

Supportive Housing for Behavioral Health Recovery

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Executive Summary: Supportive Housing for Behavioral Health Recovery

This report details a program aimed at reducing deaths of despair (DoD) in South Shore, a majority black/African American community on the south side of Chicago bordering Lake Michigan. There has been a precipitous rise in deaths related to opioid, alcohol and suicide, collectively called DoD, in Chicago and South Shore over the last decade. In 2014 only one death in South Shore was recorded as being related to opioids. Each year since the number has risen. In 2022, there were 50 deaths related to opioids recorded. Between 2014 and 2016 there were an average of 2.33 suicides in South Shore each year. In the past three years that average was twice as high at 5 suicides per year (Cook County Medical Examiner, 2023).

Behavioral health diagnoses are significant risk factors for DoD as is precarious housing and being unhoused. South Shore is a particularly vulnerable community due to high eviction rates, high rates of binge drinking, less access to medical care, discrimination, historical trauma, and low per capita incomes, all of which contribute to DoD. This program will tackle the intersection of behavioral health and housing with a focus on integrating liberatory harm reduction practices and housing first methodologies. Clients will be enrolled into one of two groups. The first group will receive partial rental payments along with case management and peer support sessions. The second group will receive only case management and peer support sessions. In total, 80 clients will be enrolled, with roughly 30 receiving partial rental payments.

The total budget for the first year of operation is \$835,530. This budget will support the salary of two full time case managers, three full time peer support specialists, a half time program manager, and the work of a lawyer. The budget will also cover costs associated with training, technology, supplies, and other related supplies in addition to the partial rent payments. This budget will be used to achieve the objectives of the program and assess outcomes. The objectives of this program are to increase housing stability, increase access to medical care, increase knowledge and usage of harm reduction practices, and improve quality of life.

Process evaluation will be ongoing. Case managers and peer support staff will actively record the number of client sessions attended and housing related outcomes, such as evictions. Additionally, the number of external services providers, such as medical centers and landlords, will be tracked. Outcome evaluation will occur one year after the last client of the first cohort is enrolled. Clients will be asked to complete a quality-of-life questionnaire before enrolling in the program and one year after enrollment. Scores will be used to measure change over the course of the year. Differences between groups receiving and not receiving housing assistance will be used to assess the effectiveness of housing assistance beyond the effect of case management/peer support.

This program aligns with Ascension's mission of focusing on vulnerable/impooverished populations and promoting wholistic, dignity focused care. It will provide needed security to people as they focus on building resilience for themselves and their community.

Background: Deaths of Despair in South Shore

The term “deaths of despair” (DoD) broadly refers to deaths from suicide, drug overdose, and alcohol abuse, a category of deaths that have been on rising precipitously (Case & Deaton, 2020). While this epidemic once seemed to be confined to White Americans, it is now obvious that this is not the case. In South Shore the epidemic is seen in opioid overdoses and suicide death trends, shown in Figures 1 and 2. Alcohol deaths are harder to track; however, they are likely occurring as approximately 18.9% of residents in South Shore report binge drinking (Nichols et al., 2019). In all, 245 people in South Shore have had recorded deaths from suicide and/or opioids between January 2014 and January 2023 (Cook County Medical Examiner, 2023).

Figure 1: Suicide trends in Chicago and South Shore
Suicides in Chicago by Year

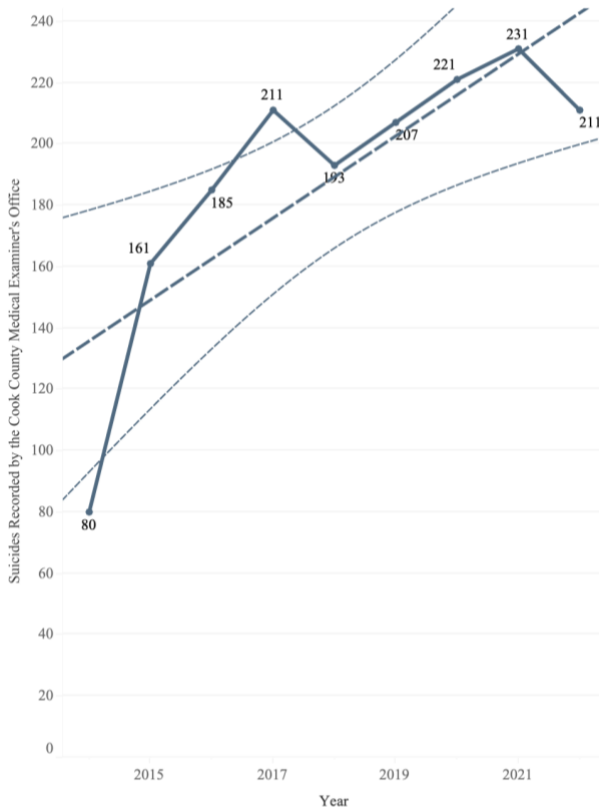
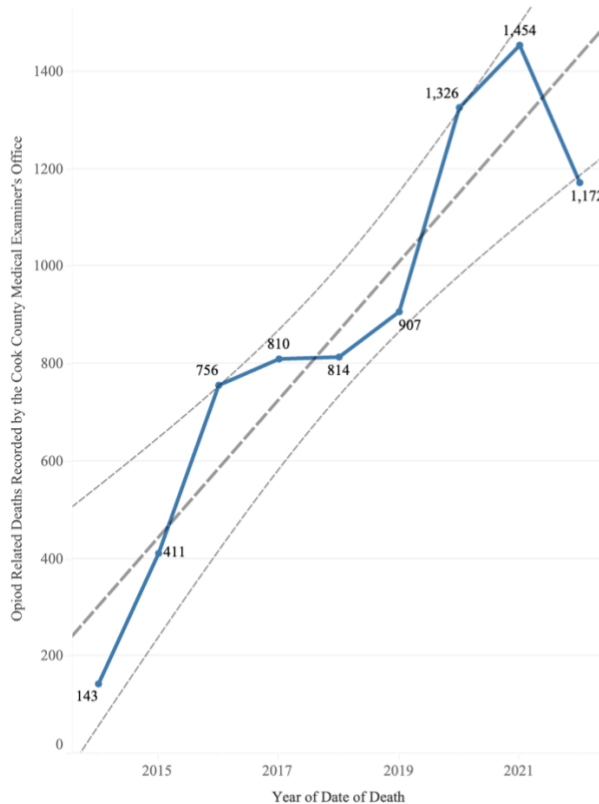
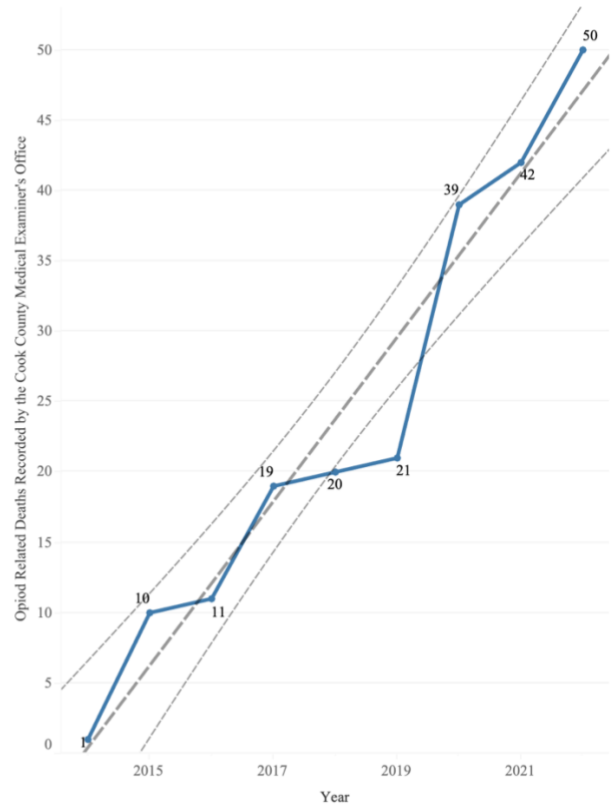


Figure 2: Opioid related death trends in Chicago and South Shore

Opioid Related Deaths by Year in Chicago



Opioid Related Deaths in South Shore by Year



Note: Data was obtained from the Cook County Medical Examiner in January, 2023.

Deaths from opioids and suicides by race in South Shore are congruent with the demographics of South Shore, a community of about 54,000 residents, of whom 92.7% are black/African American (Chicago Metropolitan Agency for Planning, 2022; James, 2018). However, in Chicago, opioid deaths are disproportionately concentrated among black residents (Jordan, 2018). Deaths of despair have been characterized as occurring in white America, leaving little attention being paid to the deaths of people of color (James & Jordan, 2018). Programs to address DoD should be community centered with knowledgeable providers and those with lived experience at the forefront to combat racially discriminatory practices and information. The ways in which opioids kill likely differ between racial groups (ex: cocaine vs heroin) which means different paths to well-being may be needed (James & Jordan, 2018). Additionally, black opioid users have less access to an already sub-optimal substance abuse treatment system and are disproportionately arrested and convicted of drug crimes compared to white opioid users due to incentive systems within the criminal justice system created by the War on Drugs (Alexander, 2012; James & Jordan, 2018). Therefore, programs must focus on building trust and avoiding punitive measures.

Despair is a heterogeneous phenomenon that can arise as an emotional, biological, behavioral, or cognitive response to a situation at an individual or community level (Shanahan et al., 2019). The Centers for Disease Control and Prevention lists several community/society level risk factors for suicide that are relevant to South Shore, including “lack of access to healthcare,” “community violence,” “historical trauma,” “discrimination,” “stigma associated with help-seeking and

mental illness,” and “easy access to lethal means of suicide among people at risk” (Centers for Disease Control and Prevention, 2022). Community level risk factors for opioid overdose are less readily available, however it is known that suicides and drug overdoses share risk factors (Colpe, 2022; Webster, 2017). Reducing DoD will require addressing the root causes of these factors, such as housing instability, financial instability, and health access/knowledge.

Unstable housing is an important modifiable risk factor for South Shore. As of 2022, 16.2% of households in South Shore spend more than 30% of their income on housing (Chicago Metropolitan Agency for Planning, 2022). Housing is also related to DoD in multiple ways. A study of people entering substance abuse treatment on the west side of Chicago found that people living alone had an increased risk of mortality, a finding that is highly relevant to South Shore where half of households are single people (Chicago Metropolitan Agency for Planning, 2022; Scott et al., 2011). Other studies have found that higher eviction rates lead to higher rates of overdose in urban counties (Bradford & Bradford, 2020; Venkataramani & Tsai, 2020). South Shore has the second highest eviction rate in Chicago (The Eviction Lab at Princeton University & Cook County Sheriff’s Office of Research, 2018). Housing instability is also related to lower access to healthcare and higher psychological distress, which are risk factors for DoD (Bradford & Bradford, 2020).

Financial instability is familiar stressor to many people. The median income per capita in South Shore is 70% of Chicago’s (Chicago Metropolitan Agency for Planning, 2022). Mental health deterioration is often linked to increasing economic insecurity, such as was experienced by many because of COVID-19 (Beseran et al., 2022). Finances can contribute not only to housing instability and mental stress, they can also be a barrier to private medical care. As of 2019, there was only one publicly funded behavioral health service provider in South Shore (Healthy Chicago, 2019). Mental health is an important intermediate factor of DoD (Beseran et al., 2022). Often one will meet the criteria for a “diagnosis of despair,” which are also on the rise, before a DoD (Brignone et al, 2020). Access to mental health treatment is important in the social ecological model of DoD. Similarly, higher access to regular medical care is related to lower levels of DoD at a county level (Zeglin, Niemela & Baynard, 2019). Increasing financial stability and providing knowledge about navigating complex treatment systems may increase access.

Deaths of despair are often the direct consequence of fentanyl, which is increasingly available in Chicago and found as a contaminant in many products (DEA Chicago Field Division, 2019). Interpersonal relationships that determine where and from whom one obtains opiates can determine whether one is exposed to fentanyl and whether they are aware of potential contamination; however, illicit drug distributors are often unaware of fentanyl contamination (DEA Chicago Field Division, 2019; Hassan, 2022). Interpersonal relationships also determine if one has knowledge of how to manage dosing and whether one has anyone available to deliver care in case of an overdose (Hassan, 2022). Interpersonal relationships with peers may also determine how much fear of stigma and social judgment one feels, which have been found to be significant barriers to seeking and continuing treatment among black mental health consumers (James & Jordan, 2018). Positive relationships within a community, which may protect against deteriorating mental health and provide important knowledge/support, are an important protective link that is often broken in the face of adversity (Shanahan et al., 2019). Programs can focus on building such relationships in order to have long lasting and wide-reaching impacts.

Project Overview:

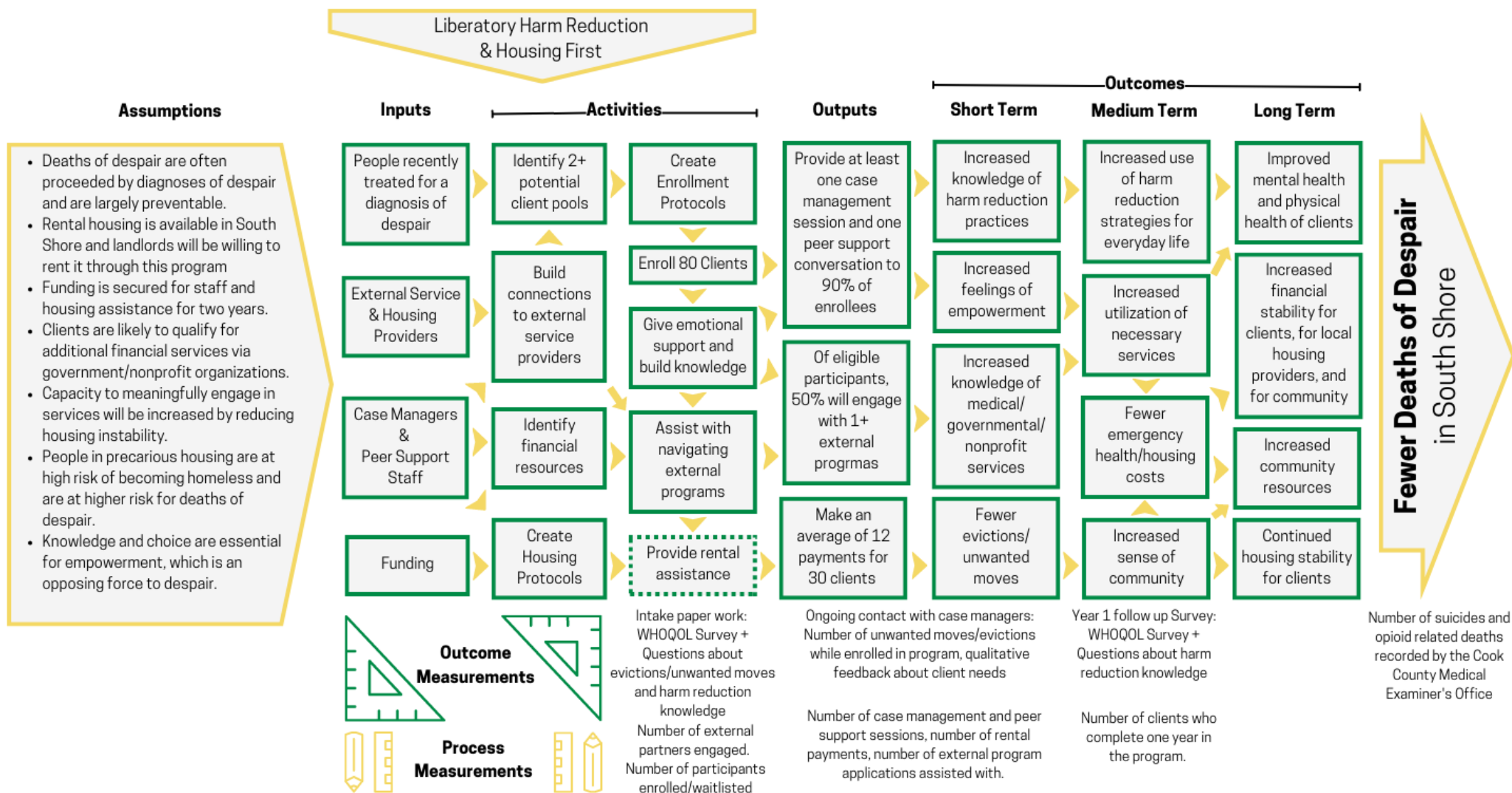
The goal of this program is ultimately to decrease the number of deaths of despair (DoD) in South Shore, to be accomplished by providing supportive housing to people at high risk. Additional objectives of the program include improving participant quality of life scores, housing stability, financial stability, and harm reduction knowledge, as measured by a modified WHOQOL survey, with added questions about housing stability and health knowledge/empowerment over the course of one year (World Health Organization, 2012).

The first program input is the wealth of knowledge that exists in the Housing First and Liberatory Harm Reduction movements, which will be incorporated into staff training (Hassan, 2022; Polvere et al., 2014). Many housing programs require recipients participate in treatment and/or remain sober. However, this is unnecessary to see improvement and can delay housing and decrease participant empowerment (Hassan, 2012; Tsemberis, Gulcur & Nakae, 2004). Traditionally, housing first models focus on people who are already homeless. However, the process of becoming homeless is traumatic. Additionally, most people experiencing homelessness in Chicago report previous precarious housing situations, indicating they could be identified before homelessness occurs (Nathalie P. Voorhees Center for Neighborhood & Community Improvement, 2019).

This program will therefore target people who have gone through recent inpatient and/or outpatient treatment for a diagnosis of despair (depression, substance abuse, etc.) who have indicated they will have no housing or unstable housing after leaving the treatment facility. While only targeting people who have contact with the medical system will introduce inequity, for this pilot program, the benefits of easier identification and follow up make this necessary. Future programs should eliminate this requirement. Leaving inpatient care is a precarious time when one is at heightened risk for becoming homeless; however, very few people receive specialized treatment for substance use disorders (National Association of Addiction Treatment Providers, n.d.). By targeting both inpatients and outpatients this program hopes to capture many people and to capture people who have only irregular contact with the medical system (i.e. emergency room). Participants will need to be 18 years of age or older and be capable of signing legal documents, such as leases, themselves. Figure 3, see next page, outlines the logic model of this program, which is discussed further below.

This program will offer either case management/peer support with housing or case management/peer support only if housing funding is at capacity or if a suitable housing situation cannot be arranged within the confines of the program. If more potential clients are identified than can be served, clients will be enrolled on a first come first serve basis and a waiting list will be created. This pilot project would aim to provide housing assistance to roughly 25-30 people over the trial period and to provide case management/peer support to another 40-50 people. Housing assistance would come in the form of partial rental payments. Rental payments would primarily be made for new apartments; however, if a client was already renting a suitable apartment but struggling to keep the apartment, rental payments could be made for existing apartments. Clients would be provided access to case management services, and peer support directly through the program. Additionally, case managers would coordinate with community service organizations to secure other needed services for clients. Case managers and peer support staff would assist clients with navigating welfare applications and inform clients of resources. Peer support staff would meet with clients to work through their goals, provide emotional support, and teach harm reduction strategies.

Figure 3: Logic Model of Supportive Housing for Behavioral Health Recovery



After funding has been secured, the first steps, shown in Figure 4, will be to hire/train case managers and peer support staff. Case managers will be licensed social workers. Peer support staff would be people with lived experience with substance abuse and/or depression, ideally from South Shore. Team members will be trained in housing first models, liberatory harm reduction principles and oriented to resources in South Shore. Next, team members will identify housing in the area, form connections with local housing providers and create housing protocols that are acceptable to landlords and potential clients (Polvere et al., 2014). Team members will identify health service providers that serve South Shore residents and form connections to expediate service provision for clients and identify resources for vulnerable populations. Behavioral health service providers with the capacity to identify and assist in enrollment of clients will be engaged to create enrollment procedures specific to their organization.

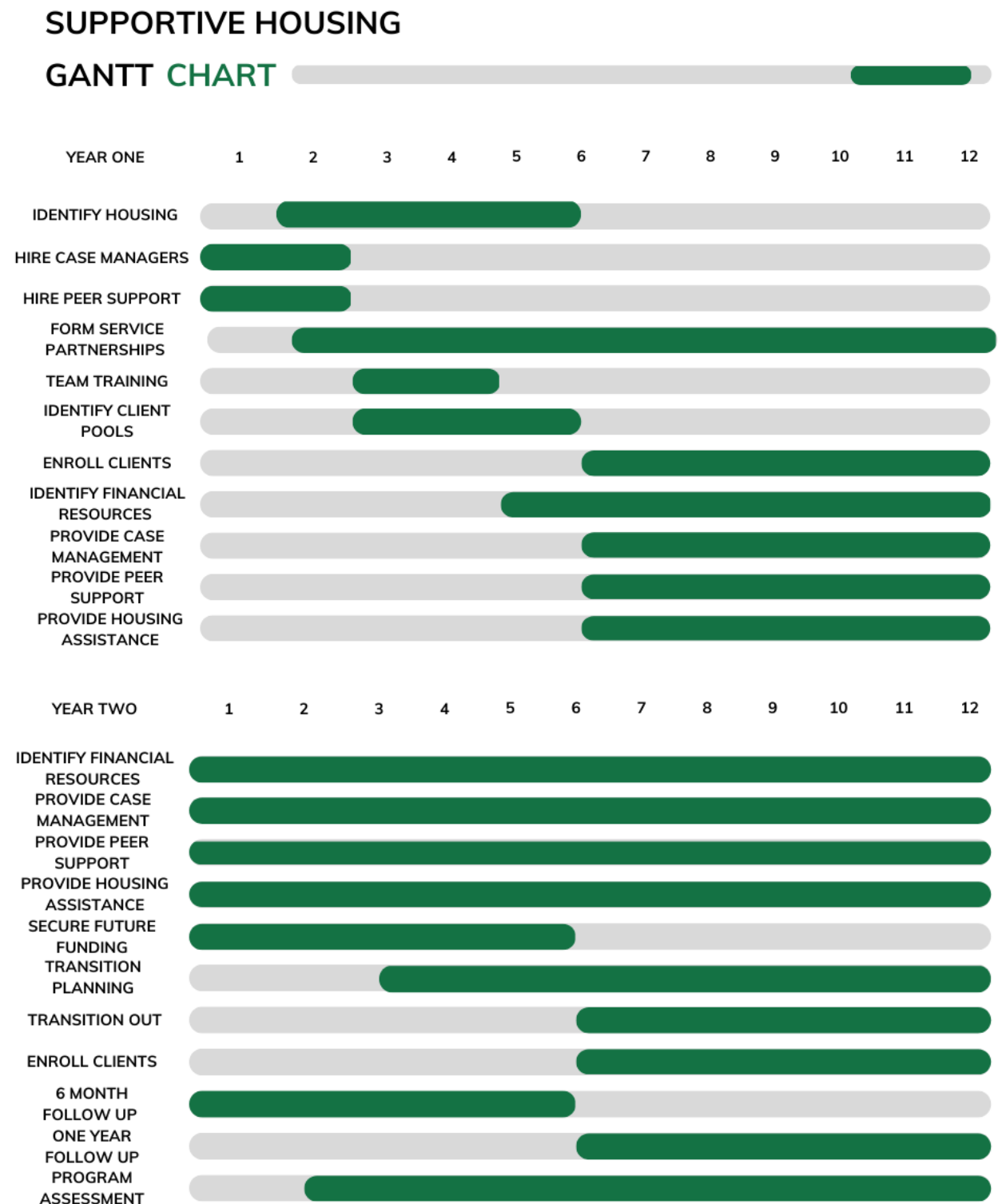
Once housing and enrollment procedures are in place, the team will begin to onboard clients. Ideally, clients would meet with their case manager and a peer supporter before leaving inpatient treatment programs and within a few days of receiving outpatient treatment. During this meeting program staff will ascertain what services the client needs and what housing would be suitable to them. Then, staff will identify if the program can meet these needs and coordinate.

This program will address determinants on the local community level by increasing the affordability of housing, addressing other barriers to housing and increasing the number of jobs for people with lived experience of mental illness and/or substance abuse. This program will address determinants on the interpersonal level by increasing health knowledge and increasing participants' sense of belonging via relationships with peer support staff. Finally, this program will address determinants at the larger community level by managing resources so that money is funneled into South Shore via rent payments/employment and making sure decisions about how that money is allocated is made by stake holders (i.e., client's choice of housing).

This program aligns with Ascension's mission of focusing on vulnerable/impooverished populations and promoting wholistic, dignity focused care (Ascension, n.d. B). Ascension will hire staff for this program, organize funding sources, and oversee the administrative tasks required for these activities. Additionally, some clients may be identified and enrolled through health facilities owned by Ascension. Ascension is well suited to run this program. This program would require substantial funds to operate and would require experienced grant writers/fund raisers in order to obtain continued funding. Ascension is a large organization with many resources (financial, staff, expertise, etc). It operates a similar housing program in South Shore (The Bettendorf Place) and has experience using multiple funding sources to fund housing programs (CHANGE Chicago Housing Authority, 2010). Additionally, Ascension has experience creating connections to services for housing clients (Ascension, n.d. A).

This program will require collaboration with many partner organizations. Partner organizations will initially be used to help identify and enroll clients. Partner organizations will also provide additional services and that patients are linked to. Examples of potential partner organization include Jackson Pk Hospital & Medical Center, South Shore Hospital, Ratcliff Behavioral Medicine & Research, UI Health, etc.

Figure 4: Two-year project timeline



Evaluation:

The program will be evaluated using a two-group cohort design. The first group will be participants who receive both case management/peer support and housing assistance. The second group will be participants who receive only case management/peer support without housing assistance. Each group will be given a survey during program enrollment and a survey one year after enrollment.

WHOQOL Survey +

The World Health Organization's Quality of Life survey has a brief version (WHOQOL-BREF) with 26 questions which has been shown to be reliable and valid for use as a measure of quality of life for homeless veterans, a group which is similar in some regards to the target population of this intervention (Garcia-Rea & LePage, 2010). Additionally, the WHOQOL-BREF has been used in cohort studies of housing first initiatives at baseline and one year follow up before (Whittaker, 2016). The survey can be evaluated using the overall score of a participant and the score of participants for specific domains such as financial well-being and health.

This program would use a modified version of the WHOQOL-BREF with additional questions about evictions/unwanted moves and knowledge/acceptability of harm reduction practices. As needed, questions from the full version of the WHOQOL survey may be included to ensure the survey covers all the domains needed for evaluation adequately.

Purpose

One of the primary objectives of this evaluation is to determine if the program positively impacts the lives of participants and if so what pieces of the program facilitate that improvement. Housing first initiatives are expensive and funding agencies need assurance that the funding is having the desired effect. Likewise, case management and peer support are time consuming, so it is important for case managers/peer support specialists/their employers to be able to evaluate the effect of that time and determine if changes need to be made. The conclusions of this evaluation would be shared with stakeholders such as leadership at the home organization Ascension, external service providers, programs from which clients have been enrolled, and landlords who have played a substantial role in housing participants. Sharing the evaluation with external service programs/landlords is important to show the effects of their efforts and to encourage their continued engagement.

Evaluations of programs can often become extractive of information, personal knowledge, and time of participants. Any evaluation that requires time and/or personal information from program participants should therefore ensure that the evaluation serves the needs of the participant as much or more than the needs of researchers or administration personnel. In this case, baseline and follow up surveys used to evaluate program outcomes will also serve as tools for case management. Case managers will be able to go through the quality-of-life surveys with participants to identify areas in which the participants may want assistance.

Objectives

The long-term objective of this program is to decrease the number of suicides and opioid related deaths recorded for residents of South Shore and surrounding communities by the Cook County Medical Examiner's Office within five years of the start of the program. This is a lofty goal, and it will take time to assess. Additionally, it will be hard to tie any change or lack of

change in deaths to this program as many factors contribute to the death rate. Therefore, several secondary objectives will be used to assess the program in the short term.

The first short-term objective is to increase both overall quality-of-life scores and domain scores of clients by 10% by the end of one year in the program as measured by the WHOQOL+ survey. Another objective is to have 60% of clients believe they have knowledge of harm reduction practices/uses by the end of one year in the program.

Additionally, an objective is to have the average number of unwanted moves/evictions per 5 participants be less than one, with an average of 0 unwanted moves/evictions per participant in the group with housing assistance throughout the year in the program. Ultimately, the goal is for program participants to have fewer evictions in the last year at the end of the program than they did at the beginning of the program.

Limitations

This evaluation is limited by the lack of a true control group; however, comparisons can be made between groups with housing assistance and without housing assistance to evaluate the effectiveness of housing assistance outside of any effect that time and case management/peer support will have. These comparisons will likely suffer from bias though, as participants who are enrolled but then decline housing assistance or are unable to be housed through the program will likely have substantial differences from participants who enroll and are placed successfully into housing. Some of these differences may be able to be identified and controlled for in analysis based on information about participants gathered during the enrollment process.

This program attempts to get at the root causes of deaths of despair, however, knowledge of the true driving force of deaths of despair is still evolving. Financial and housing instability have been linked to deaths of despair and are believed to be contributors, so while not perfect indicators of future deaths of despair, they may serve as adequate proxies.

SHORT-TERM OUTCOMES EVALUATION

EVALUATION QUESTION	OUTCOME OBJECTIVE	OUTCOME INDICATOR	BASELINE	TARGET	DATA TYPE & SOURCE	DATA COLLECTION & ANALYSIS	TIMEFRAME
Have clients learned harm reduction practices which they can use in their everyday life?	Increase client self-evaluated knowledge of harm reduction practices by the end of one year in the program.	Percent of clients who indicate they know of and feel comfortable using harm reduction practices.	Baseline will be measured by intake paperwork when clients enroll in the program.	At least 60% of clients answer yes to both knowing of and being comfortable using harm reduction practices	Dichotomous nominal variable (Yes/No) sourced from enrollment paperwork and one year follow up survey.	Baseline answers will be collected as part of the enrollment process. Outcomes will be collected as part of one year follow up survey. Assess the change in percent answering yes.	Evaluated at roughly one year post enrollment of last client in the first cohort of clients.
Has the program improved the lives of the clients?	Increase quality of life scores of clients by the end of one year in the program.	Overall score on modified WHOQOL survey, with added questions about housing stability and health knowledge/empowerment.	Baseline will be measured by intake paperwork when clients enroll in the program.	Increase scores by 10%.	Count variable sourced from enrollment paperwork and one year follow up survey.	Baseline answers will be collected as part of the enrollment process. Outcomes will be collected as part of one year follow up survey. Analysis of the mean score of participants before and after intervention, mean score changes of participants, and distribution of scores before and after intervention.	Evaluated at roughly one year post enrollment of last client in the first cohort of clients.
Has the program increased housing stability?	Decrease the average number of evictions per client in the prior year.	Average number of evictions or unwanted moves reported by clients.	Intake paperwork will ask how many evictions/unwanted moves clients had in the year prior to enrolling in the program.	Average of less than 1 unwanted moves/evictions per 5 participants. Average of 0 unwanted moves/evictions per participant in the group with housing assistance.	Count variable sourced both from internal records kept by caseworkers based on their conversations and from one year follow up survey.	Caseworkers will record if clients in the program have an eviction or unwanted move during their time in the program as part of routine follow-up. Additionally, questions on the follow up survey will ask about evictions and unwanted moves.	Evaluated at roughly one year post enrollment of last client in the first cohort of clients.

Continued on next page.

SHORT-TERM OUTCOMES EVALUATION							
Has the program increased mental/physical well-being	Increase in the reported level of mental/physical well-being.	Domain scores on modified WHOQOL survey.	Baseline will be measured by intake paperwork when clients enroll in the program.	Increase scores by 10%	Count variable sourced from enrollment paperwork and one year follow up survey.	Baseline answers will be collected as part of the enrollment process. Outcomes will be collected as part of one year follow up survey. Analysis of the mean score of participants before and after intervention, mean score changes of participants and distribution of scores before and after intervention.	Evaluated at roughly one year post enrollment of last client in the first cohort of clients.
Has the program increased financial security?	Increase in reported level of financial well-being after one year in the program.	Overall score of financial questions on modified WHOQOL survey.	Baseline will be measured by intake paperwork when clients enroll in the program.	Increase scores by 10%.	Count variable sourced from enrollment paperwork and one year follow up survey.	Baseline answers will be collected as part of the enrollment process. Outcomes will be collected as part of one year follow up survey. Analysis of the mean score of participants before and after intervention, mean score changes of participants, and distribution of scores before and after intervention.	Evaluated at roughly one year post enrollment of last client in the first cohort of clients.
LONG-TERM OUTCOME EVALUATION							
EVALUATION QUESTION	OUTCOME OBJECTIVE	OUTCOME INDICATOR	BASELINE	TARGET	DATA TYPE & SOURCE	DATA COLLECTION & ANALYSIS	TIMEFRAME
Have Deaths of Despair Decreased?	Decrease the rolling average number of deaths of despair of residents of South Shore and the surrounding communities by five years post program initiation.	Absolute number of suicides and opioid related deaths recorded for residents of South Shore and surrounding communities by the Cook County Medical Examiner's Office.	In 2020-2022 South Shore had an average of 44 opioid related deaths and 5 suicides per year.	Fewer than an average of 5 suicides per year and fewer than an average of 40 opioid deaths per year, adjusted for changes in community population.	Quantitative count data obtained from the Cook County Medical Examiner's online database.	The data is routinely collected by the Cook County Medical Examiner's office and could be downloaded on a yearly basis to calculate averages.	At the beginning of each year the rolling average for the previous 3 years could be calculated for at least five years following the program.

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