Evaluation of Permanent Supportive Housing Programs in Whatcom County

August 2025

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Executive Summary

PURPOSE

This evaluation aimed to assess the effectiveness, efficiency, and impact of existing Permanent Supportive Housing (PSH) programs in Whatcom County. It included a comparison of program effectiveness, safety standards, policies and procedures, and mortality rates. The evaluation aimed to identify areas of improvement and needed resources and partnerships to strengthen local PSH efforts.

KEY FINDINGS

Strong commitment to PSH best practices

Most programs demonstrate a clear commitment to housing stability, tenant autonomy, and voluntary services and scored above the fidelity threshold, indicating alignment with national best practices for PSH. PSH programs in Whatcom County are successfully housing individuals with long histories of homelessness and co-occurring disabilities.

Variation in program models and tenant needs

Whatcom's PSH landscape includes a mix of shared housing, single-site models, and scattered-site programs. This diversity allows programs to serve distinct sub populations. However, variation in eligibility criteria and referral practices across programs has led to a concentration of tenants with high support needs in certain programs.

Behavioral health support and safety remain challenging

Many programs reported challenges in preventing and responding to safety incidents. Staff frequently highlighted the need for stronger connections to behavioral health services and dedicated crisis response supports.

Misconceptions remain

Misconceptions remain about what PSH is and who is served by PSH programs. Some community members expect PSH to function like transitional housing or to require treatment participation or sobriety, which can lead to unrealistic expectations and stigma. Program staff emphasized the need for clear communication around PSH principles and goals.

Limitations of available data

Differences in how local PSH programs are categorized within the Homeless Management Information System (HMIS) limit the ability to analyze data at the program level.

RECOMMENDATIONS

Strengthen safety and behavioral health supports

Enhance program support to prevent and respond to safety incidents and behavioral health crises. This includes exploring a PSH-specific mobile crisis response team, increasing 24/7 staffing, hiring on-site behavioral health staff at sites serving clients with higher acuity, and strengthening partnerships with external providers.

Support collaborative quality improvement

WCHCS should work in close partnership with PSH programs to strengthen data use, promote shared learning, and support continuous quality improvement. This includes reviewing safety-related data on a quarterly basis with program staff to identify trends, challenges, and areas where additional support is needed.

Streamline data reporting

Refine WCHCS quarterly reporting in collaboration with PSH programs to reduce burden and focus on meaningful indicators. Explore adding indicators that reflect tenant experiences.

Improve understanding about PSH and cross- system communication

Address community-level misconceptions about PSH by developing and promoting accessible materials and orienting service providers from intersecting systems.

Introduction

PURPOSE OF THIS REPORT

This report presents the findings of an evaluation of Permanent Supportive Housing (PSH) programs in Whatcom County, Washington. The evaluation was commissioned by Whatcom County Health and Community Services (WCHCS).

The contract outlined that this evaluation was a response to community feedback requesting an assessment of local PSH programs. The goal of the assessment was to understand and improve Whatcom County's PSH system. The assessment aimed to:

- Evaluate the effectiveness, efficiency, and impact of existing PSH programs including a comparison of local program effectiveness, safety standards, policies/procedures, and mortality rates, with those across Washington State and the United States.
- Identify areas for improvement
- Ensure alignment with best practices in the field
- Identify additional resources and outside partnerships that may be necessary to assure success of the programs, maintain current workforce, and improve tenant stability

WHAT IS PERMANENT SUPPORTIVE HOUSING (PSH)?

Permanent Supportive Housing (PSH) is a housing model that combines affordable, long-term housing with voluntary supportive services to help individuals and families with complex needs gain housing stability. PSH is designed for

people who have experienced chronic homelessness and have disabling physical and mental health conditions who may not realistically be successful in other housing models.

In Washington State, PSH is defined in RCW 36.70A.030 as "*subsidized, leased housing with no limit on the length of stay. It prioritizes people who need comprehensive support services to retain tenancy. PSH uses admissions practices designed to lower barriers to entry that are typical in other rental housing, such as rental history, criminal history, and behavior. PSH is paired with voluntary on- or off-site supportive services. Individuals must have a disabling condition or a household member with such a condition, have income at or below 30% AMI, have experienced homelessness or been at risk of homelessness, be offered voluntary tenancy-supporting services, and pay no more than 30% of their income toward rent.*"

Unlike treatment-based or time-limited housing programs, The PSH model was originally based on the Housing First philosophy. This model emphasizes immediate access to housing without requiring sobriety, treatment compliance, or participation in services as a precondition. The Housing First philosophy recognizes that stable housing is foundational to recovery, health, and community integration. This approach contrasts with "treatment-first" models, which often require clinical or behavioral stability before offering housing- leaving many individuals with complex conditions without access.

PSH is also permanent by design. There is no time limit on how long a person can remain in the program, and tenants sign standard leases with the full legal rights of tenancy under Washington State law. While some tenants may eventually transition to other forms of housing, others will remain in PSH for many years or for the rest of their lives. Long-term tenancy is not a sign of failure in PSH, housing stability itself is considered a core measure of success.

PSH has demonstrated success in increasing housing retention, reducing the use of emergency services, and improving health and social outcomes.

PSH'S ROLE IN THE LOCAL HOUSING CONTINUUM

Permanent Supportive Housing fills a critical gap in the housing continuum for individuals and families with the highest support needs- people who are often left out of other housing options due to behavioral health challenges, past rental or criminal histories, or other barriers. In Whatcom County, PSH is the only long-term housing models specifically designed to serve people with disabling conditions who have experienced chronic homelessness.

While other housing models will work for some individuals to transition out of homelessness, they often include eligibility restrictions or offer time limited supports that make them unsuitable or unavailable for those with persistent behavioral health needs or long histories of housing instability. PSH provides a long-term solution tailored to this population, reducing the risk of repeated homelessness and allowing individuals to stabilize at their own pace.

Overview of PSH Programs

ORGANIZATIONS AND PROGRAMS INCLUDED IN THIS EVALUATION

This evaluation focuses on seven organizations that operate PSH programs in Whatcom County (see Table 1). These seven organizations were identified by WCHCS for inclusion in this evaluation. Over the course of the evaluation, we found that some units within these programs are classified as Housing with Services (HwS), rather than Permanent

Supportive Housing (PSH), in the Homeless Management Information System (HMIS). For the purposes of this report, when we refer to PSH, we are referencing the programs listed in Table 1 below. Please see the *Limitations* section and *Population being served by PSH programs* for additional information about how programs are classified in HMIS.

Each organization runs one or more programs, and there is variation in size and the sub population they serve.

Table 1: Organizations providing PSH programs in Whatcom County

Organization	Program	# of Units	Description	Contracted with WCHCS
Opportunity Council	Dorothy Place	22	A site-based program serving chronically homeless individuals with disabilities, with a focus on clients who have experienced domestic violence.	No
	22 North	40	A site-based program serving chronically homeless individuals with disabilities, including dedicated units for young adults (ages 18–24) and Veterans.	Yes
	Community Leasing	61	A scattered-site program serving chronically homeless individuals with disabilities, with units community- leased through community landlords.	Yes
Lydia Place	Heart House	11	A site-based program serving families with children; 1–2-bedroom units in a secured apartment building with on-site childcare facility.	Yes
	Baker Place	7	A site-based program serving families with children; 1-bedroom units in apartment building.	No
	A Place for Dads	1	A scattered site program with one single family home, serving families with children.	No
YWCA	Garden St PSH	6	A site-based program; 1- and 2-bedroom apartments for single female-identifying individuals or those with children.	Yes
	Forest St PSH	27	A site-based program with single-room occupancy units on the upper floors of the historic YWCA building, serving single female-identifying individuals.	Yes
Lake Whatcom Center	Lake Whatcom Center PSH	212	A site-based program serving adults experiencing chronic homelessness and with severe mental illness; private bedrooms in shared units.	Yes

	Community Leasing	55	A scattered site program serving adults with severe mental illness; multi-family apartments.	Yes
Pioneer Human Services	City Gate	37	A site-based program primarily serving justice-involved individuals, including those exiting jail, or participating in Mental Health Court and who have a behavioral health disability. Also serving veterans experiencing chronic homelessness.	Yes
	Community Leasing	3	A scattered site program where City Gate provides case management only.	No
Catholic Community Services	Francis Place	42*	A site-based program serving individuals who experience chronic homelessness; individual apartments.	Yes
Sun Community Service	Nevada Street	3	A site-based program serving individuals who experience chronic homelessness and have a disability. Tenants rent individual bedrooms within a shared house.	No
	Greggie's House	7	A site-based program serving individuals who experience chronic homelessness and have a disability. Tenants rent individual bedrooms within two adjoining townhouse- style houses.	No

*This number is no longer current. Not all 42 units are for PSH anymore.

These programs represent a mix of single-site buildings- where most or all units are dedicated to PSH- and scattered-site models- in which organizations lease or sublease units throughout the community. Some programs offer private apartments, while others have shared living arrangements with communal kitchens and/or bathrooms.

Note:

- Two organizations originally listed in the evaluation contract-Lummi Housing Authority and Mercy Housing- were not included in the final evaluation. Multiple attempts were made to reach Lummi Housing Authority staff, but no response was received. Mercy Housing was excluded at the request of WCHCS because the program has developed away from the Permanent Supportive Housing model.

Evaluation Approach

METHODS

A high-level summary of methods is outlined below. More details on methods for each component of the evaluation are included in Appendix A.

This evaluation examined how Permanent Supportive Housing (PSH) programs in Whatcom County are operating, what is working well, and where there are opportunities for improvement. To ensure a participatory evaluation approach, conversations were held with local and state partners, including PSH program leads, to identify key priorities and questions. National and state best practices for PSH programs were also reviewed to shape the evaluation design, tools, and indicators.

Based on learnings from these initial conversations and best practice review, the evaluation was guided by the following questions:

- How closely do PSH programs in Whatcom County match the ideal of PSH?
- Do PSH programs in Whatcom County have the capacity to implement and sustain evidence-based PSH programs?
- To what extent are PSH programs meeting tenant and community needs when it comes to key topics including safety, referrals, under/over enforcing leases, and provision of assistance to maintain rental subsidies?
- Do the Whatcom County PSH programs, as implemented, follow the basic principles and elements of the PSH model?
- What are strengths and areas of opportunity in different PSH programs related to safety and best practices?
- In Whatcom County, how many people died in PSH programs from 2019-2024 and what was the cause of death?
- How does the mortality rate in PSH programs in Whatcom County compare to other counties and regions?
- Has PSH achieved the expected results in Whatcom County?

A variety of methods and data sources were used to conduct the evaluation:

Each PSH organization was reviewed using the PSH Fidelity Scale, a tool that assesses how closely programs align with the core principles of supportive housing, such as offering choice, separation of housing and services, affordable housing, housing integration, and voluntary services. Additional elements not captured on the fidelity scale, such as approaches to lease enforcement, behavioral health support, and tenant safety, were also assessed.

Organizations provided documents such as lease agreements, safety procedures, staffing structures, and service plans. These materials helped build a clearer picture of how each program operates and informed follow-up questions during interviews.

Interviews and focus groups were conducted with 37 individuals, including tenants (7), staff (7), program leads (11), housing experts (4), and community stakeholders (8).

Data from organizations was analyzed to explore tenant outcomes. This included information on housing stability, program exits, service use, and mortality. Outcome data was drawn from a combination of sources:

- Program self-reported data
    - Number and demographic characteristics of tenants
    - Tenant deaths
- Homeless Management Information System (HMIS)
    - Mortality analysis- includes programs classified as PSH
    - Summary demographic statistics and outcomes- includes programs classified as PSH and HwS (Housing with Services)

- WCHCS quarterly reports

LIMITATIONS

This evaluation had several limitations. Programs varied in how they track and report information. As a result, it was not always possible to compare outcomes across organizations. There were also limitations related to the WCHCS quarterly reports used in this evaluation. Data was incomplete or missing for some programs and reporting periods, and some variables were inconsistently defined or interpreted across organizations. In addition, certain measures collected do not fully reflect key aspects of program operations, which limited the usefulness and comparability of the data. (see *Approaches to PSH monitoring and quality improvement* for more details).

We also faced some challenges accessing and analyzing data from HMIS. Data on mortality rates for all programs classified as PSH in HMIS in all Washington State counties was requested from the Washington State Department of Commerce. Data on program participant demographics, retention and positive exits was requested from WCHCS via Opportunity Council, who is contracted by WCHCS to manage Whatcom County's HMIS system. Two organizations (Lake Whatcom Center and Catholic Community Services) do not report data to HMIS. However, many households in their programs receive rent subsidies that are reported in HMIS, meaning that some tenant data is captured indirectly. As a result, data from these programs is only partially represented in the HMIS datasets. Among the organizations that do report to HMIS, we discovered that some of the programs included in this evaluation are not classified as "Permanent Supportive Housing (PSH)" but are instead classified as "Housing with Services (HwS)." As such, for our request to WCHCS, we requested data for all programs classified as either PSH or HwS. Finally, while we were able to explore patterns at a system level, we were unable to analyze HMIS data at an organization or program specific level, because local HMIS data is not categorized program-by-program.

Our initial data requests to individual organizations were also curtailed to align with HMIS data suppression standards. Additionally, we requested mortality data by organization rather than by program, which means multiple programs were grouped together in the analysis. As a result, if one program had a higher mortality rate than others within the same organization, those differences may not be visible in the aggregated results.

Lastly, while interviews and focus groups provided valuable insights, not all perspectives were represented, such as those of former tenants or community partners like law enforcement and other crisis response teams.

Despite these limitations, the findings offer a meaningful understanding of how PSH programs operate in Whatcom County and where there may be opportunities to strengthen them.

Evaluation Findings

POPULATION SERVED BY PSH PROGRAMS

Note: *Data in this section comes from the Homeless Management Information System (HMIS) and includes programs listed as either Permanent Supportive Housing (PSH) or Housing with Services (HwS). Specifically, the data presented here reflects information that is collected by organizations at the time a tenant enters a program and is based on the tenant's self-report. In HMIS, PSH programs require a verification of at least one disabling condition for entry at the household level, while HwS programs do not. In the 2019-2024 dataset we received, 50% of total tenants were*

classified as PSH and 50% were from HwS. When looking at just heads of households (excluding children and any other household members), 70% were classified as PSH and 30% as HwS.

Per the Washington State RCW 36.70A.030 definition of PSH programs, tenants "must have a disabling condition or a household member with such a condition, have income at or below 30% AMI, have experienced homelessness or been at risk of homelessness, be offered voluntary tenancy-supporting services, and pay no more than 30% of their income toward rent."

According to HMIS data, from 2019-2024, Whatcom County PSH and HwS programs served 1,298 individuals (unduplicated count), including 822 unique heads of household. Of the 822 unique heads of household:

- 88% were in a homeless, institutional, or temporary housing situation prior to program entry (see Table 2 for definitions of prior living situations used in HMIS).
    - Of those who were homeless, 76% were in a homeless situation for more than 12 months in the three years prior to program entry.
- 88% have some type of disabling condition. Disabling conditions are self-reported by clients and can include physical disability, chronic health condition, mental health disorder, substance use disorder, developmental disability, or HIV/AIDS.
- 46% are survivors of domestic violence. Of those, 38% were currently fleeing an abusive relationship at time of program entry.

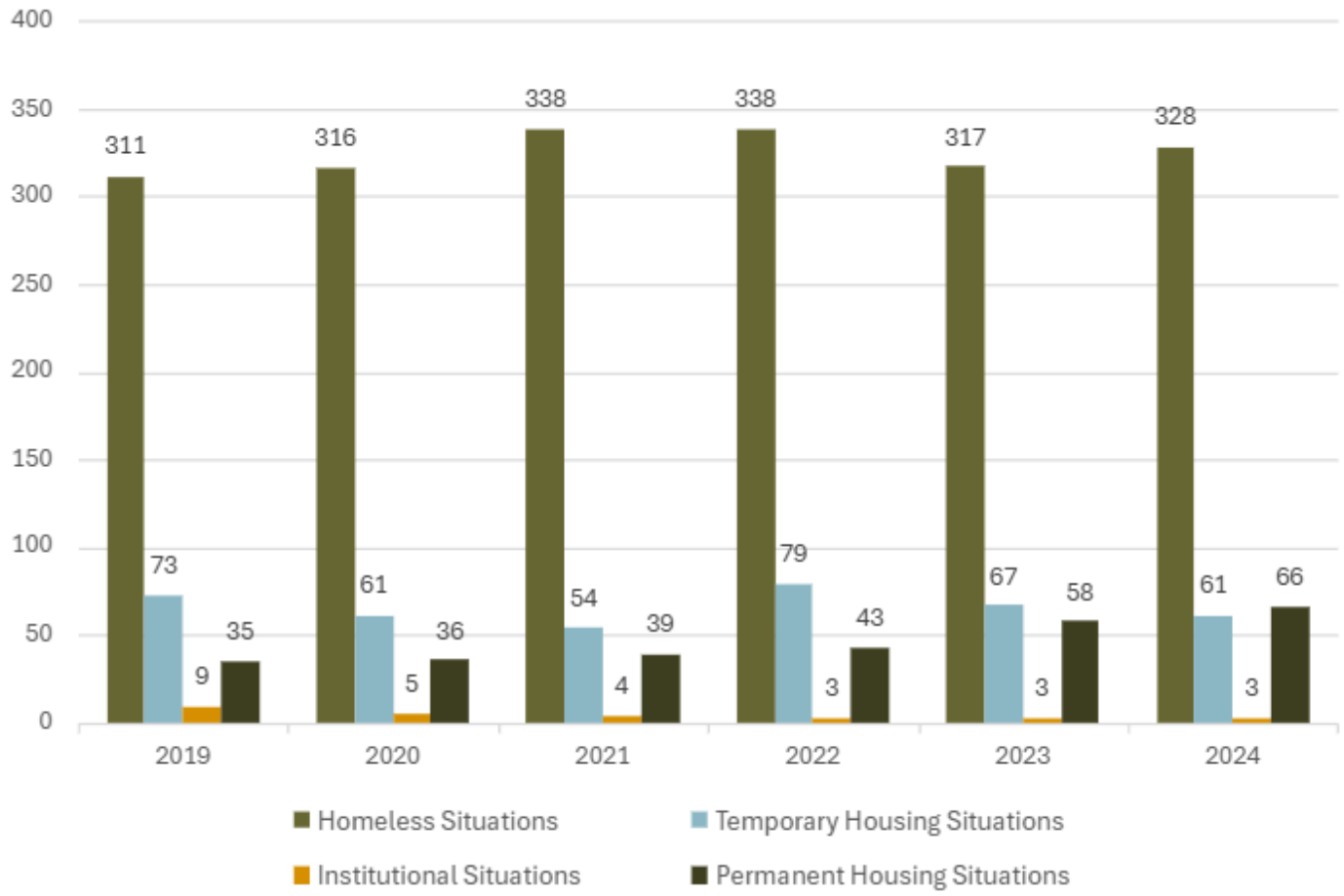
When looking in more detail at disabling conditions among the 822 heads of household:

- 83% have a mental health disorder. Of those, 94% expect it to be long-continued/indefinite and substantially impair their ability to live independently.
- 45% have a chronic health condition. Of those, 92% expect it to be long-continued/indefinite and substantially impair their ability to live independently.
- 43% have a physical disability. Of those, 92% expect it to be long-continued/indefinite and substantially impair their ability to live independently.
- 31% reported having some type of substance use disorder. Of those, 9% have alcohol use disorder only, 13.5% have drug use disorder only, and 8.5% have both alcohol and drug use disorder.
- 31% have a developmental disability.

These statistics highlight that the Whatcom County PSH programs are serving a highly vulnerable tenant population, many of whom have co-occurring disabling conditions. Of note, the vast majority (83%) have a mental health disorder, and a much smaller percentage (31%) have some type of substance use disorder. This reality contrasts with some community perceptions that PSH programs primarily serve tenants with substance use disorders.

The figures and tables below show trends over the six-year evaluation period from 2019-2024. The proportion of heads of household from each type of prior living situation has remained relatively consistent from 2019-2024 (Figure 1). The majority were in a homeless situation (see Table 2 for definitions of prior living situations used in HMIS). Of those heads of household who reported coming from a homeless situation, the majority were homeless for more than 12 months in the past three years (Figure 2).

Figure 1: PSH/HwS Heads of Households Prior Living Situation (Source: HMIS)



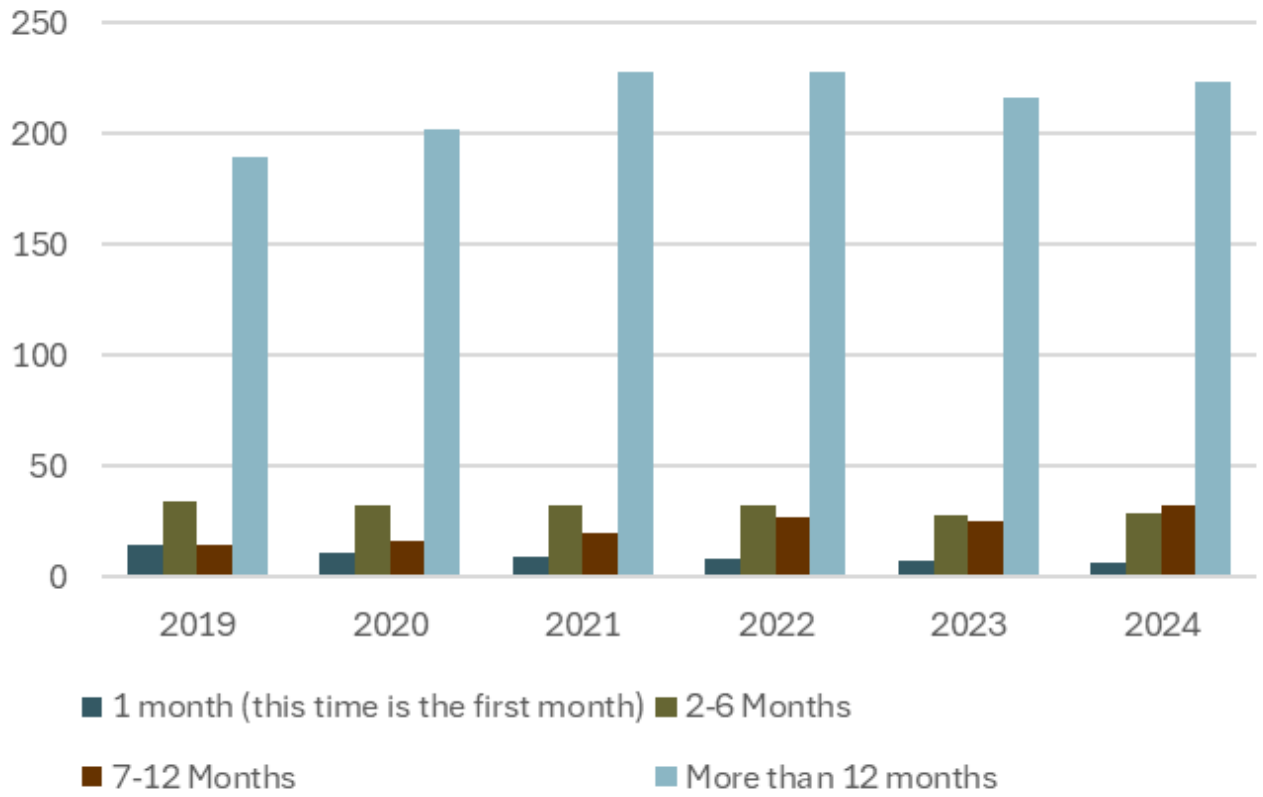
Note: Responses not included if marked as "client doesn't know", "client prefers not to answer", or "data not collected". This figure includes data from programs classified in HMIS as PSH or HwS (Housing with Services).

Table 2: Definitions of Prior Living Situations used in the Homeless Management Information System (HMIS)

Prior Living Situation	Definition from HMIS Data Dictionary 2024
Homeless Situations	• Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) • Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter • Safe Haven
Temporary Housing Situations	• Transitional housing for homeless persons(including homeless youth) • Residential project or halfway house with no homeless criteria • Hotel or motel paid for without emergency shelter voucher • Host Home (non-crisis) • Staying or living in a friend's room, apartment, or house

	• Staying or living in a family member's room, apartment, or house
Institutional Situations	• Foster care home or foster care group home • Hospital or other residential non-psychiatric medical facility • Jail, prison, or juvenile detention facility • Long-term care facility or nursing home • Psychiatric hospital or other psychiatric facility • Substance abuse treatment facility or detox center
Permanent Housing Situations	• Rental by client, no ongoing housing subsidy • Rental by client, with ongoing housing subsidy • Owned by client, with ongoing housing subsidy • Owned by client, no ongoing housing subsidy

Figure 2: Heads of Household's Total Number of Months in a Homeless Situation in the Past Three Years (for Individuals who Indicated a Homeless Situation as their Prior Living Situation) [Source: HMIS]



Note: Responses not included if marked as "client doesn't know", "client prefers not to answer", or "data not collected." This figure includes data from programs classified in HMIS as PSH or HwS (Housing with Services).

The percentage of PSH/HwS heads of household with different disabling conditions (Table 3) highlights the complex challenges faced by tenants and the highly vulnerable population served by these programs. Of note, mental health disorders were the most common disabling condition among this group throughout the evaluation period, remaining

around 84% from 2019-2024. Additionally, the percentage of heads of households with any type of substance use disorder (alcohol use only, drug use only, or both) has remained around 30% from 2019-2024. The percentage of PSH/HwS heads of household with each specific type of substance use disorder (alcohol use only, drug use only, or both) has also remained relatively consistent during the evaluation period (Table 4).

Table 3: Percentage of PSH/HwS Heads of Household with a Self-Reported Disabling Condition, by Type (Source: HMIS)

Type of Disabling Condition	2019	2020	2021	2022	2023	2024
Mental Health Disorder	85%	86%	84%	83%	84%	84%
Physical Disability	37%	42%	42%	42%	42%	42%
Chronic Health Condition	39%	41%	43%	44%	43%	44%
Developmental Disability	28%	32%	30%	30%	30%	32%
Substance Use Disorder (includes alcohol use only, drug use only, or both alcohol and drug use)	32%	30%	29%	28%	29%	31%

Note: Responses not included if marked as "client doesn't know", "client prefers not to answer", or "data not collected." This table includes data from programs classified in HMIS as PSH or HwS (Housing with Services).

Table 4: Percentage of PSH/HwS Heads of Household with Substance Use Disorder, by Type (Alcohol Use Only, Drug Use Only, or Both) [Source: HMIS]

Type of Substance Use Disorder	2019	2020	2021	2022	2023	2024
Alcohol use disorder only	11%	10%	11%	9%	10%	9%
Drug use disorder only	13%	11%	11%	11%	12%	14%
Both alcohol and drug use disorders	8%	9%	7%	7%	7%	8%

Note: Responses not included if marked as "client doesn't know", "client prefers not to answer", or "data not collected." This table includes data from programs classified in HMIS as PSH or HwS (Housing with Services).

PROGRAM TYPES AND ELIGIBILITY

Site-based vs. Scattered site programs: Some programs operate apartment-style housing while others provide shared housing arrangements with more structured rules and expectations. Shared units require careful roommate matching and clear communication of expectations, as interpersonal dynamics and behavioral health conditions can contribute to safety challenges or tenant dissatisfaction. Staff from multiple programs emphasized that compatibility in shared living situations is essential but not always easy to achieve.

Scattered-site programs are typically reserved for tenants who have already demonstrated housing stability in more structured settings and are ready for greater independence. One program lead described it as a 'lighter touch' option for those who won't require intensive onsite support.

Program entry and participation requirements vary. Some programs have the lowest barriers to eligibility, where tenants are referred exclusively through Whatcom County's Coordinated Entry system- a centralized process

managed by Opportunity Council for assessing and matching homeless individuals to housing resources. If tenants meet the referral requirements and are selected through the prioritization process, program admittance is contingent only on a signed lease that requires them to adhere to its terms (including a guest policy and other behavioral expectations for common areas). These programs often serve individuals with the highest acuity who may have been screened out or exited from other programs.

Other programs use a different referral mechanism, such as referring directly from their emergency housing programs, or have additional expectations or requirements around case management participation, engagement with behavioral health services, or adherence to sobriety policies which tenants must agree to prior to joining the program. These programs serve a unique sub-set of the homeless population in Whatcom County. Finally, some programs described intentionally specializing in serving a specific sub-population of the homeless population, including families, survivors of domestic violence, or individuals with histories of justice involvement, severe behavioral health conditions, and co-occurring substance use disorders.

Approaches to case management: While several programs include policies stating that tenants must engage in case management, interviews revealed that this is often implemented with flexibility. Participation is encouraged and regularly offered, but most programs do not enforce this as a condition for continued tenancy. Staff also shared that they use creative strategies to engage or re-engage with tenants who show less interest in engaging with services. One staff person shared their approach to a tenant who is not engaging with case management would be: *"Many knocks on their door, many phone calls, welfare check, emergency contacts etc. – usually at some point we can get connected to them and restart engagement."*

The variation in eligibility and program participation requirements allows programs to tailor their support to specific sub-populations and contributes towards providing choices for potential participants. Some tenants thrive in environments with structure, sobriety expectations, or shared living arrangements, while others benefit from greater flexibility and will refuse housing opportunities that require sacrificing too much of their independence. Having multiple models helps ensure that different needs and preferences can be met. At the same time, variation in eligibility criteria may lead to gaps in access. Some individuals may not qualify for higher-barrier programs, while others may be placed in settings that don't fully align with their needs. People with the most complex needs are often concentrated in just one or two of the lowest-barrier programs, potentially placing greater strain on those sites.

PSH BEST PRACTICES

WHAT ARE PSH BEST PRACTICES?

Permanent Supportive Housing best practices are built on a few core principles: low-barrier access to housing, choice in housing and services, separation of housing and case management, and long-term, flexible, voluntary supports that promote housing stability and autonomy. Per the Washington State Department of Commerce definition, PSH programs are supposed to provide "non-time-limited housing for persons with disabling conditions who have experienced homelessness or risk of homelessness and are offered voluntary supportive services aimed at assisting the client in maintaining the terms of their lease agreement."

One of the key tools used in this evaluation was the PSH Fidelity Scale (see Table 5 for Fidelity Scale Scores by program). The PSH Fidelity Scale itself is an evidence-based evaluation tool developed by the U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (SAMSHA). It measures how closely a program aligns with the key principles of Permanent Supportive Housing (PSH), organized into seven core dimensions:

1. Choice of housing
2. Functional separation of housing and services
3. Decent, safe, and affordable housing
4. Integration of housing with the community
5. Rights of tenancy
6. Low-barrier access to housing
7. Flexible, voluntary services

The scale uses a scoring approach that assigns a value to each indicator within the seven core dimensions, with scores averaged to create dimension-level scores and then summed to calculate an overall score. The maximum score is 28, and scores 18 and above are considered "aligned" with the PSH model, while scores below are considered less aligned. SAMSHA highlights that the fidelity scale outlines an ideal model for PSH programs which is hard to replicate in a real-world environment. Scores are intended to support programs with continuous quality improvement. While fidelity scores provide a helpful benchmark, they do not provide a complete picture. Programs can, for example, score above the threshold while still employing practices that diverge from the core PSH model. For instance, some programs apart of this evaluation scored above the threshold despite having requirements for sobriety or case management participation.

Several elements central to daily operations and tenant safety, and core to alignment with PSH best practices, fall outside of what the fidelity scale measures. We added several elements to this program assessment based on feedback from WCHCS staff, initial key informant conversations, and best practices from the WA State Department of Commerce. These include:

- Approaches to eligibility, referrals and screening of prospective tenants
- Access to behavioral health services on site and in the community
- Approaches to substance use on site (e.g., harm reduction practices, lease enforcement responses)
- Approaches to lease enforcement and program exits (e.g., thresholds, steps before eviction, use of behavioral contracts)
- Drug testing protocols (frequency, rationale, substances tested for)
- Responses to methamphetamine contamination and property damage

These distinctions highlight that fidelity scores are a useful tool, but not a comprehensive measure of alignment with best practices. Looking at fidelity scale scores in combination with these additional factors can give a more complete picture of each organization's alignment with PSH best practices.

HOW WHATCOM PROGRAMS ALIGN WITH BEST PRACTICES

A snapshot of program-specific findings, including each program's fidelity scale score along with other key program attributes, is summarized in Table 5 below.

Table 5: Program review findings for key PSH components, by organization

Organization	Programs	# of Units	Scattered or Site-based	Fidelity Scale Score*	All tenants have a lease	At least one staff person on site 24/7	At least one behavioral health provider on staff
Opportunity Council	Dorothy Place	22	Site-based	24	Yes	Yes	No
	22 North	40	Site-based	24	Yes	Yes	No
	Community Leasing	61	Scattered	**	Yes	No	No
Lydia Place	Heart House	11	Site-based	22	Yes	No	Yes
	Baker Place	7	Site-based	22	Yes	No	Yes
	A Place for Dads	1	Scattered	**	Yes	No	Yes
YWCA	Garden St PSH	6	Site-based	23	Yes	No	No
	Forest St PSH	27	Site-based	23	Yes	No	No
Lake Whatcom Center	Lake Whatcom Center PSH	212	Site-based	20	Yes	No	Yes
	Community Leasing	55	Scattered	**	Yes	No	Yes
Pioneer Human Services	City Gate	37	Site-based	19	Yes	No	Yes
	Community Leasing	3	Scattered	**	Yes	No	Yes
Catholic Community Services	Francis Place	42	Site-based	21	Yes	Yes	No
Sun Community Services	Nevada St	3	Site-based	13	No	No	No
	Greggie's House	7	Site-based	13	No	No	No

*A score of ≥18 indicates alignment with PSH core components.

** Fidelity scale scores were not calculated for community leasing, as most of the interviews focused on site-based programs.

Six of the seven organizations scored above the Fidelity Scale threshold of 18, indicating overall alignment with the core PSH principles. One smaller organization, Sun Community Services, scored below the threshold. Notably, this program was the only one that does not offer tenants a formal lease- instead, tenants sign an occupancy agreement. Other factors that contributed to the lower score for Sun Community Services included limited housing choice, more restrictive eligibility requirements, and no functional separation between property management and service provision. Some areas where several programs were not aligned with best practices included the concentration of PSH units within single buildings (rather than scattered-site housing) and not having staff available 24/7. The SAMHSA model emphasizes avoiding the clustering of people with disabilities and prioritizes housing that is typical of the broader community.

In addition to the fidelity scores, interviews with tenants, staff, and subject matter experts provided rich insight into how Whatcom County PSH programs align with or diverge from core PSH principles in practice. The following section highlights key strengths and challenges that emerged from qualitative data, illustrating how PSH best practices are interpreted and implemented across diverse program settings.

Successes and Strengths

Programs across Whatcom County share a strong commitment to tenant autonomy and to meeting individuals where they are at, an evidence-based practice reflected in SAMHSA's core PSH principles. They serve tenants with complex needs, including co-occurring mental health and substance use disorders, and histories of trauma.

Tenants described feeling respected by staff, supported in setting their own goals, and proud of their housing. As one tenant shared, *"This is a real deal apartment…I'm very proud of my apartment…this is a big deal."* Another reflected on how program flexibility helped them regain control over their routine: *"They let me change the schedule. I like to plan my week out. It gives me the opportunity to restructure my life and do things I like."* Tenants also spoke about how PSH programs have helped them reclaim normalcy. The daily stability and sense of control were echoed by others who emphasized that having a safe and reliable home has been foundational to their healing journeys.

Staff and subject matter experts agreed that maintaining a diverse set of PSH models supports the needs of different tenant populations and is essential to the overall effectiveness of the PSH system in addressing homelessness at the community level. There is no one-size-fits-all PSH model. Different program types serve different subpopulations, and variety in housing options, service intensity, and expectations is essential for tenant stability and choice. Some tenants benefit from low barrier, harm reduction approaches, while others thrive in environments with more structure and sobriety expectations. Maintaining a diverse portfolio of PSH programs- including both high-barrier and low-barrier options- is critical to ensuring broad accessibility and tenant success.

Tenant experiences shared in interviews further highlighted these successes. Tenants reported feeling respected and welcomed by staff, appreciating the flexible, individualized approaches that allowed them to define their own structure and healing process. As one tenant described, *"When you come in here, not only is it peaceful and warm… Staff tells me every time I come in: 'Welcome home.' It's the most comforting thing to hear."* Another tenant described the transition from homelessness to stable housing as both a relief and a challenge, with staff support seen as essential in navigating this shift:

> *"It was overwhelming at first. When you come out of homelessness or DV, you are kind of afraid. It's a lot to take in. You go from surviving to having all of this help. I felt pressured. I came out of flight or fight mode. It*

took time to feel the support. It took time for me to come to terms that this is a place that tries to get you on your feet."

Staff emphasized their commitment to meeting tenants where they are, even when faced with complex behavioral health and substance use challenges. Many staff and tenants described relationships built on trust and flexibility. Program staff shared a strong focus on using trauma-informed approaches in working with tenants:

> "*Trauma informed care should be at the heart of everything that we do...being compassionate and empathetic about their situations. Harm reduction is very important. We work with people at different stages in their recovery journeys. Being willing to meet with them wherever they are in their journey, understanding that things are difficult but we're here to support them wherever they are. We really value clients' voice and choice, letting them take control of their housing and recovery journey. We're here to be in the passenger seat giving directions, but they are ultimately choosing where they want to go.*"

Several programs described strong supervision practices, such as weekly one-on-ones and reflective team meetings which staff viewed as essential for managing the emotional demands of PSH work. In some programs, staff noted robust internal collaboration, clear crisis protocols, and a culture of supporting each other through challenges. This collaborative approach was seen as vital to maintaining safety and promoting tenant stability.

Gaps/Opportunities

While program diversity offers flexibility, it complicates the development of systemwide policies and procedures. Differences in eligibility criteria, service expectations, and staffing models make it difficult to apply uniform guidance across the system. Maintaining safety and stability while upholding tenant choice is often complex- especially in the absence of consistent external support such as behavioral health, around-the-clock crisis response, and coordinated law enforcement involvement (see also Program Safety). Most programs operate in dedicated buildings rather than scattered-site units, which may limit integration with the broader community and increase stigma. These programs also result in a high concentration of individuals with history of trauma, as well as behavioral health and substance use disorders in the same location.

Some programs raised concerns that current referral processes to PSH may inadvertently leave out individuals who are not already connected to Coordinated Entry or formal case management pathways, or those whose needs do not fit the housing and staffing capacity of available units. For example, one program lead noted gaps in Coordinated Entry for Indigenous families who are not prioritized by the existing assessment tools despite high vulnerability. Another program reported being pushed to accept families larger than could comfortably fit in available units, while staff also noted challenges in serving non-urban communities who face additional access barriers. Several programs felt that Coordinated Entry was helpful but not always a perfect fit; some have developed their own intake processes or request letters from providers to ensure better alignment between tenant needs and program resources. One program shared that they had stopped using Coordinated Entry except when required for specific funding streams. Staff also raised concerns that the vulnerability scoring tool used by Coordinated Entry- the SPDAT- may lead to faster housing placement for individuals with serious mental illness but can also result in faster evictions if program resources and supports do not match tenant acuity.

Councilmembers and subject matter experts (SMEs) highlighted the need for stronger public understanding and clear communication about PSH. Some expressed concern that negative community feedback- often driven by media

coverage of incidents-could impact public support for PSH funding. One Councilmember described themselves as unfamiliar with PSH principles, noting that other policymakers may be similarly unaware. Another Councilmember expressed skepticism about the Housing First model, suggesting that mandatory sobriety or employment expectations might be more effective for some tenants.

Staff spoke about the emotional demands of their work, describing compassion fatigue and the cumulative toll of supporting tenants experiencing severe trauma and instability. Balancing harm reduction with lease enforcement- particularly around methamphetamine contamination and behavioral issues- remains an ongoing challenge for many programs.

Participants also described inconsistencies and gaps in external crisis response systems (see also Program Safety). Staff often felt these systems were not always equipped or available to meet tenants' needs- particularly for tenants with decompensating mental health or substance use challenges.

PROGRAM RESOURCES AND STAFFING

PSH programs in Whatcom County operate within varied resource environments. While some benefit from strong community partnerships and purpose-built facilities, others navigate persistent challenges in building maintenance, service access, and tenant support.

Building maintenance and methamphetamine contamination: Building upkeep and unit turnover are operational challenges, particularly when methamphetamine contamination is involved. Several programs described incidents requiring full unit decontamination, often exceeding $10,000 per unit. Approaches to methamphetamine use and contamination vary. Some programs issue lease violation notices after positive test results or above-threshold exposure levels. Others adopt more flexible approaches, allowing tenants to wash their walls or clean their units themselves as a way to avoid eviction and support harm reduction. These differences reflect ongoing tensions between protecting housing assets, keeping staff and tenants safe, adopting trauma-informed, tenant-centered approaches and a lack of medical research to assess risk of harm caused by various contamination levels.

Programs also noted challenges in addressing hoarding and behavioral incidents, which may require extended repairs and delay re-tenanting.

In some cases, stable rental funding sources such as federally funded Shelter Plus Care vouchers were lost or limited, forcing providers to rely on temporary subsidies to prevent operating at a deficit. This not only adds administrative and financial burden, but also leaves units empty longer than necessary.

Referrals and access to external services: Strengthening access to behavioral health services- both within PSH programs and through external partnerships- was identified as a priority. Many new tenants already have established behavioral health or primary care providers when they join a PSH program. For those tenants who are not already connected to services, access to behavioral health and primary care remains a barrier. Wait times, especially for new referrals, can range from weeks to months, and programs noted that technology barriers, transportation challenges, and limited mobility can further limit tenants' ability to attend appointments or follow through with referrals without extra support.

Even when services are available, some tenants- particularly those who don't see their mental health or substance use as needing support- may decline to participate.

One staff person shared recent challenges with referrals:

> *"Substance use can be tricky. When we get to the place where we want an inpatient placement or that might be the solution to keep someone housed, there's often a wait to get into treatment places. That can be tough. Mental health has been super tough as of lately. I have clients who really want counseling services who might be on a list from 8-12 months. I recently went through that with someone who was on a list for 8 months, called the clinic who was on a list, and then was told they had to start all over to wait another 8 months."*

Engagement with External Crisis Response Teams: Programs frequently engage with outside crisis responders such as law enforcement (LE), mobile crisis outreach teams (MCOT), Designated Crisis Responders (DCRs), community paramedics, Adult Protective Services (APS), and staff at the local crisis triage center. While some programs report positive relationships with individual officers or crisis teams, others described inconsistent and delayed responses. Staff noted that police response times could stretch to several hours and that not all officers are familiar with or sensitive to the PSH population. The elimination of a dedicated mental health liaison officer within local law enforcement was described as a setback, with providers reporting that communication and coordination with law enforcement have declined since then.

Staff also raised concerns about the limitations of the current behavioral health crisis response infrastructure. MCOT is not available 24/7, and DCRs are often at capacity. Even when concerns are escalated or assessments were requested multiple times for the same tenant, some programs reported that DCRs assessed tenants as legally sound despite significant behavioral deterioration. These barriers are especially frustrating when staff feel that certain tenants need more support than their PSH program can provide, particularly when mental health symptoms, substance use, or a decline in activities of daily living (ADLs) jeopardize safety or housing stability. Additionally, staff acknowledged that calling law enforcement or the presence of law enforcement on site can be traumatizing for tenants.

Despite these challenges, several programs highlighted successful de-escalation and referral support from teams such as MCOT, Program for Assertive Community Treatment (PACT), and community paramedics. One organization emphasized that long-standing relationships with certain officers have made a positive difference in crisis management and collaboration. Others noted that building stronger partnerships with crisis response teams, behavioral health providers, and law enforcement would help ensure timely tenant support.

Community Partnerships: Staff and SMEs emphasized that strong external partnerships are essential to supporting tenant needs and ensuring that PSH programs don't become default providers for needs that should be met by a robust behavioral health system. They noted the importance of a well-developed behavioral health continuum, including residential treatment programs, crisis response, and other supports. They highlighted the need for both housing and behavioral health systems to offer a wide array of services and to maintain strong relationships with one another.

Unmet Needs: Participants emphasized that success in PSH requires active collaboration across systems- such as housing, healthcare, justice, and domestic violence response systems. Working in silos was identified as a persistent barrier that can leave tenants without the coordinated support they need.

Staff also highlighted gaps in resources that can limit their ability to fully support tenants, including access to legal services, transportation assistance, and follow-up support after tenants exit PSH. Some expressed concerns about what happens after tenants leave PSH-whether by choice or through program exit- and wished there were better systems in place to ensure continuity of care. They recognized that some tenants would benefit from additional stability and connection during this transition period. Some programs also expressed challenges with unit vacancies

related to repairs and improvements between tenants, identifying new tenant referrals, exiting multiple tenants within a short time due to lease violations, and lack of rental subsidies.

Staffing Models and Availability: Staffing models across PSH programs in Whatcom County vary significantly in structure, funding, and availability. Some programs are staffed 24/7, while others have only daytime coverage, limiting their ability to respond to after-hours crises or check on tenants with emerging behavioral health or substance use concerns. This variation affects who programs are willing or able to house- programs without overnight staff often hesitate to admit tenants perceived as needing higher levels of support.

Several programs described feeling stretched thin, particularly as the number of tenants with complex needs has increased. Staff talked about how hard it can be to balance respecting tenant choice with making sure everyone is safe- especially when they don't have enough staff or when tenants refuse the services offered.

Behavioral Health Staffing: Not all programs have onsite behavioral health (BH) providers. Among those that do, staff consistently emphasized the value of having BH providers on staff to build rapport, actively prevent and respond early to crises, and reduce escalations. Programs without BH providers highlighted the challenges of supporting tenants who disengage from care or need regular behavioral health monitoring. One program has had funding for a BH position for several years but faces ongoing hiring and retention challenges.

Subject matter experts echoed this need, emphasizing that while the PSH model does not traditionally expect PSH programs to directly provide BH services, rather to support connections to them, on-site access to behavioral health support can dramatically improve outcomes- especially for tenants with higher needs. They noted that proximity, familiarity, and trust are key to actively preventing behavioral health and substance use challenges by rapidly identifying early warning signs and intervening quickly.

Training, Supervision and Team Support: Most programs described having structured supervision and training opportunities for staff, though formats and frequency varied. Staff at some programs praised their weekly one-on-ones and group supervision as essential for problem-solving and self-care. One staff member mentioned: "I *only wish every agency could have supervision as regularly as we do! I didn't realize an hour of uninterrupted time every week wasn't the norm, it feels so necessary and helpful."*

Programs reported providing ongoing training in trauma-informed care, behavioral health crisis management, and de-escalation. Still, several staff members voiced the need for more training on addiction, housing voucher systems, and how to navigate increasingly complex behavioral health needs. As one staff person described:

> *"The most emphasized skillset we have here is being trauma informed. Because all residents…anyone unhoused before has trauma related to that. We do a good job of approaching people in a way that is unique to them and accommodate for their needs in a way that is understanding and empathetic. Even if we don't fully understand their situation we find ways to make them feel heard. "*

Peer counselors were described as an important part of the staffing model in at least one program, especially for building relationships and helping prevent lease violations through early engagement. Peer counselors are staff with lived experience of recovery and homelessness who provide peer support, share strategies for maintaining stability, and help tenants work toward recovery goals.

PROGRAM SAFETY

UNDERSTANDING SAFETY IN THE PSH CONTEXT

Permanent Supportive Housing (PSH) plays a critical role in stabilizing individuals with complex needs. By design, these programs prioritize low-barrier, tenant-centered approaches. However, they also navigate well-documented safety challenges (overdose risk, behavioral health crises, etc.), and property damage that stem in part from serving populations with high rates of trauma and medical vulnerability. These concerns must be understood within the broader context of the PSH model, the population served, and the limitations of surrounding support systems.

Nationally, PSH programs grapple with tensions between asset protection, resident autonomy, and safety. Site-based models may concentrate tenants with high needs in a single site, intensifying these pressures. In Whatcom County, programs are actively working to balance these realities while adapting safety protocols, staffing models, and harm reduction practices.

This section examines how Whatcom County PSH programs manage safety across multiple dimensions- from tenant experience and building location to crisis response, overdose prevention, and staff wellbeing.

TENANT AND STAFF EXPERIENCES OF SAFETY

Strengths

Tenants across programs generally reported feeling safer in PSH programs compared to when they were unhoused. Core safety factors mentioned by tenants included consistent access to a private, lockable space, basic needs (e.g., food, water, hygiene) and relief from the risks of violence or exploitation while living outside. Tenants said when incidents did occur, staff typically responded quickly and effectively- including restricting unsafe guests or exiting tenants whose behaviors endangered others.

Examples of tenant's reflections on safety in the programs:

> "*It's a secure building; they got cameras that see at doors. Everything is on camera. Security 24/7. God forbid there's a fight; [staff name] could take care of it. We have a lot of buffers.*" - PSH tenant

> "*I feel safe. Because they always have staff here and only let people in that are approved*." - PSH tenant

> "*I feel very safe. We know our roommates are all safe people, we're comfortable with each other. I feel safe in the house, safe that we know we have got house managers if anything were to occur. We have them to call; we have the program to call if anything comes up in the house. It went from being assaulted [when living on the streets] to peace and quiet and safety. A room, a door you can shut. Instead of being assaulted sexually or otherwise. It went from never knowing where you were going to sleep, never knowing if you were safe when you were sleeping. If you could sleep. Food -never knowing if you're going to eat or when you can eat, or get cleaned up, clean clothes. It went from that to being safe*." -PSH tenant

Gaps/Opportunities

While tenants typically feel safe, staff and tenants described that crises- including overdoses, deaths, and violent incidents- can be deeply traumatizing for both tenants and staff. Some tenants noted experiencing these traumatic incidents but consistently felt that staff responded quickly and effectively to support safety.

Some programs have strong post crisis response approaches such as debriefs, community meetings, and 24/7 support from on-call supervisors, but others reported gaps in grief counseling and crisis debrief resources for staff and tenants. Staff also highlighted that disengaged tenants- those who decline crisis-related support or interventions- along with inconsistent responses from external crisis response teams and law enforcement can delay needed interventions. In some cases, tenants may refuse treatment or 'present well' when crisis response arrives, preventing external teams from taking action.

In shared housing environments or large buildings, even a single tenant in crisis can affect the sense of security for others. Staff described these incidents as emotionally taxing and emphasized the need for consistent crisis response processes.

While security measures like surveillance cameras and on-site staff are seen as critical safety components, some staff reflected on the importance of balancing safety with dignity.

> *"It can feel more demeaning to be in a residential building with a lot of surveillance and feeling like you're being watched, like it's not an apartment building but it's a facility. It is difficult to balance that because security is really important. But supporting our tenants in feeling comfortable and enjoying their housing is also important.*" -PSH staff

NEIGHBORHOOD ENVIRONMENT AND BUILDING LOCATION

Strengths

Some tenants and staff emphasized that the downtown Bellingham location facilitates connection to essential services, public transit, and the broader community. Many supportive services- including parenting programs, domestic violence services, and Opportunity Council offices- are located within walking distance. Some staff also think the downtown location enhances safety for staff and tenants as onsite staff in high-need buildings can more readily access assistance during a crisis.

Gaps/Opportunities

Several PSH programs are concentrated within a few blocks in downtown Bellingham. This geographic clustering has led to a high concentration of individuals with complex needs in a small area. As a result:

- Tenants may be more exposed to triggers and safety concerns in and around the building, including visible substance use, drug dealing, loitering, crime, or pressure from former social networks.
- Trespassing is common; some programs report frequent 911 calls due to individuals entering without authorization
- Tenants sometimes struggle to maintain distance from the unhoused community, including breaking guest policies to support friends
- Businesses and community members have expressed frustration, particularly following public safety incidents- even when PSH tenants are not involved.

Additionally, public stigma toward these programs and their tenants appears heightened due to their visibility in the downtown area. A few interviewees suggested that community pushback and safety concerns may be amplified in part due to this geographic concentration.

GENERAL PROGRAM SAFETY APPROACHES

Strengths

Most programs have increased their safety approaches in recent years and reported these changes have led to improved safety for both tenants and staff. While implementation varies depending on building type, staffing capacity, and available resources, common strategies include:

- Security cameras in common spaces and entrances with regular footage review
- Locked entrances with key cards, keypads or fobs
- Strict guest policies and sign-in procedures
- Staff presence 24/7
- Routine unit inspections, with follow- up support provided to tenants if concerns arise and relevant notices filed if issues are not addressed
- Security presence
- Shatter-proof barriers at reception desks
- Staff training in de- escalation, behavioral health crisis management, and trauma- informed approaches
- Protecting privacy for tenants with a history of intimate partner violence, and facilitating transfers to new locations if necessary

In addition to physical and procedural safeguards, several programs have developed or strengthened formal crisis protocols that guide staff in responding to a range of situations- from overdoses to tenant conflict to acute behavioral health episodes. These protocols often include tiered responses based on severity, prioritize staff and tenant safety, and emphasize early engagement and de-escalation.

Gaps/Opportunities

Some programs faced challenges updating door locks or camera mechanisms due to the age of the building and cost. Only two of the seven programs had staff present 24/7. Programs without around the clock presence expressed concerns about accepting tenants with higher levels of support needs related to substance use or behavioral health challenges. Programs with a high concentration of high- acuity tenants reported staff strain and difficulty maintaining a safe and supportive environment.

> "*We reached this tipping point where the majority of people were high acuity, high [drug] use... If we have one or two or a handful of folks actively using, we can surround them with resources and case management. But if we have 30 out of 42 who have those needs, it's unmanageable. Don't want to say we'll never work with people who use substances, but we have to work with people in a meaningful way*."
> -Program Lead

RESPONDING TO SAFETY INCIDENTS

Note: Safety incidents in this evaluation include fatal and non-fatal overdoses, behavioral health crises, threats or acts of violence, medical emergencies, trespassing or unauthorized access, and other events that result in emergency response or compromise the safety of tenants or staff.

Strengths

Programs have implemented a variety of strategies to reduce the occurrence of safety incidents (see General Program Safety Approaches above). Staff emphasized that consistent structure, clear expectations, and trusted relationships with tenants were critical in preventing crises from escalating. In programs with a strong on-site presence, staff described being able to intervene early when they noticed changes in tenant behavior or dynamics in the building. As one program lead explained:

> *"Staff is very hands on. Timely crisis intervention is important. If you don't have a hands-on approach...the longer person sits in being unstable the longer it takes them coming back to baseline."*

Some programs also noted that tenants themselves contribute to a safer environment by alerting staff to concerns or checking in on one another. In buildings with on-site behavioral health services, staff were often able to notice early warning signs and work proactively with tenants to stabilize before additional intervention was needed.

Gaps/Opportunities

Individual programs vary in their building layout, staffing, eligibility requirements, and behavioral health integration- factors that appear to influence both the likelihood and management of safety incidents. Consistent systemwide data on these incidents is limited. However, available information- including the number of calls to response teams and on-site deaths-suggests that safety incidents are more frequently concentrated in a subset of programs. PSH programs with the highest number of safety incidents typically share the following characteristics:

- They serve some of the highest-acuity individuals within the homeless population, who may be screened out or deemed ineligible for other PSH programs.
- The least restrictive eligibility requirements - tenants in these programs are usually only required to pass a background check, sign and adhere to a standard lease plus a guest policy.
- Tenants are encouraged but not required to engage in case management, behavioral health treatment, or other services.
- All or most referrals through Coordinated Entry
- No behavioral health professionals on staff
- Located in the downtown Bellingham core

Note: The first four characteristics listed above are consistent with best practices in the PSH model.

Program leads noted that when too many tenants with high behavioral health or substance use needs are placed in a single building, it can destabilize the broader housing environment in the building. Having a comprehensive support infrastructure, including adequate staffing levels, on-site or readily accessible behavioral health services, 24/7 crisis response, and consistent external partnerships with providers such as substance use treatment programs and law enforcement, can help to mitigate some of these challenges.

Program leads, staff, and tenants acknowledged the occurrence of safety incidents on site, and that these incidents generally led to rapidly escalated support for the involved tenant or movement toward mutual termination or notice/eviction, depending on the severity of the incident (see the *Managing Lease Violations and Safety-Related Exits* section). Community and council members also expressed concern about safety incidents concentrated in or around PSH programs operating in downtown Bellingham, and that these can be disruptive to businesses and present a threat to individuals in the neighborhood. Interviews with national subject matter experts confirmed that these dynamics are not unique to Whatcom County. Nationally, PSH programs with the fewest entry barriers and strongest alignment with Housing First practices often serve tenants with the highest needs and see a corresponding rise in safety incidents- particularly when behavioral health service provision is not present.

Several programs acknowledged major safety challenges in the past few years and noted recent improvements in safety and that they felt they were moving in the right direction. We were unable to assess a change in safety incidents over time due to a lack of data.

Notable Program-Specific Findings

Data available from WCHCS quarterly reporting had gaps, such as incomplete records and inconsistencies across programs, and should be treated as estimates (see *Limitations* for more details). From the available data, Opportunity Council (22N) and Catholic Community Services (Francis Place) stood out as having notably higher numbers of calls to law enforcement, fire, and EMT services, and other response teams.

These programs each serve about 40 tenants in a site-based apartment building and operate with some of the lowest barrier eligibility requirements, which increases accessibility for individuals with the highest support needs who may not qualify for or remain in other programs. Both accept referrals exclusively through Coordinated Entry. Their case management approaches are among the most flexible, consistent with best practices of the PSH model.

Additionally, for 22N specifically, we were provided with some supplementary documents (including police reports) related to safety incidents, which included concerns around response times to safety incidents, adequacy of staffing, and approaches to wellness checks. We did not receive or seek out similar documentation for other programs, since a program-specific audit of safety incidents for each program was outside the scope of this evaluation.

Other programs may also have similar levels of calls to law enforcement and other response teams; however, not all programs were included in WCHCS quarterly reporting. Some do not contract with WCHCS, and therefore data were not available for those sites. For example, Dorothy Place- also managed by Opportunity Council-serves a similarly vulnerable tenant population but is not included in WCHCS data. YWCA appears in WCHCS reporting for only one quarter, but program leads and staff mentioned challenges with safety incidents and expressed a need for higher levels of building security. They also serve a highly vulnerable population while also not having staffing 24/7.

PREVENTING AND ADDRESSING BEHAVIORAL HEALTH AND OTHER CRISES

Strengths

Many PSH programs have developed or enhanced their crisis response protocols in recent years. These protocols guide staff in managing a range of situations- such as overdoses, tenant conflict, behavioral health decompensation, or environmental hazards- while centering both tenant and staff safety. Several programs reported using tiered crisis

protocols tailored to the severity and type of incident, which emphasize early de-escalation, harm reduction, and timely intervention.

Common strategies include:

- Staff training in de-escalation, behavioral health crisis response, and trauma- informed care
- Rapid involvement of behavioral health providers- either in house or through close community partnerships- at the first signs of behavioral health status change
- Policies to call 911 when staff safety is at risk instead of staff intervening or putting "hands on" a tenant
- Calling 911 or other response teams, such as Mobile Crisis Outreach Teams (MCOT), Program for Assertive Community Treatment (PACT), Holistic Engagement through Allied Recovery & Treatment (HEART), or Designated Crisis Responders (DCR) if no improvement after initial behavioral health interventions
- Direct support to staff from supervisors during crisis events and follow-up debriefs
- 24/7 on-call supervision in some programs, enabling immediate guidance or backup
- Use of regular supervision, case file reviews, and all-staff meetings to monitor tenant needs and staff well-being

Some programs have access to on-site behavioral health clinicians, which staff said improves outcomes by enabling early engagement and coordinated care. Programs with strong connections between housing and mental health providers reported quicker, more effective crisis coordination, and a clearer focus on early intervention and prevention. One staff person shared:

> *"[we do] crisis intervention. If [we notice] their mental health is decompensating - we have a camera system so we see it in shared areas - [we] generally recognize pretty quickly that their routine has changed and that an intervention is in order."*

Others noted that dedicated teams like Lake Whatcom's Holistic Engagement through Allied Recovery & Treatment (HEART) team, which provides crisis intervention and prevention, offer effective support to tenants and staff.

Gaps/Opportunities

Despite strong internal protocols and dedicated staff, several systemic and program-level challenges persist. These include:

- Barriers to external response: Staff from multiple programs described difficulty securing timely or consistent support from external crisis response teams- including law enforcement and Designated Crisis Responders (DCRs)- especially when tenants in crisis refuse help. Some reported that delayed or limited responses impeded their ability to enforce guest policies, manage trespassing, or de-escalate behavioral health emergencies. Not all response teams operate 24/7 or are sometimes at capacity.
- Communication and coordination gaps: Many programs expressed a desire to build stronger, more proactive relationships with law enforcement and emergency responders. They highlighted the need for clearer, two-way communication channels to improve crisis coordination, reduce response times, and support better outcomes for tenants.
- Inconsistent debriefing practices: Not all programs offer routine post-incident debriefs for staff or tenants.
- Variable internal capacity: Programs expressed differing levels of comfort and confidence in addressing and preventing behavioral health crises. Those that felt more equipped emphasized the importance of 24/7

staffing and access to on-site behavioral health providers, which enabled early intervention and rapid coordination. In contrast, programs without these resources faced greater difficulty supporting tenants in crisis and reported greater reliance on external partners who are not always available.

HARM REDUCTION AND OVERDOSE PREVENTION

Strengths

PSH programs in Whatcom County have adopted various harm reduction strategies to support tenant safety and reduce the risk of overdose in line with SAMHSA's best practices. These strategies reflect a commitment to meeting tenants where they are and ensuring timely responses when substance use is observed or suspected.

Common harm reduction and overdose prevention strategies include:

- Provision of harm reduction supplies (Narcan, fentanyl testing strips) and training of employees in their appropriate use
- Identifying tenants who are at higher risk of overdose and case conferencing to discuss additional support
- Safety planning for safer substance use (e.g., Never Use Alone Hotline, buddy system, etc.)
- Staff charting to track when tenants have last been seen
- Attempting to contact tenants who have not been seen by staff for a designated period of time
- Conducting wellness checks with law enforcement if staff are unable to reach the tenant
- Use of personal protection equipment (PPE) when entering units suspected to be contaminated by substances

These strategies are often implemented alongside regular tenant check-ins and efforts to build trust and engagement over time. Staff emphasized the importance of de-stigmatizing conversations around substance use and supporting tenants to identify safer practices without fear of immediate lease enforcement or eviction. In many programs, especially those that include behavioral health or clinical staff, proactive identification of high-risk tenants enabled early intervention.

Gaps/Opportunities

Despite these efforts, overdoses still occur on site in some PSH programs (See *Mortality in Whatcom County PSH Programs* section). Most programs do not have a formalized protocol for identifying tenants at high risk of overdose or adapting their interventions accordingly. Risk is often assessed informally and on a case-by-case basis. In addition, wellness check procedures are not consistently adapted across programs for high-risk individuals. While staff may attempt to contact tenants after periods of non-observation, there is often no standard timeframe or escalation protocol tailored to a tenant's known risk level. Finally, access to external supports- such as safe use spaces, specialized substance use treatment, or mobile response teams- are limited in Whatcom County.

Notable Program-Specific Findings

As previously mentioned, data collected as part of our mortality assessment had gaps and should be treated as estimates. From the data available to us, Opportunity Council (22N and Community Leasing) and Catholic Community Services (Francis Place) stood out as having a higher rate of known or suspected fatal overdoses over the 6-year period (2019-2024) compared to other Whatcom County PSH programs. As documented above, 22N and Francis Place both serve about 40 tenants at a time in a site-based setting, have some of the lowest barrier eligibility

requirements and take referrals exclusively through Coordinated Entry, which means they serve individuals with very high support needs. They also have the most flexible approaches to case management, meaning that participation in services is encouraged but not required (which aligns with PSH best practices). Overdose data was not available for Dorothy Place, another PSH program run by Opportunity Council. Lake Whatcom Center did report some known or suspected fatal overdoses, but their rate was much lower over the 6-year period than Opportunity Council or Catholic Community Services. Sun Community Services, Pioneer Human Services, YWCA and Lydia Place all reported zero known or suspected fatal overdoses from 2019-2024.

MORTALITY RATES IN THE HOMELESS AND PSH POPULATIONS

In 2024, over 771,000 individuals experienced homelessness on a single night in the U.S.[1] In recent years, there has been a notable increase in the number of deaths among individuals experiencing homelessness in the United States. Studies across multiple cities and counties consistently show that this population faces significantly elevated health risks, particularly from preventable and treatable conditions.[2] Research also shows that individuals experiencing homelessness have significantly shorter life expectancies compared to the general population.[3]

A study conducted in Washington, D.C., found that the most significant increases in deaths among the homeless population over a ten-year period, 2011-2020, were due to drug and alcohol overdose, diabetes, infection, cancer, homicide, and traffic-related injuries.[4] Similarly, in Boston, researchers identified excess mortality from drug overdose, cancer, and heart disease, among homeless adults and recommended integrating behavioral health with primary care, expanding overdose prevention efforts, and implementing structural policy reforms aimed at ending homelessness.[5]

PSH programs are intended to stably house the most vulnerable individuals within the homeless population. As such, homeless individuals who are the most medically vulnerable within the local housing pool are often prioritized for placement in PSH programs.[6] Several U.S.- based evaluations provide further insight between PSH and mortality rates of participants. These studies suggest that while PSH may not reduce mortality amongst PSH tenants compared to people living unhoused, residents in PSH programs are less likely to die from preventable causes associated with living unhoused such as accidents, homicide, infectious disease, hypothermia and exposure.[7] This might be partly explained by the fact that PSH programs prioritize individuals with complex medical and behavioral health needs. Consequently,

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[1] U.S. Department of Housing and Urban Development. The 2024 Annual Homelessness Assessment Report (AHAR) to Congress. Part 1: Point-in-Time Estimates of Homelessness. December 2024. https://www.huduser.gov/portal/datasets/ahar/2024-ahar-part-1-pit-estimates-of-homelessness-in-the-us.html

[2] Fowle & Routhier (2024). Mortal Systemic Exclusion Yielded Steep Mortality-Rate Increases In People Experiencing Homelessness, 2011–20. Health Affairs 2024 43:2, 226-233

[3] https://ldi.upenn.edu/our-work/research-updates/the-older-middle-aged-homeless-population-is-growing-and-dying-at-high-rates/

[4] Fowle & Routhier (2024). Mortal Systemic Exclusion Yielded Steep Mortality-Rate Increases In People Experiencing Homelessness, 2011–20. Health Affairs 2024 43:2, 226-233

[5] Baggett TP, Hwang SW, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. JAMA Intern Med. 2013 Feb 11;173(3):189-95. doi: 10.1001/jamainternmed.2013.1604.

[6] Henwood BF, Byrne T, Scriber B. Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. *BMC Public Health*. 2015;15:1209. Published 2015 Dec 4. doi:10.1186/s12889-015-2552-1

[7] Henwood BF, Byrne T, Scriber B. Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. *BMC Public Health*. 2015;15:1209. Published 2015 Dec 4. doi:10.1186/s12889-015-2552-1

tenants in PSH may be more medically vulnerable, which could contribute to similar mortality rates compared to people who remain unhoused despite the stability of housing.

- In Denver, Colorado, an evaluation of the Supportive Housing Social Impact Bond Initiative found no difference in overall mortality rates between the PSH group and control group which was made up of unhoused individuals who received services as usual in the community, (10% vs. 9%). However, none of the PSH participants died from environmental exposure, whereas seven deaths from exposure occurred in the control group. Additionally, those in PSH experienced fewer police interactions, shorter jail stays, and fewer shelter visits, indicating broader social benefits even when mortality rates were similar.[8]
- In Philadelphia, Pennsylvania, an evaluation of a PSH Housing First program, which offers immediate access to housing while providing ongoing community-based support services, found that while mortality rates were higher among the PSH Housing First participants than unhoused individuals, the causes of death differed significantly. PSH Housing First participants were more likely to die of natural causes (72%), whereas unhoused individuals experienced more deaths due to accidents (40%), HIV-related illness (13%), and hypothermia (6%). The findings point to the need for greater integration of medical and end-of-life care within PSH settings.[9]
- In Santa Clara County, California, Project Welcome Home compared 423 individuals randomized into PSH or standard care. Although more deaths occurred in the PSH group (37 vs. 33), researchers noted that the long-term health impacts of chronic homelessness may not be reversible even with housing. The study also highlighted potential underreporting of mortality in the unhoused control group, due to the difficulty of tracking outcomes for this population.[10]

Identifying research studies that compare mortality rates among Permanent Supportive Housing (PSH) tenants to those of unhoused individuals or the general population is challenging. There is limited availability of standardized, comparable mortality data of PSH tenants and of unhoused individuals across the country. This lack of consistent data collection and reporting presents a barrier to fully understanding the health outcomes and systemic challenges faced by PSH programs and their tenants.

OVERDOSE-RELATED DEATHS IN PSH PROGRAMS

The Whatcom Overdose Prevention Dashboard[11] presents overdose-related mortality rates per 100,000 population for both all drugs and opioids from 2012 to 2023, comparing Whatcom County to Washington State (Figure 3). Overall, Whatcom County and the state experienced notable increases in overdose deaths. In Whatcom County, the rate of deaths from any drug rose from 8.2 per 100,000 in 2019 to 51.7 in 2023, while the state's rate increased from 16.3 to 42.4 over the same period. Opioid-related deaths in Whatcom increased, rising from 5.2 to 45.9, compared to an increase from 10.1 to 35.1 statewide. These data are provided by Whatcom County Health and Community Services and Emergency Medical Services (EMS). Fatal overdoses are hard to track and characterize - they often occur

[8] Gillespie S, Hanson D, Peiffer E. What a Denver Program Shows about Supportive Housing and Mortality. Urban Wire published August 19, 2022. https://www.urban.org/urban-wire/what-denver-program-shows-about-supportive-housing-and-mortality

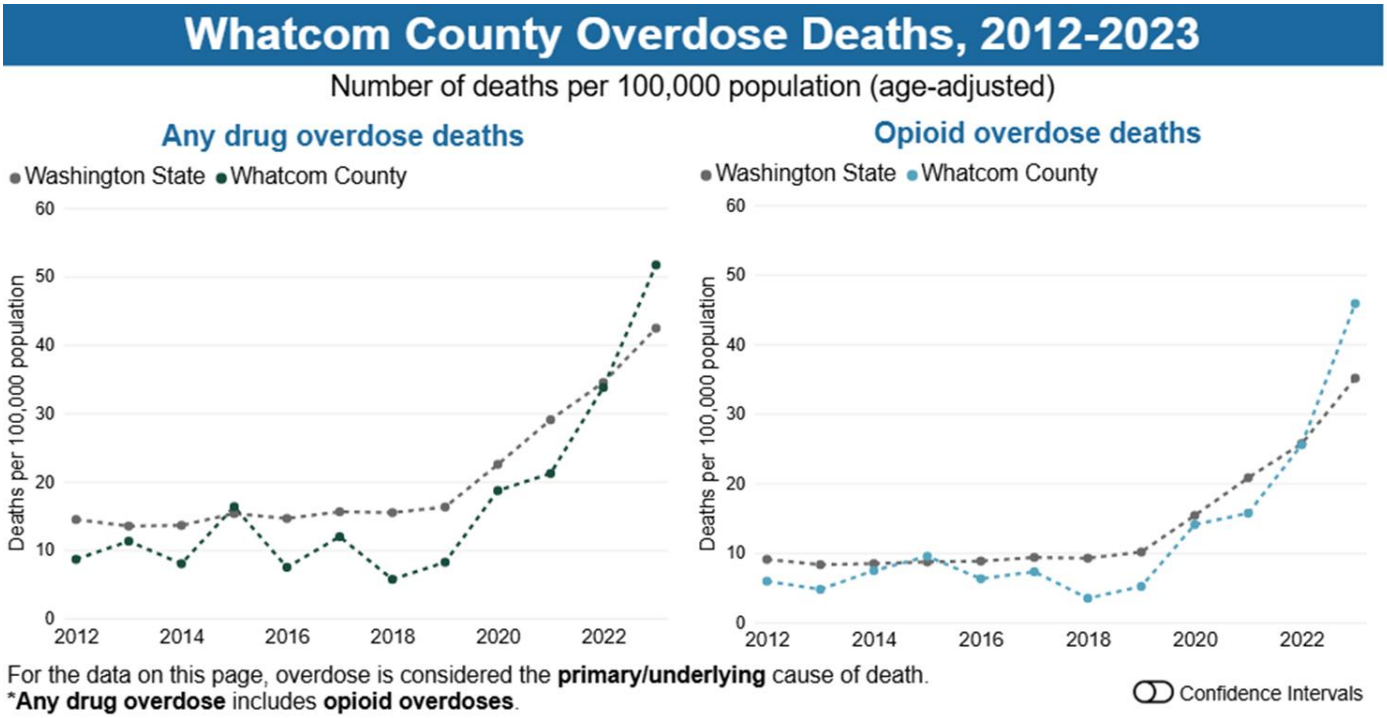
[9] Henwood, B.F., Byrne, T. & Scriber, B. Examining mortality among formerly homeless adults enrolled in Housing First: An observational study. *BMC Public Health* **15**, 1209 (2015). https://doi.org/10.1186/s12889-015-2552-1

[10] Raven MC, Niedzwiecki MJ, Kushel M. A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services. *Health Serv Res*. 2020; 55: 797–806. https://doi.org/10.1111/1475-6773.13553

[11] https://whatcomoverdoseprevention.org/data/

in conjunction with other medical causes of death. As such, the rates of overdose in the general population should be considered as an estimate.

Figure 3: Whatcom & Washington State number of overdoses per 100,000 for all drugs and opioid



Housing instability and homelessness are strongly associated with an increased risk of overdose.[12] Among the homeless population, the prevalence and severity of SUD is significantly elevated compared to housed individuals.[13] Substance use can both contribute to and result from homelessness, creating a cyclical dynamic that is difficult to break without sustained housing and supportive services.[14] Substance use disorder is complex, and it is common for individuals with SUD to seek and receive treatment many times over the course of their lives.

Permanent Supportive Housing (PSH) has emerged as a critical intervention for individuals experiencing chronic homelessness who also have co-occurring behavioral health conditions such as SUD. Many PSH tenants do not use substances. For those who do, PSH has been shown to support access to voluntary SUD treatment and recovery-related services, while prioritizing choice and autonomy for tenants in line with the core principles of PSH. Stable

[12] Byrne CJ, Sani F, Thain D, Fletcher EH, Malaguti A. Psychosocial factors associated with overdose subsequent to illicit drug use: a systematic review and narrative synthesis. Harm Reduct J. 2024;21(1):81.

[13] American Society of Addiction Medicine. (2025) Housing's Role in Addressing Substance Use and Facilitating Recovery. https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2025/01/24/housings-role-in-addressing-substance-use-and-facilitating-recovery

https://americanaddictioncenters.org/rehab-guide/addiction-statistics-demographics/homeless

[14] American Society of Addiction Medicine. (2025) Housing's Role in Addressing Substance Use and Facilitating Recovery. https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2025/01/24/housings-role-in-addressing-substance-use-and-facilitating-recovery

housing also supports recovery by reducing exposure to crisis situations and stress, increasing ability to focus on treatment and recovery, and reducing risk of arrest and reincarceration which can be disruptive to SUD treatment.[15]

As PSH programs are intended to serve the most vulnerable homeless individuals who have not been successful in other housing models, preventing overdoses while supporting tenant choice and autonomy is a nuanced, complex challenge faced by PSH programs nationally. Nevertheless, there are many recommended strategies that PSH programs can implement to support overdose prevention within the PSH model,[16] some of which programs in Whatcom County are already applying.

- Regular and updated training for staff on overdose prevention and harm reduction counseling, with refreshers scheduled to address evolving drug trends and the impact of high staff turnover
- Supporting partnerships and direct linkages with SUD medications and health care services: ensuring residents are adequately assessed for need for FDA-approved SUD medications and supporting access to buprenorphine and methadone for opioid use disorder (OUD)
- Naloxone access and tenant education: all tenants should be trained in overdose response and provided with naloxone. Useful models include tenant-led naloxone distribution programs like the Tenant Overdose Response Organizers (TORO) programs operating in Vancouver
- Overdose tracking and response: Ensuring consistent tracking processes to ensure understanding of challenges and timely support and response

MORTALITY IN WHATCOM COUNTY PSH PROGRAMS

Methods

We began by conducting a rapid literature review to understand existing evidence related to 1) mortality rates of individuals experiencing homelessness compared to the general population, and 2) mortality rates in PSH and other similar programs compared to the general population, specifically related to fatal overdoses.

In March 2025, VillageReach contacted all seven Permanent Supportive Housing (PSH) programs identified by Whatcom County Health and Community Services to request data on key mortality indicators from 2019-2024. All

[15] American Society of Addiction Medicine. (2025) Housing's Role in Addressing Substance Use and Facilitating Recovery. https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2025/01/24/housings-role-in-addressing-substance-use-and-facilitating-recovery

[16] Doran K, Torsiglieri, A, et al. Staff views on overdose prevention in permanent supportive housing. Harm Reduct J. 2025 Apr 18;22:59. doi: 10.1186/s12954-025-01215-x

American Society of Addiction Medicine. (2025) Housing's Role in Addressing Substance Use and Facilitating Recovery. https://www.asam.org/advocacy/public-policy-statements/details/public-policy-statements/2025/01/24/housings-role-in-addressing-substance-use-and-facilitating-recovery

Bardwell G, Fleming T, Collins AB, Boyd J, McNeil R. Addressing intersecting housing and overdose crises in Vancouver, Canada: opportunities and challenges from a tenant-led overdose response intervention in single room occupancy hotels. J Urb Health. 2019;96(1):12–20.

Scher BD, Chrisinger BW, Humphreys DK, Shorter GW. Resident and staff experiences of structural barriers to a housing-based overdose prevention site in Vancouver, Canada: there is a double standard if you smoke. Can J Public Health. 2025. 10.17269/s41997-025-01007-7.

programs were provided with a data collection Excel sheet to input data on the number of tenants, number of tenant deaths, the cause of death, the date of each death, and demographic characteristics of the deceased, including race, age, and gender.

We successfully obtained data from all seven PSH programs, however our ability to conduct in-depth statistical analysis was constrained by limitations in the completeness and consistency of the data received. Organizations used different processes to track tenant mortality and cause of death, and some organizations expressed concerns that their historical data may not be complete. Opportunity Council provided a partial dataset which included data for 22N but not Dorothy Place or Community Leasing, which may underestimate the total number of deaths. While we initially requested a short description of cause of death for each deceased tenant, several PSH organizations informed us that they did not collect this level of detail for all tenant deaths. To adjust to available data, we simplified our request to those programs to characterize cause of death as 1) known/suspected overdose-related deaths, 2) other cause, or 3) unknown. Finally, several organizations either did not collect or were unable to share complete demographic information. Our initial data requests were curtailed to be in line with HMIS data suppression standards.

As part of our original analysis plan, we intended to compare mortality data from PSH programs in Whatcom County to national-level data maintained by the U.S. Department of Housing and Urban Development (HUD). However, this data is not readily available through public sources. We submitted a Freedom of Information Act (FOIA) request in October 2024. Unfortunately, the data we requested was not received.

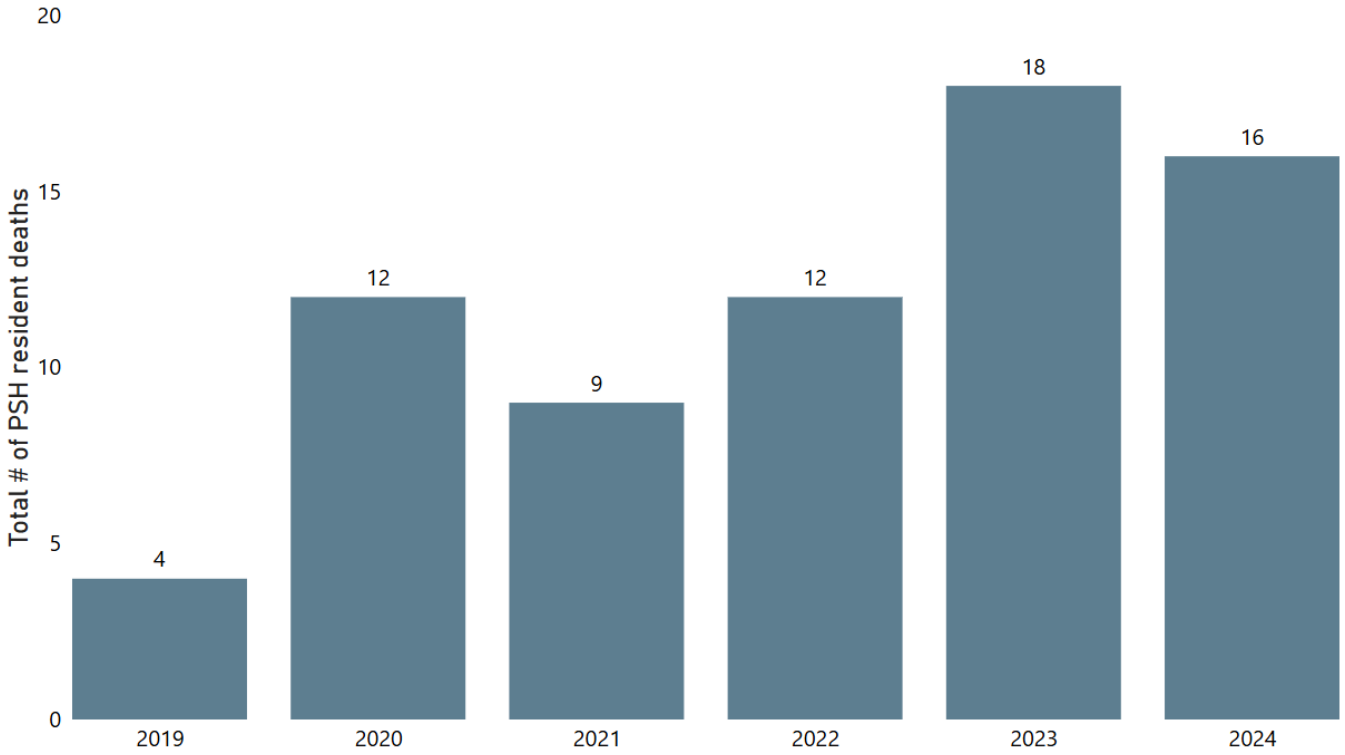
Data on mortality rates for all programs classified as PSH in HMIS in all Washington State counties was requested from the Washington State Department of Commerce. Two organizations (Catholic Community Services and Lake Whatcom Center) do not report data directly to HMIS, so data on tenants from those programs is only partially included in the datasets. Among the organizations that do report to HMIS, we discovered that some of the programs included in this evaluation are not classified as “Permanent Supportive Housing (PSH)” but are instead classified as “Housing with Services (HwS).”

Using the provided data, we were able to conduct a descriptive analysis to show trends over time and patterns in demographic data. However, these data gaps for mortality and overdose data would have resulted in inaccurate or biased statistical analysis. Due to the extent of missing data and the relatively small sample size, we elected not to conduct a statistical analysis. Moreover, it would have been methodologically and ethically inappropriate to report correlations based on incomplete and potentially biased data.

Due to limitations in the data available, findings in this section should be interpreted as estimates and may not fully reflect the experiences of all PSH tenants in Whatcom County.

There were a total of 71 reported tenant deaths during the six-year period from 2019-2024. On average there are approximately 12 deaths per year among PSH tenants across the county, with the highest number of deaths recorded during 2023 (Figure 4).

Figure 4: # of deaths of PSH tenants from 2019 – 2024 (Source: reported by PSH programs)



The mortality rate by program, along with a mortality rate for all PSH programs, from 2019-2024, can be seen in Figure 5 and Table 6. The mortality rate was calculated by dividing the number of tenant deaths each year by the total number of tenants in PSH that year and multiplying the result by 100. The mortality rates provided by the programs are higher than what is reported in HMIS, as data from Catholic Community Services and Lake Whatcom Center is not reported directly into HMIS and is therefore only partially represented.

Figure 5: Mortality rate of PSH tenants from 2019-2024 (Source: reported by PSH programs)

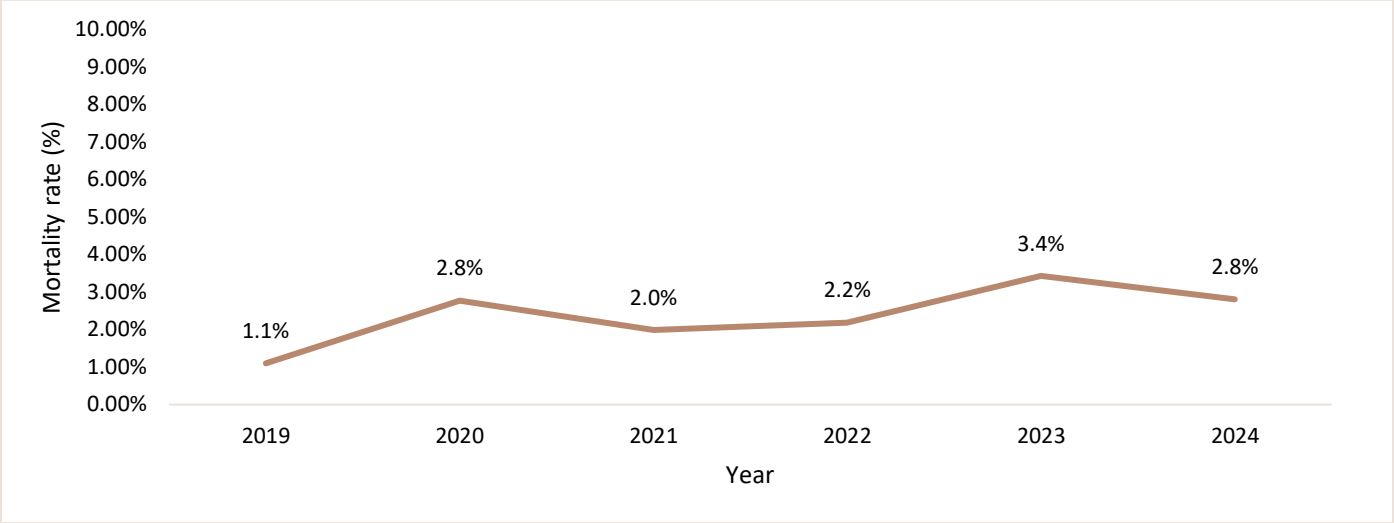


Table 6: Mortality rate for Whatcom County and by PSH Organization (Source: reported by PSH programs)

Organization	2019	2020	2021	2022	2023	2024
Catholic Community Services	0.0%	6.5%	3.7%	4.1%	2.4%	11.1%
Lake Whatcom	0.6%	3.3%	2.0%	2.0%	4.4%	0.5%
Lydia Place	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Opportunity Council	3.4%	0.0%	1.8%	2.0%	4.8%	6.1%
Pioneer Human Services	2.1%	2.4%	2.6%	2.6%	2.4%	2.6%
Sun Community Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
YWCA*	--	0.0%	0.0%	3.7%	0.0%	0.0%
All Whatcom County PSH Programs	**1.1%**	**2.8%**	**2.0%**	**2.2%**	**3.4%**	**2.8%**

* YWCA: No data available for 2019 and partial data available for 2022 & 2023

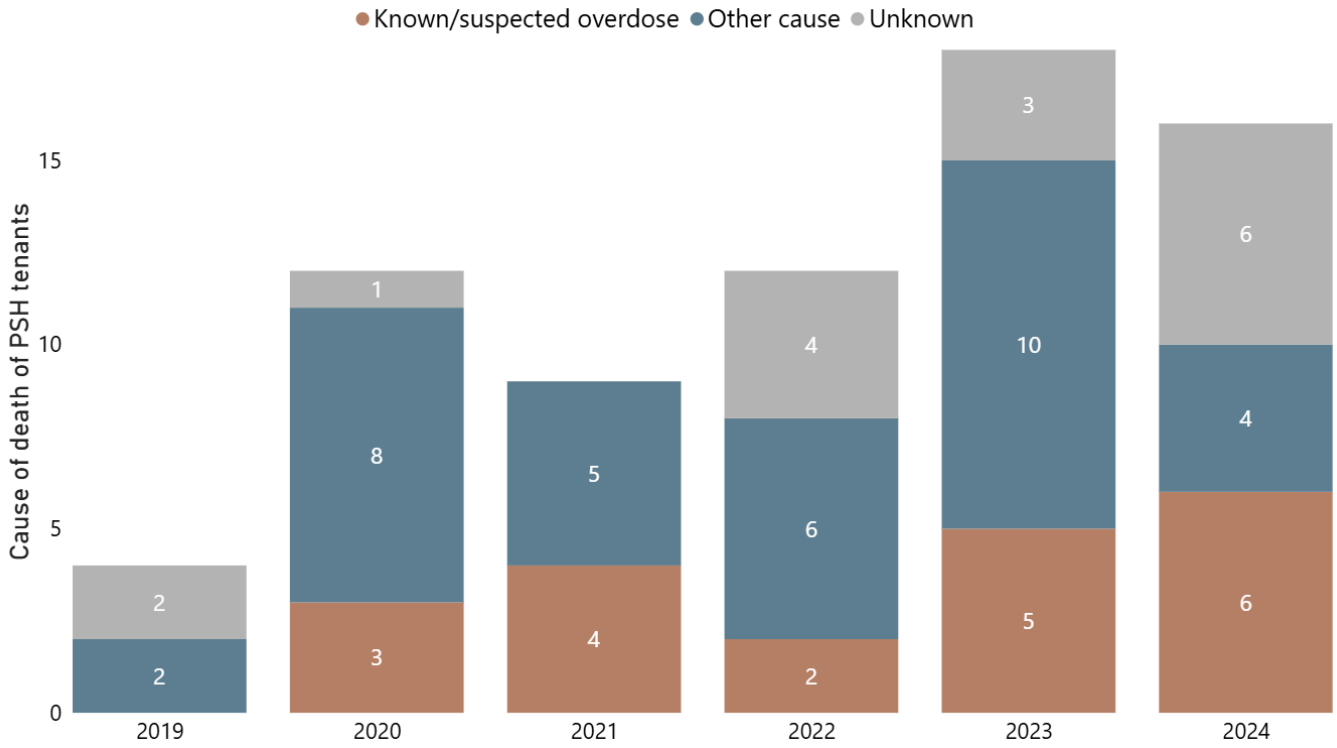
The program specific mortality rates varied notably among the 7 organizations (Table 6). Lydia Place and Sun Community Services reported zero deaths, so have a mortality rate of 0.0%. Catholic Community Services, Lake Whatcom, Opportunity Council, and Pioneer Human Services reported deaths during at least four of the six years included in the analysis.

CAUSE OF DEATH IN WHATCOM COUNTY PSH PROGRAMS

Due to limitations in available cause of death data, we categorized deaths into known or suspected overdose, other causes, and unknown. For the 71 recorded deaths, we were given cause of death for 55 PSH tenants. Of the 55 deaths

where cause of death was known, 20 (36%) of those were from known or suspected overdose, and 64% (35) were caused by other cause (See Figure 6). The number of overdoses recorded per year has increased slightly from 2019 to 2024. However, it is important to note that the number of total PSH tenants served per year has also increased, up to 571 in 2024, compared to 364 in 2019.

Figure 6: # of deaths of PSH tenants, by cause of death (Source: reported by PSH programs)

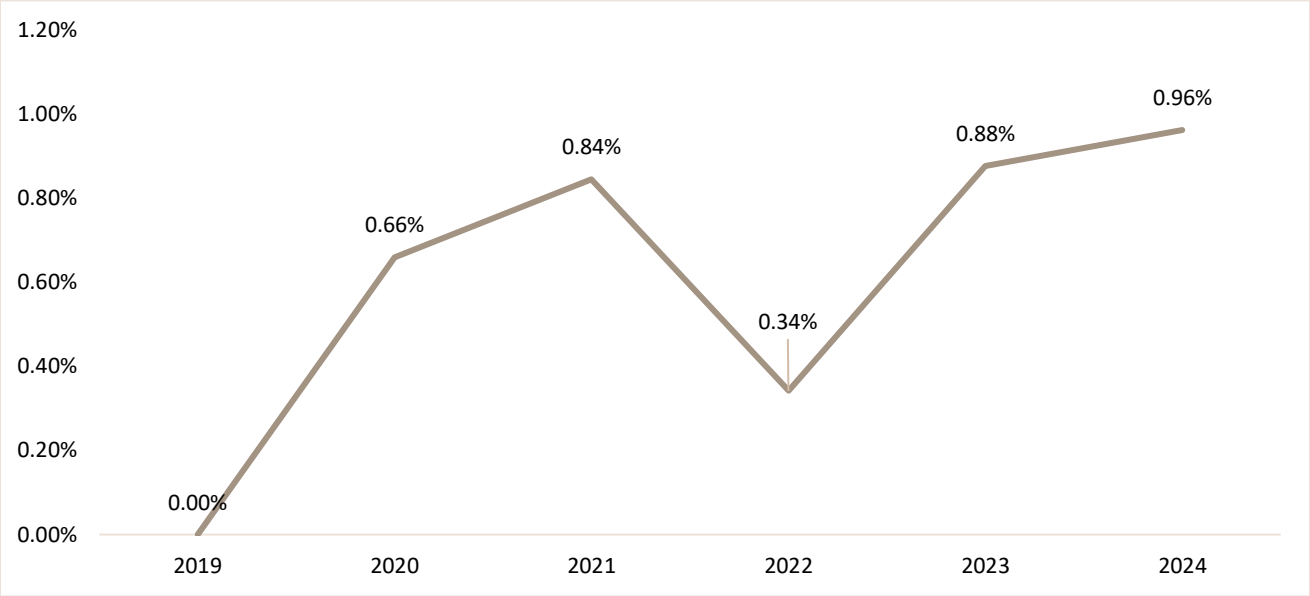


COMPARISON OF MORTALITY RATE TO WHATCOM COUNTY MEDICAL EXAMINER'S REPORT

The Whatcom Overdose Prevention Dashboard (Figure 3) shows that both Whatcom County and Washington state experienced notable increases in overdose deaths from 2019-2023. Similar trends are observed in the mortality rates among Permanent Supportive Housing (PSH) tenants for known or suspected overdose-related deaths (see Figure 7). The mortality rate for PSH has more variability. This is expected since the dataset for overdoses in PSH programs specifically is considerably smaller than the dataset for all of Whatcom County and variability occurs more in small data sets where each datapoint has more influence on the average. While we are unable to compare the two graphs directly (the Medical Examiner Report shows monthly mortality rates per 100,000 population, whereas PSH mortality

rates are calculated by dividing the annual number of known or suspected overdose deaths by the total number of PSH residents each year), we can observe a similar pattern - an increase in overdose-related deaths over time in both data sets. an increase in overdose-related deaths over time in both data sets.

Figure 7: Rate of known/suspected overdose-related deaths in Whatcom County PSH tenants from 2019-2024 (Source: reported by PSH programs)



COMPARISON OF WHATCOM COUNTY PSH SYSTEM MORTALITY RATES WITH WA STATE DATA

Note: The data source used for this section differs from the section above. The data in the previous section was collected directly from all seven organizations with PSH programs included in evaluation. The data in this section below was shared by the Washington State Department of Commerce and only includes tenants designated as "PSH" in HMIS. After discussion with WCHCS staff, we identified that some PSH programs included in this evaluation are classified as Housing with Services (HwS) in HMIS, so data from those programs is missing from the dataset we received. Given this gap, data in the graphs below should be treated as an estimate.

The Washington State Department of Commerce provided VillageReach the percentage of deaths of PSH tenants for all counties in Washington for 2019 – 2024. Mortality data for PSH tenants was provided by family type: all tenants, tenants from adult only households, and tenants from households with children. We chose to compare Whatcom County's mortality rate to 8 other urban counties in Washington State (defined for this analysis as counties with populations over 200,000+), as PSH programs in other urban counties operate in a more comparable context than those in rural counties. These urban counties were Benton, Clark, King, Kitsap, Snohomish, Spokane, Thurston and Yakima counties. We did not include Pierce County because the dataset notes indicated that Pierce County data "may be incomplete due to data transfers to new HMIS database."

All tenants (tenants from both adult only households & households with children)

When examining mortality rates among households (inclusive of tenants from both adult-only households and households with children), Whatcom County was below the average mortality rate for urban counties in three out of

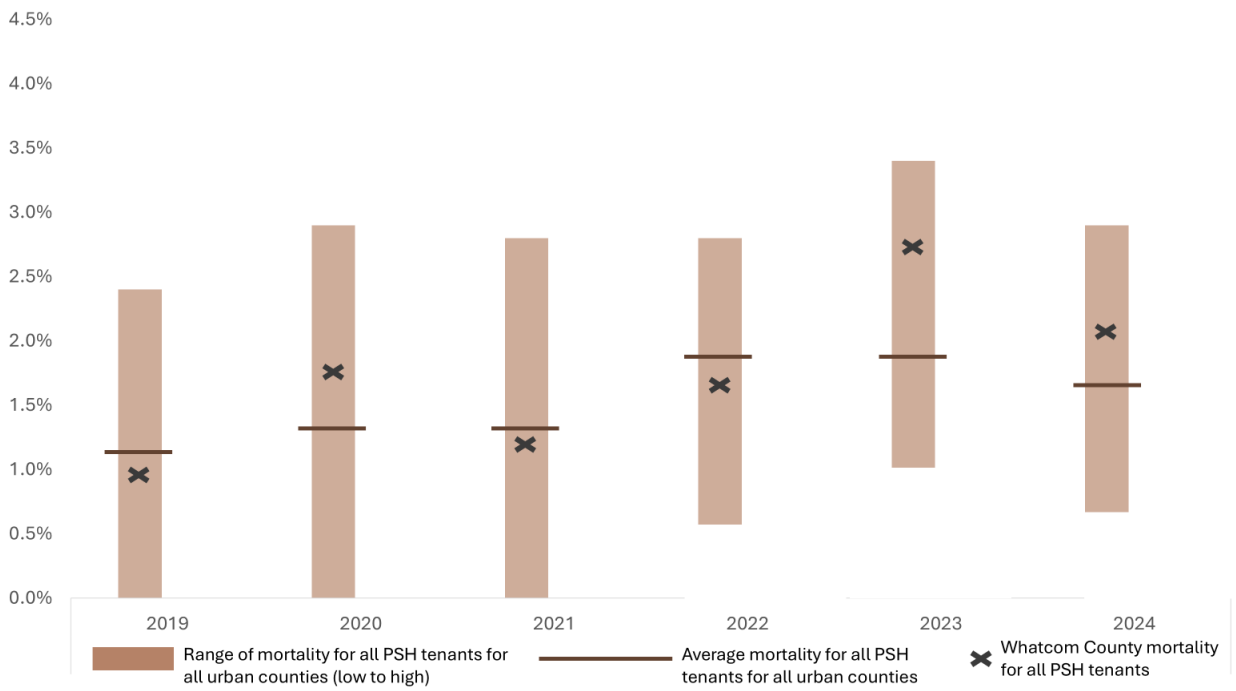
the six years analyzed and above average for three of the six years analyzed. Whatcom County's PSH mortality rate for all PSH households was within the range of reported PSH mortality rates for urban counties for all six years analyzed.

Figure 8 illustrates the range of mortality rates among all tenants across the nine urban counties, including the lowest, highest, and average values, with Whatcom County's position identified within that range.

Figure 9 provides a more detailed breakdown by displaying the annual mortality rates for each urban county individually, with Whatcom County highlighted in black for ease of comparison.

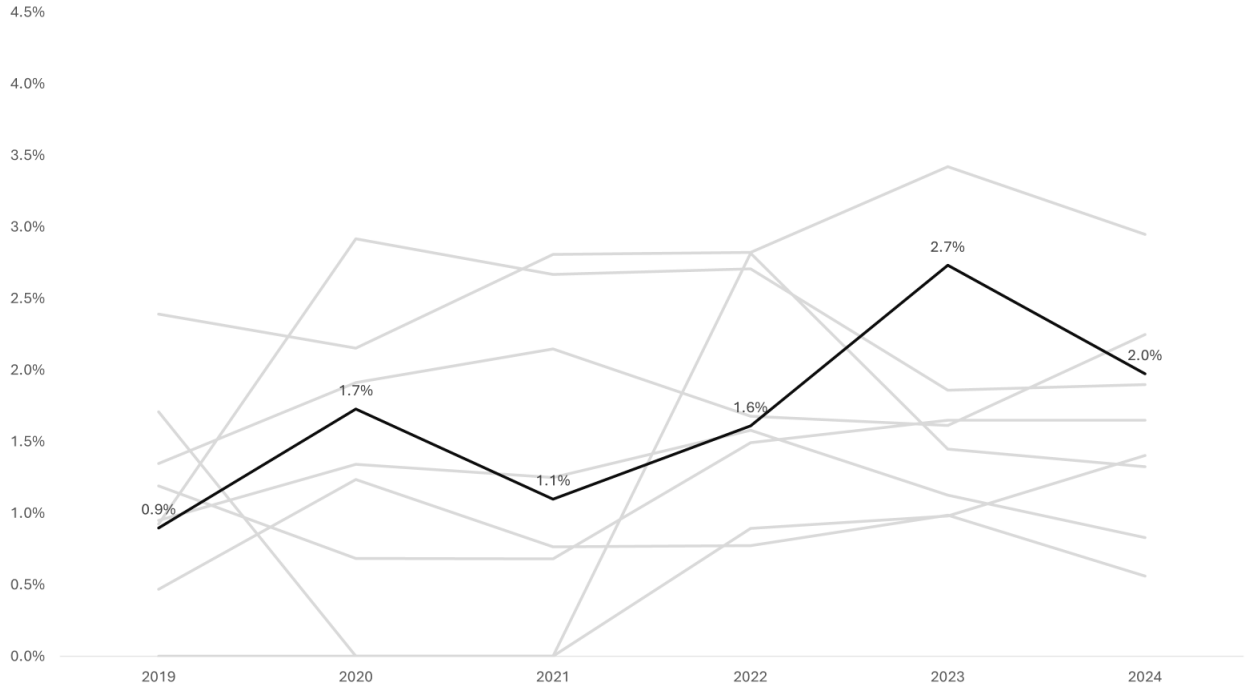
Table 7 presents the average yearly mortality rates across all urban counties, alongside the corresponding annual rates for Whatcom County. This side-by-side comparison allows for a clearer understanding of how Whatcom County's mortality trends align with or diverge from regional patterns over time.

Figure 8: Range (low to high) of mortality rates, for all PSH tenants, of urban counties, with the average mortality rate, & Whatcom County mortality rate (Source: HMIS)



Note: The Urban Counties "average" mortality rate was calculated by taking an average of nine mortality rates (the eight urban comparison counties plus Whatcom County). This means all counties were weighted equally regardless of population. We did not have access to the raw data, so were unable to calculate the average weighted for population size.

Figure 9: Mortality rate for all PSH tenants in 8 urban counties and Whatcom County (Black line) from 2019-2024 (Source: HMIS)



Note: Grey lines represent mortality rates of all PSH households in urban counties with 200,000+ residents: Benton, Clark, King, Kitsap, Snohomish, Spokane, Thurston and Yakima counties.

Table 7: Mortality rate for all PSH tenants: average of all urban counties versus Whatcom County (Source: HMIS)

Organization	2019	2020	2021	2022	2023	2024
Urban Counties (average)	1.1%	1.3%	1.3%	1.8%	1.8%	1.6%
Whatcom County	0.9%	1.7%	1.1%	1.6%	2.7%	2.0%

Note: The Urban Counties "average" mortality rate was calculated by taking an average of nine mortality rates (the eight urban comparison counties plus Whatcom County). This means all counties were weighted equally regardless of population. We did not have access to the raw data, so were unable to calculate the average weighted for population size.

Tenants from adult only households

A separate analysis was conducted focusing specifically on tenants from adult-only households in the nine urban counties (the eight urban comparison counties plus Whatcom County), as national data on mortality in PSH programs indicates that tenants from adult only households generally represent the majority of deaths[17]. Findings indicate that

[17] The U.S. Department of Housing and Urban Development. 2021 Annual Homelessness Assessment Report (AHAR) to Congress. (2023) https://www.huduser.gov/portal/sites/default/files/pdf/2021-AHAR-Part-2.pdf

mortality rates among tenants from adult-only families were a primary contributor to the elevated overall all tenant mortality observed across urban counties, which is in line with national trends.

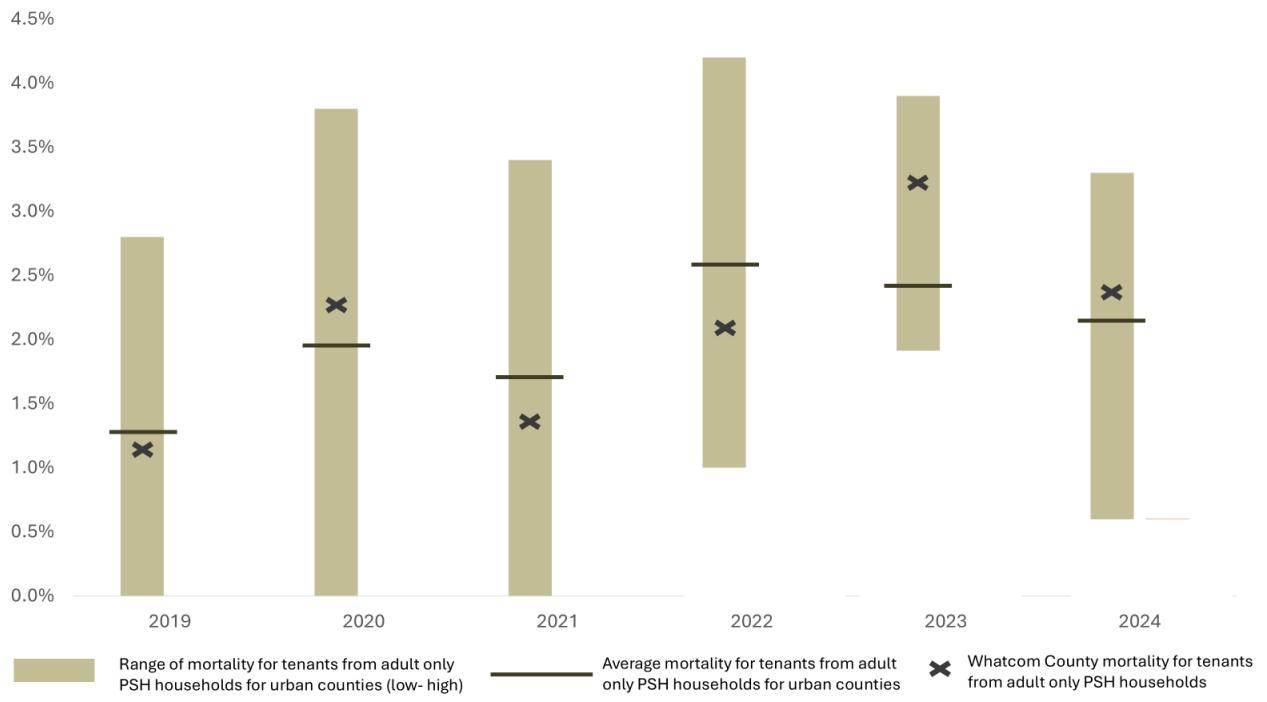
When isolating mortality rates for tenants from adult-only households, Whatcom County was below the urban county average in three out of the six years analyzed and above it for the other three years.

Figure 10 illustrates the range of mortality rates among tenants from adult-only households across the nine urban counties, including the lowest, highest, and average values, with Whatcom County's position identified within that range.

Figure 11 provides a county-by-county comparison of annual mortality rates for tenants from adult-only households, with Whatcom County highlighted in black.

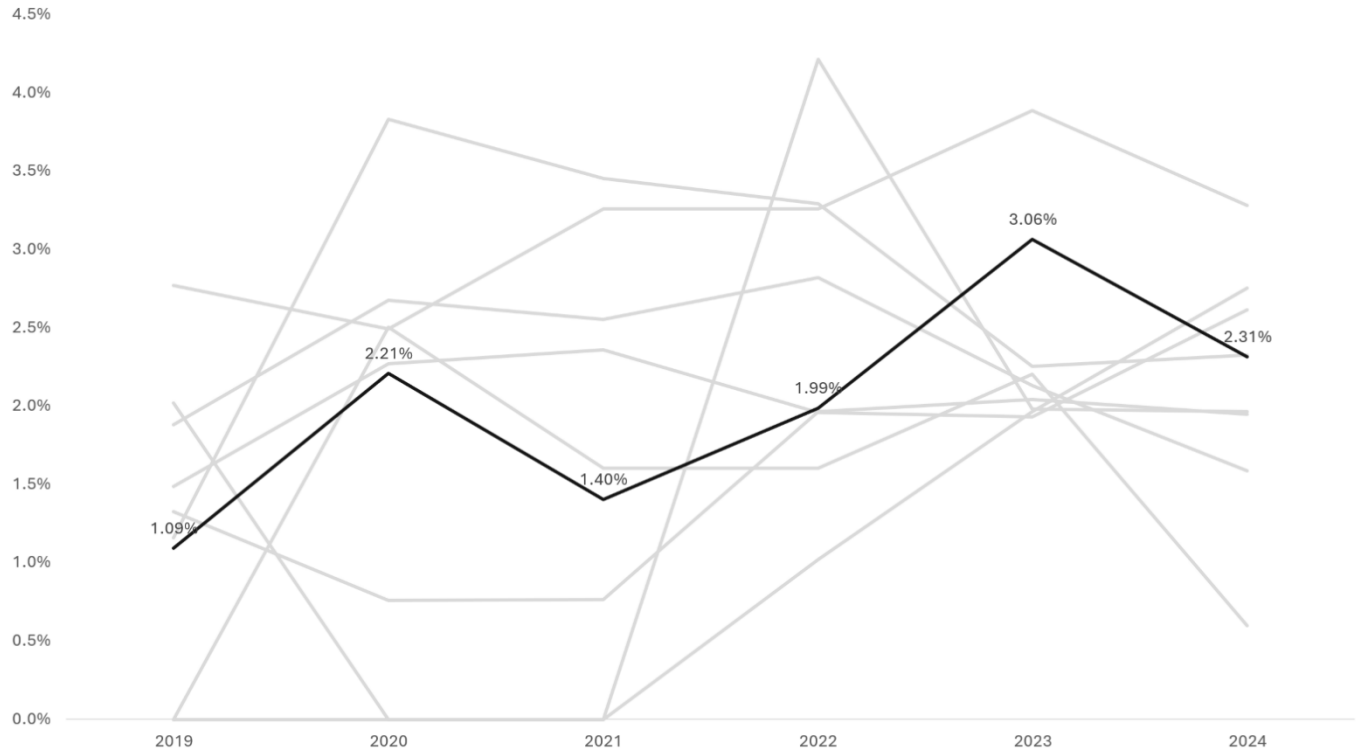
Table 8 summarizes the average mortality rate for all urban counties by year, displayed alongside Whatcom County's annual rates for tenants from adult-only households.

Figure 10: Range (low to high) of mortality rates, for PSH tenants from adult only households, of urban counties, with the average mortality rate, & Whatcom County mortality rate (Source: HMIS)



Note: The Urban Counties "average" mortality rate was calculated by taking an average of nine mortality rates (the eight urban comparison counties plus Whatcom County). This means all counties were weighted equally regardless of population. We did not have access to the raw data, so were unable to calculate the average weighted for population size.

Figure 11: Mortality rate for tenants from PSH adult only households in 8 urban counties and Whatcom County (Black line) from 2019-2024 (Source: HMIS)



Note: Grey lines represent mortality rates of PSH tenants from adult only households in urban counties with 200,000+ residents: Benton, Clark, King, Kitsap, Snohomish, Spokane, Thurston and Yakima counties.

Table 8: Mortality rate for tenants from PSH adult only households: average of all urban counties versus Whatcom County (Source: HMIS)

Organization	2019	2020	2021	2022	2023	2024
Urban Counties (average)	1.3%	1.9%	1.7%	2.5%	2.4%	2.2%
Whatcom County	1.1%	2.2%	1.4%	2.0%	3.1%	2.3%

Note: The Urban Counties "average" mortality rate was calculated by taking an average of nine mortality rates (the eight urban comparison counties plus Whatcom County). This means all counties were weighted equally regardless of population. We did not have access to the raw data, so were unable to calculate the average weighted for population size.

Tenants from households with children

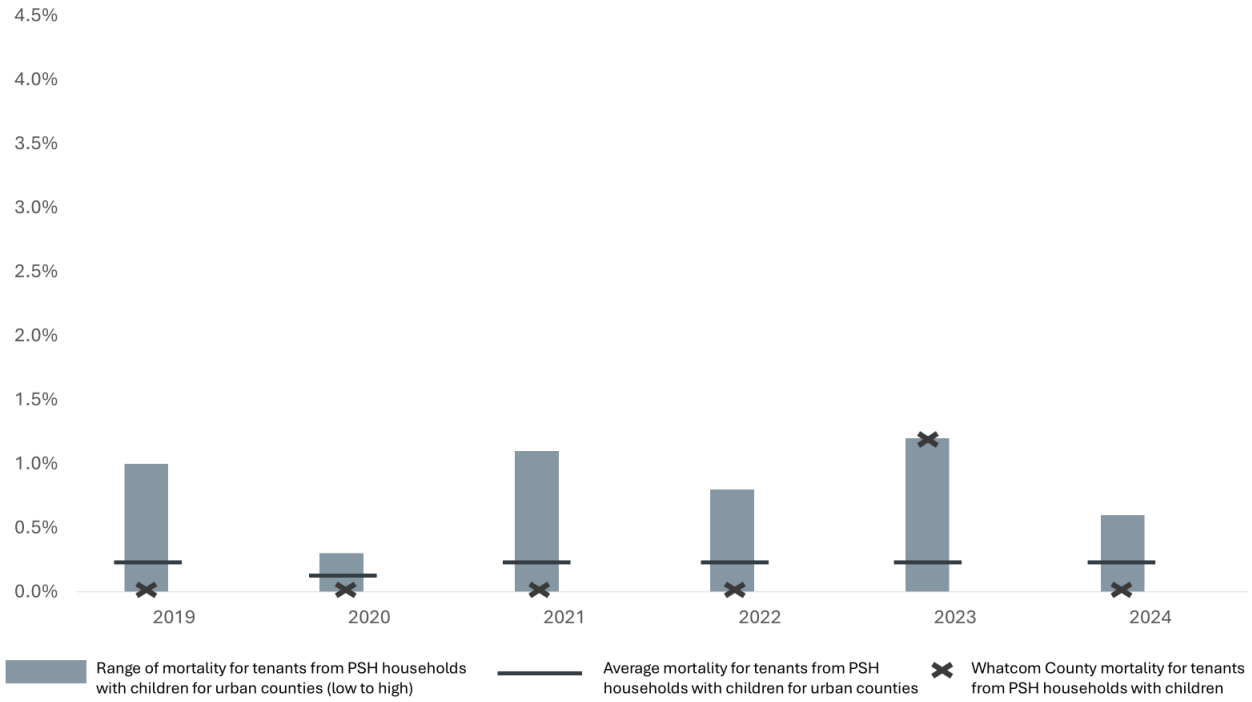
Finally, we examined mortality rates among tenants from households with children enrolled in PSH programs across nine urban counties (the eight urban comparison counties plus Whatcom County). Overall, mortality rates for this population remained consistently low between 2019-2024. Whatcom County's average remained below the urban county average in five out of the six years.

Figure 12 shows the range of mortality rates for tenants from households with children across the nine urban counties- displaying the lowest, highest, and average values- while clearly illustrating Whatcom County's placement within that range.

Figure 13 provides a year-by-year breakdown of mortality rates by county, with Whatcom County highlighted in black.

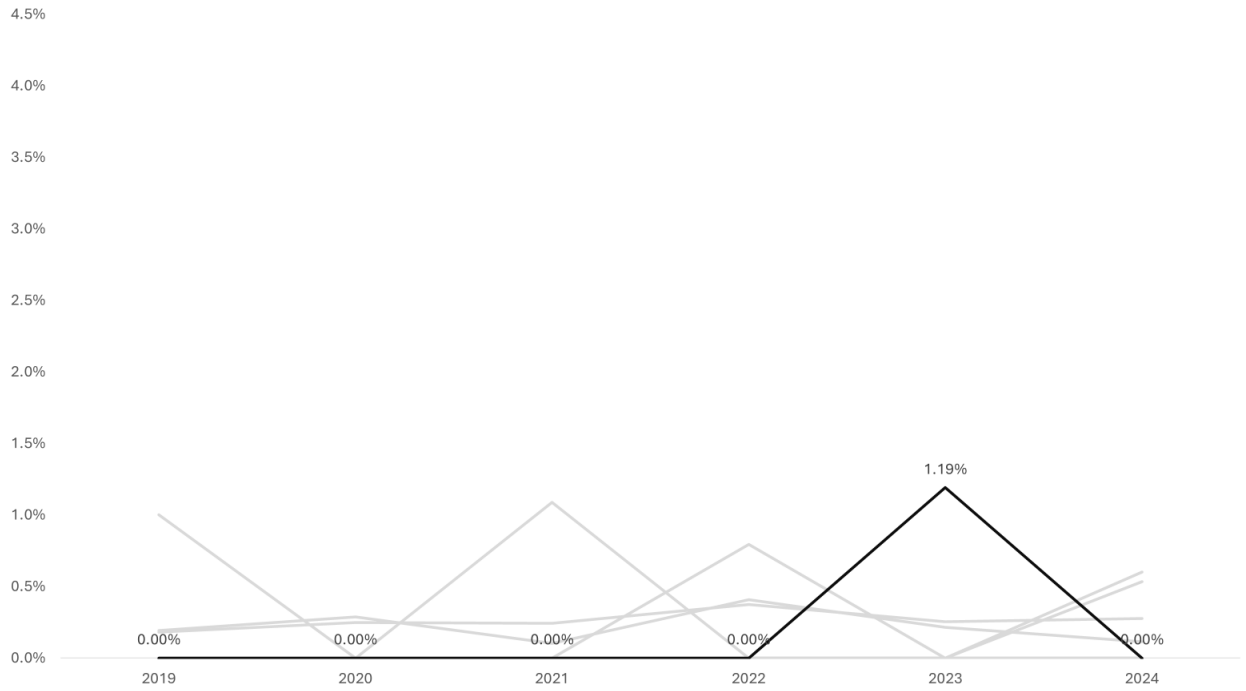
Table 9 details the annual average mortality rates for all urban counties, alongside Whatcom County's corresponding mortality rates for tenants from households with children.

Figure 12: Range (low to high) mortality rates, for PSH tenants from households with children, of urban counties, with the average mortality rate, & Whatcom County mortality rate (Source: HMIS)



Note: The Urban Counties "average" mortality rate was calculated by taking an average of nine mortality rates (the eight urban comparison counties plus Whatcom County). This means all counties were weighted equally regardless of population. We did not have access to the raw data, so were unable to calculate the average weighted for population size.

Figure 13: Mortality rate for tenants from PSH households with children in 8 urban counties and Whatcom County (Black line) from 2019-2024 (Source: HMIS)



Note: Grey lines represent mortality rates of PSH households with children in urban counties with 200,000+ residents: Benton, Clark, King, Kitsap, Snohomish, Spokane, Thurston and Yakima counties.

Table 9: Mortality rate for tenants from PSH households with children: average of all urban counties versus Whatcom County (Source: HMIS)

Organization	2019	2020	2021	2022	2023	2024
Urban Counties (average)	0.2%	0.1%	0.2%	0.2%	0.2%	0.2%
Whatcom County	0.0%	0.0%	0.0%	0.0%	1.2%	0.0%

Note: The Urban Counties "average" mortality rate was calculated by taking an average of nine mortality rates (the eight urban comparison counties plus Whatcom County). This means all counties were weighted equally regardless of population. We did not have access to the raw data, so were unable to calculate the average weighted for population size.

MANAGING LEASE VIOLATIONS AND SAFETY- RELATED EXITS

Strengths

Across all programs, staff emphasized that lease enforcement and tenant exits are treated as a last resort. The primary goal is always housing stability, even when tenants exhibit behaviors that may pose a risk to others. When safety concerns arise, programs consistently attempt to intervene early, offer support, and work with tenants to address the underlying causes of behavior. Most programs use a flexible but firm approach, offering repeated opportunities for course correction and only moving toward exit if the behavior continues or worsens.

Programs described housing retention planning as a key tool to support tenants before pursuing formal lease action. These plans often include behavioral contracts, increased check-ins, or referrals to additional services. If these steps do not lead to improvement, programs typically aim for mutual lease termination rather than formal eviction to avoid an eviction record for the tenant. Several PSH staff shared that internal transfers between programs can sometimes be arranged when a tenant may be a better fit for a different setting.

Tenants echoed the fairness of these practices, describing lease enforcement as a gradual process with clear communication and multiple chances to "turn things around." One tenant noted that "*staff don't just kick people out - they talk to you, help you fix it. It's fair*."

Staff also acknowledged the emotional toll eviction can have on tenants and shared strategies for reducing harm. In several programs, notices are delivered directly by case managers rather than posted on unit doors. This approach minimizes trauma, especially for tenants with prior histories of eviction, incarceration, or institutionalization, and leads to better acceptance and less resistance during difficult transitions. In these cases, property management still generates the notices, while case managers deliver them and provide support to tenants to stay consistent with the functional separation of property management and case management.

Gaps/Opportunities

Programs vary in their use of mutual termination versus formal eviction processes. While mutual termination is generally preferred because it avoids creating eviction records that will serve as future barriers to housing and helps to expedite exits, it is not always possible. Some organizations reported that navigating legal eviction processes can be lengthy and complex, often taking several months from initial notices to court resolutions. In cases where a tenant remains on site despite posing a safety risk, staff and other tenants may experience prolonged stress and exposure to unsafe conditions. Many staff shared similar sentiments about the challenges of navigating evictions when the safety of others is at risk:

> *"When we have an issue, because we're PSH, it takes us a number of months to have someone leave. Other tenants don't understand why the disruption is allowed to continue - unapproved guests, drug activity out front. The majority of residents do not appreciate that, you can see the trauma on their faces, you can see the other residents are triggered. It takes a while to get an eviction going or get an agreement for [the disruptive tenant] to leave...And try to work with the person to do the least damaging process possible as opposed to a new eviction on their record."*

Staff shared that balancing harm reduction with property and communal safety can be particularly difficult, especially in situations involving repeated lease violations or violent behavior. Staff frequently feel unequipped and unsupported

when navigating these situations. Many staff expressed challenges in balancing competing pressures of supporting the tenant to retain housing, while also protecting the safety of staff and other tenants, and at the same time protecting the "asset", meaning the PSH unit or buildings:

> *"It's a lot to ask a [chronically homeless] person to give up what they've been doing for 20-30 years and ...abide by our rules. So sometimes we lose...it makes me really sad, I don't like it. But we can't allow any one resident to disrupt the rest of the tenants."*

> *"In debriefing any exit, we discuss - did it serve protecting our assets or did it serve protecting family? ...we can get stuck in policies and procedures but try to ask what is the right thing we can do and can we get creative and take that path. Is it in the [tenant's] best interest, or in our best interest, or is there a version that can be both?"*

Additionally, there are inconsistencies in how programs coordinate tenant transfers, particularly when a tenant may be a better fit in a different PSH setting. While staff often rely on program-to-program communication, some organizations noted mistrust or incomplete sharing of tenant histories, complicating efforts to ensure a smooth transition and appropriate placement. These challenges are compounded by a complex rental subsidy landscape, in which funding sources and eligibility requirements vary across programs, further limiting transfer options.

Several programs identified a lack of access to legal support as a barrier. Staff are often expected to navigate complex landlord-tenant law without dedicated legal expertise. Programs also noted a gap in logistical support for tenants during the eviction process. In some instances, tenants have lost belongings due to abrupt property management action. Others may face the prospect of homelessness if alternative housing options are not quickly identified. One program reported covering hotel costs to prevent an immediate return to unsheltered homelessness.

National SMEs emphasized that these challenges are not unique to Whatcom County. Evictions and safety-related lease enforcement remain difficult across PSH programs, particularly in buildings shared by many participating households.

Notable Program-Specific Findings

One organization- Sun Community Services- does not offer tenants a standard lease but relies on occupancy agreements that can be terminated immediately. This allows for immediate exits if needed but may also raise concerns about tenant protection. All other organizations included in the evaluation had formal leases with their tenants.

METHAMPHETAMINE TESTING AND DECONTAMINATION

Strengths

Despite the significant challenges posed by methamphetamine use by tenants, all programs emphasized their commitment to maintaining a safe environment. Strategies include:

- Upfront communication with tenants during lease signing and program orientation about methamphetamine contamination, including clear explanation of lease provisions, program rules and potential consequences
- Methamphetamine contamination testing of tenant rooms and common spaces
- Decontamination of methamphetamine-contaminated units and common spaces by professionals or, in some cases where a tenant has contaminated their unit but would like to stay, they may be supported in tenant-led do-it-yourself (DIY) methamphetamine-decontamination (e.g. washing their walls)

- Clear tenant communication regarding contamination findings and expectations for remediation

Gaps/Opportunities

Programs consistently reported that methamphetamine contamination leads to significant operational and financial strain. Some sites experienced prolonged unit vacancies due to the time required for decontamination and repairs, which reduced overall unit availability. The financial implications are substantial; cleaning a single contaminated unit may cost $10,000 or more.

Balancing harm reduction with asset protection remains a difficult tension. While programs aim to support tenants through non-punitive, recovery-oriented practices, repeated contamination or high-risk behavior may lead to tenant exit- particularly in shared settings or where there is concern that contamination affects others' safety. Further research is necessary to guide and inform decontamination efforts that seek balance between a safe environment for tenants and a harm reduction for individuals with methamphetamine use disorder.

Program leads noted that the increased prevalence of methamphetamine and fentanyl have fundamentally shifted the support needs of PSH tenants. These substances pose distinct safety risks, medical complications, and behavioral patterns that strain the capacity of programs.

EMPLOYEE AND TENANT WELLBEING

Strengths

Many programs have adopted practices to support staff and tenant well-being in the aftermath of safety incidents. Staff across multiple organizations noted that supervisors are actively involved during and after crises, providing debriefing support and facilitating individual or group emotional check-ins. One organization offers free confidential counseling to staff through an Employee Assistance Program, while others emphasized the role of routine supervision and reflective practice (e.g., monthly case reviews, team meetings) in building resilience and preparedness.

Several programs also described grief support and memorial services following tenant deaths, creating space for tenants and staff to process trauma, honor lives lost, and promote collective healing.

Gaps/Opportunities

While some organizations offer grief support and post-crisis debriefs, these are not yet standard practices across all PSH programs. Staff described limited access to grief counseling for tenants following traumatic incidents, and some programs are still determining what additional trainings or emotional support structures are needed- especially for staff who are regularly exposed to death, behavioral health crises, or violence.

WHATCOM COUNTY PSH PROGRAM OUTCOMES AND MEASURES OF SUCCESS

FRAMING SUCCESS IN PSH PROGRAMS

What does it mean for a Permanent Supportive Housing (PSH) program to be effective and successful? At the state level, Washington's Consolidated Homeless Grant (CHG) outlines the primary goal: that tenants remain stably housed

or exit to another form of permanent housing. This focus on housing retention reflects PSH's core purpose- providing long-term housing stability for people with complex needs who may not succeed in other housing models.

At the local level, perceptions of what success looks like in PSH vary. Some community members emphasized goals that differ from the stated objectives of PSH programs, like participation in treatment or transitions to greater independence. These perspectives highlight misconceptions about how outcomes are defined and what it means for a program to be "working well."

While traditional measures like obtaining employment or exits to independent housing may fit well with other housing models, they don't always align with PSH's population or intent. In successful PSH programs, we expect to see prolonged housing stability, improved wellbeing of participating households, tenant-defined progress towards self-identified goals, and a reduction in related system strain- such as emergency service use or returns to unsheltered homelessness. The following section presents findings on PSH outcomes and indicators of effectiveness.

FINDINGS

TENANT AND STAFF PERSPECTIVES ON KEY SOCIOECONOMIC, HEALTH AND WELLBEING OUTCOMES

Whatcom PSH programs are profoundly meaningful for tenants in improving their safety and stability, achieving personal goals, improving physical and mental health and wellbeing, healing from trauma, and re-engaging with society.

In speaking with tenants and staff, socio-economic, mental health and wellbeing outcomes are closely linked. We spoke with tenants and staff about what has changed for tenants since they moved into the PSH program. All seven tenants- one from each organization- shared that many aspects of their lives have improved and described how programs have transformed their lives from homelessness to stability due to stable housing and supportive services. Tenants and staff described how programs allow tenants to develop and work toward self-defined goals, support psychological healing and daily autonomy, and improve tenants' physical and mental health, relationships, overall well-being and ability to re-engage with society. Specifically, tenants reported major positive mental health impacts of regaining autonomy after homelessness; agency over small, daily decisions (when to shower, what to cook) had profound positive emotional effects on tenants.

Several clear themes emerged which highlight how deeply meaningful these programs are in helping tenants retain safety, stability, to be able to set and meet goals, improve their health and wellbeing, and heal from trauma:

- An overall sense of stability: tenants repeatedly used words like stability, steadiness, and being back on track

  "My mental stability. My financial stability. My relationship with my mother got better...I feel like I'm plugged in into society again." - Tenant

  "I really needed stability and help. To be able to get my life on track and stay medicated and take care of myself. And be able to afford my own living...My family doesn't have to worry about me. I'm able to take care of my responsibilities." - Tenant

  "I don't have to face incarceration… my life is back on track." - Tenant

- Physical safety and security: no longer living in fear, coming out of fight or flight mode

"My health changed big time. It's better. My sense of security. I'm calmer. I'm not in fear anymore. I can have a window open. I feel safe." - Tenant

"It was overwhelming at first. When you come out of homelessness or DV [domestic violence], you're kind of afraid. It's a lot to take in. You go from surviving to having all of this help. I felt pressured. I came out of flight or fight mode. Now I feel the support. It took time for me to come to terms that this is a place that tries to get you on your feet. And doesn't take your children away." - Tenant

- Meeting basic self-care needs: tenants emphasized the importance of re-learning life skills to be able to take care of themselves through regular hygiene, meals and cooking, laundry, and sleep

  "A lot [has changed]. Just being able to take care of myself is huge. You can take your own shower, keep your bedroom messy or clean, you have options. I can eat what I want to eat." - Tenant

- Improvements in mental and physical health: a feeling of emotional stability, healing and recuperation, navigating health care, improved compliance with medications, reduction in depression and anxiety, increased confidence, reduction in substance use and/or sobriety

  "I would say a lot has changed. I have more steadiness in my life. I'm not worried about being homeless in the future. I'm saving money. I was relapsing quite a bit before. I didn't know where to stay. And now it's basically the opposite... I've been sober for over 2 years now. Mental health is a lot better. I had severe depression. I still have the occasional bad day, but I wouldn't even consider myself depressed anymore. Nothing close to what it was." - Tenant

- Family reunification: reconnecting with family after many years

  "[My goals when I started at this PSH program were] having my son and raising him. Initially he was living with my daughter. I reached that goal, my son is with me 100%. I also wanted to start school and I'm in the process to get in. I want to be self sufficient, independent and live with my son." - Tenant

  "To some people this is just a room and just a step to other avenues, other things, but to me this is my forever home. I hadn't been in contact with my children in ten years or more, and [program staff]...got me back in touch with my children...Re-learning how to cook and feed yourself. Just doing laundry and hygiene stuff, just relearning everything. Into a position of society." - Tenant

- Financial stability, education and employment: being able to save money and plan for the future

  "When I started, my goals were to get my own place, and to go back to school or find a job. And it took a while and I achieved both of them." - Tenant

  "My emotional health, my depression, my anxiety – all that stuff, my moods have stabilized. I've been able to get the right medications. But being here, having a home, a home base, changed everything. Changed the game. It gave me a place of security, something I had not had for years and years. And a safety, a place of safety, great comfort. Finances, getting back on track. It's like I said, it gave me the stability to branch out and do whatever I would have liked to have pursued. I just stayed home and recuperated from my years of being outside, being outdoors." - Tenant

- A sense of home: feeling welcomed, comfortable, warm and supported

"When I came in, I was homeless for a year...When you come in here, not only is it peaceful and warm. ...You get a bed, cleaning supplies, anything you need right away. I was blown away. Staff tells me every time I come in: "Welcome home" most comforting thing to hear. I have a place to live. Everyone shows me love." - Tenant

- Independence and autonomy: a sense of pride in their situation and in caring for their own space

  "18 months in shelter, before that homeless. My confidence changed. The fact that I can cook and clean my own place. It's everything. I can take a shower whenever I want." - Tenant

- Feeling integrated into society again: feeling "like a human" again and part of society

  "It's just taken me from the streets and homeless to a whole new level of society and taught me how to be human again." - Tenant

- Improved connection to resources: accessing referrals through their case manager and receiving timely help with forms to keep their subsidy assistance, medical appointments and accessing other community resources to achieve their goals

  "[PSH program staff] give me a certain amount of time to gather information, banking statement [for my rental subsidy]…all that, then I come in and [staff] will help me putting it into computer and sending it off to HUD. That's a huge help. I don't have a computer." - Tenant

  "[The PSH staff] just start you with case management and they offer up therapy and family support ...If you change your mind and no longer want a service that's ok too." - Tenant

Staff perspectives shared many of the same themes as tenants. Staff consistently reported working closely with tenants to ensure they could retain their housing subsidies:

"We go to the ends of the earth. We work really hard to get them in...We'll do everything we can to keep their subsidy and be successful in housing." - Staff

Despite varying approaches to retention, we heard consistently from program leads, staff and tenants that programs do their best to support tenants to retain housing even while issuing lease violations, up until the point that those lease violations are repeatedly or threaten the safety or stability of other tenants in the building. Across the board, staff shared a strong focus on supporting tenants to retain stable housing so that they can work on their personal goals:

"[We] focus on providing stable housing so they can work on things they identify that they want to work with - mental health, substance use, reunification...Housing is the first part to provide stability and security to work on these things." - Staff

"…housing itself is so complex. To have stable housing, someone needs to be able to maintain it. That can mean having healthcare. For us to assist someone in finding and maintaining stable housing, we also need to find and maintain healthcare. And then there's finances. People assume what we do is just find apartments and help them sign a lease. But in reality, that is such a small portion of our jobs...The housing part is maybe the easiest compared to everything else." - Staff

Staff shared that tenants' journeys and recovery experiences may not be linear, and that healing and progress can take variable amounts of time. Many tenants join PSH programs with severe trauma histories, which can present as

non-compliance with program rules or mental illness and should not immediately be viewed as a program mismatch. Some residents come with histories of incarceration or long-term homelessness and initially struggle, but many stabilize with the support of consistent, long-term relationships. Staff view safety, structure, and continuity as essential to tenant success:

> *"One of the things I'm always grateful for is there are no cut offs, no ending to the program, other than a client deciding to move on. No time limits. Get to work with folks as long as they want to work with us. A lot of folks have had a lot of abandonment, so a program ending can be super traumatic...Something we do well is offer safety, security, longevity."* - Staff

Additionally, PSH programs support tenant employment in line with the tenant's goals. This often comes after stability, healing, and recovery. More mental health needs can emerge after stabilization and can delay goals like employment. As one staff person shared:

> *"More often than not, once folks are in housing, a lot of the trauma that came up during homelessness, it comes back up... It's common to have education goals, employment goals and then they get into housing and realize they want to focus on healing – mental health, setting boundaries...That healing period often takes longer than we think. In my experience, the first year can be a lot of the intangibles, and then year two maybe they're ready to look for work, get back to school, file for divorce, learn how to clean their house, etc. It depends on the client's goals. Being really flexible is a key to working with [tenants] in our programs."*- Staff

Many tenants have severe disabilities that make traditional employment pathways challenging. Staff stressed that ongoing engagement with services is key to success in their model. Many staff support tenants with tasks like interview preparation and resume writing, and one program has a specific employment support program to help tenants find employment. While moving to independent housing is not the goal of PSH, staff do see tenants successfully move on to independent subsidized housing or jobs in their trained fields. When asked about success stories, one staff person said:

> *"There's so many. One of our residents moved on to their own housing without supports...They had been with us for 6 years...had some significant mental health [conditions]... They were very engaged when they were here - hardly ever missed their weekly appointment with their case management or behavioral health. Over 6 years, talking to us every week, went from a person who was very self-destructive, using substances, not managing their mental health. Now out there on their own, paying rent, subsidized rent and disability; it's been 8-9 months and they're successfully out there. Have had [five or six] folks graduated with their 2-year degree... able to get jobs in their new career field with an income. Folks might leave here to another subsidized housing situation, might go back into the community with a regular life. Kind of amazing that just meeting once a week over a period of time can help build self-esteem, ability with themselves, ability to imagine a different life. And gain skills to take care of what it takes to be successful without supports."* - Staff

Staff also shared that, as PSH programs serve a highly vulnerable group of individuals with complex physical and behavioral health conditions, tenants passing away is not unexpected and is a part of serving this community. One staff person shared:

> *"[we] have folks who pass away here, come here and live their life out here. Maybe this is the only housing they're ever had, and at least they're housed for their last years of life. They finish their time on earth with us."*- Staff

RETENTION AND POSITIVE EXITS

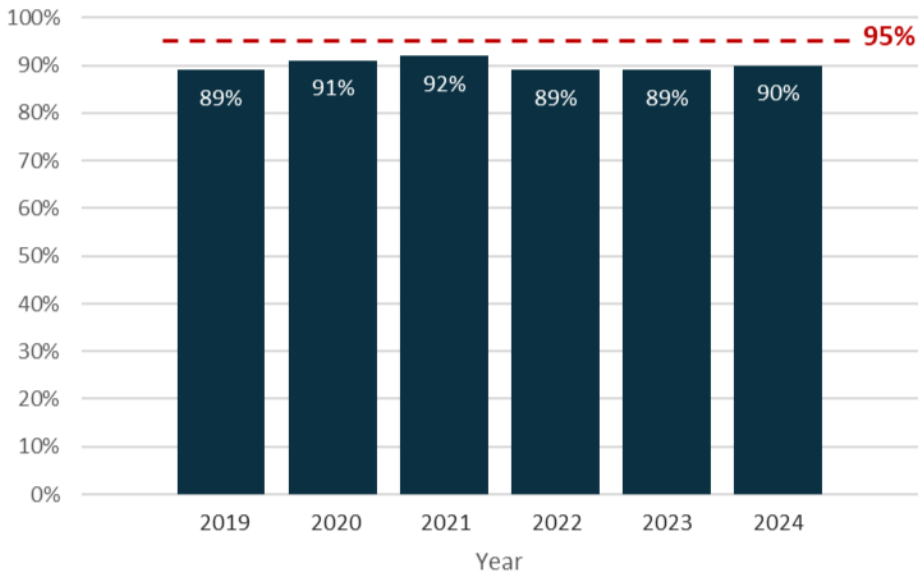
Strengths

In general, the Whatcom PSH system appears to be achieving similar outcomes to PSH systems in other counties in WA when it comes to tenants retaining stable housing.

The primary goal of PSH is to ensure that PSH tenants remain housed. The Washington Department of Commerce (WA DOC) outlines a specific calculation process using the state database to evaluate PSH outcomes[22]. This calculation shows the percent of PSH tenants who either 1) remained in a PSH program or 2) exited to another type of permanent housing (this includes rentals, ownership, or staying/living with family or friends in a permanent situation). This calculation does not include individuals who exited to foster care, a hospital or another medical facility, a long-term care facility or nursing home, or were deceased. According to the WA DOC, the statewide performance target for PSH programs is 95%, and they expect that housing outcomes should be consistent regardless of race or ethnicity.

From available data, Whatcom County PSH system yearly percentage of PSH retention and positive exits has ranged from 89% to 92% from 2019-2024 (Figure 14). These data should be considered estimates as there are some discrepancies between how PSH programs are classified in Whatcom County compared to other counties. While these estimates for Whatcom County's PSH system are just below the statewide performance target of 95%, they are comparable to the statewide average of 90% in 2022, 90% in 2023, and 92% in 2024[18] (across counties included in the Consolidated Homeless Grant (CHG) Performance Tracker).

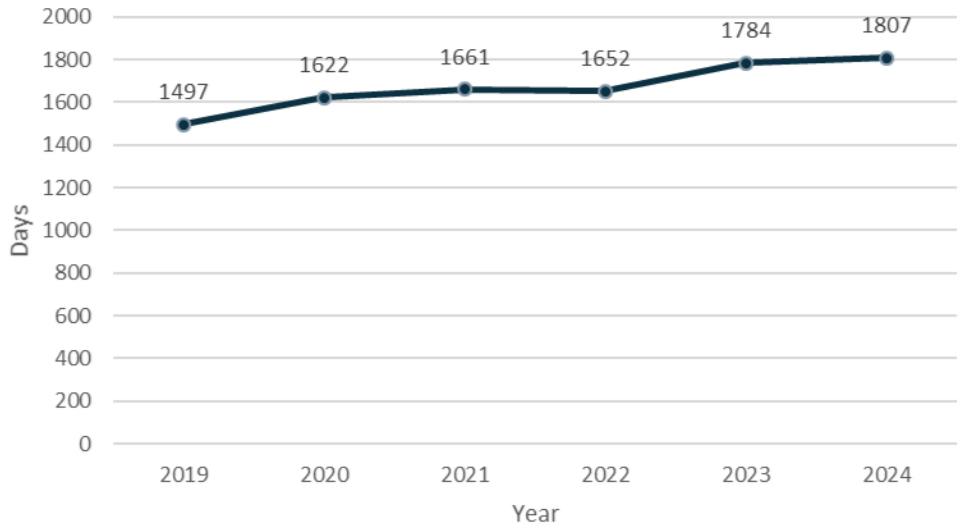
Figure 14: Whatcom County PSH and HwS Programs: Retention and Positive Exits (Source: HMIS)



[18] https://public.tableau.com/app/profile/comhau/viz/CHGPerformanceTrackerV2/OutcomesDashboard

Note: The statewide performance target of 95% is represented by the red dotted line. This figure includes data from programs classified in HMIS as PSH or HwS (Housing with Services).

Figure 15: Whatcom County PSH and HwS Programs: Average Length of Stay for PSH Tenants in Days (Source: HMIS)



Note: This figure includes data from programs classified in HMIS as PSH or HwS (Housing with Services).

PSH is intended for individuals to have no limit on length of stay. In Whatcom County in 2024, the average length of stay for PSH tenants was 1807 days, or approximately 5 years (see Figure 15). While there is no specific target related to length of stay for PSH tenants, programs see multi-year tenancy as an indicator of success. As many tenants may stay in PSH for multiple years, we would expect to see the average length of stay increasing over time and eventually reaching a plateau.

Gaps/Opportunities

The way programs are classified in HMIS makes it difficult to clearly identify, at both the program and system level, whether Whatcom County PSH programs are meeting targeted outcomes. We recommend that Whatcom County updates data collection and classification to be able to accurately track this set of metrics using HMIS data that clearly maps to programs identified as PSH in Whatcom County. Once data classification in HMIS is clarified, Whatcom County would have a more accurate picture of PSH retention and positive exits and would be able to make a clear recommendation on if program retention needs to be improved to meet the state target of 95%.

COMMUNITY PERSPECTIVES ON PSH OUTCOMES

Strengths

Most community members we spoke to are supportive of Whatcom PSH programs and highlight that they have seen programs make improvements over the past several years related to reducing safety incidents and improving

community relationships. Some programs have taken steps to implement a community task force which has supported improved connections between PSH programs operating in downtown Bellingham with community members. Some noted that, over time, PSH programs have made changes which have led them to become a valued part of the community:

> "*It's been a hot mess, they [PSH programs] put major efforts in. And the community too. They made the changes. I feel they're part of the neighborhood. I hope they feel it's a supportive and pleasant place to live. From outside it appears that way.*" - Community member

> "*…it's been night and day to what it was; a lot of learning. Everyone rose to the occasion. Now I feel 22 North is part of my neighborhood. I readily walk over and donate soup, clothing, and stop by. [This] would never have happened earlier. Things have generally gotten better. Nothing is perfect. There's a huge need for housing.*"- Community member

Community members also highlighted the importance of clear communication in shaping community perceptions. Confusion about what PSH entails was described as a challenge, but they felt that improved outreach and engagement- through the task force and direct communication- has helped shift some of the public understanding. One participant shared:

> "*They could try to be more proactive about communicating their successes. That would help with the perception of PSH. Local news tends to focus on the negative, but there's a lot of good that doesn't get shared.*"

One community member emphasized that housing stability itself is a core measure of success in PSH: *"Not dying on the street is a measure of success. Once they're in and have a roof over their head, that's a level of success I can't deny."*

Gaps/Opportunities

Councilmembers and SMEs emphasized the need for clearer public and internal communication about PSH- what it is, how it operates, and what success looks like, and what more should be tracked to understand if PSH programs are meeting their goals. Misconceptions persist, especially around the idea that "moving through" is the only measure of success. Highlighting that housing stability itself is a core success- especially for individuals with disabling conditions- was seen as key to shifting perceptions. Participants stressed the importance of talking openly about who PSH serves and why, embedding programs in neighborhoods, and promoting a shared sense of responsibility for community stability and supporting tenants.

We heard from many program leads, staff, community and Councilmembers that exposure to negative press about PSH programs vastly outweighs knowledge of success stories. Several PSH staff expressed frustration that the community does not understand the complexity or importance of their work. When asked what they have heard from the community about PSH programs, one staff member shared,

> *"Stigma, stigma, stigma. People hate homelessness. A big role of [our PSH program] is humanizing the experience, education on what homelessness actually is. There is so much negative talk about homelessness and it's really unhelpful."*

Another challenge is that the goals of PSH programs are often misunderstood by the larger community. Some people have an expectation that tenants should be moving through PSH programs into other types of housing with less supportive services. For example, one community member shared:

"...I feel that there should be enough graduations of the programs in order for it to make the programs successful from a broader societal sense. And if that's not occurring, we need to take a look at it."

While many PSH tenants do eventually move on to other housing models, this is not the primary goal of PSH. PSH is specifically designed to serve a population that may not be successful in other types of housing, and there is no limit on length of stay.

Some also have a perception that PSH programs are too lenient, and that PSH tenants would be better served by requiring sobriety or engagement in substance-use treatment programs. Many PSH tenants do not use substances, so they would not be well served by a treatment program. For those PSH tenants who do have a past or current history of substance use, they are often referred by staff to substance use disorder treatment programs, and many choose to participate in them. Central to this is one of the core principles of PSH - tenant choice and autonomy. Despite this, some feel that sobriety requirements should be part of PSH programs. For example, a Councilmember noted:

"...some of the philosophies that I think should be a part of these organizations and the programs for PSH... would be really requiring active participation in maybe a sobriety program, if a case manager determines this particular person has a substantial alcohol problem, or it could be drugs, fentanyl, any of those things...I don't think it should just be offered, I think it should be required to be active in programs to help them become healthier people."

As we heard consistently from PSH leads, staff and tenants, different types of programs are a good fit for different tenants - some may thrive in an environment with more rules and expectations including sobriety, and others may "fail out" of such an environment, which would result in them being homeless again or decline to participate in the first place. Supporting individuals who are not successful in another housing model is the goal of PSH programs. Retaining stable housing for tenants - even tenants who may still engage in substance use - is the exact challenge that PSH programs were created to address. The housing services available in Whatcom County do not currently have capacity to serve all community members or meet the needs of all unhoused individuals.

National subject matter experts shared that these different perceptions of what success means in PSH - some expecting recovery or transitions, others focusing solely on housing stability - complicates public understanding and policy discussions.

APPROACHES TO PSH MONITORING AND QUALITY IMPROVEMENT

Strengths

Internally, some program staff and leads do track and review key data points related to tenant experience and outcomes. Much of this is guided by reporting expectations from funders but also supplemented by their own tracking systems. Some programs described using these internal data points to monitor engagement, tracking tenants progress toward personal goals, and identify tenants who may need additional support. PSH programs submit routine data to HMIS, according to the 2024 data dictionary. Additionally, WCHCS has established a quarterly reporting process for PSH programs they fund, which includes programs from five of the seven organizations included in this evaluation. While this quarterly reporting mainly involves quantitative data, it does include some important metrics beyond traditional outcomes- such as resident meetings and activities, and an open-ended question about program successes and challenges.

When it came to more formal internal documentation of tenant progress and outcomes, program leads shared that they found the following data points and processes most useful in supporting tenant success:

- Keeping and reviewing a lease enforcement tracker: some programs used trackers to identify behavior patterns of clients and inform adjustments to their housing retention approaches
- Successful case management engagement: while not always tracked formally, programs consider not just the frequency of case contacts but also quality of interaction; 'successful' interactions meaning responsive to tenants needs, leading to progress or stability
- Staff turnover data: while not collected by all programs, those that do found this to be an important metric for monitoring program stability

Regarding specific indicators for understanding PSH program success, program leads and staff felt that for tenants with histories of chronic homelessness, simply staying housed in PSH is a huge success and a reflection of the program being successful. They also felt that comparing the number of years homeless to the number of years housed could be used to measure whether the program was truly helping tenants stay stably housed- the core goal of PSH. They reported this data would be inspirational and community affirming. Some staff shared pride in seeing tenants remain housed for multiple years even when other supports or progress (like employment) might come more slowly. The comparison of number of years homeless versus years housed was seen as a way to reframe narratives around tenant's pasts and help staff and tenants focus on progress.

Some programs engaged in additional internal data collection and review processes aimed at improving program quality or effectiveness. One program shared thoughtful strategies they used to track tenant progress toward personal goals:

> *"The first part is figuring out what [the tenant's goals] are. We have an interview tool we use right when we start working with them, then [after] a couple of months, 6 months, 1 year, and at our last meeting. It's self-guided – housing, community, education, employment, boundaries, substance use. In our first time, we ask them to define the categories – how do you define "community"? How do you define your "desired level of education"? Once we get their definition, we use it each time. "1-5 how satisfied are you in reaching your education goal." The con is we can only compare folks' scores against themselves. But, we are able over time to see if our case management work is helping people reach their individual goals."*- PSH staff

Even if not tracked formally, all staff and program leads clearly articulated their commitment to supporting tenants in achieving their personal goals through developing strong relationships with tenants and using active case management.

Gaps/Opportunities

As PSH programs use different approaches to monitoring process and outcomes data, this prevents a consistent analysis across all programs for key outcomes or effectiveness variables beyond what is collected in HMIS. Some programs collect required data for HMIS and WCHCS quarterly reporting (if required for their funding), and do not collect much other data beyond that. However, it is important to acknowledge that program staff often feel overburdened with existing data collection and reporting requirements, so any additional reporting should be discussed with program leads and staff and clearly tied to quality improvement.

Some programs reported keeping data stored in handwritten logs and noted challenges in verifying completeness of data records. Others recently switched systems so were unable to verify completeness of records prior to when that system had been implemented.

Some programs actively collect tenant feedback through approaches like satisfaction or wellbeing surveys, interviews, regular tenant meetings, and a tenant advisory board, but several programs did not have a formal approach in place to collect or respond to feedback. For programs that did collect this type of data, most had just started recently, or did not have a process in place to ensure this data was collected on a regular basis.

For data that programs do collect and report, many programs shared they did not have routine data review processes in place or make programmatic changes based on their data.

As mentioned previously, the PSH programs included in this evaluation are not all classified as PSH in HMIS, not all are funded by WCHCS, and some use different systems to record data. WCHCS staff shared that, due to the current HMIS setup and how programs are categorized, it is not currently possible to review program-level data.

Regarding WCHCS data, programs expressed that they were unsure what the data was used for and requested more transparency. Programs did not report being included in any sort of data review or quality improvement process with WCHCS staff. Clearer communication about data collection expectations and a consistent data review process with program leads would support an inclusive quality improvement process. In reviewing WCHCS quarterly reports for this evaluation a few challenges were noted related to data collection and use:

- Data is incomplete or missing for some programs and reporting periods. Some variables were not reported, and some programs did not submit data for all quarters.
- Some of the measures requested are already reported by programs to HMIS, which creates duplicative reporting and additional burden on programs
- Some measures may not give an accurate understanding of the programs:
    - Data is collected on 3-day, 30-day and 60-day lease enforcement notices, but this this doesn't account for 10-day notices, or mutual terminations which are common approaches used by programs to terminate tenancies.
    - Data is collected on "denied referrals", but some programs do not use the CE referral process, and others with known stricter requirements may be less likely to receive a referral in the first place.
    - Data on "Behavioral health clinician contacts" is collected but is only relevant for the limited programs who have a BH clinical on staff.
    - Data on "Vacant positions" is collected, but total ideal staff size (or a similar metric) is not, making it hard to understand the results in context (e.g. a vacancy of 2 for a staff of 4 is cause for concern while a vacancy of 2 for a staff of 24 may not be).
    - Data on "treatment plans" seems to be interpreted differently by different programs. Some report more treatment plans than their number of occupants, and some report zero.
    - Data on "complaints" is collected but without any explanation or context. Collecting data on the nature of the complaint might help the WCHCS team understand if complaints are of concern and should be addressed.

Several programs expressed frustration that these reporting requirements felt focused on challenges and deficits. For ongoing program monitoring and quality improvement, several program leads expressed interest in opportunities to report on successes and strengths. When asked which data or indicators could best tell the story of PSH, program leads shared the following (some of which are currently captured in either HMIS or WCHCS quarterly reports):

- Measures that reflect tenant-defined success, such as long-term stability and healing
- Tenant stories
- The number of community events and number of tenants attended

- The number of referrals made to mental health and SUD services
- Demographics of tenants such as length of time homelessness, self-reported SUD, and tenant age
- The number of successful Housing Retention Plans
- The number of outside providers that provided ongoing services onsite in residential facilities

System-level and contextual factors influencing PSH outcomes and effectiveness include:

- Quality-improvement approaches: Variety of program approaches to tracking/measuring outcomes, limited use of data review processes to improve program outcomes.
- Community-level contextual factors: changing substance use landscape, discrepancy between need for housing and available housing, the need for different types of programs that serve a variety of needs, challenges hiring/retaining qualified staff, etc.

Recommendations

Drawing on our findings and input from staff, tenant and subject matter experts, the following recommendations are offered to strengthen safety policies, procedures, and practices across Whatcom County's PSH programs. Most programs are already implementing strong safety practices and meeting core goals. As such, the recommendations below are focused on actionable steps to further strengthen quality and consistency across the system.

WCHCS can support quality improvement through following strategies:

- Streamline data collection processes
- Program-specific quality improvement: Work directly with each program to support program-specific quality improvement, and
- System-level quality improvement: Convene PSH programs to share best practices and co-develop solutions to common challenges

STREAMLINE DATA COLLECTION PROCESSES

Establish a collaborative quality improvement approach with PSH program leads using a combination of HMIS data, WCHCS quarterly reports, and program-specific data.

Leverage HMIS data for quarterly reporting

- WCHCS should work with the Whatcom County HMIS provider to ensure that tenants are organized programmatically in HMIS such that tenants can be identified at the program level, rather than just the intervention level or the subsidy type.
- Once PSH and HwS tenants are accurately identified by program in HMIS, WCHCS should review key HMIS indicators on a quarterly basis. Indicators can be tracked over time for each program and compared to average results across the Whatcom County PSH system. King County has a quarterly review process using HMIS data and expressed willingness to share their approach and serve as a resource for this process. This quarterly review process could include the following:
    - Review "retention and positive exits": WCHCS should re-review positive exits and retention data indicators at a County-level and program-level to have a more accurate sense of how Whatcom PSH data compares to the state target.

        - ♣ WCHCS should review this data collaboratively with programs to discuss and define targets, while being mindful that programs serving populations with different levels of need/vulnerability may have different outcomes for retention/positive exits. For example, programs serving the most vulnerable population may have a lower percentage of retention/positive exits, compared to programs serving a less vulnerable population.
    - Review key tenant demographic characteristics captured in HMIS for alignment with eligibility expectations set by the Department of Commerce. These could include reviewing the percentages of clients with mental health conditions, disabilities, substance use disorder, etc.
        - ♣ Work with programs to explore options to include HMIS indicators that will highlight the strengths and successes of PSH programs. This could include comparing the number of days in the PSH Program to number of days homeless

Streamline and simplify WCHCS quarterly reporting to reduce the reporting burden on programs

- Review data currently collected and eliminate any data points that WCHCS can pull independently from HMIS.
- Work with program leads, staff, and PSH tenants to refine remaining indicators. Ensure tenant voices are elevated and that indicators reflect tenant-perspectives on success in PSH programs.
    - Eliminate any indicators that will not either 1) help programs improve quality or 2) be used by WCHCS for reporting to key stakeholders or decision making.
    - Identify if there are any additional indicators that are not already captured in HMIS or WCHCS quarterly reporting that should be added to 1) support the quality and continuous improvement (QCI) process or 2) support public reporting or communication about PSH programs. This could include light touch quantitative or qualitative reporting that programs will not find burdensome (e.g. short narrative write-ups). Examples may include:
        - ♣ Tenant long-term stability and healing
        - ♣ Program strengths (e.g. success stories, successful case management and tenant engagement, successful housing retention plans, successful crisis response, etc.)
- For any indicators kept as part of WCHCS quarterly reporting:
    - Develop clear definitions of success that are shared with all PSH programs.
    - Provide clear information on what data will be used for

SUPPORT PROGRAM-SPECIFIC QUALITY IMPROVEMENT

Conduct regular data review sessions with each PSH program

WCHCS should conduct quarterly reviews with each program to review quarterly data and patterns over time, review the program's data in comparison with averages across the PSH system, discuss support needs or other opportunities for improvement, and identify and follow up on key action points.

Suggested Data Review Approaches

These approaches could be adapted by WCHCS and PSH programs.

- Hold meetings on a regular schedule (quarterly, or aligned with program cycles) to build consistency
- Use a simple, action- oriented agenda
- Prepare a visual, digestible data summary
    - Focus on manageable number of metrics (5-10) per meeting

    - Disaggregate data where possible
- Conduct a brief review of key indicators
    - Reinforce that data review is about learning and improving- not proving success
    - Discuss both strengths and challenges
        - ♣ Are numbers increasing or decreasing over time?
        - ♣ Are some groups doing better than others?
        - ♣ Is anything unexpected?
- Contextualize data
    - What happened when the date were collected (i.e., policy changes, staff changes, local events)?
    - Numbers show the *what*- stories and observations give you the *why*
        - ♣ Whenever possible, inlcude stories, experiences, and observations along with quantitative data
- Compare to goals or benchmarks
    - Use internal targets, state averages, or past performance as reference points, depending on the indicator
    - Is this result better, worse, or the same as expected?
- Explore root causes, not just trends
    - What surprises you about this data? What might explaing this pattern? What does this tell you about this program? What seems to be working? What might need to change? What action could we take?
- Document decisions and follow-up
    - Capture key insights and trends, decisions made, who is responsible for follow-up actions
    - Any data gaps or additional questions
    - Share meeting notes
- End with reflections or feedback
- Close the loop
    - Start next meeting with recap of past actions
    - Celebrate progress
    - Adjust metrics or visuals to improve usability of data

Beyond reviewing HMIS and WCHCS quarterly report data, these sessions should also include discussions focused on strengthening safety, crisis prevention and response, and overdose prevention as relevant:

- Safety, crisis prevention and response:
    - o During quarterly data review meetings, discuss challenges, opportunities and additional support needs related to safety. Discussion topics could include crisis prevention and response, and experiences with law enforcement, fire, EMT, and other response teams. As needed, provide additional quality improvement support to programs identified as having higher frequency of calls to law enforcement, fire, EMT, and other response teams (22N and Francis Place), along with programs that serve a high concentration of vulnerable tenants and/or reported safety or response concerns (YWCA, Dorothy Place).
    - o Support programs that currently do not have 24/7 on- site staff presence to identify feasibility of having at least one staff person present 24/7 to increase program capacity to respond to crises that occur after standard business hours. Focus on programs who have identified safety concerns based on lack of 24/7 staffing (YWCA).
    - o Support programs that currently do not have behavioral health providers on staff to:
        - ♣ [Short-term] Develop increased coordination and relationships with key response partners (mobile crisis teams, behavioral health providers, and law enforcement) to enable rapid

identification of early warning signs of tenant decompensation and rapid connection to behavioral health services, leading to an increased focus on crisis prevention instead of crisis response.

- ♣ [Medium/long term] Recruit, hire and retain at least one behavioral health provider (Lydia Place has a successful internship placement process and could be a resource for best practices here). Focus on organizations whose PSH programs serve the most vulnerable populations and take referrals directly from Coordinated Entry (Opportunity Council, Catholic Community Services, and YWCA). This may require additional funding.

- Overdose prevention approaches:
  - Support programs to develop and implement more targeted approaches to identifying individuals at high risk of overdose and responding with tailored interventions. Provide additional support to programs identified as having higher overdose rates (22N and Francis Place). These could include strategies suggested by staff, SMEs, along with best practice resources such as this recent report on Overdose Prevention in PSH programs.[19] Additionally, we anticipate that upcoming guidance from the Washington State Department of Commerce will offer recommendations tailored to the Washington State context.
    - ♣ Regular training for staff on overdose prevention and harm reduction policies and best practices: providing routine training on overdose prevention and harm reduction counseling such as individual safety planning, case conferencing, and a more sensitive threshold for initiating wellness checks
    - ♣ Review and strengthen overdose prevention and response protocols, including staff training, naloxone access, and clear emergency procedures
    - ♣ Designate staff and tenant implementation champions, responsible for promoting and supporting implementation of overdose prevention practices
    - ♣ Provide naloxone access and tenant education: train tenants in overdose response, such as tenant-led naloxone distribution programs like the Tenant Overdose Response Organizers (TORO) programs operating in Vancouver
    - ♣ Support partnerships and direct linkages with SUD medications and health care services: ensuring residents are adequately assessed for need for FDA-approved SUD medications and supporting access to buprenorphine and methadone for opioid use disorder (OUD)
    - ♣ Overdose tracking and response: Ensure consistent tracking processes to ensure understanding of challenges and timely support and response

SUPPORT SYSTEM-LEVEL QUALITY IMPROVEMENT

Building on the newly initiated PSH provider workgroup meetings, meet with programs at least quarterly to share best practices, discuss challenges and successful strategies, and collectively address solutions on key topics:

- PSH system-level challenges
  - Transfers of tenants between programs - ensuring all programs understand the process for tenant transfers, reducing the administrative burden, and ensuring clear and open communication between programs about tenant characteristics.
  - Providing appropriate support to tenants that need a higher level of care or have complex medical needs (e.g. a scenario where staff identify that a tenant is unable to complete activities of daily living independently, but designated crisis responder deems the tenant safe to remain at the PSH site) - ensuring staff understand which service provider to call in these situations, and options for escalating their concerns if they feel a tenant is inaccurately assessed.
- Safety and crisis prevention/response

    - Collectively establish standard requirements for basic safety approaches that should be standardized across programs (see list of key safety approaches in section *General Program Safety Approaches and* upcoming guidance from the Washington State Department of Commerce). Add these requirements to WCHCS contracts, if not already included. These could be grouped as required vs high priority as funding allows.
    - Best practices for crisis prevention and response, de-escalation, and managing calls to law enforcement, fire, EMT and other response teams
    - Collectively establish standard requirements for support provided for staff and tenants during and after safety incidents. Add these requirements to WCHCS contracts, if not already included.
    - Work with community partners to explore the feasibility of starting a PSH-specific mobile crisis response team (King County has this and could be a resource for best practices here) to support all PSH programs in Whatcom County.
- Managing lease violations
    - Best practices for exiting tenants identified as a safety risk to other tenants, including exploring providing additional support to programs such as legal resources or assistance navigating lease enforcement, eviction, and mutual termination.
    - Best practices for methamphetamine testing and decontamination that balance protecting the housing asset while also supporting a harm-reduction approach, including financial supports available when decontamination is needed.
- Staff training and support
    - Tailoring staff training to tenant needs: opportunities to train staff in population-specific needs (e.g., for justice-involved tenants or domestic violence survivors) to enhance program effectiveness.
    - Supporting staff well-being: best practices for regular supervision, peer consultation, and comprehensive staff training to reduce burnout and turnover.
- Program-level process and outcomes monitoring and internal quality improvement:
    - Internal program-level continuous quality improvement: Incorporating real time, light touch quality improvement approaches into internal processes. For example, some programs have already established review processes, such as tracking tenant goals and reviewing on a regular basis, while others do not.
    - Gathering and responding to tenant feedback: Implementing light-touch routine processes to promote tenant voice and engagement, and give tenants a formal voice in shaping rules, policies, and safety practices. Some strategies PSH programs use include tenant advisory boards, "tenants senate," satisfaction surveys or interviews, and check-ins during case management.

STRENGTHEN PUBLIC COMMUNICATION AND UNDERSTANDING OF PSH

Improve communication about PSH with community members, County Councilmembers, and all service providers that engage with PSH programs (law enforcement, behavioral health providers, crisis responders). Build on materials and strategies available in the WA Dept of Commerce PSH toolkit to create clear, consistent communication that explains what PSH is, who it serves, and how it benefits the broader community. This could include fact sheets, community presentations, and cross-sector orientation sessions. Address specific misconceptions and misunderstandings about PSH programs:

- The goals of PSH and what success looks like: Housing stability is the goal of PSH - "moving through" PSH to another housing model is not the primary goal of PSH.
- PSH services cannot be replaced with SUD treatment services: Not all PSH tenants have a history of substance use. Those tenants who do have a history of substance use are referred to services as needed/desired by their case managers, and stable housing is an important element of recovery.

- Limitations in accessing behavioral health services**:** Even when tenants are motivated to engage in behavioral health treatment, there are often gaps in availability. Improving access to behavioral health services requires shared responsibility across the broader community.
- Clarify referral pathways, program eligibility, and PSH best practices for those unfamiliar with PSH, particularly in systems that intersect with housing (e.g., jails, hospitals, emergency services).
- Identify PSH "champions" (e.g., program alumni, trusted providers, or Councilmembers) who can speak to PSH's value and address community concerns in public forums or conversations.
- Include real examples or testimonials from tenants and staff (with permission) in public-facing materials to humanize the work and counter stigma.
- Include messaging that explains why a diverse set of PSH models is needed to serve different tenant populations effectively

OPPORTUNITIES FOR FUTURE EXPLORATION

There are several other topics worth additional future exploration that emerged during this evaluation. While these areas were beyond the scope of the current evaluation, they deserve further consideration by WCHCS and partners to inform future planning and system strengthening efforts. These include:

- Gaps in the Coordinated Entry and PSH referral process
- Emotional and psychological demands of PSH staff, including burnout
- Strategies for strengthening onboarding, supervision, and retention of PSH staff
- Aftercare and post-exit support for tenants leaving PSH
- Broader behavioral health system capacity

Appendix A: Detailed Evaluation Methods

This evaluation applied a mixed-methods approach, incorporating document review, program-level fidelity assessment, qualitative interviews, focus groups, and quantitative data analysis across core tasks. The methods below are organized by component.

Initial key informant conversations

VillageReach conducted 13 key informant conversations with key partners and groups from October 2024 to December 2024. These conversations guided the evaluation approach and methods in alignment with best practices for participatory evaluations. A summary of key informant conversations and learnings can be found in Appendix B.

Desk review

We conducted a desk review of PSH best practices at local, state, and federal levels. We used the desk review to guide our evaluation methods and approach. This review drew on resources such as the Washington State Department of Commerce's Permanent Supportive Housing program page and guidance documents, the Substance Abuse and Mental Health Services Administration's (SAMHSA's) PSH Fidelity Scale manual and General Organizational Index, and best practices and housing stability principles from national frameworks on housing and homelessness. Insights from this review were incorporated into our document request list and the interview guides.

Program review approach (see also: What are PSH best practices under Evaluation Findings)

The program review approach was guided by the PSH Fidelity Scale to describe the adequacy of resources, staffing and programs within each PSH program.

The PSH Fidelity Scale itself is an evidence-based evaluation tool developed by the U.S. Department of Health and Human Services: Substance Abuse and Mental Health Services Administration (SAMHSA). It measures how closely a program aligns with the key principles of Permanent Supportive Housing (PSH), organized into seven core dimensions:

1. Choice of housing
2. Functional separation of housing and services
3. Decent, safe, and affordable housing
4. Integration of housing with the community
5. Rights of tenancy
6. Low-barrier access to housing
7. Flexible, voluntary services

The scale uses a scoring approach that assigns a value to each indicator within the seven core dimensions, with scores averaged to create dimension-level scores and then summed to calculate an overall score. The maximum score is 28, and scores 18 and above are considered "aligned" with the PSH model, while scores below are considered less aligned. SAMSHA highlights that the fidelity scale outlines an ideal model for PSH programs which is hard to replicate in a real-world environment. Scores are intended to support programs with continuous quality improvement. While fidelity scores provide a helpful benchmark, they do not provide a complete picture. Programs can, for example, score above the threshold while still employing practices that diverge from the core PSH model. For instance, some

programs apart of this evaluation scored above the threshold despite having requirements for sobriety or case management participation.

Several elements central to daily operations and tenant safety, and core to alignment with PSH best practices, fall outside of what the fidelity scale measures. We added several elements to this program assessment based on feedback from WCHCS staff, initial key informant conversations, and best practices from the WA State Department of Commerce. These include:

- Approaches to eligibility, referrals and screening of prospective tenants
- Access to behavioral health services on site and in the community
- Approaches to substance use on site
- Approaches to lease enforcement and program exits (e.g., thresholds, steps before eviction, use of behavioral contracts)
- Drug testing protocols (frequency, rationale, substances tested for)
- Responses to methamphetamine contamination and property damage

These distinctions highlight that fidelity scores are a useful tool, but not a comprehensive measure of alignment with best practices. Looking at fidelity scale scores in combination with these additional factors can give a more complete picture of each organization's alignment with PSH best practices.

Document review and qualitative interviews

The objectives of the document reviews were to prepare for interviews with program leads, staff and tenants, and to validate statements shared during those interviews. Reviewing the documents ahead of interviews allowed us to ask follow-up and clarifying questions based on organizational documentation.

All seven PSH operators received a request to submit key documents to VillageReach through password protected SharePoint folders. The document request list (see Table 10) was reviewed and validated by WCHCS staff prior to sending out the request. All seven organizations submitted the majority of requested documents; some were not submitted if not relevant/documented by that program. Documents were reviewed and key takeaways from each document were extracted into an excel matrix. Takeaways were used to answer key evaluation questions and inputs for the PSH Fidelity Scale. Unclear points were added to interview guides and clarified with PSH leads, staff and/or tenants as relevant. Qualitative interviews were used to add contextual information to what was documented in program policies. For more information about qualitative data collection and analysis, see Task C.

Table 10: Document Request List Sent to PSH Programs

- Program Descriptions for all housing programs included in evaluation. Description should include:
  - Number of units
  - Type of building
  - Focus of population served
  - Caseload: Average number of cases managed per staff per month
  - Case contacts: Average number of contacts between tenants and a case manager per month
- Screening document and/or eligibility/admission criteria
  - If applicable, referral criteria provided to Coordinated Entry
- Sample intake and/or assessment form
- Sample lease and occupancy agreements, lease addendums or special provision clauses
- Program policies and procedures manual
- If not included in the program policies and procedures manual, please also share:
  - House rules or program rules
  - Any program policies or processes related to program safety/security, such as: Sign-in policies for guests; Staff training on crisis response; Automatic shut offs for stoves; Policies for checking on people in crisis, or to check in on people who staff haven't heard from recently; specific language in leases around safety (e.g. use of candles, hotplates, etc.)
  - Program exit procedures (especially involuntary exit procedures) and processes for enforcing leases
  - Sample housing inspection form/policy/process
- Sample Housing stability plan/Service/Treatment plan
  - Most programs have an individualized plan for each tenant. This might be called a housing stability plan, service plan or a treatment plan or something else, but it would be the document that contains tenant goals, steps to reaching the goals, services/interventions, and their level of involvement in each.
- Job descriptions for staff offering direct services
- List of orientation/trainings for new staff and documents describing refresher trainings for all staff, and if they are offered in house or by an external provider. Please highlight any trainings specific to the PSH model.
- MOUs with partner agencies or organizations
- Internal and external monitoring and evaluation/program reports from 2019-Present, including documentation of outcomes indicators, if available

VillageReach conducted a series of semi-structured interviews and focus groups from January to April 2025, which included a total of 37 participants (see Table 11). Participants included PSH program leads, staff, tenants, community members, national and state-level PSH SMEs, and Whatcom County Councilmembers. All participants provided verbal consent to participate. Interviews were conducted either in person (four tenant interviews) or virtually via Teams or Zoom and typically lasted 60-90 minutes. Interviews were not recorded and were documented by interviewers using typed notes. Any questions not addressed during the interview were sent to participants by follow-up email.

A unique interview/focus group guide was developed for each participant type, informed by the SAMHSA Fidelity Scale and General Organizational Index, input from WCHCS staff, and findings from initial key informant conversations.

Findings were analyzed using rapid qualitative analysis (RQA), utilizing a template to summarize themes by questions across interviews and focus groups, along with affinity mapping. Relevant findings were also inputted into the Fidelity Scale scoring matrix (see Task A).

Limitations

While this work provides valuable insights into the experiences and perspectives of the different stakeholder groups included in interviews and focus groups, several important limitations should be acknowledged.

First, data collected through interviews and focus groups may be subject to response bias. Although participants were assured that their responses would remain confidential, some may still have felt hesitant to share information that could be perceived as negative, especially if it involved their host organization, landlord, supervisor, or another tenant.

Secondly, staff and tenant participants were recruited using slightly different methods for each organization depending on its size. For example, some organizations only had a small number of staff and were encouraged directly to participate, while in larger organizations staff volunteered to participate and then one was randomly chosen by program leads. Similarly, in some organizations, several tenants volunteered to participate, and one was randomly chosen to participate. In others, if no tenants volunteered then staff reached out to specific tenants to encourage them to participate. This could have led to programs leads or staff subconsciously selecting participants they felt were more likely to speak well of the programs.

Additionally, while our sample is extensive, it does not fully capture the diversity of all the tenants, providers, and community members involved in the PSH system. We did not interview tenants who had formerly lived in PSH but were exited to a non-permanent housing situation or homelessness. We also did not interview service providers such as law enforcement, DCR, or community paramedics.

Table 11: Interview Participants

Participant Type	Planned Method Recruitment Approach	Final Sample	Notes
Whatcom PSH Program leads	**Two semi-structured interviews (groups of 1-3 participants)** Purposive/snowball sampling contacted organizations directly, then organization leads recommended who should participate.	11	Two interviews were conducted with leads from each organization. Some included more than one program lead.
Whatcom PSH staff members	**Semi-structured interview** Purposive sampling, email invitations sent to staff by PSH program leads on behalf of VillageReach	7	We spoke with staff who had been at the site for at least six months. The time working at the program ranged from nine months to 12 years with a median of two years.

Whatcom PSH tenants	**Semi-structured interview** Purposive/snowball sampling. Requests shared with PSH tenants by PSH program staff. Tenants received a $50 Visa Gift Card.	7	We spoke with tenants who had been with the program for at least six months. The range of time in PSH was from 10 months to 10 years, with a median of one year. Five tenants identified as female, one as male, and one as transgender.
State PSH experts	**Semi-structured interview** Purposive sampling, reached out to them directly.	2	State-level experts work in research and evaluation roles, focusing on best practices for PSH and broader housing and health system initiatives in Washington State.
National PSH experts	**Semi-structured interview** Purposive sampling, reached out to them directly.	2	National-level experts work on homelessness policy, best practices in supportive housing, and cross-sector partnerships to strengthen PSH effectiveness and tenant outcomes.
Whatcom County Council	**Semi-structured interview** Purposive sampling, contacted directly via WCHCS leadership.	3	As we faced some challenges scheduling a focus group, we conducted individual interviews instead. Councilmembers who did not reply to the invitation were sent a data collection sheet via email, but we did not receive any responses.
Whatcom community members	**Focus group** Purposive/snowball sampling, reached out to known concerned community members, including members of the 22 North Neighbors Task Force, and encouraged them to share with others. Participants received a $50 Visa Gift Card.	5	One focus group with four participants and one individual interview were conducted.
Tribal member homeless service providers	**Semi-structured interview** Purposive sampling, reached out to them directly.	0	Unable to recruit despite multiple attempts to contact.
Total		*37*	

Program Safety

The fidelity scale does not include an assessment of program safety, and there is limited information available about safety best practices for PSH programs. As such, our approach was guided by safety priorities identified by WCHCS staff. We collected data on program safety approaches using an iterative approach which we refined over the course of our interview and document review process as we learned more about how different Whatcom PSH organizations and programs approached tenant and staff safety. We collected available quantitative data on program safety from WCHCS quarterly reports and requests to programs, along with qualitative data gathered during interviews and from document reviews. Several police reports detailing suspected overdose and deaths at PSH programs were provided to and reviewed by the evaluation team, but we did not seek out reports for every incident for all programs as this was out of scope for this evaluation.

Safety topics included:

- General organizational safety and security approaches, including any changes that have been made during the evaluation period and if those changes have been effective, what's been working well, what programs would like to do differently and what additional support would be helpful.
- Staff and tenant experiences of safety at PSH programs, including tenant experiences with program safety as compared to their experience prior to living at the program.
- Incidence of major safety concerns involving tenants (overdose, death, suicide/suicide attempts, self-injury, falls) or to others (fire or arson, hoarding, apartment takeovers, physical or sexual violence, drug selling or sex trafficking)
- Policies, trainings, or strategies to address or mitigate major safety events.
- Overdose prevention approaches and challenges.
- Linkages to behavioral health support and access to behavioral health support on staff.
- Crisis response approaches and experiences engaging with law enforcement, fire, EMT, and other responses teams.
- Lease enforcement approaches and challenges with tenants who pose a safety risk to other tenants/staff.
- How safety incidents have impacted the program's tenants and staff, including support provided to staff and tenants during and after safety incidents.

Quantitative Data Collection and Analysis

Available quantitative measures related to program safety are included in Table 12. Some of these measures were either not available consistently for all programs or were not able to be disaggregated at the program level.

Table 12: Quantitative Safety Measures

Indicator	Data Source	Notes
Calls to law enforcement, fire or EMT	WCHCS quarterly report	Only available for contracted organizations (5 of 7). Data missing from some quarters.
Calls to other response teams	WCHCS quarterly report	Only available for contracted organizations (5 of 7). Data missing from some quarters.

Program exits due to tenant being deceased *[See Mortality Analysis]*	HMIS	Access to county-level data but unable to disaggregate by program.
Program exits due to tenant being deceased *[See Mortality Analysis]*	Self-report program data	# of deaths provided by all organizations. Data missing for some programs.
Suspected fatal overdoses *[See Mortality Analysis]*	Self-report program data	# of suspected fatal overdoses provided by all organizations. Data missing for some programs.

Qualitative Data Collection and Analysis

Qualitative data on program safety was collected through document reviews, interviews, and focus groups. Relevant safety topics were included in interview guides depending on the participant type.

Of note, we received several documents, including police reports, outlining details of safety incidents that occurred at 22N, a PSH program operated by Opportunity Council. We reviewed the documents provided to us, but collecting similar data and conducting a detailed analysis of police reports of safety incidents from all programs was out of scope for this evaluation.

Program effectiveness assessment

This program effectiveness assessment was guided by PSH outcomes identified from best practice documents from the Washington Department of Commerce (WA DOC), the U.S. Department of Housing and Urban Development (HUD), and the Substance Abuse and Mental Health Services Administration (SAMSHA). According to WA DOC and HUD, **the main goal of PSH is to stably house homeless individuals with disabilities who have not been successful at maintaining permanent housing on their own**. **PSH should be permanent and without time limits[20]. As such, transitioning out of the program is not a goal of PSH. Some people will "move through" PSH to another housing model; others may stay in PSH for 10 years or 30 years. Ultimately, the goal is to stably house people.**

Beyond the core goal of housing stability, PSH programs are intended to support several other key socio-economic, mental health and wellbeing outcomes for tenants (While originally listed in our contract, after discussion with WCHCS program staff, we removed the "transition to independent living" topic from our evaluation given that transition out of PSH is not one of the goals of PSH). The objective of this evaluation was to assess the core outcome of housing stability, along with these additional outcomes from 2019-2024 with a focus on understanding strengths, areas of improvement, and areas where more data is needed to evaluate effectiveness.

As this is a retrospective assessment (looking back in time), we had to adjust our approach based on data already collected by programs. To understand what data was collected by the seven organizations included in the evaluation, we sent each program lead a program outcomes survey to identify to what extent these outcomes were tracked consistently by the included PSH organizations. We also explored data available through HMIS and WCHCS quarterly surveys.

Quantitative data availability for each outcome is summarized in Table 12. Several challenges came up during data collection and analysis.

- HMIS data: Whatcom County PSH programs are not consistently classified in HMIS. Some of the programs included in this evaluation are classified as "PSH," others are classified as "Housing with Services," and others do not participate in HMIS at all. After discussions with WCHCS staff, this assessment includes data from Whatcom County housing programs labeled as either PSH or Housing with Services in HMIS. Staff felt the combination of these two designations was a more accurate representation of PSH programs operated by the 7 organizations included in this evaluation. As such, data shown in this section for retention and positive exits differs from the data shown on the WA DOC dashboard[21], which only includes programs classified as PSH in HMIS.
- WCHCS quarterly survey data: Data is collected only for PSH programs funded by WCHCS and therefore does not cover all programs included in this evaluation. Additionally, data was missing for some quarters from certain programs. In some cases, specific variables were not reported, and one program submitted quarterly reports in a different format that did not include all the same variables. More information is provided in Table 13 and the findings section.
- Program self-report data: Programs did not document outcomes consistently. More information is included in Table 13 and the findings section.

Table 13: PSH Outcomes and outputs

Outcomes	Possible Quantitative Indicators	Quantitative data available for all organizations?	Quantitative data included in final evaluation?
Housing stability	• Retention and positive exits • Housing status at discharge from program (independent housing, hospital, homeless, death) • Number of days tenants are housed over specific periods (in last 90, 180 days, etc.) • Lease violations • Progress on housing stability goals	Housing retention and positive exits based on status at discharge available for most organizations through HMIS. Unable to match data exactly to the 7 included organizations. County and statewide data also available via WA DOC dashboard.	Yes
Progress toward personal goals	• Self-report progress toward goals	Not documented by all organizations.	No
Health status, mental health and substance use outcomes	• Self-reported mental health scores • Days hospitalized in last 90 days • Emergency room visits	Incomplete information on 911 calls and calls to other response teams available for 5/7 organizations through WCHCS	Included in Program Safety section but not included in Program Outcomes

	• 911 calls • Calls to other response teams (e.g. MCOT, community paramedics) • Substance use reported • Substance abuse treatment scale • Self-reported quality of life	quarterly reporting. Otherwise, not documented by all organizations.	and Measures of success section due to data gaps
Service Utilization	• Days hospitalized in last 90 days • Use of crisis services	Not documented by all organizations.	No
Program engagement	• Self- reported tenant satisfaction with program	Not documented by all organizations.	No
Financial stability and independence	• Employment rate • Employment status at discharge of program • Increases or decreases in income • Benefits eligibility or usage (Medicaid/Medicare, SSI, Food stamps)	Several indicators tracked in HMIS. Unable to clearly match to all PSH programs due to challenges with HMIS categorization (PHS vs HwS).	No
Community integration	• Participation in social activities outside the program • Participation in educational activities • Interactions with the criminal justice system	Not documented by all organizations.	No

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Appendix B: Summary of Initial Key Informant Conversations

Participant Type	Sample	Objective
WCHCS staff	3	Ensure clarity and alignment on goals and objectives of the evaluation

Whatcom County PSH organization leads • Lake Whatcom Center • Lydia Place • Opportunity Council • Pioneer Human Services • Catholic Community Services • Sun Community Services • YWCA	9	Introductions, discuss hopes and concerns about the approach, logistics for future data requests
County Housing & Social Services Leaders • WCHCS, Director of Health and Community Services Department • City of Bellingham Manager of Community Services and Economic Development • Whatcom County Deputy Executive	5	Introductions, discuss hopes and concerns about the approach
County and State PSH and Data Leads • Department of Commerce • Whatcom County Medical Examiner's Office	6	Discuss and receive feedback on the approach and data availability
Other Whatcom County housing programs • Sean Humphrey House	1	Clarify the scope of the project and which housing organizations will be included in the evaluation
Total	24	

Summary of learnings from key informant conversations:

- Hopes
  - To learn what's working well and what's not working for PSH and PSH-like providers so programs can integrate successful practices, especially around integrating behavioral health services
  - Identify service gaps and understand why some clients succeed while others don't
  - Integrate client perspectives and community partners (crisis services, etc.)
  - Include strengths-based evaluation approaches that capture the nuances of the topic
  - Improve communication about PSH programs to the Whatcom community
- Concerns
  - Being able to consider certain specific aspects of the systems environment - understanding the role of client acuity (especially those with high medical needs), understanding the importance of the Coordinated Entry process, acknowledging the availability of behavioral health and primary care providers and services in Whatcom County, and understanding the changing context and severity of chronic substance use and housing barriers locally and nationally

- Accounting for differences between programs in the evaluation - different client populations service, some programs don't consider themselves a "true PSH" program, some have only recently been established, others have been around for years, some are the property manager and others are not, etc.
- Data availability will vary on key PSH process and outcomes indicators, including mortality data, as many program use different approaches to data collection

Appendix C: Interview and Focus Group Guides

PROGRAM LEAD INTERVIEW GUIDE

Interview Part 1
Background
Can you briefly describe your role and how long you've been with the organization? Can you briefly describe [organization name's] housing program? Probe on any clarifying questions from document list on number of units, type of building, and population served.
• What are the critical ingredients or principles of [organization name's] services? • What is the goal of [organization name's] program?
What are you most proud of about [organization name's] housing program(s)? What do you think [organization name's] program(s) excels at?
Do you consider [organization name's] program to be a PSH program? Why or why not? • If yes, in which year did [organization name's] program start being considered a PSH program? What elements of PSH are implemented within [organization name]?
How does [organization name] define Permanent Supportive housing?

How many service-oriented staff do you have?

What other service providers do you have, and could you describe their roles (e.g. behavioral health, psychologist, psychiatrist, SUD providers, etc.)?

- If relevant, can you describe the relationship between service providers/clinical staff and case management staff?
- Are there regular meetings, areas of cooperation, or difficulty?

What is [organization name's] case load size?

- As relevant, probe on caseload for different staff.

Has [organization name] changed any practices or processes to accommodate the Permanent Supportive Housing initiative? (Changed rules about who keeps charts, how checks are written, etc.?)

Access to Housing & Eligibility

Describe the eligibility criteria for [organization name's] program.

- How are potential tenants referred to your agency? How does the agency identify potential tenants who would benefit from Permanent Supportive Housing?

Can you describe how [organization name] interacts with the Coordinated Entry process?

- What's working well? What is challenging?

What kinds of things does [organization name] require before someone is accepted as a program participant?

- If unclear: For example, a background check, other paperwork, etc.

Does [organization name's] require prospective tenants to demonstrate readiness?

- If so, what does that look like?
- As relevant, probe on: sobriety, medication compliance, willingness to comply with program rules, successfully completing a period of time in a certain program (e.g. transitional housing), engagement with case management

How are potential tenants prioritized? For example, first come, first served, obstacles to housing stability, or are they prioritized by some other metric or process?

Does [organization name] screen tenants for their capability to complete activities of daily living ? And if so, how?

Do all new tenants receive an evaluation of current housing situation, housing preferences, and support needs?

Choice of Housing

In general, how does [organization name's] approach supporting choice for tenants participating in your program, related to their housing options? What constraints to you face in providing housing choice?

- Housing options
  - ***Type of housing***: To what extent are program participants offered choice in the type of housing unit, for example, a choice among an ordinary apartment, and a unit in agency-owned housing?
  - ***Choice of unit:*** To what extent are program participants offered a choice in selecting the actual housing unit?
  - ***Waiting lists:*** Can tenants turn down a housing unit without losing their place on a waiting list?
- Choice of living arrangements
  - ***Composition of household:*** To what extent do program participants control the composition of the household? For example, do they have to have a roommate?

Separation of housing and services

In general, how does your organization approach separation of housing operations and supportive services?

Functional separation:

- To what extent does the housing management (landlord, property management, housing department within an agency) have a role in providing service?
- To what extent do the service providers (housing specialist, case managers, clinicians) have a role in providing housing (e.g. collecting rent, enforcing lease requirements, handling evictions, screening for tenancy, etc.)?

Where are the social services/clinical staff based?

Decent, safe and affordable housing

In general, how does [organization name] approach the affordability of your units?

How much do tenants pay from their income toward their rent and utilities? Is it 30 percent? 40 percent? 50 percent? More?

Please describe the type of rent subsidy that tenants usually have.

- What level of permanence to the subsidies have? For example, are they rapid rehousing subsidies, Housing Choice Vouchers, Project Based Vouchers, Shelter + Care Vouchers, etc.
- How do you approach providing support or assistance to tenants to maintain their rental subsidies?

What is [organization name's] approach to unit inspections?

- What indicators do you use?
- How often are units inspected?
- How often do units fail re-inspections?
- Are there consequences when a unit fails one or multiple re-inspections? If so, what are they?

Housing Integration

In general, how does [organization name] approach housing integration in your program?

- For example, to what extent are the housing units for individuals with disabilities scattered throughout the community, or integrated with units typical of the community? Or to what extent are those clustered with other units for individuals with disabilities or formerly homeless people?

Rights of Tenancy

Can you describe how [organization name] approaches rights of tenancy?

- Do tenants have a lease? Are there any special lease provisions?
- Do tenants have legal rights to the housing unit?
- Is tenancy contingent on complying with anything outside of the lease? For example, participating in services?

How does [organization name] approach tenants' privacy in their units? Under what conditions can service staff enter the housing unit?

Assessment

Does [organization name] give a comprehensive assessment to new tenants? What are the components that you assess?

- How often do you reassess tenants?

Safety Questions

In general, how does [organization name] approach safety for tenants in your programs?

There are many potential behaviors or events that can occur in any landlord/tenant situation that could result in safety concerns. These safety concerns could include risks to the tenant (such as overdose, death, suicide/suicide attempts, self-injury or falls) or risks to others (such as fire or arson, hoarding, apartment takeovers, physical or sexual violence, drug selling, or sex trafficking).

- How have those types of events impacted your program's tenants? How have they impacted program staff?

Does [organization name's] have any policies, trainings or strategies to address or mitigate these types of challenges? Can you describe those?

- If needing to clarify, share the following examples:
    - Sign-in policies for guests
    - Staff training on crisis response
    - Automatic shut offs for stoves
    - Policies for checking on people in crisis, or to check in on people who staff haven't heard from recently
    - Specific design strategies for buildings
    - Allowing people to move to different units to reduce chances of apt takeovers

When it comes to managing these types of behaviors or safety concerns, what has worked well?

What would you like to do differently?

What types of support would be helpful for program in addressing these types of events moving forward?

Lease Enforcement

What is [organization name's] approach to enforcing leases?

What are some reasons that tenants have recently exited the program due to eviction or mutual lease termination?

Have there been situations where you felt you should have used lease enforcement after a negative situation, but that was not done?

What is working well when it comes to enforcing leases?

What is challenging?

Flexible, voluntary services

What services are offered through [organization name's] program~~s~~?

- What hours and days are services provided?

Please describe to what extent behavioral health services are mostly provided by individual providers or if services are provided as a team

- If clarification is needed, can probe on examples:
    - All behavioral health services are provided through a team, including psychiatric services (e.g. an Assertive Community Treatment team);
    - All behavioral health services except psychiatric services are provided through a team;
    - Individual service providers are responsible for behavioral health services with specialist consults (e.g. a case manager routinely provides services but calls a substance abuse treatment provider to assess and make recommendations);
    - The primary responsibility for behavioral health services falls to one provider

How does [organization name's] philosophy approach tenant choice when it comes to services?

- How do you incorporate tenant preferences in the services you provide?"
    - Optional probe: What options are there for your services? Please give examples.
- Can program participants choose the types of services they receive? (For example, can they ask for case management or refuse case management?)
- Can tenants modify their choice of service type? For example, can someone choose to be in case management and then choose to leave case management?
- Is the choice of "no services" an option in your program?
- Do you have a standard service package that everyone receives?
- If someone requests to stop receiving services, when would staff follow up with them to see if they are interested in reengaging?

Please describe the process of developing a treatment/service plan.

- What are the components of a typical treatment/service plan and how are they documented?
- How often is the plan reviewed or followed-up on?

- Who is the primary author of the service plan?

What has been helpful in implementing Permanent Supportive Housing at [organization name]?

Are there any additional barriers or challenges that you have encountered in implementing Permanent Supportive Housing that we haven't already discussed?

What additional support or changes would be helpful to address those barriers?

What would it take to make the Permanent Supportive Housing initiative more successful in meeting the needs of the Whatcom County community?

Thank you so much for your time, that concludes the interview for today.

Next steps:

- We will send a request for a time to meet to conduct part 2 of the interview, where we will focus on training, supervision, and monitoring and evaluation.
- We will share the questions ahead of time so you can review ahead of the interview

END OF INTERVIEW PART 1

INTERVIEW PART 2

System- Level Questions

Different PSH organizations and programs serve specific sub-populations of the chronically homeless population. (E.g. Justice-involved, families, female-identifying, High BH acuity etc.)

How would you describe the sub-population that your org/program serves?

- How is this similar or different from other PSH programs in Whatcom County?
- Do you see any advantages or challenges in having different programs 'specialize' in different sub populations?

How do you see your role within the broader system of PSH programs in Whatcom County?

Behavioral Health/other Crisis Response

Your program reported X calls to police and X calls to other response services in 2024. What are those calls generally for?

To what extent do you receive the support that you need when you call those services?

Does your program have an established response process for when someone is experiencing a behavioral health crisis? Can you describe it?

What has worked well when responding to behavioral health crises?

What continues to be challenging?

Are you aware of the state level support available through OMS/ONM in situations involving security, staffing, linkages to services, repairing damages, etc.?

Program Exits

Your program reported **X** exits from your program from Jan-September of 2024 *[we have Q1-3 of Whatcom quarterly report for most programs, hoping we can get more updated data from Janie].*

- What are the most common reasons that a tenant exits your program?]
    - How often are exits related to substance use? Which substances specifically?

Your program reported issuing X 30 day comply or vacate notices, X 3-day nuisance/waste notices, and X 60-day termination for cause notices in 2024 [in the Whatcom quarterly reports for most programs].

- What steps are taken before issuing a 60-day termination for cause/exiting someone from the program? (e.g. 3 strikes rule, warnings, etc.).

[If not already answered above] How does your program approach preventing program exits?

Are there any supports, services, or resources you wish you had that would help tenants avoid eviction or program exits?

Once your program has decided that it is necessary to exit someone from the program, how long does that process usually take?

We have heard from programs that there may be scenarios where a tenant is disruptive or unsafe and the program has moved to evict that tenant, but due to the legal eviction process this can occasionally take a long time, up to several months.

- How often does your program have a situation like this?
- Have you used any strategies to avoid this type of situation that have worked well?
- What would help you reach resolutions more quickly in these scenarios? (e.g. legal support, etc.)
- Are there any supports, services, or resources you wish you had that would help tenants avoid eviction or program exits?

For tenants exited from your program, where do they usually exit to?

- How often do they exit to another PSH or housing program?
- How often do people join your program after being exited from another PSH program?
- For movement between PSH programs, how does that process get initiated? And how does that process work? Is there anything you wish was different about this process?

For tenants exited from your PSH programs for lease violations specifically related to recurrent substance use, are there other program models that you think are better suited for their needs, either within or outside of the PSH model (e.g. shelters, tiny home villages, etc.)?

Are there additional program models or services that you think are missing in the system for people wo aren't successful in PSH for reasons not related to substance use?

(E.g. Medical respite, more tiny home villages, higher support settings that are not nursing homes)

Are there any other challenges you face related to lease enforcement or program exits that we haven't already discussed?

Mortality/Overdose Prevention

You reported that your program has seen x deaths from 2019-2024 . **X** of them were likely due to overdose.

What approaches or strategies do you currently use to prevent overdoses (e.g. provision of Narcan and safe use supplies, working on a safe use plan, welfare checks, etc.)?

- Do you have a process for identifying tenants at higher risk of overdose?
- What does that look like? Do you make any changes to your approach when working with tenants you believe to be at high risk of overdose?

How does your program approach balancing tenants' rights-like privacy and autonomy- with efforts to prevent overdoses or other safety risks?

What has worked well in overdose prevention at your organization?

- What do you think could be improved?

Any supports that would help you address overdose prevention more effectively?

Process and Outcome Monitoring

You shared that your program collects [list types/categories of data collected].

- Are there outcome indicators you find most useful?

What do you think is working well about how you currently collect data?

What would you like to change?

What do you think are the most important data/indicators for monitoring the effectiveness of PSH programs in Whatcom County?

- What data/indicators do you think would really tell the story pf PSH?

Whatcom County currently requests quarterly reports from programs. These reports include data on case management, units, occupancy, new admissions, denied referrals, exits, notices, calls to law enforcement or other response teams, complaints, vacant positions, resident gatherings, individual treatment plans, behavioral health clinician contacts, and outside treatment programs.

- How do you feel about the data collected in these quarterly reports?
- Is there anything that you wish you were asked to report on?

  Probe: Are there data points you wish funders would request to better reflect program strengths?

Quality Assurance

Are there any formal or informal ways your program gathers input from tenants about policies, safety, or other aspects of the program?

IF time allows: Supervision and Case Review

Are supervisors regularly on-site? How involved are they in crisis response?

- For example, do they directly support staff working with clients, do they offer feedback, or are they not involved at all

How frequently are tenant files reviewed internally?

(E.g. for supervision, documentation quality, or program review) How often does the team hold internal case conferences or team discussions about specific tenants? o Are those case reviews structured (e.g. a checklist or template) or more informal?
Closing Reflections
Is there anything else you'd like to share that we haven't asked about?

PROGRAM STAFF INTERVIEW GUIDE

Background
Can you briefly describe your role and how long you've been with the organization?
What are the critical ingredients or principles of [organization name's] services?
What do you think [organization name's] program(s) excels at?
What do you think are some areas for improvement for your organization?
How does [organization name] define Permanent Supportive housing?
Individualized Treatment, Referrals, separation of property management and services
How do you support tenants in achieving their housing stability and personal goals? • How do you build trust and engage tenants who might be hesitant to participate in services?
To what extent do PSH staff support tenants to maintain rental subsidy assistance? • Do you feel this support meets tenants' needs, and why or why not? • What's working well?

- What's challenging?

What level of behavioral health clinical services or support is available through the program?

How do you coordinate referrals to key service providers (mental health, primary care, substance use treatment etc.)?

- What is working well?
- What is challenging?
- Do referral processes meet tenant needs?
- To what extent can tenants secure appointments once referred?

What challenges do you face when providing services to tenants?

Linkages with behavioral health support

Can you share an example of a behavioral health success story? For example, a time when you felt like a tenant got the support they needed, and their situation improved?

Can you share an example of a time your organization struggled to meet a behavioral health need? For example, a time when you felt like a tenant didn't get the support they needed, and their situation declined?

(as needed scenario question) You have a tenant who is decompensating and showing signs of increasing agitation and making threats toward other tenants.

How do you/ does your organization respond?

- Does the program have a crisis response process in place?
- What's working well?
- What is challenging?

PSH is designed to be low barrier and serve people with behavioral health and substance use needs. However, we've heard from programs that there are times when staff feel that a tenant's acuity is too high or not a great fit for PSH. This could be for a few reasons – maybe because someone's state changes after they join the program, or because the tenant's self-assessment with Coordinated Entry doesn't match their needs in reality.

Can you share a specific example of a time when your organization had a tenant that you felt was not a good fit for PSH? How did your organization respond?

(as needed scenario question): In a circumstance where you have a tenant that you feel is not a good fit for PSH, how does your organization respond?

- What's worked well about your organization's response?
- What was challenging (probe on systems level barriers)?
- What would you like to change?

What role could Coordinated Entry play for those individuals who may not be a good fit for PSH?

What happens after tenants complete their course of care (e.g. detox, inpatient treatment, etc.? (probe on coordinating with behavioral health providers).

- What is it like when tenants return to their units at that point? Do their services change once they return, and if so, how?

Safety, harm reduction, and impact of traumatic incidents

There are many potential behaviors or events that can occur in any landlord/tenant situation that could result in safety concerns. These safety concerns could include risks to the tenant (such as overdose, death, suicide/suicide attempts, self-injury or falls) or risks to others (such as fire or arson, hoarding, apartment takeovers, physical or sexual violence, drug selling, or sex trafficking).

- How frequently do these types of events occur at your program? How does your program manage them?
- What has worked well in handling these situations?
- What could be improved in how the program manages these types of incidents?
- What support is available to staff and tenants during and after these types of incidents?

[We know x, y, z has been done to improve safety.]

- Do you think those changes have been effective or are there still gaps/challenges?

- What have you heard from tenants about safety?

Lease Enforcement

Have there been situations where you felt you should have used lease enforcement, but that was not done?

Have there been situations where the organization has used lease enforcement that you felt was inappropriate or should not have been done?

Closing Questions

What feedback do you hear from community members about your program? Is there anything you feel the community does not understand, or wish they understood differently or from your perspective?

What has been helpful in implementing Permanent Supportive Housing at [organization name]?

Are there any resources or additional support that would help your organization be more effective in serving PSH tenants?

What would it take to make the Permanent Supportive Housing initiative more successful in meeting the needs of the Whatcom County community?

Thank you so much for your time, that concludes the interview for today.

END OF INTERVIEW

[If time continue with Training and Supervision. Otherwise send via Email]

Training and Supervision

When you first started in this program, did you receive any training specifically for PSH?

If yes: Can you tell me a little about the training, like what topics were covered and who gave the training?

- Was it mandatory or optional?
- Who trained: In house or outside training?
- What were the lengths, frequency?
- Do you receive refresher trainings?

- Did the training include trauma-informed care?
- How about skills related to managing behavioral health conditions such as de-escalation and responding to a behavioral health crisis?

How does supervision and peer support function in your role?

- Logistics of supervision: length, frequency, group size
- Please describe what a typical supervision session looks like
- How does the supervision help you work?
- How could supervision be improved?

How is your performance assessed?

- Does this include internal file reviews, or internal/external case conferencing?

Is there anything else you wish you had access to, that you think would improve the knowledge, skills or tools to do your job well? (e.g. mentorship, on the job training, organizational culture, professional development opportunities, etc.)

TENANT INTERVIEW GUIDE

Overview

How long have you lived in this housing program?

Can you describe your experience getting into the housing program?

- How easy or difficult was that process?
- How did you get referred to this specific program?

Were you given a choice between different programs or locations? If so, how did you choose this program?

Were you given an opportunity to learn about the program rules and expectations before you signed your lease?

- How did you feel about the program rules and expectations?

Can you describe what it's like to live at [this program]?

Probes if not covered:

- Can you describe your living situation – for example, do you live in your own unit, in a shared unit with roommates, etc.?
- What's it like interacting with other tenants who live in the building?
- What's is like interacting with staff?

Are there activities organized by program staff? Do you ever participate in those? What are they like?

What do you like or appreciate about living here?

- What do you find challenging or frustrating about living here?

Have you ever brought up a concern or complaint? What happened and how was that handled?

Have you ever been asked by program staff to share your feedback or suggestions about the programs? How often does that happen?

Do you feel the program is a good fit for you?

- Why or why not?

Services

What services or support do you receive through this program?

Are you given choices about what services you receive?

- How often do you meet with your case manager?
- Who decides how often you meet?
- If you didn't want to meet with your case manager, how would program staff respond?
- Do you feel that the services provided meet your needs? Why or why not?
- Are there any other services you wish were available here?

When you started at this program, were you asked to set goals? If you feel comfortable, do you mind sharing what those goals were?

How would you describe your relationship with staff here?

- Do you feel supported by staff when you need help with a problem? Can you give an example?
- Have you ever had a problem or issue where you did not get the support or help you needed from staff? Can you describe that experience?

Assistance to Maintain Rental Subsidies

Do program staff support you in maintaining your rental subsidy assistance? If yes, can you describe that support?

- How do you feel about the support you receive?
- Have you had any challenges in maintaining your subsidies our housing since you started in this program?

Referrals

You don't have to share specifics, but have you received any referrals to a service outside of this program like primary care doctor or mental health services since you've lived here?

For [the referral they just mentioned] were you able to get the appointment you needed? How long did it take?

Have other referrals gone differently?

Impact of Program on Tenant

What has changed for you since you moved in?

Has living here influenced different areas in your life? This could include health, employment, relationships, or any personal goals.

- Have you noticed any changes in your physical or mental health since moving in? Have things generally gotten better or worse?

- Earlier in this interview, you mentioned (health, education, employment, etc.) were your goals/hopes when moving in.
    - [If not already discussed above, go through goals one at a time]: When it comes to (health, education, employment, etc.) Has this program helped or prevented you from meeting those goals?

Safety

Do you generally feel safe in your unit/building? Why or why not?

- Have there been any events in the building that made you or other tenants feel unsafe?
    - When do you generally feel unsafe? (probe on staffing, rule enforcement, etc.)
- How does the safety of your current situation compare to your other recent living situations?

You don't have to share specifics, but are you aware of incidents like violence or threats of violence, overdoses, injuries, or other safety concerns occurring in the building?

- If so, how did staff and tenants respond?
- How do you feel about staff response? Is there anything you liked/appreciated about how staff responded to safety concerns? Is there anything you wish staff would do differently when it comes to safety concerns?

Over-or under- enforcing leases

Tenants have a right to privacy in their room/unit. How do staff in this program handle your right to privacy in your unit?

Have you had challenges or frustrations with the housing rules?

What typically happens if someone breaks a housing rule?

- How do staff handle these situations?
- Can you think of a time someone was evicted from the program that you felt was unfair?
- Can you think of a time you felt that someone should have been evicted from the program but they were not?

Closing Questions

If a new tenant moved into this program, what advice or suggestions would you give them about being part of this program?

Is there anything else this program is doing well that we haven't talked about?

Is there anything this program is not doing well that we haven't talked about?

If you could change one thing about the program, what would it be?

Demographic Questions

I'm going to ask a few brief demographic questions. You can skip any question you prefer not to answer.

What age range to you fall in?

- 18-34 years
- 35-44
- 45- 54
- 55-64
- 65 and older
- Prefer not to say

How would you describe your gender?

How would you describe your race/ethnicity?

What's your primary language?

What's your family status?

- Single, no children
- Single with children
- Married or partnered, no children
- Married or partnered with children
- Other (please specify)
- Prefer not to say

Thank you so much for your time, that concludes the interview for today.

END OF INTERVIEW

SUBJECT MATTER EXPERT INTERVIEW GUIDE

Background on subject matter expert

Can you share a bit about your experience related to Permanent Supportive Housing?

Provide background on project

Alignment with PSH

Overall, programs are well aligned with the PSH model. 6 of the 7 organizations were considered aligned with PSH using the fidelity scale. The one that scored low enough to be considered "not in alignment with PSH" was the smallest organization with only 10 units.

- Key areas where some programs were not in alignment:
  - Use of residential apartment complexes or shared housing instead of scattered site housing with individual units
  - Requirements for sobriety
  - Requirements to engage in case management
  - Presence of staff/services (case management, behavioral health clinicians, etc.) on site instead of brought to tenants as needed

Across the board, we've heard from staff and tenants about how meaningful these programs are in helping tenants retain safety, stability, set and meet goals, improve their mental health, heal from trauma, etc. After talking with staff and tenants, we have consistently heard that these programs fill a critical need in the community, and that more PSH units are needed. Many are frustrated that the community doesn't understand the complexity of what they do or the importance of their work.

I'm going to share a few of our key findings or questions that have come up so far, and for all of them I'll be asking you similar follow-up questions around if this is similar or different to what you're seeing on a national level, and in general, if you have recommendations or suggestions based on our findings.

Managing aligning PSH and meeting tenant needs

We've seen a variety of programs

- Smaller residential buildings with 20-30 units of female identifying folks and adults with children, who conduct occasional meth tests and have a team of behavioral health clinicians on site
- A larger residential building with 40 units of adults, many of whom are justice-involved, with a sobriety and case management requirement, along with a behavioral health clinician on site
- Larger residential buildings with 40-ish units of all single adults, the most true to Housing First – no requirements beyond a standard lease and an approach really focused on harm reduction, client autonomy

and choice. These buildings sometimes are home to folks who have been exited from other programs due to not complying with program rules.

We've heard that these different types of programs are all needed, and that different programs are a good fit for different needs. Some tenants will thrive in a more structured environment with strict program rules, while others are happier in a less structured environment with more flexibility in engaging with case management, substance use, lease violations, etc.

Some programs are more comfortable supporting residents with a high level or unmanaged behavioral health/substance use needs whereas others either feel less comfortable or actively avoid having those folks as tenants through eligibility screening/program rules. Ultimately this means the mix of tenants at each program is a different sub-population of the chronically homeless population. We've heard that it's important to have all different types of programs to meet different tenant needs, but also this means that the highest needs folks end up concentrated in the same residential facilities.

- How is this similar or different from what you're seeing nationally?
- What's your opinion on the benefits of different types of programs that serve different sub-populations of the chronically homeless population?
- How do you think this compares to a scenario where all programs have a "Housing First" approach leading to a more even spread of highest risk folks?

Managing safety and tenant rights

The buildings facing the most scrutiny are the larger residential facilities with the most Housing First approach that are most aligned with PSH, with their only program requirements being standard lease terms and compliance with a guest policy. These are also the facilities that tend to accept folks who may have been exited or screened out from other programs for unwillingness to comply with program rules around sobriety or case management. This can mean that the most "Housing first" programs end up with the highest concentration of folks with the highest support needs, or who are potentially the highest risk for substance use, lease violations, and potential safety incidents.

One of the reasons we were hired to conduct this evaluation is based on political and community concerns about safety at these two specific PSH properties that are the most "Housing First." They have the highest frequency of safety incidents – calls to 911 or mental health crisis teams, reports of substance use and dealing on the property and around the buildings, violent incidents on the property, and overdoses on site.

- How are other regions approaching adequately supporting those programs that really seem to end up handling the most vulnerable, highest risk folks, and thus face the greatest safety challenges managing substance use, dealing, etc.?
- How is this similar or different from what you're seeing nationally? How does this align/not align with what you're hearing from other communities?
- Do you have any advice, recommendations, or considerations for success with these larger residential buildings that are clearly filling an important need for housing in the community?

As I mentioned earlier, one property in particular has come under public scrutiny where there was a homicide along with several overdose deaths on site over the past few years. The argument from programs and staff, is that they are employing harm reductions approaches, providing safer use supplies and making safer use plans with tenants which likely reduce incidence of overdoses, and that as a Housing First approach, it's better to have someone in housing even if they end up overdosing in that housing unit, as opposed to that incident occurring on the street. The concern from community members and government funders is a feeling that the programs are negligent, and frustration that the level of oversight and the wellness check approach is inadequate to ensure tenant safety.

- How have you seen the conversation around overdose related deaths at PSH facilities handled? Have you seen any successful approaches?
- How is this similar or different from what you're seeing nationally?

I've seen that nearby King County Public Health, where Seattle is located, has just posted a position focused specifically on overdose prevention in PSH facilities.

- Have you heard of any effective strategies used in other geographies to prevent overdose in PSH facilities? How effective do they seem to be?
- Have you seen any similar initiatives in other geographies?

One of the challenges we've heard is that it can be hard having 40+ formerly chronically homeless folks, most with a behavioral health diagnosis, and many of whom also have a history of substance use, all under one roof. That there can be situations where folks trigger each other, or decompensate and become violent and make other tenants feel unsafe and then are onsite for a while time while waiting for the eviction process, or start using or dealing on site which can influence their neighbors. The building as a whole can also become a target for dealers to spend time nearby.

These organizations do operate scattered site programs, but it seems that scattered site apartments are usually reserved for folks that have already been in housing for some time, as opposed to folks entering housing for the first time.

- How are other regions approaching residential vs scattered site housing?
- How is this similar or different from what you're seeing nationally?
- Do you have any advice, recommendations, or considerations for success with these larger residential buildings that are clearly filling an important need for housing in the community?

Another key challenge is around managing situations where someone has decompensated or is consistently breaking program rules in a way that is a safety risk to other tenants – such as dealing on the property, bringing over unsafe guests, etc. That even when they've identified someone who is consistently a risk to others despite many attempts to re-engaged them, having a formal lease means that once they move to eviction the process can take months. In the interim period, staff and other tenants can feel unsafe. Some staff have mentioned they don't feel like they have the appropriate legal resources in these situations.

- How is this similar or different from what you're seeing nationally?
- Do you have any advice, recommendations, or considerations?

Another major challenge is around access to BH providers. A few have BH providers on site or in-house/on call which seems to make them much better prepared and equipped to respond to tenants quickly at the first signs of behavior change, substance use, or decompensation. However, this is not technically aligned with the PSH model, as PSH programs were not originally intended to be the providers of behavioral health services.

- What's your approach to the importance of balancing fidelity to PSH as an evidence-based model, vs using approaches that seem to be effective in supporting tenants in practice?
- How is this similar or different from what you're seeing nationally?
- Do you have any advice, recommendations, or considerations?

The programs with a a successful onsite behavioral health clinician approach were all programs with higher level of rules/expectations that require tenants to actively participate in some level of case management as a condition of retaining tenancy. One of the bigger, more "Housing First" programs has been unable to successfully hire and retain a behavioral health provider for three years despite having the funding for the position, stating that all the folks they've hired haven't managed to engage successfully with their tenant population.

• Have you seen similar challenges hiring/retaining BH providers to support PSH programs? How have these challenges been handled?
Closing Reflections • Other that what we've already discussed – any other major challenges or successful approaches for PSH that you've seen at the national level? • What can be done to make these programs better received by community members and more embedded into communities? • What is the missing link to make PSH programs safe, acceptable, and sustainable? What's needed to set them up for success?

COMMUNITY MEMBERS FOCUS GROUP GUIDE

Connection to PSH Programs
What is your connection to PSH programs in Whatcom County?
Individual- Level Perspectives
[Explain the goals of PSH programs and the role they play in the Whatcom County homelessness response] What does the phrase 'Permanent Supportive Housing' mean to you? If someone in your community is chronically homeless and has recently entered a PSH program, what do you feel would be considered a successful outcome for that person?
Program Level Perspectives
What do you think is working well within individual PSH programs in Whatcom County? What should continue? ○ If you imagine a successful program, what would that look like?
What do you think is not working well with individual PSH programs? If you could make changes to the PSH programs, what would those be?
Safety

One of the goals of PSH is to enable people to stay housed, including people with behavioral health conditions or substance use disorders, by creating a safe space focused on maintaining and improving their health.

From your perspective, how well are PSH programs achieving this goal?

What is your perception of safety within PSH programs?

- How do you think PSH programs impact the safety of tenants?
- How do you think PSH programs impact the surrounding neighborhood (positively or negatively)?
- What do you think is working well when it comes to safety? What would you like to see done differently?

Communication & Community Connections

Have you interacted with PSH tenants or staff? If so, what have those interactions been like?

How do you feel PSH programs engage with the broader community?

- Do you feel there's enough communication between PSH programs and community members? Why or why not?
- What types of communication or connection would improve relationships between PSH programs and the community?

System-Level Perspectives

When thinking about the PSH system across Whatcom County, what do you think is working well? What gaps do you see?

If it were up to you, what sort of response system would we create for people who may not be a good fit for PSH Programs?

Closing Reflections

Is there anything else about PSH programs in Whatcom County that you would like to share?

- What key takeaways do you hope decision-makers take from this discussion?

COUNTY COUNCIL INTERVIEW GUIDE

Background on project

The purpose is to evaluate existing PSH programs, identify strengths and areas for improvement, ensure alignment with best practices, and determine whether additional resources are necessary for the model's success in Whatcom County. There have been a several deaths related to overdose and a homicide that were widely reported on, along with complaints about substance use and dealing at PSH sites and in the surrounding neighborhoods, which led to community scrutiny over the PSH program and ultimately to us being hired to conduct this evaluation.

There are 7 organizations providing PSH services in Whatcom County with 540 PSH units between them. Our evaluation a couple of different components:

- *Exploring alignment with PSH as an evidence-based model (process evaluation) using the SAMSHA fidelity scale*
- *Exploring key safety approaches through a safety analysis, which is including a mortality analysis*
- *Exploring how well PSH programs are meeting key objectives of PSH focused on tenant outcomes around housing, mental health, substance use, attaining goals, etc.*

Our evaluation is ongoing. It's followed the SAMHSA evaluation guidance and included:

- *A significant review of program documents (contracts, leases, program policies and procedures, program rules, service plans, etc.)*
- *Interviews with program leads, staff, tenants, community members, county council members, and government staff from several departments*
- *Review of key quantitative data reported to HUD and collected quarterly by the county health and human services departmen*t

Council member intros

Can you share a bit about your role on the council and how housing and homelessness issues fit into your work?

Perspectives on PSH

Permanent supportive housing is designed to providing a housing option

- *"Subsidized, leased housing with no limit on length of stay*
- *prioritizes people who need comprehensive support services to retain tenancy*
- *uses admissions practices designed to use lower barriers to entry than would be typical for other subsidized or unsubsidized rental housing, especially related to rental history, criminal history, and personal behaviors.*
- *It's paired with on-site or off-site voluntary services designed to support a person living with a complex and disabling behavioral health or physical health condition who was experiencing homelessness or was at imminent risk of homelessness prior to moving into housing*

- *Services are intended to support tenants to retain their housing and be a successful tenant in a housing arrangement, improve the resident's health status, and connect the resident of the housing with community-based health care, treatment, or employment services.*
- *Permanent supportive housing is subject to all of the rights and responsibilities defined in chapter 59.18 RCW."*[1]

- *PSH participants have a lease with their landlord, and thus are* ***tenants subject to all rights and responsibilities under the Washington State Residential Landlord-Tenant Act. They have a right to privacy in their apartment, and they may choose to not engage in services.***

Can you share a little about your experience with PSH programs?

What do you see as the primary benefits of PSH?

From your perspective, what aspects of PSH programs are working well?

What aspects of PSH are you concerned about?

Are there areas where you think PSH programs might benefit from more support or refinement?

Have you heard from your constituents about PSH? What have you heard from them?

What do you think should be prioritized for changes or improvements in PSH programs?

System Level Perspectives

What role do you think PSH programs should play in the homeless response system in Whatcom County?

Thinking about the homelessness response system in Whatcom County overall, what do you see as the biggest gaps or challenges?

When it comes to PSH, what does success look like for the broader housing system and homelessness response in Whatcom County?

Deliverables
We will be sharing a report and presentation with the public after we finish our evaluation. What would be most useful for you to see in our public- facing report or presentation? What would you like to see included in that report? What would you like to see included in the deliverables that we haven't started on yet? o Are there any specific data points or insights that would help inform future council decisions?
Closing Reflections
Is there anything else about PSH or the county's homelessness response that you think is important for this discussion? What role do you see the county playing in strengthening or improving PSH programs? If you could make one change to improve the PSH system or programs, what would it be? What does an ideal PSH system look like to you?