Evaluation of the Vital Program (The Familiar Faces Intensive Care Management Team)

Results from First Three Years of Implementation

King County Department of Community and Human Services
Performance Measurement and Evaluation Unit
401 Fifth Avenue, Seattle, WA 98104
kingcounty.gov

Contents

Evaluation of the Vital Program (The Familiar Faces Intensive Care Management Team): Results from Three Years of Implementation

Program Overview

The Familiar Faces Intensive Care Management Team (Vital) provides comprehensive and integrated services to adults who are experiencing behavioral health challenges (mental health and/or co-occurring substance use disorders), need an intensive level of community-based support, and are (or are at significant risk of) experiencing homelessness. Vital is a flexible, community-based team that provides behavioral health treatment integrated with primary health care and life skills development. These team-based services center around the participants' self-determination and individual recovery goals. Additionally, Vital provides ongoing coordination with criminal-legal system partners to support reentry and reduce incarceration and crisis system utilization.

Services are provided by Evergreen Treatment Services' REACH (REACH) program in collaboration with Harborview Behavioral Health. A continuum of housing options is explored with program participants, matching individuals to housing that meets their needs. A limited number of dedicated permanent supportive housing units are offered by Plymouth Housing Group. Legal case coordination is provided jointly by prosecutorial liaisons in the Seattle City Attorney's Office and the King County Prosecuting Attorney's Office.

Eligibility for Vital is restricted to adults who have been booked into a King County jail four or more times within a 12-month period (i.e., "Familiar Faces"), twice in a three-year time frame.[1] Initial eligibility was limited to bookings in the King County Jail; however, eligibility was expanded in 2022 to include bookings in municipal jails located in King County. Vital has a low barrier to entry and no time-limit on program participation.

Vital Staffing Model

The Vital team is comprised of four care managers and a program manager from REACH; a primary care nurse practitioner, psychiatric nurse practitioner, primary care registered nurse, mental health professional, and occupational therapist from Harborview Medical Center; a housing case manager from Plymouth Housing Group; and, prosecutorial liaisons from the Seattle City and King County Prosecuting Attorney's Offices.[2] **Figure 1** provides an overview of the Vital staffing model.

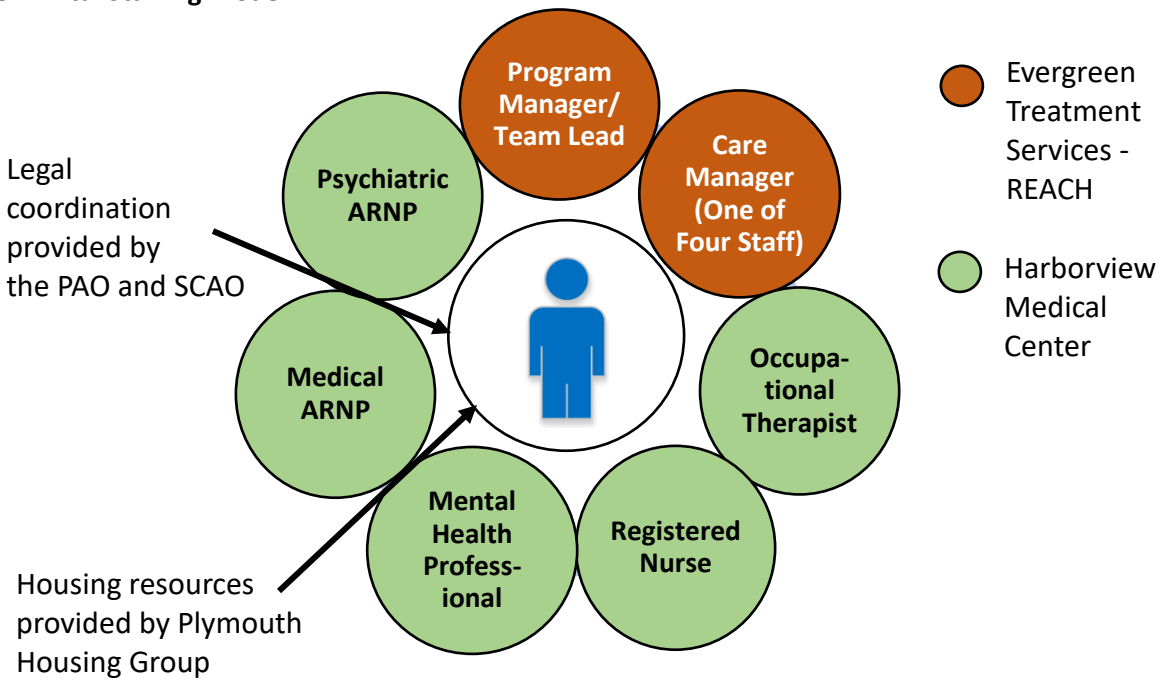
Care managers at REACH assigned to each client serve as a "golden thread," providing a consistent relationship with that client, acting as the keeper of the client's coordinated care plan, and facilitating communication among all care providers. Care managers facilitate client engagement with services (e.g., scheduling and keeping appointments); assist with housing applications, placement, and stabilization; help clients reconnect with families; explore opportunities for employment and volunteer work; and, secure benefits, including food, cash assistance, transportation, and medical benefits. They also provide or facilitate behavioral health assessments and placement in appropriate treatment programs when indicated or requested by client. The program manager at REACH provides ongoing coordination and

[1] While the term "Familiar Faces" is no longer in common use to refer to the population of individuals who frequently cycle through the criminal-legal system, this report uses the term as shorthand for the population eligible for the Vital program.

[2] As part of the Plan-Do-Study-Act (PDSA) model, the Vital team transitioned to using a mental health professional in 2019. Previously, this position was filled by a peer support specialist.

support to the Vital team, including supervision of the care managers, facilitating weekly reviews of client care plans, and troubleshooting. The program manager also maintains relationships with community partners, covers for assigned care managers in their absence, oversees data collection and reports to various steering committees and oversight bodies.

Figure 1. Vital Staffing Model



The primary care nurse practitioner provides assessment and treatment for acute and chronic medical issues, as well as preventive care, and coordinates with the registered nurse regarding medical care (e.g., ordering lab tests). The registered nurse triages client health needs and provides linkage to appropriate specialty care; the registered nurse also meets clients in the community and in dwelling places. Nursing staff facilitate clients' transitions within and between health care settings, foster their goals for improving health and managing chronic disease, assess their understanding of their diagnoses and readiness to change, educate them on their use of medications, and administer wound care. For clients who are not yet comfortable engaging in a formal treatment setting, the psychiatric nurse practitioner provides one-on-one psychiatric support, tailored assessment and treatment of mental health, preparation and delivery of medications, and coordination with Jail Health Services and former prescribers to ensure continuity of care.

The occupational therapist helps clients manage their activities of daily living (ADLs) to support sustained housing and community integration. The occupational therapist facilitates ADLs by identifying areas for skill development or environmental adaptation/modification and then providing interventions appropriate to the client's level of functioning. Interventions aim to improve a client's ability to manage medications, complete chores, prepare meals, budget, practice coping strategies, develop daily routines and healthy habits, and explore healthy social activities. Peer support specialists often serve as role models of overcoming common obstacles to recovering from mental health and/or substance use disorders. The Vital peer support specialist helped clients identify goals that promoted recovery and resilience, provided outreach services, and accompanied clients to and from appointments. After three

years of program implementation, the peer support specialist role was replaced by a mental health professional. The mental health professional provides flexible behavioral health therapy and support, support navigating the involuntary treatment system, and appropriate linkages to care.

A contractual agreement between REACH and Plymouth Housing Group establishes 20 housing units at the Pacific Apartments set aside for Vital participants. Once housed at the Pacific, clients receive the added support of a housing case manager. The housing case manager is responsible for providing client-centered support and eviction prevention services, coordinating activities that develop community, and facilitating occupational opportunities.

Service Delivery Framework

All Vital services and housing support are culturally responsive, aligned with the ideals of the King County Equity and Social Justice Strategic Plan, a trauma-informed harm reduction framework, and a person-centered model of behavior change rooted in motivational interviewing.[3] Vital also uses a housing first approach, assertive outreach and engagement, and integrated multidisciplinary care coordination.[4] Vital staff initiate contact and develop relationships through repeated visits to individuals where they are, including jails, hospitals, encampments, shelters, and other locations. Engagement in Vital begins with forming a trusting relationship that provides the context for assessing needs, defining service goals, agreeing on an individualized care plan, and linking people with needed services. Vital staff link individuals to services in a non-judgmental, non-coercive manner; services often include access to entitlements and benefits, health care, mental health and substance use treatment, and shelter or permanent housing.

Each client's immediate survival needs are triaged at the time of referral and addressed by the appropriate Vital provider(s). The harm reduction orientation uses practical strategies aimed at reducing the harmful consequences of substance use and homelessness. Holistic care plans, responsive to each clients' stage of change, are designed together with clients to help them improve self-efficacy and quality of life.[5] As such, abstinence from substances is not the focus of Vital, but rather individual wellness. Because this perspective is paradigmatically different than that of the criminal-legal system, which tends to surveil and enforce abstinence, Vital staff regularly present the benefits of the harm reduction approach to Superior Court, District Court and municipal judges. Further, information sharing with prosecutors is utilized in lieu of participating in court monitoring.

Informed by best practices of the Assertive Community Treatment model, each care manager at REACH maintains a low caseload of 15 clients, each of whom have regular access to health care providers from Harborview Behavioral Health. Recognizing that some individuals who could benefit from traditional health care services may be unwilling or incapable of accessing services in the traditional health system, Harborview staff deliver low-barrier medical and mental health support services while sited at REACH's Belltown office in downtown Seattle. When needed, the primary care and psychiatric specialists jointly provide street outreach with Vital care managers to engage individuals in need of care who are not yet comfortable coming into the REACH office. These collaborative efforts, focused on trust building and engagement, result in increased stability and improved quality of life for clients, as well as decreased reliance on emergency medical and criminal-legal systems.

---

[3] Substance Abuse and Mental Health Services Administration. (2023). *Harm Reduction*. [LINK]
[4] National Alliance to End Homelessness. (2022). *Housing First*. [LINK]
[5] Kubek, P. M., Kruszynski, R., & Boyle, P.E. (2004). *IDDT Stages of Change & Treatment*. Case Western Reserve University: Cleveland, OH. [LINK]

Funding

The Vital program is funded through King County's Veterans, Seniors and Human Services Levy, under *Strategy HS.7A: Forensic Supportive Housing Models to Reinforce Criminal Justice Diversion and Reentry with Housing*, and through the MIDD Behavioral Health Sales Tax, under *Initiative RR-13: Deputy Prosecuting Attorney for Familiar Faces*. Support for Vital is provided in-kind from the Seattle City Attorney's Office and Plymouth Housing Group. (In July 2022, Vital began receiving additional support through Trueblood diversion funding from the Washington State Health Care Authority.)

Program Eligibility and Participant Characteristics

Program Eligibility

Individuals are eligible for the Vital program if they have been booked into the King County jail four or more times within a 12-month period in at least two of the previous three years.[6] Rosters of individuals eligible for Vital were initially constructed at two time points: July 2016 and August 2017. These initial rosters comprised a total of 674 Vital-eligible individuals, though the capacity of the Vital program is only 60 individuals at a time. The original cohort of program participants was determined through a combination of eligibility criteria, random selection, and prioritization by Vital staff. Over 95% of the 674 eligible individuals had a history of involvement with the King County behavioral health system in some capacity. As of 2024, the eligibility roster for the Vital program is updated quarterly and generally contains over 1,000 individuals. As capacity allows, program staff prioritize outreach for enrollment in Vital to eligible individuals based on a variety of factors, including behavioral health system engagement (e.g., involuntary treatment), demographic characteristics, and involvement with the criminal-legal system.

Participant Demographic Characteristics

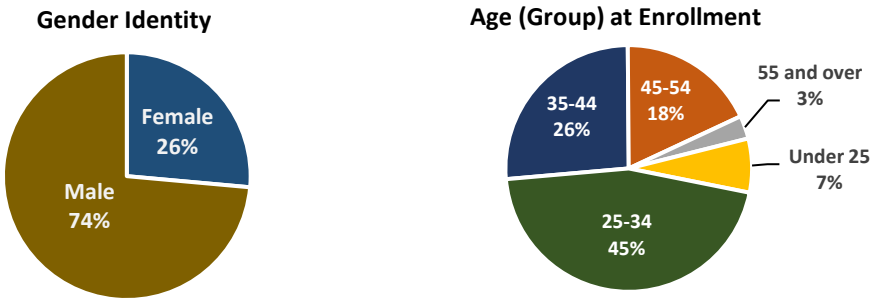
The following represent the characteristics of participants who enrolled in Vital between July 2016 and June 2018. The analysis was limited to this time frame to allow enough time to pass (subsequent to program enrollment) for outcomes to be observed. A total of 87 individuals eligible for the Vital program were enrolled during this two-year period. As shown in **Figure 2**, 74% of Vital participants identified as male and 26% as female. The mean age of Vital participants at enrollment in the program was 35 years old. Participants ranged in age from 20 to 58 years old. Of note and highlighted in **Figure 3**, 47% of Vital participants identified as Black/African American, 22% identified as White, 15% identified as Hispanic/Latina/Latino/Latinx, 15% identified with multiple race categories, 11% identified as American Indian/Alaska Native, and 4% identified as another race not listed (or race is unknown).[7] This racial/ethnic distribution departs significantly from the adult population of King County, as well as the population of Familiar Faces who have been frequently booked into the King County Jail.[8]

[6] Eligibility was expanded in 2022 to include bookings in municipal jails located in King County, in addition to bookings into King County Jail.

[7] Exclusive race categories, including a category for "multiple races," to enable direct comparison to the Familiar Faces population, which relies on the limited race categories captured by the King County Jail.

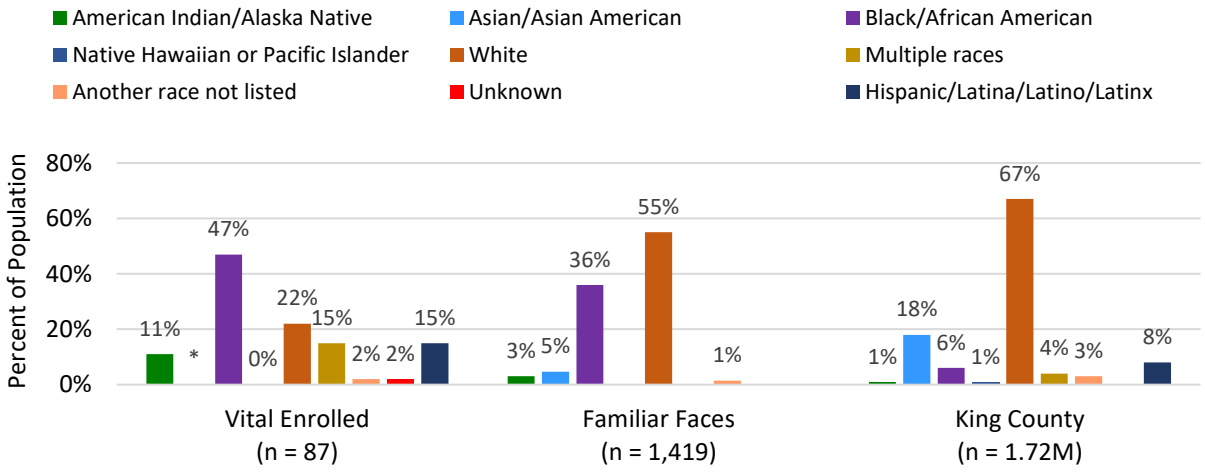
[8] Familiar Faces demographics based on 2016 data for direct comparison; King County adult population estimates derived from the U.S. Census, American Community Survey, 5-year estimates (2014-2018).

Figure 2: Gender and Age Distribution of Vital Participants (*n* = 87)



Six percent of the King County adult population and 36% of Familiar Faces identify as Black/African American (compared to 47% of Vital participants); 67% of the King County adult population and 55% of Familiar Faces identify as White (compared to 22% of Vital participants); and 8% of the King County adult population identifies as Hispanic/Latina/Latino/Latinx (compared to 15% of Vital participants). (*Note*: At the time of this analysis, the King County jail did not publish information on Hispanic/Latina/Latino/Latinx ethnicity, nor did they report identification with multiple race categories. As such, this information is unavailable for Familiar Faces in Figure 3.)

Figure 3: Race/Ethnicity of Vital Participants with Comparison Data for King County Adults and Familiar Faces (Individuals with 4+ Jail Bookings in a 12-Month Period)



*Result suppressed if group includes fewer than 10 individuals.

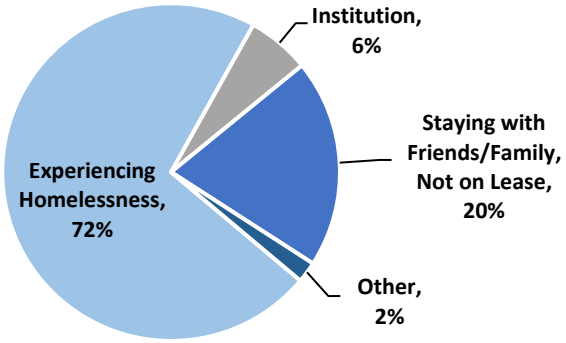
Note: Percentages in each race category are mutually exclusive, and Hispanic/Latina/Latino/Latinx is included as a distinct, non-overlapping category for direct comparison to the King County Jail/Familiar Faces data, which did not report ethnicity nor inclusive race categories at the time of this analysis.

Individuals identifying as female and people of color are overrepresented in the Vital program relative to the overall Familiar Faces population, and this is by design. Individuals who meet the program eligibility criteria are further prioritized by program staff to counteract racial disparities present in the criminal-legal system, a Familiar Faces Initiative mandate to address racial justice. Exercising professional discretion, Vital staff prioritize race (people of color), age (young adults aged 18-25 and older adults age 55+), gender (female), need (based off of engagement in other systems), chronic health conditions, psychiatric and emergency department utilization, and prior contact with REACH when determining who to offer Vital program services to.

Participants' Housing Status

Nearly all clients entering the Vital program were without stable housing. As shown by **Figure 4**, over 70% of participants entered the Vital program experiencing homelessness; all other participants who were staying with friends or family, in an institution (jail, hospital, or psychiatric inpatient facility), or transitioning into housing were at-risk of homelessness. Housing stability is difficult to conceptualize and define, particularly as individuals frequently move between homelessness, emergency shelter, staying with friends and/or family, transitional housing, supportive housing, institutional settings, hotels or motels, and independent permanent housing.[9] Even within categories (e.g., staying with friends/family), there exist varying levels of stability as individuals may have housing/shelter for one night or for several months. The point-in-time snapshot of housing status shown in Figure 4 serves to demonstrate the challenge of housing stability for most, if not all, Vital participants. An analysis of changes in housing stability over time, while limited, is explored below under *Participant Outcomes*.

Figure 4: Housing Status of Vital Participants at Program Entry (*n* = 87)



Participants' Diagnostic Characteristics

The Vital program does not necessitate that individuals have a behavioral health condition in order to be eligible for the program; however, an analysis of the Familiar Faces population demonstrated that over 94% of individuals meeting the jail booking frequency criterion had an indication of a behavioral health condition.[10] Nearly every Vital program participant had a behavioral health condition clinically diagnosed in the year prior to program enrollment or shortly after enrolling in Vital. **Figure 5** displays the distribution of behavioral health indicators among program participants. This analysis is limited to information available to the King County Behavioral Health and Recovery Division or directly provided by clinical staff on the Vital team; it is likely that many, if not most, of the individuals whose diagnostic characteristics are 'unknown' in Figure 5 may also have a behavioral health condition, but that the condition was not documented during the time frame assessed.

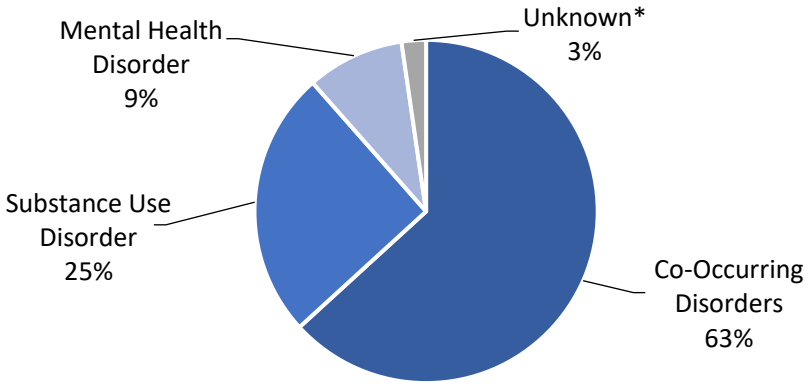
Of the 87 individuals enrolled in the Vital program between July 2016 and June 2018, 85 (97%) had a documented behavioral health diagnosis. Sixty-three percent had co-occurring disorders diagnosed (i.e., a mental health and substance use disorder), another 25% had only a substance use disorder (SUD) documented, and just under 10% had only a diagnosed mental health disorder documented. Over half of participants diagnosed with a mental health disorder, whether co-occurring with an SUD or not, were

[9] Frederick, T. J., Chwalek, M., Hughes, J., Karabanow, J., & Kidd, S. (2014). How stable is stable? Defining and measuring housing stability. *Journal of Community Psychology*, *42*(8), 964-979.

[10] King County Department of Community and Human Services and Public Health Seattle/King County. (2016, May). Familiar faces data packet: Current state – Analysis of population. [LINK]

diagnosed with a depressive disorder; the second most common diagnosis among those with a documented mental health disorder was post-traumatic stress, followed by an anxiety disorder, schizoaffective disorder, schizophrenia, any other non-mood psychotic disorder, and bipolar disorder. If the specific delusional and psychotic disorders listed above are combined, 31% of Vital participants (43% of those with any documented mental health disorder) were diagnosed with schizophrenia, schizoaffective, delusional, or any other non-mood psychotic disorder.

Figure 5: Behavioral Health Diagnosis Types among Vital Participants Within One Year of Program Enrollment (*n* = 87)



*Participants without diagnoses were enrolled in Vital for a very short time (approx. two months) and never consulted with a primary care or psychiatric care nurse.

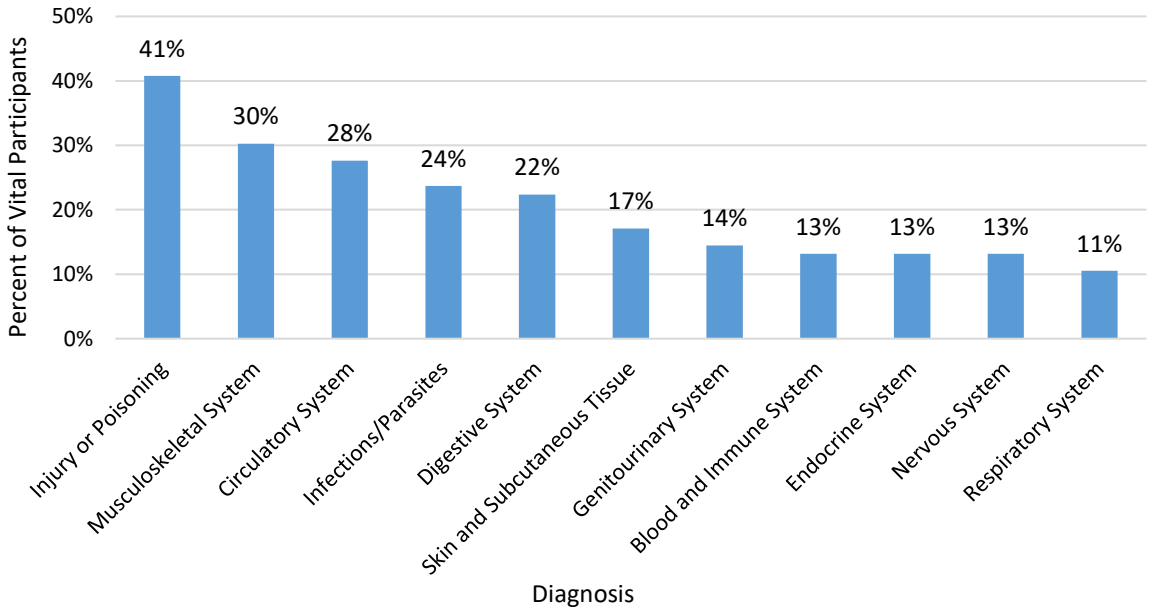
Not captured by the category of mental health disorder are cognitive impairments due to developmental delay/disability, traumatic brain injury, or other causes. Cognitive functioning is assessed, as needed, by the Vital program's occupational therapist via the Allen Cognitive Level Screen (ACLS). Of the 30 Vital program participants who completed the assessment (between 2016 and 2019), the average score was 4.4. The cognitive ability of someone who scores in this range is described as moderately impaired.[11]

Many Vital participants also experience acute and/or chronic physical medical conditions. Specific diagnoses affecting five or more Vital participants include anemia, hepatitis, diabetes, asthma,

[11] Moderately impaired: Person is aware of tangible cues (see and touch) and understands visible cause-and-effect relationships. Goal-directed actions demonstrate an awareness of a familiar end-product but fail to solve new problems, anticipate, or correct mistakes. There is no independent new learning and they cannot invent new motor actions. They do not recognize errors unless clearly visible and may request help when mistakes are noticed. Attention span is usually good for up to one hour. Minimum assistance is needed when therapists set up goal-directed activities with tangible results. Help is needed to correct repeated mistakes, to check for compliance with established safety procedures, and to solve problems presented by unexpected hazards. Extensive, situation specific training is required to learn new activities, with no expectation for generalization of learned techniques. Person may live with someone who does a daily check on the environment and removes any safety hazards and solves any new problems. Person may be left alone for part of the day with procedure for obtaining help by phone or from a neighbor. Person may manage a daily allowance and go to familiar places in the neighborhood. Allen, C. K., Austin, S. L., David, S. K., Earhart, C. A., McCraith, D. B., & Riska-Williams, L. (2007). *Manual for the Allen Cognitive Level Screen-5 (ACLS-5) and Large Allen Cognitive Level Screen-5 (ACLS-5)*. Camarillo, CA: ACLS and LACLS Committee; Allen, C. K. (1991). Cognitive disability and reimbursement for rehabilitation and psychiatry. *Journal of Insurance Medicine*, *23*(4), 247.

hypertension, alcoholic liver disease, joint disorders, cellulitis, osteomyelitis (bone infection), and external injuries (e.g., lower leg fractures). Of the 87 individuals enrolled in the Vital program between July 2016 and June 2018, 11 had no diagnoses documented by the medical staff (several of these individuals were enrolled in Vital for only a short period of time). Among the 76 program participants with physical health issues documented, half (50%) exhibited unclassified symptoms, signs and/or abnormal clinical and laboratory findings and nearly all participants had documented adverse social determinants of health, e.g., "Problems related to housing and economic circumstances". **Figure 6** presents an overview of the common (broad) classifications of medical issues among Vital participants, which does not include the non-specific medical diagnoses mentioned above.

Figure 6: Prevalence of Diagnosed Disease/Injury Types among Vital Participants Within One Year of Program Enrollment (*n* = 76)*



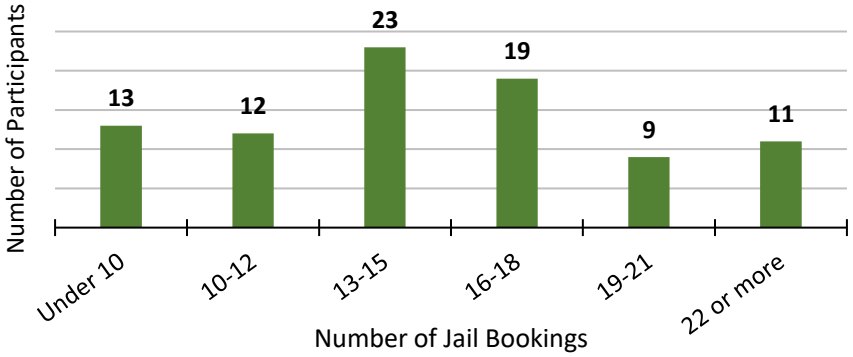
*Eleven participants have unknown or non-existent physical health diagnoses based on reports from medical staff.

The most common diagnoses among Vital participants were related to injuries and poisoning consequent of external causes (e.g., medication overdose), diseases of the musculoskeletal system (e.g., bone fractures), diseases of the circulatory system (e.g., heart disease), infectious and parasitic diseases (e.g., hepatitis), diseases of the digestive system (e.g., liver disease), and diseases of the skin and subcutaneous tissue (e.g., abscesses). Other common diagnoses (also shown in Figure 6) included diseases of the genitourinary system, diseases of the blood, endocrine diseases, diseases of the nervous system, and diseases of the respiratory system.

Participants' Criminal-Legal Justice System Involvement

Given the eligibility criteria for the Vital program (i.e., adults booked into King County Jail four or more times within a 12-month period in at least two of the previous three years), program participants have extensive, yet varying, involvement with the criminal-legal system. **Figure 7** displays the number of jail bookings among Vital participants in the three years prior to their enrollment in the program. Nearly half (48%) of Vital participants were booked into a municipal or King County Jail between 13 and 18 times in that time frame. Over 1 in 8 participants had been booked 22 or more times.

Figure 7: Number of King County and Municipal Jail Bookings During the Three Years Prior to Vital Enrollment (*n* = 87)



Due to their often-extensive involvement with the criminal-legal system, most participants have outstanding legal obligations upon enrollment in the Vital program. Participants may have upcoming court hearings, outstanding charges, or warrants; some of which they may not even be aware of. Prosecuting attorneys for King County and the City of Seattle assist with legal coordination for Vital participants, outlined in greater detail below (see *Service Delivery and Participant Outcomes*).

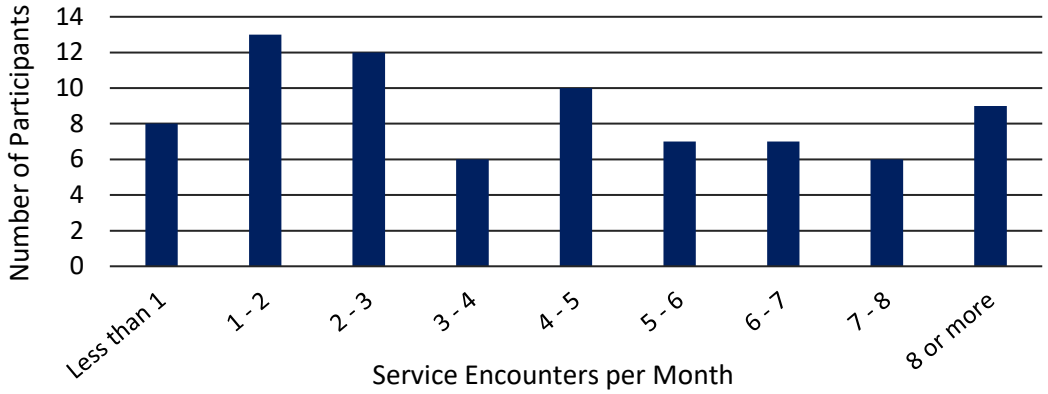
Service Delivery

Case Management

Program staff at REACH, known as "care managers," provide comprehensive case management services to Vital participants, ranging from assistance obtaining identification to identifying housing opportunities to scheduling and attending medical appointments. Case management services are tailored to program participants, as everyone has different needs and may be in a different stage of change.[12] **Figure 8** displays the average (mean) number of case management encounters that care managers had with Vital participants per month during their program participation (among participants enrolled in Vital at least six months, measured through June 2019). Half of Vital participants receive case management from a Vital care manager more than four times per month, on average, including periods of time when a participant is out of contact. While about 10% of Vital participants average less than one case management service per month, a greater proportion of participants encounter their care manager for case management *eight or more* times per month. This level of engagement speaks to the intensity of service provision and the development of relationships and trust between care managers and Vital participants, a cornerstone of this service delivery model. Not shown in Figure 8, Vital participants who are housed receive, on average, a greater number of case management service encounters than participants who are unhoused. Anecdotally, the ease of locating an individual for outreach or service may be what drives this observed difference.

[12] Kubek, Kruszynski, & Boyle. (2004). [LINK]

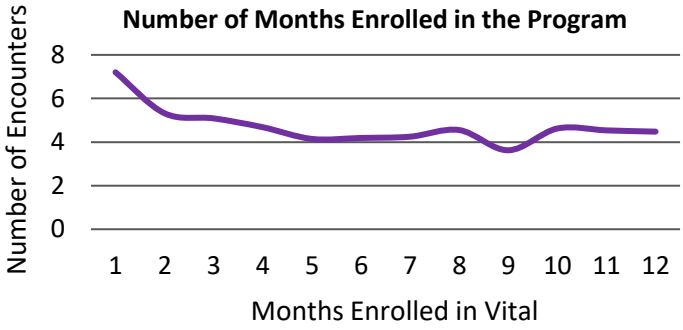
Figure 8: Average Number of Case Management Encounters per Month among Vital Participants (through June 2019)*



*Vital participants enrolled six months or more (*n* = 78).

Engagement with Vital care managers and receipt of case management services is relatively consistent over time, although (as noted in Figure 8) the level of case management needed or sought varies significantly among program participants. **Figure 9** demonstrates that the first month of participation in Vital involves a greater intensity of case management from Vital program staff; participants average over seven encounters with their care manager for case management services in their first month of program participation. After the first month, participants average between four and five encounters with their care manager (among Vital participants enrolled in the program at least 12 months).

Figure 9: Average Case Management Encounters among Vital Participants*, by Number of Months Enrolled in the Program

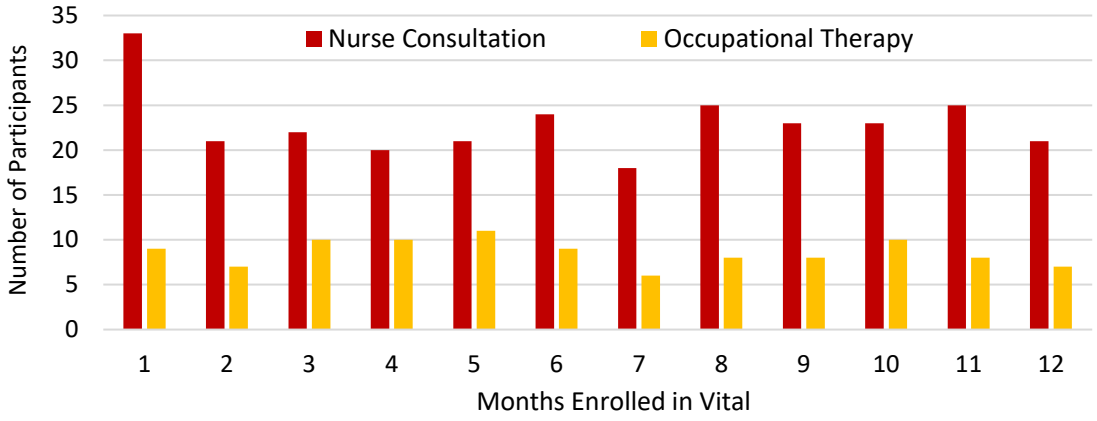


*Vital participants enrolled 12 months or more (*n* = 69).

Physical and Behavioral Health

Staff from Harborview Medical Center provide physical healthcare, behavioral healthcare, prescription access, and occupational therapy to Vital participants, ranging from wound care to medication management to assessment of daily living skills. Each participant has different needs; for example, some participants have no need for occupational therapy, and some participants need assistance managing chronic conditions. **Figure 10** displays the number of participants who received a nurse service encounter and/or occupational therapy from Harborview staff per month during their program participation (among participants enrolled in Vital at least 12 months, measured through June 2019); Harborview nursing staff include a registered nurse, a primary care advanced registered nurse practitioner (ARNP), and a psychiatric ARNP. More than half of Vital participants received a nurse service encounter in their first month of program participation, and approximately one-third of Vital participants speak to a nurse in any given month thereafter. About one-eighth of Vital participants work with the Harborview occupational therapist each month.

Figure 10: Number of Vital Participants with Nurse Service Encounters (Physical or Behavioral Health), by Duration of Program Enrollment*



*Vital participants enrolled 12 months or more (*n* = 69).

As observed with case management services, Vital participants who are housed receive, on average, more nurse service encounters and occupational therapy than participants who are unhoused, and again, anecdotal evidence suggests the ease of locating an individual is somewhat responsible for this difference. Among the 69 Vital participants represented in Figure 10, 65 (94%) received at least one service from a Harborview nurse during their first 12 months in Vital, and 41 (59%) had at least one service from the occupational therapist. Over the course of those first 12 months in Vital, participants who were housed received, on average, twice as many nurse service encounters and four times as many occupational therapy service encounters. This may be because Harborview staff are better able to treat and assist participants with a consistent residence, or because participants who are housed are generally more stable and accessing services with greater frequency.

Legal Coordination

The prosecutorial liaisons with the King County Prosecuting Attorney's Office and the Seattle City Attorney's Office provide legal coordination for Vital participants to varying degrees, depending on the extent of involvement of each participant with the criminal-legal system. Legal coordination for Vital participants includes covering court hearings; assisting with outstanding warrants; proposing alternative case resolutions; holding, reducing, or declining to file charges; reviewing participants' criminal-legal history and helping determine eligibility for alternative sentencing; and, coordinating information across law enforcement, judicial, and correctional jurisdictions. For example, prosecutors may provide information on sentencing alternatives such as electronic home detention or participation in a program at the Community Center for Alternative Programs. They may also share information about impending court dates or jail release dates with Vital care managers. Further, because many Vital participants have extensive criminal-legal system involvement in multiple jurisdictions, prosecutors help coordinate interagency communications regarding Vital participants' status in different jurisdictions. In most reporting years, more than two-thirds of Vital participants receive some form of legal coordination from one or both prosecuting attorneys' office(s).

Housing Navigation

Generally, Vital staff outreach to potential program participants upon release from the King County Jail or *in-reach* to potential participants while they are still incarcerated. As such, with few exceptions, individuals enrolling in the Vital program are without stable housing. While many Vital participants gain

access to permanent housing over time, the process can be very protracted. The Vital program has access to 20 housing units set aside (i.e., reserved) through the Plymouth Housing Group, though these units are typically filled and only become available when a unit turns over. This "turnover" requires a program participant to leave the Vital program, relinquish the housing unit, or obtain a different housing resource, a rarity in an environment with limited available options for individuals with significant barriers to housing. Many renters require paperwork to be signed with a witness present, a near impossibility when prospective rental staff lack access to the jails. Prospective tenants require appropriate documentation, or the ability to make appointments and meet requirements in a short time frame, something which can be challenging for an individual experiencing homelessness. Further, many Vital participants do not technically qualify as "homeless" using HUD's definition, which is an eligibility requirement for certain housing resources, after being incarcerated for 90 (or more) consecutive days, a qualification that disproportionately affects persons of color.

Twenty vouchers through the King County Housing Authority were originally provided for the Vital program, but these vouchers could not be used because a landlord partnership could not be secured. Landlords are often reticent to house individuals with high acuity behavioral health concerns or histories of involvement with the criminal-legal system due to the perceived risk and liability. Further complicating housing navigation for Vital participants was the prioritization tool used for housing placements at the time of Vital implementation. Program participants often received a low score on this tool, the *Vulnerability Index - Service Prioritization Decision Assistance Tool* (VI-SPDAT), deprioritizing them for housing. (Aside: Racial inequities observed in who received priority using the VI-SPDAT led King County to create alternative methods of prioritization beginning in 2018 and fully discontinue use of the VI-SPDAT in 2020.[13])

Participant Outcomes

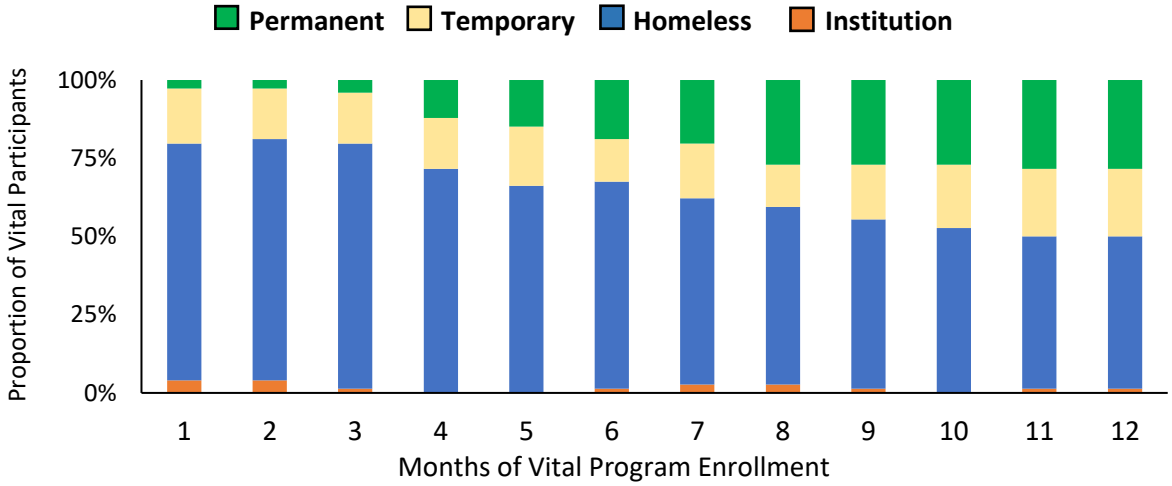
Changes in Housing Status among Vital Program Participants

Vital program staff submit monthly reports to King County that contain information on participants' demographic characteristics, housing status, and program enrollment updates. There were 28 distinct housing statuses among Vital clients enrolled between July 2016 and June 2018. These were collapsed into four categories: Permanent, Temporary, Homeless, and Institution (see **Appendix A** for a complete list of housing status designations and classifications). For example, an individual living in an encampment would be considered experiencing homelessness, and their housing status would be classified as *homeless*, whereas an individual living in a psychiatric facility would be classified as in an *institution*, and an individual staying with friends or family (not on the lease) would be classified as having *temporary* housing.

Because Vital participants are enrolled for different lengths of time, **Figures 11** and **12** display changes in participants' housing status grouped by minimum length of time in the program. Housing statuses for participants enrolled in the Vital program for 12 months or more (n = 74) are presented in Figure 11, and housing statuses for participants enrolled in Vital for 24 months of more (n = 37) are displayed in Figure 12. Housing status updates through June of 2019 are provided here for consistency with other outcome measures and service characteristics.

[13] Bitfocus. (2022, February). *Removal of the VI-SPDAT as a Portion of the Housing Triage Tool (HTT).* [LINK]

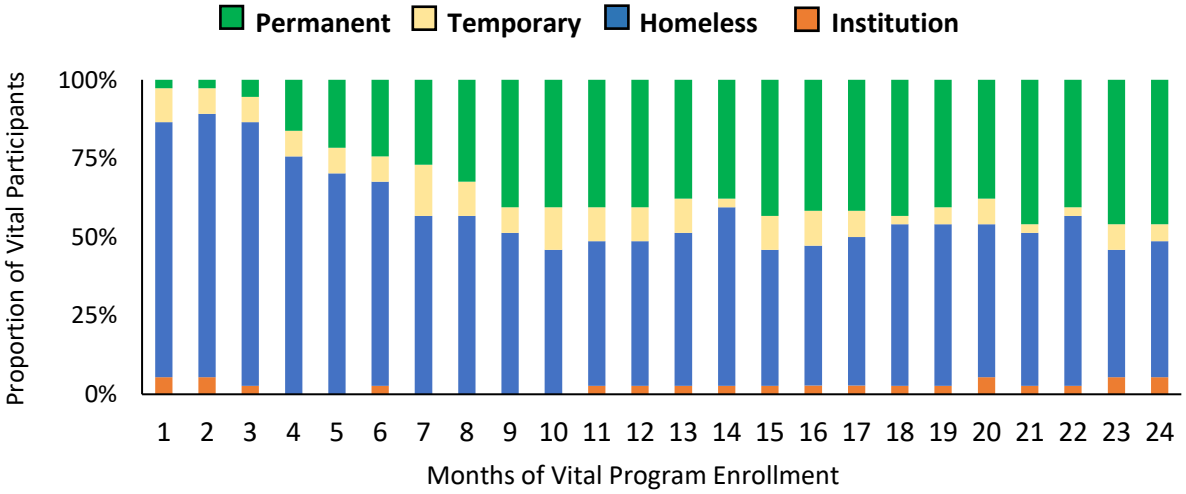
Figure 11. Housing Status at One-Month Intervals for Vital Participants Enrolled at Least 12 Months (*n* = 74)



Six months following enrollment in Vital, 19% of participants had permanent housing and 14% had temporary housing (among participants enrolled in the Vital program for at least 12 months; Figure 11). After 12 months of participation, 28% had permanent housing and another 22% had temporary housing, indicating that more participants obtain permanent or temporary housing over time while enrolled in the program. Of note, nearly all Vital participants entered the program experiencing homelessness, in an institution, or unstably housed.

A subset of individuals represented in Figure 11 were enrolled in the Vital program for 24 months or more (as of June 30, 2019). The housing status (by month) for this subset of participants is represented in Figure 12. Among this subset of participants enrolled in Vital for 24 months or longer, 24% were permanently housed at six months and 41% were permanently housed at 12 months. At the 24-month mark, 46% were permanently housed.

Figure 12. Housing Status at One-Month Intervals for Vital Participants Enrolled at Least 24 Months (*n* = 37)



There are several important considerations when assessing Vital participants' housing status over time. First, Figures 11 and 12 represent a point-in-time view of housing status across participants and do not track individual housing trajectories. Many Vital participants experience multiple housing placements and loss of housing throughout their duration in the program. Second, among participants who secure permanent housing and remain stably housed, attributing causality between program participation and housing stability is difficult. Participation in the Vital program certainly helps individuals obtain housing, but when assessing retention, it is possible that participants remain enrolled in the Vital program longer because they are housed, that they retain permanent housing because of engagement with the Vital program, or that they remain engaged in the program and retain housing because of underlying, unexplored factors (e.g., individual readiness).

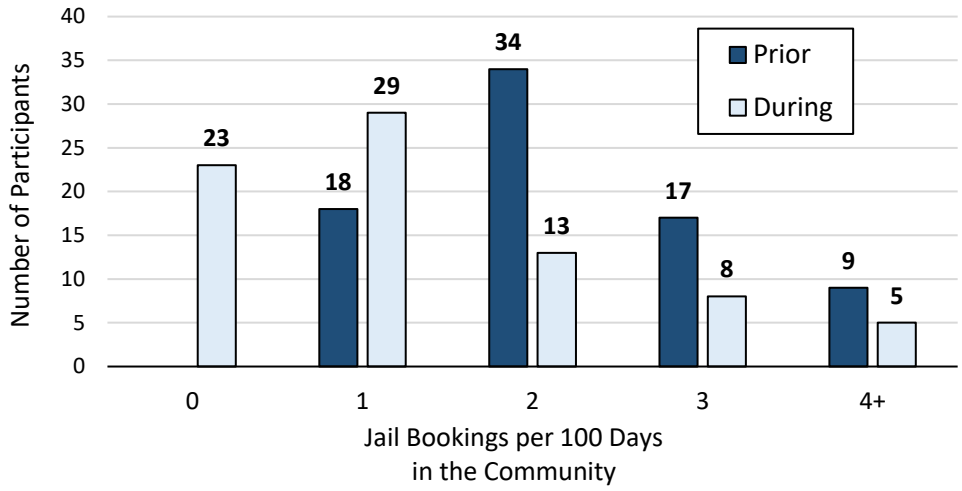
Jail Utilization among Vital Participants

As stated in the *Program Overview* above, eligibility for the Vital program is restricted to adults who have been booked into the King County jail four or more times within a 12-month period, in at least two 12-month periods over a three-year time frame. The following analysis explores the frequency of booking into municipal or King County jails during the three years prior to participants' enrollment in the Vital program, as compared to the frequency of booking into municipal or King County jails while Vital program participants were enrolled in the program. (Municipal jails include Enumclaw, Issaquah, Kent, Kirkland, and South Correctional Entity [SCORE] jails.)

Individuals included in this analysis spend a significant amount of time incarcerated (both before and after Vital program enrollment), and some move in and out of King County with regularity. As such, it is critical to assess the frequency of jail bookings only during periods of time when an individual had the *opportunity* to be arrested and incarcerated for a legal violation. Hereafter, the time periods during which, to the best of our knowledge, Vital program participants were living in King County and not institutionalized (i.e., in jail or the state hospital) are referred to as "community tenure". Subsequent analyses control for community tenure; a description of this measure for Vital participants before and after program participation is provided in **Appendix B.**

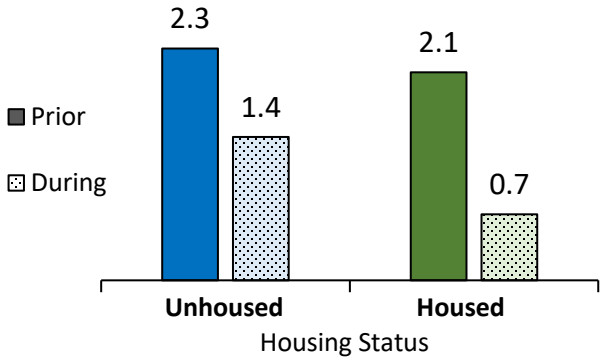
Figure 13 displays the distribution of participants by the number of jail bookings (rounded) before and during program enrollment *per 100 days* of community tenure. Bookings are expressed in terms of community tenure to standardize the measure across all participants. During the three years prior to participation in the Vital program, the median number of jail bookings per 100 days of community tenure for participants was 2.2, ranging between 0.7 to 9.1. While enrolled in Vital, the median number of jail bookings per 100 days of community tenure for participants was 1.0, ranging between 0.0 to 9.8.

Figure 13. Number of Jail Bookings per 100 Days of Community Tenure for Vital Participants (Rounded), Prior to and During Program Enrollment (*n* = 78)



The magnitude of the difference in jail bookings was significantly different between participants who were housed versus those who were unhoused during Vital enrollment. "Housed," here, refers to a participant living in temporary or permanent housing for at least 50% of their duration in the program. Using this criterion, 34 participants were counted as housed, and 44 participants were counted as unhoused. **Figure 14** displays the difference in median jail bookings prior to and during program enrollment per 100 days of community tenure by housing status. During the three years prior to participation in Vital, the median number of jail bookings per 100 days of community tenure for housed participants was 2.1, and while enrolled in Vital, 0.7. This is a significantly greater decrease than that experienced by unhoused participants. Among unhoused participants, the median number of jail bookings per 100 days of community tenure was 2.3 during the three years prior to participation in Vital, and while enrolled in Vital, 1.4.

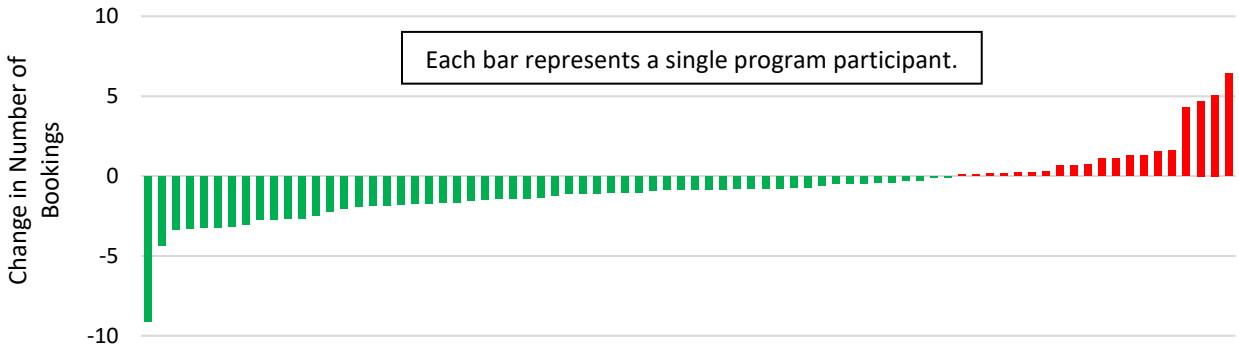
Figure 14. Median Number of Jail Bookings per 100 Days in the Community for Vital Participants, by Housing Status, Prior to and During Program Enrollment (*n* = 44 [unhoused], 34 [housed])



Over 74% of participants experienced a reduction in their number of jail bookings (as demonstrated by **Figure 15**). The median decline in jail bookings across all participants was about one booking (0.9) per 100 days of community tenure. Similar trends are observed when looking at the mean values; the mean number of jail bookings per 100 days of community tenure prior to Vital program participation was 2.4, whereas the mean number of bookings while enrolled in the Vital program was 1.6 (a statistically

significant reduction [t =3.39, df = 77, p < 0.001]). Generally, unlike median values, mean values are sensitive to outliers in the data; as such, outlying data (more than three standard deviations from the mean) were removed and the data re-analyzed. Ignoring outliers, the mean number of jail bookings per 100 days of community tenure prior to Vital program participation was 2.2, while the mean during Vital program participation was 1.3 (a statistically significant reduction [t =5.70, df = 73, p < 0.001]).

Figure 15. Change in the Number of Jail Bookings per 100 Days of Community Tenure, by Vital Program Participant

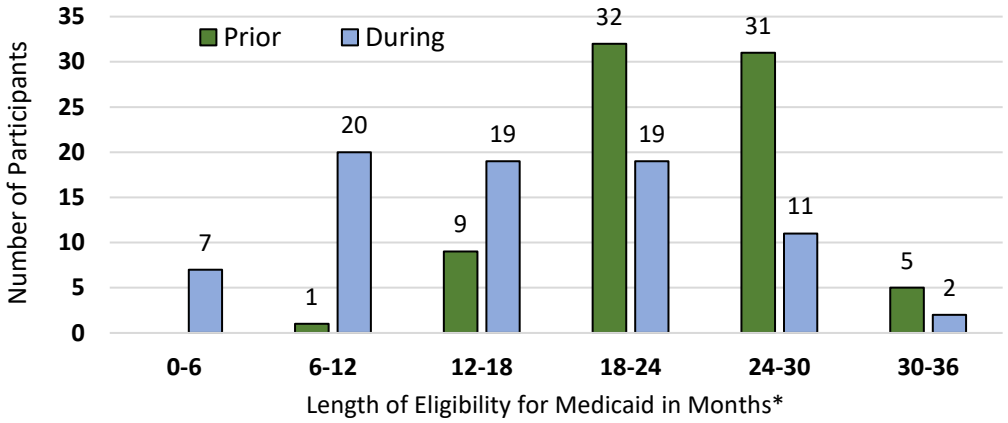


Hospital Emergency Department Visits Billed to Medicaid among Vital Participants

Because of the time frame of this evaluation and data limitations, the results below should be interpreted with caution. Emergency department (ED) utilization could only be measured using ED visits for which a Medicaid claim was filed, and several participants in Vital (n = 8) were not eligible for, nor enrolled in, Medicaid during the evaluation time frame. ED utilization is measured only when participants were enrolled in Medicaid consistently, defined as at least 10 months in any 12-month period. To maximize the validity of the estimates, participants are only included in this analysis if at least six months of Medicaid eligibility/enrollment (and concomitantly, ED visit data) exist for the participant. These parameters constrict the sample size from 87 to 47 participants.

Controlling for community tenure is not necessary when looking at ED utilization and Medicaid enrollment. Apple Health, Washington State's Medicaid program, has residency requirements which preserve the assumption that a person is in the community (in state at a minimum) during periods of Medicaid eligibility and enrollment. Further, an individual may visit the ED while incarcerated or in an institution. **Figure 16** displays the number of days that Vital participants were Medicaid-eligible during the three years prior to enrollment, as well as the number of days these participants were Medicaid-eligible while enrolled in the Vital program during the time frame of this analysis. The number of Medicaid-eligible days during the three years prior to enrollment ranged from 196 days to 1,096 days (of a possible 1,096 days), with a median of 885 days (29-30 months). The number of Medicaid-eligible days for Vital program participants ranged from 191 days to 854 days, with a median of 489 days (16-17 months).

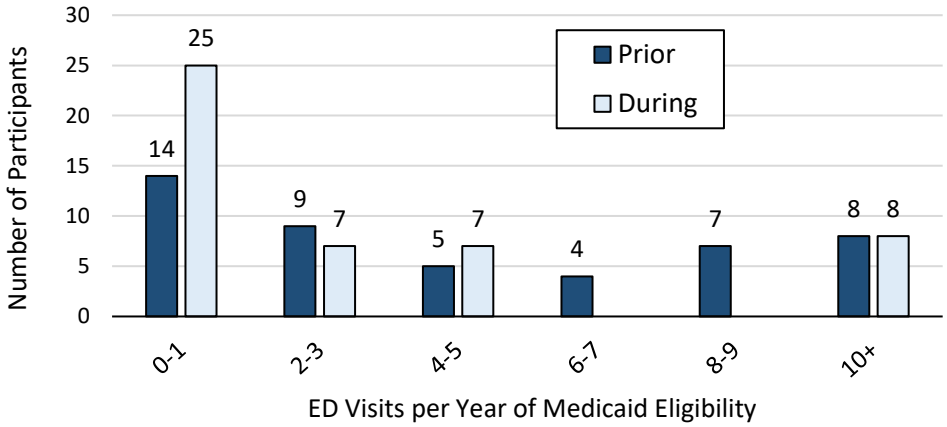
Figure 16. Length of Medicaid Eligibility (Days) for Vital Participants, Prior to and During Program Enrollment (*n* = 47)



*6-month periods are inclusive of the lower bound, not the upper bound (i.e., 6-12 months equals 6 or more, but less than 12, months)

Figure 17 displays the distribution of Vital participants by the number of ED visits before and during program enrollment *per year* of Medicaid eligibility. ED visits are expressed in terms of years of Medicaid eligibility for ease of interpretation and to standardize the measure. During the three years prior to participation in Vital, the median number of ED visits per year of Medicaid eligibility was 4.8, ranging between 0.0 to 33.4. While enrolled in Vital, the median number of ED visits per year of Medicaid eligibility was 1.4, ranging between 0.0 to 77.3.

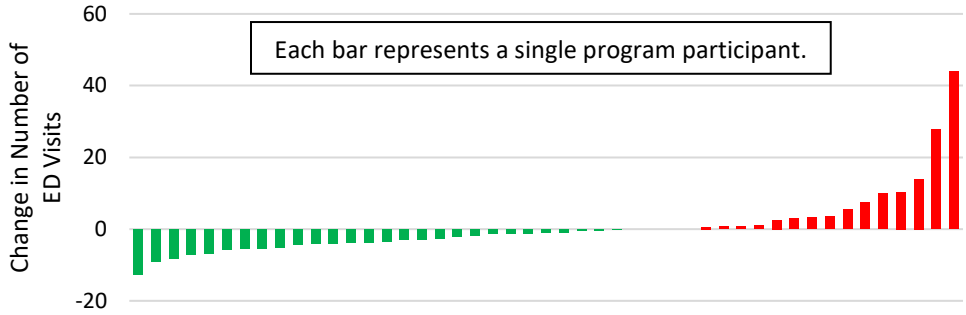
Figure 17. Number of Emergency Department Visits per Year of Medicaid Eligibility for Vital Participants (Rounded), Prior to and During Program Enrollment (*n* = 47)



Sixty percent of participants in the Vital program experienced a reduction in their number of ED visits, while Medicaid eligible (as demonstrated by **Figure 18**). The median decline in ED visits, across all Vital participants was just under one ED visit per year of Medicaid eligibility (about one less ED visit every 13-14 months). Somewhat different from the median, the mean number of ED visits per year of Medicaid eligibility prior to Vital program participation was 6.0, whereas the mean number of ED visits per year while enrolled in the Vital program was 6.6 (a non-significant difference [t = -0.41, df = 46, p = 0.68]). These mean values are heavily influenced by outlying observations, however. Ignoring outliers, the mean number of ED visits per year of Medicaid eligibility prior to Vital program participation was 5.4,

and the mean number of ED visits per year of Medicaid eligibility while enrolled in the Vital program was 5.0 (a non-significant difference [$t = 0.41$, $df = 46$, $p = 0.69$]).

Figure 18. Change in the Number of Emergency Department Visits per Year of Medicaid Eligibility, by Vital Program Participant



Participants' Experience and Perspective

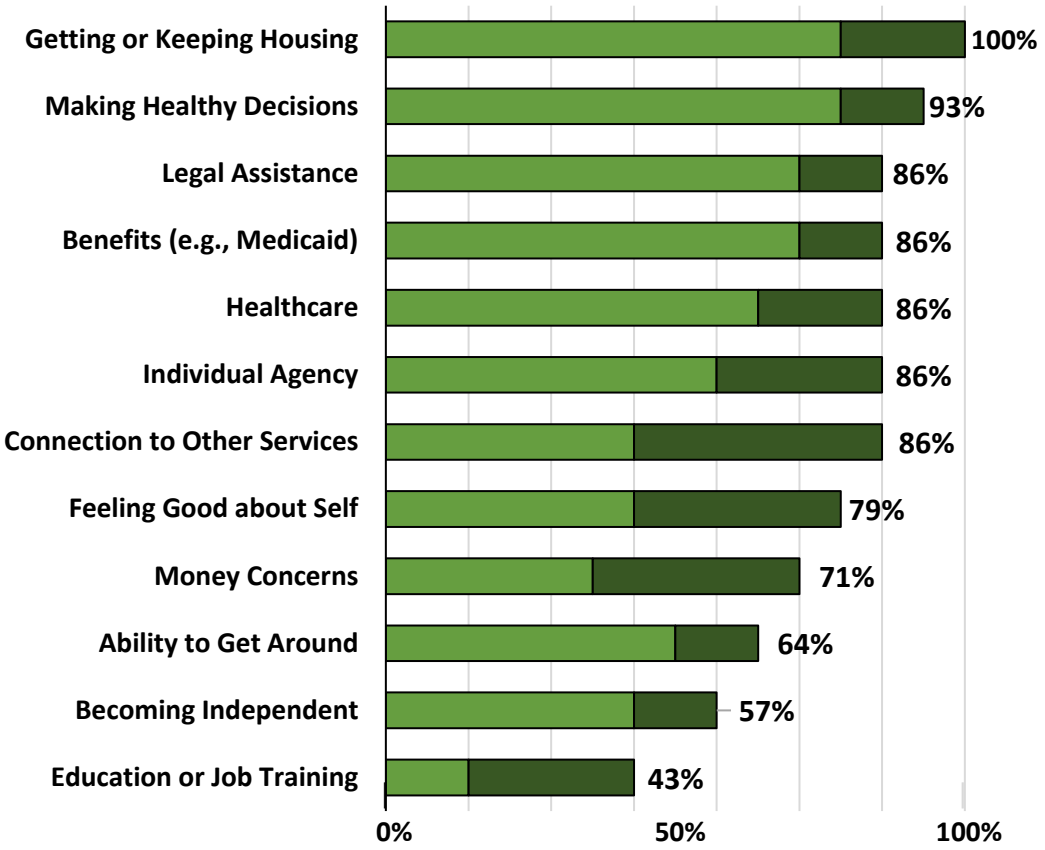
Participant Survey

In February and March 2022, fourteen Vital participants completed surveys, representing 22% of participants. Surveys required about 30 minutes to complete. The survey was designed by King County DCHS' Performance Measurement and Evaluation unit, though the surveys were administered by Vital program staff because of their rapport with program participants. Participants were asked about their needs, the impact of the Vital program on their lives, satisfaction with the program, and how the program could be improved. A complete list of the interview questions can be found in **Appendix C**.

All Vital participants surveyed reported satisfaction with the program overall and with the frequency of contact they have with program staff. Fifty-seven percent of participants surveyed selected the highest level of satisfaction (i.e., "very satisfied"), and 43% selected "satisfied" with the Vital program overall. When asked about their satisfaction with the frequency of contact with Vital staff, 64% reported the highest level of satisfaction (i.e., "very satisfied") while the remaining 36% reported "satisfied". Half of survey respondents reported needing or wanting help with housing, healthcare, day-to-day living, education, counseling, banking, and clothing. While housing was frequently cited as the "best thing" about the Vital program, the most frequently mentioned resource was having someone to interact with and open up to.

Figure 19 displays the percent of Vital participants surveyed who reported a specific need upon enrolling in the program and visually displays the proportion of those participants who reported that Vital staff helped to address that need. Every participant surveyed (100%) identified getting or keeping housing as a need, and 79% of them noted that Vital staff helped them address this need. Nearly every respondent (93%) reported needing help with, and the vast majority also identified that Vital staff helped with, making healthy decisions. Most respondents (86%) identified needing help with legal assistance, benefits (e.g., Medicaid), healthcare, individual agency (i.e., ability to do the things they want to do), and connection to other services. The proportion of participants reporting that Vital staff members helped them with these needs varied; for example, most participants felt Vital staff were able to help with legal assistance and obtaining benefits, whereas only half felt that Vital staff were able to help connect them to other services in the community.

Figure 19. Participants Identified Needs (%) and Proportion Reporting that Vital Has Helped*



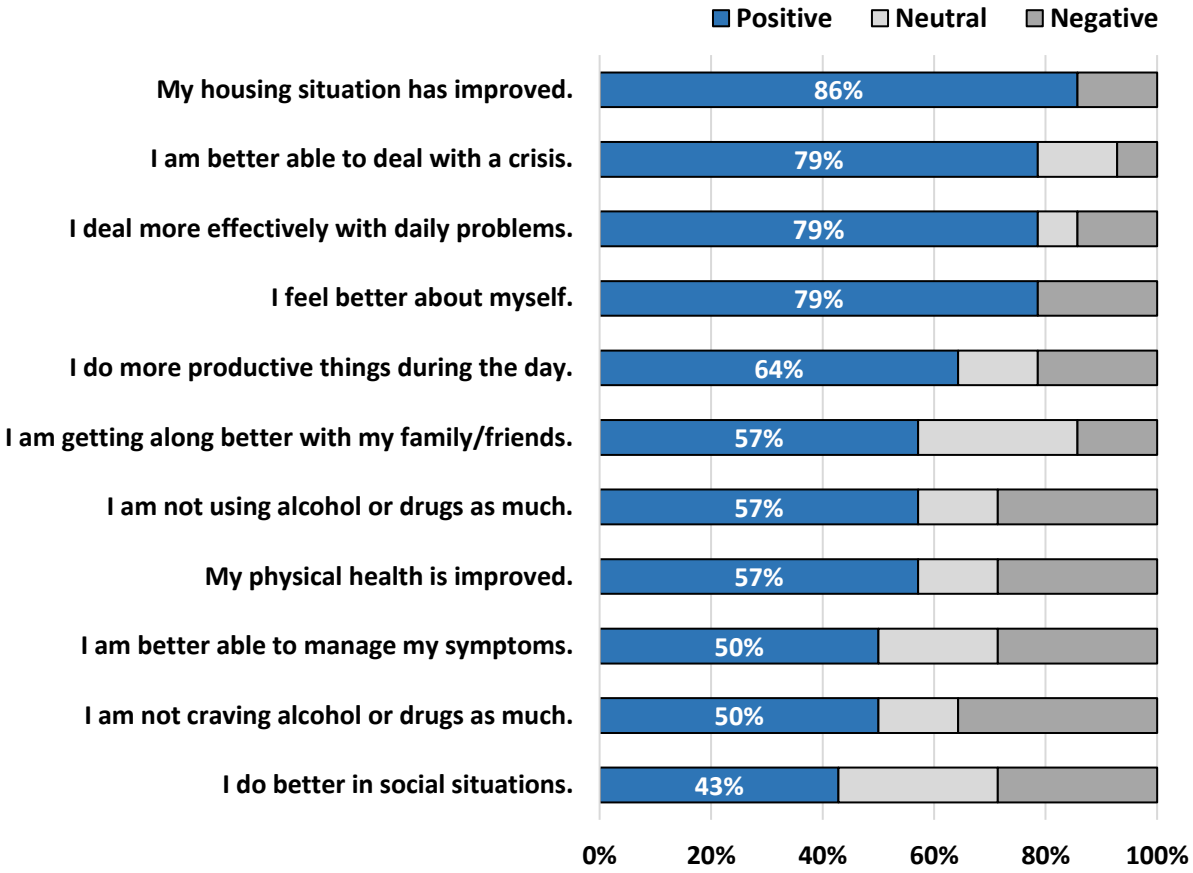
*Percentages represent participants reporting a specific need upon enrolling in Vital. Lighter-shaded bars represent the proportion who reported that Vital staff helped to address that need.

Those participants who identified needing help getting around or becoming independent mostly indicated that Vital staff were able to help them address these needs; conversely, participants who identified money concerns or needing education or job training did not express as much confidence in the Vital program's ability to help address those needs.

Figure 20 displays participants' perceptions that the Vital program had a direct impact on different aspects of their daily living, from health management and substance use to mental health and crisis management. Participants were asked to rate their level of agreement with various statements; Figure 20 rank orders the statements that received the highest level of agreement to the lowest. Eighty-six percent of respondents agreed with the statement that their housing situation improved as a direct result of the Vital program, and 79% agreed that they were better able to deal with crises, deal more effectively with daily problems, and feel better about themselves. Most participants surveyed agreed, although to a lesser degree, that they were more productive during the day, got along better with family or friends, decreased substance use, or felt improvement in their physical health. Fewer survey respondents felt the Vital program helped them to better manage their symptoms, reduce cravings for alcohol or drugs, or do better in social situations.

Taken together, survey responses indicate that Vital participants felt more strongly that the program helped them with daily living, decision making, and material assistance (e.g., housing, legal aid) versus economic self-sufficiency, substance use, or social interaction.

Figure 20. Participant's Perception of Vital Program's Direct Impact*



*Positive perception indicative of Vital participants who "agreed" or "strongly agreed" with each statement as a direct result of working with Vital staff. Concomitantly, negative perceptions reflect participants' responses of "disagree" or "strongly disagree" and neutral perceptions reflect participants responses of "don't know" or "does not apply".

Case Studies (Names changed to preserve participant anonymity)

Case Study #1: Peter

Peter was referred to the Vital program by a Department of Public Defense (DPD) mitigation specialist who recognized Peter's need for support in the community and believed he might meet criteria for Vital. Once it was confirmed that Peter was eligible, he was visited in custody and enrolled in the program. At the time, it was not known that Peter was also enrolled in Sound Mental Health's Forensic Intensive Supportive Housing (FISH) program, which is similar to Vital in its provision of multidisciplinary, wrap-around support services. In an effort not to duplicate services, Vital began coordinating with FISH early on, with a plan for Peter to be served by one program or the other once housing was obtained.

Given his numerous open court cases in multiple jurisdictions throughout King County, it became clear that the robust legal advocacy and prosecutorial resources of Vital were of great value to Peter. Vital's flexible and readily available outreach services and jail clearance (i.e., Healthcare Badge access to the jail) proved to be of great importance as well. Having previously been housed and evicted from a transitional housing option through FISH, it was reported to Vital that it was unlikely FISH would be able to re-house Peter in a timely fashion. As such, it was ultimately agreed upon by Peter and the providers involved that he would be best served by the Vital program, and he was subsequently discharged from FISH.

Within two days of Peter's enrollment in Vital, staff assisted him with completing the VI-SPDAT, and he was soon offered a housing opportunity through Coordinated Entry for All. With Peter's permission, his Vital care manager advocated for a permanent supportive housing option that provided medication management onsite. Early on, Peter identified housing as a primary goal while also expressing the need for more hands-on support keeping appointments, resolving his court cases, and addressing his substance use and health concerns. At enrollment, Peter reported having been homeless for three years and having spent most of the previous year in jail or in the hospital—a pattern he described as exhausting but seemingly impossible to escape without the appropriate supports.
Peter's care manager with Vital was diligent in her efforts to establish a "warm hand-off" every time Peter was released from custody to ensure he was provided with basic needs (e.g., clothing, food, bus tickets), which proved essential to building a quick, therapeutic alliance. Within two months of enrollment, Peter was involuntarily hospitalized twice, during which time he was visited by Vital staff regularly. Legal coordination was critical during these hospitalizations and information was shared by the Vital care manager to relevant legal partners for court continuances to be issued in place of warrants or failures-to-appear.

Vital staff continued to track the housing process, completing documents with Peter as needed within the appropriate timelines and, when a move-in date was secured, worked swiftly with the support of the prosecutorial liaisons to ensure Peter would be released from jail directly to housing. Since being housed, Peter's contact with crisis response systems (emergency departments, ITA court, etc.) has significantly diminished. He continues to have trouble tracking court dates and relies on the support of the Vital team, in coordination with DPD, to evaluate his options within the court process and understand the consequences of not appearing or not following through with court-ordered obligations. The Vital psychiatric ARNP became Peter's prescriber for his psychiatric medications. Peter benefits from having a provider who has the flexibility to visit him at his place of residence if/when there is a concern with medication dosage or treatment. Peter engages regularly with primary care through Vital and has established a goal of completing [redacted] treatment next year. Recently, Peter was accompanied by the Vital registered nurse to his [redacted] appointment, completing the initial phase of this treatment.

Peter speaks openly about his drug use with his Vital care team and has expressed an interest in completing a chemical dependency assessment as he contemplates the social and health benefits of reducing his use. His contemplation includes an interest in [redacted] treatment and he demonstrates insight to the benefits of such treatment, including improved stabilization to better keep appointments and take his medication daily. Peter regularly receives [redacted] and overdose prevention education from Vital.

Throughout his engagement with Vital, Peter has accepted support from the Vital occupational therapist. He completed the Allen Cognitive Level Screen (ACLS) and scored a 5.2 indicating mild cognitive functional impairment. According to the ACLS, individuals who score at this level may live

alone with weekly checks to monitor safety and examine potentially dangerous effects of impulsive behavior. They may succeed in supportive employment with a job coach and participate in valued community events. A person with this score is able to learn new ways of doing things through trial-and-error problem solving. The person detects the best effect by exploring distinctive properties of objects and trying different actions. They exercise poor judgment with no symbolic thought to plan actions or anticipate potential mistakes. They may make hasty or impulsive decisions, or make abrupt changes in their course of action. The determination of what is best may be made according to personal preferences or social standards. The person can imitate a series of new directions; new learning is recognized and repeated during the process of doing an activity. Persons may also need memory and planning aids to effectively function at a desired standard.

Based on findings from the abovementioned cognitive assessment, support from the occupational therapist and the broader Vital care team has included:

- Providing assistance in developing healthy habits and routines that include a balance of social, recreational and productive activities.
- Providing guidance and coaching for all higher-level activities of daily living requiring complex problem solving, abstract reasoning and pre-planning (e.g. taking medications, managing health conditions and finances, and organizing a daily routine).
- Providing concrete examples of case and effect relationships (due to inconsistent abstract reasoning), which will be most effective in helping him to consider the pros and cons of his actions and to support good decision making.
- Providing access to a wall calendar or pocket planner, use of a phone calendar, or to-do lists to help him remember important appointments and accomplish daily tasks.
- Providing verbal and visual reminders, as needed for important tasks and appointments.
- Providing oversight to assure scheduling and follow through with medical issues to manage health conditions, as needed.

Case Study #2: Samantha

After determined to be eligible for the Vital program, Samantha was visited by a Vital case manager in the King County Jail and enrolled in the program. At enrollment, she expressed a desire to receive treatment for her co-occurring behavioral health diagnoses, to secure supportive housing, and to resolve her legal cases. The case manager was able to establish a quick rapport with Samantha through a shared sense of culture and experience.

Within one year, Vital staff were able to navigate the Coordinated Entry for All system to access permanent supportive housing at [redacted]. Over multiple years, Samantha's case manager spent countless hours in courtrooms across various jurisdictions, using legal advocacy (in which Vital case managers are well-versed) to help amplify Samantha's voice and actualize her goals. Aided by prosecutorial liaisons, the hours of legal advocacy were successful in, first, allowing Samantha to move into housing on electronic home detention (EHD) and, second, reducing a felony charge which could have carried a prison sentence to a misdemeanor charge which qualified for mental health court.

For months on EHD, Samantha demonstrated unparalleled persistence and commitment to her goals. Amidst great adversity, she complied with a complex, demanding court order by maintaining sobriety

and medication compliance, completing her DOC obligation without violation, and remaining confined to her apartment with little-to-no stimulation, all the while experiencing treatment-resistant psychosis. Once released from EHD and eligible for mental health court, Samantha continued to comply with court obligations by attending frequent probation appointments and providing negative urinalysis tests. By satisfying the court's requests, Samantha has achieved what many would describe as the impossible. And yet, she did not stop at simply meeting court obligations, but went far beyond: establishing primary and dental care, committing to a fitness regimen, and participating in culture-focused programming at REACH.

Conclusion and Next Steps

The Vital program has been in operation for over eight years and, in that time, learned many lessons about providing services to individuals deeply involved in the criminal-legal system, experiencing homelessness, and living with co-occurring behavioral health disorders (in addition to significant comorbid physical health conditions). Housing resources, legal assistance, case management, and physical and behavioral healthcare are essential to support the *whole* person, rather than remedying one barrier to individuals' ability to thrive (e.g., criminal-legal system involvement) while neglecting other barriers (e.g., health, housing, daily living, etc.). This implementation evaluation demonstrates that Vital participants experience promising outcomes related to decreased jail bookings, increased housing stability, and decreased reliance on hospital emergency rooms for healthcare. However, this study also highlights that long-term stability for participants will be difficult to achieve without the support that Vital offers. Housing persists as a significant moderator of access to services and positive participant outcomes, i.e., without housing resources, the Vital program's impact is attenuated.

As part of King County DCHS's ongoing commitment to being a learning organization, additional evaluation of the Vital program is underway. Interviews with staff and managers of the Vital program have been completed, and recommendations for program improvement are forthcoming. Also, program partners (mentioned in this evaluation report) have requested additional layers of analysis, for example, disaggregating the *type* of nurse consultations utilized by Vital participants (i.e., psychiatric ARNP, primary care ARNP, registered nurse, and now mental health professional) to provide services to participants most effectively. Further, while this evaluation assessed the initial implementation of the Vital program, a follow-up study using updated data is warranted.

Appendix A. Housing Status Classification Scheme

Housing Status Documented	Classification
Emergency shelter	Homeless
Encampment	Homeless
Homeless	Homeless
Shelter	Homeless
Street	Homeless
Street, car, or another public place	Homeless
Hospital – Psychiatric facility (90+ days)	Institution
Immigration hold	Institution
Inpatient drug and alcohol treatment (90+ days)	Institution
Jail/Incarcerated (90+ days)	Institution
Jail awaiting placement for restoration	Institution
Prison	Institution
Skilled nursing facility	Institution
Work release	Institution
Independent permanent housing	Permanent
Permanent supported housing	Permanent
Supportive housing	Permanent
Unsubsidized housing	Permanent
Couch surfing	Temporary
Hotel/motel (agency-paid or self-paid)	Temporary
Medical respite	Temporary
Sober transitional housing	Temporary
Sobering center	Temporary
Staying with family/friends, not on lease	Temporary
Temporary housing	Temporary
Transitional housing	Temporary

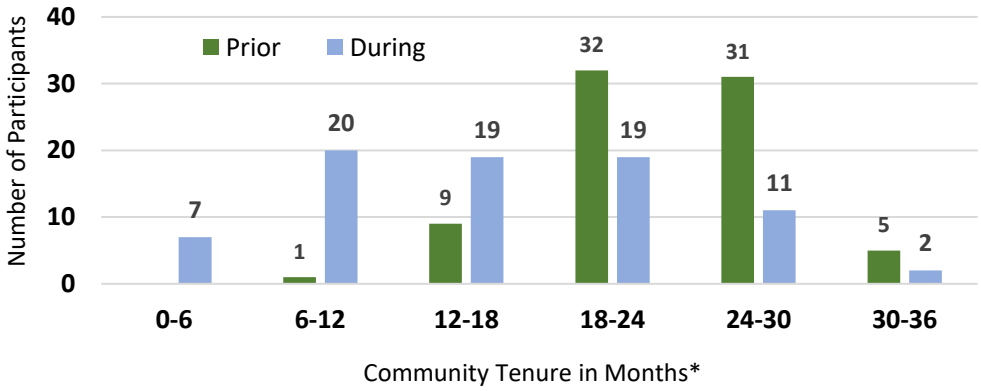
Appendix B. Community Tenure among Vital Participants

The measure of community tenure prior to Vital program enrollment was calculated from the first time (in the three years prior) an individual encountered the criminal-legal or behavioral health system in King County. For most Vital program participants, this time period entails the full three years prior to enrollment.

Community tenure was more difficult to measure once a participant exited the Vital program; participants have died, relocated outside of King County, and other circumstances which preclude a possible jail booking *in* King County. As such, the estimation of community tenure subsequent to Vital program enrollment extends only to a participant's exit date from the Vital program (or through June 30, 2019, which was the cutoff date for this analysis).

Figure A displays the estimated community tenure for Vital program participants during the three years prior to enrollment, as well as the estimated community tenure of participants while enrolled in the program. The estimated community tenure of Vital program participants prior to enrollment ranged from 343 days to 996 days (of a possible 1,096 days), with a median of 718 days (23-24 months).

Figure A. Community Tenure of Vital Participants, Prior to and During Program Enrollment (*n* = 78)



*6-month periods are inclusive of the lower bound, not the upper bound (i.e., 6-12 months equals 6 or more, but less than 12, months)

The estimated community tenure of Vital participants during program participation ranged from 51 days to 970 days, with a median of 448 days (14-15 months). Exemplified by Figure A, the amount of time each participant spent in the community (outside of an institutional setting), before or after Vital program enrollment, can vary significantly. As such, controlling for community tenure is a proximal, though essential, method of capturing individuals' varying levels of opportunity to engage in, and be arrested for, a legal violation.

Note: Shorter community tenure for program participants during their enrollment in Vital is reflective of the time period of this analysis, and not lengthier institutional stays.

Appendix C. Vital Program Participant Interview Questions

1. Overall, how satisfied are you with how often you are in contact with Vital program staff? (Very Dissatisfied, Dissatisfied, Neutral, Satisfied, Very Satisfied, Declined to answer)
2. (Yes or No) When you joined the Vital program, did you need to work on:
    a. Getting or keeping housing?
    b. Getting care for your health needs (example: finding a provider, medications, attending medical appts)?
    c. Money concerns?
    d. Feeling good about yourself?
    e. Being able to do the things you want to do?
    f. Your ability to get around?
    g. Making healthy decisions?
    h. Getting benefits such as Medicaid, SSI or food stamps?
    i. Getting education or job training?
    j. Getting legal assistance (example: attending court, communicating with defense, court advocacy)?
    k. Becoming more independent?
    l. Getting connected to other services in the community (specify)?
2. (Follow-up for each of the above) If yes, did working with Vital staff make this better?
3. Are there other things you need or would want help with? If yes, please describe.
4. How much you agree or disagree with each of the following statements (Strongly Disagree, Disagree, Agree, Strongly Agree, Don't Know, Does Not Apply)?
    a. As a direct result of the Vital program, I deal more effectively with daily problems.
    b. As a direct result of the Vital program, I am better able to deal with a crisis.
    c. As a direct result of the Vital program, I am getting along better with my family/friends.
    d. As a direct result of the Vital program, I do better in social situations.
    e. As a direct result of the Vital program, my housing situation has improved.
    f. As a direct result of the Vital program, I am better able to manage my symptoms.
    g. As a direct result of the Vital program, I do more productive things during the day.
    h. As a direct result of the Vital program, my physical health is improved.
    i. As a direct result of the Vital program, I am not craving alcohol or drugs as much.
    j. As a direct result of the Vital program, I am not using alcohol or drugs as much.
    k. As a direct result of the Vital program, I feel better about myself.
5. Overall, how satisfied are you with the Vital program? (Very Dissatisfied, Dissatisfied, Neutral, Satisfied, Very Satisfied, Declined to answer)
6. What has been the best - or most helpful - thing about the Vital program?
7. What suggestions do you have to improve the program?
8. Is there anything else you'd like to tell us about the program?