Examining Implementation of the Los Angeles County Office of Diversion and Reentry Supportive Housing Program

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About This Report

This report examines the implementation of the Los Angeles County Office of Diversion and Reentry's (ODR) supportive housing program. This program was initiated in 2016 to provide community support to individuals in the Los Angeles County jail system who were deemed candidates for diversion from incarceration. To date, the program has diverted and provided community support to over 3,000 individuals. In this report, we use information collected from observations of the program's operations as well as from program staff and participant interviews to describe how the program is implemented, identify its key facilitators and challenges, and illustrate participant experiences. This report will be relevant to entities interested in alternatives to incarceration and permanent supportive housing program implementation for populations involved with the criminal justice system. The Rose Hills Foundation sponsored this research.

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Summary

In 2015, Los Angeles County created the Office of Diversion and Reentry (ODR) to provide jail-based mental health diversion programs. The aim of these programs was to reduce the number of people incarcerated with serious mental illness who could be safely cared for in the community. The largest ODR effort to date is the housing program. This program was modeled after an existing County effort targeting frequent hospital system users and then enhanced to address the unique needs of the jail-based population. In many ways, the program is innovative compared with other supportive-housing initiatives that target individuals involved in the criminal legal system. For example, this program identifies potential participants at the time of incarceration and uses a court diversion approach. Also, the ODR program initially places individuals into interim housing, providing further assessment before placement in permanent supportive housing (PSH). Moreover, the program is unique by virtue of its large size, having diverted over 3,000 people within the first four years of operation.

The goals of this study were to (1) describe the program's implementation, including how participants are identified and enrolled, what services are provided, and what resources are needed to operate it; (2) describe program facilitators and challenges as expressed by program administrators and key service providers; and (3) obtain participant perspectives. We attended service-provider meetings and interviewed program administrators (n = 8), key service providers (n = 7), and clients (n = 12) to assist with our study goals. ODR program staff also reviewed drafts of this report and provided input.

This study is important for several reasons. First, it allows for a comprehensive understanding of how the ODR Housing Program operates, which might serve as a roadmap for other jurisdictions looking to implement similar initiatives. Second, the study enables us to identify implementation successes and challenges, including lessons learned since the program's inception; this information can provide a context for interpreting past and future evaluations of the program's effectiveness. Finally, the study supplies provider and client perspectives on the program, a piece often missing from more outcome-based evaluations.

To describe the program's implementation, we developed a one-page graphic that shows a client's pathway through the program, from referral to housing placement, including key program milestones (e.g., screening, suitability, jail release, and housing services), the approximate time between milestones, and the entities involved at each milestone (see Chapter 3). We explain what happens at each of these phases, provide guidance in regard to the program's overall staffing requirements, and include the estimated costs of treatment and housing.

In terms of program facilitators and challenges, we learned the following:

- *Although having wraparound services and strong communication among partner organizations is important for meeting clients' needs, coordinating these services across multiple stakeholders can prove challenging.* The ODR program relies on contracted service providers who offer intensive case management; interim housing services; "bridge" mental health services; and permanent support in housing navigation, placement, and retention. The program also encompasses services from other county entities, including the Department of Mental Health (DMH), Probation, and in some cases the Department of Public Health (for substance use disorder treatment). ODR staff, service providers, and clients perceived these high-quality wraparound services as critical to the program's success. At the same time, such service provision can pose challenges, such as the need for frequent communication and coordination across numerous providers. The ability to scale up across this diverse set of providers may also prove challenging over time.
- *The limited availability of mental health and substance use treatment services throughout Los Angeles County's current system of care has required the program to fill these gaps, but a lack of integrated services remains an issue.* Although the program was designed to link clients to the DMH Full Service Partnership (FSP) program for ongoing mental health services support, there have not always been enough slots available for the number of ODR clients in need. ODR developed bridge mental health services to fill this gap, but that may mean clients need to transition care throughout the life of the program. Additionally, service providers and clients mentioned challenges accessing substance use treatment (provided by Los Angeles County Substance Abuse Prevention and Control [SAPC]), including outpatient and especially residential care. Integrated co-occurring care for both mental health and substance use appears lacking in Los Angeles County.
- *ODR Housing serves clients with serious clinical needs, and the program model has evolved to maximize success in permanent supportive housing.* The ODR program model places individuals into interim housing, to assess readiness, before transitioning them into more permanent (and potentially independent) living arrangements. The model was modified over time to provide lower client-to-case-manager ratios and to offer psychiatric support when an FSP slot was not available. ODR staff have recognized that scattered-site supportive housing may not be a suitable long-term solution for many, so they are building a portfolio of higher-level care settings to address this challenge. These modifications demonstrate ODR's nimbleness in identifying and responding to client needs.
- *Clients are largely satisfied with the program, and ongoing provider training will ensure the continued provision of high-quality services.* ODR Housing clients expressed satisfaction with the program, especially in regard to continued mental health and case management services support, from prerelease to permanent housing placement. Some clients were unsure about the range of services available to them, although those who had been in the program longer seemed more informed about these options. Clients did raise concerns regarding disruptive behavior and substance use in the interim housing sites, and service providers expressed the need for more staff training to address clinical issues in those settings.

The ODR program is the first of its kind in Los Angeles County. It helps fulfill a critical need to provide wraparound services and housing for those involved in the criminal justice system who experience serious mental health disorders and homelessness—a population that is disproportionately Black and Hispanic. As a testament to this need, thousands of people have been diverted since the program was initiated in 2016—thousands who would have otherwise remained in the County jail for significant lengths of time. And diversion rates continue to increase. Therefore, the County may consider the following recommendations for ongoing implementation:

- *Increase staff training opportunities*. This will ensure that staff from all organizations, including interim housing sites, are prepared to serve clients who have significant clinical needs.
- *Expand ODR's focus on equity in program implementation and outcomes.* This includes the extent to which the program can continue to address racial disparity in the jail's mental health population. It also includes the extent to which ODR can serve other underserved populations (e.g., those in the lesbian, gay, bisexual, transgender, and other queer [LGBTQ+] community).
- *Explore process measures, including early attrition rates.* An earlier study focused on clients who had reached PSH, but tracking participant "flow" through the program, along with exits at each program milestone, would also have value.
- *Monitor outcomes based on client characteristics and program progress.* This might include examining the outcomes of clients with different backgrounds (e.g., those of diverse racial and ethnic groups or genders) and program experiences (e.g., those whose intensive case management services [ICMS] and FSP services are provided by the same agency). Ultimately, this type of monitoring would assist Los Angeles County and other regions with more efficient resource allocation.

Given the community's interest in providing alternatives to incarceration, eliminating racial disparities in incarcerated and jailed mental health populations, and addressing the overwhelming rates of homelessness in Los Angeles County, continuing to expand and refine this model will be important in supporting the County's "care first, jails last" vision into the future.

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Abbreviations

CFIR	Consolidated Framework for Implementation Research
DHS	Department of Health Services of Los Angeles County
DMH	Department of Mental Health of Los Angeles County
FSP	Full-Service Partnership of the Los Angeles County Department of Mental Health
FUSE	Frequent Users System Engagement (of the Corporation for Supportive Housing)
HUD-VASH	(U.S. Department of) Housing and Urban Development—Veterans Administration Supportive Housing
ICMS	intensive case management services
LGBTQ+	lesbian, gay, bisexual, transgender, and other queer
ODR	Office of Diversion and Reentry (in Los Angeles County)
PSH	permanent supportive housing
RHO	Returning Home-Ohio
SAPC	Substance Abuse Prevention and Control (Los Angeles County)

1. Introduction

In 2015, the Office of Diversion and Reentry (ODR) was established in Los Angeles County. Housed within the County's Department of Health Services (DHS), ODR operates jail-based clinical diversion programs, designed largely for individuals with mental health diagnoses. These programs aim to reduce incarceration rates in the Los Angeles County jail system by diverting individuals who can be safely cared for in the community. The largest of these programs is the ODR Housing Program, which has diverted over 3,000 individuals since its inception in 2016.[1]

The goal of the ODR Housing Program is to reduce the number of individuals with mental illness in the Los Angeles County jail system, while also acknowledging that many of those individuals were experiencing homelessness at the time of arrest or at risk for homelessness upon release. The program was modeled after the Los Angeles County DHS Housing for Health program, an existing County program for frequent users of the hospital system (i.e., individuals with at least two inpatient hospitalizations or emergency department visits in the past year); to address the specific needs of its target population, however, the ODR Housing Program added enhancements (e.g., more clinical supports, a lower case management ratio, communication with legal stakeholders). As such, the ODR Housing Program involves partnerships among a number of organizations that provide wraparound services to support clients in the community.

The ODR Housing Program provides enrolled clients with permanent supportive housing (PSH), which includes a long-term housing subsidy along with access to supportive services. ODR uses a field-based, intensive case management service model, which includes assignment to a case manager and access to specialized psychiatric care. Individuals are eligible for the program if they are currently incarcerated on a felony charge, have a serious mental health disorder, and are experiencing homelessness. The program is currently offered to pretrial defendants. To enroll in the program, clients plead guilty or no contest and are placed on probation for a term of approximately 3–5 years. The program provides prerelease jail services and immediate interim housing with supportive services upon release from jail. These services continue long term, even after the client's probation term has ended.

Housing is a critical need for individuals in the criminal justice system, especially those with serious mental illness, who may find themselves cycling through jail, homelessness, and emergency health services. For decades, permanent supportive housing programs have addressed the needs of individuals who have serious mental illness and are experiencing homelessness. Research shows that these programs can increase housing stability and reduce the use of crisis care (Aubry et al., 2020; Gilmer, Manning, and Ettner, 2009; National Academies of Sciences,

[1] Number of individuals diverted as of October 2020 (Health Services, 2020).

2018). Even if criminal justice involvement is not a prerequisite for enrolling in such a program, enrolled individuals often have had contact with the criminal justice system (Bean, Shafer, and Glennon, 2013; Clifasefi, Malone, and Collins, 2013; Tejani et al., 2014; Tsai and Rosenheck, 2013). Regardless, PSH programs designed specifically for individuals involved in the justice system are less common than more generalized programs. In this chapter, we begin by reviewing the evidence base for supportive housing programs that specifically serve individuals involved in the justice system.

PSH Programs for Individuals Involved in the Justice System

To better understand the evidence base for initiatives like the ODR Supportive Housing Program, we examined both peer-reviewed and gray (i.e., nonacademic) literature. Our goal was to identify supportive housing programs that serve only populations involved in the justice system, describe the features of these programs, and examine their effects on justice-system and housing-related outcomes. In reviewing the literature, we identified two main categories of programs that have been studied: (1) programs specifically designed to serve individuals involved in the criminal justice system and (2) programs that did not require clients to be involved in the criminal justice system, but for which the study examined criminal justice outcomes. We discuss findings for both types of programs below (for details on the study methods used, see Appendix A).

Programs Specifically for Individuals Involved in the Justice System

Findings from selected studies of programs that were specifically designed for those in the criminal justice system (e.g., those with a recent jail stay) are presented in Table 1.1.[2] One of the most well-established models for populations involved in the justice system is the Corporation for Supportive Housing's Frequent Users System Engagement (FUSE) model. FUSE focuses on individuals who are frequent users of jails, homeless shelters, hospitals, and other crisis-related public services. Currently, 18 jurisdictions are implementing FUSE programs that focus on individuals involved in the justice system. Though the specific definition of "frequent users" varies, programs often focus on individuals who have multiple recent jail and shelter stays (e.g., Aidala et al., 2013; Listwan, Hartman, and LaCourse, 2018). Studies of the FUSE model have suggested that clients can achieve substantial reductions in rearrest and reincarceration outcomes (Aidala et al., 2013; Listwan, Hartman, and LaCourse, 2018; Thomas et al., 2020) and maintain stable housing (Aidala et al., 2013; Thomas et al., 2020).

Other program models feature elements similar to the FUSE model, such as combining PSH with mental health treatment. The Corporation for Supportive Housing Returning Home

[2] Note that we also include a preliminary outcomes study based on the ODR Housing Program (Hunter and Scherling, 2019).

initiative is one such model (Corporation for Supportive Housing, 2011; Corporation for Supportive Housing, 2014), pairing prerelease coordination for incarcerated individuals with postrelease housing and supportive services, which could include case management, mental health treatment, substance use treatment, and employment services (Fontaine et al., 2012). One example of this approach, The Returning Home-Ohio (RHO) program partnered with a range of supportive housing providers across the state, who offered project-based and scattered-site housing to individuals returning to the community with a range of needs (e.g., mental health and/or substance use disorders). In addition to contact with program staff, many participants received mental health treatment (60 percent received medication and 56 percent received supportive therapy), and about one-third received outpatient substance use treatment. This program resulted in decreased criminal justice involvement, especially for misdemeanor offenses, and participants had low rates of return to shelter settings (Fontaine et al., 2012). A similar program in Denver offered both scattered-site and project-based housing along with assertive community treatment, an intensive treatment and case management approach, and mental health and substance use treatment. This program was associated with 79 percent housing retention at two years, though 64 percent of clients had at least one jail stay by two years (Cunningham et al., 2019; Gillespie et al., 2017a; Gillespie et al., 2017c).

Findings from these studies reveal other key considerations related to supportive housing programs for this population. First, there is evidence that participation in this type of program can affect more than just criminal justice and housing outcomes. For example, in New York, FUSE clients spent fewer days in psychiatric hospitals or residential drug treatment settings than those in a comparison group, and were less likely to report recent substance use (Aidala et al., 2013). This finding is especially meaningful because individuals referred to supportive housing through a jail-diversion program have been found to be significantly more likely to have a history of substance use than individuals referred through other pathways (Casper and Clark, 2004).

Second, though a jurisdiction may have a large number of individuals who meet criteria for a given program (e.g., due to multiple stays in publicly funded criminal justice and/or housing systems), there can be challenges in enrolling these individuals. For example, in the first eight months of the D.C. FUSE program, 110 individuals were identified as potential participants; of those, 51 met with the program's transition coordinator, and only 14 were enrolled in the program (Fontaine, Gilchrist-Scott, and Horvath, 2011).

Third, the pathway to permanent housing is not always direct. In D.C. FUSE, many clients were housed in interim housing, halfway houses, substance use treatment settings, or hotels before moving to permanent housing (Fontaine, Gilchrist-Scott, and Horvath, 2011). Similarly, in a program in Denver, it took 63 days from program referral to lease-signing. Challenges to housing eligible participants included clients' reluctance to leave their networks on the street; finding the right housing placement; difficulty navigating court dates and paying fines; and significant physical and mental health barriers to independent living (Gillespie et al., 2017c).

Finally, housing alone may not be sufficient to address the needs of individuals involved in the justice system experiencing mental health concerns. For example, Salem and colleagues (2015) studied the outcomes of individuals in Canada who were arrested but found not criminally responsible on account of mental disorders. Individuals in this sample were hospitalized in psychiatric facilities and, following their release, were sent either to independent or supportive housing. Those in independent housing were 2.43 times more likely to reoffend, 2.76 times more likely to commit a new offense against a person, and 1.36 times more likely to experience a psychiatric readmission than those in supportive housing. This study suggests that the additional provisions offered by supportive-housing settings are key to the success of individuals involved in the criminal justice system who have serious mental illness.

Table 1.1. Summary of Findings

Program	Target Population	Key Services	Methods	Key Findings
FUSE Model Programs				
New York City (Aidala et al., 2013; Corporation for Supportive Housing, 2009)	4+ jail stays and 4+ shelter stays in the past five years	PSH (project-based, scattered-site); intensive case management services and/or assertive community treatment	Pre/post with matched comparison group (*N* = 188)	FUSE I: In the year following housing placement, clients experienced a greater decrease in shelter days (92% reduction) and jail days (53% reduction) than a matched comparison group (71% and 53% reduction, respectively).
			Pre/post with propensity-matched comparison group (*N* = 130)	FUSE II: In the two years after housing placement, clients spent 19.2 fewer days incarcerated—40% less time than those in a comparison group. About 91% of clients were in permanent housing at one year and 86% at two years, compared with 28% and 42%, respectively.
Mecklenburg County, N.C. (Thomas et al., 2020; Listwan, Hartman, and LaCourse, 2018)	4+ jail stays and 4+ shelter stays in the past five years; homelessness, mental health, and/or substance use concerns	PSH; intensive case management services	Two-group descriptive comparison (*N* = 84)	An initial descriptive comparison study found that, in the four years after enrollment, 60% of MeckFUSE participants were arrested, compared with 74% of comparison group participants. Comparison group members were 21 times more likely to be arrested in the follow-up period.
District of Columbia (D.C.) (Fontaine, Gilchrist-Scott, and Horvath, 2011)	3+ jail stays and 3+ shelter stays (or one continuous year of shelter use) in the last three years; a serious mental illness	PSH; assertive community treatment	Single-group descriptive (*N* = 10)	A preliminary-outcomes study found that 10 of the first 11 clients were in permanent housing within four months of release. Four were reincarcerated in the first ten months.
Other Program Models				
ODR Housing Program	Justice involvement, experiencing homelessness, and a serious mental health diagnosis	PSH; intensive case management services, mental health services, and substance use disorder treatment	Single-group descriptive	Among those in PSH, housing stability was 91% at 6 months and 74% at 12 months. Of those who had been housed at least a year, 14% had a new felony conviction during their first year in the program.

Program	Target Population	Key Services	Methods	Key Findings
Returning Home-Ohio (RHO) (Fontaine et al., 2012; Fontaine et al., 2009; Markman et al., 2010)	A pending release from Ohio state prison, behavioral health or developmental disorder, or history of or current risk of homelessness	PSH (project-based, scattered-site); supportive services such as case management and behavioral health services	Two-group descriptive comparison (*N* = 239)	RHO clients had fewer rearrests than the comparison group within one year (27% versus 37%). Rates of misdemeanor arrests were lower, though rates of felony arrests were not significantly different. RHO clients were 40% less likely to be rearrested and 61% less likely to be reincarcerated. Similar housing outcomes were identified across groups, with 10% of the sample returning to emergency shelters.
Denver Supportive Housing Social Impact Bond Initiative (Cunningham et al., 2019; Gillespie et al., 2017a; Gillespie et al., 2017c; Gillespie et al., 2017b)	Frequent cycles through jail and homelessness; a history of mental illness and substance use	PSH (project-based, scattered-site); assertive community treatment; behavioral health services	Single group descriptive (*N* = 533 in latest report, though it varies across reports and outcomes)	In the first three years of the program, 383 clients were housed. After entering housing, 47% had at least one jail stay by 6 months, 62% by one year, and 64% by two years. Housing retention rates were 92% at 6 months, 85% at one year, and 79% at two years.
California Full-Service Partnership Housing Programs (Kriegel, Henwood, and Gilmer, 2016)	Serious mental illness and experiencing or at-risk of homelessness, including jail-diversion clients	Recovery-oriented PSH; mental health treatment	Two-group pre/post (*N* = 4,231)	Residents of jail-diversion housing programs had a significant reduction in days spent in justice-system settings, from one year preenrollment to one year postenrollment (adjusted mean = 41-day decrease), compared with those in nonforensic housing programs (adjusted mean = 10-day decrease). Jail-diversion clients also had a greater increase in days spent in congregate or residential settings than did nonforensic clients (adjusted mean = 68-day increase versus 41-day increase).
Supportive Housing for Individuals Not Criminally Responsible on Account of Mental Disorder (NCRMD)	Canadians found NCRMD who were conditionally discharged by a court to either independent or supportive housing	Not stated; services likely varied across sites and providers	Two-group descriptive comparison (*N* = 837)	Individuals released to independent housing were 2.43 times more likely to be convicted or found not NCRMD for any offense and 2.76 times more likely to commit a new offense against another person than those released to supportive housing.

Programs Reporting on Justice-System Involvement Among Supportive Housing Clients

Though only a handful of studies focused on programs specifically designed to serve individuals in the criminal justice system, many studies examined justice-system involvement among PSH participants. In this section, we describe highlights from the relevant studies. A table describing the complete results appears in Appendix B.

An important finding was that justice-system involvement can be common among clients of programs that serve people with a history of homelessness and mental health conditions or substance use disorders (Bean, Shafer, and Glennon, 2013; Clifasefi, Malone, and Collins, 2013; Tejani et al., 2014; Tsai and Rosenheck, 2013). Further, many of these studies provided evidence that PSH is often associated with reduced justice-system involvement and that participants who have a history of justice-system involvement can achieve positive outcomes in PSH programs—even if that is not an explicit focus of the program. Studies have found that participants experience reductions in arrests (Bean, Shafer, and Glennon, 2013; Hanratty, 2011), jail bookings (Clifasefi, Malone, and Collins, 2013; Hickert and Taylor, 2011), and jail days and incarceration (Driscoll et al., 2018; Hanratty, 2011; Hickert and Taylor, 2011). These effects have been observed for as long as 18 to 24 months after clients' enrollment in a program (Driscoll et al., 2018; Hickert and Taylor, 2011).

Many of these studies use a pre/post design with no comparison group. However, a quasi-experimental study of the New York/New York program (CUSC Institute, 2019) found that the subset of participants who had a history of justice-system involvement experienced significant decreases in days spent in prison or jail (Culhane, Metraux, and Hadley, 2002) compared with those in a matched control group. Another quasi-experimental study demonstrated a significant decrease in justice-system costs, from the two years preintervention to two years postintervention, for individuals receiving supportive housing versus a comparison group (Gilmer, Manning, and Ettner, 2009).

Other rigorous studies provide more equivocal findings. For example, in the randomized controlled trial of At Home/Chez Soi, a Housing First program (National Alliance to End Homelessness, 2016)[3] implemented in five cities across Canada, about one-third of participants in the intervention and comparison groups were arrested during the 24-month study period, and both groups had a decline in contact with the justice system compared with the prestudy period (Goering et al., 2014); the evaluators hypothesized that the lack of program elements specifically designed to address justice-system involvement may partially account for the lack of effect. This

[3] Housing First programs are predicated on the belief that providing individuals with housing serves as a foundation for addressing other key psychosocial needs. Rather than being required to fulfill certain prerequisites before entering housing, such as completing substance use treatment services, clients enter housing upon identification and are offered supportive services, including mental health and/or substance use treatment, after housing entry, to promote housing stability (National Alliance to End Homelessness, 2016).

might include program elements specifically designed to address factors that have been shown to increase the risk of criminal justice involvement, such as employment and a lack of prosocial peers. A quasi-experimental study of another program also found that reductions in justice-system involvement among program clients were not significantly different than those observed in a comparison group (Larimer et al., 2009).

Some studies suggest that the nature of the supportive housing offered may make a difference. There are two basic housing types typically provided: (1) scattered-site housing, which refers to housing units situated in private, market-rate apartments in the broader community, with mobile supportive services provided; and (2) project-based housing, which refers to housing units that are part of a supportive housing building that also has onsite supportive services. An analysis of At Home/Chez Soi found that scattered-site housing within the general community was associated with significantly lower rates of convictions during the follow-up period, whereas project-based housing resulted in only marginally significant reductions (Somers et al., 2013). These findings are similar to those of a study of a Housing First program in Australia, which also found that clients in scattered-site housing experienced a decrease in the mean number of justice-system contacts from baseline to one-year follow-up, while those in project-based housing experienced an increase in justice-system contacts (Whittaker et al., 2016). In this case, researchers hypothesized that the difference resulted from a greater police presence near the project-based housing site and greater oversight by onsite staff. The timing of supportive services may also play a role: a study of PSH for individuals with substance use disorders found that those who received treatment before admission into housing had a lower likelihood of incarceration and higher rates of voluntary discharge than those who were actively using substances when they entered housing (Hall et al., 2020).

Though fewer studies have focused on housing outcomes, a small number of studies have found that individuals involved in the criminal justice system can achieve housing stability in these programs. For example, a study of supportive housing for adults with mental health and/or substance use disorders found that 72 percent of participants were continuously housed for two years or moved out to other appropriate housing. It also found that the percentage of individuals with criminal histories who achieved this outcome was similar to the percentage of those without such a history (Malone, 2009). In addition, individuals with higher numbers of property or drug crimes had lower housing success rates, although this effect was not significant after adjusting for other covariates (e.g., move-in age, presence of substance use disorders). Further, a study of a project-based housing program for individuals experiencing chronic homelessness with severe alcohol problems in Seattle found that criminal history was not a predictor of housing retention over a two-year follow-up period (Clifasefi, Malone, and Collins, 2013). In another study, the rate of stable housing (i.e., staying in the program for a year or more or moving to other stable housing) was 63 percent; the group that achieved stable housing included a substantial number of individuals who were in jail before enrolling (Hickert and Taylor, 2011). However, an analysis of At Home/Chez Soi participants found that time in jail in the

three months before baseline was associated with a lower likelihood of stable housing at one year, although the effect was quite small (Odds Ratio = 1.02) (Volk et al., 2016).

Another key finding is that housing stability and likelihood of contact with the justice system are related. A study of At Home/Chez Soi participants found that people who were unstably housed spent more time in prison across the study period than did those whose housing became unstable during the intervention (Kerman et al., 2018). By contrast, those who obtained housing later in the program then experienced a decrease in prison time. A study of New York/New York III, which focused on individuals with substance use disorders, found that individuals who were housed for more than a year were less likely to be incarcerated (Hall et al., 2020). Another study found that each additional month of PSH was associated with 5 percent fewer bookings and 7 percent fewer jail days (Clifasefi, Malone, and Collins, 2013). It is important to note, though, that incarceration might be the reason an individual lost housing or spent fewer days in PSH settings, highlighting the complexity of the relationship between housing and justice-system involvement.

Present Study

These studies provide insight into the types of programs that have been developed to address criminal justice and housing outcomes in populations involved in the justice system. Though some of these studies yield promising results, limitations to the research methods used (e.g., lack of rigorous, well-controlled studies) make it difficult to know how effective the studied programs are. There is also variation in the nature of the programs: some programs place clients directly into PSH, while others have an interim stage built in before placing clients into permanent housing; programs use a mix of scattered-site and project-based housing; the model used for providing supportive services varies; and some programs offer additional services, such as mental health or substance use disorder treatment. This variation across programs makes it difficult to identify what the key elements of a program of this nature might be. Therefore, there is more work to be done to understand how these programs operate and how well they succeed in addressing criminal justice, housing, and mental health needs.

The Los Angeles County ODR Housing Program includes many of the program elements that have been implemented in other jurisdictions, including PSH with supportive services and mental health treatment. However, it is also unique—most notably in that it operates as a formal jail diversion program and has served a large volume of participants since the program's inception. In addition, the program has already demonstrated initial promise, with a recent analysis among the first participants showing a housing stability rate of 91 percent at six months and 74 percent at 12 months. Only 14 percent were convicted of a new felony during the 12 months after being housed. This initial examination also showed that the participant population was diverse: 66 percent were male, 31 percent female, and 3 percent transgender; 46 percent were Black/African American, 29 percent Hispanic/Latino, and 27 percent White (see Hunter and Scherling, 2019).

The purpose of this report is to examine the implementation of the Los Angeles County ODR Housing Program by doing the following: (1) describe the program's implementation, including the ways that participants are identified and enrolled, the services that are offered, and the resources that are needed to operate the program; (2) describe program facilitators and challenges as expressed by program administrators and key service providers; and (3) obtain participants' perspectives of the program.

This study is important for several reasons. First, it allows for a comprehensive understanding of how the ODR Housing Program operates. The program is complex, involving many partner organizations, and it is constantly evolving in response to the needs of clients and shifts in local policy. Developing a thorough understanding of the program's operation will yield insight into how it compares with similar programs serving individuals involved in the justice system and may serve as a roadmap for jurisdictions looking to implement similar programs. Second, this study is important because it enables us to identify implementation successes and challenges by exploring the lessons learned since the inception of the program. Such information can also provide context for the interpretation of past and future evaluations of the program's effectiveness. Finally, this study is important in that it supplies provider and client perspectives on the program, a piece often missing from more formal outcome-focused evaluations.

In subsequent chapters, we describe our study methods (Chapter 2), provide a comprehensive description of the program's components and operations (Chapter 3), discuss the challenges and facilitators to implementation from the perspective of the program's service providers (Chapter 4), and report clients' perceptions of the program (Chapter 5). We then review our key findings and recommendations (Chapter 6).

2. Methods

To examine ODR Housing implementation, we took a multipronged approach. We conducted a literature review of existing supportive housing programs that serve individuals involved in the justice system, allowing us to contextualize the operation of the ODR Housing Program. We conducted interviews with key program stakeholders, including ODR staff and contracted providers of case management services and interim housing. To gain a better understanding of the program's operations and its coordination across entities, we also attended meetings hosted by ODR staff for representatives of the service provider organizations. Finally, we conducted client interviews to gain their perspectives on the program's services and effectiveness.

It is important to highlight the data-collection time frame for this study. The majority of data collection took place before the COVID-19 pandemic affected the United States (before March 2020). However, a small number of provider interviews and all client interviews took place after March 2020. Given that most data collection took place pre-COVID-19, our description of the program and its operation focuses on that time frame. However, the program has continued to evolve in response to COVID-19, and to the extent possible, we provide details about these changes when discussing results. Finally, we shared a draft of this report with ODR staff in February 2021. They provided feedback on the draft in June 2021, which included details such as program changes that took place after our data collection ended and contextual data regarding ODR client demographics; we have added these details to this version of the report.

Program Stakeholder Interviews

We conducted a series of semistructured interviews with three ODR Housing stakeholder types: (1) ODR leaders, administrators, and clinical staff; (2) intensive case management services (ICMS) providers; and (3) housing (interim or PSH) staff. The interview protocol was tailored to each interviewee's organization and role but broadly focused on the flow of clients through the program; the nature of ICMS and housing services; communication across program stakeholders; and perceptions of the program's effectiveness, challenges, and facilitators (see Appendix C for the interview protocol). We conducted 15 interviews in total (eight with ODR staff, four with staff from different ICMS providers, and three with staff of different housing organizations), either with individuals or pairs of staff members, and we took detailed notes during each interview.[4]

[4] Staff from three other ICMS organizations and four other interim housing sites did not respond to requests to participate in an interview.

We also digitally recorded the interviews to aid in our analysis.[5] All interviews, except for two with housing staff, took place before the onset of the COVID-19 pandemic.

We synthesized the interview data regarding the program's operation into a detailed program description. That description includes the program's major resource categories, which could inform future budget planning. We also used the interview data from program staff to identify challenges and facilitators in the program's implementation. To analyze the interview data for this purpose, we developed a codebook based on the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2009). CFIR is one of the most widely used frameworks for implementation research, providing a comprehensive overview of how a program's implementation is influenced by characteristics in five major domains: (1) the intervention (i.e., the ODR Housing Program), (2) the individuals delivering it (i.e., the employees of ODR and partner agencies), (3) the "inner setting," or the within-organizational contexts (i.e., the ODR setting), (4) the "outer setting," or extra-organizational contexts (i.e., the Los Angeles County and other ODR partner-organization settings), and (5) the process of implementation. The codebook was developed and refined by three members of the research team, using a combination of deductive and inductive coding. We deductively sought codes that fit within the five CFIR domains but inductively identified the specific codes based on overlap among participants' responses. The codes represented (a) general themes that summarized the content of participants' responses and (b) more nuanced subthemes that focused on a specific aspect of a general theme. One member of the research team then coded all interview notes. All coding was reviewed by a second researcher, and 90 percent agreement was achieved on a subset of five interviews. We also identified key points that exemplified each theme, and transcribed quotes verbatim to present as part of our study findings.

ODR Provider Meeting Observations

ODR hosts monthly meetings to convene relevant managerial and supervisory staff from ODR, ICMS, and housing organizations. Six meetings from 2019 through July 2020 were attended by research team members who took detailed notes on the topics covered during each meeting. We used these notes to provide descriptive material that informed our understanding of program operations and provide additional context for interpreting the implementation successes and challenges identified in the interviews. Further, our project leader (Hunter) attended quarterly Just in Reach Pay for Success executive committee meetings through November 2020, where program operations were also discussed (Hilton Foundation, 2017).

[5] We were unable to digitally record interviews with two ODR staff and relied on interview notes for analysis.

Client Interviews

We also conducted semistructured interviews with clients of the ODR Housing Program (for the interview protocol, see Appendix C). Our goal was to interview individuals in both interim housing and PSH to represent clients with varying degrees of experience in the program. To recruit these interview participants, we partnered with one ICMS provider (that serves clients in both interim and permanent housing) and one interim housing provider (that operates multiple houses and serves clients from multiple ICMS providers) to disseminate information about the interviews. Interviews occurred via telephone, due to COVID-19, and were conducted by a clinical psychologist and a master's level researcher with expertise in qualitative methods. The project team members conducted two interviews together, to ensure fidelity to the interview guide, then conducted the remaining interviews independently. Though the interview guide was not designed to ask about sensitive topics (e.g., details about mental health treatment or psychiatric symptoms), given the nature of the population, the clinical psychologist was available to discuss any issues that arose during interviews conducted by the master's level researcher. Our protocol was reviewed and approved by the RAND Institutional Review Board. All client responses were kept confidential. It was made clear during the consent process that there was no expectation that clients discuss the specifics of their treatment or mental health symptoms, although some clients opted to share such information, as well as details of challenging situations they had experienced with staff and clients.

We received contact information for 15 clients and were able to schedule and complete interviews with 12 clients during our study time frame, including seven residing in interim housing and five living in PSH. We did not collect demographic information from the clients, because the interviews were brief and virtual and we wanted to reinforce their confidential nature. Interviews were recorded for the purposes of filling in interviewer notes and identifying illustrative quotes.[6] The interviewers met periodically during data collection to discuss themes that were emerging and to determine when saturation had been achieved. To analyze the data, we developed a codebook, based deductively on the key themes represented in the semistructured interview guide (i.e., the enrollment process; the perceptions of services related to interim housing, case management, mental health, and other supports; the process of preparing to move to PSH and the actual transition to permanent housing, when relevant; and the strengths and limitations of the program). Codes were developed and refined by the two members of the project team who conducted these interviews. All interviews were reviewed by both members of the team, given their brevity compared with the stakeholder interviews. One member of the team coded all the transcripts, and the second member reviewed all the codes and transcripts. All new codes applied by the second coder were reviewed by the first coder and discussed until consensus was reached on the application of all codes.

[6] We were unable to digitally record interviews with two clients and relied on interview notes for analysis.

3. ODR Housing Program Description

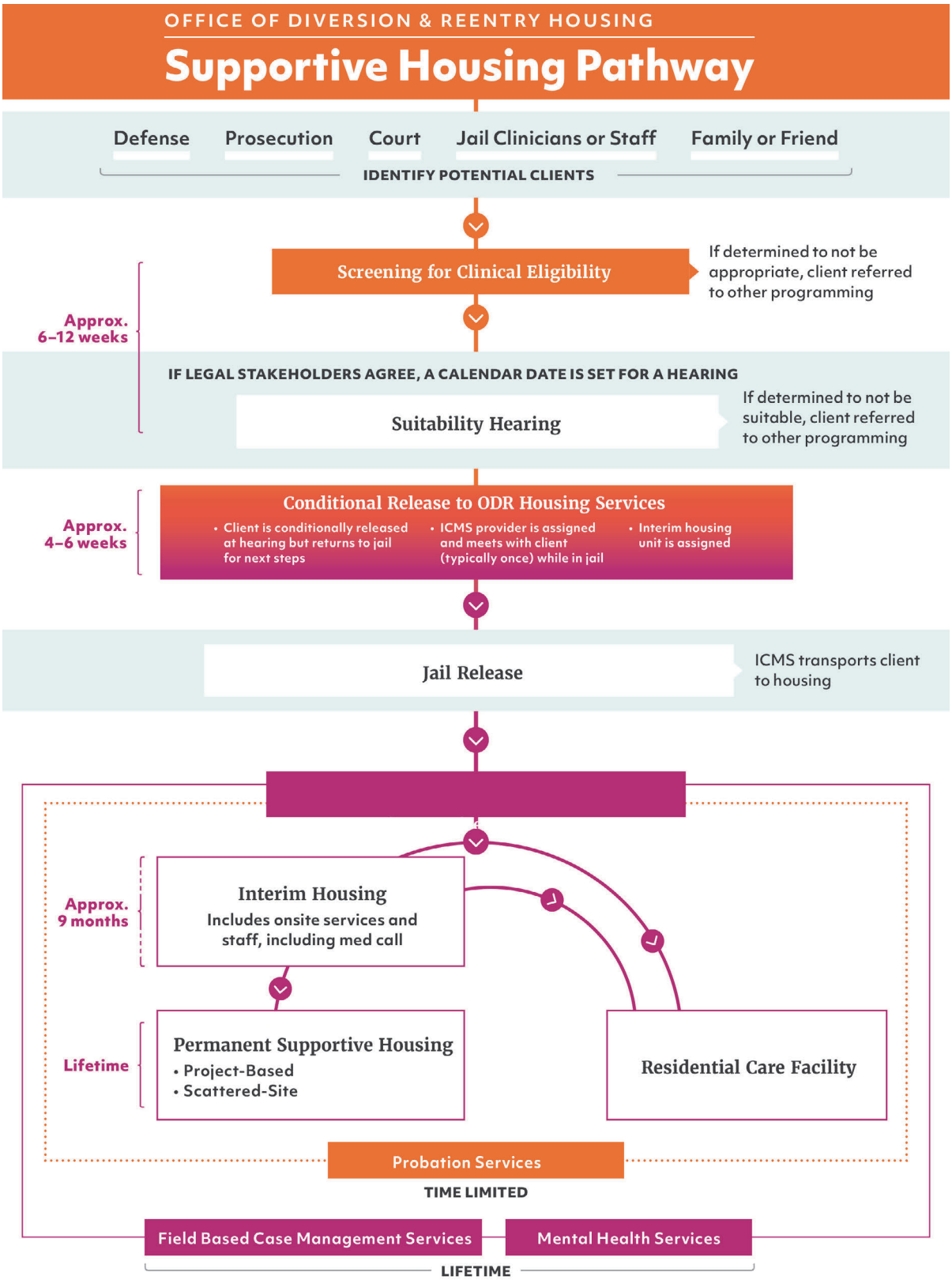
Program Overview

In this section, we provide an overview of the ODR Housing Program by describing the client pathway through the program, beginning with client identification, ending with housing enrollment, and including the supportive services provided throughout. A visual summary of this pathway appears in Figure 3.1.

Program entry begins with identifying potential clients in jail and then assessing their clinical eligibility and legal suitability. Individuals who are found to be both clinically eligible and legally suitable are admitted to the program and ultimately released from custody and placed under Probation supervision by court order. Once individuals enter the program, they receive field-based ICMS, provided by social services agencies under contract with ODR. They also receive mental health services, typically provided in partnership with the Los Angeles County Department of Mental Health (DMH) Full-Service Partnership (FSP) program. Individuals directly enter interim housing upon release from custody. Once they are determined to be housing-ready, they become eligible for placement in PSH, which may be in scattered-site apartments, project-based housing, or a residential care facility.

In the next sections, we provide a detailed description of the nature of services provided across the program pathway.

Figure 3.1. Office of Diversion and Reentry Housing Pathway



Referral and Enrollment

Potential ODR Housing clients are primarily referred by defense attorneys, though some are identified by family members, jail clinicians, community-based treatment providers, or other ODR programs (e.g., the Felony Incompetent to Stand Trial [FIST] program). The official referral must ultimately come from the defense attorney, with the client's permission. Clients generally have felony charges and a history of homelessness.

Eligibility is determined based on clinical and legal factors. Regarding *clinical* factors, ODR aims to identify individuals with serious mental health disorders, such as schizophrenia and other psychotic disorders or bipolar I disorder.[7] To assess clinical eligibility, ODR clinical staff begin by conducting a record review. This includes a review of jail medical records, which can include treatment progress notes, clinical diagnoses, current medications, psychiatric evaluation findings, and information about where a potential client is housed in the jail (e.g., in moderate- or high-observation mental health housing). Clinical staff also review County databases regarding a potential client's previous receipt of mental health treatment (e.g., outpatient mental health treatment, psychiatric hospitalizations).

It is often possible for ODR clinicians to determine clinical eligibility based on the record review, though at times a clinician will also meet with a potential client in jail to conduct a more in-depth assessment. For example, there may be a person whose current diagnosis would not qualify them for the program (e.g., depression), but a qualifying diagnosis has been documented in county health treatment records (e.g., schizoaffective disorder). In this case, an ODR staff member may meet with the individual to obtain more information about their mental health history and current status. There are also cases of young individuals whose clinical history reflects limited use of mental health services but whose symptoms suggest they may be experiencing a first episode of psychosis, which would result in an in-person assessment with an ODR psychiatrist.

In addition to determining whether someone is clinically appropriate for the program, ODR staff review an individual's *legal* history to determine whether there are factors that might bar them from candidacy (i.e., a judge is unlikely to view certain serious charges, such as murder or rape, as acceptable for diversion). If initial clinical and legal reviews suggest that a client will not be approved for diversion in court, ODR clinicians generally communicate this to the client's defense attorney so that an alternative pathway can be determined. Assuming there are no obvious legal bars, however, once a potential client is determined to be clinically eligible for the program, and the attorney agrees, ODR places the individual's name on a prospective program list, which is submitted to the court for determination by a judge. ODR attempts to prioritize

[7] ODR also operates a Maternal Health Diversion program that provides services comparable to those of the ODR Housing Program. The program is open to women who are pregnant during their jail stay. Women do not have to have mental illness to be eligible for that program.

clients by arrest date, such that those who have been in jail longer are placed on the court calendar earlier.

Once a list of potential clients is submitted to the court, an affidavit is submitted to the presiding judge. The judge has the authority to approve—or not approve—those on the list. If the judge approves the affidavit, a suitability hearing is placed on the schedule. The suitability hearing is an adversarial hearing during which the legal stakeholders discuss whether the individual will be diverted to the ODR Housing Program and under what conditions. The judge has the ultimate authority to determine if someone will be diverted. At the time of our data collection, the ODR Housing Program was operating in courtrooms in two regions of the County, though expansion to a third region was in progress.

On the day of the suitability hearing, ODR staff meet with the potential client to discuss the program and assist with legal proceedings. Staff noted that, in theory, potential clients have learned about ODR Housing from their attorneys, but there are times when an individual has received limited information about the program and what it entails. Some potential clients may have met with ODR clinicians prior to the suitability hearing. For others, this is the first opportunity for ODR staff to provide more information about the program. If there are concerns about clinical stability, an ODR psychiatrist also meets with the client to develop a stabilization plan prior to release.

If a potential client is found to be legally suitable for diversion by the judge, they will be conditionally released to ODR. Though conditionally released, the client actually returns to jail so that program stakeholders can prepare for their physical release. Jail staff are notified that a person has enrolled in ODR Housing, and the ODR psychiatrist works with the client to prepare their medications for release (e.g., shifting to a long-acting injectable medication). ODR also assigns an ICMS provider, who typically arranges to meet the client in jail, completes an intake assessment, and then requests placement at an interim housing or residential care facility. Facility placements are made by ODR staff based on availability, preference, and fit. As a result of the various release-planning steps, it takes about four to six weeks for a new client to be physically released from jail following the suitability hearing.

Clients are generally matched to an ICMS agency based on agency availability. However, there are occasionally requests for a specific ICMS agency. For example, some clients may have been connected to publicly funded mental health services through a given agency; in that case, efforts are made to match the client to that same agency for ICMS.

Supportive Services

Upon their release from jail, enrolled clients are provided with housing and two key supportive services—ICMS and mental health services. In this section, we provide an overview of the supportive services, and in subsequent sections, we describe how these services are tailored to support clients as they transition from interim housing to PSH.

Field-Based Intensive Case Management Services

At the time of our data collection, ODR had contracts with seven organizations to provide ICMS. ICMS case managers assist clients with a range of services, which includes obtaining needed benefits, such as Medi-Cal insurance (California's Medicaid program), General Relief (a program in Los Angeles County that provides financial assistance to low-income, low-resource individuals), and federal Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). ICMS providers also help clients address basic needs, such as obtaining clothing, necessary documents (e.g., driver's license, birth certificate), and connections to physical health services (e.g., dental and primary care). Finally, providers help clients to pursue educational or vocational goals. There is flexibility with respect to the program model used by ICMS organizations; for example, one agency described using Assertive Community Treatment as their approach to ICMS. Some ICMS agencies offer additional services, such as life skills courses, mental health services, or substance use groups. At the time of data collection, all ICMS case managers were required to meet with their clients in person at least monthly, though ICMS staff noted that contact often happens more frequently, whether in person or virtually.

Mental Health Services

The ODR Housing Program was designed such that clients receive their mental health treatment through the Los Angeles County DMH FSP program, which provides community-based, intensive mental health services (Los Angeles County Department of Mental Health, undated). However, there are a limited number of FSP slots, which means that, at times, no slots are available, especially in certain geographic areas. Given the clinical vulnerability of clients during their initial weeks in the program, ODR provides funding to ICMS agencies for embedded mental health staff, including psychiatrists, to serve as "bridge" providers when FSP slots are not available. Ultimately, the goal is for FSP to serve as the primary mental health provider, although it can sometimes take months for a slot to open for a client. Some ICMS agencies are also FSP providers, and it was described as the ideal situation if a single agency can be both the ICMS and FSP provider. Clients typically receive both psychiatric medication services and therapy as part of the mental health services provided.

Interim Housing

The first placement after release from custody is typically at an interim housing site, though some clients are able to go straight to a residential care facility; in addition, a small number of clients must complete a substance use disorder treatment program before entering interim housing, as directed by the judge. This first phase of the process, in addition to immediately providing clients with a place to live, also connects them with supportive services (e.g., public benefits) and helps them to become "housing-ready."

As previously noted, before a client is released from jail, ICMS agencies work with ODR staff to identify an interim housing assignment. Assignment is based mostly on the availability of beds in the housing sites, but other factors affect housing placement as well, such as gender and geographical restrictions (e.g., for registered sex offenders). Once a housing placement has been found, the ICMS and interim housing providers develop a plan for the client's release and transfer. Typically, the ICMS agency is responsible for release and transfer. At the time that we conducted the interviews, about 20 clients were being released per week. ICMS staff sometimes bring clothing and food to the client pickup and then ideally make a warm hand-off to the interim housing program manager.

Interim housing is provided in congregate settings. At the beginning of the ODR Housing Program, ODR contracted for beds in settings that served multiple programs, but over time ODR has developed interim housing specifically for their clients. This has allowed ODR to have more oversight and to better accommodate the growing population of ODR Housing clients. There are generally about 20 people per house, and onsite services include case management, medication monitoring, meals, and other amenities (e.g., laundry). At the time of the interviews (January and February 2020), ODR had contracted with and was providing direct oversight to about 70 interim housing sites.

Clients are also supervised by Probation upon entering interim housing. ICMS case managers support clients' ability to attend their ongoing probation meetings. ODR clinical staff complete and submit FSP referrals to DMH on the client's behalf. In addition, when clients are released from jail, they typically have 30 days of medications, and the referral to FSP can take months. So while waiting to be connected with an FSP provider, the ICMS agency serves as a bridge prescribing provider.

During their time in interim housing, clients are supported by onsite housing staff in addition to their ICMS and mental health providers. Housing staff and services may vary from site to site. In addition to meeting clients' basic needs (such as meal services and hygiene kits), housing staff may assist in coordinating clients' appointments with Probation, ICMS, and mental health providers, and some interim houses offer group programs (e.g., substance use groups, educational programs). Housing staff may also assist in tracking client progress to PSH readiness, which includes teaching clients to become independent with respect to medication management. For example, nursing staff members in interim housing work with clients to learn how to manage their medications, communicate weekly with ICMS providers about any issues related to medication adherence, and work with the pharmacist to ensure client medications are up to date. Housing staff are in frequent communication with ICMS providers about client needs and housing readiness and about any incidents that have taken place. This communication generally takes place via telephone or email on an as-needed basis.

Preparing for Permanent Supportive Housing

Throughout their time in interim housing, ODR clients are preparing for the eventual transition to PSH. A key hallmark of ODR Housing is that, although probation lasts three to five years, PSH services are available to a client for life. ODR, ICMS, and housing staff work together to determine whether a client has demonstrated indicators of housing readiness. Staff from different organizations described a range of housing-readiness indicators, such as current mental health stability and the ability to independently manage medications, engage with ICMS staff, follow probation requirements, establish supports in the community, follow through with medical and mental health appointments, and develop money management and budgeting skills. Staff told us that specific metrics vary from client to client, but as one provider described it, they are looking to determine if a client has demonstrated emotional and financial stability. ICMS staff noted that they are transparent with clients about the process of becoming housing-ready and that this process begins when clients enter the program.

When ICMS staff believe that a client is ready for PSH, they will make a formal recommendation to ODR staff. Though ICMS is responsible for making this recommendation, input from interim housing providers, FSP providers, and legal stakeholders is a key consideration. ODR clinical staff review each recommended client. If a client is not approved, a plan is put into place to address the reasons the person was not approved. On average, clients spend six months to one year in interim housing, but they can spend much longer if they are not seen as ready for PSH.

As one ODR staff member noted, housing-readiness is not a traditional stage in homeless services that take a more Housing First approach; however, ODR staff described certain advantages to this stage. First, including an interim housing stage ensures that all clients have housing from the moment they are released from jail. This helps to provide stability during a stressful transition and was perceived as helping to retain clients in the program. This was also described as a factor in increasing judges' support for the program. Second, some staff described the significant clinical needs of the population served by this program and how that could translate into challenges living in independent housing. They observed that the interim housing stage allows clients time to establish a support system outside of ICMS and housing services, so that they are better prepared to live independently.

Permanent Supportive Housing

Once a client has been approved as housing-ready, the process of identifying a suitable PSH placement begins. At the time the interviews were conducted, there were three primary PSH placements available—scattered-site housing, project-based housing, and residential care facilities.

Scattered-Site Housing

Scattered-site housing refers to individual housing units located in privately owned apartment buildings across Los Angeles County. Unlike in interim housing settings, there are no onsite supports, although clients receive field-based ICMS and mental health services following their placement. Brilliant Corners is the agency involved in providing PSH services for ODR Housing, and they have three teams of staff: the Housing Acquisition Team, which works to identify housing units; the Tenancy Support Team, which facilitates the move-in process and provides retention services; and the Operation Team, which is responsible for the financial aspects of the arrangement, including paying rent. Most ODR Housing clients find their housing in collaboration with Brilliant Corners, leveraging a pool of available apartments that Brilliant Corners has identified. Brilliant Corners will show a client units that may be a good fit and help them complete the application and leasing process. The process of identifying a unit can take time, especially if there are client circumstances that place certain restrictions on where they can live (e.g., they are on a sex-offender registry or have a prior gang affiliation). There is also a subset of clients who work independently with their case managers to identify units; in this case, Brilliant Corners begins their involvement when the lease is signed. The lease is a standard renter's lease.

On behalf of ODR, Brilliant Corners pays rent for ODR participants directly to the landlord. The organization also pays for one-time housing expenses (e.g., security deposits). Clients are responsible for covering 30 percent of the rent if they have a source of income, which can include employment, SSI/SSDI, or General Relief. The Tenancy Support Team provides retention services to support clients in their independent housing setting. This can include making regular visits to the client, alongside a case manager, and serving as a liaison with the landlord for any issues that arise (e.g., maintenance problems). ICMS agencies may also become involved in certain types of landlord issues, such as in the case of client behavioral concerns.

ICMS agencies provide additional support to clients to facilitate the transition to PSH. This includes addressing client-specific barriers to community integration, such as helping a client navigate and get involved in their new community. ICMS staff also described increasing the frequency of contact with clients in the first month or two after the transition to permanent housing. Some agencies have additional supports available, such as an occupational therapy intern who also works with the client on independent living skills during their transition to the PSH setting.

Project-Based Housing

For the first few years of the ODR Housing Program, all PSH was in scattered-site units. There was increasing recognition, however, that a subset of clients was not achieving readiness for scattered-site housing, and other clients experienced difficulty in retaining their scattered-site housing placement because they required additional supports. For these reasons, ODR Housing

began developing project-based housing sites. As noted earlier, project-based housing includes onsite case management support. At the time the interviews were conducted, there was one small project-based site and several more in development. During the ODR provider meetings and interviews, ICMS agencies discussed the types of clients that might be prioritized for project-based housing. These included individuals who had higher-acuity mental illness, who required more prompting to maintain their units, who had difficulty remembering to take their medications, or who tended to do better when not socially isolated. Each project-based housing site was designed to be overseen by a single ICMS organization, which would have onsite staff available to residents. Program staff anticipated that the housing-readiness threshold would likely be somewhat lower for these clients. For some clients, project-based housing might be a stepping stone to scattered-site housing, but for others, it might be their permanent housing setting.

Residential Care Facility

Some ODR Housing clients have significant clinical needs that require a higher level of care. For these clients, PSH may be in the form of a licensed residential care facility, which is enriched with onsite mental and physical health services. Depending on the availability of beds, some clients are able to immediately enter a residential care facility upon release from jail, while others first spend time in an interim housing setting. At the time of the interviews, ODR had begun shifting away from a reliance on beds in the existing network of residential care facilities in Los Angeles County. Instead, it was beginning to develop its own residential care housing with intensive onsite services, in part to meet the need for more placement spots.

Permanent Supportive Housing Retention

Though PSH is available to ODR Housing clients for life, there are circumstances under which a client may lose housing. First, clients may be evicted for lease violations, such as altercations with other building residents or a failure to maintain the unit. Second, there are times when a client's clinical acuity interferes with the ability to maintain housing. One staff member described a time when the clinical team recommended that a client relinquish a unit due to decompensation. A situation like this may also be an indication that a higher level of care is needed, such as through a residential care facility or a sober-living center. Finally, some clients are reincarcerated. Though an effort is made to retain client units while they are incarcerated, there are circumstances (e.g., being sentenced to a longer period of incarceration) under which individuals may lose their existing units and have to search for new units upon their release. There may also be times when a client is not reinstated to the program after a rearrest or incarceration, which may result in losing their housing unit. More detail on rearrest and program reinstatement is provided in the next section.

Rearrest and Program Reinstatement

Despite the substantial supports provided to clients in this program, a certain number of clients are rearrested while in the program. The circumstances of rearrest vary. Some clients are not compliant with the conditions of their probation, or they leave their housing without notice. Staff noted that when clients leave their housing without notice, it is often in the 24 hours after release. Substance use can be another issue; for example, one provider described how individuals who begin to lose control over their use can become less engaged in treatment, violate the conditions of their interim housing, and ultimately walk away from the program. When someone leaves housing without notice, a bench warrant is issued. Program staff noted that, consistent with harm reduction approaches, they attempt to clear the warrant and are sometimes successful but that other times the client returns to custody. Clients may also be rearrested on new charges and return to custody.

In the case of a bench warrant or rearrest for a less serious charge, ODR will review the case with the relevant providers to determine if there are ways they can better support the client; they might determine, for example, that a client's medications should be adjusted, medication adherence is an issue, or a higher level of care is needed. The client will return to court, where any new program conditions will be discussed, and the judge will decide whether the client should be reinstated to the program. Of note, ODR staff described making a significant effort to maintain clients in the program, even after multiple violations, in keeping with its harm-reduction approach. Staff noted that as long as program staff and the judge can identify ways that services can be adjusted, clients will be reinstated in the program; some clients have had as many as five reinstatement hearings. Whether a client returns to the program after being arrested for a new felony charge generally depends on the severity of the charge and whether the district attorney and judge agree to reinstatement.

If the court determines that a client can be reinstated, a plan is made for a return to housing. One staff member noted that returns to incarceration are more common among clients in interim housing, because those who have reached PSH are often more stable and higher functioning. Interim housing sites try to hold beds for individuals who are rearrested, although there may be cases in which it is not appropriate for the client to return to the same site (e.g., if there have been altercations with housing staff or residents). In the event that a client in permanent housing is rearrested, the program will work with the judge and district attorney to see if returning to ODR housing placement is an option. Similarly, the program makes efforts to place a client with the same ICMS agency unless there are circumstances suggesting that it would not be appropriate. Some ODR clients are referred by a judge to residential substance use treatment programs as a result of reinstatement hearings. Residential substance use treatment beds are a resource of the Department of Public Health's Substance Abuse Prevention and Control (SAPC)

and are not easily accessed by ODR. There are relatively few substance use treatment beds available in the community, so it is often very difficult to link someone to treatment directly from custody.

Communication Among ODR and Partner Agencies

Given the number of organizations involved in providing services under ODR Housing, communication is key. Discussions with staff highlighted the many ways that organizations stay in communication with each other. First, though ODR administers and oversees the program, staff members described the development of policies and practices as collaborative, with ODR willing to consider input from those directly serving clients. Second, there are regular meetings that provide an opportunity for interagency communication. These include weekly meetings between ODR staff and housing providers, biweekly meetings between ODR staff and ICMS providers, and monthly meetings with ODR staff, ICMS organizations, and Brilliant Corners. These meetings were increasingly being used as a forum to identify and discuss barriers and solutions to serving clients. There were also monthly telephone calls with ODR, ICMS agencies, and Brilliant Corners, largely serving as an opportunity for ODR to share information. The partner organizations also communicate regularly with each other; for example, one staff member described weekly meetings between Brilliant Corners and the ICMS agencies, and another staff member indicated that interim housing staff send weekly emails to ICMS agencies with information about client medication adherence.

Finally, staff across the different agencies described frequent ad hoc communication with each other. This included near daily communication with court judicial assistants to schedule hearings; daily communication between ODR and ICMS agencies to address client issues (e.g., delays in jail release, clinical needs, housing concerns); contact between interim housing staff and ICMS, FSP, and ODR staff to discuss client concerns (e.g., if a client has a specific need that needs to be addressed); and ad hoc communication between ICMS and FSP clinical staff. ICMS agencies and Brilliant Corners collaborate to find suitable units for clients, discuss housing concerns (e.g., landlord issues), and situations in which a client has been rearrested and may not be in housing for a period of time. Frequent communication appeared to be the norm, occurring in person, via telephone, and via email.

Resources Required to Operate ODR Housing

Significant resources are required to operate a program like ODR Housing. Although a formal cost analysis or budget impact analysis was not within the scope of this project, we were able to identify important resource categories involved in the operation of the ODR Housing Program. This can provide useful information about the resource “ingredients” involved in program implementation (Levin and McEwan, 2000). Decisionmakers in other jurisdictions

considering investment in programs like ODR Housing can use local price data to estimate the potential budget impact of the program in their jurisdiction.

It is important to recognize that research on the economic benefits of supportive housing programs has been largely equivocal (Aubry et al., 2020; National Academies of Sciences, 2018). Many studies have focused on short-term "cost savings" resulting from reductions in medical or social services, which can be difficult to achieve with such a high-need and chronically underserved client population. Indeed, the suggestion that supportive housing programs should be expected to produce cost savings has been rejected on ethical grounds (Kertesz et al., 2016; National Academies of Sciences, 2018). Thus, we present this resource information for the purposes of budget planning in jurisdictions committed to housing individuals with longstanding homelessness, criminal justice involvement, and chronic health conditions.

For our project, we identified important resource categories by obtaining details through program staff interviews and follow-up conversations with program and stakeholder leaders. In the year that we began collecting this information about resource use (i.e., calendar year 2019), the ODR Housing Program enrolled 856 new clients and was thus providing services to well over 1,000 clients annually (when including clients enrolled in previous years who continued to receive services) (Los Angeles County Department of Health Services, 2020b). Table 3.2 lists each resource "ingredient," along with details about which entities incur the expenses and which ODR Housing Program activities (as described in Figure 3.1) are involved. We identified resources from the perspective of Los Angeles County (which funds ODR), so those resources that involve partnering noncounty organizations (e.g., ICMS agencies) are presented as contracts rather than being fully itemized. Also, regarding personnel, ODR was unable to provide a program-specific breakdown of employee effort by program, because staff provide effort to other ODR and county initiatives beyond this Housing program. Thus, we list the number and type of ODR employees who work on the ODR Housing Program, but these data do not necessarily represent full-time equivalent positions, and other jurisdictions may find a different mix of positions fits best with their specific programming. Finally, the ODR Housing Program required participants to enroll in other county services (i.e., mental health, probation), which can have budget implications; the potential cost offsets/increases associated with those services are also listed, since ODR Housing is a county program.[8]

[8] We were unable to quantify Sheriff's Department resources as part of this description, although Sheriff's Department staff coordinate with ODR and ICMS staff in preparation for jail release.

In March 2021, a report submitted to the Los Angeles County Board of Supervisors projected the treatment and housing cost estimates for enriched residential services and permanent supportive housing (see Table 3.1; Los Angeles County Department of Health Services, 2020a). These projected estimates included the costs to ODR and associated DMH costs and were developed by the working group that authored the report. A report submitted to the Los Angeles County Board of Supervisors in November 2021 provided the treatment and housing cost-estimates for interim housing (Los Angeles County Department of Health Services, 2020a). These estimates exceed the supportive housing costs typically associated with targeting populations not involved in the criminal justice system; for example, Los Angeles County's Housing for Health program costs were estimated to be less than $20,000 per year (Hunter et al., 2017). Of note, the Housing for Health program, which identifies frequent users of the health system experiencing homelessness, pairs ICMS with PSH. It does not have a bridge mental health service component like the ODR program, for example, and has a higher case-management-to-client ratio.

Table 3.1. Annual Treatment and Housing Cost-Estimates

	Enriched Residential[a]	Interim Housing[b]	PSH[a]
Annual Treatment Costs	$39,200	$25,185	$28,200
Annual Housing Costs	$45,625	$32,120	$38,325
Total Costs	$84,825	$57,305	$66,525

[a] Los Angeles County Men's Central Jail Closure Workgroup, 2021.
[b] Los Angeles County Department of Health Services, 2020a.

Table 3.2. Resources Required for Operation of the Office of Diversion and Reentry Housing Program

ODR Housing Resource	Role with ODR Housing Program	Amount[a]	Expenses Incurred by	Program Stage(s) Involved[b]
ODR Personnel[c]				--
Director	Oversee all operations	1 position	ODR/DHS	All/general
Deputy Director	Assist director in overseeing all operations	1 position	"	"
Medical Director	Oversee overall program operations	1 position	"	"
Director of Clinical Programs	Oversee client eligibility assessment and enrollment, collaborate with service provider team	1 position	"	"
Director of Housing	Oversee operation of interim housing sites, provide oversight and support of contracts with ICMS providers, develop PSH supply	1 position	"	"
Program Specialist	Provide clinical oversight to potential and enrolled clients, coordinate links to other service providers	3 positions	"	"
Staff Analyst	Oversee caseloads and track client statuses	4 positions	"	"
Psychiatrist	Conduct clinical eligibility assessments, supervise psychiatry residents, address prerelease client medication needs, consult with housing and ICMS providers	3 positions	"	Screening for eligibility, ODR Housing services (if delays with mental health services in community)
Psychiatry Residents	Conduct clinical eligibility assessments, provide bridge psychiatry services prior to client assignment to FSP	Variable number of part-time positions	"	"
Nurse Practitioners/ Registered Nurses	Oversee the medication provided in the interim housing sites and their nursing staff; administer some medications (e.g., long-acting injectables)	Variable, depending on the needs of interim housing sites	"	Interim housing

ODR Housing Resource	Role with ODR Housing Program	Amount[a]	Expenses Incurred by	Program Stage(s) Involved[b]
General administrative expenses associated with program operation		Percentage of overall expenses	ODR/DHS	All/general
ODR Facilities and Administration (overhead)	Represent client's needs and desires with respect to enrollment	Hourly rate	Legal organization	Screening for eligibility, suitability hearing
Public Defender/Legal Aid Court Costs	Court holds hearings to make assignments	Per hearing	County court	Suitability hearing
Intensive Case Management Services	Support clients in their transitions into supportive housing, their links to other services, and their achievement of goals; provide bridge mental health services	Monthly rate paid by ODR; rate is enhanced to allow lower caseloads for these case managers	ICMS provider (via contract with ODR)	Conditional release, jail release, interim housing, PSH placement
Interim housing services	Provide a supportive environment for clients to achieve readiness for PSH	Operated by ODR; if not, monthly rate paid by ODR	ODR/DHS or interim housing provider (via contract with ODR)	Interim housing
PSH Services (unit holding fees, rent, move-in expenses, repairs, staff, and operating expenses)	Work with clients to identify, secure, and successfully transition into permanent housing in the community	A bill is sent to DHS for actual expenditures	Board and Care (via contract with DHS)	PSH placement
Board and Care Housing	Provide clients with a higher level of long-term support for their medical and behavioral health	ODR provides a monthly payment to enhance the Supplemental Security Income licensed-care rate	Board and Care provider (via contract with ODR), Social Security	PSH placement
Mental Health Services	Address client mental health needs and promote their mental health	Potential cost offset/increase for county	DMH	Jail release, interim housing, PSH placement

ODR Housing Resource	Role with ODR Housing Program	Amount[a]	Expenses Incurred by	Program Stage(s) Involved[b]
Substance Use Treatment Services	Address client needs related to substance use and promote healthy approaches to substances	Potential cost offset/increase for county	SAPC, Department of Public Health	Jail release, interim housing, PSH placement
Probation Services	Monitor client legal status and enforce compliance with terms of release	Potential cost offset/increase for county	Probation	Jail release, interim housing, PSH placement

[a] Resource use is based on the ODR Housing Program operations in 2019–2020.
[b] Activities listed correspond to those illustrated in Figure 3.1.
[c] Positions listed are for all ODR employees who work on the ODR Housing Program; they do not necessarily represent full-time equivalent positions. We did not obtain a program-specific breakdown of employee effort by program.

Ongoing Changes to the ODR Housing Model

Based on our discussions, we found that the ODR Housing Model has been constantly evolving in response to provider input, client needs, and the expansion to other court hubs in Los Angeles County. The program also changed in certain ways as a result of the COVID-19 pandemic. Although the majority of our data collection with staff took place before the pandemic, those conversations and ongoing discussions in early 2021 gave us insight into ways that the program continued to evolve during the pandemic.

First, as a result of the pandemic, ICMS providers were not allowed to meet with clients in Los Angeles County jail facilities. ODR was also working to release clients from custody over a shorter timeline because of the risks to their health in jail custody. Once released, rather than going directly to their interim housing sites, clients were transported to a "reception site" established by ODR to be tested for COVID-19. Clients who were outside of congregate settings for more than three days also went to these reception sites to be tested before returning to housing. As another response to the pandemic, ODR Housing started to perform ongoing surveillance testing, which involved testing 20 percent of the staff members and clients for COVID-19 on a weekly basis. When individuals tested positive, they were isolated from other program staff and clients.

Despite the pandemic, the program has continued to grow. ODR staff stood up 200 new beds within two weeks to accommodate the increased jail releases that occurred during the first few months of the pandemic. New sites consisted of two specialized quarantine and isolation locations and four sites that conducted COVID-19 admissions directly from the jail before moving individuals into placements. ODR Housing also set up a surveillance regime for testing and an outbreak management system, and it vaccinated approximately 3,000 people as vaccines became available. Between December 2019 and January 2021, the program enrolled more than 860 new clients (Los Angeles County Department of Health Services, 2019; Los Angeles County Department of Health Services, 2021). The program continued to standardize protocols regarding medication management and medication call at the interim housing sites. They also established new "interim housing plus" sites for higher-need clients, such as those who were having difficulty in existing interim housing sites or were at risk for being remanded to jail. These interim housing sites had a psychiatrist onsite weekly, and the possibility of adding other integrated services (e.g., onsite groups) was under discussion. Finally, ODR was collaborating more formally with the FSP program to ensure more availability of treatment spots for ODR clients.

Summary

This chapter provided an overview of the ODR Housing Program by describing the client pathway through the program, including the initial determination of eligibility, the services offered, and the transition from interim to supportive housing. In the next chapter, we examine provider perspectives on the implementation of ODR Housing.

4. Provider Perspectives

To explore the factors that facilitated the implementation of ODR Housing, as well as challenges to implementation, we conducted a series of provider interviews. As described, interviews were conducted with 15 staff members from ODR, ICMS organizations, and organizations involved in providing interim housing or PSH. Our analysis was based on the CFIR, a commonly used implementation framework that characterizes how a program's implementation is influenced by characteristics in five major domains: (1) the intervention (i.e., the ODR Housing Program), (2) the individuals delivering it (i.e., the employees of ODR and partner agencies), (3) the "inner setting," or within-organizational contexts (i.e., the ODR setting), (4) the "outer setting," or extra-organizational contexts (i.e., Los Angeles County and the various ODR partner-organization settings), and (5) the process of implementation. Using this framework allowed us to capture implementation themes specific to the ODR Housing Program and staff, but it also helped to determine the influence of external factors (e.g., the broader system of care in Los Angeles County, the capabilities of contracted organizations). Our goal was to capture the range of factors that influence the implementation of the ODR Housing Program. In all, we identified 43 themes and subthemes that spanned all five CFIR domains; 18 (42 percent) were facilitators and 25 (58 percent) were challenges. In the subsequent sections, we summarize the findings by CFIR domain, including exemplar quotes for each theme or subtheme in the accompanying tables. The order in which the items are presented does not convey salience or prevalence.

Intervention

We identified six themes (plus two subthemes) related to characteristics of the ODR Housing Program itself (Table 4.1). First, staff noted key strengths of the program. The housing-centered approach was described as important, because the program is designed to offer clients a pathway to permanent housing, which is a key goal for promoting clients' long-term stability. Given that the program is initiated in jail, interviewees also found it helpful that ODR provides clients with long-term care, oversight, and funding (for services and housing), from jail release through all interim and permanent housing placements. Moreover, the wraparound support that clients receive—such as case management, transportation, behavioral health services, medical services, and vocational services—was viewed as critical to clients maintaining housing. Feedback on the wraparound model was more mixed, however, as staff identified challenges related to coordinating so many providers. Some interviewees also felt that the wraparound services largely focused on clinical problems and could do more to promote clients' integration and functioning in the community, such as assisting with vocational opportunities and prosocial network-building.

Other challenges related to the ODR Housing Program model were identified as well. One area for improvement was the need to better match the level of support provided in PSH with clients' ongoing needs; interviewees acknowledged that some program clients likely require long-term supports at a level similar to that provided in interim housing (e.g., onsite staff) and may therefore have more trouble in a scattered-site housing setting. Though the development of project-based PSH was in progress at the time we conducted the interviews, those housing sites had not yet opened. Another challenge is that a subset of clients leave housing and drop out of the program, often very early in the postrelease process. Currently, there is little understanding of why this is happening and how to prevent it. Finally, because clients are assigned to the program by the court, continued oversight from court and Probation can be used to influence client behavior (through the potential of legal consequences for not following the conditions of their release). This was described as a facilitator by providers, but we also acknowledge the risk of coercion or punitiveness present when involving Probation in a rehabilitative program.

Table 4.1. Intervention Domain Themes and Exemplar Quotes

Theme/Subtheme	Type	Exemplar Quote
Housing-centered approach	Facilitator	"One thing I especially appreciate about ODR Housing is the fact that housing is a stable component . . . they have housing when they are released from custody, and so if they engage in treatment in a meaningful way, then there is independent housing lined up for them as well." (ICMS provider)
ODR services follow clients	Facilitator	"We really have great access to the clients at every stage—[in] jail, we stay involved when they come through court, in housing, and we stayed involved when they come back through again. . . . Because we're really involved at every level, we understand [their needs] and can address them better." (ODR staff)
Wraparound service model	Facilitator	"People come here with so much support. They have ICMS, FSP, our case managers, and our nurses. They come in with all these services wrapped around them. It's almost impossible for them to fail." (SH provider)
Coordination challenges	Challenge	"I wish the emails weren't too many, but when you have a lot of people involved, there are always going to be about 50 emails a day. They're so intense and so many." (ICMS provider)
Lack of community focus	Challenge	"I also think that there's some opportunities to have stronger, financially supported community-integration work that is about folks really feeling connected to where they're at. . . . It's not just about 'Are we keeping you housed?' because that's what [we do], but 'Are you really able to thrive?'" (SH provider)
Difficulty matching permanent housing supports with client needs	Challenge	"We have been operating for several years with a kinda one-size-fits-all housing. . . . We have clients who are in interim housing for quite some time; they like it there. How do we build people toward independence and provide the pieces that provide value?" (ODR staff)
Early attrition	Challenge	"ODR will see a bunch of people leave the house within the first hour, the first minute, the first couple days. . . . I don't know the best way to tackle that." (ODR staff)

Theme/Subtheme	Type	Exemplar Quote
Justice-system oversight	Facilitator	"Through adult-to-adult relationships and meeting people where they're at, hopefully we don't have to use that, but given the nature of the program, [probation officers] can be a resource." (ODR staff)

NOTE: SH = supportive housing (interim or permanent).

Individuals

There were relatively few references to individual provider characteristics in our interviews, but two themes and one additional subtheme were identified (Table 4.2). The main facilitator described was the presence of exceptional staff members across ODR and its partner organizations. Characteristics that made staff exceptional included high levels of dedication to clients and staff having relevant history and experience (e.g., coming from the communities and/or populations being served). The considerable support provided by ODR and its partner organizations to staff was also noted. Interviewees acknowledged, however, that recruiting and retaining exceptional staff can be difficult, in light of the challenges faced in these positions—such as burnout and the challenges involved in working with clients who have serious mental health concerns and a long history of unstable housing and traumatic experiences. Staff also expressed a desire for more training in clinical issues (e.g., mental health problems, substance use) that are prevalent in the ODR Housing client population.

Table 4.2. Individual Domain Themes and Exemplar Quotes

Theme/Subtheme	Type	Exemplar Quote
Staff are dedicated and represent the communities being served	Facilitator	"We hire from within the community, so they have relationships already built with those neighbors. So we can keep [neighbors] calm, and they can contact us directly if they see anything or have any concerns, and we'll be on top of it." (SH provider)
Staff-retention challenges	Challenge	"Our line staff—in particular our case managers who have the daily face-to-face contact with the clients—if working with one or multiple clients who aren't connected to a mental health provider other than use and the client needs it, we find a lot of staff get burned out easily." (ICMS provider)
Staff training in clinical issues	Challenge	"One struggle we've kind of consistently had with housing is having staff that's trained and equipped to deal with the client base . . . so working on de-escalation tactics, and understanding mental health on a deeper level." (ICMS provider)

NOTE: SH = supportive housing (interim or permanent).

Inner Setting

In this analysis, we restricted the inner (i.e., intra-organizational) setting to characteristics of ODR, as they are the originators of the ODR Housing Program and oversee its implementation.

Of course, numerous other organizations are involved in implementing ODR Housing Program activities, which underscores the dynamic and fuzzy boundary that often separates inner versus outer setting, especially with complex, collaborative programs like this. Notwithstanding, we identified four themes related to ODR characteristics (Table 4.3).

ODR was described (both by its own employees and by ICMS/supportive housing collaborators) as having numerous strengths. The staff were considered highly collaborative and communicative, which supported program implementation and relationships with other organizations. ODR program leaders were described as effective and highly engaged. The ODR Housing Program's flexibility was identified as another facilitator, as this allowed for timely responses when new programmatic or client needs arose. The main challenge related to ODR had to do with the program's harm-reduction philosophy of care and efforts to do "whatever it takes" for the client. Some staff viewed this as a facilitator, but other staff had divergent views; for example, some reported that this care philosophy was "too lax" and didn't allow the enforcements necessary for client success, whereas others described the approach as being overly rigid and not giving clients sufficient chances when they made a mistake. In sum, a unified view of the philosophy of care did not emerge across interviewees.

Table 4.3. Inner-Setting Domain Themes and Exemplar Quotes

Theme/Subtheme	Type	Exemplar Quote
Effective and collaborative ODR communication	Facilitator	"ODR is transparent and accessible. They're not in an ivory tower where we can't get ahold of them. . . . I think that has a lot to do with the success. They are on the ground, they are hands-on. We really appreciate that." (SH provider)
Effective and engaged leadership	Facilitator	"My leadership, the people who work with ODR housing, do a fantastic job of clearing the way for us to be able to do the job. So they're really dealing with political things, I'm rarely aware." (ODR staff)
Program flexibility	Facilitator	"There have been meetings where we scrap what we're doing and start something new. There's a structural thing in place that allows for that kind of nimbleness . . . and ODR is a partner." (SH provider)
Disagreement regarding philosophy of care	Challenge	"ODR is liable ultimately for clients' success, so more control means peace of mind, but I don't think that is a lasting effect. . . . You need to teach how to fish, and [to do that], you don't need to give people the fish, you got to let them make mistakes." (ICMS provider)

NOTE: SH = supportive housing (interim or permanent).

Outer Setting

For purposes of our analysis, "outer setting" refers to extra-organizational contexts—that is, the Los Angeles County system of care, including the various ODR partner organizations that provide case management and housing. This domain had, by far, the most themes, which is unsurprising given that ODR Housing serves a high-need client population and involves

coordination among numerous service organizations. We identified eight outer setting themes and an additional 13 subthemes (Table 4.4).

One major theme was that the program is addressing important client population-level needs around housing, psychiatric care, and connection with social services. This was seen as positive, though it was noted that there is a subset of clients who do not successfully advance through the program, especially those who do not do well in interim housing due to substance use and/or mental health problems. It was also noted that safe and affirming housing options are extremely limited in Los Angeles County for sexual- and gender-minority individuals, especially transgender clients. A related theme was the fact that some clients are rearrested (sometimes repeatedly) while in the program, again often as a result of difficulty managing their substance use and/or mental health problems. The purpose of the program is to prevent future criminal justice involvement by managing these issues in the community, but when law enforcement gets involved and rearrests a client, this disrupts their relationships and services within the community (i.e., the client "starts over," to some extent, upon the next release). A final related challenge is that clients often encounter stigma from a variety of sources (e.g., landlords and neighbors in the community, medical providers) due to their mental health, gender-/sexual-minority orientation, and/or criminal justice background; this can impede their progress in stabilizing and obtaining permanent housing.

Two other themes related to connecting clients with needed services once they enter the program: unfortunately, community-based treatment services for substance use (provided through the Department of Public Health) and mental health (provided through the DMH FSP) are limited, even though these services are seen as key to the program. These treatment gaps have been a longstanding challenge in Los Angeles County and have been identified by multiple workgroups and reports to the County Board of Supervisors in recent years. Both types of services were repeatedly mentioned as a challenge to obtain for clients; substance use treatment services were often described as inappropriate or unhelpful, whereas mental health services were described as not having enough capacity to take on clients. On the other hand, staff reported that Los Angeles County offers access to a robust social safety-net system for clients (e.g., Social Security, Medi-Cal, County Benefit Entitlement Services). This factor was broadly described as a facilitator, though specific challenges were noted, including delays in accessing these benefits upon release from jail and the fact that undocumented immigrant clients are not necessarily eligible.

Another two outer-setting themes were related to the relationships among partner agencies (i.e., ICMS, interim housing providers, Brilliant Corners, the permanent housing provider) and between these partner agencies and ODR. In general, partnerships with ODR were described as strong, built on the foundation of collaboration and communication described earlier. However, numerous challenges were also noted, such as different approaches to client services, communication difficulties, insufficiently specified service contracts, and contracted service providers sometimes feeling micromanaged by ODR. Large bureaucracies like DMH and Los Angeles County Jail were noted as especially difficult for ODR and their partner agencies to collaborate with. In terms of relationships among service providers, two challenges were noted. One was that substance use and mental health services are highly siloed in Los Angeles County, such that it is difficult to get a well-coordinated response for clients with co-occurring disorders. This reflects a broader coordination challenge in Los Angeles County, but it affects ODR Housing clients given their prevalence of co-occurring disorders. The other challenge is that ICMS agencies encounter difficulties coordinating with other organizations—in particular, with defining where their role with ODR Housing ends and the other agency's role begins (especially if the other agency also provides some case management).

Finally, funding was described as an important facilitator to ODR Housing, given the intensity of services provided and the concomitant resource needs. In general, funding for the program was described as robust, and the fact that the program can pay partners based on an expected number of clients or slots (rather than on a fee-for-service basis) was seen as advantageous. However, a few partner agencies expressed a different view of the payments they received, stating that the funding was not sufficient for the intensity of services expected. Moreover, concerns were noted about the sustainability of funding from current sources.

Table 4.4. Outer-Setting Domain Themes and Exemplar Quotes

Theme/Subtheme	Type	Exemplar Quote
Addressing important needs	Facilitator	"There's clearly a homeless crisis. This [program] needs to be expanded. It's clearly showing results. . . . Why is it only in LA county?" (SH provider)
Some subgroups need more care	Challenge	"The ones that can't make it through the program are probably our most severe cases. They need a higher level of care—that's either drug rehab or something like that. It's mostly drugs. Sometimes a mental health issue. . . . " (SH provider)
Lack of resources for LGBTQ+ clients	Challenge	"There are participants who should not be in the South LA area, when you are transgender. . . . We only have one transgender/LGBTQ+ interim housing. So it can be a challenge because there may not be room. Why do we wait until someone can be assaulted or can land in the hospital?" (ICMS provider)

Theme/Subtheme	Type	Exemplar Quote
Limited community-based mental health and substance use treatment services		n/a
Substance use services	Challenge	"The one thing I'd love for us to get good at is substance use treatment. We don't have a lot of options, and a lot of the clients struggle with it. It's really kinda depressing that we don't have that much that can meet the needs." (ODR staff)
FSP slots	Challenge	*FSP slots is a huge problem. What that means is that you can't use state Medicaid . . . to treat one of the highest need populations, because the department that can bill Medi-Cal says it's full and can't create capacity*.[a] (ODR staff)
Assistance with benefits	Facilitator	"ICMS services include taking the client to DPSS to get Medi-Cal or general relief reactivated or created from scratch." (ODR staff)
Delays with benefits	Challenge	"[The] most vulnerable time for all these clients is postrelease, because they don't have their insurance turned on. Before we developed a system with our pharmacy, [some clients] wouldn't get meds upon release or would have a 30-day supply." (ODR staff)
Undocumented clients lack some benefits	Challenge	"For our undocumented folks, housing isn't an issue, we are still able to utilize [permanent housing services]. But not having Medi-Cal, it's difficult to find treatment for them, sometimes finding appropriate medications to use." (ICMS provider)
Interagency partnerships involving ODR		n/a
Strong partnerships	Facilitator	"[ODR understands that it's] important to power-share and let their nonprofit partners in the room be honest about what's working or not working without fear of our contracts being cut." (SH provider)
Partnership challenges	Challenge	"I think within ODR, we're very communicative and able to address things, but we have to partner with huge bureaucracies, and I don't know how that works for [the clients]." (ODR staff)
Relationships among partner agencies		n/a
Substance use and mental health siloes	Challenge	"There aren't facilities in LA that are really equipped to deal with co-occurring disorders. . . . [Most require] that they are 'ready,' and for most of our clients, they aren't there. And a lot of that relates to where they are with their mental health." (ICMS provider)
ICMS coordination with other agencies	Challenge	"It's hard to provide just case management, be asked to do clinical stuff, then have to tell the FSP you have to do *x* and *y*—they don't like to be told what to do. There are a lot of chefs in the kitchen." (ICMS provider)
Client rearrests	Challenge	"Clients will often get rearrested in the program. May be in interim housing for a couple of months, and then have to start back over and stabilize again. . . . It's a lot of substance use, or not taking their medications as prescribed." (ICMS provider)

Theme/Subtheme	Type	Exemplar Quote
Dedicated funding	Facilitator	"To do this work, it costs money, especially as ODR is continuing to provide PSH for all the clients. . . . It costs money in the long run. Same thing on [the] ICMS side of things—costs money to continue to deliver services." (ODR staff)
Concerns about funding sustainability	Challenge	*This can't be taken to scale. I don't know how sustainable it is unless you can bill Medi-Cal, and you can't bill Medi-Cal in LA County without a passthrough [with DMH].*[a] (ODR staff)
Insufficient funding amounts	Challenge	"I think the program is supposed to be a wraparound FSP program . . . [but] it's not paid as such. The expectations are really high, and we don't get paid for the high expectations." (ICMS provider)
Funding tied to client slots	Facilitator	"ODR has a process or system that is attractive to the provider by providing the necessary funding for these beds. Even if the bed is empty, they still pay. . . . No other agency I know of does that." (SH provider)
Community stigma toward clients	Challenge	"The neighbors might complain and be concerned about having mental health folks in their community, and that they are protected and safe." (SH provider)

NOTES: SH = supportive housing (interim or permanent); LGBTQ+ = lesbian, gay, bisexual, transgender, and other queer; DPSS = Department of Public Social Services.
[a] Quote is paraphrased from interview notes because we were not able to audio-record the interview.

Process

Lastly, we identified six themes and four subthemes related to the ODR Housing implementation process (Table 4.5). An important challenge has been the availability of appropriate housing options: there has not been enough housing stock to meet program demand, with interim housing noted, in particular, as causing bottlenecks that increase clients' length of time in jail. There is also a need for more project-based PSH options, which provide more supports for clients than does scattered-site housing. A notable facilitator in this area is that ODR has worked to ensure more housing-site availability (including opening ODR-specific interim housing and PSH sites that they manage) and has expanded housing options into more areas of Los Angeles. As part of this expansion process, another important facilitator has been ODR's ability to partner and build relationships with local communities in advance of opening new housing options.

More generally, interviewees described how ODR Housing has rapidly grown as a program in the past few years. Overall, this was described as a facilitator and indeed a welcome surprise in contrast to initial projections for success. However, rapid growth has also brought challenges, as ODR and partner agencies need to continuously add staff and sites to keep pace with program scale-up. Another challenge related to continued growth is the extensive initial effort needed to get court and probation stakeholders to buy into the program and refer clients; although this is no longer a challenge in the courts where they currently operate, staff described having to begin these

efforts again with each expansion to a new court. From our follow-up discussions with ODR, we gathered that a need for additional funding and resources was a key part of this challenge.

With the ODR Housing Program having existed for only a few years and undergoing rapid changes, ODR staff and partners are still learning what is needed to make the program successful, and they have actively sought regular evaluations and feedback as they expand. The program is not only relatively new, but is also complex, which interviewees indicated required more problem-solving than many other programs they had experience with. Finally, one area of learning that has coalesced for ODR is in regard to the helpfulness of consolidating key roles under their direction. For example, ODR has taken over housing-assignment activities from another county program (Housing for Health) and collaborates in the hiring of clinical staff for their partner organizations. This allows for greater oversight and consistency in how the program operates while streamlining the number of partner organizations, where possible. Relatedly, in response to client needs and a lack of available supports from other sources like DMH FSP, ODR has also emphasized increasing clinical supports in all program activities over time. This has included, for example, funding mental health providers within ICMS agencies to ensure continuity of services while clients wait for an FSP slot (an effort to address the concern about limited slots for services in the Los Angeles County system of care) and modifying caseload ratios from 1:20 to 1:15.

Table 4.5. Process Domain Themes and Exemplar Quotes

Theme/Subtheme	Type	Exemplar Quote
Housing availability		n/a
Not enough housing	Challenge	"When we grew, we didn't have the housing in place. Making sure resources meet the need or match the demand—that's been hard." (ODR staff)
Need for project-based housing	Challenge	"My feeling—and I think it's the feeling of the office—is that more project-based housing [is needed] . . . housing that has all services onsite so it's not a fractured treatment team." (ODR staff)
Increased program-specific housing	Facilitator	*We also have coming online our own Board and Care. . . . We've worked for a year on getting this up and running—that's the ideal thing, 100 percent control and by our design*.[a] (ODR staff)
Community relationships	Facilitator	"We are doing better in communities; communities are becoming more welcoming. [The Housing Director] does a good job of making sure neighborhoods feel they are supported." (ODR provider)
Rapid growth	Facilitator	*Word got out pretty fast that we had "special sauce" and it was working . . . we don't want justice by zip code, we want access to the resource across the county. And the push came from the Superior Court itself*.[a] (ODR staff)
Continuous scale-up	Challenge	"The program is growing, and it's growing really rapidly, and so at times we're just trying to keep up with the number of clients that are coming out [of detention]." (ICMS provider)

Theme/Subtheme	Type	Exemplar Quote
Justice-system buy-in	Challenge	"The biggest thing is finding judges who are willing to have ODR courtrooms, willing to put these clients on probation in the community, work with them from reinstatement to reinstatement, so probation is satisfactory." (ODR staff)
Ongoing learning	Challenge	"I think for the most part, people are trying their best to meet the needs, but [and this is different from other programs] . . . there are a lot of 'on a case-by-case basis,' where we're all trying to go in and very much problem-solve." (SH provider)
Consolidating roles under ODR	Facilitator	"Seeing all the different systems everyone has to interact with . . . [we decided that] if we can subtract one of those off their plate, [we] can bring a lot more oversight. I think that will simplify a lot of our process in the administration of the program in-house." (ODR provider)
Increasing clinical supports	Facilitator	"We had to add a nurse to the team. . . . It's helped a lot because there's a lot of medication stuff going on. . . . When a person isn't doing well or suicidal, you need to talk to them and take them to the hospital. And that's a clinical service." (ICMS provider)

NOTE: SH = supportive housing (interim or permanent).
[a] Quote is paraphrased from interview notes because we were not able to audio-record the interview.

Summary

Our interviews with program staff provided insight into the key facilitators and challenges to implementing the ODR Housing Program. Regarding facilitators, respondents cited the importance of a housing-centered approach and the associated wraparound services. Interviewees also described the critical role of ODR and provider organization staff, including their dedication to the program and strong communication across entities. Strong leadership from ODR was also a key facilitator. Interviewees described the importance of the flexible program model, including ODR's willingness to adapt and build on the program based on feedback from providers and the needs of the clients.

However, there have also been certain challenges to implementing ODR Housing. Though partnerships are a key element of the program, we learned that coordinating across so many organizations can be a challenge. Some interviewees also described opportunities to improve upon existing services, especially for certain client subgroups. For example, some clients continue to benefit from more highly structured environments, and scattered-site housing may not be the right type of PSH placement for these clients. We also learned that there are opportunities to improve care for lesbian, gay, bisexual, transgender, and other queer (LGBTQ+) clients. Finally, connecting ODR clients with the necessary community-based treatment programs has posed a challenge; limited DMH FSP slots and a lack of integrated mental health and substance use disorder treatment programs are two examples of this. Some of these challenges point to potential opportunities for program improvement, and we heard examples of ways that ODR has worked to address some of these challenges. For example, ODR has developed project-based housing options and provided embedded mental health services when FSP slots are unavailable. However, ODR has limited control over many

factors contributing to these challenges, such as those that reflect broader weaknesses in the Los Angeles County system of care. Examples include the countywide need for more intensive substance use disorder services and the need for safe housing options for LGBTQ+ individuals; the latter was highlighted in background memos for the Los Angeles County Alternatives to Incarceration Workgroup (Vera Institute of Justice, 2020a; Vera Institute of Justice, 2020b), which was convened by the County Board of Supervisors to develop a roadmap to support a "care first, jail last" philosophy to care in the County.

5. Client Perspectives on ODR Housing

Our 12 client interviews provided insight into what services they received, which services they found most helpful, and what opportunities exist for improvement. Certain contextual factors are important to know when interpreting these client data. First, all data collection took place after the onset of the COVID-19 pandemic (August and September 2020). Clients' length of time in the program ranged from one month to over three years at the time of the interviews. Some clients (n = 8) enrolled in the program before the pandemic, but some enrolled around the beginning of the pandemic or later (n = 4). The pandemic has affected the nature of services provided to clients; most notably, many services have become virtual to the extent possible. Clients enrolled in ODR Housing pre-COVID-19 were able to describe their pre-COVID-19 experiences as well as the changes that took place in the program. Those who enrolled after the onset of the pandemic, however, do not have a frame of reference for the "typical" operation of the program, which means some of their impressions of the program and its services were likely shaped by the pandemic in ways they may not have even known or been able to articulate. Second, due to COVID-related shutdowns, clients in interim housing were encouraged to stay in their houses as much as possible, and some had access only to the shared telephone at the house. As a result, privacy concerns may have affected their responses in ways that would not have been an issue if in-person interviews had been possible. For example, some clients appeared to be in shared spaces during their interviews, so they may not have felt comfortable being fully honest in their responses or may have provided less detail than if they had been in a private space. Third, there were times during the interviews when it was unclear if a client was referring to ICMS or housing staff. This likely reflects the complexity of the program and, to some extent, what might be perceived as overlapping roles (e.g., clients might have an ICMS case manager and a case manager through interim housing). Finally, the program was designed to serve individuals with serious mental illness and other serious clinical needs. Although many clients did not have difficulty engaging in their interviews, others seemed to be actively experiencing mental health symptoms during the interview process. These symptoms may have affected their responses, though we were careful to code only information relevant to the questions being asked during the interview.

Overall, clients reported that they were very satisfied with their experiences in ODR housing. For example, clients made comments such as, "I've gotten way more out of it than I ever expected" and "It's been really life-changing." We asked clients about their experience with each stage of the program, from enrollment to interim to permanent housing (when applicable), and about their perceptions of the benefits and limitations of the services they received. In this section, we describe the findings that emerged from these interviews, organizing them by the program milestones and services discussed in Chapter 3. We also highlight overall client satisfaction with the program. Key findings from the interviews are summarized in Table 5.1.

Table 5.1. Summary of Key Findings

Program Milestone or Services	Key Themes
Enrollment	• Most learned of the program through defense attorneys. Many were interested in the opportunity to be released from jail and to obtain housing; others were interested in treatment services (e.g., substance use treatment).
Interim housing	• Benefits included the availability of group sessions, meals, and laundry facilities and assistance applying for jobs and completing benefits paperwork. • Challenges included problematic behavior by other residents and the need for additional staff support.
Preparing for PSH	• Clients in interim housing were largely aware of the steps needed to be ready for PSH, such as obtaining their ID, connecting with benefits, and adhering to medications.
PSH	• ICMS providers assisted in the search for housing (e.g., visiting neighborhoods and apartments). • Additional supports for the transition included frequent case manager visits, a chance to become oriented to the neighborhood, assistance with errands, and transportation to service appointments.
Behavioral health services	• Mental health services were well received, though it sometimes took time to establish care and buy into the importance of treatment. • Transitions of care were frequent but not perceived as an issue. • Those who attended substance use groups found them beneficial.
Impact of COVID-19	• Challenges included isolation, reduced employment opportunities, the need for virtual communication with providers, and local COVID-19 restrictions. • Unexpected benefits included perceptions of reduced risk (e.g., for substance use) due to less time spent in the community, and reduced travel time to services.
Rearrest and reinstatement	• Substance use relapse was a common cause of rearrest. • Those who had been arrested were offered the opportunity to re-enroll, though sometimes with additional oversight.
Overall satisfaction	• Most clients were very happy with their experiences. • Clients named several benefits, including obtaining an apartment, needed services, and assistance in improving their lives.

Enrollment

The clients interviewed had largely heard about the ODR Housing Program through their defense attorneys, although at the time, clients were unclear about the particular details of eligibility and the program rules. Although some clients had heard certain details about the ODR program from others incarcerated at the jail, the majority of them initially received the full details from the judge when in court.

Regardless of whether clients were always aware of the full details, they reported being interested in joining because of the prospect of getting out of jail and into housing. Some participants were drawn to the possibility of receiving other services, such as substance use treatment or dental care. Regarding the decision to enroll in the program, one participant said,

> After I heard they give you permanent housing, and they help you with your SSI, and your [General Relief], and then they give you housing, I decided it would be a good choice for me, so I could stay off the drugs and work on myself.

Once they were conditionally released into the program, clients reported that it took anywhere from two weeks to three months until they left jail and transitioned to their first interim housing placement. Some releases were faster because they occurred after the COVID-19 pandemic began, and those clients were sent to isolate in a separate location before being placed in their designated interim housing sites.

Interim Housing

When asked about the most helpful services received in interim housing, participant responses included the availability of group sessions, assistance with filling out job applications and benefits paperwork, and help with ensuring they could attend various medical appointments. Participants were appreciative that meals were included with housing, although those who had been in multiple interim housing placements noted differences in the quality of food provided across placement sites. One client described the support provided by interim housing staff as follows:

> I think that they pretty much facilitate to all our needs. Our needs are taken care of. Our wants are things that we have to work for. So I can't expect them to give me . . . money in my pocket, but they put little incentives out. If you are resident of the month, you get a gift card. . . . They give you something to strive for. . . . And a lot of them have been through things in their lives, so we can always sit and stop and talk to one of them.

Clients who had enrolled in the program more recently (e.g., less than three months) were unsure of the services available to them, including those available through housing, ICMS, and mental health providers. Some clients who had been enrolled for a longer period indicated that it could take from a couple of weeks to a month to be connected to ODR services, sometimes because of their own reticence to genuinely engage with the mental health and substance use treatment services being offered. Clients who were in the program for longer were better able to articulate the services they received as a result of the program.

Regarding challenges experienced while in interim housing, about two-fifths of participants described having difficulties with other residents. These difficulties included situations in which other residents were using drugs or alcohol, which is not inconsistent with a harm-reduction model but can present a challenge to residents who are attempting to stay sober. Other participants described concerns over disruptive or aggressive behavior and felt that staff could have been better prepared to handle some of these situations. A couple of participants cited difficulty in accessing support for basic needs (e.g., clothing, hygiene products) without an income or outside support from friends or family; that said, ODR providers receive funds to purchase clothing and hygiene products, so this may also reflect a lack of understanding on the clients' part as to how to access such supports.

Preparing for Permanent Supportive Housing

Most of the interviewees in interim housing felt ready for permanent housing, although one thought they needed more time sober before they would be eligible. One client referenced a need to complete a checklist provided by ODR before looking for permanent housing:

> They have a list, a checklist, to make sure we have our ID, make sure we have our social security, they make sure we have our income-verification form, and they make sure that we're med compliant. The number one is that we're med compliant . . . once we get all those ducks in a row, then we're ready.

Most participants seemed to know what they needed to accomplish before beginning the search for permanent housing, but at least one participant was unclear why they were still in an interim housing setting.

Permanent Supportive Housing

ODR clients who had been approved for or were already in permanent housing described the process for finding permanent housing. Many reported being supported by their ICMS case managers, who would present them with options, visit potential neighborhoods, and help them settle into their new setting. In addition to finding apartments and setting up interviews with landlords, program staff, including ICMS case managers, helped find furniture for clients' new living spaces and, if needed, clothes and other essentials (e.g., diapers). They also helped set up utilities in the new apartments. As one client said about the transition to permanent housing,

> My case manager showed me around the area, schools nearby, markets nearby, police station nearby, restaurants to go eat. She showed me around, and she asked me if I liked the area and if I was comfortable with the apartment, and [said that if I was not] that I was able to look for another one. But I actually went to two places, and this was the one I chose. So I had options. The guy from ODR helped getting power and utilities set up quickly—he was really attentive and told me to call if I needed anything.

One client had lived in two different permanent housing locations and described the support he received when he had wanted to improve his living conditions by moving—in his first housing placement, his neighbor was sensitive to the noise made by the client moving around his apartment. The program honored his request for a new placement.

At the beginning of their residence in permanent housing, clients reported receiving frequent visits from their ICMS case managers, which was per the program design. ICMS case managers would check in to see how things were going, making sure the client had enough food, for example, or determining if they needed transportation. Participants reported that case managers visited two to three times a week when they first moved into PSH, then returned to weekly check-ins as they settled into their housing. Since March 2020, clients reported that they had not been receiving in-person visits but were instead doing phone or text check-ins with their assigned ICMS providers. Clients also reported that their ICMS case managers helped drive them to group meetings, doctor and therapist appointments, and on other errands. They also assisted clients in

finding jobs. Overall, the clients in permanent housing were extremely happy with the program, and many made some version of the comment, "ODR saved my life."

Behavioral Health Services

Behavioral health services were, for the most part, well received by the clients. Some of the newer clients had not yet received an appointment with a therapist. Other clients described a bumpy beginning as psychiatric medication dosages were figured out and as the clients themselves began to buy into the idea of receiving help for their mental health concerns. Clients who had received group and one-on-one sessions with therapists reported that sessions were helpful, with some clients expressing a preference for one or the other. Other clients cited medication as the most helpful part of their mental health treatment:

> I am getting the right dose of medication. I am happy. . . . The medication the psychiatrist gave me was just dead-on right, it just helped me out so much.

Some clients reported that their care had been transferred across multiple providers since entering the program, though they did not perceive this to affect quality.

Not all clients interviewed were required to participate in substance use disorder treatment; however, a couple of clients reported attending substance use groups even when not required to, because they found it beneficial. In general, clients did not have substantive complaints about these services.

Impact of COVID-19

Because the client interviews took place after the beginning of the COVID-19 pandemic, we asked questions to assess how COVID-19 had affected them. Clients reported that COVID-19 had presented challenges. Clients looking for employment found opportunities drying up, which felt like a setback on their road to recovery. Some case managers were continuing to visit clients in-person, as clients noted that isolation could be a trigger for substance use. One client described a close-call with relapse, indicating that attending 12-step meetings virtually had been a challenge. The client described being able to stay sober by grounding himself using techniques learned through counseling, which included thinking about the progress he had made in the ODR Housing Program (e.g., no longer using drugs or alcohol, having an apartment). Others highlighted how difficult it was to have limited freedom to leave their interim housing settings due to local COVID-19 restrictions, especially after being released from incarceration. As one client stated,

> They had us locked down. . . . I felt falsely imprisoned.

However, there have also been unexpected benefits from the pandemic. One client in recovery in interim housing said the stay-at-home order had been good for her because it eliminated the temptations she experienced when leaving the property:

> It's been helpful to stay inside rather than be outside and getting triggered to use.

Other clients reported appreciating that they had a reason not to leave their apartments or not to have to travel to their ICMS provider's office, now that services were provided virtually.

With the pandemic, certain services also became harder to access, as many offices were closed for in-person visits. In particular, applying for benefits had become more challenging without an in-person option; clients reported sometimes waiting for hours on the phone. Also, clients had to call or email case managers to get ahold of them, instead of just dropping into the office. Although some clients felt like their case managers had been responsive, others expressed having trouble hearing back when they needed services.

Rearrest and Program Reinstatement

A few clients reported that they were rearrested or reincarcerated while enrolled in the program, generally because they'd had difficulty staying sober while in interim housing. For example, when asked about challenges to being released to interim housing, one client said,

> Staying sober [is a challenge]. I first relapsed about four times. I left a couple of days each time.

Clients who described being rearrested or incarcerated did not provide substantial detail about the experience of being rearrested, but they indicated that they were offered the chance to reenroll in the program with the addition of stricter penalties if they got into trouble again. As the same client noted,

> My attorney and my judge agreed that I can't go off the premises at all without permission because of my relapses. Sometimes I just want to go to the market and buy myself some shrimp or coconut juice, and I can't do that. I have to get somebody to do it for me. It's still a lot easier than jail. This is like freedom compared with jail.

Overall Satisfaction and Opportunities for Improvement

Finally, participants were asked if they would make any changes to the program or if they noted any opportunities for improvement. Some clients mentioned the prolonged time between getting accepted into the program and being picked up from jail. Overall, however, clients who had experience with the program were very happy with it. Even a client who expressed dissatisfaction with the level of oversight from ODR and Probation noted that they would likely recommend the program to peers. In general, clients perceived program benefits to be the assistance they received in obtaining their own apartments, acquiring needed services, and improving their lives. One client reflected that potentially the only downside to the program is that a person must get arrested before entering. Another client stated the following:

> I don't think there's anything I'd want to change. I'd probably keep it the same as it was right now. They have services, they help people out with clothes, shelter, help you get jobs, help you get assistance. It's been a good program for people that want to straighten their lives up and get back on track.

Summary

These interviews provided important insights into client experiences in ODR Housing, including those experiences that occurred during the onset and duration of the COVID-19 pandemic. In general, clients were satisfied with their experiences. Many described the benefits of ICMS, particularly as it related to preparing for PSH. Clients also described mental health services as important, even though some experienced multiple transfers of care across providers.

Most clients we spoke to enrolled in the program because it provided a pathway out of jail and into housing. Clients in interim housing seemed to understand the process involved in becoming permanent housing-ready; however, most of the challenges described by clients related to the interim housing sites. Clients who had obtained PSH seemed largely satisfied and described the support they received from case managers for the transition into PSH.

6. Conclusion

This study examined the ODR Housing Program implementation. Though other jurisdictions have implemented similar program models that pair PSH with other wraparound services, such as the FUSE model, this program is unique in certain key ways. First, other FUSE programs have identified clients through different pathways (e.g., upon jail reentry [Fontaine et al., 2012], using a registry of individuals experiencing chronic homelessness (Thomas et al., 2020) through shelters (Aidala et al., 2013). By contrast, ODR Housing is a jail-diversion program, identifying potential participants incarcerated in the Los Angeles County jail system and diverting them through court intervention. In addition, although many other programs reviewed use a Housing First model, ODR Housing clients do not immediately enter PSH. Instead, ODR Housing provides clients with transitional housing upon their release, then delivers ICMS services and connections to mental health treatment to help them prepare for a PSH placement. They have found that this model is most successful, given the significant clinical needs of their clients. Finally, this program is unique by virtue of its relatively large size, having diverted over 3,000 people and now continuing to expand. It is the first program in LA County that has successfully diverted significant numbers of people with serious mental illness, most of whom are people of color, out of the jail and into long-term housing. Longer-term evaluations should be conducted, especially after COVID-19 and as the program expands.

Key Findings

In this section, we describe the findings that emerged from our analysis.

Although having wraparound services and strong communication among partner organizations is important to meeting clients' needs, coordinating these services across multiple stakeholders can prove challenging.

The ODR Housing Program provides wraparound services, including long-term housing subsidies, intensive case management, mental health services, and time-limited community supervision. These services are provided by different county and contracted service providers, which require a significant level of coordination and communication. Both ODR staff and providers described the focus on housing as being critical to the success of the program, as housing is a pathway to long-term stability for clients. They also emphasized that the supportive services, including ICMS and mental health services, are key to clients' ability to maintain stable housing. Likewise, clients indicated that the prospect of obtaining housing was an important reason for participating in the program and described ICMS and mental health services as helpful.

But offering wraparound services doesn't come without challenges. Providers described the frequency of contact that takes place across the organizations involved in this program, indicating that it can sometimes be overwhelming. ODR has scheduled regular communication with the different service provider entities to provide a forum for case conferences, and that was reported to be effective from a clinical perspective, though it required a lot of time and effort by the service providers. Despite the coordination needed across providers, many providers cited effective leadership from ODR and strong communication across the organizations as a key facilitator. They also noted that ODR staff is flexible in response to feedback from contracted service providers, ensuring that the program's services remain relevant and tailored to the population being served.

It is also worth considering the client experience of being served by such a wide range of providers, including the ICMS case manager, interim housing staff, Brilliant Corners staff, mental health providers, and a probation officer. ICMS case managers play an important role in helping clients coordinate and keep track of their appointments and services, and interim housing case managers appear to assist with those coordination efforts. However, the large number of providers and appointments may be difficult for clients to juggle, especially in their early days in the program.

The limited availability of mental health and substance use treatment services through the Los Angeles County DMH and the Department of Public Health SAPC has required the program to fill these gaps, but a lack of integrated services remains an issue.

ODR Housing was designed such that mental health services would be provided through the Los Angeles County DMH FSP program, which provides the highest level of outpatient care available. However, waiting lists for an FSP slot can be lengthy, leaving clients with a gap in needed mental health treatment services. In recognition of this challenge and of the need for continuity of mental health services immediately upon release from jail, ODR has filled this gap by funding bridge mental health providers through the ICMS agencies, even though this comes at greater cost to the program. In addition, some clients noted that they have had multiple mental health providers since entering the program, which might reflect turnover among FSP providers but might also indicate the transition from bridge mental health providers to FSP. Although the clients we spoke with did not necessarily describe this as a detriment to their treatment, having a consistent mental health provider would likely be beneficial, as we learned that behavioral health issues are a commonly cited reason for program exit. ODR has done what it can to address this gap in the broader system of care, but there are aspects of the situation that are beyond their control.

In addition, we found that substance use treatment services were often needed but were much more challenging to acquire and not well integrated into the program service model. More work is needed to fully integrate substance use treatment into the ODR Housing Program. Discussions about colocating mental health support were noted. In addition, follow-up

discussions with ODR indicated it had a program that provided onsite outpatient substance use disorder treatment in interim housing settings through a partnership with the Department of Public Health's SAPC. This effort had to be discontinued, however, following a review from the California Department of Health Care Services (DHCS). Though SAPC continues to work with DHCS, they have not been able to resume these colocated services. Clients reported that some ICMS agencies provided substance use services on an outpatient basis, but it's not clear if a consistent set of offerings is available to all ODR Housing clients. We also learned that higher levels of substance use treatment, such as referrals to residential care, were difficult to access due to the limited availability of treatment slots but could be beneficial to many clients.

Another key issue is the lack of integration of care for health, mental health, and substance use disorders in the Los Angeles County system of care generally. In large part, this is due to the fact that mental health care is provided by DMH, whereas substance use treatment services are provided by the Department of Public Health's SAPC, resulting in siloed services. There may be ways to address this issue; for example, other research at RAND has highlighted the need to train and support county mental health providers to address substance use (Watkins et al., 2021). Similarly, primary care providers have been able to successfully adopt and implement substance use care in Los Angeles County, which includes treatment for individuals experiencing homelessness (Hunter et al., 2018; Watkins et al., 2017). However, this has yet to become a widespread practice, and more resources are needed to support further integration of care for multiple co-occurring conditions that many participants experience.

ODR Housing serves clients with serious clinical needs, and the program model has evolved to maximize success in permanent supportive housing.

Some of the supportive housing literature has emphasized a Housing First approach, placing clients in PSH as a way to help them attain the stability needed to address other concerns (e.g., mental health, substance use, employment). The ODR Housing model is different in that clients first enter interim housing and then formally work with ICMS and interim housing staff to become permanent housing-ready. This includes an emphasis on developing independent living skills, such as medication management and budgeting. Most clients appeared to be aware of the specific achievements they were working toward in order to begin their PSH search. At least one client we spoke with, however, did not have insight into why they had not been recommended for PSH yet, suggesting there may be opportunities to communicate these expectations even more clearly with clients.

Given the significant needs of the clients, the program has continued to evolve to more effectively serve the population. As described previously, this program was first built on the Housing for Health program model that identifies candidates in the county health care system, but key changes have been made since the program's inception. This includes modifying the case-manager-to-client-ratio from 20:1 to 15:1, given the higher needs of the clients. Also, more support for psychiatric bridge mental health care has been provided to ICMS providers, as some

clients are not assigned to a FSP mental health provider upon release due to the lack of available DMH slots. In addition, as the program has been implemented, there has been some recognition that scattered-site housing may not be a suitable long-term solution for many clients who need higher levels of support. The program is expanding its portfolio of higher level of care settings, including project-based housing—where services are provided onsite, so that clients who prefer or need more support can reside there long term.

Clients are largely satisfied with the program, and ongoing provider training will ensure the continued provision of high-quality services.

ODR Housing clients were generally happy with their experience in the program. They described the benefits of mental health and case management services and highlighted the importance of the pathway to housing. From providing support, to starting prerelease, to establishing permanent housing placement, this pathway is considered a key strength of the program by providers and clients alike. Though clients experienced some transition in their case managers or mental health providers, the clients we spoke with were largely satisfied with the services they received. Clients who had been in the program longer seemed to be more aware of the range of services available to them, which suggests it may take time to understand all the moving parts of the program. It might also reflect that more recently enrolled participants were largely receiving services after the onset of the COVID-19 pandemic, which limited in-person services and caused delays.

Clients did raise some concerns about the interim housing sites. These congregate housing sites often have a number of residents (e.g., we spoke with a program that operated sites ranging from about 20 to 40 residents) who commonly share rooms. The clients we spoke with reported concerns about disruptive behavior and substance use on the part of other clients, and some felt that staff could have been better prepared to handle the situations. During our provider interviews, providers frequently emphasized how dedicated the staff members were. However, they also noted a need for additional staff training on clinical issues, such as de-escalation. Interim housing staff may be a good target for these additional training efforts.

Limitations

There are several limitations of this study. The study is based on program observations that took place over a 1.5-year period and on interview data collected over a course of nine months, all of which occurred approximately four to five years after program inception. Although the program was fully implemented at the time of the study, it was evolving during the study period, and after our data collection ended it continued to change—often dramatically due to the COVID-19 emergency. For entities interested in replicating this program model, we encourage you reach out directly to program operators to obtain the most up-to-date information on

implementation. That said, this report provides lessons learned since the program's initial launch and expansion, which could be useful for other regions interested in implementing the approach.

Our qualitative research is limited in a number of ways. Regarding the provider interviews, we do not include perspectives from law enforcement, including the Sheriff's Department and the Probation Department, as these groups were not represented in the program operations meetings we attended. Coordination with these entities is an important part of the program; for example, the Sheriff's Department is involved in coordinating jail release, and clients are under the supervision of Probation for several years. However, these agencies are not providing social services in the same way that ICMS, interim housing, and Brilliant Corners are. In addition, we had challenges recruiting staff in the interim housing programs, in part because this recruitment took place in the early stages of the pandemic, when organizations were focused on adapting to the emergency situation.

Regarding client interviews, we relied on program staff to advertise the opportunity for clients to participate in our data collection, so it is possible that the recruitment effort was biased in a number of ways. We were able to partner with only one ICMS agency and one interim housing organization for recruitment. Though we developed generic recruitment flyers, it is possible that providers offered the opportunity to participants who had previously expressed positive views of the program. Also, we were not able to identify and interview participants who may have been dissatisfied and therefore left the program. Finally, as discussed earlier, we conducted client interviews by phone, and clients were not always able to participate in a private setting due to the nature of the pandemic and the housing they were provided at the time.

Our effort to document the resources required was hampered by the lack of information on direct service levels. In addition, county employees are responsible for working on several initiatives at once, and it was not feasible during our study to track efforts specifically devoted to this particular program. Other jurisdictions interested in implementing this program are likely to have different staffing configurations and level of demand for the program, which will influence the resources required for implementation and require adaptation from the Los Angeles County approach.

Next Steps

The ODR Housing Program has continued to expand and evolve, even during the COVID-19 era. In addition, there is ongoing interest in community-based alternatives to incarceration in Los Angeles County (Los Angeles County Alternatives to Incarceration Work Group, 2020). The county is currently in the process of closing one of the jails within the Los Angeles County jail system, which will require an overall reduction in the census of the jail. As part of these efforts, a workgroup is identifying opportunities to serve individuals in the community rather than in a correctional setting, including the potential for increased rates of diversion through ODR programs (Los Angeles County Department of Health Services, 2020a; Solis and Kuehl, 2020).

With growth comes considerations regarding scalability. ODR staff continue to work to establish new interim and PSH sites. In addition, the program has expanded from one to three courthouses in Los Angeles County. As the County continues to expand diversion offerings, Los Angeles County, and ODR specifically, may consider the following recommendations for ongoing implementation of its housing program.

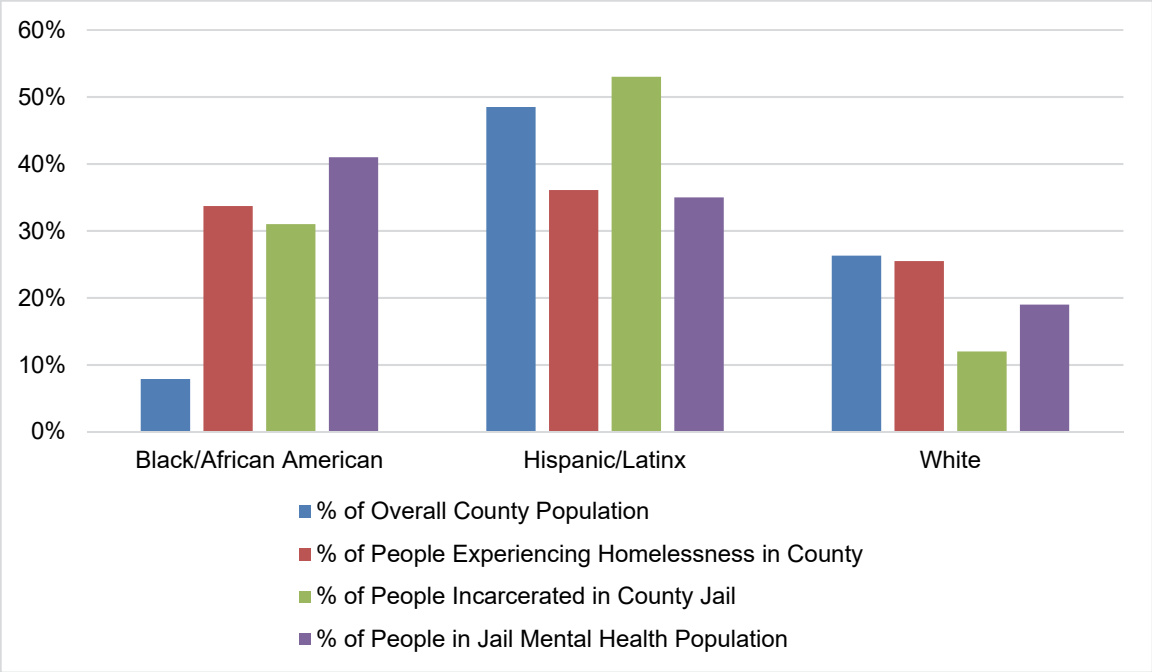
Increase staff training opportunities.

Staff members from across organizations are dedicated to this program. However, they are serving a population with significant clinical needs. This may especially present challenges to staff members who do not have formal clinical training, such as staff of interim housing sites. As the program establishes additional interim housing sites, standardized staff training opportunities may help to ensure high quality services across the portfolio. Our discussions with ODR indicated that they have already been responsive to staff training needs; for example, in May and June 2020, ODR hosted nonviolent crisis intervention trainings for providers, which were over and above the trainings the providers are required to host on their own per their contracts. The County should continue to ensure adequate resources to provide these trainings to ODR-contracted provider staff in the future.

Expand equity considerations in program implementation and outcomes.

It is also worth noting the extent to which the ODR Housing Program might address racial disparities in the jail population in Los Angeles. Black residents of Los Angeles are disproportionately likely to be experiencing homelessness and to be incarcerated in the County jail system. And a recent study conducted by ODR staff members found that the jail mental health population—the target population for the ODR Housing Program—has a higher proportion of Black individuals than the overall jail population (Appel et al., 2020) (see Figure 6.1). Moreover, there is evidence that Black individuals in the jail's mental health population are equally appropriate for diversion as their counterparts in other racial/ethnic groups (Holliday et al., 2020). Increased diversion rates for Black individuals will be necessary to begin addressing this racial disparity. ODR demonstrates some promise in this area; for example, recent data provided by ODR indicated that Black individuals constitute about 35 percent of the jail's mental health population but make up about 40 percent of those individuals diverted through ODR (Tamis, 2021). In addition, it is important to explicitly monitor rates of enrollment and program outcomes, such as housing stability and recidivism rates, by demographic characteristics, to see how well the program is serving the various populations it engages and ensure it is not inadvertently perpetuating existing inequities among Los Angeles County's diverse populations. This is also true for other minority groups that experience stigma, discrimination, and health disparities, such as LGBTQ+ individuals.

Figure 6.1. Demographic Characteristics of People Experiencing Homelessness and Incarceration in Los Angeles County



SOURCES: Appel et al., 2020; Los Angeles County Department of Health Services, 2020a; and Los Angeles Homeless Services Authority, 2020.

Explore process measures, including early attrition rates.

Early reports on the program's outcomes evaluated only housing stability and new felony convictions among clients who had reached the PSH phase of the program (Hunter and Scherling, 2019). It appears that program attrition is highest, however, in the earlier phases of the program. Monitoring attrition and outcomes after enrollment, not just after PSH placement, may provide better insight into how well the program is functioning and meeting the needs of its participants. To do so, the program could track "flow" through the program and exits after each program milestone (before and after housing transitions and the receipt of various services or benefits). RAND has assisted other PSH initiatives in conducting these types of analyses (Hunter et al., 2021; McBain et al., 2020).

Monitor outcomes by client characteristics and program progress.

Monitoring the outcomes after release could also result in a better understanding of how well the program is working for different clients, whose experiences may differ based on the availability of services at their time of release. For example, some clients have FSP-embedded with their ICMS/Housing provider, whereas others receive care from an FSP provider separate from their ICSM provider. Does this influence attrition or other program outcomes (e.g., housing stability, recidivism)? There might also be efforts to understand whether certain interim housing providers,

ICMS providers, or geographic settings result in better or worse outcomes for specific clients. For example, we learned that transgender clients may be particularly vulnerable when placed in certain areas of the region or in housing not specifically designed to serve transgender populations.

Conclusion

This report provides insight into the implementation of a PSH program for individuals involved in the justice system with serious mental illness. This program offers diversion from jail into community treatment, and it previously demonstrated promising outcomes related to justice-system involvement and housing stability. Findings from this study demonstrate that it has been well received by staff and clients alike. Though there are some challenges to implementation, such as a lack of integrated mental health and substance use treatment in Los Angeles County, this program is an example of the way that community support can provide an alternative to incarceration among individuals experiencing serious mental illness.

Appendix A. Literature Review Methods

We searched for the academic literature using EBSCO, ProQuest, Pubmed, Scopus, and Web of Science. Search terms used were related to housing and criminal justice. Housing terms included "support* housing" and "housing first," and criminal justice-related terms included recidiv*, rearrest, and incarcerat*. Relevant subject, keyword, and/or MeSH terms were identified to capture these concepts, depending on the database. Wildcard characters were used to expand search terms (e.g., "incarcerat*" to capture both "incarcerated" and "incarceration"). Results were limited to English-language articles published in peer-reviewed journals as well as research reports. The search returned 242 results. Removal of duplicates yielded 126 unique results.

We then reviewed the abstract of each article to determine whether it met our inclusion criteria. We included articles that focused on supportive housing interventions that included individuals involved in the justice system (i.e., individuals with a history of arrest, conviction, or jail stays). Articles were included if they reported housing or recidivism outcomes. We excluded articles based on publication type, excluding study protocols, summary briefs, policy essays, issue briefs, interim reports, and demonstration designs. A total of 40 unique publications were retained for full-text review.

We supplemented the search with a hand search of references in relevant articles identified through the literature search, articles known to the research team, and articles identified through a targeted literature search for additional articles related to supportive housing and mental health courts. This yielded an additional 27 articles.

After conducting a full-text review, a total of 41 articles met our inclusion criteria and were available to the research team. Using a structured data-abstraction form, we identified the key findings from each of these articles, including the nature of the population and housing intervention and outcomes related to criminal justice, housing, health, and cost.

Appendix B. Literature Reporting on Justice-System Involvement Among Supportive Housing Clients

Table B.1 provides details of the studies reporting on justice-system involvement among supportive housing clients.

Table B.1. Studies Reporting on Justice-System Involvement Among Supportive Housing Clients

Source	Program	Geographic Area	Target Population and Sample Size	Key Services	Study Design
Bean, Shafer, and Glennon, 2013	Project H3: Homes, Health, Hope	Phoenix, Ariz., USA	Medically vulnerable people experiencing homelessness. Participants had at least one of the following: physical/mental/substance trimorbidity, frequent hospitalization history, chronic illness, or were elderly. *N* = 20	Housing First, harm reduction, and peer support. Housing units were delivered in a scattered-site configuration.	Single-group pre/post
Casper and Clark, 2004	Transitional supportive housing in Brooklyn	Brooklyn, N.Y., USA	Supportive housing residents with a DSM-IV Axis I diagnosis and a history of incarceration. A matched control group consisted of individuals without a history of incarceration. *N* = 56	Case management such as medication monitoring, skills training, and housing support.	Pre/post with matched control group
Clifasefi, Malone, and Collins, 2013	Housing First program in Seattle	Seattle, Wash., USA	Individuals experiencing chronic homelessness with a history of alcohol abuse residing in project-based Housing First units. *N* = 95	Twenty-four-hour onsite staffing, intensive case management, nursing and medical care, referrals to other providers, and assistance with basic needs.	Single-group pre/post
Culhane, Metraux, and Hadley, 2002	New York/New York (NY/NY)	New York, N.Y., USA	People with a serious mental illness diagnosis and a recent history of homelessness, either in shelters or unsheltered. *N* = 6,676	Scattered-site housing units with community-based or site-based service support, or congregate-site supportive housing units, such as community residences, long-term treatment facilities, and adult homes.	Pre/post with matched control group
Cusack and Montgomery, 2017	U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH)	Various, USA	Veterans experiencing homelessness who enrolled in HUD-VASH and subsequently exited the program. *N* = 1,060	Permanent housing subsidies, case management, and medical, mental, or substance use services from the Veterans Administration or from community-based providers.	Single-group descriptive

Source	Program	Geographic Area	Target Population and Sample Size	Key Services	Study Design
Driscoll et al., 2018	Alaska Housing First	Anchorage and Fairbanks, Alaska, USA	Individuals experiencing chronic homelessness. *N* = 68	Housing First with optional formal case management, transportation, medication monitoring, and alcohol and money management. Housing units were delivered in a congregate-site configuration.	Single-group pre/post
Gabrielian et al., 2016	HUD-VASH	Los Angeles, Calif., USA	Veterans enrolled in a supported housing program who either exited the program without stable housing or stayed in the program, stably housed. *N* = 102	Rapid housing placement with case-monitoring activities focused on "monitoring" and "supportive care."	Descriptive comparison with matched control group
Gilmer, Manning, and Ettner, 2009	Reaching Out and Engaging to Achieve Consumer Health (REACH)	San Diego, Calif., USA	Individuals experiencing homelessness with serious mental illness. *N* = 338	Housing First in congregate-site or scatter-site configurations, including team-based Assertive Community Treatment case management and outpatient services.	Pre/post with propensity score-matched control group
Goering et al., 2014	At Home/Chez Soi	Various, Canada	Individuals experiencing homelessness with a mental illness. *N* = 2,148	Scattered-site or project-based units with Assertive Community Treatment (including a nurse, social worker, psychiatrist, and peer supporter) or intensive case management.	Randomized controlled trial
Hall et al., 2020	New York/New York (NY/NY) III	New York, N.Y., USA	Individuals experiencing homelessness with a substance use disorder but not with a serious mental illness, enrolled in a substance use treatment program. *N* = 1,937	Scatter-site and congregate-site housing units with flexible case management, including assistance in obtaining government benefits and substance abuse, mental health, and primary care services, either onsite or by referral.	Pre/post with propensity score-matched control group
Hanratty, 2011	Heading Home Hennepin's Housing First programs	Minneapolis, Minn., USA	Individuals who have been homeless for one continuous year or at least four times in the past three years, with a disability that limits their ability to work for at least one month. *N* = 528	Housing First in scatter-site units, with case management for long-term housing placement and assistance with income.	Pre/post with propensity score-matched control group

Source	Program	Geographic Area	Target Population and Sample Size	Key Services	Study Design
Henwood, Katz, and Gilmer, 2015	Permanent supportive housing in California	Various, Canada, USA	Individuals experiencing homelessness with a serious mental illness, age 35 or older. *N* = 7,076	Not stated; services likely vary across sites and providers.	Single-group pre/post with difference-in-differences estimator
Hickert and Taylor, 2011	Homeless Assistance Rental Program	USA	Individuals experiencing homelessness who either struggle with mental illness; are aging out of foster care; or are in jail, in criminal justice programs, or in substance abuse programs. *N* = 102	Case management and support services, including substance abuse and mental health treatment and alternatives to incarceration programming.	Single-group pre/post
Hunter, Buenaventura, and Cefalu, 2018	Mentally Ill Offender Crime-Reduction Program	Los Angeles, Calif., USA	Incarcerated individuals with a tri-morbid diagnosis (physical, mental, and substance use disorder) preparing to reenter the community. *N* = 98	Needs assessment, reentry planning, benefits-application assistance, and referrals to medical, substance use, and other community-based providers.	Single-group pre/post
Kerman et al., 2018	At Home/Chez Soi	Various, Canada	Individuals experiencing homelessness with a mental illness. *N* = 2,039	Scattered-site or project-based units with Assertive Community Treatment (including a nurse, social worker, psychiatrist, and peer supporter) or intensive case management.	Randomized controlled trial
Larimer et al., 2009	Housing First program in Seattle	Seattle, Wash., USA	Individuals experiencing chronic homelessness with severe alcohol problems. *N* = 134	Congregate-site housing units with case management and support services, including meals and health care services.	Single-group pre/post compared with propensity score-weighted, waitlisted participants
Malone, 2009	Seattle Downtown Emergency Service Center housing	Seattle, Wash., USA	Individuals experiencing homelessness with behavioral health disorders. *N* = 347	Congregate-site or scattered-site housing units with supportive services, including psychiatric treatment, counseling, social supports, and assistance with obtaining food and meeting other basic needs.	Single-group pre/post

Source	Program	Geographic Area	Target Population and Sample Size	Key Services	Study Design
Roy et al., 2016	At Home/Chez Soi	Various, Canada	Adults who were homeless or precariously housed, had a mental illness diagnosis, and reported at least one arrest in the six months before enrollment. *N* = 584	Scattered-site units with Assertive Community Treatment (including a nurse, social worker, psychiatrist, and peer supporter) or congregate-site units with intensive case management.	Single-group descriptive
Somers et al., 2013	Vancouver At Home	Vancouver, British Columbia, Canada	Individuals experiencing homelessness and a mental disorder with a history of psychiatric hospitalization and justice-system involvement in the past two years, as well as a low level of community functioning. *N* = 297	Scattered-site units with Assertive Community Treatment (including a nurse, social worker, psychiatrist, and peer supporter) or congregate-site units with intensive case management.	Randomized controlled trial
Stergiopoulos et al., 2015	At Home/Chez Soi	Various, Canada	Individuals experiencing homelessness with a current psychotic or bipolar disorder, moderate disability, and a history of mental illness hospitalization, a recent arrest or incarceration, or comorbid substance use. *N* = 1,198	Scattered-site housing with off-site intensive case management services.	Randomized controlled trial
Tejani et al., 2014	HUD-VASH	Various, USA	Veterans experiencing homelessness who were admitted to the HUD-VASH program with or without a history of incarceration. *N* = 14,557	Supported housing with case management.	Three-group descriptive comparison
Thomas et al., 2020	Housing First Charlotte-Meckenburg	Mecklenburg County, N.C., USA	Individuals experiencing chronic homelessness. *N* = 330.	Permanent housing and wraparound support (e.g., psychiatric treatment, substance use treatment, and employment services).	Two-group pre/post
Tsai and Rosenheck, 2012	HUD-VASH	Various, USA	Chronically homeless adults enrolled in supported housing programs with or without a history of incarceration. *N* = 751	Permanent housing units, supportive primary health care, and mental health services.	Three-group descriptive comparison

Source	Program	Geographic Area	Target Population and Sample Size	Key Services	Study Design
Tsai and Rosenheck, 2013	HUD-VASH	Various, USA	Veterans experiencing homelessness with a psychiatric or substance use disorder who were admitted to the HUD-VASH program. *N* = 1,160	Scattered-site housing units with case management, housing vouchers, and placement assistance, and referral to treatment providers.	Clustering analysis
Tsai, Mares, and Rosenheck, 2010	Collaborative Initiative to Help End Chronic Homelessness	Various, USA	Individuals experiencing chronic homelessness enrolled in supported housing programs with either a Housing First or residential treatment-first model. *N* = 709	Permanent housing units, supportive primary health care, and mental health services.	Two-group descriptive comparison
Volk et al., 2016	At Home/Chez Soi	Various, Canada	Individuals experiencing homelessness, or who are precariously housed, with a mental illness diagnosis. *N* = 2,255	Scattered-site units with Assertive Community Treatment (including a nurse, social worker, psychiatrist, and peer supporter) or congregate-site units with intensive case management.	Randomized controlled trial
Whittaker et al., 2016	Housing First programs in Sydney	Sydney, New South Wales, Australia	Individuals with a chronic history of homelessness. *N* = 63	Housing First, including wraparound tenancy case management services and health support services. Housing units were delivered in either a scattered-site or congregate-site configuration.	Two-group comparison pre/post

NOTE: DSM-IV = *Diagnostic and Statistical Manual of Mental Disorders, 4th Ed.*

Appendix C. Interview Protocols

Staff Interview Protocol

Introduction (all groups: ODR, Intensive Case Management (ICMS) providers, Brilliant Corners)

1) Can you start by telling me about your role at [organization]?
    a. Potential probes: How long have you been with [organization]? How long have you been working with ODR Housing?

2) Can you tell me about your role providing services with the ODR Housing program?
    a. How much of your role is dedicated to the program?

Flow of Services (all groups)

We're interested in learning more about the typical flow of an individual through ODR Housing.

3) Let's start with the enrollment process.
    a. [ODR] How are individuals identified as appropriate for the program?
        a. Once someone is identified as eligible, what takes place? (Potential probes: Collaboration with legal stakeholders, court hearings)
    b. How are individuals connected to case management providers? To Brilliant Corners?
        a. Potential Probes: When does Brilliant Corners get involved with providing services? When do the ICMS providers get involved with providing services?
    c. Once an individual is enrolled in the program, what happens? Where do clients go after they leave the jail?
        a. (Potential probes: while still in jail; at the point of transfer from jail; once they are settled into housing)

4) Next, let's talk about interim housing.
    a. Do all clients enter interim housing straight from the jail? If not, where do the others go?
    b. How long are clients generally in interim housing?
    c. What forms of interim housing are available?
    d. What types of services do clients receive while in interim housing?

5) Tell me about the process of an individual getting permanent housing.
    a. What is the wait-list process like?
    b. Are there milestones that clients have to achieve to enter housing?

c. Are there different requirements or factors that are taken into consideration for different types of housing (e.g., scattered site vs. project-based)?
d. What happens when a housing placement cannot be secured? Is housing availability ever a consideration in when planning a client's release from the jail?

6) What factors shape the placement decision for clients?

a. Clinical factors (e.g., diagnosis, acuity, treatment adherence)
b. Other considerations (e.g., gender, housing-related history)
c. Client preferences?

7) What issues may lead to a housing placement being terminated? What do you do to try to prevent this from happening?

a. Do you have termination guidelines? What are they?
b. If you cannot prevent a placement from being terminated, what happens to the client after they leave housing?
c. What happens to a client if they are re-arrested after moving into a housing placement? What if they are reconvicted or returned to jail?

ODR

8) Are there any differences in the types of services offered by the case management providers?

a. Potential probes: Populations they specialize in; when and where they provide services
b. How does this fit together with the services offered by Brilliant Corners?
c. Are there certain models that they follow when providing services (e.g., Assertive Community Treatment)?

Housing Services (Brilliant Corners)

9) What sorts of housing options have been provided to ODR clients? (Potential probes: single unit, collaborative housing)

10) Are there any requirements that clients must meet before they are ready for permanent housing? What are they?

11) What type of support is provided to participants as they await and obtain permanent housing? What is offered by Brilliant Corners vs. other providers? (Potential probes: Move-in support, communication with property manager, liaising with case manager, temporary housing?)

a. What types of providers do you have that work with ODR Housing clients?
b. What is the typical caseload?
c. How often do you meet with clients? Does this change during the course of the program?

d. How often do you meet in person vs. by phone? Where do you meet in person?
e. Is Brilliant Corners providing case management services for anyone in ODR Housing? How is this determined?

12) What financial obligations do clients have for the housing?

13) What types of services do clients have access to within the housing (e.g., mental health, substance use, money management, health)?

a. Who determines the available services (e.g., Brilliant Corners, ODR, case manager provider)? Who provides those services (e.g., case manager, through linkage/referral)?
b. What type of assessment(s) are done with clients? How does this relate to service eligibility? (Potential probes: Housing readiness, substance use/mental health, physical health)

Case Management Providers

14) What type of screening or assessment(s) do you do with ODR Housing clients? (Potential probes: Housing readiness, substance use/mental health, physical health)

15) Tell me about the types of case management services you provide.

a. What is the typical caseload?
b. How often do you meet with clients? Does this change during the course of the program?
c. How often do you meet in person vs. by phone? Where do you meet in person?
d. What types of linkages/referrals are most commonly provided?

16) What types of services do clients have access to within the housing (e.g., mental health, substance use, money management, health)?

a. Who determines the available services (e.g., Brilliant Corners, ODR, case manager provider)? Who provides those services (e.g., case manager, through linkage/referral)?
b. What type of assessment(s) are done with clients? How does this relate to service eligibility? (Potential probes: Housing readiness, substance use/mental health, physical health)

Communication (all groups, unless indicated)

17) [ODR] Who do you interact with during the process of identifying individuals for enrollment in ODR Housing? (Potential probes: judges, PDs, DAs, jail medical providers/social workers)

a. Who provides information vs. who has decision-making authority?

18) What type of interaction do you have with the other stakeholders involved in ODR housing?

19) What type of interagency communication is involved in key decisions about the ODR program? (Probe: eligibility, temporary and permanent housing placements)

20) Who establishes the policies and practices related to this program (Probe: ODR, provider agency, some combination)?

21) What role does ODR have in overseeing the services provided by the other agencies?

22) [Brilliant Corners, ICMS] Who do you talk to when you have challenges providing services?

    a. Do you receive regular supervision? If so, by whom?

Perceptions of the Program/Barriers/Facilitators (all groups, unless indicated)

23) How well do you think the ODR housing program meets the needs of the clients you serve?

24) [For Case Managers/Brilliant Corners] How does the ODR Housing intervention compare to other programs that you oversee? What differences are there when serving this population, if any?

25) What challenges are experienced in implementing this program? What about challenges to serving this population? (Potential obstacles: Finding case management providers; coordinating across multiple case management providers; finding housing options)

26) Are there any common obstacles that clients encounter in this program? What are they?

27) What has facilitated the implementation of this program? (Potential probes: Collaborations with the other agencies; training; other resources)

28) What are the major resources that you and your agency need to deliver the program?

    a. We would like to set up a separate meeting to discuss how we can track program costs and potential savings. Who from your agency should be included in that meeting?

29) Are there additional resources that you need to implement the program?

30) [ODR] As the County looks to expand diversion offerings, what type of expansion do you envision for this program?

    a. In expanding this program, what barriers do you anticipate? What resources are needed to expand these services?

31) Is there anything else that you think would be valuable for me to know about this program or your organization? If you could start at the beginning again, knowing what you know now, what would you change?

Client Interview Protocol

Introduction and Enrollment

1) To get us started, how long it has been since you were released from jail into the program?
    a. [If current housing status is unknown] Are you currently in interim or permanent housing?

I'd like to learn a little more about how you came into contact with the Office of Diversion and Reentry and became part of this program.

2) How did you first learn about this program? (Potential probes: Public defender, family member, someone in jail)

3) Why did you decide to be part of the program? What were you hoping to get out of it?

4) We're interested in learning about the court process. How did the court process go? Are there things that would have made that process easier on you? (Potential probes: More information in advance of the court date; knowing more about the program)
    a. Have you had to go through a reinstatement hearing – for example, because you violated probation? How was that different from the first court date?

5) How long did you wait to be released after the suitability hearing? What was that like?

Housing and Services

Now I'm interested in learning more about the types of services that you've received through ODR Housing. We'll walk through them one by one.

Interim Housing

Let's start with your housing placement after leaving jail.

6) Where do you go when you were released from jail? (Potential probes: Interim housing, Board and Care) How did that go?
    a. What aspects of your housing have been most helpful (were most helpful)?
    b. What challenges have there been (were there)?

7) We know that housing staff may play a number of roles – including providing day-to-day support and case management.
    a. What services have been (were) most helpful?
    b. Are there services that have been (were) less helpful? What are they?

Case Management

Next, I'm interested in hearing about services you receive from the case manager that you meet with regularly (approximately once a week). They might be from an organization like VOA [Volunteers of America], Project 180, Alcott, Telecare, St. Joseph's Center, or the People Concern.
[*If additional clarification is needed*: The case management providers may have a number of roles in your care, including linking you to services, helping to prepare you for the move to permanent housing, and overseeing your psychiatric medication.]

8) What services provided by your case manager have been (were) most helpful?

9) Are there services that have been (were) less helpful? What are they?

Other Services (Full Service Provider, Benefits)

10) We know that the goal is for people in this program to get mental health treatment. You may have heard the term "full service partnership" to describe your mental health provider.
    a. Are you currently receiving mental health services? Who is providing those services (FSP, provider through case manager or housing site)?
    b. How long did it take to get connected to your mental health provider after you left jail? Who assisted in getting you connected to them?

11) Some people may also have taken part in substance use treatment.
    c. Have you completed substance use treatment since joining this program? [If no] Are you waiting for substance use treatment? How long have you been waiting?

12) What has been most helpful about these services? Are there aspects of these services that have been less helpful?

Permanent Housing

(if in interim housing)

13) Are you prepared to move to permanent housing? Why or why not?

(if in permanent housing)

14) How long did it take for you to move to permanent housing after you left jail?

15) Were you prepared to move to permanent housing? Why or why not?

16) What type of support did you receive for the transition to permanent housing (e.g., met with case manager more often, obtaining furnishing, learning to grocery shop, getting to know your new neighborhood)?

d. From Brilliant Corners
e. From case managers
f. From other providers

17) How was the transition to permanent housing? Are there things that have gone well (e.g., enjoying having own space, sense of stability)? Are there things that have been difficult (e.g., isolation)?

Impact of COVID

18) How have you been impacted by COVID over the last few months? (Potential probes: housing, relationships, health, mental health, access to services)
    a. Has this program helped you to navigate these changes? If so, how?

19) Have you been able to access the supports you need to navigate COVID and any related impact on your life?
    a. If so, which resources, supports, or services have you accessed?
    b. If not, what has gotten in the way? (Potential probes: lack of technology, not knowing what is available, concerns about exposure)

Perceptions of Services

20) Are there any challenges to staying housed that you've experienced since entering the program? (Potential probes: Rearrest, neighborhood safety, not feeling comfortable in the house, not stable on meds, issues with landlords, issues with making rent)

21) Have you experienced any discrimination or unfair treatment since being in the program? This could include unfair treatment from any source, including providers, landlords, or neighbors, or based on any characteristic (age, race, gender, mental health status, criminal justice status).

22) We've talked about many different types of services that you receive through this program. Are there any services you are not receiving that you need to help you live in permanent housing? What are they?

23) We talked before about some of the reasons that you participated in ODR Housing, including [recap here]. Have you gotten the benefits you thought you would?
    a. Are there other benefits of this program? (Potential probes: benefits of having stable housing; benefits of services receiving; ability to focus on strengthening other areas of life, such as employment)

24) If you had to change any aspects of the program, what would they be?
    a. Are there any services that aren't available that would be helpful? What are they?

25) Would you recommend this program to a friend? Why or why not?

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