:20). Frontline workers expressed some frustration with the separation of housing and services, and the voluntary nature of harm-reduction and supportive services. For example, some frontline workers talked about how some clients simply experienced the "natural consequences" of certain behaviors, such as drug dealing, the failure to pay rent, and disruptive activities (B-04:160). Another frontline worker said: "I don't know if clients are getting the clear expectation of what moving into housing is going to look like. Like you are going to have to pay rent. You can't drink yourself stupid under the pavilion. You can't do these things. Housing is a right and you should have it but with rights comes responsibilities" (B-09:98). Similarly, another added, "I don't think they have a really good understanding of what independent living is" (B-09:98).

One frontline worker explained that the biggest challenge for him was the fact that there was no requirement for a recovery process and that clients could refuse mental health treatment. He went to explain: "You still have to meet them where they are and try your best to work with them and to find out if there's a way that you can either sway them to go, you know, to recovery or help them become a positive and productive member of society, you know, whatever that may be and whatever that may take…. And I have to accept that, because my job is not to change that person, but to help them" (B-10:55). Another said "All we can do is offer what we have. But it's up to them to engage. So, if they're still not engaging, it's still going to be the same outcome of losing housing, ultimately" (B-04:96).

Frontline workers also expressed some frustration around the lack of resources, saying "We need more substance abuse clinics. We need more inpatient places for them to go to when the clients have no health insurance" (B-08:52). Another said they needed more "support workers," as well as greater "ability to move a person to a higher level of care," such as supportive housing, assisted living, or housing with 24-hour wraparound services on-site (B-04:134 and B-10:119, respectively). Finally, one of the frontline workers pointed out the tension in housing people with very problematic behaviors within a community setting, saying: "At what point is their behavior so problematic that it's impacting the other tenants. So how do we reconcile that? We have folks who have gone through traumas and now they're housed and they're paying for this place, but they've got somebody going up and down the hallway and

urinating and bleeding down the hallway. And so the tension between housing this individual and providing a safe space for the tenant, for the other tenants“ (B-09:49).

Table 3: Challenges (n=43)

Category	Examples of Participant Responses
Housing	**Affordable housing availability** “Trying to find affordable housing because, at one point, it was easy to get four or $500 a month rent in Charlotte. Help a person to come out of his shelter and go in. […] But now you're looking at what? $800 a month. And clients only have $735 a month.” (B-08:85)
	Landlords “I mean, it's finding landlords that are willing to work with people. That's one of the biggest barriers, finding the landlords that are willing to work with people. And then the majority – a lot of places, landlords that are willing to work with people are going to be in drug-infested neighborhoods where there's a drug dealer living next door to them. And when people first come in, they in that thing, snitches get stitches, and all that street mentality, you know.” (B-07:88)
	Need for another single site “We need more housing. We need another Moore Place. We need two or three other Moore Places.” (B-09:125)
	Vouchers amount “The voucher amounts just do not jive with how quickly these rental units are increasing at just a rapid rate.” (B-06:85)
Community Engagement	**Commitment to Housing First overall** “So I would challenge the Housing First initiative to think more creatively about what we're doing, because it's evident to me that the community, they're in but they're not all the way in. We can't just wait and be like, "Well, we've got this mayor who says we're going to get affordable housing." I think we have enough capacity within the agencies to figure out different ways to get people into housing, whether it's buying out a different apartment complex. I mean there have been other ways that have creatively gotten people into housing. I think that is still a barrier, to figure out how to get those pieces together to push that further.” (B-06:108)
	Commitment to Housing First through landlords engagement “I think id just like the buy-in from the community because I think that is so hard when we're trying to work with landlords don't really understand Housing First and who don't want to understand Housing First or, you know, how to work with our clients. And so I think landlords need a little more incentive from the state, from the city” (B-10:139)
	Commitment to raising awareness about homelessness “And I'm saying that. I remember years ago when I was at my other life, my other career, when I was in public broadcasting. And we did a lot of programs that addressed such issues in the community that I was in. And so, it created an awareness. And as other people knew about things, there was more support for. So how widespread is it actually known in Mecklenburg County? […] I just think there was even more awareness outside of those that do work. Just say to the public and community in general that may spark some more interest in it. And there might be more landlords that come forward. There might be more employers to offer jobs to people that are unemployed” (B-08:100)
	Commitment to social issues overall “Right. It's a wrap. So if you a person that's working hourly. And your operation shuts down, you don't get paid. And that's hard to articulate to the rent man. "Well, you know, it snowed and so my business closed. And I can't work." I have very strong feelings about that. That we're just not doing – that this community is not standing up to what it could do. To what it has the capacity to do. It's making it so difficult for people to be treated fairly. And humanely.” (B-08:48)

VI-SPDAT & Coordinated Entry	**Based on assessor** "I think that's a benefit of outreach is that we get to know somebody before doing the assessment, whereas if they go to the shelters or with Megan it's just how they present in that moment. [...] I can speak for myself. I get frustrated sometimes with not the tool itself from coordinated entry, but I think that's I want to say, I think sometimes certain assessors are not as strong as others in terms of how much they're going to dig, and how much they're really going to take the time to get to know you versus to get you out the door. Sometimes our clients, when they come to see me and I open up their assessment, I'm horrified. I'm like, "Wait, what? How did you not end up on the registry?" Or I see inconsistencies or I see questions answered no where I'm like, "Oh my god, you are drunk every time I see you, but do you have any substance abuse issues? No." (B-06:117)
	Client transparency "Everybody wants to present themselves in the best light so that negative information, we don't share because then you'll be – you're already labeled as homeless. Chronically homeless. And then a frequent user of the medical system. Or criminal man. So people try to avoid that so they don't tell you the best part of the story." [...] "There are some challenges like with folks who may be more vulnerable than they present. Or even less vulnerable than they may present." (B-08:15 and B-08:61, respectively)
	Protocol "Sometimes coordinated entry can be, it's kind of difficult. You're asking people serious questions the first time meeting them, so I actually see that being like a barrier, and then it takes time to build relationships with individuals. Coordinated entry sometimes doesn't give the best picture of what a person is going through, and then, also, our community has the vulnerability index. FG_member created the vulnerability index review because sometimes that doesn't get the accurate picture of what our people are going through. I feel like it helps to get the people on the registry, but sometimes it doesn't show how vulnerable they are or exactly where they are. [...] You have to ask it a certain type of way, like you ask the question, and then, if you don't really build rapport with the person, people, kind of like these questions, if you ask the person, "Well, have you ever been beat up?" [...] "Do you ever engage in risky behavior?" like selling drugs, unprotected sex, sharing needles, [...] People say no, but if you actually talk to them, you'll see, "You bought drugs. That's a risky behavior," or, "You did sell drugs. That's a risky behavior." But they don't look at it like that because it's not worded how they would see it, how people would understand it." (B-06:116)
Housing First Model Tensions	**Harm reduction approach to services** "So we have a lot of people who present intoxicated from Day One for the lease signing. And I get that that's an artifact of their illness and a product a lot of times of long-term trauma and a system that's failed them, but we are very much on the front line of some very intense and sometimes problematic behaviors." (B-09:20)
	Integrated housing "I think the other part of that whole piece is the tension between those very problematic behaviors within a community setting, at what point is their behavior so problematic that it's impacting the other tenants. So how do we reconcile that? We have folks who have gone through traumas and now they're housed and they're paying for this place but they've got somebody going up and down the hallway and urinating and bleeding down the hallway. And so the tension between housing this individual and providing a safe space for the tenant, for the other tenants." (B-09:49)
	Meager aspect of resources to do Housing First "And the lack of resources. We need more substance abuse clinics. We need more inpatient places for them to go to when the clients have no health insurance. It kind of leaves them out, in the cold. Even if they get into housing, a program, the likeliness of them being successful, being around those same people in that same housing program, is a barrier to their success." (B-08:53)

	No requirements for participation in psychiatric or substance use treatment "That's very challenging. You know, especially when you're in a recovery process yourself. You know, then you have to deal with people that are not forced into or they look at that as being a mandate, 'cause, you know, that they have to be in a recovery program, you know. And then those that refuse mental health, you know, you have to deal with them still. You know, you still have to meet them where they are and try your best to work with them and to find out if there's a way that you can either sway them to go, you know, to recovery or help them become a positive and productive member of society, you know, whatever that may be and whatever that may take. You know, 'cause sometimes you may have a person that's drinking, that don't want to stop drinking, that you ain't nothing you can tell them to do or say that's going to get them to stop. And I have to accept that, because my job is not to change that person, but to help them to go to a—or to better their life, whatever that may be. You know, better may just be a reduction of them drinking so much." (B-10:55)
	Voluntary aspect of services and separation from housing "I don't know if clients are getting the clear expectation of what moving into housing is going to look like. Like you are going to have to pay rent. You can't drink yourself stupid under the pavilion. You can't do these things. Housing is a right and you should have it but with rights comes responsibilities." (B-09:98)

Appendix H : HFCM/Community Leaders

Interviews with Community and HFCM leaders identified a number of successes and challenges related to the initial implementation of HFCM (2016-2017). These findings are reported in greater detail in the 2018 Interim Process Evaluation Report and are summarized below. The tables below (1 through 13) reflect initial code categories developed from the analysis of stakeholder interviews. Stakeholder interviews included 29 interviews with 33 stakeholders from project leadership, steering committee, working committee, directors of supportive housing and rapid rehousing agencies, and community leaders in homelessness. The number and percentage in the left hand column reflect the number of interviews in which the categories were discussed by research participants. Example quotations from the interviews are provided for the subcategories.

Interpretation note:

The purpose of this qualitative analysis is to understand leadership perspectives on the success and concerns of the HFCM effort, not to understand the concepts statistically. While the analysis captures the concepts that were repeated by multiple respondents (represented by the number and percentage), both convergent and divergent perspectives are valuable in understanding the implementation of HFCM.

Successes.

Key stakeholders identified a number of successes related to the implementation of HFCM. Collaboration emerged as one of the most frequently identified successes, with a majority of stakeholder interviews noting this. For example, stakeholders described how the initiative had created new and different collaborative relationships, such as new relationships with the business community, health, and housing sectors. New or stronger cross-sector relationships were formed as a result of the committee meetings, including: the Charlotte-Mecklenburg Public Library, the Charlotte-Mecklenburg Police Department, Cardinal Innovations, local hospital systems, and the Charlotte Housing Authority. Stakeholders also described how new relationships with volunteer groups from churches and other organizations were formed. Many of these new partners brought new resources which contributed to the capacity to implement the effort and house individuals experiencing chronic homelessness.

In addition, the number of individuals housed was identified as a success in the majority of the stakeholder interviews. Stakeholders described how providers were being creative in finding housing solutions, working with greater numbers of landlords and property managers to house more than 700 individuals. The initiative also brought greater education and awareness to the issues of chronic homelessness and the lack of affordable housing. Media coverage by The Charlotte Observer and other news outlets highlighted the importance and effectiveness of the Housing First model and helped to provide a clearer understanding of what distinguished chronic homelessness from other forms of homelessness. Similarly, stakeholders described the importance of the data and research being gathered through HFCM. The development of the By-Name List was described as a “best practice,” a tool that could also be used with other homeless populations, as well as adapted to inform other community-based initiatives being implemented in Charlotte (A-11:33). The evaluation research being conducted by UNC-Charlotte was also described as “incredibly important” because it provided ongoing feedback about implementation and outcomes of the effort (A-05:27).

Table 1: Success - Collaboration (n=24, 83%)

Category	Examples of Participant Responses
Collaboration	**Community & Multi-sector Collaboration** "What's working in the overall effort? I think just the whole community effort, the bringing together of the entire community that's what I think is really working is that it's every sector. It's university, it's the not-for-profit, it's the for profit, it's the private, it's all of the different sectors that have come together and are cooperating and sitting at the table and everybody's got a voice. And it's the church and houses of worship and it's all these different groups that are coming together and are working together. And I think that – and even the police so it's government. It's everybody's working together so I think that's what's working. I think that's what's making it work." (A-12:31)
	Resources "And I think we were in one meeting where Bank of America stepped up and they funded a portion of it. I think Cardinal Health came in and they funded a portion of it. We had funded a portion of it." (A-24:52)
	Service Sector Collaboration "I think there's a greater sense of maybe community with providers too, that I think some relationships have really been developed and enhanced in this process because there are so many meetings about it, but work groups, I think too, that brings this synergy together that it is connecting outreach with Cardinal with a permanent supportive housing with a Shelter plus Care, with HMIS, with all, so I do think that there's a greater sense of community." (A-28:52)

Table 2: Success - Housing (n=21, 72%)

Category	Examples of Participant Responses
Housing	**Reducing Chronic Homelessness** "Well, definitely. I mean first success is you know housing over 500 people. Let's start there. That's the biggest one and that gives us a great sense of pride to be a part of something like this when you have families that need it so much." (A-20:07)
	Outreach "The outreach & engagement effort has worked extremely well (although we need more of it)." (A-30:15)
	Housing First "I think Housing First has been huge. A lot of agencies that maybe weren't operating that way before are now having low barriers to entry just trying bringing clients. I know there are pilot programs with rapid rehousing around chronic homelessness." (A-18:49)
	Financial Impact & Cost Effectiveness "And look at the impact that they're having. Look at how much money they've saved. Look at these people's lives have been changed. So it's life change, but it's also like, duh, you just saved us how much money? Oh, that's awesome. So that's just a logistical thing. But it's just as important as all of the other little factors, I think. So I think that's probably the biggest thing for me, is the finances." (A-22:28)
	Landlords "Well, when I first started I think we were working primarily with 2 property managers, now we've got closer to a dozen." (A-07:44)

Table 3: Success – Awareness & Education (n=14. 48%)

Category	Examples of Participant Responses
Awareness & Education	**Partners** "Before I think that there might have been, and I don't mean this in a bad way, but the folks uptown I think were able to walk by the issue and maybe thought that there are – or didn't know or somebody else is working on this problem and so I think that it is now a community issue. And when I say that it's not the homeless services network should be fixing it or the county or the city, this is something that we as a community have to embrace and figure out how to fix." (A-11:46)
	Community "I think we've really changed the conversation in much of the broader community about homelessness. I think there was generally this accepted, assumed rather reality that homelessness was this huge, monolithic social problem for which there was no answer. And I think we have changed the conversation to, "Yes, there is an answer." (A-17:19)
	Homelessness & Housing First "...it certainly made the Housing First model more front and center, which I think is good. And that changed the way I thought about homelessness, so I think that's a good thing." (A-06:36)
	Connection to Affordable Housing "...it's made us realize that we need to get more involved in affordable housing and so we as an organization have always been involved in trying to help with affordable housing initiatives, but we've become more involved." (A-12:46)

Table 4: Success – Data/Research (n=14. 48%)

Category	Examples of Participant Responses
Data/Research	**Evaluation** "I'm just so pleased that we were able to get this beautiful huge study paid for, and I think that it will serve as a model, good or bad, with its good and bad aspects for other community efforts." (A-16:62)
	By-Name List "I think this idea of utilizing a by name registry is huge. And I think that we can carry that forward. Having worked with the registry, it is really quite – honestly it's moving at times to watch the providers utilize it and say, "Okay, Joe came last week and he simply needs this paperwork filled out." And someone at the shelter can say, "Well, he's at the shelter, I saw him there yesterday. Well, can you tell him –" and so it is this – the idea of absolutely knowing who the individuals are, what their needs are and what resources are available to them, I think that that's the only way that we're gonna have success. (A-11:72)
	VISPDAT & Prioritization "I think a big win is...having an evidence based way of prioritizing people, which I'm sure there's different philosophies about that but really being able to prioritize those that are most vulnerable, getting them connected to resources and housing." (A-28:30)
	Data Management & Reporting "So I think the data management is particularly effective. It really helps to have good data and I think that they're doing a really good job of putting that data together, doing those reports so that we understand. You can't fix the problem until you really understand it and it's very helpful to understand what the problem is." (A-12:24)

Table 5: Success – Management (n=13, 45%)

Category	Examples of Participant Responses
Management	**Leadership** "I think the Urban Ministry Center's done an outstanding job, particularly Liz, who by now I know has moved on. And also with the Center City Partners. I think that together they've really done a good job. They run very clean, effective meetings, I think – very targeted and very responsive, good between meetings, sending information. So I think they've done an excellent job of managing. I've been very pleased with them." (A-04:07)
	Communication "I've been really impressed about their PR and how they've been able to get out in front of things and making sure that the public knows. I've been really, really impressed with that. I've been – you know I have to say I've probably had to steal some of it because it was like they deal with the same issue I have. You know on the PR side of "I don't want those people next to me." So being a data-driven, more I would say evidence-based driven type PR is something that I've been working on myself because I've seen to work so well for them of getting that information out to people and then moving forward." (A-20:47)

Table 6: Success – Organization Level Successes (n=11, 38%)

Category	Examples of Participant Responses
Organization Level Successes	**Employee/Volunteer Engagement** "I think for us being able to provide financial support or volunteer support, team member engagement around the effort, and then also see that the program was working is kind of a success from an internal standpoint, that you know that the funding that you're providing is making a difference." (A-24:17)
	Staff "I'm proud of my staff. Because we did all of this without any extra staff. I also tracked labor hours. And so, to date, it's been almost 5,600 additional labor hours that we've put in. With no temps. And that's not counting – I should say this – that's not counting my case worker staff." (A-21:16)
	Mutual Benefit "Make no mistake, this is not a one-way benefit. People say, 'Well, you're helping the community so much.' What this does is it transforms how we educate students." (A-15:04)
	Awareness/Education "And so we have become more educated as a result of doing all of this which is a very good thing for all of us. We've become more educated and that's very good. But so we can talk about this issue with more authority and with more intelligence." (A-12:47)
	None "I hate to say this but we were doing it before and we're doing it now and it really didn't change the success, it really is just a changing in when we house people." (A-19:113)

Table 7: Success - Structure, Goal (n=9, 31%)

Category	Examples of Participant Responses
Structure, Goal	**Commitment** "I think what's working well is that people have stuck with it. A lot of times people get sort of, over time, they get a little bit apathetic and the level of interest and engagement goes away. I don't see that happening with this group. I think they are incredibly committed and they're keeping the process moving forward." (A-05:27)
	Solution Focused "I'm proud of the way our community came together, and so solution oriented." (A-14:44)
	Specific "Having a very specific goal and a very specific tasks I think were very helpful too because my, you know sort of what I heard reading between the lines was that in these groups had worked together fairly frequently but maybe not in such a specific direction or with a really specific goal. And I think that infrastructure and those very specific asks were helpful overall in moving work forward." (A-13:40)
	Big & Bold "I think having a big goal that everybody's working toward and being able to quarterly see how many fewer people are homeless as a result of Housing First. I think that that's worked well." (A-04:14)

Challenges & Concerns

Stakeholders, however, also reflected on some of the challenges and concerns that emerged during the implementation of HFCM. One of the most common challenges and concerns had to do with the structure and framing of the problem HFCM was trying to address. Some questioned the decision to focus solely on chronic homelessness, describing how other key problems facing the community were inter-related (e.g., overall homelessness, street homelessness, mental health, poverty, lack of economic mobility, and lack of affordable housing). The goal of "functional zero" was also a concern for stakeholders, with some stakeholders wondering what "ending" chronic homelessness meant. Several stakeholders described the goal of ending chronic homelessness as a "moving target" or a "stretch goal," noting that while individuals were being housed, others were still being added to the By-Name List (A-07:50 and A-24:25, respectively).

Similarly, concerns about the lack of ability to meet the demand for affordable housing increased for some stakeholders after the plans to develop a single site were tabled. As one funder noted, "I worry that at some point we're gonna run out of scattered site. We've been fortunate to date, but we're gonna have to create some inventory ourselves" (A-14:60). A few stakeholders expressed concern that the chronically homeless population needed another single site development in Charlotte. As one community leader noted, "There's that very fragile population that needs that Moore Place type of housing opportunity and there's not enough of that" (A-11:87). Moreover, while providers worked hard to partner with new landlords and property managers, others noted that landlords and property managers can pick and choose which subsidies and clients they will accept, making it particularly challenging to house those with a criminal background and sex offenders.

Stakeholders also expressed concern about waxing and waning momentum of HFCM relating to communication, project management, and funding. For example, stakeholders described how there was more regular and ongoing communication at the beginning of the project, with many describing how, over time, they knew less about important HFCM decisions that were made and implemented, such as the extension of the project through 2017, the shift away from a single site strategy, and turnover in project management personnel. The decisions regarding these situations were typically shared after they occurred, missing the opportunity to engage the steering and working committee members in discussion and/or problem solving. Stakeholders, at times, also expressed concerns about the project managers capacity, given that the initial managing staff had demanding jobs already. Taking the lead for managing and coordinating HFCM became an added layer of responsibility, falling under "other duties as assigned."

There were also concerns about sustaining the financial support for HFCM, particularly with respect to the ongoing costs of subsidies, housing-related costs, operation costs, and wrap around services, prompting one stakeholder to remark "There's never enough money to do all the things that you want to do" (A-05:11). Others were more concerned that some community partners were not as invested financially in the initiative as they could have been throughout the effort, citing the lack of participation by certain corporate entities, state government agencies, and local government agencies. There was also concern about competing capital campaigns that were happening in the community at the same time as HFCM, with some wondering about the "burnout and lack of funding among some of the top funders" (A-06:12).

Table 8: Challenges/Concerns – Structure (n=25, 86%)

Category	Examples of Participant Responses
Structure, Problem	**Relationship to homelessness** "Room In the Inn is still operating at capacity, okay? So we solved – we've gotten most of the chronic-homeless people who wanna be housed into housing but we still have tons of homeless people." (A-19:89)
	Relationship to street homelessness " we have data that show we've really decreased the amount of chronic homelessness in uptown. But the overall prevalence of homelessness uptown has not decreased, in fact has increased." (A-09:39)
	Cause of Inflow "Also that the initiative has been so laser focused on the chronically homeless that it has failed to take stock of those who are at risk for chronic homelessness and are aging in – that's actually a community issue, not even a HFCM issue (as it's a different data set)." (A-30:18)
	Relationship to poverty, racism, & Opportunity Task Force "You know and we have economic segregation in Charlotte. The data plays that out. I mean the data is there. It's very clear and the other sad part about it: It happens to come down along racial lines. So that's what we need to be working on." (A-19:129)
	Relationship to affordable housing "I also think that we need to pull out how we really need permanent supportive housing or subsidized housing with the conversation around affordable housing" (A-28:153)
	Relationship to mental illness "I wish we could hear or dive more deeply I guess into the issue is that around mental illness. I think that it's something that we don't talk about in our community but it is clear that it is a disabling condition that I think if we could get a handle or understanding on, it might allow us to make tremendous progress in ending homelessness." (A-11:64)
Structure, Goal	**Meaning of Ending Chronic Homelessness?** "Because we've been saying we're gonna end homelessness for a long time and I think that we haven't done our job well as to what that means. And so we just have to be okay with saying, "You know what, tomorrow there's gonna be a homeless person on our street but we have the infrastructure and the process in place to move them quickly into housing." And that, for us that means ending homelessness, right?" (A-11:67)
	Moving Target "I think part of the effort – I guess one of the barriers has always been there was a target set at the beginning, but that number was never going to be a static number…so it's a moving target. It's always been a moving target." (A-24:25)

	Not Meeting Goal "I think obviously not reaching our goal is always a concern. We made a commitment we were going to do something. So obviously we didn't make it. And so we need to regroup and figure out what's a realistic goal for us. Or are we ever – they talk about the functional zero thing. So is that really where we're headed? So I think we make sure that it's clear where we're going, so we're just – because the other problem that you ultimately have is you just keep going and going, and there's no end game. And we want to make sure we have an end game." (A-05:30)
	Is ending it the right goal? "If the goal was to house them, yes, we have to say it's been amazing. And what are we, about halfway through our number? I don't have it in my head. But I can't imagine that was the community goal. And not even – we could say no, that wasn't just the community goal. The community goal was to have a system in place for all new people who've become chronically homeless. That would be obviously a great thing. To me, that would be the definition of success." (A-03:01)
Structure, Strategy	**Lack of system level transformation** "We can do this push to get people housed and we are. We can interview folks and figure out what they need and how they got there and now it's how do we create systemic community-wide change that includes a really solid funded strategic infrastructure to make sure that things don't get down the path as far as they have with these 500 or so unhoused individuals who have multiple needs?" (A-15:12)
	Lack of organization level transformation "You know, everybody thinks it's be a great idea to end chronic homelessness, but they're not willing to do their business differently in order to hasten the process." (A-16:46)
	Single site strategy shift "The HFCM Steering Committee was then informed that single site just wouldn't work and scattered site was the way to go. I think this created some distrust with UMC and also lost HFCM the full buy-in of some stakeholders/partners. I am not sure HFCM ever fully recovered after that." (A-30:12)
	Is Housing First the right strategy? "we need to shift and move to Housing First and we have and we continue to do it and we will continue to do it but I've been continuing to advocate that that's not the only solution we need to be employing" (A-19:72)
	Relationship to other efforts/strategies "So I think the barrier a little bit is the – I think it was the creation of a new task force that – doing something that a task force that had already been developed by the city, it just made the work a little difficult and convoluted in understanding who was doing what in the community and how they related to one another." (A-11:17)

Table 9: Challenges/Concerns – Management (n=23, 79%)

Management, External Communication	**General** "I don't feel like we may have been as effective in raising the general community awareness around this, I think we had some wins along the way but … there's a lot of noise, there's a lot of other priorities" (A-13:23)
	Complex Messaging "I think that maybe one of the struggles or barriers I guess is that talking about homelessness is always really difficult and then the messaging around it. And so I think that we might have created some confusion in the community in the overall messaging. I think that people weren't aware of who was working on what and how they did relate." (A-11:102)

	Perceived Decrease in Communication "From a complete outsider's perspective, I feel like I heard more about the project when it first started. And since then, I felt like communication has trickled off some, but that could just be that I'm not as tuned in as I was earlier in the project. But from a publicity standpoint and what you hear out and about, I think it's been quieter recently." (A-01:17)
	Success "I guess the only thing is the external communication about the success that's happening. I know that there have been some things done, but I'm not sure that people in the uptown really are aware of the success that's occurred." (A-04:10)
	Participant Privacy "I think it's -- although I have mixed feelings, I think it is helpful to keep stuff out on social media and stuff to let people know what's going on... I have mixed feelings because at the same time, sometimes it looks like you're giving so much information and personally identifying information." (A-28:105)
Management, Internal Communication	**General** "[During project management transition] ...many things, including communication, with HFCM suffered during this time, in my view." (A-30:23) "I think that there's been some siloed decisions that have impacted this entire initiative..." (A-28:11)
	Single Site Strategy Shift "And when the kickoff occurred at Moore Place, the talk about how great Moore Place was, that was when the housing first big kickoff was and then when Moore Place expanded 35 units, there was another press conference to, again, reinforce the greatness of single site and how important and how successful this is. So then there's like an offline conversation that comes back to the group and says, 'eh, we're going in a different direction.: " (A-28:126)
	Progress & Ongoing Assessment "Their goal is to hire enough social workers, through the funding, in order to give the great one on one attention to the homeless and the would-be homeless that arrive on any given day of the week or month or year. What I don't know is the magnitude of that effort and how it's faring thus far. If they felt they'd needed to hire 'x' and they've hired 50% of 'x', I don't know that. And then where that is in the process and how they're doing." (A-08:29)
	Accuracy "'Cause the talking point with that is, well, we've already housed 400 and some odd people so we can do it, what's a 120 more? And it's like, no we haven't housed 420 something, we've done 200, which is still a lot but it's not like. Permanent supportive housing's been the number one place where folks have gone, I get that but it's not like, 'well we've already done 400.' No, we've already done 200 so his talking points aren't accurate and so I think it gets to the steering committee who's very well-intended but maybe not as informed, 'well yeah that's great, what's a 100 more after...basically 500?' " (A-28:119)
Management, Partner Participation & Engagement	**Partner Participation/Engagement** "Because HFCM has brought together so many diverse partners from different sectors, it has sometimes felt challenging to have meaningful roles for everyone. The shelter and housing providers are on the front lines. Then you have the corporate entities such as the banks and institutions such as the library, just to name a few. I think it has been hard to maintain the engagement of the latter groups because this work is not their core line of business." (A-30:14)

	Committee Engagement "I would engage the steering committee more. That's the thing. 'Cause I think what happened is there was a lot of energy, and then it fizzled, and people have moved on to other projects now. And you're trying to go back and kinda capture that energy, and it's kind of cast." (A-06:23)
	Health & Mental Health Partners "We worked hard though to try to get mental health to the table. And we had a couple of failed efforts where we just had the wrong people at the table that would come, would listen, but it didn't end up in additional resources, and staffing, and commitment." (A-14:74) "Now they could be at the table as, you know, I view them, I know they're not non-profit but they are corporate and you know, some investment because we could save them a ton of money by keeping these folks out of ERs" (A-15:09)
	Elected Officials "I just know that it is really important that we sit around the table and build relationships with each other, and it's important, and it helps, and there are positives that can come out of that, but there's still a lack of community will here. I guess that's what it is that sort of bothers me, is that there still isn't community will, especially among elected officials, to do something really big and really important about this problem." (A-16:40)
	Meetings "I think the challenges, so giving people meat to work on in the working group and at the steering committee." (A-09:58)
Management, Urban Ministry Center	**Urban Ministry Center Role** "I think they were probably the right project managers to have but as a service provider themselves it does raise a question. Are they an honest broker, a project manager, or to what extent are their efforts directed at expanding their own scope of work? I don't see how you deal with chronic homelessness without necessarily expanding their scope of work and people like them. So, I'm not articulating that in this case it necessarily was a conflict of interest but if we're looking at this from the standpoint of building theory and informing efforts in the future I would pose that as areas for consideration." (A-25:39)
	Project management transition "because there's been some transition in the project management piece of it, I think that folks are trying to understand how that's going to work going forward." (A-11:23)
	Project management capacity "Well, as I mentioned earlier, I realized right away the job is bigger. Even though I was only part of the project management, that was bigger than running an organization. Was more than I could do the way I wanted to do it, so that was one of the first barriers that I confronted." (A-17:51)
Management, Data & Research	**Monitoring Progress** "I think that if we were to start now…to really evaluate ourselves, you know, and not necessarily wait till you guys are done with your official evaluation, but just in general for us to say 'Okay, here's where we've come. What can we do differently to hasten this process? What changes can we make in the way that we do business so that we can have a really good chance of getting this done by the end of 2017?' " (A-16:50)

	Understanding By-Name List & Inflow "Anyway, we need to look at some other cities and see what their numbers are. Because we housed 428 people in the first 19 months, and that's 57 percent. We estimated when we started, based on all our experience – and we had a logical way we arrived at our estimate, which was 450 people. Before we did the registry, we thought 450 people. Makes sense given all the data we had ever seen about this community's chronically homeless population. And how we got to 740 in less than two years is hard to explain. And chronically homeless people are not mobile, so we know they're not moving here from other places." (A-17:68)
	Data access & sharing "Yes and using the HMIS for the frequent user stuff and the Chronic Registry and the Veteran Registry, it should all be in one place and then you can also see people on three different lists, oh wow, because we don't it's siloed." (A-28:136)
	Defining success "And then we're out with [number housed] yesterday and, of course, that's a success measure. And to me, of course the other measure is where the person is…And I don't know if it's where are they six months, where are they one year, where are they two years, five years? I don't have enough expertise to know what that period is. But there's got to be one established and we've got to go back and measure ourselves against it, of course." (A-03:02)
Management, Planning & Implementation	"We should've given ourselves six months to get ready to start implementing, because we had to get four other agencies trained in Housing First. We didn't have any money in the bank when we started. Our data strategy probably could've taken – we could've given more attention to how we were gonna manage data, and collect data, and how we were gonna shape the registry, and manage the registry. So I think that would be another – I don't know if barrier's the right word or just miscalculation." (A-17:52) "Because of such a vast variety of partners, if we could have six, eight weeks of really defining roles and responsibilities – and as dorky as this sounds – creating a data definition. So that we know what support services mean for everybody. So we know not just the definition of chronically homeless, but we know 'This is somebody that served by Path, this is what they get. Somebody that served by Hud Vash, this is what they get. And these can be our expectations.' " (A-21:28)

Table 10: Challenges/Concerns –Challenges/Concerns – Housing (n=21, 70%)

Category	Examples of Participant Responses
Housing, Site	**Failure to develop single site** "I think one of the big barriers or challenges that I think everybody kinda knew was the ability to build another Moore Place, and then the success of the initiative hinging so much on whether that could or couldn't be done and whether it could or couldn't be done and what impact that makes the larger community feel from a success standpoint." (A-24:27)
	NIMBY "One ongoing challenge is, of course, just the stigma related to homeless and the challenge of geographically to find right places for supportive housing." (A-25:29)
	Is there scattered site capacity? "I worry that at some point we're gonna run out of scattered site. We've been fortunate to date, but we're gonna have to create some inventory ourselves." (A-14:60)

	Need scattered/single site units "And then having places to put people continues to be a big challenge. If we had that single site for, even if it was 125 additional single site places to put people that'd be huge for the numbers we're trying to get to." (A-10:43)
	Transportation "I have concerns and I understand with the distribution of poverty and putting people everywhere but if you don't have access to transportation or the services that you need and they're just putting you in a place where it's a higher income people living isn't, in itself, a good thing and I think that we struggle with that 'cause then people say, 'well, we want to disperse, it should be everywhere.' Yes, but you have to have equal access to everything and equal opportunity and putting you in different places you don't necessarily get that." (A-28:66)
	Population needs single site "there's that very fragile population that needs that Moore Place type of housing opportunity and there's not enough of that." (A-11:87)
Affordability	**Additional Units** "We need more affordable housing 'cause without places for people to go, they're gonna end up right here." (A-10:25)
	Additional Subsidies "Just not having rental subsidies." (A-09:23)
	Below 30% AMI "I unfortunately see sometimes from the city perspective, affordable housing is really looking at 60 percent and above and that's usually where elected officials feel comfortable, in my opinion." (A-28:153)
Landlords/Property Managers	**Need More** "The community has over 300 more people to house. So, we're probably not going to keep using the same 12 property managers to get all of them, so…." (A-07:45)
	Build/maintain relationships "We just call random places – cold calling, Zillow, Craigslist – just to try to find new landlords. And then we try to mediate, build those relationships with the landlords so that is something does happen, they can call us and let us know what's going on. We can try to intervene as best as we can. So we try to maintain those relationships with the landlords." (A-18:18)
	Refuse some subsidies "And also, some property managers, not every property manager will take, say, a Shelter Plus Care voucher, will say ok we'll take a Housing Choice voucher also, so sometimes you're looking for different property managers as well or landlords. And then we actually have a third program, MeckFUSE, and sometimes they'll take, they'll work with them, but they won't work with the other two programs. So, it's finding, the biggest challenge, is finding landlords and property managers to work with whatever voucher you're trying to house someone with at that moment." (A-07:37)
	Refuse some clients "Or my criminal background that landlords are saying, "No, no, no, no, you need – I'm not gonna even going to accept you with X, Y and Z on your history here, you need – to do something about those before I even touch you" and it's the same landlord after landlord after landlord…" (A-19:118)
Subsidy Requirements	"Another HOPWA restriction is that if you live in subsidized housing, you cannot get assistance with utilities later on if you need it. They feel like you're already getting help. Getting help again is what they call double dipping." (A-27:18)

Table 11: Challenges/Concerns – Resources/Funding (n=14, 48%)

Category	Examples of Participant Responses
Resources/Funding	**General** "I think the biggest thing is financial support." (A-22:33)
	Ongoing Operations "There will need to be some serious examination in terms of what resources are needed to adequately support the system itself of moving people from homelessness into permanent housing. The areas where I would be most concerned are where … Organizations like that will tend to provide upfront money but not operational sustaining money over time. So, where that oftentimes falls back to the governmental entities and which of the three governmental entities are prepared to do any of that and what are we actually talking about." (A-25:32)
	Multiple Community Initiatives/Requests "there's so many capital campaigns happening right now. Even in the housing space, I think of four off the top of my head, and there's just not the money there was before the financial crisis. And so I think there's a little bit of a just burnout and lack of funding among some of the top funders." (A-06:12)
	Subsidies & Housing-Related Costs "More resources for deposits. A lot of these landlords now are charging double deposits." (A27:16)
	From Specific Partners "I would have liked to have seen more philanthropic investment by corporate Charlotte" (A-15:13) "But we have relied on and continue to rely on in this community is those federal dollars coming from HUD to address the issue and we've had very little investment by the local – out of local – resources and state resources. Even through the state we've had the Emergency Solutions Grant but that's, again, federal money coming through the state and there has not been – the State of North Carolina has not – invested in this issue and the County of Mecklenburg has not invested in this issue and the City of Charlotte has not invested in this issue, in terms of real dollars, you know?" (A-19:96)
	Volunteers "one of the great resources that I think we have is we have 23,000 employees here in Charlotte so from a volunteer perspective, from a leadership perspective those are resources that we can really bring to there. And I don't know that, that was in the scope of this project." (A-13:14)

Table 12: Challenges/Concerns – Services (n=10, 34%)

Category	Examples of Participant Responses
Services	**Capacity** "And are we gonna run out of social workers? There are only so many social workers trained in Housing First. And if we're gonna make this strategy work, you've got to have social workers who are all in. So hadn't happened yet." (A-17:53) "I'm particularly concerned with regard to case management and the support of behavior healthcare interventions that are needed." (A-25:34)
	Scattered Site "Well, scattered site can certainly work. That's not necessarily a bad thing but the kind of support services that have to be wrapped around, and the frequency of the support services, and the logistics of the support services is a little bit more challenging. But it can result potentially in much greater integration of the people into society in general." (A-25:40)
	Maintaining Housing "I guess with Housing First, the approach, I'm not so sure if this relates to Housing First Charlotte-Mecklenburg, but helping people maintain housing. We still have people getting evicted, even people who have supportive services. Some would argue that that's because we can't force them to get any treatment. I'm not sure if I would fully argue that. I don't know if there's an answer to how you help somebody who's lived on the streets for 20 years maintain housing." (A-18:12)
	Provider Differences "I can see different core competencies, and different strengths in different housing providers. Specifically in regards to followup and stabilization service." (A-21:12)
	Processes & Planning "We took all 30 of our first 30 clients at one time. That was stupid. With our next ten, we're taking them two at a time and trying to get people housed before we bring in the whole caseload. There are just too many people with too many needs and challenges to bring in that many people at once." (A-27:12)

Table 13: Challenges/Concerns – Public Perception/Understanding (n=5, 17%)

Public Perception/ Understanding	**General** "I think one of the things that hinder us is maybe misconceptions or all the things that you project onto people that are homeless. So like moving people into a new community that had another spot that was a potential place to build. And the community kind of erupts, says, "I don't want these people here." And you're like if you look at the history of what's happening at Moore Place, there is none. There's all these idea of, hey, we're going to have people in poverty here, so it's going to bring more crime or bring this or bring that. And I think that lack of knowledge and education really affects the program as a whole." (A-22:64)
	Street Homelessness "Again, I think there's a perception piece, especially if you live or work in the uptown, that nothing has changed. In fact, it's gotten worse." (A-04:17)
	Panhandling "And the other thing that ties into it is the panhandling. And so we get a lot of pressure on panhandling even though our chronically homeless are really not heavy panhandlers. Some of them, a little bit, they're not heavy panhandlers. Our heavy panhandlers are coming from other places." (A-10:52)

Summary

Data provided by the stakeholders assisted in highlighting some of the most visible achievements of HCFM, such as greater and deeper collaboration among community partners, the creation of the By-Name List, and improved education and awareness about the issue of chronic homelessness. Moreover, data provided by the stakeholders helped to shed light on the variety of constraints and contextual issues faced by HFCM. Chronic homelessness is a complex problem exacerbated by individual, social factors (e.g., poverty, aging, mental illness, substance abuse, and domestic violence), community factors which are shaped by market forces (e.g., the number of jobs paying a livable wage; lack of safe and affordable housing, and lack of access to supportive services), and the capacity issues that nonprofit service providers face on an ongoing basis (e.g., limited funding, multiple roles and responsibilities) (Bryson & Patton, 2015; Carman & Hefner, 2012; Stroh & Goodman, 2007).