The City of Seattle Human Services Department (HSD) thanks community leaders and neighbors in the Chinatown-International District and Little Saigon for their ongoing commitment to addressing neighborhood needs and the needs of those experiencing homelessness. HSD looks forward to a continued partnership that supports services to address homelessness and that supports a safe and vibrant neighborhood. HSD also partners with the Downtown Emergency Service Center (DESC) to provide access to homeless services to unsheltered people with high needs in our community. DESC is a dedicated provider of homeless and stabilization services serving those living with serious behavioral health conditions or substance use disorders. DESC operates several programs in Seattle, including emergency shelters and supportive housing, in addition to the Navigation Center.

The Navigation Center opened on July 12, 2017 in the Little Saigon neighborhood and slowly ramped up both in the number of people served and the services offered through the end of 2017. In the first nine months of 2018 (between January- September or the third quarter), 46% (61) of individuals or couples that left the Navigation Center entered permanent housing. This result exceeds the performance standard that was adopted for enhanced shelters serving single adults. In enhanced shelters serving single adults 40% of households leaving the program are expected to enter permanent housing. The Navigation Center is an enhanced shelter that provides 85 of the 1,411 enhanced shelter beds in which HSD invests.

Seattle's Navigation Center, inspired by San Francisco's Navigation Center, specifically serves unsheltered adults with very high needs including serious behavioral health conditions, physical disabilities and substance use disorder. It offers an environment that people living with these conditions can more effectively navigate than the environment in most other emergency shelters. It provides onsite behavioral health and harm reduction services, 24-hour access, storage for possessions, the ability for partners to stay together, space for pets, as well as full meal service. Once a client enters the Navigation Center, they are connected to individualized services and begin creating a plan to find permanent housing. The low staff to client ratio increases individualized services and provides a supportive relationship to help individuals find pathways to permanent housing and stability.

The attached report, created in partnership with The Harm Reduction Research and Treatment (HaRRT) Center at the University of Washington-Harborview Medical Center, chronicles the first year of the Navigation Center. HSD is grateful to these experts for their commitment to this project. We look forward to continuing to improve services for people experiencing homelessness at the Navigation Center.

Navigation Center Program Evaluation Results: Part 1

Understanding Stakeholders' Perspectives in Their Own Words

March 21, 2018

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with important contributions from the Navigation Center Evaluation Advisory Board and others acknowledged on the back page.

Executive Summary

Background: On June 9, 2016, former Mayor Ed Murray signed into effect an Executive Order creating Seattle's Navigation Center (hereafter "the Center"). Funded by the City of Seattle Human Services department and operated by the Downtown Emergency Service Center (DESC), the Center is a low-barrier, 24-hour, 60-day, referral-only shelter program for adults experiencing homelessness. The low-barrier aspect of the Center means that shelter and services are offered without preconditions such as sobriety, mental health treatment, or service participation requirements. In contrast to existing shelters, clients are afforded more autonomy: There are no curfews or lock-out times, and they can bring pets, partners, and possessions with them. As outlined in the Executive Order, the goal of the Center is to "assist people who are unsheltered into housing as rapidly as possible, and to increase the capacity of providers to provide tailored services utilizing an intensive service model based on flexible, housing first practices."

The Harm Reduction Research and Treatment (HaRRT) Center at the University of Washington-Harborview Medical Center was contracted by the City of Seattle's Human Services Department to conduct a 13-month (July 2017-August 2018) program evaluation of the Center. The evaluation is divided into 2 parts:

- **Part 1 (July 2017-February 2018)** entailed qualitative interviews and focus groups to document and analyze stakeholders' (i.e., Center guests; DESC, REACH and SPD onsite and outreach staff and management; and City partners) experiences with and perceptions of the Center as well as potential points for improvement of the Center's policies, procedures, amenities, services, and community-building efforts.
- **Part 2 (November 2017-August 2018)** entails the assessment of changes in guests' substance use, mental health, physical health, and quality of life prior and subsequent to their entry into the Center. Guest satisfaction at the end of stay is also being assessed.

Purpose: The purpose of the present report is to describe the findings from Part 1 of the HaRRT Center program evaluation and provide the City with recommendations based on key stakeholders' experiences with and perceptions of the Center. This report reflects a snapshot of the Center's initial implementation and areas for program improvement.

Methods: Four types of data were collected, including

a) 30 hours of naturalistic observation at the Center (August-October 2017);
b) review of Center documentation (August-January 2018);
c) one-on-one interviews with guests (*n*=40; August-October 2017) and other key stakeholders (*n*=8; August 2017-January 2018); and
d) focus groups with key stakeholders (*n*=4 focus groups, *n*=36 participants; October-December 2017).

These data were then subjected to conventional content analysis to provide a thematic description of participants' and staffs' experiences with and perceptions of the Center as well as recommendations for program improvement. We have documented these themes in the order participants described their experiences with the Center, from outreach and orientation to the day-to-day experience at the Center to the challenges over the longer term of ensuring that guests' and staff's on-the-ground experiences shape future Center policies and procedures. These data provide policy-makers and program management with points to consider in striving to meet the Center's stated goals (e.g., securing permanent housing for guests) as well as program improvement around operations, and future replication.

Primary Findings and Recommendations:

- **Outreach and orientation**
  - **Finding:** Despite their initial skepticism, most guests indicated that outreach and orientation to the Center were important and helpful. In fact, since initial data collection closed, outreach staff have reported that requests for Center referrals from people living in encampments has spiked. At the same time, guests did not feel the expectations set by these initial conversations fully aligned with the realities of their stay at the Center.
  - **Recommendations:** Both outreach and onsite staff should be clear and transparent with communication about the Center's purpose, policies and procedures—especially regarding length of stay—to avoid misunderstandings and to ensure potential guests can make an informed decision about whether the Center will be a good fit.

- **Length-of-stay policy**
  - **Findings:** The Center's originally planned 60-day length of stay was viewed by both guests and the majority of staff as unrealistic, potentially destabilizing, and unlikely to create impactful and lasting change.
  - **Recommendations:** Length of stay should be flexible and renewable based on individual guests' needs and the availability of permanent housing or other appropriate accommodations (e.g., long-term residential treatment). Guests should not be exited to homelessness—even sheltered homelessness (e.g., motels)—due to preset length-of-stay limits. Onsite staff should clearly communicate expectations and what is required to maintain shelter at the Center to minimize the uncertainty of whether, when, or why people will be granted extensions.

- **Harm-reduction approach to substance use**
  - **Findings:** Guests and staff value the Center's low-barrier, harm-reduction approach, which does not require abstinence from substances to maintain Center residency. Guests and other stakeholders also appreciated that some rules and limits are necessary to keep people safe.
  - **Recommendations**: A more transparent and more clearly communicated substance-use policy developed together with guest input is needed to clarify for all stakeholders what substance-use behaviors are acceptable onsite. Safer consumption spaces should be clearly designated and appropriately appointed.

- **Safety**
  - **Findings:** Overall, guests reported feeling safer staying in the Center than on the streets. Guests also felt there was room for improvement given widespread theft. Women, in particular, expressed concerns about the potential for physical and sexual assault, especially given coed sleeping spaces.
  - **Recommendations:** The Center offers the option of separate-gender or coed sleeping spaces and accommodates room change requests, as needed. These options should be continued to ensure guest comfort and safety. More secure means of storing personal property are necessary.

- **Amenities and Services**
  - **Findings:** Guests were largely happy with current amenities and services but had suggestions that could improve service provision and guest satisfaction.
  - **Recommendations:** Future Centers should exchange dormitory-style sleeping areas with more individual, couples and family sleeping areas. Provision of guest kitchen and secure cold storage access was highlighted as important for guests' quality of life. Guests also requested further onsite services (i.e., medical, mental health and substance-use treatment, and vocational services) or better connection to these services with external providers. It should be noted that most requested

services have been added since initial data collection (i.e., access to a mobile medical van and onsite substance-use and mental health counseling).

- **Community-building with staff and guests**
  - **Findings:** Staff are largely positively regarded by guests. There were also concerns expressed by guests that inadequate staffing, lack of clinical training, and disparate lived experiences create service gaps and miscommunications. Regarding guest-to-guest relationships, most guests reported keeping to themselves, although some appreciated and desired a sense of community at the Center.
  - **Recommendations:** More staff on swing, night and weekend shifts are needed. We further recommend all-staff trainings (ideally ongoing) in cultural humility, de-escalation, harm-reduction approaches, trauma-informed care, and motivational interviewing. Additionally, more community-based participatory approaches, such as the institution of community advisory boards or community governance, could help build relationships and decrease crime and interpersonal conflict.
- **Alignment of higher-level policy mandates and on-the-ground realities**
  - **Findings:** Front-line staff have concerns that City-level policy mandates are not always clear, feasible or desirable for on-the-ground implementation (e.g., confusion about the Center's mission, developing length-of-stay policy).
  - **Recommendations:** All-stakeholder meetings should be regularly convened on a monthly basis to clarify priorities, roles and procedures and create clear communication channels. Front-line staff and guest perspectives should be taken into consideration in planning, instituting and enforcing changes in higher-level policies and procedures.

Conclusions: On the whole, perceptions of and experiences at the Center were positive. Participants appreciated the Center's low-barrier outreach and engagement, harm-reduction approach to substance use, and commitment to fulfilling guests' basic needs (e.g., shelter, food, security). However, participants also felt the 60-day length-of-stay limits should be eliminated to avoid returning guests to homelessness. Guests also provided well-founded suggestions for enhancing services, including

- Providing safer consumption spaces and more secure storage to improve safety and security,
- Offering greater access to more social services and treatment (e.g., medical, mental health and substance-use treatment), and
- Expanding amenities to support development of independent living skills (e.g., access to guest kitchen and cold storage to support cooking skills and nutrition).

Some of these suggestions have been enacted upon the writing of this report (e.g., increased access to onsite medical, mental health and substance-use treatment). Limitations of this report include the fact that it is a point-in-time snapshot of perceptions of the Center and that it does not take into account quantitative measures of Center effectiveness in addressing guests' needs. Subsequent reports will supplement these data and will serve to address these limitations.

Background

Efforts to end homelessness have precipitated a reduction in its prevalence nationwide. The 2015 point-in-time count indicated that 564,708 individuals were homeless on a given night in the US, which represents an 11% reduction from 2007.[1] This overall decline was primarily driven by a decrease in people who are homeless in unsheltered locations.[1] In contrast to these national figures, homelessness in King County, Washington has increased over the past few years. In fact, the point-in-time count conducted by the Seattle/King County Coalition on Homelessness indicated that the number of unsheltered homeless individuals in Seattle alone increased by 19% from 2015 to 2016. Those experiencing unsheltered homelessness are disproportionately affected by medical, psychiatric and substance-use issues, with an estimated average age of death between 47 and 52 years of age.[2]

In the wake of these concerning findings, former Seattle Mayor Ed Murray and King County Executive Dow Constantine joined Portland, Oregon, California and Hawaii in declaring a state of emergency in November 2015. Together with Seattle City Councilmembers, the Mayor directed staff efforts to address the growing crisis of unsheltered homelessness in Seattle and on June 9, 2016, signed into effect an Executive Order[3] creating Seattle's Navigation Center (hereafter referred to as "the Center"), which is supported in part by private donations and City of Seattle general funds.

Navigation Center Overview

The Center opened its doors to its first guests on July 12, 2017. As it currently operates, the Center is a low-barrier, 24-hour, 60-day, referral-only shelter program for adults experiencing homelessness. The low-barrier aspect of the Center means that shelter and services are offered without preconditions such as sobriety, mental health treatment, or service participation requirements. In contrast to existing shelters, clients are afforded more autonomy: There are no curfews or lock-out times, and they can bring pets, partners, and possessions with them. The goal of the Center, as outlined in the Executive Order, is to assist people who are unsheltered into housing as rapidly as possible and to facilitate provision of tailored services for this population.

Center priority population. Guests are referred to the Navigation Center by the City-designated outreach organization, REACH. Unsheltered, single adults experiencing homelessness are referred based on the priority population criteria established by the City of Seattle's Human Services Department (HSD). This includes people with chronic medical, psychiatric, and substance-use disorders. Given the vast overrepresentation of People of Color in the homeless population,[1] and the City's commitment to addressing racial disparities, the priority populations for the Center include American Indian/Alaska Native, Black/African American, and Multiracial individuals.

Center services provision. The Downtown Emergency Service Center (DESC) was awarded the contract to operate the Center and provides onsite case-management services. The Center was designed to offer low-barrier shelter in a 24-hour facility that is tailored to fit the needs of the priority population. Onsite staff are charged with helping guests fulfill basic needs for shelter, hygiene, nutrition, secure and accessible storage, as well as supportive services and case management. The ultimate goal is to connect guests to permanent housing or other appropriate, long-term placement (e.g., residential treatment setting). Center staff work to encourage, facilitate, and support clients' progress and activities toward housing and stability.

The Center is a part of the DESC Housing Program and is under the direction of the Director of Housing Programs and the Executive Director. DESC employs approximately 17 full-time equivalent (FTE) onsite case managers and service coordinators, including a Project Manager (1.0 FTE) who oversees Center operations and

staff. Additional clinical coverage includes an onsite licensed mental health case manager (.5 FTE), substance-use case manager (.5 FTE), and on-call staff (approximately 2.05 FTE). DESC also employs janitorial staff (3.0 FTE), and maintenance staff (1.0 FTE) who are coordinated and supervised by the DESC facilities supervisor (1.0 FTE).

Qualitative Evaluation Methods

Aim

The aim of Part 1 of the Center Evaluation was to document participants' perspectives on and experiences with the Center to elucidate its strengths and areas for improvement.

Setting

The primary setting for the data collection was the Center, which is located at 606 12th Avenue S, Seattle, WA. Additional focus groups (*n*=2) and key stakeholder interviews (*n*=2) were conducted offsite for stakeholder convenience.

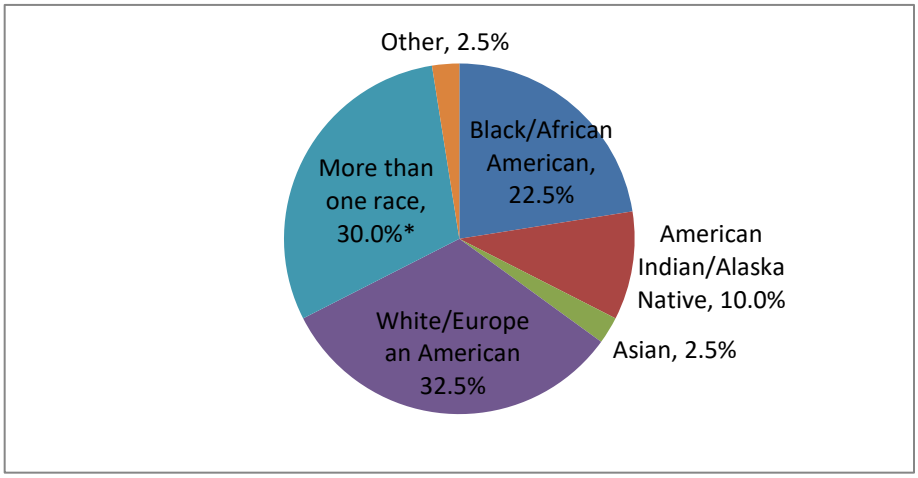
Evaluation Advisory Board (EAB)

Prior to launching the evaluation, the UW team assembled the EAB, which comprises members representing the perspectives of guests, onsite and outreach staff, management, City officials, and other community partners. The purpose of the EAB is to help plan and oversee the evaluation process, provide multi-perspective context that is helpful to evaluators, and assist in data interpretation and dissemination. EAB meetings were held monthly during the evaluation period.

Participants

Participants included Center guests (*n*=40), onsite (*n*=13) and outreach (*n*=20) Center staff and management, as well as City officials and other key stakeholders (n=4) who were invested in the Center outcomes. Guest participants' mean age was 44.9 (*SD*=9.6) years, and the majority reported male sex assigned at birth (40% female, *n*=16). Self-reported racial identities of guest participants are shown in Figure 1, with 10% of the sample identifying as Hispanic/Latinx. More detailed sociodemographic data on guest and stakeholder participants are featured in Tables 1 and 2 in Appendix B.

Figure 1. Self-reported racial identities of guest participants in the evaluation (n=40).



* Of the 30% reporting More than one race, 10 out of 12 participants identified as having American Indian/Alaska Native heritage plus something else.

Data Sources and Measures

Sociodemographic measure. Single items assessing age, birth sex, race, ethnicity, education level, employment information, and military service were used to describe the participant sample.

Qualitative data sources. Four types of data were collected for primary analyses: a) field notes from naturalistic observations, b) written documentation about the Center, c) transcripts from one-on-one interviews with guests (*n*=40) and other key stakeholders (*n*=8), and d) transcripts from focus groups with other key stakeholders (*n*=4 focus groups; *n*=36 participants).

Field notes. Field notes were used to document data obtained during unobtrusive, naturalistic observations. These data were used to inform the focus group and one-on-one interview prompts and also provided the evaluation team with information regarding the setting, workflow, staff-guest interaction style, day-to-day activities, and potential points for program improvement.

Existing Center documentation. Documentation included the Mayor's June 9, 2016 Executive Order, the HSD 2016 Request For Qualification [RFQ], and information from DESC regarding Center policies, procedures and organization.

Interview and focus group prompts. Open-ended prompts were used in the context of semi-structured interviews to elicit participants' perspectives on various topics pertaining to the Center, including key program elements, strengths and areas for improvement, day-to-day experiences, interactions with staff and other guests, and hopes and visions (see Appendices A and B for interview prompts for guest and other stakeholder interviews, respectively).

Procedures

All data collection for this report was conducted between July 2017 and January 2018. Starting in July 2017 and continuing throughout the project, evaluators requested documentation on the Center for review from the HSD and DESC. From August to October 2017, evaluators engaged in 30 hours of naturalistic observations, which included members of the evaluation team conducting 2-hour blocks of observations at the Center to understand day-to-day activities and operational procedures. These data were assembled and brought to the EAB, where they were initially used to inform the interview and focus group prompts, and then later used for background and context. Between August and October 2017, one-on-one, semi-structured interviews were conducted with 40 guest participants, and between October 2017 and January 2018, 8 additional key stakeholders. Additionally, 4 focus groups with 5, 4, 12, and 15 participants, respectively, were conducted between October and December 2017.

Potential interviewees and focus group members were identified by Center staff and EAB members and were then approached by the evaluators who inquired about interest in participation in a confidential interview or focus group to ascertain their experiences with the Center. Interviewers informed potential participants in interviews and focus groups of the purpose and procedures of the interviews as well as their rights and role as participants in the program evaluation. Participants were informed that their participation in the interview or focus group would not affect their service provision or their jobs, and that comments would be aggregated and shared without personally identifiable information. Participants provided written, informed consent (see Appendix C). Semi-structured interviews lasted 45 to 60 minutes, and focus groups lasted 1 to 1.5 hours. Guest participants received a $20 payment for their time, and were assured prior to the interview that they would receive this incentive regardless of what they had to say. Other key stakeholders were not paid for their time beyond their existing FTE. Light refreshments were provided at key stakeholder focus groups.

Data Analysis Plan

Sessions were audio recorded and transcribed for qualitative analysis. Transcripts were stripped of identifying information prior to data coding. The goal was to provide a conventional content analysis of participants' perceptions of the Center. Conventional content analysis is a qualitative analysis method used to interpret the content of text data through a systematic classification process involving coding and identifying themes.[4,5] In conventional content analysis, the evaluator does not start with preconceived, theory-based notions about what types or categories of codes will be identified. Instead, the researcher allows the data to drive the codes and categories.[4]

Atlas.ti version 7 was used to manage the data.[6] Data were independently coded using a constant comparative process.[7,8] Initial coding was conducted using a line-by-line technique, whereby coders narrated the actions occurring in the interviews.[7] Following independently conducted initial coding, evaluators created a codebook during consensus meetings, wherein incident-by-incident codes (i.e., codes that applied to a singular and distinct topic or event) were pooled and idiosyncratic or redundant codes were collapsed or removed. For example, if various participants brought up their experiences with case managers, chemical dependency counselors, and on-call staff at the Center, we would collapse these experiences to the more general category of "interactions Center staff." In the next coding phase, we used the categories and codes outlined in the codebook to independently code the transcripts.

Results

Interviews and focus groups focused primarily on perceptions of the Center's policies and procedures, amenities and services, and building community.

Policies and Procedures

Primary topics of discussion included procedures surrounding the orientation and transition to the Center, length of stay, substance-use policy, general house rules, and security procedures. Respondents expressed mixed perspectives on most policies and procedures, balancing the pros and cons of more versus fewer rules and guidelines with an eye toward ensuring both autonomy and safety. On one topic, however, both guests and staff were unequivocal: A preset, time-limited length of stay was perceived as potentially destabilizing and ineffective in achieving the Center's primary goal of helping guests obtain permanent housing.

Initial outreach and orientation to the Center is important and helpful. At first, many guests reported being wary of attempts from outreach staff for various reasons. First, there were concerns about being approached by police during clean-ups when they were in possession of illegal substances or were in withdrawal (e.g., "We had dope all over the place…We tried to get them the hell away from us…"; "I'm sick. You're in my way."). Second, guests noted they generally feared police presence (e.g., "I was a little leery. A lot of people would think the cops…they're watching everybody who comes in here so now they can know what everybody does…"). Third, guests felt uncomfortable because of the clean-ups as a preface to outreach (e.g., "It's sweeping. …They're coming down the highway, raising havoc on all the homeless people…stealing the homeless people's valuables."). Despite a skeptical start, however, most guests reported being surprised that their experiences with the outreach team and SPD were relatively positive (e.g., "They were actually pretty pleasant…").

During the outreach experience, most guests expressed concerns about not being able to bring in what came to be known as the "3 Ps": partners, pets and personal possessions. They were thus relieved to hear they did not have to separate themselves from valued possessions or loved ones to receive shelter at the Center. One guest indicated that he and his wife would rather be "in a tent than separated," so he turned down two other offers from outreach staff. When he was approached a third time and learned they could be together at the Center, they accepted the outreach team's offer. Another guest professed, "It's not that I mind going to jail [for warrants that could be discovered during the clean-ups]. It's I have a wife and a cat that need to fend for themselves while I'm there. So, it was a relief when I got [to the Center]. It was just kind of amazing. I had no idea how bad I needed the break until it happened." It should also be noted that, since initial data collection closed, outreach staff have reported that requests for Center referral from people living in encampments has spiked.

After arriving at the Center, the majority of guests reported a positive move-in and transition experience. They praised onsite staff for being welcoming and helpful in orienting them to the Center. Guests reported feeling onsite staff balanced being "professional and very warming as well," especially when conveying a few simple rules. As one guest put it, "Basically, don't set the place on fire, don't fight, don't steal. Use your brains. It was informative enough without dragging it into something long and unnecessary." It is important to note that only one guest reported a different experience, noting they felt the orientation was "robotic, corporate…They're just doing their job." A few guests suggested making the length-of-stay policy more transparent, which we expound upon in the next section.

The Center's originally planned 60-day length of stay was viewed by both guests and staff as unrealistic, potentially destabilizing, and unlikely to create impactful change. According to the City of Seattle's Executive

Order and RFQ (2016) documentation, the stated primary goal of the Center is, "to work with individuals to move into permanent housing." This point was clearly understood by both guests and other key stakeholders. When asked, 100% said obtaining permanent housing was what they had understood the primary goal of the Center to be. More important, all guests and other key stakeholders stated that obtaining permanent housing for guests was also their hope and vision for the Center.

It is thus unsurprising that, early on, many guests were confused when they learned they would have guaranteed shelter for only 60 days. As one guest recalled, "It floored everybody… I'm like, 'What? 60 days?!'" Another guest recalled disappointment because "there was a promise of housing within 60 days" as staff were charged with helping guests transition from the Center into permanent housing. Guests and staff alike felt the length-of-stay policy should be more upfront, consistent, and transparent. As one guest noted, "They need a big fat sign outside, '60 days only.'"

With this in mind, some guests reported they might not have accepted a referral to the Center had they known they would not have guaranteed housing at the end of their stay. The primary concern was being displaced both from their home on the streets and then from the Center 60 days later. One guest said, "If I knew [about the 60-day stay policy], I would've said no. I would have tucked myself away and been okay with that."

Guests felt the 60-day time frame was not only unrealistic but potentially destabilizing. As one guest noted, "It's not reasonable to think they can get us housing within 60 days. No way. It's cruel that they bring us in here. …Once we got here, and we got settled, then I'm like, 'What do you mean we're only here for 60 days?'" This sentiment was echoed by staff: "I thought it was brutal to have someone come in for 60 days. …When we talk about individuals dealing with trauma [and] they're reintegrating back into society."

Guests and staff noted that the destabilization could affect guests' mental health. One guest noted, "If you have to go back out on the streets again [after 60 days], that's going to be harder because you got used to being inside. Now, you have to go back out there? No. That's really going to be a mental disturbance to a lot of people." Staff agreed: "Expecting people in crisis with a hard background of years and years of trauma to get it together in 60 days? It's just not gonna happen." Staff noted that a time-limited length of stay that results in a return to homelessness is incongruous with their professional mission and ethical imperative:
"In my perspective, it's not trauma-informed care if you stabilize somebody and then put them back out to the streets. And it can be more harmful to continue to move people around."

Other guests pointed out the economic and practical disruptions. By accepting the temporary shelter stay, they would lose the physical protections and infrastructure they had built outside to survive. One guest reflected that "it would be even harder for me now because I lost most of my things that I had out there—my survival tent and those kinds of things—that I would have to start all over." Another suggested that guests need adequate time and support to meet their instrumental needs before they are "exited" from the Center: "Keep the people who are willing to get on their shit and get the things taken care of that they need to get taken care of: Job, housing. Keep them here. …See what needs to be done to help these people."

Aside from the destabilizing effects, the 60-day length of stay was widely believed to be inadequate to adjust to temporary shelter at the Center and then attain permanent housing. One guest noted that "60 days isn't a whole lot of time—even if you sign up for housing and all that stuff on your first day, there isn't a guarantee that the housing people you're talking with are gonna be finished with that in 60 days." Another key stakeholder agreed, "…even if you are provided with all the things that the Center has to offer, we recognize that 60 days is not enough time. Our concern since the beginning was that there wasn't enough housing after people's transition to the Center, so where do they expect to put people?" One staff member noted that "the majority of people we see [on the streets] and you put into a shelter, you're going to see back on the street….99%." They went on to indicate that one reason people could be relegated to homelessness is when people "ran out of time at the Center."

As of the writing of this report, it is our understanding that no guests have been permanently exited from the Center to homelessness for exceeding a program time limit. DESC has recently developed a City-approved length-of-stay extension policy and accompanying "housing plan", which stipulates what requirements guests need to fulfill in order to obtain an extension, renewable for up to 150 days.

Guests and staff reported valuing the Center's harm-reduction approach and having boundaries that keep guests safe. The Center's harm-reduction approach was one of the main reasons guests said they felt welcome. One guest shared a common sentiment: "I have an addiction and--that I didn't have to hide the addiction, that it was okay--that had everything to do with [accepting housing at the Center]." Many guests felt they would not have been able to move into housing if the policy required abstinence from substances. One guest noted, "I didn't feel like I was ready to quit using even though I did want shelter. …I probably wouldn't be here if it wasn't for the policy." Staff also noted that a harm-reduction approach was an important facilitator for building positive relationships with guests, noting that "people are really open with us about their substance use because there is no punishment" and that it is key in "building rapport and curbing stigma." Both staff and guests reported feeling positively about having a "safe place" where substance users can work towards filling unmet needs, like obtaining housing, but also where they can build up "wellness" and "being more positive." Guests and staff also both felt positively about contributing to harm-reduction in the larger community, knowing there are "a lot less needles found out there on the streets because of things like [the Center]."

On the other hand, guests also felt there needed to be some clear "boundaries," "limitations," or "rules" regarding some behaviors around substance use for the health and safety of other guests. Specific suggestions from guests included designated consumption spaces (e.g., a room or an outside courtyard to accommodate smoking) as well as a no-tolerance policy for drug sales and distribution onsite.

Guests appreciate a low-barrier approach with few rules, but also reported that more structure is needed to feel comfortable. As noted in prior sections, the Center's low-barrier approach (e.g., the 3 Ps) makes it more accessible to guests but also creates unique challenges. On the one hand, guests reported appreciating the simplicity and flexibility of the Center. It allows "the freedom to do what you want to do," but conveys a respect for autonomy by recognizing that guests "are not children" and "gives [them] responsibility." On the other hand, guests also struggled with a perceived lack or inconsistency of rules or structure. One guest noted that this creates "chaos" and that staff are "letting [guests] have too much power." Another guest said that a "lack of enforcement of certain rules and a passiveness—'Oh, you're not supposed to do that.' It doesn't change anything." Although many of these concerns were stated more generally, a couple of guests noted that a desire for rules was meant to help reinforce "common courtesy" in the Center community (e.g., "Flushing a toilet, picking up a dish, just simple things.").

Guests feel safer in the Center than on the streets, but there is room for improvement. Guests reported the safety procedures and policies at the Center largely created an environment that feels "safer in here. Far better [than being outside]." These included the Center's security cameras and the presence of onsite staff that can provide assistance as needed. Some of the aspects that make the Center a low-barrier facility (e.g., coed sleeping rooms), however, also make it feel less secure for women. A few female-identifying guests had concerns about the potential for physical and sexual assault, and one guest reported witnessing domestic violence onsite. People felt the nature of the dormitory-style rooms contributed to arguments, disagreements, and behavioral dysregulation because of "living in close quarters and having to share space." Most people felt that if they had their own, individual sleeping space, these issues would be resolved. "I think it might help to—I realize this place has already been designed—but if they're designing another place, more of like a smaller

[individual] room." Guests also noted that property theft is rampant and expressed a desire for more security or more secure ways to lock up property (e.g., "They need to fix the lockers because all these plastic foot lockers--you can pull out the sides and reach into them.")

Amenities and Services

Guests appreciated the Center's amenities and case management and had helpful suggestions for additional services that could build community and better prepare them for subsequent housing.

Guests appreciated amenities. Guests confirmed that the Center was meeting one of its key goals by fulfilling basic needs, including sleeping spaces, regular meals, full bathrooms, and case management. Food was the most frequently cited amenity, and guests appreciated they had 3 meals a day. However, they also wished for more variety in meals and access to kitchen facilities (e.g., heating implements, cooking equipment) to prepare their own food and to secure cold storage to avoid food theft. Onsite staff supported guests' requests. One staff member commented on the importance of cooking to support guests' cultural connectedness: "I know a lot of people want to cook their own food and according to their own culture and taste…so that would be good." Another onsite staff member said that a kitchen guests could access "would add a lot of warmth…some lightness in their lives."

Guests often mentioned their access to laundry, shower facilities, and sleeping space in one breath, noting that these amenities make for a "peaceful environment" that is "comfortable and safe" in contrast to life on the streets (e.g., "Is my tent gonna be here? Is someone gonna be in there? Is a rat gonna be in there?"). Some guests mentioned concerns about the sleeping spaces. While acknowledging a need for coed spaces, some guests, especially female-identified guests, felt unsafe sleeping in a room with others. Additionally, nonprivate sleeping spaces can lead to conflicts about activity during quiet hours. One guest reported that "there are those in the room that just don't care and will flip on the light and make all kinds of noise, and it's like, 'Wow! Everybody has to wake up.'"

Guests commented positively about other amenities, including janitorial services, computer access, and safer-use kits. Guests wished, however, that there were better transportation options because the location of the building is far removed from services they were used to receiving. Some guests noted that the bus often did not stop for them and sensed drivers had "blacklisted" them or were avoiding them.

Guests had suggestions regarding services. Guests were appreciative of existing, onsite case management, which they found helpful in supporting their efforts to obtain housing. Guests wanted more help with case management around obtaining identification cards as well as social security and other benefits. Guests also expressed interest in vocational support and life skills training to help them successfully transition to and maintain housing. Additionally, guests felt that provision of onsite medical, mental health, and substance use/chemical dependency services was key (e.g., treatment groups, suboxone) to a successful program.[*]

In addition to basic services, some guests felt that the introduction of meaningful and community-building activities (e.g., volunteer opportunities at the Center) could bolster a sense of structure, provide positive alternatives to substance use, build confidence, and help them learn useful skills that could help them in subsequent housing. One guest exclaimed, "Give us projects! There's a lot of people here used to be landscapers, painters, artists. They're all here, and their talents are waiting to be utilized." Some guests asserted that community-building activities could strengthen relationships to other residents that could decrease community problems, including interpersonal conflict and theft. As one resident noted, it's important to offer activities, but "not just something else to do. Something that's engaging and beneficial and

[*] Since the analysis was completed, access to medical (e.g., mobile medical van), mental health and substance-use treatment professionals have been added to the Center's services.

meaningful." Another resident suggested that community-building activities are important "because [guests] come in with a lot of that already because they've built community in their encampments. And so, [it's] just like supporting each other along the way." One guest who had moved into housing during her stay noted that there should be some way for people to maintain their relationships with guests who were still living at the Center. This guest mentioned feeling like she had "been cut off from [her Center] family once [she] moved into housing." She suggested that the Center host monthly alumni nights or alumni speaker panels to allow people to come together as community and model for current guests that achievement of housing is possible.

Building Community

The importance, effectiveness and challenges of building community was viewed from 3 key perspectives: relationships between guests and staff, relationships among guests, and relationships among various agency and government stakeholders.

Onsite staff are positively regarded by guests and could also benefit from further training. By and large, guests reported satisfaction with their relationships with onsite staff. When describing onsite staff in terms of demeanor and approach, guests primarily used positive descriptions, such as "upbeat," "polite and nice," and "warming spirits." They appreciated staff's availability ("You don't have to have an appointment to talk to someone if you're having a problem, which is cool."), support ("She has been my backbone here. She's gone above and over and beyond what she needed to do to help me…"), and client-centered approach ("They actually engage you and talk to you and are actually interested.") One guest noted, "I don't like complimenting staff. Ever. But they are incredibly helpful, willing to stop what they are doing and go this extra mile for you right now because that's what you need. They are very client-oriented." Only one guest felt differently, noting, "They talk down to you. They act like this is a prison setting. I'm not in prison. Don't treat me like a prisoner. And they do."

Despite the overall positive sentiment, some guests did feel there was room for improvement. First, guests reported a need for more onsite staff on swing, night and weekend shifts. Also, many guests felt onsite staff could benefit from more training. One guest noted that "a lot of them just kind of back off like they're scared." This was believed to be due to the fact that "most of them never had the position of power. Now that they do, they don't know how to handle it." Another felt onsite staff needed more training in "dealing with aggressive people off the streets" and noted that "empathy training gives employees a better perspective as to what they're dealing with…A lot of people can't believe being raped or having addiction or an alcohol problem."

Most guests report "keeping to themselves," although some appreciate community-building. The majority of guests noted that they "keep to themselves" or maintain a "safe distance" from other people in general. Concerns primarily centered on a lack of trust in others ("They got your back with their right hand…They've got a knife in the left hand, stick it in your back. It's a ruthless group of people."), not being "big on people," or not wanting to get close to others due to prior, painful interpersonal losses ("I put up a wall because they either fail or die, and I've just lost too many people…If I let them close, I end up getting hurt.")

In contrast, a few guests reported a greater sense of connectedness or community with other guests. One guest noted that "almost all of us knew each other from somewhere out here," and two referred to the Center community as "family." One guest acknowledged being "a people person. I get along with everybody." Two others acknowledged having different types of relationships with guests ("Some are friends, some are acquaintances.") and "weeding out the ones I didn't want to be around and the people I do." One guest acknowledged the challenges of community-building at the Center, noting that "it's taken a lot for all of us to – in my little group—trust one another."

Both onsite and outreach staff expressed concerns about a perceived disconnect between the City-level policy mandates and the realities on the ground. On-the-ground staff expressed concerns that the day-to-day work does not always conform to the hopes and expectations laid out in City-policy mandates. While the City's support shows their confidence in the ability of onsite and outreach staff on the ground to implement the program, some staff noted that the work "is way more complicated, and it's way more time consuming than that. You're dealing with other humans that have their own aspirations and issues and things. And it doesn't fit neatly into all that." Some staff shared concerns that available resources (e.g., housing) are not always adequate to fulfill the Center's mission. One staff member noted that some partners feel confident that outreach staff "can get [people] housing. Just go there, and they'll get [them] housing. But, there isn't housing to be had here in Seattle, so it's hard."

Additionally, staff had concerns that Center program roles and priorities (as layed out by City-level policy mandates) are unclear or conflicting. One ground staff member noted, "It is confusing, like, on a daily basis. What's our agenda? What's our agenda? We come in. We got this piece of paper. Who's going where?" Another staff member wondered aloud, with the changing roles and mixed messages, "What is our specialty [supposed to be]?" One staff member ascribed some of the confusion to the fact the overseeing entity is "missing that [overarching] leadership component that brings together all voices, so everyone feels really clear about what it is you're trying to do." Another staff member referred to the fact that "[different stakeholders'] agendas are driven by different goals." Many staff members acknowledged that the confusion around Center leadership has been especially pronounced since the former mayoral administration began transitioning out. There are unresolved concerns about how the City will work with its key partners moving forward to address the "silos" (i.e., different key stakeholder groups working with or for the Center), and there is an expressed need for a "unified mission" amongst all Center staff, management and key stakeholders.

Discussion

Using the words of key stakeholders, this evaluation served to document perceptions and identify areas of improvement for the Center. Among stakeholders, it was largely understood that the primary intention of the Center was to provide low-barrier shelter and case-management services to people experiencing homelessness with the ultimate goal of helping guests attain permanent housing. Guests desired more transparency about the policies and procedures at the Center but felt positively about outreach and onsite staffs' efforts. In fact, at the writing of this report, outreach staff reported a spike in expressed interest in the Center on the part of people living in encampments.

All stakeholders, however, expressed frustration about the initial length-of-stay policy. Given the current, well-documented dearth of housing stock in Seattle, it was widely agreed that a predetermined, 60-day length-of-stay limit is inadequate to bridge guests to permanent housing. Further, both onsite and outreach staff expressed concerns about challenges associated with trying to procure stable housing for individuals with histories of chronic homelessness who often have co-occurring and complex medical, psychiatric and substance-use conditions. The result is that guests, pulled away from their known infrastructures on the streets, feel anxiety due to the possibility of a return to homelessness.

Otherwise, participants expressed gratitude and appreciation for the Center's amenities, services, policies and procedures, including the low-barrier, harm-reduction approach to substance use. Guests and staff provided well-founded suggestions for further enhancing services, some of which have already been implemented (e.g., increased access to medical, mental health and substance-use treatment). These suggestions also included means of increasing security and safety (e.g., safer consumption spaces and more secure storage) and improving amenities to support development of independent living skills (e.g., access to guest kitchen and cold storage to support cooking skills and nutrition).

Limitations

Some limitations of this report should be noted. First, guests were interviewed between August and October of 2017. Thus, interviews reflected early policies, amenities, and services, and the views represented in this report may not capture perspectives of newer guests experiencing the current policies and procedures. That said, many of the themes that have been shared in this report continue to resonate with individuals who participated in this process as recently as February 2018, which speaks to their ongoing relevance. Second, this report represents stakeholders' perspectives on the Center in their own words, but does not provide a quantitative evaluation of its effectiveness in helping guests attain housing, improve psychiatric, medical or substance-use outcomes or address the larger homelessness crisis in Seattle and King County.

Conclusions and Future Directions

Despite its limitations, this report provides useful information about experience with and perceptions of the Center from multiple perspectives (e.g., guests, outreach and onsite staff, management and City Officials). These data provide policy-makers and program management with points to consider in striving to meet the Center's stated goals (e.g., securing permanent housing for guests) as well as program improvement and future replication. Subsequent, planned quantitative evaluations from both the current evaluators as well as City staff will respond to outstanding questions about the Center's effectiveness in helping guests attain housing and addressing medical, psychiatric and substance-use outcomes. In the meantime, as one participant concluded: "This place is really changing, change for the better because even though we do drugs, we don't have to do as much to survive. We have other options. So, this place gives us the option to be more positive, you know, be a better citizen out there."

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Table 1.
Baseline Descriptive Data for the Guest Study Sample (*N* = 40)

Variable	*M* (*SD*) / %
Age	44.9 (9.6)
Gender	
Female	40.0
Male	60.0
Race	
American Indian/Alaska Native/First Nation	10.0
Asian	2.5
Black/African American	22.5
Native Hawaiian/Pacific Islander	0.0
White/European American	32.5
"More than one race"	30.0*
Other	2.5
Ethnicity	
Hispanic/Latino/a	10.0
Education	
Less than 12th grade	20.0
12th Grade	10.0
GED	22.5
Vocational School	7.5
Some College	32.5
College Graduate	5.0
Some Graduate School	2.5
Advanced Degree	0.0
Employment	

Full-Time Employment	5.0
Part-Time Employment	10.0
Disability	15.0
Unemployed (No Assistance)	65.0
Unemployed (GAU, GAX, ABD)	5.0
Retired	0.0
Have Ever Served in the Military or Armed Forces	
Yes	7.5

Note. * 10 out of 12 participants identified as having American Indian/Alaska Native heritage plus something else.

Table 2.

Baseline Descriptive Data for the Staff and Management Study Sample (*N* = 44)

Variable	*M* (*SD*) / %
Age*	38.2 (12.0)
Gender	
Female	37.2
Male	39.5
Other	9.3
Missing	14.0
Race	
American Indian/Alaska Native/First Nation	0.0
Asian	4.7
Black/African American	11.6
Native Hawaiian/Pacific Islander	0.0
White/European American	65.1
"More than one race"	11.6
Other	2.3
Missing	4.7
Ethnicity	
Hispanic/Latino/a	16.3
Missing	2.3
Education	
Less than 12th grade	0.0
12th Grade	0.0
GED	0.0
Vocational School	2.3

Some College	4.7
College Graduate	53.5
Some Graduate School	11.6
Advanced Degree	27.9
Employment	
Full-Time Employment	93.0
Part-Time Employment	0.0
Disability	0.0
Unemployed (No Assistance)	0.0
Unemployed (GAU, GAX, ABD)	0.0
Retired	0.0
Other	0.0
Missing	7.0
Military or Armed Forces	
Yes	2.3
No	88.4
Missing	9.3

Note. * Missing information from N=2

APPENDIX A
Guest Interview Questions

Interview prompts (Note: Allow participants to discuss each topic for about 5 minutes before moving on, depending on the richness of the data.)

- How long have you been staying here? (prompts: # of days/weeks, try to get specifics)
- What is your understanding of the Navigation Center? (Prompts: What is this place for? What is its intention? Why was it built?)
- What were your expectations when you first got here?
- What does your day-to-day experience of the Navigation Center look like? (Prompts: What does a typical day look like? How do you spend your day?)
- What would make your stay here at the Navigation Center better?
- What was it like to go from where you were living before to here?
    - What made you say YES?
    - What kind of paperwork did you fill out?
    - What information did you receive before coming here?
    - Did you meet with a staff member when you got here? What happened? What was your orientation like? (Prompts):
- What is your understanding of the rules?
- What are some things you like about the Navigation Center?
- What are some things you would like to change about the Navigation Center?
- What are some services that you would like to see offered here? (i.e., ones that you feel would make your experience here better).
- How would you describe your relationship with other guests?
- How would you describe your relationship with staff?
- What do you think about the substance use policy at the Navigation Center? (Prompts):
    - How is this different from your experiences at other places you have stayed?
    - How did this influence your choice to come here over other options?
    - How safe/comfortable do you feel using substances here?
- What are your hopes and vision for the Navigation Center?
- What would indicate to you that the Navigation Center is “successful”? (Prompts: what do you think this place needs to be doing in order to fulfill its mission?)
- Is there anything else you feel like we should know?

APPENDIX B

Key Stakeholder Interview Questions

Interview prompts (Note: Allow participants to discuss each topic for about 5 minutes before moving on, depending on the richness of the data.)

- What do you understand the intention/mission of the Navigation Center to be?
- What is a typical day like in your role as it pertains to the Navigation Center?
- How would you describe your role/job description (what do you see as your primary job?)
- What is the process (from your particular role) of connecting potential guests to the Navigation Center?
- What are some of the benefits/challenges of working on this project?
- What does harm reduction mean to you?
- What do you understand/think about the substance use policy at the Navigation Center?
- How would you describe your relationships with guests?
- What services do you feel are essential in making this a successful program?
- What do you feel could substantially improve guests' experience of the Navigation Center? What about staff's experience of working here?
- What could have better prepared you for your role?
- What are your hopes and vision for the Navigation Center?
- Is there anything else you feel like we should know that we haven't covered today?

APPENDIX C
SAMPLE CONSENT FORM

University of Washington
CONSENT FORM
NAVIGATION CENTER GUEST

PROJECT CONTACT
Seema Clifasefi, Lead Evaluator, PhD, (206) 543-3452, seemac@uw.edu

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KEY PROJECT PERSONNEL
Susan Collins, PhD, Co-Evaluator, (206) 744-9181, collinss@uw.edu
University of Washington Project Staff: Victor King, Silvi Goldstein, Joey Stanton,
To contact any of the above project staff members, please email: harrtlab@uw.edu
* We cannot guarantee the confidentiality of e-mail communication

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EVALUATORS' STATEMENT

We are asking you to take part in an evaluation interview being conducted by the University of Washington. The purpose of this consent form is to give you the information you will need to decide whether you'd like to be included in the evaluation results or not. Please read the form carefully. You may ask questions about the purpose of the evaluation, what we would ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the evaluation or this form that is not clear. When we have answered all your questions, you can decide if you want to take part in the evaluation or not. This process is called "informed consent." We will give you a copy of this form for your records.

PURPOSE OF THE EVALUATION

The purpose of this interview is to help us learn more about your experiences at the Seattle Navigation Center so that we can: a) document what is working well, b) what your ideas are to make Seattle's Navigation Center the best place it can be, and b) identify potential areas of improvement to help enhance the service options Seattle's Navigation Center offers.

EVALUATION PROCEDURES

We are asking you to participate in a 45-60 minute one on one interview with UW project staff. If you choose to take part in this interview, we will ask you questions, primarily around your day-to-day-experience staying at the Seattle Navigation Center. Questions may include:

- What is a typical day for your like here at the Navigation Center?
- What are some things you like about the Navigation Center?
- What are some things you would like to change about the Navigation Center?

You may choose not to respond to any questions that you don't want to answer, and you may stop the interview at any time without any negative repercussions. We will de-identify all interviews and will not be sharing your individual responses. Your responses will not be attached to your name.

AUDIO RECORDING

We will also ask if we can audio record the interview. The recording will be used to make sure we accurately record all the information you give us. We will also write down your answers. The evaluation team will not label the recording with your name or other personal identification. The recording will be stored on a password-protected, secure server on a password-protected computer. The recording will be destroyed at the completion of the evaluation, no later than August 31, 2018. No one but the UW project staff will have access to the recording.

RISK, STRESS, OR DISCOMFORT

Risks associated with participation are primarily related to the sensitivity of some of the questions we may ask you. For example, you will be asked about your thoughts, feelings, and experiences about staying here at the Navigation Center, that may be private. If you are upset by any of the process or you become concerned for any reason as a result of your participation in this interview, please feel free to contact the project lead, Seema Clifasefi (seemac@uw.edu).

BENEFITS OF THE EVALUATION

There may be no direct benefit to you for participating in this evaluation; however, your participation may lead to the development of more effective programming at Seattle's Navigation Center and help the City of Seattle and Navigation Center staff better help people in the future.

SOURCE OF FUNDING

The evaluators at the University of Washington have been contracted by the City of Seattle to conduct this work.

CONFIDENTIALITY OF EVALUATION INFORMATION

Your participation in the interview is confidential. That means everything you tell us will be kept private.

- Your name will not be on the interview.
- The information you provide to us through these interviews will not be linked to your name (we separate this consent form with your interview responses). Your information will be marked with an evaluation ID instead. Your data will therefore be collected without identifiers.
- We will keep the audio recording from the interview on password-protected computers. The audio recording will be destroyed at the end of the evaluation, no later than August 31, 2018.
- Your name will not be used in any reports or publications from this evaluation.

However, if we learn that you intend to harm yourself or others, we must report that to the authorities.

OTHER INFORMATION

It is your choice to participate in this evaluation interview. Nothing bad will happen to you if you choose not to participate. The services you receive from Navigation Center staff or other providers involved in the Navigation Center will not be affected in any way by your decision to participate or not participate in this evaluation. You can stop the interview at any time and that will not affect your current or future services with the Navigation Center.

You will receive a $20 cash honorarium for completing the interview.

If you have any questions, we can answer them now. You can also contact any one of the people listed at the beginning of this form.

Printed name of evaluation staff obtaining consent **Signature** **Date**

DO YOU HAVE ANY QUESTIONS?

PARTICIPANT'S STATEMENT

√ This evaluation has been explained to me.
√ I volunteer to take part in this evaluation.
√ I have had a chance to ask questions.
√ If I have questions later about the evaluation, I can ask one of the project staff listed above.
√ √ I will receive a copy of this consent form.

___ Yes
___ No

Please mark whether or not you would like to participate in the audio recording sessions.

Printed name of participant **Signature of participant** **Date**

Copies to: Evaluators, Participant

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Navigation Center Program Evaluation Report - Part 2

Guest Satisfaction and Health-related Outcomes

Susan E. Collins, PhD
Seema L. Clifasefi, PhD

Harm Reduction Research and Treatment (HaRRT) Center
University of Washington – Harborview Medical Center

with important contributions from UW HaRRT Center staff, the Navigation Center Evaluation Advisory Board and others acknowledged on the back page.

Draft date: August 29, 2018

Executive Summary

Background: On June 9, 2016, former Mayor Ed Murray signed into effect an Executive Order creating Seattle's Navigation Center (hereafter "the Center"). Funded by the City of Seattle Human Services department and operated by the Downtown Emergency Service Center (DESC), the Center is a low-barrier, 24-hour, referral-only shelter for adults experiencing homelessness. The low-barrier, harm-reduction aspect of the Center means that shelter and services are offered without preconditions, such as abstinence from substances, mental health treatment attendance, and service participation requirements, and safer-use strategies are employed onsite. In contrast to existing shelters, guests are afforded more autonomy: There are no curfews or lock-out times, onsite substance use is allowed, and guests can bring pets, partners, and possessions with them. As outlined in the Executive Order, the goal of the Center is to "assist people who are unsheltered into housing as rapidly as possible, and to increase the capacity of providers to provide tailored services utilizing an intensive service model..."

The Harm Reduction Research and Treatment (HaRRT) Center at the University of Washington-Harborview Medical Center was contracted by the City of Seattle's Human Services Department to conduct a 13-month (July 2017-August 2018) program evaluation of the Center. The evaluation is divided into 2 parts:

- **Part 1 (July 2017-February 2018)** entailed qualitative interviews (*n*=40) and focus groups (*n*=4 groups, 36 participants) to document and analyze stakeholders' (i.e., Center guests; DESC, REACH and SPD onsite and outreach staff and management; and City partners) experiences with and perceptions of the Center as well as potential points for improvement of the Center's policies, procedures, amenities, services, and community-building efforts. This report was completed on March 21, 2018.
- **Part 2 (November 2017-July 2018)**, which is the focus of the current report, entailed the assessment of changes in guests' (*N*=37) self-reported health outcomes prior and subsequent to their entry into the Center. Guest satisfaction and perspectives on housing were also assessed at the final time point.

Purpose: The purpose of Part 2 was to work with the Center guests to document their self-reported physical and mental health status, substance use and related problems, and quality of life over the first few months of their stay. Additionally, overall satisfaction with Center services and guests' perspectives on housing were assessed. By focusing on guests' self-reported health-related outcomes and perspectives on services, the UW HaRRT Center evaluation was meant to complement the City's parallel housing and service utilization report.

Methods: This evaluation comprised a single-arm, longitudinal, within-subjects design testing changes in self-reported substance use, mental health, physical health and quality-of-life outcomes during participants' transition into the Center (baseline), and at 30, 60 and 120-day intervals. Participants were 37 newly referred guests who were interviewed between November 2017 and July 2018, were at least 18 years of age, and agreed to participate in the evaluation component.

Primary Findings:

- **Substance-use and related harm:** Participants' were **23% less likely to report any alcohol or drug use for each month after their move-in date**. Participants' experience of substance-related harm, including overdose, did not change in a statistically significant way.
- **Safer-use strategies:** For each month after move-in, participants were **22% more likely to report having access to naloxone**, **12% more likely to use clean injection equipment**, and **20% more likely to report giving clean equipment to someone they know**. These findings are vital in supporting individual and community-level health because consistent and broad implementation of safer-use strategies, such as wide distribution of the overdose rescue drug (i.e., naloxone) and clean injection equipment (i.e., cookers, syringes, cottons), are scientifically effective ways to reduce risk of overdose and bloodborne illness transmission for the affected individual and the larger community.[a]
- **Mental health:** There were no significant changes over time on participants' assessment of their emotional well-being, ability to fulfill their roles due to emotional problems, or feeling of being connected to others socially.
- **Physical health:** There were no significant changes over time on participants' assessment of their own day-to-day physical functioning, ability to fulfill their roles due to physical problems, changes in feeling fatigued versus energetic, or experience of pain. However, participants reported **significantly better "general health"** over time.
- **Quality of life:** There were no statistically significant improvements on participants' assessment of their general quality-of-life or on involvement in meaningful activities.
- **Perspectives on housing next-steps:** Participants were highly interested in housing, but were wary that they would need continued and tailored support (e.g., financial support, including rent assistance; case management; medical, psychiatry, substance-use treatment services; vocational rehabilitation; caregiving) to maintain their positive trajectories in housing. Guests also pointed to the necessity of financially sustainable permanent housing instead of time-limited models, such as rapid rehousing.

Conclusions and recommendations: Participants evinced positive self-reported changes on various important health-related outcomes, including increased safer substance-use practices, decreased substance use, and improved general physical health. Thus, low-barrier, enhanced, harm-reduction shelter services may support positive, health-related changes for people experiencing homelessness and substance-related harm in the short term. Moving forward, we recommend a) centering guests' voices in Center quality improvement and decision-making, b) expanding and enhancing Center services (e.g., adding onsite medical services), and c) ensuring ongoing case management and support after guests move into housing. Finally, we recommend an ongoing, longer-term evaluation that expands outcomes to include changes in publicly funded service utilization (e.g., emergency healthcare and jail) and housing attainment and maintenance. Such ongoing and more comprehensive evaluation will build on these positive initial and short-term findings to determine the longer-term impact of low-barrier, enhanced, harm-reduction shelter on people who use substances and their communities.

[a] For more information on safer use strategies and public health outcomes, please see compiled literature at the HaRRT Center website (https://depts.washington.edu/harrtlab/).

BACKGROUND

Efforts to end homelessness have precipitated a reduction in its prevalence nationwide. Based on 2017 estimates, 553,742 people in the US are homeless on any given night, which represents an 14% reduction from 2007.[1] This overall decline was primarily driven by a decrease in people who are homeless in unsheltered locations.[1] In contrast to these national figures, homelessness in King County, Washington has increased over the past few years. In fact, the point-in-time count conducted by the Seattle/King County Coalition on Homelessness indicated that the number of unsheltered homeless individuals in Seattle alone increased by 15% from 2017 to 2018. Those experiencing unsheltered homelessness are disproportionately affected by medical, psychiatric and substance-use issues, with an estimated average age of death between 47 and 52 years of age.[2]

In 2015, public awareness of this issue was raised as former Seattle Mayor Ed Murray and King County Executive Dow Constantine joined Portland, Oregon, California and Hawaii in declaring a state of emergency regarding homelessness. Together with Seattle City Councilmembers, the Mayor directed staff efforts to address the growing crisis of unsheltered homelessness in Seattle and, on June 9, 2016, signed into effect an Executive Order[3] creating Seattle's Navigation Center (hereafter referred to as "the Center"), which is supported in part by private donations and City of Seattle general funds.

Navigation Center Overview

The Center opened its doors to its first guests on July 12, 2017. As it currently operates, the Center is a low-barrier, 24-hour, referral-only shelter for adults experiencing homelessness. The low-barrier aspect of the Center means that shelter and services are offered without preconditions such as sobriety, mental health treatment, or service participation requirements, and safer-use strategies are employed onsite (e.g., access to clean injection equipment and naloxone). In contrast to existing shelters, guests are afforded more autonomy: There are no curfews or lock-out times, and guests can bring pets, partners, and possessions with them. The goal of the Center, as outlined in the Executive Order, is to assist unsheltered people into housing as rapidly as possible and to facilitate provision of tailored services for this population.

Center priority population and outreach. Outreach to potential guests is conducted by the City-designated outreach entity, the Navigation Team, which comprises staff from REACH and the Seattle Police Department. Unsheltered, single adults experiencing homelessness are referred based on the priority population criteria established by the City of Seattle's Human Services Department (HSD). This includes people with chronic medical, psychiatric, and substance-use disorders. Given the vast overrepresentation of People of Color in the homeless population,[1] and the City's commitment to addressing racial disparities, the priority populations for the Center include American Indian/Alaska Native, Black/African American, and Multiracial individuals.

Center service provision. The Downtown Emergency Service Center (DESC) was awarded the contract to operate the Center and provides onsite case-management services. The Center is a part of the DESC Housing Program and is under the direction of the Director of Housing Programs and the Executive Director. During this evaluation period, DESC employed 17 full-time equivalent (FTE) onsite case managers and service coordinators, including a Project Manager (1.0 FTE) who oversees Center operations and staff. Additional clinical coverage

includes an onsite licensed mental health case manager (.5 FTE), substance-use case manager (.5 FTE), and on-call staff (approximately 2.05 FTE). DESC also employs janitorial staff (3.0 FTE), and maintenance staff (1.0 FTE) who are coordinated and supervised by the DESC facilities supervisor (1.0 FTE). In planning stages are an additional case manager (1 FTE) and service coordinator (1 FTE) as well as an increase of the mental health case manager's position to full-time to accommodate planned program expansion. These latter changes were not yet made during the time frame of the present evaluation.

Onsite staff are charged with helping guests fulfill basic needs for shelter, hygiene, nutrition, secure and accessible storage, as well as supportive services and case management. Additional services include onsite mental health and substance-use counseling. The ultimate goal of the Center is to connect guests to permanent housing or other appropriate, long-term placement (e.g., residential treatment setting). Thus, Center staff work to encourage, facilitate, and support guests' progress and activities toward permanent housing.

Onsite harm-reduction strategies comprise a key component of the Center services and aim to support both individual- and community-level health. All staff are trained on overdose rescue using naloxone, and naloxone is accessible by staff in 2, onsite locations. Staff provide sharps containers to individuals and maintain Center-wide sharps containers throughout the building. Staff return sharps to needle and syringe exchange facilities where they are exchanged for clean equipment. At the Center, staff provide up to 1 clean injection kit (i.e., cottons, cookers, water, syringe, tourniquet) per day, 1 glass bubble per month, and 1 glass stem per week. Literature and posters on safer use are posted onsite. Staff also take guests to the needle and syringe exchange to facilitate their own access to naloxone and clean injection equipment.

METHODS

Aim

The aim of Part 2 of the Center Evaluation was to document before-and-after changes in guests' substance use, mental health, physical health, and quality of life as well as guests' satisfaction with their stay and perspectives on housing at the 120-day time point.

Setting

The primary setting for the data collection was the Center, which is located at 606 12th Avenue S, Seattle, WA.

Evaluation Advisory Board (EAB)

Prior to launching the evaluation, the UW team assembled the EAB, which comprises members representing the perspectives of guests, onsite and outreach staff, management, City officials, and other community partners. The EAB assists in planning and overseeing the evaluation process, providing multiperspective context for the data collection, and interpreting and disseminating findings. The EAB met monthly during the evaluation period for a total of 13, 1.5 hour meetings between August 2017 and August 2018.

Participants

Participants were individuals with lived experience of homelessness who were living at the Center (*n*=37). The primary inclusion criterion was being a new referral to the Center (i.e., having moved in within 2 weeks of the baseline evaluation). Exclusion criteria included refusal or inability to consent to participation in the evaluation or constituting a risk to the safety or security of other guests or staff.

Measures

Sociodemographics. The *Personal Information Questionnaire* comprises single items that were created for use with a similar population. This measure assessed age, gender, birth sex, race, ethnicity, education level, housing history, employment status, military status, and current use of medical, psychiatric and substance-use treatment services.

Substance use and substance-related harm. The *Alcohol and Other Drug Timeline Followback (TLFB)* is a set of calendars that allows for psychometrically valid retrospective evaluation of daily alcohol and other drug use.[4] The TLFB was used to aggregate self-reported alcohol and other drug use to create the 7-day abstinence outcome and descriptive outcomes for frequencies of specific substance use.

The *Short Inventory of Problems (SIP-AD)* is a validated 15-item, Likert-scale questionnaire that measures social, occupational and psychological substance-related problems over the past 30 days.[5] It was used as a reflection of substance-related harm.

Safer-use strategies. The *Safer-Use Strategies Questionnaire* was designed together with the EAB to assess self-reported overdose, access to and use of naloxone, and access to and use of clean injection equipment.

Physical and mental health. The *RAND 36-Item Short Form Health Survey Version 2 (SF-36)*[6] measures physical (i.e., physical functioning, role-physical, bodily pain, general health) and mental (i.e., vitality, social functioning, role-emotional, mental health) health domains. This measure is reliable and valid in diverse populations and applications.[7]

Quality of life. The *Meaningful Activity Participation Assessment* (MAPA)[8] is a 28-item, psychometrically validated tool designed to measure level of engagement in general life activities that bring meaning to people's lives. Respondents are presented with a list of various activities they may encounter in their day-to-day lives (e.g., socializing, writing, physical exercise, reading, prayer/meditation, community organization, computer use). Each activity is then rated on 2, 4-point Likert scales assessing the frequency with which they engage in that activity and the level of meaningfulness ascribed to each. The 2 scores for each item are combined multiplicatively, and a summary score, which reflects the overall level of engagement in meaningful activities, is formed.

An additional single item was used to assess participants' own definition of *quality of life* and rate their current status on a Likert scale, where 1 = lowest quality of life possible and 10 = highest quality of life possible.

Guest satisfaction. We also assessed issues related to *satisfaction with and perceived effectiveness of the Center* at the 120-day assessment with a 23-item questionnaire developed collectively by the EAB. Primary components assessed included a) the Center's accommodations, amenities and staff, b) the Center's in-house mental health and substance-use services, c) the Center's connection of guests to outside mental health and substance-use services, d) the Center's connection of guests to housing, and e) level of concern regarding substance use, safer use, violence and theft in the Center.

Housing perspectives. This measure was created for the purpose of this evaluation using EAB input and comprises 18 dichotomous, fill-in-the-blank and open-ended items to assess participants' current and anticipated future housing status, their perspectives on housing, potential barriers to housing, and facilitating factors.

Procedures

All data collection for this phase of the report was conducted between November 2017 and July 2018. Potential participants were identified by Center staff according to the above inclusion/exclusion criteria and were told about the opportunity to participate in the UW HaRRT Center evaluation. Those individuals who were interested made an appointment with UW HaRRT Center staff where they were informed of the purpose and procedures of the assessment interviews as well as their rights and role as participants in the program evaluation. Participants were informed that their participation in the interviews would not affect their service provision at the Center, their information would be kept confidential, and their comments would be aggregated and shared without personally identifiable information. UW staff further explained that the evaluation was to take place over a 4-month period and participants would meet and be interviewed up to 4 times—at baseline and 30, 60 and 120 days—to assess before and after changes in substance use, physical and mental health, and quality-of-life outcomes. Additionally, satisfaction with the Center and perspectives on housing would be assessed at the 120-day assessment.

Interested participants provided written, informed consent and completed the baseline assessment with evaluation staff, which included all measures listed above, except the satisfaction and housing perspectives measures, which were only administered at the 120-day assessment.

At the end of each assessment appointment, UW HaRRT Center staff scheduled participants for their next assessment. Each assessment lasted between 40 to 60 minutes. Participants received a $20 honorarium for each assessment session they participated in (for up to a total of $80), and were assured prior to the interview that they would receive this incentive regardless of what they had to say.

Data Analysis Plan

Using SPSS 19 and Stata 13, descriptive analyses were conducted to a) characterize the sample and b) describe participants' satisfaction with the Center and its ability to connect guests with other clinical, treatment and social services.

Generalized linear modeling was used to test whether guests reported statistically significant changes in their substance use, substance-related harm, incorporation of safer-use strategies, mental health, physical health, and quality of life. Time was the primary predictor in these models and was coded as follows: 0=baseline, 1=30-day follow-up, 2=60-day follow-up, 4=120-day follow-up. An additional predictor, days at the Center, was used as a measure of exposure to the intervention and thereby a representation of dose-response. This variable was not a consistent predictor of the outcomes and led to model instability (likely due to the lack of variability and low sample size). It was thus not included in the primary analyses reported on below.

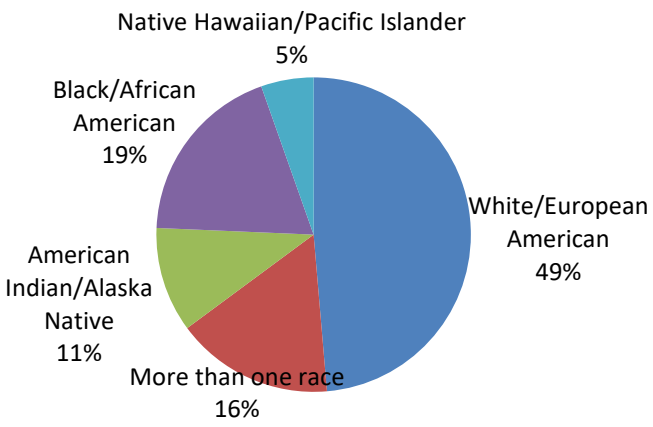
When outcomes were normally distributed (i.e., quality-of-life, physical, emotional well-being, social functioning, energy vs fatigue, experience of pain, general health, meaningful activities, QoL), dichotomous (i.e., substance use, overdose, safer-use strategies), ordinal or nonnormally distributed (i.e., role limitations), or skewed and overdispersed counts and integers (i.e., substance-related harm, physical functioning), we used Gaussian, logistic, ordered logistic, and negative binomial regression models, respectively.[9] We addressed data nonindependence using the modified sandwich estimate of variance, which is robust to clustering resulting from repeated measures.[9] To enhance interpretability of the effect sizes, exponentiated coefficients are presented for logistic, ordered logistic, and negative binomial models, where *IRR/OR* < 1 indicates an inverse association, *IRR/OR* = 1 indicates no association, and *IRR*/*OR* > 1 indicates a positive association. Alpha was set to $p = .05$. Confidence intervals were set to 95%.

RESULTS

Overall Sample Description

Participants in this evaluation (*N* = 37) had an average age of 45.92 (*SD* = 11.26) years, and 54.1% reported female sex assigned at birth (*n* = 20). The racial diversity of the overall sample is shown in Figure 1. Additionally, 5.4% reported Hispanic/Latinx heritage. Assessment session attendance reached 100%, 89%, 86% and 78% for assessments at 0, 30, 60, and 120 days, respectively. On average, participants attended 3.54 (*SD*=0.79) assessment sessions.

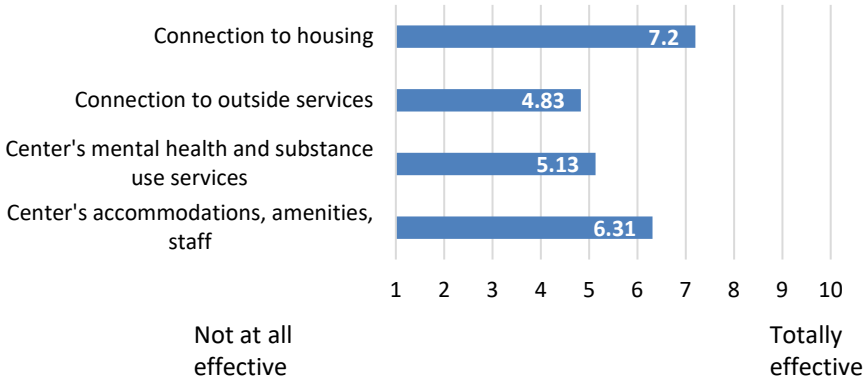
Figure 1. Racial backgrounds of participants



Guest Satisfaction with the Center and Use of Specific Services

Center's accommodations, amenities and staff. Toward the end of their stay at the 120-day assessment, participants rated their perceived effectiveness/satisfaction with the Navigation Center's accommodations, amenities and staff at a mean of 6.31 (*SD* = 2.57) on a scale of 1 to 10, where 1 is "not at all effective" and "10 is totally effective." Please see Figure 2 for the mean ratings for the guest satisfaction and effectiveness scales.

Figure 2. Guest Satisfaction with Center



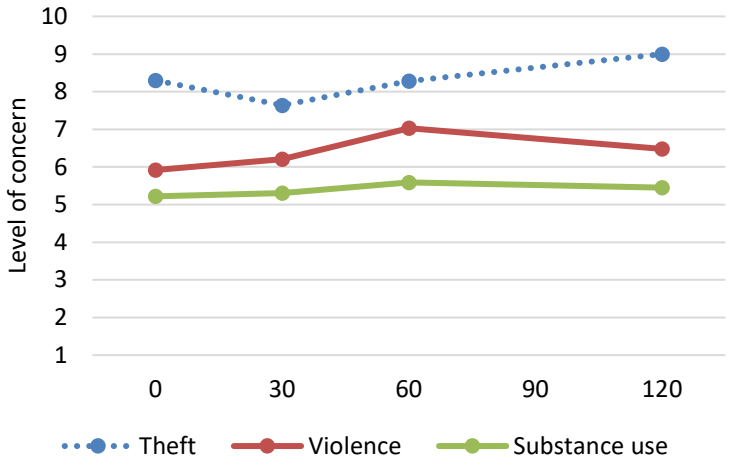
Center's in-house services addressing guests' mental health and substance-use needs. The Center's in-house mental health and substance-use treatment services were rated around the midpoint of the scale, averaging 5.13 (*SD* = 3.20; see Figure 2).

It should, however, be noted that these ratings were made based on relatively low self-reported utilization of these services. For example, although 41% and 51% of participants reported receiving substance-use and mental health services, respectively, only 16% and 11% of the sample reported receiving these services at the Center.[b]

[b] It should be noted that the data collection for this evaluation occurred as these services were being ramped up in the Center and thus may not be reflective of current service utilization.

Connection to other services. The Center's effectiveness in connecting guests to outside mental health, medical and substance-use treatment services was rated around the midpoint between "not at all effective" and "totally effective" (*M* = 4.83, *SD* = 2.84). This is shown in Figure 2.

Figure 3. Potential points of concern



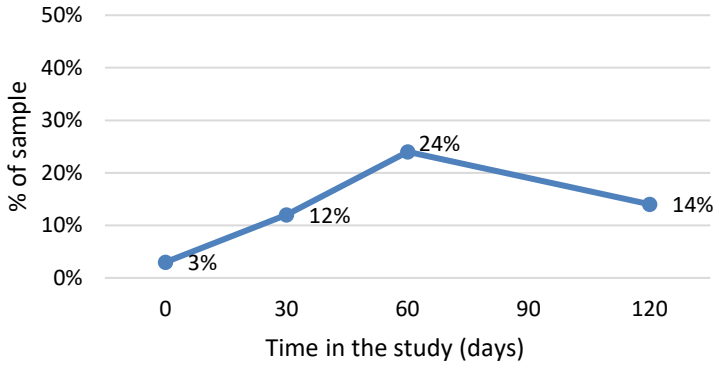
Satisfaction with connecting guests to housing was rated highest of these different services categories at 7.20 (*SD* = 2.38). This finding was key as it is the primary goal of the Center and as guests' perception of the importance of housing was rated consistently high—with an average of 9.45 (*SD* = 1.78) across the length of their stay.

Other issues facing guests. Guests also responded to prompts assessing their level of concern about themes raised in Part 1 of the evaluation: theft, violence, and substance use in the Center. Findings indicated no significant changes in guests' concerns over the course of the evaluation (*p*s > .15), and these trajectories are shown in Figure 3.

Substance-use Outcomes

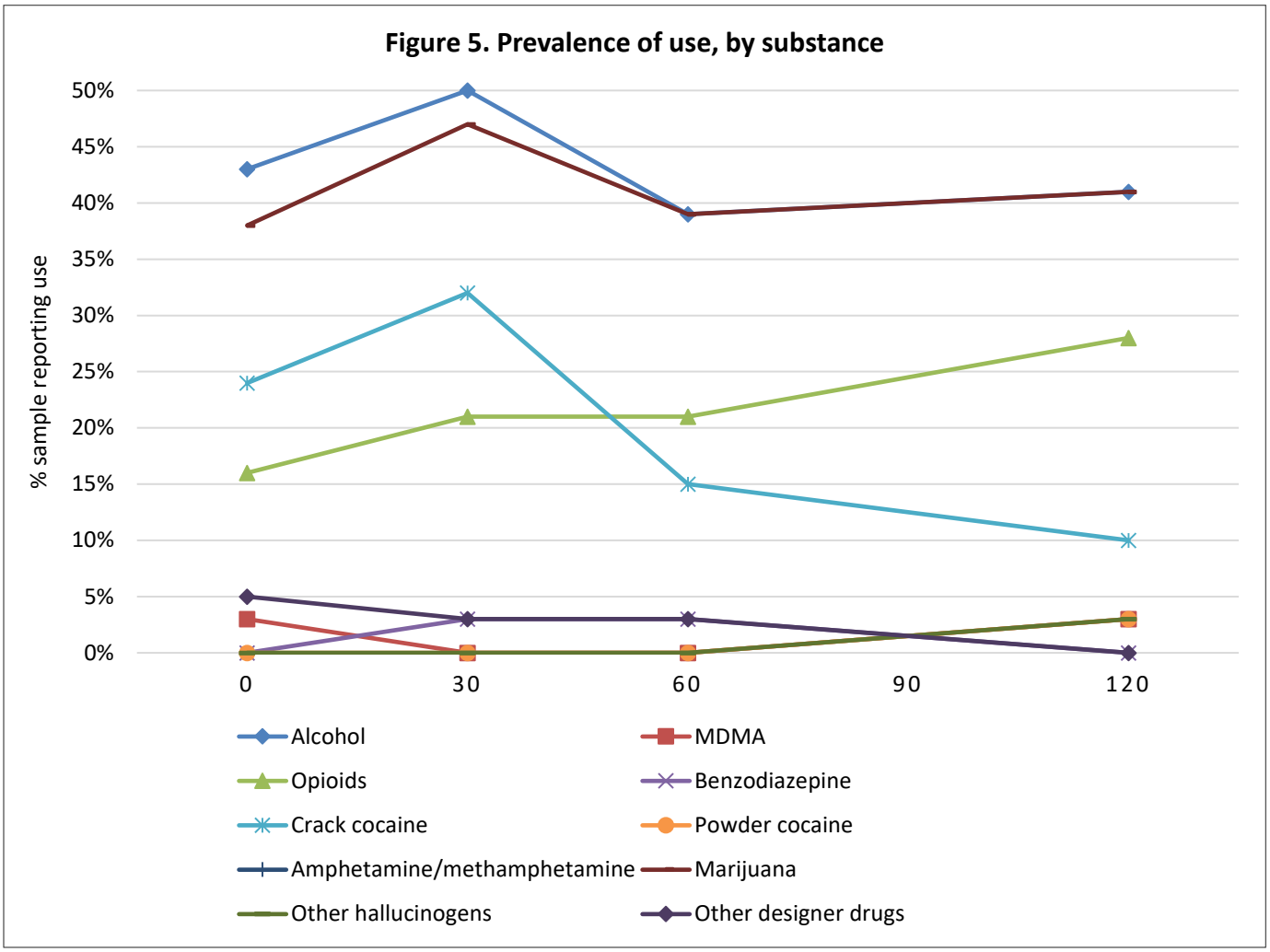
Abstinence from alcohol and other drugs. Findings indicated changes in abstinence from substances significantly increased over time, Wald $\chi^2(1, N=133) = 8.50$, $p = .004$. Specifically, each passing month brought a 23% decrease in participants' likelihood of any substance use in the past 7 days (see Figure 4).

Figure 4. Abstinence from AOD



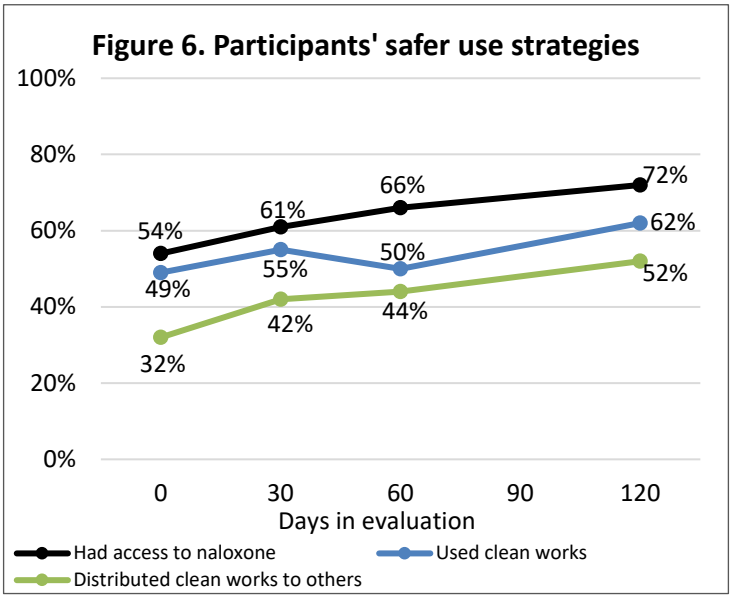
In breaking down prevalence of use by type of substance, participants reported no statistically significant change in alcohol, opioid, powder cocaine, cannabis, other hallucinogen, and other designer drug use (*p*s > .17). However, there were statistically significant decreases in participants' self-report of benzodiazepine, Wald $\chi^2(1, N=133) = 8.03$, $p = .005$, and crack cocaine, Wald $\chi^2(1, N=133) = 4.71$, $p = .03$. Figure 5 shows the prevalence of use across substances and time in the evaluation.

Substance-related harm. There were no significant changes on participants' self-report of substance-related harm in general, Wald $\chi^2(1, N=130) = 2.93$, $p = .09$, or on opioid overdose more specifically, Wald $\chi^2(1, N=131) = 2.91$, $p = .09$.



Safer Substance Use

Participants reported consistently high levels of staff support for safer substance use (*M* = 8.12, *SD* = 2.8). This level of perceived support for safer substance use did not show statistically significant changes over the course of the evaluation, Wald $\chi^2(1, N=125) = 0.47$, $p = .49$. Participants also reported greater exposure to and implementation of safer-use strategies over the course of the evaluation. For each month that passed, participants were 22% more likely to report having access to naloxone, Wald $\chi^2(1, N=131) = 4.14$, $p = .04$. They did not, however, report being statistically significantly more likely over time to carry or use naloxone (*p*s > .09). For each month that passed in the evaluation, participants were 13% more likely to use clean injection equipment, Wald $\chi^2(1, N=131) = 3.91$, p



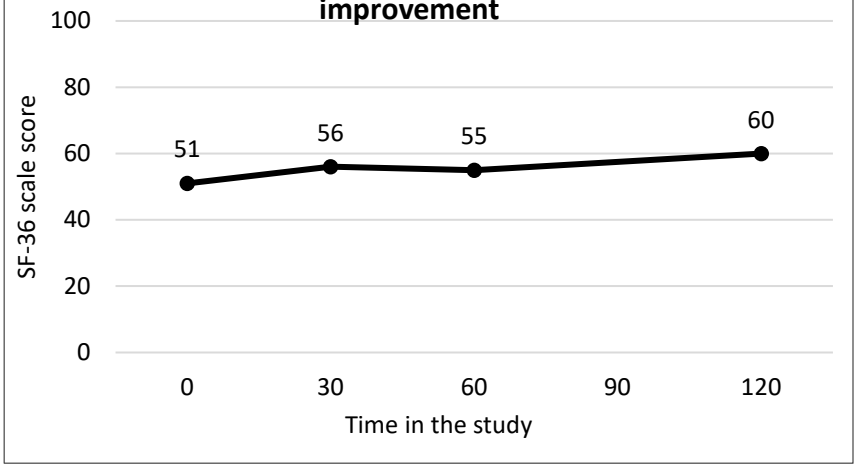
= .048, and 20% more likely to say they distributed clean injection equipment to someone they know, Wald $\chi^2(1, N=131) = 3.99$, $p = .046$.

Physical Health Outcomes

There were no significant changes over time on people's assessment of their own day-to-day physical functioning, ability to fulfill their roles due to physical problems, changes in feeling fatigued versus energetic, or experience of pain (*p*s > .61).

On the other hand, participants did report better general physical health, $F(1, 36) = 4.29$, $p = .046$, such that each month that passed during the evaluation was associated with a 1.88 higher score on this scale, which ranged from 0-100 (see Figure 7 to the right).

Figure 7. Self-reported general health improvement



Mental Health Outcomes

There were no significant changes over time on participants' assessment of their own emotional well-being, ability to fulfill their roles due to emotional problems, or feeling socially connected (*p*s > .19).

General Quality-of-life Outcomes

There were no significant changes over time on participants' self-reported involvement in meaningful life activities and self-defined QoL (*p*s > .51).

Perspectives on Housing After Center Stay

At the 120-day assessment (*n* = 29), 22 participants were still staying at the Center, among whom 3 had concrete plans for subsequent housing. A few participants (*n* = 7) had left the Center: 1 to medical respite, 4 to permanent supportive housing, and 2 to unsheltered homelessness ("tent," "tent city"). Among the 4 who were housed, there were mixed reviews. While 2 participants reported being "happy and relieved" and that housing "would make a big difference in [their] life," the 2 others felt "uncomfortable" and "were still processing things," trying to get their bearings in housing. Despite some doubts, the 4 participants with housing at 120 days felt that their future housing outlook would be "better than it is right now," reflecting hope about the future.

Surveying the full sample to understand potential barriers to attaining and maintaining housing, participants' concerns were myriad. They included, for example, a need to coordinate with others to attain housing (e.g., "My CM was too busy before"); struggling with "myself. [It's] hard to stay focused [when having] emotional issues…"; trying to manage and accommodate pets, people and possessions in a new living situation; and having a criminal record. Reflecting on support that people felt they would need in housing, participants commonly suggested financial support, vocational rehabilitation, mental health counseling, substance use treatment, and case

management. A key point made by members of the EAB was that time-limited supportive models, such as rapid rehousing, are not sustainable over the longer-term. Instead, continuous case management and financial support is needed in the form of either a) ongoing case management and rent assistance in independent housing or b) permanent, supportive housing.

DISCUSSION

The present evaluation served to document guests' self-reported physical and mental health status, substance use and related harm, and quality of life during their stay at the Center. At the final, 120-day assessment, overall satisfaction with the Center and perspectives on housing were documented as well.

Connection with Housing

Findings from this evaluation echoed those of the Part 1 analysis, such that connection to housing was a priority. Participants consistently rated the importance of housing highly, and also rated connection to housing as the most effective of the Center's amenities and services. That said, at the 120-day assessment, only 4 of the 29 participants we were able to interview had moved into housing, and none of those move-ins had occurred by the originally intended 60-day lenth-of-stay limit at the Center. Fortunately, the current extension policy has enabled guests to stay at the Center until they are housed: 22 people were continuing their stay at the Center when they completed their 120-day assessment for this evaluation. The City's report, which will be released shortly, will provide more comprehensive and longer-term data on the Center's success in connecting guests to housing versus returning to homelessness. However, to date, no individuals have been returned to homelessness due to length of stay (Personal communication, C. Schrag, August 21, 2018).

Connection with Other Services

Satisfaction ratings and utilization of other Center services, including mental health, substance-use and medical services, landed on the midpoint of the one-to-ten satisfaction and effectiveness scale. It should be noted, however, that these onsite services were slowly ramping up over the course of the evaluation period. Thus, ratings of this first wave of residents may not be indicative of current practices that are now more firmly in place. Nonetheless, the results from part 1 of this evaluation have been and may continue to be used to guide future efforts to improve services. Ongoing evaluation is recommended to monitor changes in outcomes as the Center's amenities, staffing and services are modified over time.

Safer Substance Use

For people who are not yet ready, willing or able to stop using substances, employing safer-use strategies, such as carrying naloxone and using clean injection equipment (i.e., cookers, syringes, cottons), are key to reducing risk of overdose, bloodborne illness transmission and other medical sequelae both for the affected individual and the larger community.[10-14] In the current evaluation, we noted strong evidence that safer substance use was increasingly embraced by staff and guests. Key to the effectiveness of these strategies is high coverage of and access to comprehensive harm-reduction interventions,[14] including medication assisted treatment, clean injection equipment, and naloxone.

Fortunately, the Center has incorporated some of these strategies to increase safer use and decrease individual- and community-level harm. Center management reported that they are exchanging between 1,500 and 2,000 syringes a week, which removes these biohazards from circulation and thereby reduces risk of bloodborne illness and inadvertent injury for substance users and the larger community.

In our evaluation, the Center's implementation of safer-use strategies has been noted by guests and incorporated into their use patterns. For example, participants reported strong staff support for safer use at the Center as well as significant self-reported increases in access to naloxone as well as use and distribution of clean equipment. Additionally, participants reported decreased substance use over the course of the evaluation, showing a 23% reduction in prevalence of alcohol and other drug use for each passing month at the Center. This finding corresponds to those of our prior studies that have shown the provision of shelter and housing within a harm-reduction framework is associated with reduced substance use and other positive outcomes.[15,16] These collective findings allay concerns that a harm-reduction approach would constitute "enabling behavior" on the part of providers that could increase substance use and substance-related harm.[17,18] In fact, the opposite appears true: Low-barrier shelter and service provision that includes safer-use strategies appears to promote both safer use, which reduces risks to the substance user and the larger community, and less use overall.

Physical Health, Mental Health and Quality-of-Life Outcomes

Participants reported a statistically significant albeit relatively small improvement in their general physical health. This finding suggests that low-barrier shelter has the potential to support perceived general health within a short amount of time.

On the other hand, we observed no significant changes over time on other physical and mental health outcomes. One potential explanation for the lack of statistically significant findings is that the relative brevity of the 120-day evaluation period may not be adequate to engender and register these changes. Further, the achievement of positive and sustained changes in physical and mental health in this population likely also requires consistently meeting many other basic needs, including food security, permanent housing, and adequate medical and mental health services.

Perspectives on Housing

Understandably, participants were highly focused on housing as a key next-step after their stay at the Center. Many participants looked forward to attaining housing, noting that it would "be better than being out on the street." However, most participants were wary, knowing that housing is the first step, but also acknowledging they would need ongoing support to continue on a positive trajectory once housing was attained (e.g., financial support, rent assistance, case management, caregiving, and services addressing medical, psychiatric and substance use problems). Fortunately, participants were able to elucidate potential barriers and maintain hope that, with some support, they could successfully move from the streets into housing and thereby move along their own, self-defined pathway to recovery.

Limitations

Limitations of this evaluation deserve mention. First, this evaluation relied on self-report data, which are known to be subject to reporting bias. However, this concern can be mitigated when timeframes are relatively short, the target behavior is not stigmatized, and negative consequences are not tied to disclosure.[19-22] Our evaluation design meets these criteria.

Second, the evaluation comprised data on participants' experiences during the first 120 days of their stay at the Center. This brevity may, in part, explain the nonsignificant findings for longitudinal changes on some outcomes. Chronic and severe health-related problems associated with homelessness and substance use disorder often require more time to resolve, even after crucial interventions, such as shelter and case management, are applied. However, this window on people's trajectories after moving into the Center also highlighted its potential as a setting in which people could use substances more safely and even attain abstinence from alcohol and other drugs.

Final Recommendations

Based on the findings highlighted in this report and discussions with the EAB, we recommend the following next-steps for the Center:

- **Community members' and guests' voices** should be centered in future Center evaluation, quality improvement, and decision-making. We have found monthly advisory board meetings comprising Center guests, staff and management to be helpful in ensuring different perspectives are integrated.
- **Onsite services could be expanded** (e.g., onsite medical services) and enhanced to better meet guests' medical, mental health, and substance-use treatment needs and thereby better position them to attain and maintain housing following their stays at the Center.
- Consistent and highly supportive **case management is needed to help people successfully transition into and maintain housing** over the longer term after their stay at the Center.
- The 2 reports we have generated this year represent early and short-term findings that have already informed day-to-day Center operations. However, **ongoing evaluation of the Center is necessary** to account for changing parameters both internal and external to the Center and ensure its services, staffing and amenities are responsive to guests' and the larger community's needs. We would recommend a 2-year study that assesses guests' longitudinal outcomes for a) self-reported perspectives on the Center and its impact on their health and well-being, b) housing attainment and maintenance following Center stays, and c) publicly funded service utilization (emergency healthcare, jail).

Conclusions and Future Directions

Despite its limitations, this report provides important information about guests' self-reported physical and mental health status, substance use and related harm, and quality of life during their stay as well as their overall satisfaction with the Center and perspectives on housing next-steps. These data may provide policy-makers and program management with points to consider in striving to meet the Center's stated goals (e.g., securing permanent housing for guests) as well as in program improvement and future replication. Subsequent quantitative evaluations from the City will respond to outstanding questions about the Center's effectiveness in helping guests attain and maintain permanent housing after their stay at the Center. Additional recommendations include continuing to involve guest voices in Center activities, expanding onsite services, ensuring continuity of case management after transitions to housing, and continuing evaluations of the Center on multiple indices. Perhaps most important, this 2-part UW HaRRT Center evaluation has shown that listening

to guests and staff about how to address the needs of this population is key. As one guest noted, “The system needs to keep listening to the people that are experiencing homelessness.” The answers are here. It’s just a matter of listening.

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NOTES

- Appendices available upon request, including consent forms, measures, and analysis output.
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