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Bringing Hope to Those Forgotten: Is the Provision of Transitional and Supportive Housing Effective in Reducing Homelessness? A Quantitative Analysis of WillBridge of Santa Barbara, Inc.

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BRINGING HOPE TO THOSE FORGOTTEN:
IS THE PROVISION OF TRANSITIONAL AND SUPPORTIVE HOUSING
EFFECTIVE IN REDUCING HOMELESSNESS?
A QUANITATIVE ANALYSIS OF WILLBRIDGE OF SANTA BARBARA, INC.

A dissertation submitted

by

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ABSTRACT

This quantitative study was conducted to determine the effectiveness of homeless housing programs in increasing the income, life skills, and residency of clients. Data were gathered for 43 clients of WillBridge of Santa Barbara, Inc., provider of both transitional and supportive housing to homeless, mentally ill clients; 17 study participants were current clients, 26 had exited the program. Data collected included client participation in each of several program activities, as well as data on employment, income, and residency factors. The goals of the study were to determine not only the overall effectiveness of the program, but also the impact of specific program activities on meeting each program goal. Results from the study support the effectiveness of the program in meeting goals: both income and life skills were significantly improved amongst clients, and several clients obtained residency, as defined by this study. The prediction that specific program activities would be significantly related to client change was supported: Attainment of employment was significantly related to the completion of job applications, attainment of a bank account, participation in interview training, and resume writing; increase in income was significantly related to interview training and having employment; having contact with a family member was significantly related to obtainment of housing upon exit from the program. This study contributes to the body of knowledge on the effectiveness of homeless housing programming; transitional and supportive housing programs providing services to homeless, mentally ill clients can utilize the results to
provide areas for specific focus when working with clients toward goals of attaining employment, and increasing income, life skills, and residency. It is reasoned that the inclusion of program activities shown to be effective in this study will prove similar effectiveness in each of these areas in other programs. Additional program evaluation research, utilizing a larger sample taken from several transitional and supportive programs, is suggested to further knowledge of the effectiveness of specific program components on positively impacting homeless individuals. The electronic version of this dissertation is available free at OhioLink ETD Center, www.ohiolink.edu/etd.
ACKNOWLEDGMENTS

The inspiration for this research lies in the hearts of the founders, employees, and clients of WillBridge of Santa Barbara, Inc., who allowed me into their “homes,” and shared so much of their time, stories, and aspirations with me. This dissertation is dedicated to WillBridge’s mission to reduce homelessness, by “creating opportunities to embrace life changes.” Through my work on this project, I gained a unique understanding of the lives of the “forgotten,” and was moved by the growth these individuals experienced with the support of WillBridge. It is my hope that this research will serve as part of a service provision groundwork, one that promotes transitional and supportive housing program components that are designed to best serve the needs of homeless, mentally ill individuals. It is also my hope that this project will spark additional research into effective solutions for these members of our society.

In addition to the gratitude I have for those who allowed themselves to be embodied in this research, I also have the support of an entire team of individuals to thank, whose contributions made this research possible. To my Dissertation Committee, in particular Dr. Sharleen O’Brien, Dr. Ryan Sharma, and Dr. Juliet Rohde-Brown, your input, insight, and encouragement were integral to the completion of this project. You were each a constant source of knowledge, providing ideas, helping through roadblocks, and promoting my movement through
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CHAPTER I: BACKGROUND AND RATIONALE FOR THE STUDY

Introduction and Background

“Grab on to the firm hands of God. Trust the one, the few, the many he sends your way. You may trip, or stumble, or even fall, but one day at a time, faith WillBridge your path.”

--Lynnelle Williams, Founder of WillBridge

Homelessness knows no bounds, has no limits. It claims victims of all genders, races, abilities, and ages. In an Annual Homeless Assessment Report to Congress (AHAR), the U.S. Department of Housing and Urban Development (HUD) reported that on a single night in 2011, a total of 636,017 people were experiencing homelessness in the United States; two-thirds of these homeless individuals were lucky enough to be staying in a shelter or housing program, while the other one-third were unsheltered, sleeping on the streets, in their cars, in abandoned buildings, or in another location not meant for human habitation (AHAR, HUD, 2011).

Of these homeless individuals, a large number were considered chronically homeless, meaning they had been continually homeless for a year or more, or had at least four episodes of homelessness during the last three years; of these chronically homeless individuals, many also have severe disabilities. Nearly four in ten (36.8 percent) sheltered homeless adults have a disability, which is staggering in comparison to 24.6 percent of the poverty population and 15.3 percent of the total
U.S. population having disabilities (AHAR, HUD, 2010). A homeless adult, therefore, is nearly 2.5 times more likely to have a disability than an adult in the U.S. population as a whole (AHAR, HUD, 2010); these homeless individuals are at a particularly higher risk of homelessness if their disability is one related to substance abuse or mental health, as these disabilities can make it increasingly difficult to work and to earn enough income to afford housing.

The effects of homelessness are widespread, and deleterious to both the individual and society at large. Individuals living in homelessness experience an array of adverse conditions, including mental and substance use disorders, extreme poverty, malnutrition, victimization, social stigma, and bias (Rosenheck, 2000; Rickards et al., 2010). The negative impact of homelessness on society is equally great, as it contributes to increased heath care costs, as well as increased legal system costs, for communities (Rickards et al., 2010).

In response to the deleterious effects, and in an effort to reduce their impact on both the individual and on society, numerous public policies, programs, and advances have been created to address homelessness, stimulating the construction of several homelessness programs and service provisions. The primary goals of these initiatives were to address the needs of homeless individuals, improving their access to support, mental health, substance abuse, and other services; this provision of services was aimed at helping the homeless to move into permanent housing and achieve residential stability (Rickards et al., 2010). Some of these programs and
service components included street outreach and engagement, co-occurring mental health and substance abuse treatment, permanent and supportive housing, and programs involving collaboration between community and health support systems (Rickards et al., 2010).

The initiatives proved effective in increasing housing stability and reducing treatment costs, amongst homeless clients (Mares & Rosenheck, 2007; Rosenheck et al., 1998), increasing their support service usage, including mental health, physical health, substance abuse treatment, and housing assistance services (Rosenheck et al., 1998), while also improving quality of life and increased mental health functioning (Mares & Rosenheck, 2007). The results of these initiatives suggested that such programming could positively impact homeless individuals, as well as society, by reducing the negative impacts corresponding to chronic homelessness.

In the years since the establishment of these initiatives, numerous housing programs have been developed to address the issue of homelessness; these programs are comprised of emergency shelters, transitional housing programs, and supportive or permanent housing for homeless individuals; these programs offer different levels of care and service provision. Research evaluating these housing programs has shown that they have similar effectiveness in reducing the negative impact of homelessness, by increasing residency and housing stability for homeless individuals (Bolton, 2005; Steriopoulos et al., 2010; Washington, 2002).
While many of the larger initiatives and housing programs are government based, and therefore heavily researched, there are also several smaller housing programs, those started by individuals with personal experience and the desire to use that experience to address and aid the large-scale social problem of homelessness. Without large government grants, these programs are often left to compile evidence of their effectiveness on their own. This is how the current research endeavor developed, as a program evaluation of a transitional and supportive housing program in Santa Barbara, CA. While the founders of this program, WillBridge of Santa Barbara Inc. developed their programs overall structure, as well as individual service components from many years of experience working with the homeless population, and were succeeding in growing their programs size, they had not yet evaluated their effectiveness in areas that providers of grants and funding for housing programs were eager to see. In a partnership between WillBridge, Antioch University of Santa Barbara, and the researcher, a program evaluation was conducted, with the goal of providing data regarding not only the overall effectiveness of the program, but also on the specific impact of particular program components and activities on this effectiveness.

**WillBridge of Santa Barbara, Inc.**

In November 2003, Lynnelle Williams and Gale Franco-Trowbridge, who had years of experience between them working to provide services for homeless individuals, came together to establish their own transitional and supportive housing
program, WillBridge of Santa Barbara, Inc. The goals of the program, which has now been in operation for 10 years, are similar to those of previously researched homeless housing programs; the program focus is on effectively increasing the residency and housing stability of their homeless clients, particularly homeless individuals who also have a mental illness. Additional goals of the homelessness services provided by the program include increased income and increased life skills of clients; the program provides a collaboration of comprehensive services, a strategy proved effective by previous public policy, in order to best meet these goals.

Williams and Franco-Trowbridge, in founding WillBridge, noticed that there was a gap in homelessness services in their community; specifically, they noticed a need for an alternative solution to the incarceration, violent crimes, and assaults that the chronically homeless and mentally ill were faced with when living on the street. They saw opening WillBridge as an opportunity to utilize their skills, resources, and combined career experiences, to assist homeless individuals in obtaining a positive and productive future. As described by Williams (2003),

WillBridge is a path to restoration; creating opportunities to embrace life changes. The program focus is on rebuilding self-confidence, self-esteem, and self-respect. Structure, discipline, peer-accountability, and self-accountability aid in reintroducing people to interactive and fruitful daily lives. . . . One day at a time, and one person at a time, WillBridge is
committed to helping each person who is ready for a life changing experience.

Since WillBridge was founded in 1993, the program has provided housing, food, clothing, and a number of supportive services to hundreds of homeless, mentally ill clients. While the program is largely influenced by service components that have proved effective in large-scale homeless housing research, and the success of the program can be seen in growing numbers of clients and the expansion of housing sites, WillBridge has yet to compile empirical data as additional evidence of their effectiveness in meeting program goals. This type of data would prove useful to the program, as they apply for grants and other funding, to continue supporting their vision of helping each homeless individual “who is ready for a life changing experience.”

This research project developed as a means of meeting the need for such empirical data, regarding the effectiveness of WillBridge in meeting its goals of reducing homelessness, by increasing the income, life skills, and residency of their homeless, mentally ill clients. It goes one step further to evaluate the specific impact of program activities and components in meeting each of these goals. Program activities such as assistance in opening a bank account, budgeting, completing job and housing applications, job interview training, resume writing assistance, participation in pro-social activities, medication compliance, and engagement in referrals for mental health, medical health and substance abuse were tracked, and
then statistically analyzed for their level of impact on overall program goals. The results and discussion of the resulting data provide explanation for how WillBridge can incorporate this research into their programming, as well as areas for focus and improvement. Also addressed in the discussion of this data is the generalization of results as a means to improve and organize the development of similar homelessness housing programs, as well as areas of proposed focus for future research in this area.

Scope of the Study

This quantitative research study has the goal of contributing to the knowledge base of homeless housing program effectiveness, by providing a quantitative evaluation of the effectiveness of WillBridge of Santa Barbara, Inc. in meeting its goals of reducing homelessness by increasing the income, life skills, and residency of their clients. Now a well-established transitional and supportive housing program, WillBridge provides services for homeless individuals who also have a mental illness. Beyond the provision of housing, the WillBridge program delivers outreach, case management, and several support services to clients, including referrals to health care, mental health care, and substance abuse treatment, as well as support in employment, life skill, and housing attainment. Program services, such as assistance in opening a bank account, budgeting, completing job and housing applications, job interview training, resume writing assistance, participation in pro-social activities, medication compliance, and engagement in referrals for mental health, medical
health and substance abuse, are provided with the primary goals of increasing the income, life skills, and residency of clients.

This quantitative study goes beyond determining whether the WillBridge program is effective as a whole in accomplishing these primary program goals, by also measuring which of the particular program components and support services contribute to each individual goal, and to what degree. Such evaluation will provide increased knowledge of transitional housing program service components and their impacts on clients. The resulting data will be valuable in many facets, providing input on the structure and development of new housing programs, as well as to the revision of existing programs that provide housing and support services to homeless individuals, particularly those with a mental illness.
CHAPTER II: REVIEW OF THE LITERATURE

Literature Review

The problem of homelessness is one that continues to exist and grow; this is a consequence of many complex factors, including increased rates of unemployment and poverty, coupled with decreased and limited access to affordable housing. While specific reasons vary, research shows that the main factor contributing to homelessness is an inability to obtain affordable housing. According to the United States Department of Housing and Urban Development (HUD), an estimated 12 million renter and homeowner households now pay more than 50 percent of their annual incomes for housing; a family with one full-time worker, earning a minimum wage, typically cannot afford the rent for a two-bedroom apartment anywhere in the United States (HUD, 2012). This percentage is in stark contrast to the generally accepted definition of housing affordability, which is no more than 30 percent of monthly income going toward housing costs; families or individuals who pay more than this amount can have difficulty affording and meeting their basic needs, such as clothing, food, and health care (HUD, 2012).

When the discrepancy between earned wages and living costs becomes unmanageable, many families and individuals become unable to meet rent and mortgage payments; some of these individuals, particularly those with certain risk factors, eventually succumb to homelessness. While inadequate income and inability to afford housing are large social risk factors contributing to homelessness, there are
also individual factors to take into consideration, as being risk factors for homelessness. Persons with a disability, for example, are at higher risk of homelessness because certain disabilities can make it difficult to work and earn enough to afford housing; this is particularly true when the disability is one relating to substance abuse or mental health issues (Stergiopoulos et al., 2010). In addition to having a disability, certain socio-demographic characteristics, such as being male, poor, of minority ethnicity, or poorly educated, have also been found to be factors associated with homelessness (DeLisi, 2000). Incarceration may also be a factor increasing the risk of homelessness, as it often causes a weakening of community and family ties, as well as decreased opportunities for employment and housing (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005).

Taking both social and individual risk factors into account, it is evident that homelessness can affect a great number of diverse individuals; the homeless population today is comprised of those from various ethnic backgrounds, and includes both men and women, as well as single individuals and families, unaccompanied youth, and individuals with severe and persistent mental health and substance use issues (AHAR, HUD, 2010). This homeless population is left without a place to call home, and with little access to the social, familial, community, and health supports they need to regain control of their lives.

The overarching problem of homelessness has prompted public awareness of the need for programs and interventions specifically designed for homeless
individuals. Over the past few decades, numerous local and government policies, initiatives, and programs have been developed to support such interventions, and have shown different aspects of effectiveness in meeting the unique needs of the homeless population. In particular, a great deal of focus has been directed toward the service needs of homeless individuals with a disability, such as mental health issues and problems with drugs or alcohol; it is this subpopulation of the homeless that are most susceptible to chronic, or long-lasting homelessness, while at the same time being most resistant to engaging in services (Stergiopoulos et al., 2010).

Defining Homelessness

Before beginning a review of homelessness services, programs, and their effectiveness, it is important to first define differing categories of homelessness. In reference to defining homelessness, a 2011 HUD report proposed four possible categories under which individuals and families qualify as homeless. The categories are,

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence; this includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
2. Individuals and families who will imminently lose their primary nighttime residence;
3. Unaccompanied youth, and families with children and youth, who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition;

4. Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member. (HUD, 2011)

This definition of homelessness provides a snapshot of the general, highly diverse makeup of a homeless individual. These individuals have no residence to sleep in or place to call home, include women, children, and families, and also include those who have experienced life-threatening situations causing them to leave their home. In defining homelessness it becomes evident that the category is broad, and encompasses a large area of the social spectrum.

In addition to defining the concept of homelessness as a whole, there has also been work done to differentiate and categorize homelessness types. In research conducted on the homeless population, it was identified that there were clusters of individuals who remained homeless for extended periods of time or who frequently cycled in and out of homelessness (Kuhn & Culhane, 1998). Kuhn and Culhane (1998) termed these individuals “chronically” and “episodically” homeless. In 2006, the U.S. Department of Housing and Urban Development (HUD) combined these two terms, defining them as chronic homelessness:
A chronically homeless person is an unaccompanied adult with a disabling condition—most commonly with a serious mental illness, substance-related disorder, developmental disability, or chronic physical illness or disability—who has been continuously homeless for one year or longer, or had at least four homeless episodes during the last 3 years. (HUD, 2006)

This definition of chronic homelessness has come to be widely accepted for purposes of research and literature on homelessness; this subgroup of homeless individuals have been specifically targeted by programs and services, due to the more severe nature of their homelessness and the risks it poses on the individual and society.

In addition to defining categories of homelessness, there has also been work done to define and measure varying degrees of homelessness, in reference to the residency status of homeless individuals. These definitions work to categorize homelessness, maintaining consistency and comparability amongst research studies conducted with this population (Orwin, Scott, & Arieira, 2003). HUD, in conducting annual homelessness reports, distinguishes two categories of homelessness: sheltered and unsheltered. A homeless individual is considered sheltered if they are in an emergency shelter or transitional housing program for homeless persons. A homeless individual is considered unsheltered if they are living in a place not meant for human habitation, such as the streets, abandoned buildings, vehicles, parks, and train stations (AHAR, HUD, 2010). The terms “sheltered: and “unsheltered” are
often used in the literature on homelessness, particularly when describing homelessness statistics.

Research by Orwin, Scott, and Arieira (2003), worked to extend and further define such categories of homelessness, making them less broad, and more specific, for research purposes. Their research took into consideration residential status categories used in prior research, as well as residential categories outlined in the Addiction Severity Index, 5th edition, which was designed to assess lifetime and previous month problem severity in several areas (medical, employment/finances, alcohol, drug, legal, psychiatric, and family/social area) (McLellan et al., 1992). The four resulting residential status’ categories homelessness types from highest to lowest residential stability:

1. Stable Housing: (a) own house/apartment, (b) own SRO (single-room occupancy) room, (c) group home, boarding house, or board-and-care facility, or (d) parent/guardian’s house/apartment.

2. Institutional Housing: (a) residential treatment or recovery program, (b) hospital (including psychiatric facility, (c) nursing home, (d) jail or prison, or (e) corrections half way house.

3. Marginal Homelessness: (a) in a hotel/motel, (b) in someone else’s SRO room, (c) in someone else’s apartment or house (not parent/guardian, or (d) transitional housing.
4. Literal Homelessness: (a) on the street or other outdoor place, (b) in a vehicle, abandoned building, or indoor public place, or (c) in emergency shelter. (Orwin, Scott, & Arieira, 2003)

The defining of these categories becomes important to research conducted on the homeless population, as housing programs seek to provide evidence for their effectiveness in decreasing homelessness and increasing residency among homeless individuals. How one defines “homeless,” “shelter,” and “residency” can influence study and research results, and must be taken into account when reviewing the impact of homelessness, as well as the effectiveness of programs and services addressing the problem.

**Negative Impacts of Homelessness**

The negative impacts of the problem of homelessness are wide-ranging and deleterious to both the individual and society. Individuals experiencing homelessness are often subjected to a vast array of adverse conditions, including mental and substance use disorders, extreme poverty, and malnutrition, as well as social and physical victimization (Rickards et al., 2010; Rosenheck, 2000). The three main areas of adverse impact of homelessness on the individual, as outlined by Rickards et al. (2010), are behavioral health and substance use conditions, poor physical health, and encounters with the legal system. Along with these areas, the criminalization of homelessness has an additional adverse impact, as it exposes the homeless population to the experience of stigma, prejudice, and violent acts. Each of
these factors contribute to adverse impacts on a larger social scale; these social impacts include increased health care and emergency medical costs, as well as increased legal system costs, which are related to increased rates of crime and incarceration (Rickards et al., 2010).

**Behavioral health and substance use.** The first main area of adverse impact, behavioral health and substance use conditions, refers to the increased occurrence of psychiatric conditions and substance use among homeless individuals. Among the homeless, mental illnesses such as schizophrenia, bipolar, major depression, psychotic disorders, substance use, and personality disorders are common (Folsom et al., 2005; Martens, 2002). Research suggests that between one-fourth and one-third of homeless individuals also have a severe mental health disorder; half of these individuals also have a co-occurring substance use disorder (Folsom et al., 2005). This is alarming in comparison to statistics from the general U.S. population, which suggest that only one in 17 individuals have a severe mental health disorder, with one-fourth of these individuals also having a co-occurring substance use disorder (Kessler, Chiu, Demler, & Walters, 2005).

The US Department of Housing and Urban Development’s Annual Homeless Assessment Report to Congress (AHAR, 2010) showed similar prevalence of mental health and substance usage issues amongst homeless individuals who were sheltered; 26.2 percent had a severe mental illness and 34.7 percent had chronic substance use issues. The rates amongst chronically homeless were even more staggering;
according to analyses of data from The National Survey of Homeless Assistance Providers and Clients (NSHAPC), over 60% of people who are chronically homelessness have experienced lifetime mental health problems, and over 80% have experienced lifetime alcohol and/or drug problems (1996). Based on NSHAPC data, those individuals who have co-occurring disorders are more likely to reside in emergency shelters, rather than in more permanent forms of shelter or housing, have had three or more episodes of homelessness within the past year, and have longer (more than 24 month duration) episodes of homelessness, than homeless clients who do not have co-occurring disorders (1996).

**Physical health impact.** Another main area of adverse impact of homelessness on the individual is poor physical health. Long periods of homelessness threaten the health and well being of homeless individuals; individuals who endure homelessness often suffer from chronic and severe health conditions (Barrow, Herman, Cordova, & Struening, 1999). These health conditions, which include asthma, arthritis, vision impairment, skin and bone problems, cardiovascular diseases, frostbite or hypothermia, diabetes, dental disease, seizures, and cognitive impairments, are often the result of homelessness, or are worsened by its conditions (Ensign & Santelli, 1997; Kermode, Crofts, Miller, Speed, & Streeton, 1998; O’Connell et al., 2004). The physical health problems of homeless individuals are exacerbated by several conditions of homelessness; homeless individuals may be more vulnerable to these problems due to personal habits or living conditions, such
as inadequate food intake, high-risk behaviors such as smoking, insufficient sleep accommodations, lack of hygiene, exposure to extreme weather, and habituating in areas with high rates of infectious disease or pollution (Kermode et al., 1998; Krieger & Higgins, 2002; Wiecha, Dwyer, & Dunn-Strohecker, 1998).

Homeless individuals are also subject to common illnesses, such as colds and flus; these illnesses, however, are often worsened by homelessness conditions, such as poor health care and unsanitary living conditions, often making them more detrimental to homeless individuals than to the general public (Sachs-Ericsson, Wise, Debrody, & Paniucki, 1999). Homeless individuals also have a high prevalence of AIDS and HIV infection; The National Alliance to End Homelessness estimates that 3.4 percent of homeless people were HIV-positive in 2006, compared to only 0.4 percent of adults and adolescents in the general population (Centers for Disease Control and Prevention, 2008). Homeless individuals with a co-occurring mental illness may be at an even higher risk of poor health; a study by Desai and Rosenheck (2005) found that 43.6 percent of persons who are homeless and have a severe mental illness have needs for medical care that have not been properly addressed.

**Legal system involvement.** In addition to behavioral health issues, substance use issues, and poor health, homelessness adversely impacts both the individual and society by increasing their involvement in the criminal justice system, thereby increasing their risk for arrest and incarceration. The NSHAPC reported that 54 percent of homeless clients had been incarcerated (1996); homeless individuals
may be subject to these high rates of criminal justice system involvement due to a variety of factors. One such factor, it is thought, is that homelessness itself may be criminogenic, or tend to produce criminality in itself; this criminality may be reflective of the efforts of homeless individuals to survive with limited resources (McNiel, Binder, & Robinson, 2005). Certain socio-demographic characteristics, such as being male, poor, of minority ethnicity, or poorly educated, have also been found to be associated with both homelessness and risk of criminal justice system involvement (DeLisi, 2000). While some research suggests that homelessness increases risk of incarceration, it has also been suggested that the association between homelessness and incarceration is bi-directional; incarceration may in fact increase the risk of homelessness, by reducing community and family ties, as well as opportunities for employment and housing (Kushel, Hahn, Evans, Bangsberg, & Moss, 2005).

Additional factors also contribute to increased rates of criminal justice system involvement among homeless individuals; poor health, substance abuse, and mental illness, all common among homeless individuals, increase their risk of criminal justice system involvement (Kushel et al., 2005). Individuals who are homeless and have a mental illness or other co-occurring disorders are more likely to be arrested and to be incarcerated for longer periods of time than non-homeless inmates (McNiel, Binder, & Robinson, 2005).
The provision of statutes and laws, meant to address the problem of homelessness, have also criminalized it; this criminalization creates an increase in offenses committed by homeless individuals. For example, there is legislation that makes it illegal to sleep, sit, or store personal belongings in public places, in cities where people are forced to live in public spaces; there is selective enforcement of loitering or open container laws, against homeless persons; and there are also laws that punish people for begging or panhandling, designed to move poor or homeless individuals out of a particular community area (NCH, 2006). This high risk for committing criminal offenses increases involvement with police and sheriff employees, public defenders, court officials, jails, and prisons (McNiel et al., 2005); collectively, the increased involvement of homeless individuals with the legal system requires a great deal of aid and resources, creating substantially increased legal costs to the community.

Criminalization, stigma, prejudice, and violent acts. In addition to putting the homeless population at a high risk for committing crimes, the criminalization of homelessness also increases their risk for being the victims of crime. This victimization is thought to be due, in part, to social stigma and prejudice toward the homeless population. According to the National Coalition for the Homeless (NCH), there is a documented relationship between increased police action in regards to homelessness and increased numbers of hate crimes and violent acts against the homeless population (2012); for example, in states that have enacted severe anti-
camping, panhandling, anti-feeding, and other criminalization of homelessness laws, hate crimes against homeless individuals frequently occur (NCH, 2012). One possible explanation for this correlation is that homelessness laws send negative messages regarding the homeless population; this message is then reflected in the attitudes that the general population has toward homeless people, and may contribute to stigma, prejudice, and violent acts against them.

According to the NCH, in the past twelve years (1999-2010), there have been 1,184 documented acts of violence against homeless individuals by non-homeless, housed perpetrators; 312 of these homeless individuals lost their lives as a result of the attacks (2012). These violent acts include everything from murder to assaults, rapes, robberies, and setting people on fire (NCH, 2012). The experience of such violent crimes puts homeless individuals at an increased risk for serious traumatic injuries, as well as increased risk for psychological trauma (Lam & Rosenheck, 1998).

**Increased health care and emergency medical costs.** Increased health care costs among homeless individuals are associated with several factors. Population-based studies have shown that homeless individuals have higher rates of emergency department use as compared to the general population; homeless individuals are three times more likely to use an emergency department at least once in a year (Kushel, Vittinghoff, & Haas, 2001). Kushel, Perry, Bahgsberg, Clark, and Moss (2002), in a study on emergency department use among the homeless, found that
40.4 percent of study respondents had one or more emergency department visits in the previous year; 7.9 percent exhibited high rates of use, with more than three visits, and accounted for 54.5 percent of all emergency room visits. Factors associated with these high use rates included unstable housing, crime victimization, arrests, physical and mental illness, and substance abuse (Kushel et al., 2002).

**Increased legal system costs.** In addition to increased health care costs, another main area of adverse impact of homelessness, on society, is increased legal system costs. Homeless individuals, particularly those who have a mental illness or other co-occurring disorder, are at a greater risk of legal system involvement, both as crime perpetrators and victims (McNiel et al., 2005). Offenses committed by homeless individuals are often related to their homelessness; these offenses include violent crimes, property crimes, drug related offenses, and public disorder offenses (Greenberg & Rosenheck, 2008). This increased involvement of homeless individuals with the legal system requires a great deal of aid and resources, creating substantially increased legal costs to the community.

**Public Policy Response to Homelessness**

A realization of the widespread negative impacts of homelessness called for the evolution of governmental response and development of public policy; such policy was needed to both acknowledge and counteract these impacts, lessening their effects on individuals and society. The earliest response to homelessness was informal and crisis-based, taking the form of short-term emergency shelters and
emergency food programs (Couzens, 1997). During the time of this emergency strategy development, in the 1980’s, it was believed that homelessness was a short-term problem, one that would be eradicated with the end of the recession; it was quickly realized that the problem of homelessness was far more persistent, and in need of a more permanent and well-thought out response. In 1987, the U.S. Congress responded to this need, passing the McKinney-Vento Homeless Assistance Act, which was the first federal law of its kind, implemented to specifically address homelessness.

The McKinney-Vento Homeless Act (1987). The McKinney-Vento Homeless Act (1987) originally consisted of 15 programs, providing a wide range of services to homeless individuals at a local level; these service programs were expected to establish a multi-tier homeless support system, meeting the varied needs of different classes of homeless individuals. Fundamental to the model of program services established by The McKinney Act (1987) were three levels of homelessness support: emergency shelter programs, transitional housing, and permanent supportive housing. These support levels were differentiated by the degree of assistance, services, and permanency of housing they provide, from lowest to highest level; the model was referred to as the Continuum of Care (CoC), whereby homeless clients move from one tier of service to another in their transition to stable housing (Interagency Council on the Homeless, 1994).
At the first level of care in the CoC model are emergency shelter programs, which are intended to provide short-term housing and services to those with immediate needs; emergency shelters provide services to a diverse population of individuals, from those with minor to severe physical disabilities, mental health issues, and homelessness histories (Kuhn & Culhane, 1998). At the second level of care in the CoC model are transitional housing programs; these programs are designed to provide temporary housing and support services to homeless individuals who are not ready for, or do not yet have access to, more permanent forms of housing. Transitional housing programs are considered to be “service intensive” and aimed at “promoting housing readiness through the provision of treatment and therapeutic services, as well as services enabling homeless clients to achieve self-sufficiency through housing assistance, case management, employment, and training” (Wong, Park, & Nemon, 2006, p. 69). At the third level of care in the CoC model are permanent supportive housing programs. These programs provide long-term community-based housing and support services for homeless individuals with disabilities, such as mental illness and physical disabilities, with the purpose of enabling them to live as independently as possible in a permanent setting (HUD, 2002).

Since the passage of The McKinney Act (1987), there has been a great deal of funding and growth in all three levels of support and services outlined by the CoC model. A study by Wong, Park, and Nermon (2006) compared the organizational
and service aspects of these programs, examining the extent to which they are consistent with the CoC model. The study found five distinct domains of services provided to clients by homeless shelter and housing programs:

1. Basic needs services, including the provision of food, clothing, and transportation.
2. Treatment services, including health care, mental health care, and substance abuse treatment.
3. Services promoting self-sufficiency/independence, including life skills training, case management, housing assistance, and employment assistance.
4. Services for women and children, including education and child-care.
5. Legal and veteran services.

In comparing the provision of these services, significant differences were found across emergency, transitional, and supportive housing programs; transitional housing programs, overall, offered more services than either of the other two programs, especially in regards to services promoting self-sufficiency and independence (Wong, Park, & Nemon, 2006).

Research in this area has become extensive, conducted in efforts to determine the effectiveness of homeless housing programs and best organize and implement their service components. Transitional housing in particular has become of increased interest to researchers, as it is the level of care that has the goal of “promoting housing readiness” for clients and offers the most services promoting independence.
(Wong, Park, & Nemon, 2006, p. 69). It is hoped that through the provision of these services, that homeless individuals will be able to obtain more permanent and stable housing, and to retain that housing for a longer period of time, reducing the repetitive nature of homelessness, and thereby reducing the negative impacts it has on both the individual and society.

**Access to Community Care and Effective Services and Supports**

**Program.** The McKinney Act (1987), and resulting CoC model of service provision, inspired a new era of homelessness programming. It was realized through research on this programming, that fragmentation of service and support systems was a hindrance to the delivery of community-based care for people with severe and persistent mental illness, particularly those who are homeless (Goldman et al., 1992). Appropriate care for these individuals requires a wide range of services, including mental and physical health care, income support, housing assistance, substance abuse treatment, and social and vocational training. Programs addressing these service needs had already been developed, however, they all worked independently of one another; there was still a need for greater integration and coordination of service delivery. It was reasoned that an integration of support services, or a “coming together” of services in one unified program, would improve both their accessibility and effectiveness amongst homeless, mentally ill clients (Goldman et al., 1992).
In 1993, the U.S. Department of Health and Human Services initiated the Access to Community Care and Effective Services and Supports (ACCESS) program, in efforts to address the need for greater homelessness service integration. The ACCESS program was a 5-year, 18-site program with two major goals: To increase service system integration through site-specific development strategies, and to evaluate the impact of these strategies on homeless clients with mental illness. All sites involved in the program received funding in order to provide assertive outreach and case management services to clients. It was proposed that the factors related to coordination of service delivery could be identified at two distinct levels:

1. At the inter-organizational or service system level, it was believed that “service delivery can be improved by strengthening or centralizing relationships between agencies to foster cooperation and communication.”

2. At the client level, it was believed that “delivery of comprehensive services can be effected directly by clinical case management teams” (Rosenheck et al., 1998, p. 1610).

Essentially, the ACCESS program aimed to increase communication and relationship strength between support agencies, while also unifying the delivery of these support agency services through a case management team. The goal being that services such as mental health, physical health, substance use treatment, and housing assistance agencies, would be brought together, and delivered to clients through one single program.
A study by Rosenheck et al. (1998) examined the relationship between levels of service system integration at the beginning of the ACCESS project and differences in access to services and housing outcomes among clients who received case management. Clients were eligible for case management if they were homeless, had a serious mental illness, and were not already involved in community treatment. The study measured client use of services that had already been established as effective in the care of homeless individuals: housing assistance, mental health services, general health care, substance abuse services, income support, and vocational rehabilitation; the integration of these services, defined by the diversity and number of services used, was compared to the housing outcomes of program clients (Rosenheck et al., 1998).

The results from the Rosenheck et al. (1998) study found significant changes from baseline to follow-up, on almost all measures of service use and housing outcomes; clients increased their service usage of psychiatric care, substance abuse care, medical care, housing services, income support, and job assistance. The impact of an integrated service system and case management was particularly prominent in the usage of housing services, and the attainment of independent housing for clients; the percentage of clients who had lived in an apartment or house of their own increased from 5 percent at baseline, to 25 percent at a 3 month follow-up, and 44 percent at a 12 month follow-up (Rosenheck et al., 1998). The conclusion from this study, and from the implementation of programs such as the ACCESS program, is
that the integration of service systems is related to improved access to housing and better housing outcomes among homeless people with mental illness. These findings had, and continue to have, great impact on the development of homelessness programming.

**Collaborative Initiative to Help End Chronic Homelessness.** To date, one of the largest compilations of research on homelessness service and residency provision was derived based on the Collaborative Initiative to Help End Chronic Homelessness (Rickards et al., 2010). This initiative, influenced by the McKinney Act and research on service system integration, was a coordinated effort by the U.S. Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD), the Veterans Affairs (VA), and U.S. Interagency Council on Homelessness (ICH), with the intent of being a “comprehensive programmatic response” to the issue of homelessness, particularly chronic homelessness (Rickards et al., 2010, p. 155). The primary goals of the initiative were to,

- Address the complex needs of individuals experiencing chronic homelessness by improving access to support, mental health, substance abuse, and other health and recovery services, create additional permanent supported housing for individuals experiencing chronic homelessness, help those living in the streets and in shelters to move into permanent housing, and provide assistance to help them achieve residential stability. (Rickards et al., 2010, p. 155)
Although each of the departments involved in this effort had already developed supportive programs addressing homelessness, the CICH initiative was the first large-scale collaborative approach, between several governmental agencies, to programming; the initiative coordinated cross-department funding, program monitoring, and technical assistance for creating and managing the programs (Rickards et al., 2010).

The CICH initiative funded 11 communities with 3 to 5 year grants to support the implementation of particular services that previous research had shown to be effective components in aiding the homeless (Rickards et al., 2010). These services included the provision of primary health care services, mental health services and substance abuse treatment, case management, housing, and service integration, all of which were evaluated and measured to determine the effectiveness of the initiative (Mares & Rosenheck, 2007). Using program evaluation methodology, effectiveness of the initiative was measured: CICH clients had increased housing stability, reported improved quality of life, increased their mental health functioning, and had reduced treatment costs (Mares & Rosenheck, 2007). The results of the CICH initiative suggested that such programming could positively impact homeless individuals, as well as society, by reducing the negative impacts that correspond with homelessness.

The CICH responded to the need for collaboration in addressing the needs of the homeless. By providing this collaboration of large systems in addressing
homelessness, the CICH proved effectiveness in areas beyond the attainment of housing; it also increased mental health functioning and reduced treatment costs amongst clients. The needs of homeless individuals are complex, and there are continuously new understandings of how to best meet these needs. Through government involvement and the initiation of public policy, the development and revision of homelessness programs has been strongly influenced; most notably, there has been movement toward an increased collaboration between systems and a multi-faceted approach to the construction of programmatic components.

**Effectiveness of Housing Programs and Support Interventions**

Beyond the CICH initiative, several different models of housing and support programs have been implemented in response to homelessness, with several of these programs also focusing on homeless individuals with serious mental illness. As is indicated by research, this subgroup of homeless individuals has a great need for support; they are at an increased risk for homelessness, particularly chronic homelessness, and are at an increased risk of negative impacts such as incarceration, health issues, and violent victimization (Rosenheck, 2010). In order to counteract these negative impacts, this subgroup demands programs that work to address their particular needs, as well as research determining the effectiveness of services in meeting those needs.
**Housing program research.** Several studies, implementing different methodological designs, have been conducted to evaluate the impact and effectiveness of different interventions and programs for homeless individuals with mental illness (Nelson, Aubry, & Lafrance, 2007; Rosenheck, 2000). These studies have largely focused on the effectiveness of particular programs in meeting program and client goals, as well as on ascertaining how the overall program, including several components, impacts clients in important areas of well being, independence, and functioning.

Washington (2002) completed a qualitative study evaluating the effectiveness of a transitional housing program by conducting in depth interviews with ten participants who had graduated from the program and acquired permanent, stable, independent housing. The study asked clients which of the program’s support services enabled them to attain housing and remain self-sufficient and independent. The participant’s responses demonstrated that the most helpful services focused on budgeting, job training, and leadership skills; budgeting classes provided knowledge of how to prioritize responsibilities and rationally use low income, while job training aiding clients in making career choices and also focused on the social aspects needed to secure a job, such as grooming for an interview, interviewing skills, and resume writing. Other services that participants reported as being helpful, in making their transition from homelessness to independence, included networking with community
resources, aid with housing, employment, and financial aid referrals, and counseling (Washington, 2002).

The Washington (2002) study results are in line with additional studies that have utilized different research methodologies. In a program evaluation conducted by Bolton (2005), a supportive housing program was evaluated utilizing a longitudinal, qualitative approach. This particular housing program targeted homeless individuals with diagnoses of severe mental illness, and the study tracked their progress in meeting program goals over a 5-year span. Through program evaluation, five outcome goals for the participants of this particular housing program were determined: increased socialization, psychiatric functioning, adult living skills, quality of life, and housing stability. Specific services provided by the program included crisis intervention, hospitalization if needed, psychotropic medication evaluation and prescriptions, education on medication management, outpatient counseling, skill training related to self-care, health care, housekeeping, mobility, drug use, money management, interpersonal relationships, vocational/educational pursuits, leisure time, and community participation (Bolton, 2005).

The results of the Bolton (2005) study found that this particular program, as implemented, was successful in helping the homeless. Housing stability was achieved for 84% of clients, management of psychiatric symptoms was achieved for 80%, attainment of adult living skills achieved by 73%, socialization goals were met for 72%, and the quality of life goals were met for 54% of the clients. Predictors of
change in these areas included demographic variables, baseline measures and length of stay in the program, complexity and severity of mental illness, client satisfaction with the program, and compliance with treatment (Bolton, 2005). The results of these studies suggest that several program factors play a role in determining the success of a participant in transitional housing; this information can be used to inform best practices in housing program development.

**Housing program versus standard treatment.** With respect to the housing outcomes of homelessness programs, research has been done to compare some form of permanent housing and support to standard treatment; in this comparison there was evidence for a greater improvement in stable housing for clients who participate in housing and support interventions (Nelson, Aubry, & Lafrance, 2007). There have also been studies comparing permanent housing and case management services with case management only; a study by Rosenheck, Kasprow, Frisman, and Liu-Mares (2003) demonstrated that housing plus case management was more effective than case management alone in creating better housing outcomes for clients. During a 3-year follow-up to the study, participants who had housing plus case management services as part of their program had 16 percent more days housed than the case management only group, and 25 percent more days housed than the standard care group. The experimental group also experienced 35 percent fewer days homeless than each of the control groups (Rosenheck et al., 2003).
The Rosenheck et al. (2003) study also suggested that homeless clients who enter housing and support programs obtain a better quality of housing when compared to those provided with standard treatment or case management alone, including fewer housing problems, a higher subjective quality of life regarding one’s housing, and more choice and control over one’s housing (Rosenheck et al., 2003). The results of this study also had implications from a societal perspective; cost-effectiveness ratios suggested that the experimental housing plus case management program had only modestly increased societal costs (Rosenheck et al., 2003).

Positive impacts of homeless housing programs. In addition to evaluating the effectiveness of homeless housing programs in meeting client goals, evaluation of the positive individual and social impacts of these programs has also been a major focus area of research. An important finding of research on the homeless, mentally ill population, is that as participants in housing and support programs, they show greater reductions in the use of institutional services, including hospitalization, jails, and prisons, than participants in comparison groups (Rosenheck et al., 2003; Tsemberis, Gulcer, & Nakae, 2004).

Other facets of the positive impacts of homelessness programming have also been researched. A study by Hurlburt, Wood, and Hough (1996) reported that homeless individuals participating in housing and support programs were more likely to be involved in community programs, and to stay involved in them, than those not engaged in a program. One of the most important of these community programs, the
study suggested, was engagement in case management services (Hurlburt, Wood, & Hough, 1996). There are also studies that have found a reduction in substance use amongst clients, for programs that have a substance abuse treatment component; a study by Drake, Yovetich, Bebout, Harris, and McHugo (1997) found that a group of clients, who had substance treatment integrated with mental health and housing interventions, had fewer institutional days and more days in stable housing, made more progress toward recovery from substance abuse, and showed greater improvement of alcohol use disorders than a standard treatment group (Drake et al., 1997). This study also suggested improvements in the psychiatric symptoms, functional status, and quality of life, of those clients who received integrated treatment (Drake et al., 1997).

Additional studies evaluating the effectiveness of homelessness programming, including case management and assertive community treatment as service components, have shown this programming to be superior when compared to standard treatment in several areas. In homeless, mentally ill clients, this type of homelessness programming produces more positive self-ratings of overall health and well-being, improves ability to meet basic needs, increases contact with family members, improves overall life satisfaction (Lehman et al., 1999; Shern et al., 2000), increases personal income, and improves interpersonal adjustment and self-esteem (Morse et al., 1997). Several research studies have emphasized the need to develop continuous treatment teams (CTT) to treat severely mentally ill clients; these teams
provide comprehensive services, including outreach services, long-term housing assistance, and intensive case management.

A study by Morse, Calsyn, Allen, Tempelhoff, and Smith (1992) compared the effectiveness of the continuous treatment team (CTT) approach against two other approaches (day treatment and outpatient therapy) in assisting homeless mentally ill individuals. In the Morse et al. (1992) study, the CTT approach employed clinical case managers to work intensively with their clients. Service provision was targeted to three main areas: (a) individual change, (b) environmental change, and (c) providing support to minimize the disparity between clients' needs and environmental resources and demands. Program activities associated with individual change included forming a therapeutic relationship, helping clients learn effective problem solving strategies, linking clients with psychiatric medication services, teaching community living and interpersonal skills, and providing crisis intervention. Program activities associated with environmental change included caseworker advocacy in obtaining resources for welfare, housing, and health needs. Program activities related to providing support included money management services, medication management, and transportation.

Results of the Morse et al. (1992) study showed that clients in all three conditions (CTT, day treatment, and outpatient therapy) had improved income, psychiatric symptoms, self-esteem, and interpersonal adjustment. Clients in the CCT approach, however, showed particularly positive outcomes on two variables: days of
remaining stably housed in the community and personal satisfaction with their treatment program.

**Summary of the Literature**

Throughout the literature on supportive and transitional housing, many common themes emerge. The main overarching theme is that homeless, mentally ill individuals are best aided by the provision of supportive housing, delivered in conjunction with a collaboration of support services, in order to make their transition off of the street and into independent housing of their own. The importance of system integration and case management was another re-occurring theme in the literature. Clients who participate in case management and engage in diverse and numerous services, such as health care, mental health care, substance abuse treatment, life skills training, housing assistance, and employment assistance, have been shown to gain significant improvement in their global well-being, finances, mental and physical health, and residency (Rife, First, Geenlee, Miller, & Feichter, 1991). Service collaboration and case management provide clients with an effective treatment approach, by strengthening relationships between service agencies and bringing them together to aid in the care of each client.

The program components reviewed in the literature, that have been shown to contribute to homeless housing program effectiveness, include budgeting, job training, and leadership skills, networking, housing referrals, crisis intervention, collaboration with medical and mental health care, medication evaluation and
prescriptions, education on medication management, outpatient counseling, skill training related to self-care, health care, housekeeping, drug use, money management, interpersonal relationships, vocational and educational pursuits, and community participation.

The provision of programs that incorporate these service components has been shown to have a positive impact, on both an individual and social level. On an individual level, the positive impacts of homeless housing programs include the improved socialization, psychiatric functioning, living skills, quality of life, employment, and housing stability of clients. On a social level, the positive impacts of homeless housing programs are evidenced by greater reductions in the use of institutional services, including hospitalization, jails, and prisons, as well as reduced treatment costs amongst clients. Continuous research is necessary to ensure that homelessness programs, which include the provision of housing, case management, and support services, are providing the best care and outcome for the individual, as well as best solution to a social problem.

**Gap in the Literature**

What emerges from the literature on homelessness, particularly with regard to chronic or mentally ill homeless individuals, is that homelessness is a widespread problem with numerous negative impacts on the individual and society. There is a need for a collaborative, systematic, and multi-faceted approach to homelessness programs that seeks to reduce homelessness by increasing residency and stability
among clients. The culmination of research suggests that in order for a transitional housing program to be successful in the goal of reducing homelessness, by moving individuals from the street into independent, stable housing, the program should combine several components: the provision of safe housing and case management; referrals for community resources and housing; networking with medical, mental health, and drug treatment programs; the provision of educational program services that teach job skills, money management, and the development of daily living skills; and the promotion of socialization and community involvement.

The limitation of many previous studies on homeless housing program effectiveness is that they do not provide data on which particular program aspects contribute to the acquisition of client and program goals. Rather, these studies show that the overall program, including all components as a whole, is successful in accomplishing program goals. Additional quantitative studies, that serve to operationalize specific program components, will be helpful in determining which particular components aid the homeless, mentally ill client in attaining program goals, such as obtaining employment, housing, or increased levels of personal functioning. The current quantitative research study has the goal of making such a determination, and of contributing to the knowledge base of homelessness program effectiveness, by providing a quantitative evaluation of a WillBridge of Santa Barbara, Inc., a transitional and supportive housing program in Southern California.
Now a well-established housing program, providing services for homeless individuals who also have a mental illness, WillBridge provides outreach, case management, housing, and the provision of several services to their clients, including referrals to health care, mental health care, and substance abuse treatment, as well as support in life skill development, with the primary goals of increasing the income, life skills, and residency of their clients. This quantitative study will go beyond determining whether the WillBridge program is effective as a whole in accomplishing these program goals; it will also measure which particular program components contribute to each goal, and to what degree. Such evaluation will provide increased knowledge of homeless housing program components and their impacts, and be valuable to the development of new housing programs, as well as to the revision of existing programs that provide services to homeless, mentally ill clients.

Research Questions

The research and design for this study is non-experimental, quantitative, and founded on practice-based participatory research; the data collected and measured was derived based on program evaluation methodology, and developed in conjunction with WillBridge’s key stakeholders. This methodology was used to develop a Program Theory (Appendix A), and ultimately a Data Plan (Appendix B), for WillBridge of Santa Barbara, Inc. The WillBridge Data Plan was then used as a guideline to create Case Manager Weekly (Appendix C) and Monthly (Appendix D)
Checklists. These checklists were implemented into the WillBridge program, for client tracking, in order to gather the data necessary to answer the question of whether their program is meeting its intended goals of increasing the income, life skills, and residency of clients. Data from these checklists, in conjunction with data from the client ADL measure, intake, and exit data, were collected to answer the research questions proposed by this study.

The purpose of this study, then, is to determine:

1. Is there a statistically significant difference between the income and life skills of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it?
   a. Specifically, is there a significant relationship between participation in the WillBridge program and client change of income?
   b. Also, is there a significant relationship between participation in the WillBridge program and client change in life skills, as measured by the Measure of Activities of Daily Living (MADL) scale?

2. What are the housing outcomes for the WillBridge program, measured by percentage of clients who obtain residency, as defined by this study, upon exit?
3. Is there a significant relationship between specific WillBridge program activities and client change in income and attainment of employment?
   a. Specifically, which of the program’s activities are most indicative of attaining employment?
   b. Also, which of the program’s activities are most indicative of increasing income?

4. Is there a significant relationship between specific WillBridge program activities and client attainment of residency, as defined by this study?
   a. Specifically, which of the program’s activities are most indicative of obtaining independent housing?

**Defining of Key Terms**

**Income**

Income, for the purposes of this study, will be defined as the total dollar amount of income, per month, brought in by a client through employment and/or government benefits.

**Life Skills**

Life skills, for the purpose of this study, will be defined as client score on the Measure of Activities of Daily Living (Appendix E). This measure rates level of independence in completing a number of life skills, including bathing, dressing, grooming, completion of chores, management of finances, home maintenance, and management of medications.
Employment

Employment, for the purposes of this study, will be defined by any paid, legal employment obtained by a client.

Residency

Residency, for the purpose of this study, will be defined as a client’s exit from the WillBridge program into a more permanent form of housing. This includes residency in independent housing, permanent supportive housing, long-term residential treatment, with a family member.

Independent Housing

A client’s attainment of independent housing is a major goal of transitional housing programs. Independent Housing, for the purposes of this study, will be defined as the client’s attainment of an individual lease or outside supportive housing. Moving in with family or friends, or being transferred to residential treatment, will not be defined as a client’s attainment of independent housing.

Research Hypotheses

Research Hypothesis One

1. There will be a positive relationship between the income and life skills of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it.
a. Specifically, participation in the WillBridge program will be positively related to a client’s increase in income.

b. Also, participation in the WillBridge program will be positively related to an increase in clients’ life skills, as measured by The Activities of Daily Living Measure used in this study.

**Research Hypothesis Two**

2. Clients participating in the WillBridge program will move from homelessness and obtain residency, as defined by this study.

**Research Hypothesis Three**

3. The implementation of WillBridge program activities will be significantly related to client change in income and attainment of employment.
   
a. Specifically, the completion of job applications, attainment of a bank account, ability to budget one’s own funds, participation in interview training, and resume writing, will be significantly related to client increase in income and attainment of employment.

**Research Hypothesis Four**

4. The implementation of WillBridge program activities will be significantly related to client attainment of residency, as defined by this study.
   
a. Specifically, attendance in school or vocational instruction, employment, medication compliance, having family contact,
average change in ADL score, participation in pro-social activities, and engagement in referrals, will be significantly related to client obtainment of residency.
CHAPTER III: RESEARCH DESIGN AND METHODOLOGY

Research Design

The research and design for this study will be non-experimental, quantitative, and founded on practice-based participatory research. Practice-based research aspires to conduct research in a manner that engages and involves participants; rather doing research in or on a particular population, this type of research strives to do research with that population, involving them in key elements throughout the research process. The principles of participatory research include trust building, long-term relationships, shared decision making, and identification of population relevant clinical questions (Westfall et al., 2009). The data collected and measured was derived based on program evaluation methodology, and was collected through observer report, by WillBridge case managers. The three measures utilized to collect data were developed specifically for this study: (a) Weekly Case Manager Checklist, (b) Monthly Case Manager Checklist, and (c) Measure of Activities of Daily Living.

The WillBridge housing program was developed in 2003 and has since then grown in size significantly. In making efforts to gain funding, key stakeholders in the WillBridge program realized that, while they had their growth in size and clientele to show as evidence of their “success,” they did not yet have empirical data to demonstrate and verify such effectiveness. Through a grant, WillBridge was able to obtain program evaluation services from Antioch University, Santa Barbara. Several meetings occurred between WillBridge key stakeholders and the program
evaluation team; the researcher for this study worked on the evaluation team as a Graduate Assistant. Through these collaborative meetings, a Program Theory (Appendix A) was developed, delineating the activities, outputs, outcomes, and impacts of the WillBridge program. The activities outlined in the Program Theory refer to specific program services provided to clients; the outputs refer to the specific measurable product derived from each activity; the outcomes refer to what immediate outcome, or goal, the activity works toward achieving; and the impact refers to the impact of attaining that goal on a broader scale.

The purpose of the development of a Program Theory was to create an outline of the main goals of the WillBridge program, and the services that are provided in efforts to reach those goals. The resulting WillBridge Program Theory (Appendix A) identified three main areas of focus for which the program provides services. These areas of focus are (a) homelessness services, (b) outreach, and (c) community enrichment. The current research study focused solely on the area of homelessness services, as this is the domain where the greatest amount of program activities reside, and is also an area of particular focus for WillBridge, as they attempt to gain funding for their program. In the area of homelessness services, the developed Program Theory revealed three main outcomes, or goals, of the program: 1) increased income, 2) increased life skills, and 3) increased residency.

In order to measure the effectiveness of the WillBridge program in meeting these three main goals, a Data Plan (Appendix B) was developed utilizing
information from the Program Theory. The Data Plan outlines each of the program goals set forth in the Program Theory, and then identifies the particular program activities related to the attainment of each goal. For example, on the WillBridge Data Plan, under the program goal of “increase income,” is the program activity of “assisting with job applications.” Also, under the goal of “increase residency” is the program activity of “assisting with public housing applications.” Next, the Data Plan outlines specific indicators, or the quantifiable measures to be collected in regards to each program activity; also outlined is how each of these indicators is to be tracked. For example, an indicator, or quantifiable measure of the activity “assisting with job applications” is, “the number of job applications submitted.” The Data Plan shows that this particular indicator will be tracked weekly, and reported as “average number of unemployed clients.” Each WillBridge program goal is outlined and organized by the Data Plan in this manner.

As the next step in the program evaluation process, the Data Plan was used as a guideline to create Case Manager Weekly (Appendix C) and Monthly (Appendix D) Checklists. These checklists were implemented in WillBridge’s client tracking, to gather the data necessary to answer the question of whether they are meeting their intended program goals. As the objective is to determine the effectiveness of their program in meeting its said goals, this research study was designed to answer the main question of whether the transitional housing program implemented by
WillBridge of Santa Barbara, Inc. is effective in attaining its three main goals of increasing the income, life skills, and residency of homeless, mentally ill clients.

This research study is non-experimental and quantitative in design; the data was collected through observation. The measurement instruments used, the Weekly and Monthly Checklists and the Measure of Activities of Daily Living, were completed by WillBridge case managers for each client. The case managers are assigned clients and follow that particular client base throughout their stay at WillBridge. The case manager was the sole person responsible for completing the instruments for their clients. The Weekly Case Manager Checklists were completed on a weekly basis, and the Monthly Case Manager Checklists were completed on a monthly basis, for each client, throughout their stay at WillBridge. Upon time of data collection, the most recent Weekly and Monthly Case Manager Checklists were collected, indicating client’s current status, or for exited clients, their status just prior to exit. The data on these Checklists summarizes which program activities were engaged in by the client throughout their participation in the WillBridge program.

The Measure of Activities of Daily Living were also completed by case managers, and completed twice for each client, once at admission into the program, and once at exit, or at current status, for clients still participating in the program at the time of final data collection. Data from these measures is quantitative in nature, and appropriate for statistical analysis.
There are methodological advantages to using observation as a data collection method: a) observation is a direct measure of behavior that provides concrete evidence of the subject being studied; b) observation enables researchers to evaluate behavior within its context; and c) observation is appropriate for studying behavior that study participants may not be aware of, or behavior that may not be accessible through self-report (Barker, Pistrang, & Elliot, 2002). These methodological advantages are in line with the assumptions made by the current study, as it sought to collect data on individuals who are mentally ill and homeless, and who often have other disabilities. Self-report, in this instance, might not have yielded accurate accounts of client ability, participation, and behavior, as it collects data only on the client’s personal sense of these factors. Observation, on the other hand, provides direct measures and data, collected by outside observers who are reasoned to have a more objective and overall view of the client. In addition, this research seeks to study and evaluate client behavior in its context; observation allows data to be collected in their environment, as a part of the clients’ natural program services at WillBridge. With consideration of the research goals particular to this study, observer report will provide the most accurate collection of data.

There are several methodological advantages to using a quantitative research method; these advantages best served the research purposes of this study. This study sought to determine the effectiveness of a program in meeting its goals, and in particular, gaining a better understanding of what specific program components
contribute to the attainment of each goal. A quantitative method allowed for statistical analysis of each individual study variable, and aided in a greater precision of measurement in determining which components contribute to WillBridge’s program effectiveness. This research study, which aims to contribute to the body of knowledge on transitional housing program structure, is well suited by a quantitative method, in that the findings may be generalized to a wider population. Such generalization will allow for assumptions that this study’s findings can be related to other transitional housing programs, particularly those with a similar client base of homeless, mentally ill individuals.

In addition, the WillBridge program is aided by having an evidence base for their practices. WillBridge may use data from this study in future grants and proposals for funding, as support that their program is effective in attaining its service goals. A quantitative method lent itself to statistical analyses of the data WillBridge is collecting, and allowed for statistical inference of how well these data met the study predictions, that WillBridge is effective in increasing the income, life skills, and residency of its clients. WillBridge now has numerical data, which facilitates communication of findings, to share for the purposes of gaining grants and funding. While it may have been possible to complete this study qualitatively, such a method would not have provided for the statistical data and generalizability sought by the research results.
The type of data collected for this research also lent itself to a quantitative, rather than qualitative, method, as it was best collected by observation, and was not meant to be an in depth exploration of the clients. The clients may not have provided accurate self-reports of their progress, as such self-report would have provided data based on their personal sense of ability and participation, rather than objective observation. Observatory data that are collected with the purpose of finding relationships between study variables are most appropriate for a quantitative method. Once data was collected and analyzed, it was used to answer the study’s research questions; discussion of the meaning and impact of these results is provided.

**Participants**

Participants were clients of WillBridge of Santa Barbara, Inc., residing in one of their transitional or supportive housing units for a minimum of 30 days. In order for a current client to participate in the study, the individual must have been at least 18 years old, and have given consent for their information to be provided to the research. The clients of WillBridge are homeless, and often suffer from mental illness. In an effort to ensure informed consent, clients had to have been at WillBridge for at least 30 days, before being allowed to participate. This was reasoned to give the client a chance to settle in to the WillBridge program, and also to give them time to receive medical and psychiatric care, including medication allotment and management.
Data from previous clients, who had been at WillBridge for a minimum of 30 days, was also included in this study. Informed consent was not required of these individuals, as it was part of their agreement with WillBridge that their data may be used for research and funding purposes. Also, as clients who are no longer in the program, they are not subject to the potential negative impacts of this research, such as any repercussion for non-participation from WillBridge case managers. Their information was provided to the researcher without identifying data included.

Instrumentation

Case Manager Checklists

Development of the measures. Most variables in this research were measured using Weekly (Appendix C) and Monthly (Appendix D) Case Manager Checklists. These checklists were developed through a program evaluation process and derived from the content of the resulting Program Theory (Appendix A) and Data Plan (Appendices B) for WillBridge of Santa Barbara, Inc.

The WillBridge Program Theory and Data Plan identified three main desired outcomes of the program’s homelessness services: 1. Increase income, 2. Increase life skills, and 3. Increase residency. These are considered to be the main “goals” of the program, and were the focus of this study, with regards to the effectiveness of the program in meeting them, and also which particular program activities contribute to that effectiveness. The WillBridge Program Theory outlined each of these desired outcomes and associated them with the related service activities that the program
engages clients in; these activities were then associated with their measurable outputs on the WillBridge Data Plan.

As outlined by the Program Theory, the first program outcome/goal, of “increased income” is associated with several activities that WillBridge offers and engages clients in: (a) assisting clients in completing job and disability applications, (b) helping clients to open back accounts and maintain a budget, (c) assist clients in building resumes, and (d) train clients in interview skills and proper attire (Figure 1a). The Data Plan then outlines the indicators, or measurable aspect, of each program activity, and associates that activity with the specific indicator to be tracked in its regard (Figure 1b). These “increase income” indicators include, for each client, the (a) source and amount of their monthly income (tracked monthly), (b) duration of their employment (tracked monthly), (c) attainment of a bank account (tracked weekly), (d) ability to maintain a budget (tracked monthly), and (e) the number of job and disability applications submitted (tracked weekly). Each of these indicators was tracked/measured on a weekly or monthly basis, by use of the Weekly and Monthly Case Manager Checklists, which were created specifically for such measurement.
As outlined by the Program Theory, the second program outcome/goal of “increased life skills” was also associated with several of the activities that WillBridge provides clients: (a) assisting clients in completing social services and
school/training applications, (b) community field trips, (c) assignment of chores, (d) teaching activities of daily living (ADL’s), (e) transporting clients to appointments, and (f) one-on-one meetings with case managers (Figure 2a). The Data Plan then outlines the indicators, or measurable aspects, of each these program activities (Figure 2b). These indicators to be tracked with regards to “increased life skills” activities include, for each client, their (a) attendance in school or vocational training, (b) employment, (c) participation in pro-social activities or groups, (d) maintenance of ADL’s, (e) medication compliance, (f) family contact, (g) engagement in referrals, (h) compliance with action plan made in conjunction with a case manager, and (i) compliance with house rules. Each of these indicators will be tracked/measured on a weekly basis, by use of the Weekly Case Manager Checklist.

**Figure 2a: Program Theory Outline of “Increase Life Skills”**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Output</th>
<th>Outcome</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist clts in completing applications for</td>
<td># of soc. Services apps</td>
<td>Increase life</td>
<td>Increase self-determination in the</td>
</tr>
<tr>
<td>-Social Services</td>
<td></td>
<td>skills</td>
<td>homeless population</td>
</tr>
<tr>
<td>-School/training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Field trips</td>
<td># of school/training apps</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assign residential clients chores</td>
<td># of field trips</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teach ADLs</td>
<td># of chores assigned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-counsel on hygiene</td>
<td># of hygiene counsels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-teach and assign cooking duties</td>
<td># of cooking lessons/assignments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-counsel on med compliance</td>
<td># of med compliance counsels</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transport clts to appts</td>
<td># of transports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1:1 mtgs w/ case mngr</td>
<td># of 1:1 mtgs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Figure 2b: Data Plan Outline of “Increase Life Skills”**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Indicators</th>
<th>How to Track</th>
<th>Reported As</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Life Skills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assistance with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Social services applications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o School applications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Community field trips</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Assignment of chores</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hygiene counsels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medication compliance counsels</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cooking lessons</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Referrals to substance abuse services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intervention for family reunification</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical and MH referrals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Encourage pro-social activities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• client attendance in school/vocational training (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of all clients</td>
<td></td>
</tr>
<tr>
<td>• client employed (yes/no)</td>
<td></td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of all clients</td>
</tr>
</tbody>
</table>
| • Participation in pro-social activities/groups: number of activities; times per week | Weekly (in 1:1 mtgs) | % participating of all clients | % of clients in 1, 2, or 3+ activities  
\[ \times \text{activities/week} \]
| • Maintenance of ADLs           | ADL Measure at referral, intake, and discharge       |                       | % client change (at threshold)      |
| • medication compliance (yes/no) | Weekly (in 1:1 mtgs)                                 | % of clients complying with prescriptions |
| • Engagement in referrals (yes/no) | Weekly (in 1:1 mtgs)                                 | % of clients engaging in referrals   |
| • Compliance with action plan (yes/no) | Weekly (in 1:1 mtgs)                                 | % of clts with >= 80% compliance   |
| • Compliance with house rules (# of write-ups) | Weekly (in 1:1 mtgs) | % of clients above threshold decreasing to below threshold between months |

As outlined by the Program Theory, the third program outcome/goal of “increased residency” was also associated with several of the program activities that WillBridge offers to clients: (a) one-on-one meetings with a case manager, (b) obtainment of clothing for clients, (c) assistance with applications for housing, (d)
assistance in getting into residential treatment, (e) assistance in family reunification efforts, and (f) connection with mental health and substance abuse treatment (Figure 3a). The Data Plan then outlines the indicators, or measurable aspects, to be tracked with regards to “increased residency” activities include, for each client, (a) where they are discharged to (independent housing, residential treatment, family, or “other”) (tracked at discharge) and (b) number of housing applications completed in each housing category (tracked monthly, by use of the Monthly Case Manager Checklist) (Figure 3b).

**Figure 3a: Program Theory Outline of “Increase Residency”**
**Figure 3b:** Data Plan Outline of “Increase Residency”

<table>
<thead>
<tr>
<th>Activities</th>
<th>Indicators</th>
<th>How to Track</th>
<th>Reported As</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Residency</td>
<td>Transitional housing</td>
<td>At discharge</td>
<td>% going to each category</td>
</tr>
<tr>
<td></td>
<td>Basic needs: Clothing, shelter, food</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Application for public housing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referrals to residential treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intervention for family reunification</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For clients defined as “chronically homeless” – discharged from WillBridge to: Independent housing, residential treatment, family, other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>For clients not defined as “chronically homeless” – discharged from WillBridge to: Independent housing, residential treatment, family, other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Housing applications (Section 8; MHA – Garden St.; Artisan Ct.; El Carillo; Senior)</td>
<td>Monthly (checklist)</td>
<td>% of clients in each category</td>
</tr>
<tr>
<td></td>
<td>Application completion (30/60/90/90+ days)</td>
<td>Monthly (checklist)</td>
<td>% of clients in each category</td>
</tr>
</tbody>
</table>

**Weekly and Monthly Case Manager Checklist.** The Weekly and Monthly Case Manager Checklists served as the primary method of data collection for this study and were completed by WillBridge case managers for each client. The case managers are assigned clients and follow that particular client base throughout their stay at WillBridge. The case manager was the sole person responsible for completing the instruments for their clients. The Weekly Case Manager Checklist was completed on a weekly basis, and the Monthly Case Manager Checklist was completed on a monthly basis, for each client, throughout his or her stay at WillBridge.
Measure of Activities of Daily Living

The Measure of Activities of Daily Living used in this study (Appendix E) was created by combining two established and well utilized measures, the Katz Index of Independence in Activities of Daily Living Scale (Katz, Ford, Moskowitz, Jackson, & Jaffee, 1963) (Appendix F) and the Instrumental Activities of Daily Living Scale (Lawton & Brody, 1969) (Appendix G).

The Katz Index of Independence in Activities of Daily Living. The Katz Index of Independence in Activities of Daily Living (Katz ADL) Scale (Appendix F) was developed as a standardized quantitative measure for evaluating treatment, prognosis, and functional changes in older people and people with chronic illnesses in institutionalized settings (Katz et al., 1963). The scale is a long established and widely used index of activities of daily living (ADL) that has been described as the most appropriate scale to assess an individual’s ability to perform ADL independently, regardless of their condition (Cohen & Marino, 2000). While the original KATZ ADL scale ranked seven categories of dependency, it was difficult to interpret, and a modified form of the scale was later developed (Katz & Akpom, 1976). In this modified form, six ADL categories are given a rating of dependence/independence with regards to the person’s ability to perform bathing, dressing, toileting, transferring, continence, and feeding. Through observation and interview, clinicians rate each ADL activity on a three-point scale of independence; the most dependent degree of performance during a two-week period is recorded. A
score of 6 indicates full function, a score of 4 indicates moderate impairment, and a score of 2 or less indicates severe functional impairment (Katz & Akpom, 1976). Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care for clients accordingly (Shelkey & Wallace, 1998).

**Reliability and validity.** Little formal reliability and validity reports exist in the literature; however, the Katz ADL is used extensively to signal functional capabilities of older people in clinical and home settings and has consistently demonstrated its evaluative utility, signaling functional capabilities in clinical and home environments (Shelkey & Wallace, 1998).

**Strengths and limitations.** The Katz ADL Index serves as an assessment of the basic activities of daily living and has been found to be useful in creating a common language about patient function for all practitioners involved in their overall care (Shelkey & Wallace, 1998). The limitation of the scale, however, is that it does not assess more advanced activities of daily living. Also, although the Katz ADL Index is sensitive to changes in declining health status, it is limited in its ability to measure small increments of change, as it is based only on three-point scale (Shelkey & Wallace, 1998).

**The Instrumental Activities of Daily Living Scale.** The Lawton Instrumental Activities of Daily Living (IADL) Scale (Appendix G) is an instrument appropriate in the assessment of independent living skills (Lawton & Brody, 1969). The living skills assessed by this scale are considered to be more complex than the
basic activities of daily living measured by the Katz ADL Index. The IADL has shown usefulness for identifying how a person is functioning at present, and to identify improvement or deterioration over time (Graf, 2008). There are eight domains of function measured with the Lawton IADL scale: ability to use a telephone, shopping, food preparation, housekeeping, laundry, mode of transportation, responsibility for own medications, and ability to handle finances. Clients are scored according to their highest level of functioning in that category. A summary score ranges from 0 (low function, dependent) to 8 (high function, independent) (Lawton & Brody, 1969).

The IADL is intended to be used with older adults, and can be used in a variety of settings; however, the instrument is not useful for institutionalized older adults. It can be used as a baseline assessment tool and to compare a client’s baseline function to future assessments for knowledge of skill gain or decline (Graf, 2008). This IADL is widely used both in research and in clinical practice.

**Reliability and validity.** Few studies have been performed to test the reliability and validity of the Lawton IADL scale. Lawton and Brody (1969), however, tested the IADL concurrently with the Physical Self-Maintenance Scale (PSMS) and inter-rater reliability was determined with a sample of 12 subjects; correlation between the scores of two raters was 0.85. The same Lawton and Brody (1969) study found the reproducibility coefficient for the IADL to be 0.96 for men and 0.93 for women.
Validity of the Lawton IADL was also tested by Lawton and Brody (1969) using a sample of 180 subjects who were given the scale, and also up to four additional tests that measured different domains of functional status: self-care activities, physical health and mental health, and behavioral and social adjustment. The correlations between the IADL scale and the other measures of functional status ranged between 0.40 and 0.61.

**Strengths and limitations.** The strengths of the Lawton IADL include that it has the ability to measure more complex levels of function than an ADL instrument, it is relatively quick (administration time is 10-15 minutes) and easy to administer, and it provides self-reported information about the functional skills necessary to live independently (Graf, 2008). The strengths and deficits in skills that the IADL identifies can assist practitioners in targeting the best care for clients, and can also identify readiness or appropriateness of a client for independent living. Limitations of the IADL include that raters rely on a self-report method of administration rather than requiring the client to demonstrate the functional skill. This may lead either to an over or under-estimation of the client’s ability (Yasuda et al., 2004). Another limitation of the IADL is that it may not be sensitive to small or incremental changes in client functioning (Graf, 2008).

**Measure of Activities of Daily Living.** The Measure of Activities of Daily Living used in this study (Appendix E) was created by combining the Katz Index of Independence in Activities of Daily Living Scale (Katz ADL) (Katz, Downs, Cash,
& Grotz, 1970) (Appendix F) and the Instrumental Activities of Daily Living Scale (Lawton IADL) (Lawton & Brody, 1969) (Appendix G). ADL from each scale were reviewed with WillBridge key stakeholders to determine which daily living skills were important to track/measure, and most in line with the skill level and needs of their transitional housing clients. The specified ADL from both the Katz ADL and Lawton IADL were then combined to create the Measure of Activities of Daily Living (Appendix E). The measure assesses independence in performing bathing, dressing, grooming, mouth care, toileting, walking, climbing stairs, eating, shopping, cooking, managing medications, using the phone, chores, laundry, driving or using public transit, managing finances, and home maintenance.

The scoring for the Measure of Activities of Daily Living ranges from 0 to 3 for each item, and is based on rater observation, not self-report. A score of “0” means that the client “cannot do,” or is not at all able to perform, the skill; a score of “1” means that the client is able to perform the skill, but only completely “dependent” on another person; a score of “2” means that the client is able to perform the skill somewhat independently and only “needs help” from another person; a score of “3” means that the client can perform the skill and is completely “independent” in ability to do so. The score from each individual item is added together for a total score, with a maximum score of 51. The Measure of Activities of Daily Living was completed by WillBridge case managers for each client, at both intake and at exit, or at current status for clients still in the program at time of data
collection, to assess the level of independence the client has in performing ADL, as well as any gain or decline in functioning.

**Reliability and validity.** As a measure developed specifically for WillBridge, the Measure of Activities of Daily Living scale has not yet been used in research; there are no specific reliability or validity measures for its use. However, the scale is closely modeled after two well-established measures of ADL, and is meant to measure skills in the same manner as those measures. It is reasoned that the Measure of Activities of Daily Living scale has similar validity and reliability to the scales it is derived from.

**Strengths and limitations.** The strengths of the Measure of Activities of Daily Living scale are that it is relatively quick and easy to administer, and measures *both* basic and advanced ADL (rather than one or the other). In addition, it provides observer-reported information; having a case manager actually observe clients perform each ADL task will increase accuracy of the measure, particularly in comparison to client self-report of ability. In addition, the skills included in the measure were selected for their appropriateness with the particular population being studied. The strengths and deficits in these particular skills will act as a measure of independence for clients, assisting case managers in targeting the best care for them, as well as identifying readiness or appropriateness of the client for independent living.
Limitations of the Measure of Activities of Daily Living scale include that it is not a previously researched measure, and does not have specific data regarding its validity or reliability. Inter-rater reliability is unknown, and it may be possible that individual raters consider the skill level necessary for “dependent” and “independent” ratings differently, which may skew the scores and affect statistical analyses of the results. Another limitation of the measure is that it is based on a 4-point scale, which may not be sensitive to small or incremental changes in client functioning.

*Appropriateness of Measure for study.* The Measure of Activities of Daily Living scale was developed specifically for the clients at WillBridge, who served as the population for this study. The scale was derived by combining two established and well-utilized measures, the Katz Index of Independence in Activities of Daily Living Scale (Katz ADL) (Katz, Ford, Moskowitz, Jackson, & Jaffee, 1963) and the Instrumental Activities of Daily Living Scale (IADL) (Lawton & Brody, 1969). The Katz ADL has long stood as a standardized quantitative measure for evaluating treatment, prognosis, and functional changes in older people and people with chronic illnesses in institutionalized settings; it has the ability to assess an individual’s ability to perform ADL independently, regardless of their condition (Katz et al., 1963). The IADL is also intended to be used with older adults, and can be used in a variety of settings; it has usefulness for identifying how a person is functioning at present, and to identify improvement or deterioration over time.
The clientele at WillBridge are adults with mental illnesses and a history of homelessness; their demographic make-up is in line with the intended population for ADL/IADL measures, and therefore in line with the intended population for the Measure of Activities of Daily Living scale. In addition, the goal of using the Measure of Activities of Daily Living scale is to identify a client's present functioning (at intake) and their improvement or deterioration over time, after engagement in the WillBridge program (at current or exit). An additional goal of the scale is to evaluate the prognosis and level of independence (readiness for independent living) of clients. Each of these goals is in line with the functional use of ADL/IADL scales, and therefore in line with the Measure of Activities of Daily Living scale to be used in this study.

**Data Collection Procedures**

The participants, as a part of their stay at WillBridge of Santa Barbara, Inc., had their information collected through an Intake Form, Weekly and Monthly Case Manager Checklists, and a Measure of Activities of Daily Living scale; this data collection was already in place as a mandatory aspect of their participation in the WillBridge program. Upon data collection, each current client who had been at WillBridge for at least 30 days, was given an Informed Consent form, by the researcher, explaining the scope of the study and giving them the option to participate, or not to participate. Participants were asked to sign the consent form, and place it in an envelope collected by the researcher. Case Managers were not
informed as to whether or not a current client decided to participate. If a client chose to participate, their information from all forms was included in the study; those who opted not to participate did not have their information included.

Once informed consent was given, the researcher accessed all information from the client’s WillBridge file, including their Intake Form, Weekly and Monthly Case Manager Checklists, and a Measure of Activities of Daily Living scale. This access was given by one of the WillBridge founders. In addition, information from several exited clients was provided to the researcher, as informed consent was not necessary for these clients. The measures for these clients were given to the researcher without identifying information. The quantitative data from all measures was then collected, compiled, and statistically analyzed to answer the research questions set forth by this study.

Data Analysis Procedures

The qualitative data collected in this study was organized and analyzed using computer software, specifically, the Statistical Package for the Social Sciences (SPSS). The steps involved included data preparation, data entry, data transformation, and statistical analysis. The statistical test used for analysis varied for each research question.
Research Question One

1. Is there a statistically significant difference between the income and life skills of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it?

   a. Specifically, is there a significant relationship between participation in the WillBridge program and client change of income?

   b. Also, is there a significant relationship between participation in the WillBridge program and client change in life skills, as measured by Activities of Daily Living Scale?

Independent variables. The independent variables for this research question:

   1) Income: Interval variable: Measured as the average income, per month, at client intake into the WillBridge program;

   2) Life skills: Interval variable: Measured as the total score from the Measure of Activities of Daily Living scale at client intake into the WillBridge program.
**Dependent variables.** The dependent variables for this research question:

1) **Income:** Interval variable: Measured as the average income, per month, at client current status (after at least 30 days in program) or at exit from the WillBridge program;

2) **Life skills:** Interval variable: Measured as the total score from the Measure of Activities of Daily Living scale at client current status (after at least 30 days in program) or at exit from the WillBridge program.

**Statistical test.** This two-part research question, determining the significance in change of client income and life skills, was analyzed using a Wilcoxon matched pairs test.

**Research Question Two**

2. What are the housing outcomes for the WillBridge program, measured by percentage of clients who obtain residency, as defined by this study, upon exit?

The answer to this question was reported as a percentage of exited clients who obtained residency, as defined by this study. A breakdown of exit data, referring to placement and residency details, is also provided.
Research Question Three

3. Is there a significant relationship between specific WillBridge program activities and client change in income and attainment of employment?
   a. Specifically, which of the program’s activities are most indicative of attaining employment?
   b. Also, which of the program’s activities are most indicative of increasing income?

Independent variables. The independent variables for this research question are program activities related to employment and income:

1) Job application completion
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client has completed job applications;

2) Obtaining a bank account
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client has a bank account;

3) Job interview training
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client has received job interview training;
4) Resume writing assistance
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client has received resume writing assistance;

5) Budgeting ability
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client has received budget training.

**Dependent variables.** The dependent variables for this research question:

1) Employment
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client is employed.
      Employment, for the purposes of this study, will be defined by any paid, legal employment obtained by a client;

2) Income
   a. Interval: Measured as the total dollar amount of income, per month, brought in by a client through employment and/or government benefits.

**Statistical test.** This research question seeks to ascertain which particular WillBridge program activities are significantly related to employment and increased
income among clients. A Spearman rank ordered correlations test was used to make this statistical determination.

**Research Question Four**

4. Is there a significant relationship between specific WillBridge program activities and client attainment of residency, as defined by this study?

   a. Specifically, which of the program’s activities are most indicative of obtaining residency?

**Independent variables.** The independent variables for this research question:

1) Client attendance in school or vocational training
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client is attending school or vocational training;

2) Client employment
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client is employed.

   Employment, for the purposes of this study, will be defined by any paid, legal employment obtained by a client;
3) Participation in pro-social activities
   a. Interval variable: Measured as the average number of pro-social activities participated in per week;

4) Maintenance of ADL
   a. Ordinal variable: Measured by the total score on the Measure of Activities of Daily Living (Appendix E) scale;

5) Medication compliance
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client is compliant with medications;

6) Family contact
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client has had contact with a family member;

7) Engagement in referrals
   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client is actively engaged in referrals (substance abuse, medical, mental health, etc.).
Dependent variable. The dependent variable for this research question is,

1) Residency

   a. Nominal variable: Measured as a “Yes” or “No” with regards to whether or not the client obtained residency upon exit from the WillBridge program. Residency, for the purposes of this study, is defined as the client’s attainment of permanent supportive housing, independent housing, long-term residential treatment, or moving in with a family member.

Statistical test. This research question seeks to ascertain which particular WillBridge program activities are significantly related to the obtainment of independent housing among clients. A Spearman rank ordered correlations test was used to make this statistical determination.

Methodological Assumptions and Limitations

The use of a qualitative research design provides this study with the assumption that the data collected could be analyzed to produce statistically valid answers to the research questions and that the findings will be generalizable to similar environments/populations. To assume generalizability of study results, it is assumed that the population of clients at WillBridge is similar in compilation to the populations of other transitional housing programs. It must be taken into consideration, however, that although the clients at WillBridge are mentally ill and
were homeless at intake, the community of Santa Barbara, where the program is located, is a rather affluent community; even those individuals who are homeless may be different in demographic make-up than homeless individuals in less affluent communities. This difference in demographics may impact the generalizability of study results, and is taken into consideration when discussing the study outcomes.

In respect to data collection, there are several assumptions made in using observer report, and in having the case managers complete the measures for this study. First, it is assumed that the observer/case manager report is more reliable than the self-report of clients. Second, it is assumed that the ratings of different case managers will be made similarly, with inter-rater reliability. Lastly, it is assumed that the case managers will complete the measures as intended, and as outlined in the study proposal.

There are methodological advantages to using observation as a data collection method, one of which is that such observation is appropriate for studying behavior that research participants may not be aware of, or behavior that may not be accessible through self-report (Barker, Pistrang, & Elliot, 2002). This methodological advantage is in line with the assumptions made by this study, as it sought to collect data on individuals who are mentally ill, have a history of homelessness, and who often have other disabilities. Self-report, in this instance, may not yield accurate accounts of client ability, participation, and behavior. With consideration of the population and research goals particular to this study, observer
report is considered to provided reliable data for analysis. The limitation of observer report, however, is that the observer may not accurately complete the measures, and may over-estimate or underestimate aspects of the data for particular clients. This is taken into consideration when discussing results of the study.

There are also methodological assumptions and limitations related to the choice of measures to be used in this study. The three measures, the Weekly and Monthly Case Manager Checklists and the Measure of Activities of Daily Living, were all created specifically for this study; they have no previous research regarding their use for this population or type of study, or research regarding their validity or reliability. It is assumed that, for the Measure of Activities of Daily Living, usefulness, reliability, and validity are comparable to that of the Katz ADL and Lawton IADL. This assumption is considered when discussing results of the measure. It is also assumed that, for the Case Manager Checklists, they measure what they are intended to measure, and that they provided accurate data for analysis. The limitation, again, is that this measure has no previous research regarding their use for this population or type of study, and no research regarding specific validity or reliability.

There were two main goals of this research. The first was to determine the effectiveness of WillBridge in reaching its program goals, increasing income, life skills, and residency for homeless, mentally ill clients. The second was to generalize the findings of the research to transitional housing programs with similar clientele, in
order to contribute to their program effectiveness. The extents to which the results are generalizable are dependent on the clients who opted to participate in the research. It must be considered that the WillBridge clients who consented to participation in the study may differ from those who do not. The clients who consented to participate may be higher functioning, and therefore have a less debilitating mental illness or homelessness history. However, the inclusion of several exited clients, who did not have to consider consent to participate, increases the generalizability of results. These factors were taken into account when discussing the results of the study.

**Ethical Considerations**

The researcher, Antioch University, and WillBridge of Santa Barbara, Inc. are committed to ethical research and the protection of participants in research. The potential benefits and risks of participation in this study were considered, and precautions were put into place to minimize any risks. Participation in this study was completely voluntary and anonymous for current WillBridge clients. All information collected was kept confidential and no identifying client information was associated with research findings. Potential study participants were given all information regarding the rationale behind this study, as well as the research procedure and any potential risks and benefits to participation; all participants who were current clients in the program must have signed an informed consent, opting to participate, before their inclusion in the study.


Considerations and Precautions

Although completion of the measures used in this study, the Weekly and Monthly Case Manager Checklists and The Measure of Activities of Daily Living scale, were part of the program requirements for WillBridge clients, current clients had a choice of whether or not to have the information from those forms used in this study. Participation was completely voluntary and current clients were in no way penalized for opting not to participate. It was considered that WillBridge’s knowledge of a client’s participation might influence the treatment of that client; for example, a client who opts not to participate may be treated less favorably than a client who opts to participate. For this reason, and as precaution to minimize this risk, all current clients must have signed informed consent to participate. Once consent was obtained, their client information was provided to the researcher by one of the WillBridge program founders; none of the case managers, who work with the clients on a daily basis, knew whether or not a client decided to participate in the study.

It was reasoned that the participants in this study, adult clients of WillBridge of Santa Barbara, Inc. were capable of giving informed consent. It was considered that the clients of WillBridge have a history of homelessness, and often suffer from mental illness. In an effort to ensure informed consent, clients had to have been at WillBridge for at least 30 days before being allowed to participate. This time period gave the client a chance to stabilize and settle in to the WillBridge program, and also
time to receive medical and psychiatric care, including medication allotment and management, before participating in the study.

Current clients who had been at WillBridge for 30 days were given the consent form, by the researcher, with the option to choose to participate, or not to participate. The study and the consent form were explained to the client, and the client was also given time to read over the form’s contents. Clients marked their choice of whether or not to participate, signed the Consent Form, and placed it in an envelope that was handed to the researcher. The researcher shared the names of consenting clients with a WillBridge program founder, who provided the researcher with their client information and data. This step was taken as precaution to safeguard against case managers knowing whether a client decides to participate, and to reassure participants that they will not face penalties should they choose not to. Once a client chose to participate, their name was assigned a code number, and for purposes of the research, that code number was the only identification for their information. WillBridge does not have access to these code numbers. Also, there was no inducement to participate, other than the possibility of furthering research on the needs of homeless individuals like the clients themselves, which was explained in the Informed Consent Form.

Those participants who opted to participate in the study were made aware that they were allowing the researcher access to their Intake Form, all Weekly and Monthly Case Manager Checklists, and all Activities of Daily Living measures from
their stay at WillBridge. They were also informed that the overall results of the study would be made available to them, and that they would be welcome to ask any questions they may have of the researcher regarding the study. Participants were provided the researcher’s contact information, as well as the researcher’s supervisor’s contact information, should any concerns or questions arise. Participants were also informed that they could opt out of the study at any time, with no penalty. A reputable referral will be provided for therapeutic support should a participant need it.

**Potential Benefits and Risks to Study Participation**

Since the information requested by this study was already being collected as a part of the program requirements at WillBridge, the researcher did not foresee any additional risks to the participants, regarding the data collection necessary for this study. One potential risk, however, may be that participants would feel obligated to give their consent for participation in the study, or fear penalties from the WillBridge staff, should they choose not to participate. In an effort to minimize this risk, clients of WillBridge were given Informed Consent Forms that outlined the voluntary nature of the study, and were given a clear choice of saying yes or no to participation on that form. They were also be asked to fill out these forms with only the researcher present, and to return them in an envelope to the researchers, reassuring them that the WillBridge case managers would not know whether or not they chose to participate. As an additional safeguard, any WillBridge client who received the informed consent
form, and feels any distress regarding their choice to participate or not, may contact the study investigators with their concerns, and steps will be taken to insure that they receive proper support.

The benefits to this research study were also considered, in reference to both the individual participant and the existing body of knowledge on transitional housing program effectiveness. Previous qualitative studies exploring homelessness services have focused mainly on whether transitional and supportive housing programs are effective in reducing homelessness by increasing residency among clients. While the first order of the current study was to determine WillBridge’s program effectiveness in increasing residency, it also sought to determine the effectiveness of the program in increasing the income and life skills of clients. The effectiveness of a transitional housing program in increasing these two particular areas has little prior research.

In addition to determining transitional housing program overall effectiveness in increasing residency, income, and life skills among clients, this study attempted to go one step further, by determining which particular program components are most indicative of increased income, life skills, and residency among clients. This study takes a step toward identifying what program components are most important to include in the development of transitional and supportive housing programs, as well as indicate areas of focus for existing programs.

Participants who chose to participate in this study may obtain personal benefit as well, in feeling that they have contributed to a better understanding of
what program services are most helpful to provide to homeless individuals in transitional housing; these clients, therefore, can gain a sense of achievement in that they have contributed to the future care of other homeless individuals like themselves. In addition, the findings that certain WillBridge program components are effective in meeting the goals of increasing income, life skills, and residency among clients, gives participants reassurance that the services they are receiving are worthwhile and beneficial on a personal level. In the event that the program components had been found to not be effective, participants would be advised that the knowledge gained from the study will be used to inform the improvement of homelessness programing, including contributing to the improvement of the WillBridge program.

It is this researcher’s belief that the risks associated with participation in this study were no more than minimal, and were outweighed by the potential benefits to society, as the results can be used to inform the treatment of a large population of individuals. A better understanding of effective homelessness services is needed to reduce homelessness, and to provide the most ethical and proper care for those suffering from it.
CHAPTER IV: RESULTS

Sample Selection and Characteristics

All participants, for inclusion in the study and data analysis, had to have resided at WillBridge for a minimum of 30 days, and had at least one Weekly and one Monthly Case Manager Checklist completed in its entirety, as well as two Measures of Activities of Daily Living completed, one at intake, and one at current status or status upon exit. WillBridge had been collecting data on these forms for their clients, as part of their program requirements, for approximately six months. Case manager turnover had occurred during this time, and data from several clients was incomplete. Only clients of current WillBridge case managers, with complete data sets, were included in data analysis.

Upon collection of client data, a total of 43 participants met all requirements for inclusion into the study and data analysis. Of these 43 participants, 17 were current clients in the WillBridge housing program, residing in one of their three housing sites; 26 participants were clients who had already exited the WillBridge program. All clients were homeless at their intake and had a history of mental illness. Additional demographic data was not collected for the purposes of this study, as its purpose was to gain an overall understanding of housing program effectiveness for homeless, mentally ill individuals; additional demographic variables were not a primary focus.
Preliminary Data Analysis

The purpose of this study was to determine if there was a statistically significant difference between the income, life skills, and housing of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it. Table 1 displays the frequency counts for selected participant variables, including program status, employment status, number of pro-social activities participated in per week, and current housing status. Of the 43 participants included in this study, 34.9% were currently employed or employed upon exit from the program. The number of pro-social activities per week ranged from “none” (16.3%) to “7-10” activities (14.0%). Of the 26 participants who had exited the WillBridge program, 14 (53.8%) had obtained residency, as defined by this study (Table 1).

A look was also taken at the overall percentage of clients engaged in each program activities. Table 2 displays the frequency counts for participation in program activities sorted from highest to lowest frequency. The most common types of participation for clients were medication compliance (97.7%) and being engaged in referrals (79.1%). The least common participation was for interview training (25.6%) and school or vocational training (25.6%). (Table 2).

For purposes of this research, significance of findings will be reported based on an alpha level set at $p < .05$. However, due to the exploratory nature of this study,
and the small sample size (N=43), findings that are significant at the $p < .10$ level will also be noted, to suggest possible avenues for future research.
**Table 1**

*Frequency Counts for Selected Variables (N = 43)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Category</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Exited from Program</td>
<td>26</td>
<td>60.5</td>
</tr>
<tr>
<td></td>
<td>Still at Program</td>
<td>17</td>
<td>39.5</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No employed</td>
<td>28</td>
<td>65.1</td>
</tr>
<tr>
<td></td>
<td>Employed</td>
<td>15</td>
<td>34.9</td>
</tr>
<tr>
<td><strong>Number of Pro-Social Activities/Week</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>None</td>
<td>7</td>
<td>16.3</td>
</tr>
<tr>
<td></td>
<td>1-3 Activities</td>
<td>20</td>
<td>46.5</td>
</tr>
<tr>
<td></td>
<td>4-6 Activities</td>
<td>10</td>
<td>23.3</td>
</tr>
<tr>
<td></td>
<td>7-10 Activities</td>
<td>6</td>
<td>14.0</td>
</tr>
<tr>
<td><strong>Current Housing Situation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>No permanent housing</td>
<td>12</td>
<td>27.9</td>
</tr>
<tr>
<td></td>
<td>Permanent housing</td>
<td>14</td>
<td>32.6</td>
</tr>
<tr>
<td></td>
<td>Housed at WillBridge</td>
<td>17</td>
<td>39.5</td>
</tr>
</tbody>
</table>
Table 2

*Frequency Counts for Participation in Program Activities Sorted by Highest Frequency*

*(N = 43)*

<table>
<thead>
<tr>
<th>Activity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Compliance</td>
<td>42</td>
<td>97.7</td>
</tr>
<tr>
<td>Engaged in referrals</td>
<td>34</td>
<td>79.1</td>
</tr>
<tr>
<td>Family Contact</td>
<td>33</td>
<td>76.7</td>
</tr>
<tr>
<td>Budgeting Ability</td>
<td>25</td>
<td>58.1</td>
</tr>
<tr>
<td>Bank Account</td>
<td>18</td>
<td>41.9</td>
</tr>
<tr>
<td>Job Applications</td>
<td>16</td>
<td>37.2</td>
</tr>
<tr>
<td>Resume Writing</td>
<td>12</td>
<td>27.9</td>
</tr>
<tr>
<td>School or Vocational Training</td>
<td>11</td>
<td>25.6</td>
</tr>
<tr>
<td>Interview Training</td>
<td>11</td>
<td>25.6</td>
</tr>
</tbody>
</table>
Answering the Research Questions

Research Question One

Research Question 1 asked whether there was a statistically significant difference between the income and life skills of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it:

a. Specifically, is there a significant relationship between participation in the WillBridge program and client change of income?

b. Also, is there a significant relationship between participation in the WillBridge program and client change in life skills, as measured by the Measure of Activities of Daily Living Scale (MADL)?

To determine the answer to Research Question 1.a., the relationship between participation in the WillBridge program and client change of income, a Wilcoxon matched pairs test was conducted, comparing average monthly client income at intake and average monthly client income at current status or exit from the program. Results showed a significant improvement in income among clients of the WillBridge program ($p < .000$, $N=43$). The average monthly income at current or exited status ($M=957$) had significantly increased from average monthly income at intake status ($M=494$). The average increase in monthly income was $M = 463.33$
which was significant at the \( p = .001 \) level (Table 3). Table 3 displays the results of the Wilcoxon matched pairs test comparing the client’s income at intake and currently. The Wilcoxon test was used instead of the more common paired \( t \) test due to the small sample size (\( N = 43 \)).

To determine the answer to Research Question 1.b., the relationship between participation in the WillBridge program and client change in life skills, as measured by the Measure of Activities of Daily Living scale (MADL), a Wilcoxon matched pairs test was conducted, comparing client MADL scores at intake to client MADL scores at current status or exit from the program. Results showed a significant improvement in life skills among clients of the WillBridge program (\( p < .000, N=43 \)). The MADL score at current or exited status (\( M=47.5 \)) had significantly increased from the MADL score at intake status (\( M=45.5 \)). Table 3 also displays the results of the Wilcoxon matched pairs test comparing the client’s ADL score at intake and currently. The average increase in ADL score was \( M = 2.00 \) which was significant at the \( p = .001 \) level (Table 3).

Preliminary data analysis was also run to determine correlations between the significant increases in both income (measured by current/exit monthly income minus intake income) and life skills (measured by the MADL) and all program variables that data was collected for, using a Spearman’s rho test. In regards to life skills, results indicate that those clients still in the WillBridge program have a greater change in MADL score, in comparison to clients who have exited the program
Table 3

Changes in Income and Activities of Daily Living Based on Program Participation. Wilcoxon

Matched Pairs Tests (N = 43)

<table>
<thead>
<tr>
<th>Outcome Variable</th>
<th>Time Period</th>
<th>M</th>
<th>SD</th>
<th>z</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intake</td>
<td>493.65</td>
<td>455.68</td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Current or at Exit</td>
<td>956.98</td>
<td>499.62</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Activities of Daily Living (ADL)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Intake</td>
<td>45.53</td>
<td>7.24</td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td></td>
<td>Current or at Exit</td>
<td>47.53</td>
<td>5.90</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
($r = .003, p = .439, N = 43$). Additionally, the lower the client MADL score was at intake, the greater their gain in MADL score was at current or exited status ($r = .000, p = -.558, N = 43$). In regards to income, results indicate that the lower client monthly average income was at intake, the greater the gain in income at current or exited status ($r = .001, p = -.439, N = 43$). Additionally, the higher their income at current or exit status, the greater their income gain ($r = .000, p = .534, N = 43$).

**Research Question Two**

Research Question 2 asked what the housing outcomes were for the WillBridge program, measured by percentage of clients who obtain residency, as defined by this study, upon exit. Of the 43 participants in this study, 26 had exited the WillBridge program. Fourteen of those 26 (53.8%) had obtained residency, defined as a client’s exit from the WillBridge program into a more permanent form of housing, including residency in independent housing, permanent supportive housing, long-term residential treatment, with a family member. Of the 14 clients who obtained residency upon exit, ten (71.4%) obtained independent housing, defined as the client’s attainment of an individual lease or outside supportive housing. Four clients (28.6%) obtained residency with a family member or friend.

**Research Question Three**

Research Question 3 asked whether there was a significant relationship between specific WillBridge program activities and client change in income and attainment of employment:
a. Specifically, which of the program’s activities are most indicative of attaining employment?

b. Also, which of the program’s activities are most indicative of increasing income?

To answer Research Question 3.a., determining which of the program’s activities were most indicative of attaining employment, a Spearman rank ordered correlations test was conducted. Table 4 displays the Spearman rank ordered correlations between the client’s employment status and 14 variables, including the five program activities predicted to be specifically indicative of attaining employment: 1) the completion of job applications, 2) attainment of a bank account, 3) ability to budget ones own funds, 4) participation in interview training, and 5) resume writing. Additionally, a “Total Employment Program Activities Scale” variable was constructed; this variable measured the total number of employment specific program activities that a client had participated in. A Spearman rank ordered correlations test was used instead of the more popular Pearson product moment correlations due to the small sample size (N = 43) used in this study.

Inspection of Table 4 found employment status to be significantly related to 9 of 14 total variables, including four of the five variables specifically related to the attainment of employment: a) the completion of job applications ($r_s = .35, p < .05$), b) attainment of a bank account ($r_s = .27, p < .10$), c) participation in interview training ($r_s = .35, p < .05$), and d) resume writing ($r_s = .31, p < .05$). The largest correlations
Table 4

Spearman Rank-Ordered Correlations for Selected Variables with Employment, Income Increase, and Housing Status

<table>
<thead>
<tr>
<th>Variable</th>
<th>Employment $^a$</th>
<th>Income</th>
<th>Housing $^b$</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$N = 43$</td>
<td>$N = 43$</td>
<td>$n = 26$</td>
</tr>
<tr>
<td>Job Applications $^a$</td>
<td>.35 **</td>
<td>.21</td>
<td>.01</td>
</tr>
<tr>
<td>Bank Account $^a$</td>
<td>.27 *</td>
<td>.17</td>
<td>.08</td>
</tr>
<tr>
<td>Interview Training $^a$</td>
<td>.35 **</td>
<td>.31 **</td>
<td>.21</td>
</tr>
<tr>
<td>Resume Writing $^a$</td>
<td>.31 **</td>
<td>.20</td>
<td>-.05</td>
</tr>
<tr>
<td>Budgeting Ability $^a$</td>
<td>.03</td>
<td>.14</td>
<td>-.02</td>
</tr>
<tr>
<td>Total Employment Program Activities Scale</td>
<td>.43 ****</td>
<td>.35 **</td>
<td>.12</td>
</tr>
<tr>
<td>School or Vocational Training</td>
<td>.13</td>
<td>.17</td>
<td>.14</td>
</tr>
<tr>
<td>Employed at Exit/Currently $^a$</td>
<td>1.00</td>
<td>.51 ****</td>
<td>.10</td>
</tr>
<tr>
<td>Change in ADLs</td>
<td>-.10</td>
<td>.04</td>
<td>.32</td>
</tr>
<tr>
<td>Number of Prosocial Activities/Week</td>
<td>.39 ***</td>
<td>.21</td>
<td>-.02</td>
</tr>
<tr>
<td>Medication Compliance $^a$</td>
<td>.11</td>
<td>.15</td>
<td>.22</td>
</tr>
<tr>
<td>Family Contact $^a$</td>
<td>.40 ***</td>
<td>.26 *</td>
<td>.33 *</td>
</tr>
<tr>
<td>Engaged in referrals $^a$</td>
<td>.26 *</td>
<td>.06</td>
<td>-.26</td>
</tr>
<tr>
<td>Total Independence Program Activities Scale</td>
<td>.69 ****</td>
<td>.42 ***</td>
<td>.18</td>
</tr>
</tbody>
</table>

* $p < .10$.  ** $p < .05$.  *** $p < .01$.  **** $p < .005$.  ***** $p < .001$.

$^a$ Employment Coding: 0 = No 1 = Yes.

$^b$ Housing Coding: 0 = Other 1 = Residency.
reported by this Table were between the attainment of employment and the Total Employment Program Activity Scale ($r_s = .43, p < .001$) and the total independence program activity scale ($r_s = .69, p < .001$) (Table 4). The “total independence program activity scale” is a variable created to total each of the program activities related to obtainment of residency that a client has engaged in.

To answer Research Question 3.b., determining which of the program’s activities are most indicative of increasing income, a Spearman rank ordered correlations test was conducted. Table 4 displays the Spearman rank ordered correlations between the client’s income increase and 14 relevant variables, including the five program activities predicted to be specifically indicative of increasing income: 1) the completion of job applications, 2) attainment of a bank account, 3) ability to budget ones own funds, 4) participation in interview training, and 5) resume writing. Inspection of the table found income increase to be significantly related to 5 of 14 variables, including one of the five specific to increasing income: a) interview training ($r_s = .31, p < .05$). The largest correlations found were between increase in income and current employment ($r_s = .51, p < .001$) and the total independence program activity scale ($r_s = .42, p < .005$) (Table 4).

**Research Question Four**

Research Question 4 asked whether there was a significant relationship between specific WillBridge program activities and client attainment of residency, as defined by this study:
a. Specifically, which of the program’s activities are most indicative of obtaining residency?

To answer this question, of which program activities were most indicative of obtaining residency, a Spearman rank ordered correlations test was conducted. Table 4 displays the Spearman rank ordered correlations between the client’s housing status and 14 variables, including the seven program activities predicted to be specifically indicative of obtaining residency: 1) attendance in school or vocational instruction, 2) employment, 3) medication compliance, 4) having family contact, 5) average change in ADL score, 6) participation in pro-social activities, 7) engagement in referrals. Inspection of Table 4 found housing status to be significantly related to one of the seven variables, with housing status significantly related to having family contact ($r_s = .33, p < .10$) (Table 4).

**Conclusion**

In conclusion, this study determined whether there was a statistically significant difference between the income, life skills, and housing of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it, for 43 clients. The primary findings of the study were that, for WillBridge housing program clients, a) there was a statistically significant increase in income and life skills; b) 58.6% of clients who had exited the program obtained residency; c) attainment of employment was significantly related to several program activities, including the completion of
job applications, attainment of a bank account, participation in interview training, and resume writing, as well as to the total number of program activities that clients engaged in; d) increase in income was significantly related to interview training and employment; and e) obtainment of residency upon exit was significantly related to having contact with a family member. In the final chapter, these findings will be compared to the literature, conclusions and implications will be drawn, and a series of recommendations will be suggested.
CHAPTER V: DISCUSSION

Summary of Findings

Income and Life Skills

This study had four main hypotheses. The first hypothesis predicted that there would be a positive relationship between the income and life skills of clients at their intake to the WillBridge housing program, when compared to their overall progress in these areas after at least 30 days in the program, or at exit from it. Specifically, it was predicted that participation in the WillBridge program would be positively related to a clients increase in income, as well as positively related to an increase in clients’ life skills, as measured by The Activities of Daily Living Measure used in this study. The results indicated that this hypothesis was supported; clients in the WillBridge program showed significant improvement in both income and life skills from their intake to their current or exited status. These implications of all results will be discussed later in the chapter.

Residency

The second study hypothesis predicted that clients participating in the WillBridge housing program would be able to move from homelessness and obtain residency, as defined by this study, at exit from the program. The results indicated that this hypothesis was supported. Over half of the clients (53.8%) in the study, who had exited from WillBridge, obtained residency in independent housing, permanent supportive housing, long-term residential treatment, or with a family
member. Of those clients who obtained residency, almost three-quarters (71.4%) transitioned into independent housing, acquiring an individual lease or permanent supportive housing upon exit from WillBridge.

**Employment and Income Factors**

The third study hypothesis predicted that the implementation of WillBridge program activities would be significantly related to client change in income and attainment of employment. Specifically, it was predicted that the completion of job applications, attainment of a bank account, ability to budget ones own funds, and participation in interview training, and resume writing, would be significantly related to client increase in income and attainment of employment. The results indicated that this hypothesis was supported. This study found that attainment of employment was significantly related to several program activities, including the completion of job applications, attainment of a bank account, participation in interview training, and resume writing, as well as to the total number of program activities that clients engaged in; increase in income was significantly related to interview training and having employment.

**Residency Factors**

The fourth study hypothesis predicted that the implementation of WillBridge program activities would be significantly related to client attainment of residency, as defined by this study. Specifically, it was predicted that attendance in school or vocational instruction, employment, medication compliance, having family contact,
average change in ADL score, and participation in pro-social activities, as well as referrals, would be significantly related to client obtainment of residency. The results indicated that this hypothesis was partially supported, in that having contact with a family member was significantly related to obtainment of housing upon exit from the program.

**Comparison to the Literature**

The findings from this study are in line with several previous research studies conducted to evaluate the impact of an integrated service system and case management on homeless individuals utilizing housing programs; results from these studies showed significant changes from baseline to follow-up, on almost all measures of service use and housing outcomes, including increased service usage, housing services, income support, and job assistance (Lehman et al., 1999; Morse et al., 1997; Rosenheck et al., 1998; Shern et al., 2000). Particularly prominent in the findings of the Rosenheck et al. (1998) study were the usage of housing services, and the attainment of independent housing for clients; the percentage of clients who had lived in an apartment or house of their own increased from 5 percent at baseline, to 25 percent at a 3 month follow-up, and 44 percent at a 12 month follow-up. The results from the current study do not include follow-up data, but do work to further suggest that homeless housing programs, specifically those that utilize integrated services and case management, are effective in providing income support, job
assistance, increased usage of services, and increased attainment of housing amongst homeless individuals.

Additional studies evaluating the effectiveness of homelessness programming, including case management and assertive community treatment as service components, have shown this type of program to be superior when compared to standard treatment in several areas. In homeless, mentally ill clients, this type of homelessness programming produces more positive self-ratings of overall health and well-being, improves ability to meet basic needs, increases contact with family members, improves overall life satisfaction (Lehman et al., 1999; Shern et al., 2000), increases personal income, and improves interpersonal adjustment and self-esteem (Morse et al., 1997). The current study, while not providing comparison to standard treatment, provides further support for the provision of case management and integration of services; integrated services were utilized in the WillBridge program model, as clients were provided referrals to outpatient counseling, substance abuse treatment, psychiatric medication, and health care. The results from the current study provide further support for the practical application of both case management and integration of services, in that clients participating in such programming also showed increases in contact with family members, personal income, and ability to meet basic needs.
The results from the current study are also in line with research on the Collaborative Initiative to Help End Chronic Homelessness (CICH), a large-scale housing program created with the intent of being a “comprehensive programmatic response” to the issue of homelessness, particularly chronic homelessness (Rickards et al., 2010, p. 155). The services provided by this program are in line with the services provided by WillBridge, and examined in this study; they include the provision of primary health care services, mental health services and substance abuse treatment, case management, housing, and service integration (Mares & Rosenheck, 2007). CICH clients had increased housing stability, reported improved quality of life, increased their mental health functioning, and had reduced treatment costs (Mares & Rosenheck, 2007). Results of the current study further support the provision of such services, as they also suggest increases in housing stability and increased daily functioning in clients utilizing such services.

The results of the current study also provide further support for the findings of Washington (2002) and Bolton (2005). The Washington study asked clients of a transitional housing program which of the program’s support services had enabled them to attain housing and remain self-sufficient and independent; client responses demonstrated that the most helpful services focused on networking with community resources, housing referrals, employment referrals, financial aid referrals, and counseling (Washington, 2002). Responses from clients also demonstrated that the most helpful services focused on budgeting, job training, and leadership skills;
budgeting classes provided knowledge of how to prioritize responsibilities and rationally use low income, while job training aiding them in making career choices and also focused on the social aspects needed to secure a job, such as grooming for an interview, interviewing skills, and resume writing. The current study provides additional evidence for the importance of such program activities, particularly for focus on job training skills, when working in effort to increase the employment and income of homeless clients.

The Bolton (2005) study utilized program evaluation methodology, similar to that utilized in the current study, evaluating the effectiveness of a supportive housing program. The program provided several services, many of which are in line with the services provided by WillBridge and evaluated by this study. The services provided by the supportive housing program studied by Bolton included crisis intervention, hospitalization if needed, psychotropic medication evaluation and prescriptions, education on medication management, outpatient counseling, skill training related to self-care, health care, housekeeping, mobility, drug use, money management, interpersonal relationships, vocational/educational pursuits, leisure time, and community participation (2005). The results of the study found that this particular program, as implemented, was successful in helping the homeless: Housing stability was achieved for 84% of clients, management of psychiatric symptoms was achieved for 80%, attainment of adult living skills achieved by 73%, socialization goals were met for 72%, and the quality of life goals were met for 54% of the clients. Predictors
of change in these areas included demographic variables, baseline measures and
length of stay in the program, complexity and severity of mental illness, customer
satisfaction with the program, and compliance with treatment (Bolton, 2005).

The results from the current WillBridge study provide additional support for
the implementation of several of these previously studied program services as being
effective. The current study variables match several Bolton (2005) study variables:
1) Medication compliance (education on medication management); 2) engagement in
referrals (outpatient counseling and drug use referrals); 3) support in performance of
life skills (skill training related to self-care, health care, housekeeping, and mobility);
4) budgeting (money management), 5) vocational/educational pursuits, and 6)
participation in pro-social activities (leisure time and community participation). The
current study provided similar results, showing significant increases in life skills, as
well as increases in housing stability. The current study went one step further,
identifying which of the particular program services were most indicative of the
results, rather than which demographic and client factors are indicative of change.

Methodological Limitations

The most pressing methodological limitation of these research findings is in
reference to the small sample size utilized to analyze and obtain results. The small
sample size greatly increases the possibility of type II error, failing to reject a false
null hypothesis. This error would leave the results open to the possibility that
unfound relationships exist between study variables; there may be significant
relationships between additional transitional and supportive housing program activities and employment, increased income, and obtainment of residency. A larger sample may have provided statistical evidence of these relationships. In addition, the small sample size increases the likelihood that sampling error may have impacted the results, making this sample not truly representative of the homeless, mentally ill population utilizing such housing programs.

In regards to the composition of the sample utilized in this study, there may have been influencing factors specific to included participants. For example, several current clients refused consent to participate in the study; it may be that the general makeup of those who consented to participate differs from those who did not. It may be that non-consenting individuals had more severe homelessness histories or mental illness; this could impact the sample in its consisting of a larger percentage of higher functioning clients. However, the inclusion of several exited clients, who did not have to consent to participate, increases generalizability; these factors are taken into consideration in light of discussing the generalizability of the results.

In addition, to assume generalizability of study results, it is assumed that the population of clients at WillBridge is similar in compilation to the populations of other transitional housing programs. It must be taken into consideration, however, that although the clients at WillBridge are mentally ill and were homeless at intake, the community of Santa Barbara, where the program is located, is a rather affluent community; even those individuals who are homeless may be different in
demographic make-up than homeless individuals in less affluent communities. This difference in demographics may impact the generalizability of study results, and is taken into consideration when discussing the study outcomes.

The sample that was utilized in this study was limited to homeless, mentally ill individuals; the results may not be applicable to other sub groups of homeless individuals. There are several additional limitations to the design of this study that may compromise the interpretation or generalizability of the findings. As a study of program activity variables influencing transitional and supportive housing effectiveness with a practice-based sample, there are limited controls on outside variables; a number of outside variable may have influenced the study results.

Program evaluation studies, evaluating the effectiveness of community-based programs and utilizing practical treatment conditions and community samples, have better generalizability to practical application; however, such studies also have lower experimental control than those conducted with lab-based samples. In addition, this study did not utilize a control or standard treatment group, which limits the ability to attribute the effectiveness of the WillBridge program to the impacts of the program activity variables.

Conclusions and Implications of Findings

There were two main goals of this research. The first goal was to determine the effectiveness of WillBridge, a transitional and supportive housing program in reaching its program goals: increasing the income, life skills, and residency of
homeless, mentally ill clients. The second goal was to generalize the findings of the research to transitional and supportive housing programs with similar clientele, in order to contribute to their program effectiveness.

**Effectiveness of Transitional and Supportive Housing**

In light of discussing the first research goal, the results of the current study suggest that homeless housing programs, like that of WillBridge, with the provision of transitional or supportive housing, case management, and program services such as those evaluated in this study, can indeed be effective in increasing the income, general life skills, and residency of homeless clients. Although the results of this study did not show a significant relationship between increased income and life skills and the obtainment of residency, it can be reasoned that increases in income and life skills can ultimately contribute to clients’ independence; such an increase in independence can thereby increase a client’s ability or likelihood in obtaining residency or independent housing, which is the ultimate goal of most housing programs serving homeless individuals. Ideas for further research will be suggested to address this study area.

In addition, the results from this study suggest that several transitional and supportive housing program components contribute to the obtainment of employment: the completion of job applications, attainment of a bank account, participation in interview training, and resume writing, as well as to the total number of program activities that clients are engaged in, are all significantly related to
clients’ employment. Results also suggest that interview training is specifically important when working with clients toward increasing their income. These results provide evidence that the provision of such services, including assistance with completing these particular tasks, are indicative of positive growth in homeless individuals working toward increasing their income and obtaining employment. Homeless housing programs that have the goal of assisting clients in attaining employment or increasing their income should consider including assistance with job applications and attaining a bank account, as well as the provision of interview training and resume writing assistance into the structure of their program.

Additionally, the knowledge that the total number of program activities a client engages in has a significant impact on their attainment of employment provides direction for homeless programs to encourage increased client participation in all program activities, rather than only specific activities related to income and employment. For case managers or housing program employees working with homeless clients who have the specific goal of obtaining employment or increasing income, this knowledge becomes useful in providing several areas for specific focus. It can be reasoned that employment and increased income have an impact on clients’ independence, making them more likely candidates for the eventual attainment of residency or independent housing.

The results from this study also suggest that among several program services related to the goal of increased residency, having contact with a family member may
specifically contribute to the ultimate obtainment of residency for transitional and supportive housing clients. It can be speculated that having contact with a family member increases a client’s support system, connects them to additional resources, and/ or provides them increased emotional or financial resources. It may also be considered that having contact with family may lead to a family member providing the client with residency or allowing the client to live with them. This is an important finding, and contributes to the knowledge of areas of programming importance for work with homeless individuals, by suggesting that focus be placed on attaining contact with a family member when working with a homeless client toward the goal of obtaining residency.

While the results of this study did not find a significant relationship between the obtainment of residency and other program activities that were reasoned to be related, it should be considered that a large percentage of clients (53.8%) obtained residency upon exit from the WillBridge program. Program activities, such as attendance in school or vocational instruction, employment, medication compliance, daily living skills ability, participation in pro-social activities, and engagement in referrals, may indeed have contributed to the obtainment of residency. It is important to consider the value of these program activities and their impact, even if not statistically significant, on increased residency of housing program clients. The obtainment of residency is often the ultimate goal of homeless housing programs, as the move from homelessness to “housed” ultimately works to decrease homelessness
numbers, and may therefore also decrease the negative impact of homelessness on both the individual and society. Further research on the effectiveness of program activities on increasing residency will be suggested.

**Generalizability of Findings**

The second goal of this research study was to generalize the findings to transitional and supportive housing programs with similar clientele to the WillBridge program, in order to contribute to their program effectiveness. In discussing generalizability, it is considered that sampling error may have impacted results, making this study sample not truly representative of the homeless, mentally ill population utilizing such housing programs. While the sample may have been skewed by differences in general make-up of those who opted to participate versus those who did not, the inclusion of several exited clients, who did not have to consider consent to participate, increases the generalizability of results.

In addition, while the study utilized a small sample size, each client did meet criteria of being homeless at their point of intake into the program and having a mental illness. The results of this study are thought to be generalizable to transitional and supportive housing programs providing services to clients also meeting these criteria. Due to the high rate of mental illness among homeless individuals, most housing programs serve clients of the same general make-up of the current study participants; these housing programs can utilize the results of this study to gain knowledge of areas for program focus in working toward client goals of
attaining employment, and increasing income, life skills, and residency of clients. It is reasoned that the inclusion of program activities shown to be effective in this study will prove similar effectiveness in each of these areas.

**Recommendations for Future Research**

Although the results of this study did not show a significant relationship between increased income and life skills and the obtainment of residency, it can be reasoned that increases in income and life skills can ultimately contribute to clients’ ability to obtain residency or independent housing, which is the ultimate goal of most housing programs serving homeless individuals. In addition, although program activities, such as attendance in school or vocational instruction, employment, medication compliance, daily living skills ability, participation in pro-social activities, and engagement in referrals, did not result in being significantly related to residency in this study, they may indeed have contributed to the obtainment of residency. The small sample size utilized by the current study could have contributed to type II error; this error would leave the results open to the possibility that unfound relationships exist between study variables. There may indeed be significant relationships between additional transitional and supportive housing program activities and employment, increased income, and obtainment of residency; a larger sample may have provided statistical evidence of these relationships. Future research is recommended, utilizing a larger sample, to evaluate transitional and
supportive housing programs, determining not only their overall program effectiveness, but also the impact and effectiveness of specific program activities.

In addition, the small sample size used in this study increases the likelihood that sampling error may have impacted the results, making this sample not truly representative of the homeless, mentally ill population who utilize such transitional and supportive housing programs. Further research is suggested in this area, to be conducted on a larger scale and across several programs; the utilization of study participants from several programs would serve to decrease sampling error, thereby increasing generalizability of results. Additionally, further research should be conducted to determine homeless housing program effectiveness for mentally ill clients in particular, as was the focus of the current study; this research is valuable due to the increased negative impacts homelessness has on the sub-population of mentally ill individuals.

Further research is also recommended based on researcher observation when conducting this research; in presenting the purpose of this study to potential participants from the WillBridge program, interesting themes emerged from their feedback. Several clients of the program expressed that while research on universal program components was indeed valuable, their personal beliefs on what made the program work for them was based more on the overall mission of the program. Among those themes expressed, one considered the importance of the individualized “action” or treatment plans utilized by the program. Clients reported that they found
more value in “being met where they are at,” rather than having universal program services or activities applied to them regardless of individual situation. Clients also reported that being treated like an individual, having individual goals considered, and receiving assistance in reaching those particular goals was the most valuable service they received from the program. Further qualitative research in the area of homeless housing programs may be conducted to evaluate these themes, and to identify their significance in helping clients meet program goals. Such research could provide valuable additional knowledge in the formulation of housing program theory, creating a base for the creation of future program organization and policy.

Lastly, while a great deal of research has been conducted on the positive impact of transitional and supportive housing programs on the individual, there is a disproportionate amount of research on the impact of such programming on a larger social scale. Research demonstrating the positive impact of these programs on social issues, such as emergency health care and legal system costs, may provide additional community and government support for transitional and supportive housing programs, and perhaps even fund additional homelessness resources.

In conclusion, the problem of homelessness is vast, claiming victims of all genders, races, abilities, and ages, and negatively impacting individuals, families, children, communities, states, and entire nations. The current study contributes to the body of research and knowledge on the effectiveness of transitional and supportive housing in decreasing homelessness, by increasing the income, life skills,
and residency of clients. This research is meant to play a role in constructing a solution that will reduce the number of homeless individuals in coming years. Every life changed is valuable. Every person moved from the street to a home makes a positive impact on the problem. Additional research is necessary to continue building upon theory and best practices to accomplish the goal of reducing homelessness and its negative impacts, bringing hope to so many of those who feel forgotten.
CHAPTER VI: REFERENCES


## Appendix A: WillBridge Program Theory

### Homelessness Services

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>OUTPUT</th>
<th>OUTCOME</th>
<th>IMPACT</th>
</tr>
</thead>
</table>
| Assist clts in completing applications  
- Jobs  
- Disability  
Help clts open bank account; build and maintain budget  
Assist clients in building resumes  
Train clts in interviewing skills/dress  
| # of job applications  
# of disability apps  
# of bank accounts  
# of resumes  
# of mock interviews  
| Increase income  
| Increase self-sustainability of the homeless population  
| |
| Assist clts in completing applications for  
- Social Services  
- School/training  
Field trips  
Assign residential clients chores  
Teach ADLs  
- counsel on hygiene  
- teach and assign cooking duties  
- counsel on med compliance  
Transport clts to appts  
1:1 mtgs w/ case mgr  
| # of soc. Services apps  
# of school/training apps  
# of field trips  
# of chores assigned  
# of hygiene counsels  
# of cooking lessons/assignments  
# of med compliance counsels  
# of transports  
# of 1:1 mtgs  
| Increase life skills  
| Increase self-determination in the homeless population  
| |
| 1:1 mgs focused on strengths/encouragement  
Get clothing for clients  
Assist clients with applications for city or county housing  
Assist clients in getting into residential tx  
Assist clients in family reunification efforts  
Get clts connected with mental health/substance abuse services  
Have clients write their story  
| # of 1:1 mtgs  
# of clts given clothes  
# of apps for public housing  
# of referrals to residential tx  
# of reaches/interventions for family reunification  
# of referrals to MH or substance abuse services  
# of stories written  
| Increase Residency  
| Reduce homelessness in the community  
| |
| Referrals to substance treatment  
Drug and alcohol testing  
Provide transportation to appts  
Create Action Plan  
| # of referrals  
# of tests  
# of transports  
# of Action Plans  
| Monitor Sobriety  
| Assist in Recovery  
| |
### Outreach

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>OUTPUT</th>
<th>OUTCOME</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals:</td>
<td># of referrals to:</td>
<td>Increase access to support services</td>
<td>Increase # of homeless individuals utilizing support services</td>
</tr>
<tr>
<td>- Detox</td>
<td>- Detox</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- AA</td>
<td>- AA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Mental health</td>
<td>- Mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Social services</td>
<td>- Social services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shelters</td>
<td>- Shelters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical care</td>
<td>- Medical care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship Building:</td>
<td># of art projects</td>
<td>Increase Contact</td>
<td>Increase Trust and Hope</td>
</tr>
<tr>
<td>- Art in the Park</td>
<td># of foot washing services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Foot washing</td>
<td># of street contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Street outreach</td>
<td># of individuals receiving supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Supply distribution</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Community Enrichment

<table>
<thead>
<tr>
<th>ACTIVITIES</th>
<th>OUTPUT</th>
<th>OUTCOME</th>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hold community forums</td>
<td># of community forums</td>
<td>Increase city exposure to WillBridge mission</td>
<td>Increase community awareness</td>
</tr>
<tr>
<td>Write press releases</td>
<td># of press releases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Write articles</td>
<td># of articles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Publish newsletter</td>
<td># of newsletters</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notify appropriate agencies of threats to public health; identify trends</td>
<td># of incidents reported</td>
<td>Assist in controlling the spread of communicable diseases</td>
<td>Increase community safety</td>
</tr>
</tbody>
</table>

Note: All WillBridge theory, data, and client forms were created by Melissa Cervantes, M.A. and Ryan Sharma, Psy.D., who have shared rights to their use with WillBridge of Santa Barbara, Inc.
### Appendix B: WillBridge Data Plan

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Indicators</th>
<th>How they are tracked</th>
<th>Reported as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Income</td>
<td>• Job applications</td>
<td>source of income (job, payee, or public assistance)</td>
<td>Monthly (checklist)</td>
<td>% of all clients in each category</td>
</tr>
<tr>
<td></td>
<td>• Disability applications</td>
<td>For income: monthly amount</td>
<td>Monthly (checklist)</td>
<td>$X_{\text{month/category}}$</td>
</tr>
<tr>
<td></td>
<td>• Opening a bank account</td>
<td>For employment: type (categorical); monthly income; duration (in weeks)</td>
<td>Monthly (checklist)</td>
<td>Type: % of employed Duration: # of weeks</td>
</tr>
<tr>
<td></td>
<td>• Resume writing</td>
<td>Has a bank account (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of clients entering without a bank account</td>
</tr>
<tr>
<td></td>
<td>• Budgeting</td>
<td>Ability to maintain a budget (yes/no)</td>
<td>Monthly (checklist)</td>
<td>% of all clients with income</td>
</tr>
<tr>
<td></td>
<td>• Interview training</td>
<td># of job applications submitted</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>$X_{\text{unemployed range?}}$</td>
</tr>
<tr>
<td>Increase Life Skills</td>
<td>• Assistance with:</td>
<td>client attendance in school/vocational training (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of all clients</td>
</tr>
<tr>
<td></td>
<td>o Social services applications</td>
<td>client employed (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of all clients</td>
</tr>
<tr>
<td></td>
<td>o School applications</td>
<td>Participation in pro-social activities/groups: number of activities; times per week</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% participating of all clients % of clients in 1, 2, or 3+ activities $X_{\text{# activities/week}}$</td>
</tr>
<tr>
<td></td>
<td>• Community field trips</td>
<td>Maintenance of ADLs ADL Measure at referral, intake, and discharge</td>
<td>X client change (at threshold)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assignment of chores</td>
<td>medication compliance (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of clients complying with prescriptions</td>
</tr>
<tr>
<td></td>
<td>• Hygiene counsels</td>
<td>Family contact (making contact, no family, no desire, traveling to see family)</td>
<td>Monthly (checklist)</td>
<td>% of clients in each category</td>
</tr>
<tr>
<td></td>
<td>• Medication compliance counsels</td>
<td>Engagement in referrals (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of clients engaging in</td>
</tr>
</tbody>
</table>
### Increase Residency

- Transitional housing
- Basic needs: Clothing, shelter, food
- Application for public housing
- Referrals to residential treatment
- Intervention for family reunification

For clients defined as “chronically homeless” – discharged to: Independent housing, residential treatment, family, other

At discharge | % going to each category

For clients not defined as “chronically homeless” – discharged to: Independent housing, residential treatment, family, other

At discharge | % going to each category

- Housing applications (Section 8; MHA – Garden St.; Artisan Ct.)
- Application completion (30/60/90/90+ days)

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Activities</th>
<th>Indicators</th>
<th>How they are tracked</th>
<th>Reported as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monitor Sobriety</td>
<td>Referrals to Substance abuse care</td>
<td>Client engaged in substance abuse programming (yes/no)</td>
<td>Weekly (in 1:1 mtgs)</td>
<td>% of clients with substance problems engaged</td>
</tr>
<tr>
<td></td>
<td>Drug and alcohol testing</td>
<td>Client sober (yes/no)</td>
<td>Weekly</td>
<td>% of client with substance prob. staying sober</td>
</tr>
<tr>
<td></td>
<td>Provide transportation</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### OUTREACH

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Indicators</th>
<th>How they are tracked</th>
<th>Reported as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Utilization of Support Services</td>
<td>Referrals to: Detox, Mental health, Social services, shelters, medical</td>
<td>Referrals made (# of)</td>
<td>Per outreach event (tracking form)</td>
<td>( \overline{x} ) referrals/event Total referrals</td>
</tr>
<tr>
<td>Increase Contact</td>
<td>Street contacts: Art projects, Foot washing services, Outreach</td>
<td>Attendance (# of) Repeat attendance (# of) Military Vets (# of)</td>
<td>Per outreach event (tracking form)</td>
<td>Total # attending % repeat attenders (repeat/total) % congregating</td>
</tr>
</tbody>
</table>

### COMMUNITY ENRICHMENT

<table>
<thead>
<tr>
<th>Goals</th>
<th>Activities</th>
<th>Indicators</th>
<th>How they are tracked</th>
<th>Reported as</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Community Knowledge</td>
<td>Community forums Press releases</td>
<td>Number of forums, releases, articles, and newsletters</td>
<td>Yearly</td>
<td># of events and places of exposure</td>
</tr>
<tr>
<td>Increase Community Safety</td>
<td>Notify agencies of threats to public health</td>
<td>Number of incidents reported</td>
<td>Yearly</td>
<td># of incidents, nature of the threat</td>
</tr>
</tbody>
</table>
Appendix C: Case Manager Weekly Checklist

Client Name: ___________________________ Date: ________________

Income
Has the client completed any job applications in the past week? If so, how many? ___

Does the client have a bank account?    Y       N

If yes: Was the account obtained during their stay at WillBridge?    Y       N

Life Skills
Is the client adhering to their action/treatment plan?    Y       N

Is the client complying with house rules?    Y       N

If no: How many (in last week): Write-ups? ___ Incident Reports? ___ Sanctions? ___

Is the client attending school?    Y       N

Vocational Training?    Y       N

Does the client participate in pro-social activities? (volunteer, church, outings) Y       N

If yes: Type of activity/Times attended per week:

1. Activity: ___________________________ Times Per Week: ____________

2. Activity: ___________________________ Times Per Week: ____________

3. Activity: ___________________________ Times Per Week: ____________

Does the client engage in referrals? (substance abuse, medical, mental health) Y       N

Is the client compliant with medication?    Y       N

Monitor Sobriety
Does the client have a history of substance use?    Y       N

If yes: Is the client engaged in the recommended substance use program? Y       N

Has the client used substances/relapsed in the past week? Yes ___ No ___
Appendix D: Case Manager Monthly Checklist

Client Name: ___________________________       Date: ____________

Income
Is the client employed?     Y     N

If yes: Type of Employment/Job Title: ___________________________

    Monthly Income: __________________

    Average hours worked per week during last month: _____________

What additional sources of income does the client have? (Type/Amount per month)

1. Source: ___________________________       Monthly Income: _________

2. Source: ___________________________       Monthly Income: _________

Has the client participated in/been counseled in job interview training?   Y     N

Has the client received assistance in writing a resume?      Y     N

Has the client maintained a budget for the past month?     Y     N

Has the client participated in budget training?     Y     N

Life Skills
What level of contact did the client have with family this month?

☐ No Family ☐ No Desire for Contact ☐ Contact Did they travel to visit? Y     N

Is client recommended to attend individual or group mental health therapy? Y     N

If yes: How many individual/group counseling/therapy sessions were attended in the past month?

Residency
Has the client applied for housing in the last month? Y     N For which housing?

☐ Section 8 ☐ MHA ☐ Artisan Ct. ☐ El Carrillo
## Appendix E: WillBridge of Santa Barbara Measure of Activities of Daily Living

### Client Name:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Needs Help</th>
<th>Dependent</th>
<th>Cannot Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Dressing</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Grooming</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Mouth care</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Toileting</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Walking</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Climbing stairs</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Eating</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Shopping</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Cooking</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Managing medications</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Using the phone</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Chores</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Laundry</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Driving or using public transit</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Managing finances</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Home maintenance</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix F: The Katz Index of Independence in Activities of Daily Living

Exhibit 3.7 The Index of Independence in Activities of Daily Living: Evaluation Form

For each area of functioning listed below, check description that applies. (The word “assistance” means supervision, direction, or personal assistance.)

**Bathing**—either sponge bath, tub bath, or shower

- Receives no assistance (gets in and out of tub by self if tub is usual means of bathing)
- Receives assistance in bathing only one part of the body (such as back or a leg)
- Receives assistance in bathing more than one part of the body (or not bathed)

**Dressing**—gets clothes from closets and drawers—including underclothes, outer garments and using fasteners (including braces if worn)

- Get clothes and gets completely dressed without assistance
- Gets clothes and gets dressed without assistance except for assistance in tying shoes
- Receives assistance in getting clothes or in getting dressed, or stays partly or completely undressed

**Toileting**—going to the “toilet room” for bowel and urine elimination; cleaning self after elimination, and arranging clothes

- Goes to “toilet room,” cleans self, and arranges clothes without assistance (may use object for support such as cane, walker, or wheelchair and may manage night bedpan or commode, emptying same in morning)
- Receives assistance in going to “toilet room” or in cleansing self or in arranging clothes after elimination or in use of night bedpan or commode
- Doesn’t go to room termed “toilet” for the elimination process

**Transfer**—

- Moves in and out of bed as well as in and out of chair without assistance (may be using object for support such as cane or walker)
- Moves in and out of bed or chair with assistance
- Doesn’t get out of bed

**Continence**—

- Controls urination and bowel movement completely by self
- Has occasional “accidents”
- Supervision helps keep urine or bowel control; catheter is used, or is incontinent

**Feeding**—

- Feeds self without assistance
- Feeds self except for getting assistance in cutting meat or buttering bread
- Receives assistance in feeding or is fed partly or completely by using tubes or intravenous fluids
Exhibit 3.8 The Index of Independence in Activities of Daily Living: Scoring and Definitions

The Index of Independence in Activities of Daily Living is based on an evaluation of the functional independence or dependence of patients in bathing, dressing, going to toilet, transferring, continence, and feeding. Specific definitions of functional independence and dependence appear below the index.

A—Independent in feeding, continence, transferring, going to toilet, dressing and bathing.
B—Independent in all but one of these functions.
C—Independent in all but bathing and one additional function.
D—Independent in all but bathing, dressing, and one additional function.
E—Independent in all but bathing, dressing, going to toilet, and one additional function.
F—Independent in all but bathing, dressing, going to toilet, transferring, and one additional function.
G—Dependent in all six functions.
Other—Dependent in at least two functions, but not classifiable as C, D, E or F.

Independence means without supervision, direction, or active personal assistance, except as specifically noted below. This is based on actual status and not on ability. A patient who refuses to perform a function is considered as not performing the function, even though he is deemed able.

Bathing (sponge, shower or tub)
Independent: assistance only in bathing a single part (as back or disabled extremity) or bathes self completely
Dependent: assistance in bathing more than one part of body; assistance in getting in or out of tub or does not bathe self

Dressing
Independent: gets clothes from closets and drawers; puts on clothes, outer garments, braces; manages fasteners; act of tying shoes is excluded
Dependent: does not dress self or remains partly undressed

Going to toilet
Independent: gets to toilet; gets on and off toilet; arranges clothes; cleans organs of excretion; (may manage own bedpan used at night only and may or may not be using mechanical supports)
Dependent: uses bedpan or commode or receives assistance in getting to and using toilet

Transfer
Independent: moves in and out of bed independently and moves in and out of chair independently (may or may not be using mechanical supports)
Dependent: assistance in moving in or out of bed and/or chair; does not perform one or more transfers

Continence
Independent: urination and defecation entirely self-controlled
Dependent: partial or total incontinence in urination or defecation; partial or total control by enemas, catheters, or regulated use of urinals and/or bedpans

Feeding
Independent: gets food from plate or its equivalent into mouth; (precutting of meat and preparation of food, as buttering bread, are excluded from evaluation)
Dependent: assistance in act of feeding (see above); does not eat at all or parenteral feeding

## Appendix G: Lawton Instrumental Activities of Daily Living Scale

### INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE (IADL)

M.P. Lawton & E.M. Brody

<table>
<thead>
<tr>
<th>Category</th>
<th>Item</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Ability to use telephone</strong></td>
<td>1. Operates telephone on own initiative; looks up and dials numbers, etc.</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Dials a few well-known numbers</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. Answers telephone but does not dial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4. Does not use telephone at all</td>
<td>0</td>
</tr>
<tr>
<td><strong>B. Shopping</strong></td>
<td>1. Takes care of all shopping needs independently</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Shops independently for small purchases</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>3. Needs to be accompanied on any shopping trip</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4. Completely unable to shop</td>
<td>0</td>
</tr>
<tr>
<td><strong>C. Food Preparation</strong></td>
<td>1. Plans, prepares and serves adequate meals independently</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Prepares adequate meals if supplied with ingredients</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>3. Heats, serves and prepares meals or prepares meals but does not maintain adequate diet</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>4. Needs to have meals prepared and served</td>
<td>0</td>
</tr>
<tr>
<td><strong>D. Housekeeping</strong></td>
<td>1. Maintains house alone or with occasional assistance (e.g. “heavy work domestic help”)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2. Performs light daily tasks such as dishwashing, bed making</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>3. Performs light daily tasks but cannot maintain acceptable level of cleanliness</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4. Needs help with all home maintenance tasks</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5. Does not participate in any housekeeping tasks</td>
<td>0</td>
</tr>
</tbody>
</table>

| **F. Laundry**            | 1. Does personal laundry completely                                  | 1     |
|                           | 2. Launders small items; rinses stockings, etc.                      | 1     |
|                           | 3. All laundry must be done by others                                 | 0     |

| **G. Responsibility for own medications** | 1. Is responsible for taking medication in correct dosages at correct time | 1     |
|                                           | 2. Takes responsibility if medication is prepared in advance in separate dosage | 0 |
|                                           | 3. Is not capable of dispensing own medication.                        | 0     |

| **H. Ability to Handle Finances** | 1. Manages financial matters independently (budgets, writes checks, pays rent, bills goes to bank, collects and keeps track of income) | 1 |
|                                   | 2. Manages day-to-day purchases, but needs help with banking, major purchases, etc. | 1 |
|                                   | 3. Incapable if handling money.                                         | 0 |

Appendix H: WillBridge Intake Form

Date: ________________

Last Name: ________________ First Name ________________ MI: __

Social Security Number: ______-_______-_______
Date of Birth: ___/___/____ Age: ______

Last Address: ________________________________

City: ________________________________

State: ___ Zip Code: ____________ Resident: Yes__ No__ Date of arrival in Santa Barbara: ____/____/____

Height: _____ Weight: _____ Color of Eyes: _______ Color of Hair: _______
Veteran: Yes ___ No___

Homeless: YES or NO Number of: Months ______ Years ______

How many episodes of Homelessness: 1 2 3 4 5 6 7 8+ Time frame: ______ - ______
(circle one) (year) (year)

Next of Kin

Name: ____________________________ Telephone: (____) _______ - ____________

Address: _________________________ City & State: ________________ Zip Code: ________

Client Profile

Gender: Male _____ Female _____

Age Group: 13 – 18 ___ 18 – 25 ___ 26 – 64 ___ 65 – 75 ___

Ethnicity: African American: _____ Asian-Pacific Islander: _____

Latino/Hispanic: _____ Native American: _____

Unknown/Other: _____

Medications/Allergies:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Income: SSI SSDI VA GR Unemployment
Appendix I: Informed Consent

Antioch University and WillBridge of Santa Barbara, Inc. are committed to the ethical protection of participants in research. This consent form explains the Case Manager Checklists and Activities of Daily Living (ADL) measure used during your stay at WillBridge, and asks if you want the information from those forms to be a part of a study on the usefulness of housing programs for homeless persons. Participation in this study is voluntary and anonymous. If you choose to participate, one of the founders of WillBridge, Lynnelle Williams will allow me access to your forms. Lynnelle will not share with any case manager or other employee whether or not you choose to participate. If you choose to be a part of the study, your information will be kept confidential and your name will not be included in any part of the study or results.

Case Manager Checklists are completed weekly and monthly by your case manager while you are at WillBridge. They gather information on income and employment, counseling and drug/alcohol treatment, social activities, participation in your individual action plan, drug/alcohol use, and housing information. The information on these forms tracks your progress at WillBridge, and is used to help WillBridge figure out how to best help homeless persons with housing and independent living.

The Activities of Daily Living (ADL) measure is completed when you first come to WillBridge, and again a few weeks after. It will also be completed when you leave WillBridge. This measure covers many areas of daily living skills, such as grooming, bathing, cooking, medication management, chores, and house maintenance. The measure gives an idea of your ability to complete tasks that are important in caring for yourself. WillBridge completes these forms to track your progress over the course of your time in their program.

While completion of these forms is a required part of your stay at WillBridge, your choice to have the information from them used in this study is completely voluntary. You will in no way be penalized for choosing not to be a part of this study. If you do want to participate, we ask that you check the space next to “Yes, I want to
participate” at the bottom of this form. Then sign your name and put this form in the envelope you were given, for the researcher to collect. By choosing to participate, you allow the researchers to use the information from your Intake Form, all Weekly and Monthly Case Manager Checklists, and all Activities of Daily Living measures from your stay at WillBridge. Again, all of this information will be kept confidential and your name will not be included in any part of the study or results.

This study is going to look at the services WillBridge provides clients, and try to figure out which services are most helpful to homeless individuals in transitional and supportive housing. If you decide to participate, your information may help WillBridge improve their program, and may also help others to create better programs for homeless individuals. Please remember that your choice to participate is completely voluntary, and that none of the employees at WillBridge will know whether or not you decided to be a part of the study. There will be no penalty for choosing not to participate. If you feel that you are being penalized in any way, or if you have any other questions, you can contact the researcher, and steps will be taken to make sure that you get support. When the results of this study are complete, you can ask to have them, and will also be free to ask any questions you may have.

If you have any questions about this study please contact the researcher, Melissa Cervantes, M.A., or her supervisor, Sharleen O’Brien Dolan, Psy.D., at Antioch University, Santa Barbara, 602 Anacapa St., Santa Barbara, California, 93101, (805) 962-8162 x 5309. If you agree to participate, and want to have your information included in this study, please check “Yes, I want to participate,” and sign on the space below that you understand your rights and agree to participate in this study.

Yes, I want to participate______ No, I do not want to participate____

____________________________________
Signature of Participant

Melissa Cervantes, M.A., Researcher
Antioch University, Santa Barbara, CA

Sharleen O’Brien, Psy.D., Supervisor
Antioch University, Santa Barbara, CA
Appendix J: Insuring Informed Consent of Participants in Research

Questions to be answered by AUSB Researchers:

1. Are your proposed participants capable of giving informed consent? Are the persons in your research population in a free-choice situation? …or are they constrained by age or other factors that limit their capacity to choose? For example, are they adults, or students who might be beholden to the institution in which they are enrolled, or prisoners, or children, or mentally or emotionally disabled? How will they be recruited? Does the inducement to participate significantly reduce their ability to choose freely or not to participate?

The participants in my study, adult clients of WillBridge of Santa Barbara, Inc. are capable of giving informed consent. The decision to provide their information to this study is completely voluntary, as will be explained in the accompanying documents. The clients of WillBridge are homeless, and often suffer from mental illness. In an effort to ensure informed consent, clients will have to have been at WillBridge for at least 30 days, before being allowed to participate. This will give the client a chance to settle in to the WillBridge program, and also give them time to receive medical and psychiatric care, including medication allotment and management.

Clients who have been at WillBridge for 30 days will be given the Informed Consent Form, with the option to choose to participate, or not to participate. The Informed Consent Form will presented and explained to each client by the researcher, completed by the client, placed in a provided envelope, and collected by the researcher once completed. In order to access and collect the client data/forms for only those clients who choose to participate, the researcher will share the names of those who have given consent with one of the WillBridge program founders, Lumnelle Williams. Williams does not have day-to-day contact with clients, and does not determine any specific aspects of their program components; day-to-day client interaction and program components are determined by case managers. Williams will not share the consenting names with any other member of the WillBridge team, including the case managers. This step is taken as precaution to safeguard against members of WillBridge knowing whether a client decides to participate, and to reassure participants that they will not face penalties should they choose not to. Williams is not in any way invested in this particular study, and is able to use client information for other research purposes. It is reasoned that Williams will not have any reason to penalize a client for choosing not to participate in this study. There will, however, be
resources provided to participants and non-participants, should they in any way feel that they are being penalized.

For those clients who opt to participate, their name and data will be assigned a code number, and for purposes of the research, that code number will be the only identification for their information. WillBridge members will not have access to these code numbers. Also, there will be no inducement to participate, other than the possibility of furthering research on the needs of homeless individuals like themselves, which is explained in the Informed Consent Form. The Forms collected will be kept in a locked cabinet for the duration of the study. Once the study is completed and all results have been analyzed, all client forms will be shredded and disposed of.

For additional data to be used in this research, regarding the residency outcomes of past WillBridge clients, WillBridge will provide the researcher with non-identifying summary data. No client names or identifying information will be included in this summary data. The data will include only a total summary of how many past clients from WillBridge have obtained residency, and what type of residency was obtained.

2. **How are your participants to be involved in the study?**

Participants will be clients of WillBridge of Santa Barbara, Inc., residing in one of their transitional or supportive housing units. All clients in these housing units who have been at WillBridge for at least 30 days will be given an Informed Consent form, explaining the study, and giving them the option to participate, or not to participate. The clients will be presented with this consent form by the researcher, who will explain the purpose for the study, as well as potential benefits and harm that may come with their participation, as stated on the form. The researcher will read through the informed consent form with any client who is unable to read. The client will then complete this consent form and enclose it in a provided envelope for the researcher to collect. Those clients who opt to participate will have their data included for the purposes of this study. WillBridge, as a part of its programming, uses non-identifying client information regularly for the purposes of research, grant writing, and evaluation purposes. At the start of this program evaluation process, WillBridge signed an agreement to share this client data with the researcher as part of this dissertation. The clients of WillBridge are of the understanding that their non-identifying information is to be used for WillBridge's research purposes, regardless of their participation in this particular study.
3. **What are the potential risks – physical, psychological, social, legal, or other?** If you feel your participants will experience “no known risks” of any kind, indicate why you believe this to be so. If your methods do create potential risks, say why other methods you have considered were rejected in favor of the method chosen.

Since the information being requested by this study is already being collected as a part of the participants stay at WillBridge, I do not foresee any additional risks to the participants, regarding the data collection necessary for this study. One potential risk, however, may be that participants may feel obligated to give their consent for participation in this study, or fear penalties from the WillBridge staff, should they choose not to participate. In an effort to minimize this risk, clients of WillBridge will be given Informed Consent Forms that outline the voluntary nature of the study, and will be given a clear choice of saying yes or no to participation on that form.

4. **What procedures, including procedures to safeguard confidentiality, are you using to protect against or minimize potential risks, and how will you assess the effectiveness of those procedures?**

Clients will be asked to fill out consent forms in private, and return them in a pre-addressed, stamped envelope to the researchers, reassuring them that no members of WillBridge will know whether or not they chose to participate. As an additional safeguard, any WillBridge client who has received the informed consent form, and feels any distress regarding their choice to participate or not, may contact the study investigators with their concerns, and steps will be taken to insure that they receive proper support.

5. **Have you obtained (or will you obtain) consent from your participants in writing? (Attach a copy of the form.)**

Each participant will be asked to sign an informed consent form and return it to the researchers in a pre-addressed, stamped envelope to the researchers at Antioch University, Santa Barbara. Envelopes returned from WillBridge clients asking not to participate in the study will not be included in the data collection; however, all participants who received the informed consent form will have access to the researchers, should they experience any distress associated with any level of study participation or non-participation.
6. What are the benefits to society, and to your participants, that will accrue from your investigation?

Qualitative studies exploring homelessness services have focused mainly on whether transitional and supportive housing are effective in reducing homelessness by increasing residency among clients. While the first order of this study is a program evaluation determining such effectiveness in increasing residency, it also looks at increased income, and life skills of clients in transitional housing. In addition to determining program effectiveness in these areas, this study attempts to go one step further, in determining which particular program aspects are most indicative of increased income and residency among clients. This study could be the first step in identifying what program components are most important to include in the development of future transitional and supportive housing programs, as well as indicate areas of focus for existing programs. Participants who choose to participate in this study may obtain personal benefit, in feeling that they are contributing to a better understanding of what services are most helpful to provide to homeless individuals in transitional and supportive housing, and therefore may be helping in the future care of other homeless individuals like themselves.

7. Do you judge that the benefits justify the risks in your proposed research? Indicate why.

I do believe that the risks associated with participation in this study are minimal, and are clearly outweighed by the potential benefits to society, as they have the potential to inform the treatment of a large population of individuals. A better understanding of effective homelessness services is needed to reduce homelessness, and to provide the most ethical and proper care for those suffering from it.

Both the student and her Dissertation Chair must sign this form and submit it before any research begins. Signatures indicate that, after considering the questions above, both student and faculty person believe that the conditions necessary for informed consent have been satisfied.

Date: ______________________  Signed: ____________________________
   Student

Date: ______________________  Signed: ____________________________
   Dissertation Chair
### Appendix K: Permissions

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Sep 03, 2013

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