THE KEY TO UNLOCKING HOMELESSNESS IN AMERICA:
Emerging Trends in HUD-Sponsored Research
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From Street Life to Housing: Consumer and Provider Perspectives on Service Delivery and Access to Housing

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Many Years of Work on Homelessness

Early 1990s: Survey on Homeless Shelter Users in Boston

1992-96: Boston McKinney Homeless Demonstration Project

1999-2007: Homeless Management Information Systems

2001-04: Dissertation "Bridges and Barriers to Housing for Chronically Homeless Street Dwellers: The Effects of Medical and Substance Abuse Services on Housing Attainment", with support from HUD DDRG

2005-07: Housing First for Chronically Homeless Street Dwellers

Current: "Housing First" for Homeless Families

Dissertation Research: Bridges and Barriers to Housing for Chronically Homeless Street Dwellers: The Effects of Medical and Substance Abuse Services on Housing Attainment

- Increased focus nationally and locally to ending "chronic" homelessness in 10 years but little is known about how to accomplish this goal
- Background: DPH homeless task force
- Study population: Chronically homeless street cohort at risk of death 2000-2003 identified by Boston Health Care for the Homeless Program, N=153
- Overarching research question: What are the bridges and barriers for this group of chronically homeless street dwellers to leaving the streets?

5 Sub-Questions

- What are the residential benefits for chronically homeless street dwellers based on medical and substance abuse services?
- What are homeless service providers' theories of homelessness and assumptions about how services may improve housing and health status of chronically homeless street dwellers ?
- What factors enable homeless street dwellers to move along the CoC and attain housing?
- What are the barriers to connecting homeless street dwellers with services so that they can move along the CoC and attain housing?
- What changes in the service delivery approach for homeless street dwellers would improve housing and other outcomes?

Methodology

- Mixed-method research approach
  - Medical and substance abuse service data, and housing outcomes 2000-2002
  - In-depth interviews with homeless medical and substance abuse service providers:
    - BHCHP Street Outreach team
    - BHCHP Respite Care Program
    - Detoxification Staff
  - In-depth interviews with current and former high-risk cohort members in housing

Collecting Data

Life on the Streets

- Survival
- Violence
- Feeling worn out
- Friendships/Community on the Streets
- Staying clean/Concealing your homelessness
- Sense of pride of surviving on the streets
- Psychological impact
- Why shelters do/did not work

Table 1: Service Use Patterns of High-Risk Homeless Street Dwellers 2000-2002

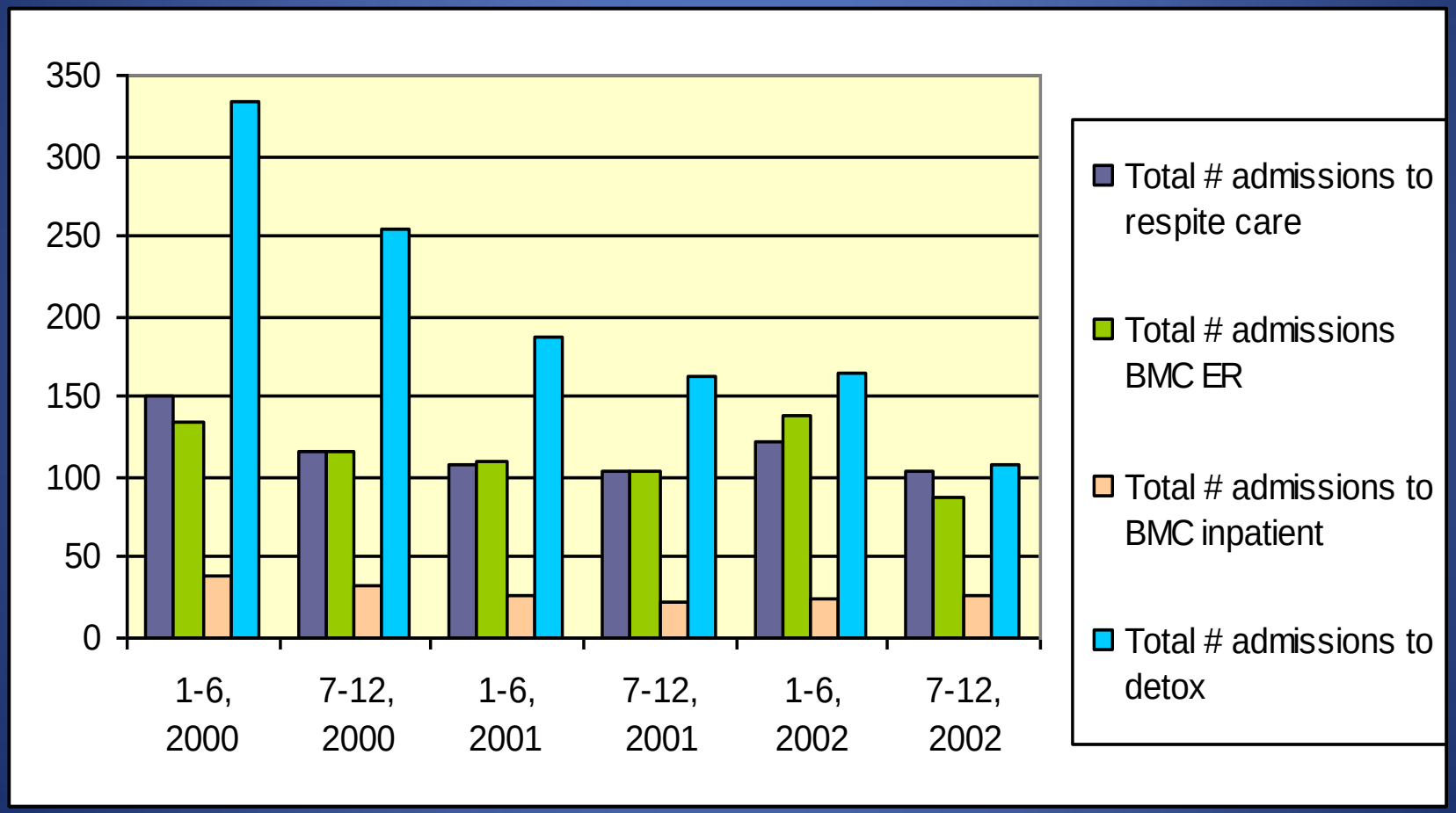
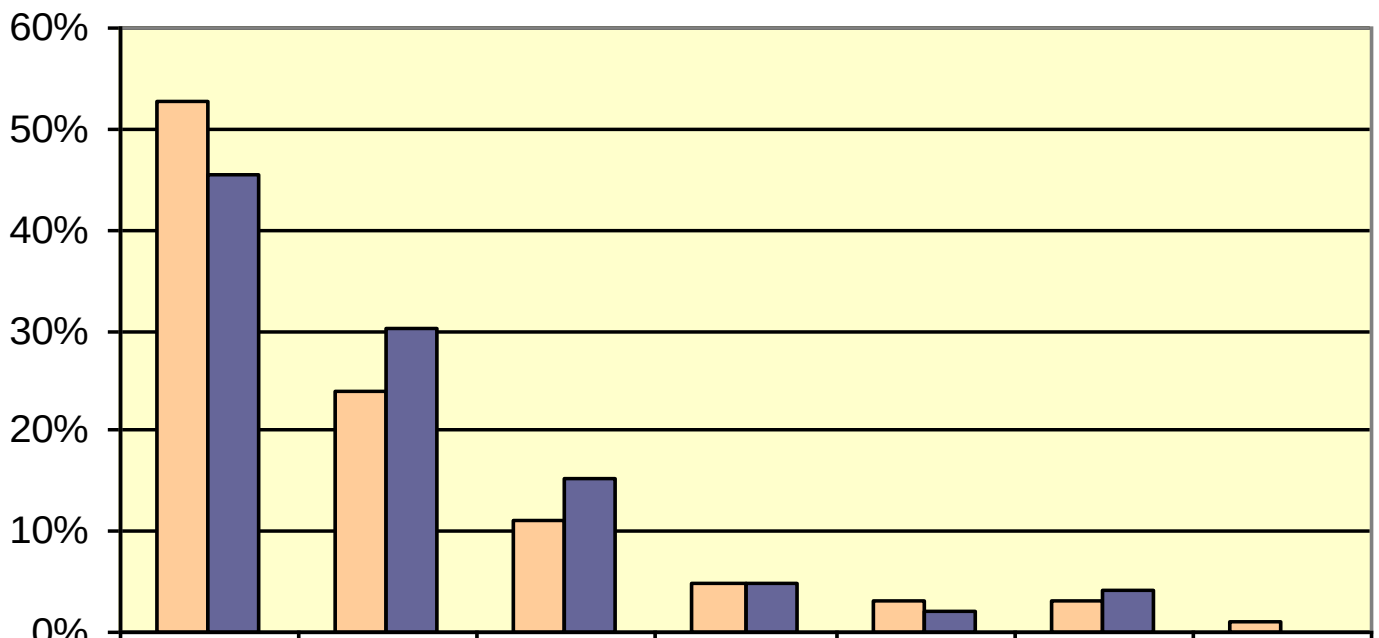


Table 2: Housing Outcomes at the End of 2002



	Remaining hi risk on the streets	Housed/long-term program	Deceased	Lost to Follow-up	Moved Out of State	Jail/Prison	Homeless Shelter
All High Risk N=174	53%	24%	11%	5%	3%	3%	1%
High Risk 1-6,2000 N=101	45%	30%	15%	5%	2%	4%	0%

Table 3: Percent of Each Respondent Group on Theories of Homelessness

Homelessness Theories	Street Outreach Team (N=6)	Respite Care Providers (N=8)	Detoxification Service Providers (N=4)	Current High-Risk Street Dwellers (N=9)	Former High-Risk Street Dwellers (N=9)
Lack of Affordable Housing	17%	13%	0	11%	22%
Insufficient Income	67%	0	50%	22%	22%
Mental Health	100%	63%	75%	0	22%
Substance Abuse	50%	63%	75%	56%	89%
Medical Problems	17%	13%	0	0	0
Trauma/Abuse	17%	38%	25%	22%	0
Prison/Jail	17%	25%	25%	22%	0
Unstable Families/ Loss of or Break-up with Spouse	50%	38%	50%	22%	33%

Table 4: Percent of Each Respondent Group on Service Needs and Program Logic

Major Service Needs	Street Outreach Team	Respite Care Providers	Detoxification Service Providers (N=4)	Current High-Risk Street Dwellers (N=9)	Former High-Risk Street Dwellers (N=9)
Housing	17%	38%	25%	100%	56%
Mental Health	83%	38%	75%		11%
Substance Abuse	33%	50%	75%	56%	33%
Medical Problems	50%	25%	50%	44%	44%
PTSD	0	13%	0	0	0
Life Skills Training/Job Training	17%	13%	25%	0	0
Consistent Support	17%	13%	0	0	0
Program Logic					
Developing Provider-Consumer Relationships	100%	50%	50%	89%	89%
Access to Medical Services	67%	100%	50%	67%	89%
Continuity of Care	50%	38%	75%	11%	0
Decreasing Mortality	33%	0	0	11%	11%
Linkage to Housing	33%	25%	75%	11%	44%

Provider and Consumer Views on Service Need and Delivery

- Disagreement between providers and consumers on major service needs
- Primary role of outreach and respite care: Access to medical care and forming trusting relationships, and of detox staff: medical detox but no long-term relationships
- Most providers believed that housing can only be achieved attending long-term treatment programs

Table 5: Providers and Consumers Views on Bridges to Housing

BRIDGES TO HOUSING	Street Outreach Team (N=6)	Respite Care Providers (N=8)	Detox Service Providers (N=4)	Current High Risk Street Dwellers (N=9)	Former High Risk Street Dwellers (N=9)
Service Coordination					
Within Own System of Care	33%	50%	75%	22%	44%
With Other Homeless Programs Providing Housing	50%	63%	75%	0	56%
With Mainstream Agencies (DMH/DMR)	50%	63%	0	11%	22%
Service Processes					
Provider-consumer relationships	67%	38%	50%	56%	56%
Consistent support/ Continuity of Care	50%	63%	0	0	44%
Client Centered Approach/Consumer Involvement	50%	25%	50%	11%	22%

Table 6: Providers and Consumers Views on Barriers to Housing

BARRIERS TO HOUSING	Street Outreach Team (N=6)	Respite Care Providers (N=8)	Detox Service Providers (N=4)	Current High Risk Street Dwellers (N=9)	Former High Risk Street Dwellers (N=9)
Lack of Funding					
Lack of Program Capacity	0	38%	50%	11%	0
Lack of Re ferral Options	83%	86%	50%	78%	33%
Lack of Housing	0	25%	0	44%	33%
Housing Application Process	33%	25%	0	33%	22%
Insufficient SSI Income	33%	13%	0	22%	22%
Service Provision					
Unskilled Staff	17%	25%	50%	22%	0
Service Eligibility					
Eligibility Rules	33%	25%	25%	0	0
Criminal Records	0	25%	25%	11%	0
Health Insurance	17%	13%	50%	0	0
Personal Factors					
Untreated MH and/or SUD	33%	50%	0	0	11%
Lack of Skills	33%	25%	50%	0	0
Fear of Change	17%	38%	50%	11%	0

Provider and Consumer Views on Bridges and Barriers to Housing

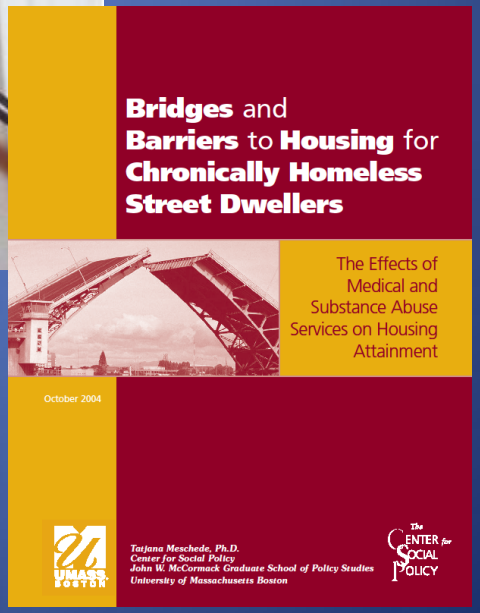
- Service providers stressed the need for good service coordination and adequate referral options.
- Consumers stressed the need for access to stable and affordable housing.
- Both stressed need for good provider-consumer relationships.
- Impetus to leave the streets when faced with severe illness.

Consumer and Provider Recommendations

- Create more affordable housing
- Address housing needs when providing medical/substance abuse services
- Creation of different types of housing programs and better coordination of care
- Continuous and reliable support after moving into housing
- Education of staff in homeless and mainstream programs
- Client centered services

Street, Shelters and Homes: New Directions for Addressing Chronic Homelessness in Boston

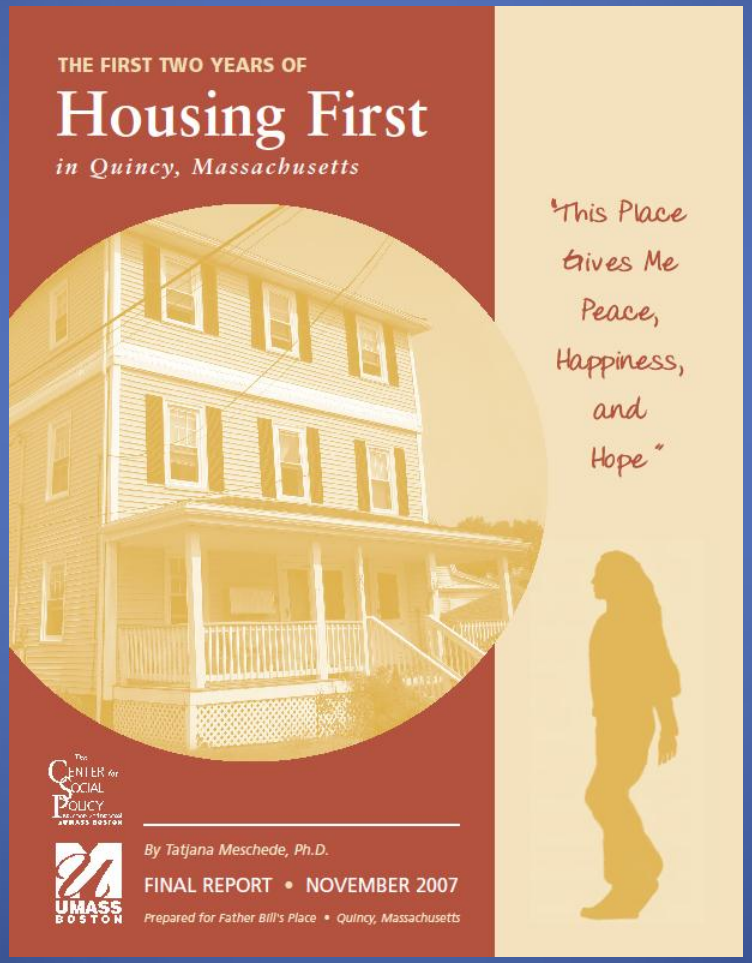
Boston Faneuil Hall; October 28, 2004



Select Policy Implications

- Increasing the affordable housing stock
- Establish Housing First models
- Establish support systems during transition to housing, and continuous support afterwards
- Provide a more integrated system of care that includes housing, medical, substance abuse and mental health, and allow for client input
- Reduce bureaucratic barriers to housing
- Reduce shelter stays/Rapid rehousing

Housing First



Housing First in Quincy, MA

- Father Bill's Place vision
  - to house every homeless person in a short period of time vs housing them in the emergency shelter.
- First house (Claremont street) opened in May 2005. Capacity for 12 women.
- Second house (Winter street) started housing men in November 2005. Capacity for 16 men.
- By May 2007, 52 Housing First units were created.
- Harm reduction approach: low-threshold for continued tenancy, even with continued substance abuse.

Claremont Street House

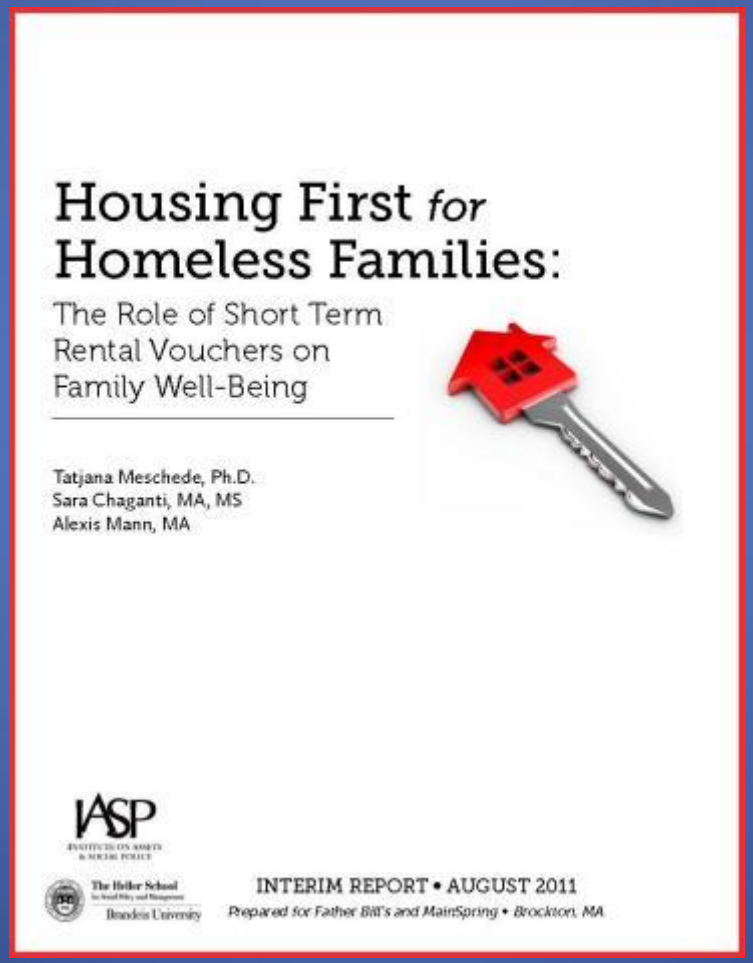
Select Major Findings

- Service needs are high among these Housing First residents with 46 percent having a physical disability, 86 percent mental health challenges, and 64 percent substance abuse issues.
- Of all Housing First residents who moved during the first year of this program, 86 percent remained housed a year or more after their move.
- Overall quality of life improved dramatically for all Housing First residents after leaving the shelter, including increased sense of independence, control of their lives, and satisfaction with their housing.
- After their move into the Housing First residences, most residents began to address medical needs that they were not able to focus on during their homelessness. In addition, not being exposed to disease in the crowded shelter environment prevented many from getting sick and spending time in the hospital.
- Hospital stays were dramatically reduced when comparing the year before access to Housing First and the year after for the group of women at one of the SRO residences. Inpatient hospitalization decreased by 77 percent, and hospital emergency room visits by 83 percent.

Select Major Findings cont.

- The number of residents receiving SSI income increased due to their move to Housing First.
- The FBP work crew provides an opportunity for many to work during the day. Few were able to access employment outside of the FBP. Barriers accessing employment include explaining gaps in past employment and fears of losing SSI income.
- Their new homes helped Housing First residents to reunite with family members and build stronger relationships with each other. However, residents ranked the support they received from staff higher than any other.
- Shelter staff noted improvements in daily living activities and health status for all formerly chronically homeless individuals residing in Housing First. While not all shelter staff was supportive of this model prior to its implementation, all thought that it worked well for all residents, and is a model that should be replicated for more chronically homeless people.
- Even though the rules at the Housing First residences don't allow drinking and abuse of substances, sobriety is not a requirement to enter housing. Case managers shared a number of creative ideas on how to best address this problem to enable open communication between staff and residents who continue to use substances. One option was temporarily removing these residents from Housing First so that they could enter treatment programs.
- Providing housing for those who were chronically homeless reduced chronic homelessness in the Quincy/Weymouth Homeless Continuum of Care (CoC) by 19 percent between January 2006 and January 2007.

Current Project:
Housing First for Homeless Families



Housing First for Homeless Families: The Massachusetts Pilot Program

- Implemented in Fall 2009, “Housing First” seeks to end homelessness and encourage family self-sufficiency by using short-term rental vouchers.
- Once established in stable housing, families receive homeless stabilization services and are connected with community resources.
- Families are eligible for 2 housing voucher extensions of 6 months each

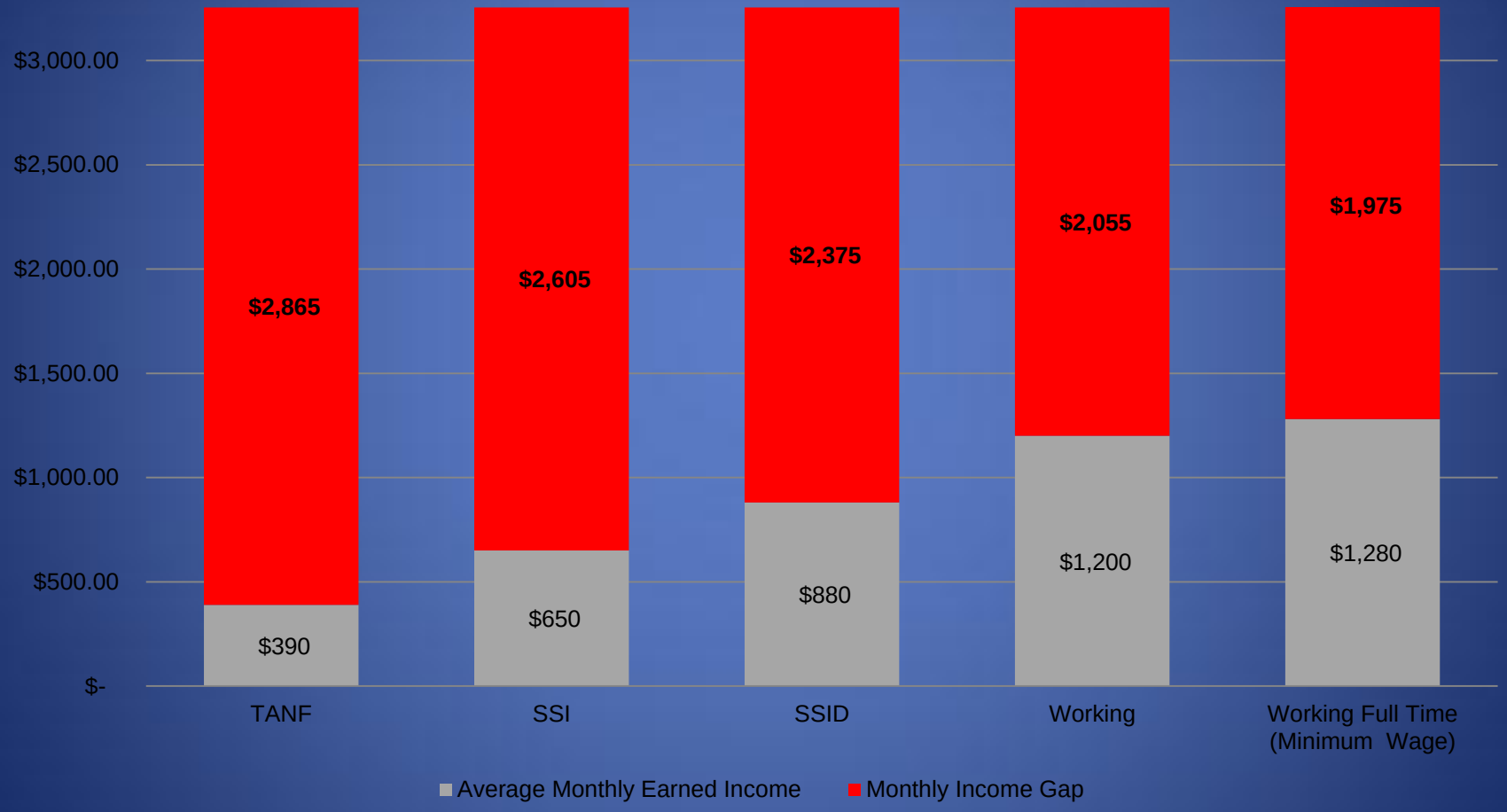
Housing First for Homeless Families: The Project

- 134 families housed between August 2009 and May 2010 through FBMS.
- Data Sources:
  - In-depth interviews and focus groups with FBMS staff (supervisors, stabilization workers, triage workers, children's advocates, workforce development staff)
  - Interviews with other statewide key stakeholders (DHCD, ICHH, One Family Campaign and Firemen Foundation, The United Way of Greater Plymouth).
  - In-depth interviews with a diverse sample of 22 client family heads of household, about a year after they entered the "Housing First" program.
  - Analysis of data from the Homelessness Management Information System (HMIS)
  - Quantitative data from two surveys designed by the IASP research team and merged with the HMIS database.

Preliminary Findings

- Families tend to be headed by young single mothers, with one or two children. More than half of the 208 children are under age 5 (57 percent).
- Major reasons for becoming homeless include separation from family/divorce, job loss, and illness/disability.
- Family incomes are too low to pay for market rent in Brockton with most of the families relying on public benefits as their sole income source..
- Eighteen percent of family heads are employed at program entry; however hourly wages are low, ranging from $8.00 to $14.00. With the very low level of education among household heads (61 percent with a high school diploma or GED, 30 percent did not complete high school), most can only find low-wage, non-benefited jobs, often with irregular work schedules and fluctuating hours.

Figure 1: Economic Reality: Gap Between Current Income and Income Needed* to Afford a 2 Bedroom FMR apartment in Brockton



Program Assessment

- All stakeholders agree that rapid re-housing is a much better strategy for most homeless families than living in a shelter or a motel.
- Consistent stabilization services are critical to success of this program.
- Cost-effectiveness: Providing short-term rental vouchers and stabilization services is less expensive than providing shelter or putting families up in hotels.

Housing Outcomes

- Few are able to sustain their homes upon program exit. Of the 60 families who left the program by June 30th, 2011
  - 25 percent are able to retain their housing
  - 23 percent receive Section 8 rental vouchers or live in public housing
  - 20 percent disappeared.
  - 18 percent are doubling up with family or friends, and eight percent are back in shelter.
- Most families were hoping to receive a long-term housing voucher.