

THE FIRST TWO YEARS OF
Housing First
in Quincy, Massachusetts

*“This Place Gives Me
Peace, Happiness, and Hope”*

By Tatjana Meschede, Ph.D.

FINAL REPORT • NOVEMBER 2007

Prepared for Father Bill's Place • Quincy, Massachusetts



Acknowledgements

This report is the result of many individual contributions. Foremost, I want to thank all interview and focus group participants for their willingness to share their experience with me. I also would like to thank Julia Tripp for conducting the focus groups and their transcription, and Donna Haig Friedman for editing this report. In addition, I appreciate the support of Jennifer Craven and Brent Soares for arranging meetings with Housing First residents. I would also like to thank the entire Housing First team for sharing their experiences of implementing this housing model, including Sharon Blaney, Jennifer Craven, Nicole Fitzgerald, Jessie Gaeta, Brent Soares, Jill St. Martin, Hope Wilson, and John Yazwinski. Finally, I would like to thank Jill St. Martin for showing me the shelter and the residences, and organizing the focus group, and Nicole Fitzgerald for all her hard work of getting me the data used for this report. Without all your contributions, this evaluation and report would not have been possible.

The Boston Foundation supported this evaluation project through a grant to Father Bill's Place.

“You can’t imagine what this place means to me. I still can’t believe I live here. This place gives me peace, happiness and hope for my future.” (Housing First resident)

Table of Contents

Executive Summary	5
Introduction	9
Data Collection	10
Evolution of FBP's Housing First Models	10
Selection of Housing First Residents	11
Housing Tenure	13
Who are the Housing First Residents?	14
Experiences with Housing First: The Residents Speak	15
Comparing Shelter Life to Housing First: Quality of Life.....	15
Health.....	16
Incomes and Financial Needs	16
Social Supports	17
Identity: Still a Homeless Person?	19
Daily Activities	19
Sense of Neighborhood.....	21
Stepping Stone or Permanent Housing?	21
Staff Assessments/Lessons Learned	22
Approaches to Dealing with Substance Abuse	22
Does Housing First Work for All?.....	23
Impact of Housing First on the Larger Community	24
Reduction in Chronic Homelessness	24
Reduction in Shelter Usage.....	24
Reduction in Use of Medical Services.....	25
The Costs of Sheltering and Housing Homeless People.....	26
Conclusions	27
Recommendations	28
References	31
Appendix: Logic Model of Evaluation Framework	33

List of Figures

Figure 1: Housing Outcomes	13
Figure 2: Extent of Physical, Mental Health, Substance Abuse, and Domestic Violence Victimization Among Housing First Residents	14
Figure 3: Average Daily Shelter Census 2003-2007	25
Figure 4: Annual Bed Rates for One Person in Housing First and in the Shelter	26

Executive Summary

Housing First is a housing and support services program that attempts to move the most disabled homeless people directly to housing prior to treatment, using housing as the transforming element to support participation in treatment. This approach does not require sobriety or participation in long-term treatment programs unlike the traditional continuum of care approach. Promising results have been demonstrated in a number of projects using this model (Tsemberis & Eisenberg, 2000).

For the past ten years, **Father Bill's Place** (FBP), a homeless shelter and housing program in Quincy, Massachusetts, has moved steadily towards providing permanent housing with supportive services, rather than emergency shelter, as the preferred solution to ending homelessness. In May, 2005, FBP opened the doors to its first Housing First project providing 12 units to chronically homeless women. By May of 2007, FBP had created a total of 52 Housing First units.

This evaluation report draws on a range of data sources, including qualitative in-person interviews and focus groups with Housing First residents and their case managers, as well as quantitative information on each Housing First resident. The sections to follow describe the characteristics of Housing First resident, document their experience in moving from long-term shelter life to their Housing First residences, and highlight the impact of Housing First on its residents as well as the larger community.

Major Findings

- Between May 2005 and May 2007, FBP created 52 Housing First units, 44 Single Room Occupancy (SRO) units and eight units in shared apartments.
- These Housing First units provided 64 mostly chronically homeless shelter guests the opportunity to leave their lives in the emergency shelter and move into their own rooms.
- 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.
- 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.
- Housing chronically homeless individuals reduces the use of emergency shelters. Between May 2003 and May 2007, the FBP average daily shelter census was reduced by about 30 homeless people in need of shelter.
- Of all Housing First residents who moved during the first year of this program, 86 percent (56 out of 64) remained housed a year or more after their move.

- Twelve individuals left the program. Reasons for leaving included death for two, moving into other permanent housing, disagreement with rules, unknown destination and other. Two individuals moved back into the emergency shelter. Those who left Housing First and did not move into other permanent housing were mostly struggling with substance abuse.
- 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.
- 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.

- Categorical eligibility criteria, for example funding limited to serving only the homeless mentally ill, constrains the much needed flexibility essential for creating and implementing successful programs.
- Sheltering homeless people is more expensive than housing them. Annual per person shelter costs are more than \$3,500 higher than comparable expenses for a Housing First unit. This cost estimate is low; for example, it does not include savings of expensive hospital care costs.

Recommendations

Program Level

- **Expand Quincy’s successful Housing First model** by adding more units with ranging levels of staff support tailored to the needs of the Housing First residents.
- **Establish access to daily activities** outside the residence. Visiting social clubs, engaging in volunteer work or finding employment are essential to promote the expansion of social networks, improved self esteem, and leaving the homeless identity behind. Instituting more structured employment counseling and preparation opportunities would be beneficial to all Housing First residents in their quest to reintegrate into society.
- **Educate tenants living in congregate based housing about severe mental illness and substance abuse.** Those who live with fellow residents who have severe mental illness need to be supported and guided in how to best address such behavior. Further, finding creative solutions for those residents who continue to use alcohol and other illegal substances after moving into Housing First is critical for offering housing for all chronically homeless persons.

Homeless System Level

- **Increase funding for Housing First programs.** As this model in Quincy and similar models in other communities have demonstrated, this is a successful and cost-effective model to end homelessness.
- **Allow more flexibility in funds** for homeless programs and allow local programs to decide on how to best use these funds in their vicinity. For example, funds for shelter beds could be much better used for innovative housing models. Similarly, funds restricted to certain populations, e.g. the homeless mentally ill, could also be used to serve individuals who may not exactly fit this funding category.
- **Promote research** on determining factors for success in Housing First, as well as which Housing First model fits with particular tenant characteristics.

Introduction

Among all homeless people, there is a group of chronically homeless individuals¹ who struggle with homelessness for years, adapt their lifestyle to the emergency shelters and the streets, and face numerous barriers to leaving their homeless plight behind (Kuhn and Culhane, 1998). Years of life in the shelters and the streets, accompanied by malnutrition, lack of health care and often extensive substance abuse and mental health problems, take a toll on their health, and place them at increased risk of death (Hwang, 2000). Successfully housing chronically homeless individuals is critical for survival, and new service models have created viable housing options for this population (Tsemberis et al., 2002).

Aside from the human plight, chronic homelessness also results in an enormous public financial burden. While comprising about ten percent of the homeless population, chronically homeless individuals use up to half of all homeless services dollars (Kuhn & Culhane, 1998). In addition, these individuals disproportionately account for expensive medical care like emergency room visits, inpatient hospitalizations, and substance detoxification (Meschede, 2004), as well as other public services.

To end homelessness for its chronically homeless population, Quincy, Massachusetts began implementing Housing First models that build upon an approach for housing chronically homeless street dwellers with psychiatric disabilities. This Housing First model is a housing and service program that attempts to move the most disabled homeless people directly to housing, prior to treatment, using housing as the transforming element to support participation in treatment. This approach does not require sobriety or participation in long-term treatment programs as has been customary in the traditional continuum of care approach, which builds on successful completion of treatment programs before access to housing is granted. A comparison of this low demand housing approach with the traditional treatment model revealed that 88 percent of the Housing First residents remained in housing after a five year period as compared to 47 percent of those in the traditional treatment/housing model (Tsemberis & Eisenberg, 2000). Compared to the traditional homeless Continuum of Care (CoC) approach to housing, the Housing First approach also reduced public costs at a greater rate (Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003).

For the past ten years, Father Bill's Place (FBP) in Quincy, Massachusetts, has moved steadily towards providing permanent housing with supportive services rather than emergency shelter as a solution to ending homelessness. According to John Yazwinski, Executive Director of FBP, the vision for the future is to be able to independently house every homeless person entering FBP within a short period of time instead of "housing" people in the shelter for prolonged periods. As such, sheltering homeless people in large emergency shelters should be a picture of the past.

¹ The federal definition of chronic homelessness refers to "unaccompanied individuals with a disabling condition who have been homeless for over a year or have had a least four episodes of homelessness over the past three years."

Data Collection

This report builds on the following data sources:

Interviews

First, a total of 24 in-person interviews were conducted with Housing First residents and their service providers. Five of these interviews were conducted shortly after residents moved into their new residence, and again six to nine months following the first interview.

Interviews were also conducted with case managers of the Single Room Occupancy (SRO) residences. Staff was asked to reflect on the first few months of experience with the women at the different Housing First models, impacts of the housing model on the residents' lives, and lessons learned from the various models.

Permission to audiotape the interviews was given for all but one Housing First resident, and all taped interviews were transcribed for analysis. All Housing First residents who agreed to be interviewed were given a \$10.00 supermarket gift card.

Focus Groups

Two focus groups were conducted with residents at one SRO program, at baseline shortly after residents moved into their rooms, and again a year after. Both focus groups were audio taped and transcribed. All focus group participants were given a \$10.00 supermarket certificate for their time.

Administrative Data

In addition, administrative data on demographic characteristics, health service needs, and housing tenure for all Housing First residents are used for descriptive purposes. Point-in-time homeless counts for the Quincy-Weymouth CoC were included in the analyses, as well as information on the comparative costs of providing shelter beds and Housing First units.

Case note review

Case notes of the women at one of the SRO residences were reviewed to count the number of hospitalizations for medical, mental health and substance abuse needs one year before and one year after participating in Housing First.

Meeting Notes

Finally, notes taken at regular meetings with Housing First and FBP staff are included in the analyses to document the process of implementation and expansion of Housing First.

Evolution of FBP's Housing First Models

Housing First began in Quincy in May 2005 when ten chronically homeless women moved from the shelter to the Claremont House, a congregate Housing First SRO residence that provided rooms for up to 12 women. Over the next two years, Quincy's

Housing First program increased dramatically. As of June 2007, this program included 44 Single Room SRO units and eight units in shared apartments.

Father Bill's Place's goal is to offer a number of different Housing First models to its homeless population depending on level of need for supportive services. The first house to open as a Housing First model, the Claremont House, provides SRO rooms to 12 women with shared kitchen, bathroom, and laundry facilities. Claremont House residents receive supportive services to help them live independently, including one onsite case manager who connect them with resources, services, and employment opportunities.

The Father McCarthy House, which opened next in the Fall of 2005 and provides SRO units for up to 18 men, was based on a slightly different approach. While also offering rooms to its residents, all men, with shared bathroom, kitchen, and laundry facilities, there was no on-site case manager present during the first year of operation. However, with less supervision, some of the men at Father McCarthy House were having a harder time moving from the very strict shelter rules to independent living. Consequently, FBP created a similar case management model as it had established for the Claremont House. As two FBP case managers explain,

“As you know in the beginning with the Father McCarthy House, there were really no supportive services. Case management was all pulled from the shelter. It just wasn't working and it wasn't fair to the individuals. Different case managers were involved, and the left hand didn't know what the right hand was doing all the time. That's one of the big reasons why I felt that they needed a central person. I think it's a great move that they have [the new case manager] over there. You need some stability; you need one case manager as far as the house goes.” (FBP staff)

“It's a learning experience. In the beginning it was a struggle. With no staff presence there, things happened over and over again, and there was no person to go to. Different things have happened with individuals coming in and out of the house; individuals who are not supposed to come into the house. One of the biggest things for me is that you give everybody a chance, but when their behavior starts to affect the safety and the rights of the other individuals, then you have to look at whose rights are being violated here.” (FBP staff)

Fourteen additional SRO Housing First units opened during 2006. Shared apartments, all with two Housing First tenants, were added as a Housing First option in the Fall of 2006 to provide Housing First for another eight homeless persons. This study focuses on the first two SRO Housing First models as well as on residents in shared apartments.

Selection of Housing First Residents

Housing First residents are selected from long-term shelter users or from individuals staying in places not meant for human habitation but who receive services from FBP. In their selection process, FBP does not shy away from those with the most challenging needs, i.e. individuals with chronic substance abuse problems or those with severe mental

illness who are not medication compliant. To the contrary, those with the most challenging barriers to housing are purposefully selected for participation.

Unlike in other communities, Housing First in Quincy has no exclusion criteria. For example, prior criminal conviction is not an exclusion criterion, and persons with criminal justice histories are evaluated on a person-by-person basis. The inability to pay rent also does not exclude a person from participating in Housing First.

The following story exemplifies the commitment of FBP staff to support the most challenging individuals in Housing First. This chronically homeless and severely mentally ill woman had been served by FBP for more than seven years. Refusing to take any medication, she had gotten used to the shelter routine and had no desire to move from the shelter to her own room. When taken to her new residence, she refused to stay there. While her refusal didn't come as a surprise to shelter staff, it posed a big challenge for them.

“The biggest challenge was when [one of the women] resisted to move in. We had to say that she was ineligible for services from the shelter in order for us to prevent her from staying here [at the shelter]. That was a big challenge for a lot of the staff here because we have such a long history with [her]. And to have to turn her away and the whole tough love motto is very challenging.” (FBP staff)

After being refused shelter services for about a week, this woman agreed to sleep in her Housing First room and has since established a long-term tenancy. Now living there for more than two years, she started calling it her home about four months after the move.

“One of the seriously mentally ill women referred for the first time to the Claremont House as her home last week. She was talking to one of the women on the first floor and said, I'll be home later. And that was huge. She went out about one month ago and went to Wal-Mart with her sister, her sister came to visit with her, and she went and bought herself a grandfather clock that she set up on her own and put in her room. So she has this big beautiful grandfather clock in the middle of the room. But she is doing wonderful. She was so institutionalized and so used to set ways of life, wake up at 6:30 am breakfast at 7:30, out to the library by 9.” (FBP staff)

Housing First in Quincy is not entirely restricted to chronic homeless individuals although they have priority status. For example, when a young woman, age 18, who was completing high school and was also working was in need of shelter, FBP did not hesitate to move her into one of the unoccupied rooms at the Claremont House. Housing First allowed this young woman to be able to complete her education and keep her employment without being faced with life in the crowded shelter environment. She stayed for about eight months and moved into a one bedroom apartment with her boyfriend. With the completion of her nurses assistant certificate (CNA), she was able to afford fair market rent. This example provides a glimpse of what the future may hold when emergency shelters will be an artifact of the past.

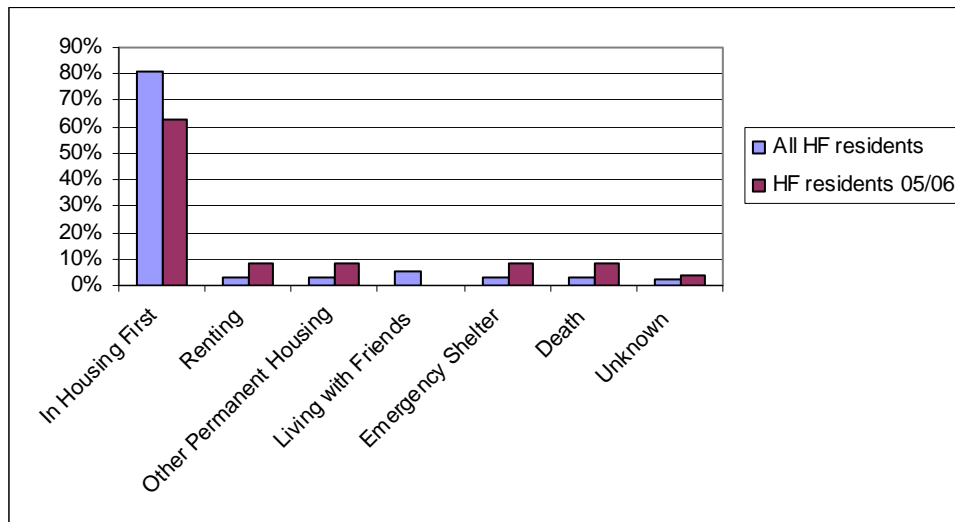
Housing Tenure

During the two year period from May 2005 to May 2007, a total of 64 people have moved from the shelter to any of FBP’s Housing First placements. Eighty-seven percent of the Housing First residents have achieved stable housing tenure thus far, regardless of when they moved into the Housing First residence, 81 percent remaining in the original Housing First apartments and six percent in other permanent housing. Further, five percent of all Housing First residents were living with friends, and another three percent had returned to the shelter. Two (three percent) were deceased.

Of the 24 Housing First residents who moved to their new home during the first year of Housing First in Quincy (May 2005-May 2006), 15 are still in their Housing First placement after one year or more, four moved to other permanent housing, two are in shelter, and two are deceased. Excluding those who have died, 91 percent of these individuals continue to be stably housed.

These housing tenure rates are as high as in other Housing First projects (Stefancic and Tsemberis, 2007) and compare favorably to other studies that document a housing tenure rate in supportive housing for the homeless mentally ill (Padgett, Gulcur and Tsemberis, 2006; Lipton et al., 2000).

Figure 1: Housing Outcomes



Twelve individuals left the program during the two plus years of this program’s operation. Reasons for leaving included moving to other permanent housing for three, death for two, disappearance or unknown destination for one, disagreement with rules for one and other for the remaining individuals. Those who left the program were mostly struggling with substance abuse.

“[Asking the Housing First resident to leave] was definitely a challenge. We are not in the business of making people homeless, and that was difficult because someone was not doing the right thing and she was making very poor choices. And she didn’t come back; the case manager and I had to pack her stuff. That was

very difficult. She is back in the shelter now. ... That was a big challenge for the staff to say that this isn't working and that she can't stay there [in her Housing First SRO unit]." (FBP staff)

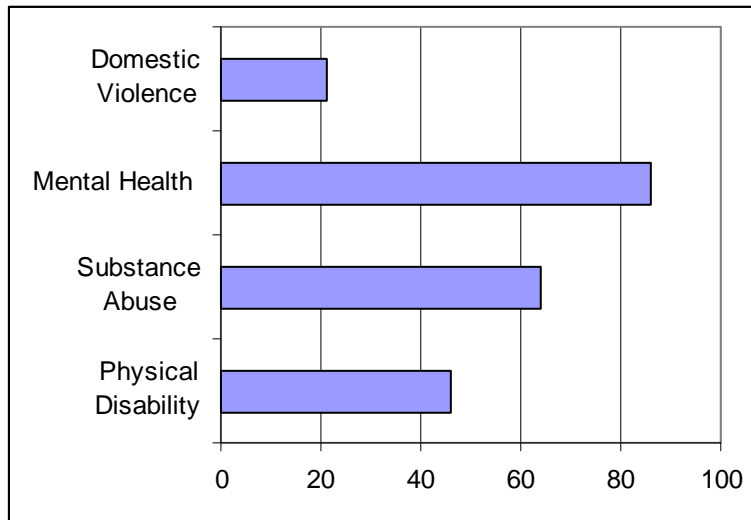
Who are the Housing First Residents?

Housing First provides residences for a diverse group of individuals struggling with chronic homelessness. Among them are 27 women (42 percent).² The majority are Caucasian (91 percent) closely resembling the people seeking assistance from FBP's emergency shelter. Averaging 45 years of age, Housing First tenants reported the following high levels of disability:

- 46 percent have a physical disability;
- 86 percent are identified with mental health challenges;
- 64 percent abuse alcohol and/or drugs.

Further, 21 percent (33) of the women report having been exposed to or having suffered domestic violence.

Figure 2: Extent of Physical, Mental Health, Substance Abuse, and Domestic Violence Victimization Among Housing First Residents



Most stayed at the FBP emergency shelter prior to moving into their Housing First unit (91 percent) while seven percent stayed outdoors in places not meant for human habitation such as the streets, woods, cars, or abandoned buildings. Housing this latter group of individuals poses the greatest challenges as long-term street dwellers have not stayed indoors or lived with others for a long time.

² This disproportionate rate of women is the result of the program design (more beds were made available for women) and does not resemble the proportion of chronically homeless women among Quincy's chronic homeless population.

While there are no consistent data for all Housing First residents on the length of their homelessness, interview data point to a range from just under one year to more than ten years. Reasons for homelessness include a combination of structural and personal factors and vary for each Housing First resident, including, health problems and subsequent loss of employment, domestic violence, mental health hospitalization and release into homelessness, family break-up, and struggles with substance abuse.

Experiences with Housing First: The Residents Speak³

In this next section of the report, Housing First residents detail their experiences with Housing First, comparing it to shelter life and evaluating its impact on their lives.

Comparing Shelter Life to Housing First: Quality of Life

Life at the shelter was dictated by shelter rules, waiting in long lines to get a bed, food, or access to the bathroom and showers, and spending the day outside.

“We had to be out of the shelter by 7:30, and we were out on the streets by 8:00. I went to the library, walking. When not feeling well, I was allowed to stay in. When it was raining or snowing, everybody was allowed to stay in. First thing in the morning, I went to McDonalds across the street for coffee. Sometimes I had to come back to the shelter for work, other days I was just out for the day.” (Housing First resident)

The most noticeable change for Housing First residents was regaining control over their lives. Many shared examples of how their lives were controlled by strict rules when living in the shelter, and how they appreciate being able to lead an adult life now that they live in their own rooms.

“FBP had a lot of control over us, when to eat, when to shower, I lived at this place for exactly one year. You resent the control, you are 51, and these kids tell you what to do ... I am grateful but I want my freedom, my life again. Now – I have peace and quiet, a lot more peace, have TV, come around whenever I want, not have to answer when you are late. ... Getting my life back was a big thing; don’t have to answer to ‘why you were late.’ Don’t have to stand in line.” (Housing First resident)

Disbelief was a common emotion of Housing First residents during their first days in housing.

“The first day here I crashed and I got depressed. Because I never thought I would have my room again. So it put me into a little bit of a depression. I couldn’t

³ Please refer to the Quincy Housing First interim report for a detailed report on Housing First residents’ experiences during their first year in Housing First. Moving Here Saved My Life: The Experience of Formerly Chronically Homeless Women and Men in Quincy’s Housing First Projects. <http://www.mccormack.umb.edu/csp/publications/QuincyHousingFirstInterimReport2006.pdf>

believe it; I was in a shock because I have a very, very nice room.” (Housing First resident)

“It was weird being here [the first day at the Housing First Residence]. I couldn’t believe it. I was looking around and thinking wow.” (Housing First resident)

Health

Life in the shelter or the streets takes a toll on homeless persons’ health. Often, their health care is not at the top of the list of things that need to be addressed when finding shelter and food are more immediate needs.

“My health is better than in the shelter. Every cold makes its round in the shelter, you would be sick all winter.” (Housing First resident)

After settling in their new homes, most started to attend to their health care needs and mental health issues which they had neglected during their homelessness. As one of the case managers summarized,

“Housing First residents address their medical needs much more than when they were in the shelter. One of the women has skin cancer, and she ignored it for a couple of years. Now she has that treated. Another woman had surgery done. If she would be in the shelter, she would have overlooked that problem a little longer. I think because they have a place to recuperate after surgery, that that encourages them to stay on top of their health issues.” (Housing First case manager)

Incomes and Financial Needs

Information on access to incomes before and after entering Housing First were not included in the agency’s administrative data collection. However, detailed information on the first group of Housing First residents indicate that 96 percent were able to be approved for SSI income after moving into Housing First, thereby having income resources needed to purchase basic life necessities such as food, clothing and other household items.

For those on SSI, monthly incomes range from \$400.00 to \$800.00 with most SSI incomes falling into mid \$600s. In addition, most Housing First residents are eligible for Food Stamps; however, the Food Stamp amounts were often so low (\$10.00/month) that many did not apply. Those eligible for higher Food Stamp amounts received between \$10 and \$150 per month.

Even with SSI incomes, resources are tight for all Housing First residents. All with any income are required to pay 30 percent of their incomes as rent to FBP. Making ends meet with what was left after rental payments is challenging. Many talked in detail about how they stretch their limited resources, for example, by visiting soup kitchens or food pantries.

“I go to food pantries. When I get my check the first of the month I buy food. I don’t even bother to get Food Stamps. I would get \$10 per month for Food Stamps and I find food is the biggest expense.” (Housing First resident)

Social Supports

Studies on impacts of social supports on housing tenure among formerly homeless individuals point to a number of factors critical in maintaining housing. For example, social support among the homeless was found to enhance general quality of life (Lam and Rosenheck, 2000), improve mental health symptoms (Coyne and Downey, 1991), and reduce the risk of illness (Dean and Lin, 1977), all critical factors in promoting housing stability. In addition, social supports were found to have beneficial effects on housing status (Calsyn and Winter, 2002).

Housing First residents who participated in this study were asked about support from family, friends, staff and partners. Most of the Housing First residents felt that when they stayed at the shelter, their relatives were reluctant to keep in touch due to the stigma of homelessness and shelter living. With the move to housing, regardless of housing type, many of the Housing First residents are able to build stronger relationships with their relatives, having them come to visit or schedule regular visits with family members. As greater relationships with relatives are an important predictor of housing stability (Pickett-Schenk, Cook, Grey, & Butler, 2007), these overall stronger family ties promote successful housing outcomes for Housing First residents.

Housing First residents are also able to reconnect with their own children which, in most cases, they had not seen their children in many years.

“My family is talking with me again. I started to talk with my daughter again. I had my first phone conversation with her last Wednesday. She is seven and a half, and my mother [who has legal guardianship of the girl] wouldn’t let me talk with her before, but now she lets me.” (Housing First resident)

Due to spending years in homelessness, almost all of the Housing First residents had depleted their relationships with the non-homeless people they knew before becoming homeless. Some shared their sorrow about having long-time friends who did not provide support when they became homeless.

“Friend, we have known each other for a good many years. But I really don’t discuss a lot of things with her. When I was living with her, I found out from someone else that she wasn’t really talking a lot about her feelings, about the whole situation in general, and I prefer people to be upfront. If you hide your feelings, things can’t get resolved. Don’t go to someone else and talk when I should be the one you should be talking to. I like her but I lost some my respect for her.” (Housing First resident)

Very few continue to have connections with their non-homeless friends. Those who do think that support from non-homeless friends and family helped through the time they spent at the shelter.

“My cousin and my girl friends have been preventing me from shooting myself – I tell you. I never thought that I would end up in a homeless shelter. I lived from pay check to pay check but after losing one job after another, I couldn’t do it anymore.” (Housing First resident)

On average, support from staff was rated higher than support from family and friends. Some of the Housing residents rely on staff to a larger extent than others do; regardless of level of need, all spoke highly of the staff.

“They are very caring and professional people. They are comfortable with you and they work for you. But you can’t cross that line, you can’t be too friendly. I talked to them about my problems. They tell you if I go about something the wrong way. They try to steer you in the right direction.” (Housing First resident)

Fellow Residents in the SRO settings are sources of support as well as aggravation. Close friendships among Housing First residents were evident in the two SRO settings included in this study.

“We had a pretty close knit group ... the guys are like my brothers, I have a lot fun with them at Father McCarthy House.” (Housing First resident)

Dissatisfaction was mostly related to the housemates with mental health challenges.

“There are so many different personalities here; some have total lack of manners. Some are schizophrenic, and this is hard. Calling the cops at one in the morning when she was seeing things. Sometimes she is way out there, and sometimes she can be pretty down to earth.” (Housing First resident)

Staff recognize the impact of women with severe mental illness on the other residents and provide support when difficult situations arise.

“Some of the women are more mentally ill than others. And the ones who are less mentally ill are definitely struggling, dealing with someone else’s mental health. So that can be very stressful and adds tension. Overall they are doing really well. The majority of the problems that are coming up are very petty, interpersonal stuff. Other than that, they pull together pretty good. They usually communicate well with each other ... and are very supportive of each other.” (FBP staff)

Identity: Still a Homeless Person?

Many of the Housing First residents shared how they felt they were perceived by the non-homeless population during their homeless experience.

“And it doesn’t matter what the conditions were [that caused your homelessness], drugs, alcohol, divorce, loss of employment. You end up homeless as a result of one of those things or a combination. Once you hit homelessness, you are automatically, seen as this irresponsible, drinking, druggy person. Can you imagine? I got turned down at this animal shelter as a volunteer because I was considered homeless. It was the stigma of Father Bill’s.” (Housing First Resident)

Even though the move into Housing First increased the self-esteem and self-perception of all study residents, the struggle of overcoming the image of a homeless person by the outside world is described by one Housing First resident as follows.

“Don’t get me wrong; I’m a realist and a pessimist. The conditions here are a lot better than being in a shelter, but you are still seen as a homeless person. It’s a long hard fight to get out from under the label of being homeless and I wouldn’t wish it on my worst enemy even though there’s one or two I would love to see homeless.” (Housing First resident)

However, for most, the rise in self-esteem was more prominent.

“You’re more open; more alive now; more social.....when you’re homeless, it’s different. ... My self esteem has gone way up.” (Housing First resident)

“It makes me feel good to provide for myself. I am able to take care of my medical issues, by myself; got a roof over my head. I can put food on the table. I have the things I need.” (Housing First resident)

Daily Activities

Engaging Housing First residents in meaningful daily activities can be challenging. The expectation is that residents engage either in work as part of the work crew, volunteer work, or work outside of FBP.

“It depends on the client. If a client has a mental health provider, they may go to a day program. Another client does the work crew a couple days a week, and then he meets with his provider once a week and then his psychiatrist once a month. I have another client who volunteers around like at the animal shelter or the churches – doing something, like serving meals and also has a provider that he meets with. So its making sure that they do have some structure. Some guys will fight me nail and tooth, but you have to be creative. Sometimes they’ve become so set with staying in their rooms and other times I convince them to do different things and I find by not being so forceful and just being creative. ‘Oh that’s going to benefit you – I know you like music; I know you can volunteer your time in a

music store. It's just trying to find what interest them and get them out." (FBP staff)

In order to provide work experience as one avenue for improving work skills for their shelter guests and Housing First residents, FBP has instituted a work crew that supports shelter operation (cleaning, doing laundry) and/or upkeep of all the housing (maintenance work, landscaping) that is operated by FBP.

"I don't work at the shelter, but am occasionally part of the crew that goes out doing painting. On Wednesdays, I'm going to be doing the offices down the streets, cleaning, whatever they come up with, that's what I'll do. I'll be cleaning and stuff like that." (Housing First resident)

Furthering their education has also become a possibility for Housing First residents since they left the shelter. Some of Quincy's Housing First residents attend computer classes and college courses, and one resident has completed an online certificate granting program.

Increasing their incomes through employment is on the mind of many. Few have gained employment after moving into Housing First while others have faced many barriers. Housing First residents alluded to some of the barriers they experienced when they lived in the shelter, such as using the shelter address on their job application and other continuing challenges to gaining employment, such as explaining gaps in employment histories, and fears of losing public entitlements.

"I am looking for work. I couldn't do before because when they saw the address at the shelter, they would discriminate even though they are not allowed to. A different address helps. ... I had a couple of interviews but they didn't go so well. It's hard to explain a gap period of time when you didn't work. It's not going to be easy finding a job." (Housing First resident)

I need to look for a part time job. I am on such a fixed income, so additional money would help. I think I can make up to \$900 a month [the actual limit is \$840] without impacting my benefits. It's a balancing act. I have to be concerned about my medication, so I need to keep my MassHealth which is a big issue. If I can't keep my MassHealth, I would need to quit my job." (Housing First resident)

Employment, however, is a critical component in promoting residential stability, and access to employment should be addressed shortly after moving into Housing First. As Shaheen and Rio (2007) contend,

"... employment should be offered as early as possible ... facilitating employment is an unrecognized and underutilized practice for preventing and ending homelessness." (p.341)

Sense of Neighborhood

Housing First residents were asked about their sense of their neighborhood. Most of them feel very comfortable in the neighborhood; however, they also reported that they were not very connected with people in their neighborhood, reporting that they know or had limited interactions with one or two neighbors.

“I know a couple of neighbors. Some send the clear message ‘Stay away from me.’” (Housing First resident)

“I’ll be honest – I don’t want them in my business and I don’t want to know theirs. If they need help, and I can help them, fine. If not, I am not sitting around to talk. A couple of older ladies, they’re nice. I talked to some in the morning, they are nice. I simply say hi in the morning.” (Housing First resident)

Stepping Stone or Permanent Housing?

The question of Housing First as a stepping stone or permanent housing was mostly discussed by study participants in the SRO residences. Many viewed living in the SRO residence as a major improvement over shelter life; however, it was also seen as a step toward more independence.

“You don’t have to wait in line for food anymore. You can sleep as long as you wish. You can go to bed any time. Basically, you don’t have the dependency you have at the shelter. I love living here. It’s not like a shelter but you have to abide by the rules otherwise it would be too crazy. They make it so you can get your independence, get ready for a job or apartment, that’s what this is all about. This is a step towards getting more independent. It’s good. I like it here because we can cook our meals, we can get up when we want. This is a stepping stone to independent living.” (Housing First resident)

While some expect to stay in their SRO residence, most would prefer to live in their own apartment.

“Housing is not bad but it is really not what I would like. I would like a one bed room apartment with a little kitchen and a little living room, just a place to put me and my junk. I am on the housing list in Boston but I will probably die on the housing list in Boston.. I don’t care about getting rich but I would like my own apartment.” (Housing First resident)

“I am not the SRO type of guy, I need to get my own apartment.” (Housing First resident)

Access to housing vouchers (the most common way for Housing First residents to leave their SRO units and move into their own apartments) has become more challenging after formerly homeless individuals moved into an SRO residence. For example, one of the women in a SRO room applied for Section 8 and was denied based on her housing status.

She is no longer considered a homeless person and therefore lost her priority status for a housing voucher.

Staff Assessments/Lessons Learned

Case managers and other shelter staff share their opinions and assessments of Housing First in this section of the report. When planning began for the Housing First residences, many of the staff were very excited about the prospect of providing an alternative to shelter life.

“I thought it was a great idea right away. Definitely a new approach that obviously hasn’t been tried before. Housing these women first helps with their self-esteem issues, and they feel better and more confident about going out to work or pursue other types of income. It definitely helps them get ready.” (FBP staff)

Some, however, were worried about focusing on the chronically homeless and doubted this approach had any chance of success.

“I thought that their choice of choosing the ones who have been homeless the longest were first priority, and the ones who have been homeless the longest are those with pretty severe substance abuse and mental illness, and I did not think that it would work. I thought it would end up a house of ill retreat; that the substance abusers would continue to use and bring it into the house. And the people with mental illness would get worse without some real structure, go off their medication. I thought it would be total chaos.” (FBP staff)

After a few months of observing the model, staff who were initially skeptical of this housing model turned to being entirely supportive of this approach to ending homelessness for the chronically homeless.

“No one is more shocked than I am [to see how successful the model has been]. When we had a meeting before I was pessimistic, thought from a medical standpoint that this is not going to work. We are going to have the ambulance over there every day, a lot of drama, and that hasn’t happened. I think I am the most surprised.” (FBP staff)

Approaches to Dealing with Substance Abuse

Rules at the HF residences state that drinking and abuse of substances is not permitted. At the same time, sobriety is not a requirement to enter housing. Case managers shared a number of ideas on how to best address this problem when individuals with substance use disorders move into housing.

“In the case of those with substance abuse, I would like for them to sign a contract that they would check in with their case manger, that they would be attending AA or NA meetings, trying the best that they could. Give them more support, more so

than the other ones. I think they need more structure, especially when they are trying to stop.” (FBP staff)

Case managers at both SROs included in this study acknowledge continued substance use and put practices in place to open up communication with the residents about it. For example, at the Father McCarthy House, the case manager meets regularly with residents to have open communication about substance use and avoid for individuals to isolate and withdraw from interaction with other residents and staff when they continue to use. When substance abuse tends to get out of control, individuals are brought back to the shelter and are referred for treatment while their room is kept for them.

“We have one individual, let’s say, he struggled [with substance abuse] while he was over there. I brought him back [to the shelter] for a couple of days; and got him into treatment and a program, and through the help of the services that we’re able to get for him - now he’s back there [in his SRO] and he’s doing very well.” (FBP staff)

Nevertheless, this approach did not work for all, and two residents were asked to leave. In both cases, the safety for fellow residents was compromised when people from the streets were brought to the residences.

Does Housing First Work for All?

FBP staff and administrators agree that Housing First is a good model for all homeless individuals.

“I think it [Housing First] can benefit anyone who comes through here, especially if they’re individuals who have been here off and on throughout the years. There are special cases where people do come in who haven’t been here two years, and we feel it can benefit them, because here may not be the [best] place for them. We’ve taken cases where people have struggled within shelter environments throughout their history; move them in there and their behavior changes 360 degrees. Because they’re not put in with a bunch of people; and we’ve got good results from it.” (FBP staff)

Even when residents had to be asked to leave due to continued substance abuse and behavior endangering fellow residents, staff felt that Housing First provided them with a glimpse of what life in housing could look like.

“I think it was beneficial for all the women that moved. Even the one woman who was using drugs and ended up not staying, it was still beneficial for her because she saw what she could have if she would stabilize a little more. I think for everybody it was an excellent experience, how good they can have it. Accomplish things in their lives that they thought they would never be able to accomplish and they thought they never could have.” (FBP staff)

FBP's evolving Housing First experiences beg the question: Which model works best for whom? To answer this question, large random assignment control studies need to be conducted to test the different personal factors of Housing First residents and the different models of housing and supports. However, as the Quincy Housing First logic model in Appendix A details, many components need to be in place to ensure successful implementation of this model.

“This model can work for everyone with the right supports in place, like the house manager and other case manager, making sure they are not falling through, that they are getting to appointments. That's key.” (FBP staff)

Regardless of the model, FBP leaders and case managers believe that consistency of case management is critical to Housing First's success. Case managers who have been working with their clients in the shelter continue to work with the same individuals, with few exceptions, once they are placed in Housing First. As such, supportive services build upon the trusting relationships between case managers and their clients that take long to build, especially for those who have been homeless for many years.

Impact of Housing First on the Larger Community

The success of Housing First should not only be measured by housing tenure of its residents and impacts on the lives of homeless people fortunate to have accessed a Housing First placement but also by its impact on the larger homeless and non-homeless communities. Reduction in chronic homelessness, reduction in the number of people seeking emergency shelter, and reduction in use of expensive medical services are examples of such measures.

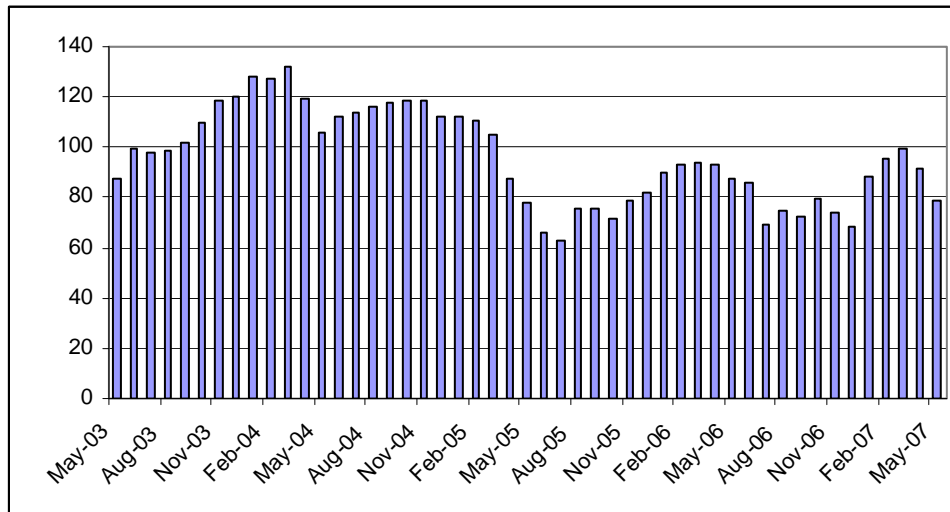
Reduction in Chronic Homelessness

Each January, Quincy conducts a one day point-in-time count of its homeless people. Between January 2006 and January 2007, the number of chronically homeless people decreased by 15, which translates into a 19 percent reduction in the extent of chronic homelessness in the city. This means that fewer homeless people walk the streets of Quincy during the day when the shelter is closed, hanging out in parks, or visiting the library or other public places.

Reduction in Shelter Usage

Between May 2003, two years before the first Housing First residence opened, and May 2007, two years after the first house opened, the average daily shelter census was reduced by about 30 people, from about 110 to 80 people. Average daily bed count for homeless women is reduced from ranging between 20 and 25 women per night to 15-20 women. As a result, the women's shelter was closed and a room was opened for women at the men's shelter. For homeless men, average daily shelter counts were ranging between 50-70 after May 2005, down from ranging between 80 and more than 100 before Housing First was implemented in Quincy.

Figure 3: Average Daily Shelter Census 2003-2007



Reduction in Use of Medical Services

Preliminary information on the use of Emergency Room (ER) services and hospitalization at Quincy Medical Center for a subgroup of Housing First residents before and after their move to Housing First points to a dramatic reduction in inappropriate use of costly medical services. For the group of women at one of the SRO residences, who were among the first to access Housing First, there was a 77% decrease in number of inpatient hospitalization days in the year after moving into housing (four days), compared with the previous year (44 days). Further, hospital emergency room (ER) visits decreased by 83% for the same time period.

“I came to the shelter July 1st, and there was a girl that had bronchitis. And in three weeks I was in the hospital. In the year before I moved to here, I was in the hospital four to five times, each time for COPD [Chronic Obstructive Pulmonary Disease], emphysema and asthma. I have not been in the hospital since I moved here [about nine months ago].” (Housing First resident)

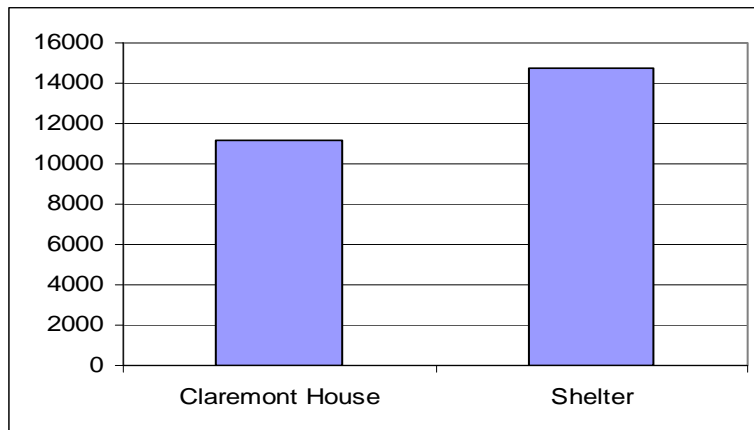
At an average cost of \$640 for an ER visits and \$1,800 for each day spent in the hospital (MHSA, 2007), the reduction in hospital costs for medical problems alone amounted to \$51,750 for this group of Housing First residents. For more comprehensive medical cost reduction analyses, access to Massachusetts Medicaid data is needed so that all medical care expenses can be included.

Preliminary evidence also indicates that the number of admissions to inpatient psychiatric care decreased by 86 percent, however, access to that information is not consistently available for the subgroup of women who were among the first to move to Housing First. Access to outpatient psychiatric care, in general, increased for all in need of such care. After leaving the shelter, most of those in need of psychiatric services began regular visits with their psychiatrist and therapists, a much less costly alternative than psychiatric hospitalizations.

The Costs of Sheltering and Housing Homeless People

On average, a shelter bed in Quincy costs \$40.35/day which includes expenses for direct care and case management, amounting to an annual per person expense of \$14,728. The comparable average costs of a Housing First bed amounts to \$30.67/day, yielding \$11,195 in annual per person expenses. Just comparing these bed rates yield a difference of over \$3,500 per person in higher annual expenses for staying at the shelter.

Figure 4: Annual Per Person Bed Rates in Housing First and in the Shelter



Financing Housing First projects can be challenging. When Quincy began its first Housing First project in May 2005, no state-level public funds were available for such projects. As such, FBP had to look for alternative funding sources and was able to use a number of different funding sources to start their first Housing First residence, mostly through HUD McKinney-Vento funds, City of Quincy, HOME fund, Neighborhood Reinvestments, Federal Home Loan Bank, and local businesses and foundations' contributions. Later, when Massachusetts began to fund its statewide Housing First initiative, Home and Healthy for Good, Quincy was able to use some of these new resources to expand its program.

Fragmented funding for homeless services poses many challenges for those who provide services to homeless individuals. Categorical eligibility criteria for funding, for example limited to serving only the homeless mentally ill, constrains the much needed flexibility essential for creating and implementing successful programs, as demonstrated with FBP's Housing First innovations. Further, the state disallows the use of its funding for shelter beds to be used for more appropriate responses, such as Housing First. As one administrator states,

“Why baby-sit the homeless when the dollars could be used for Housing First?”

Homeless funds should be made available to service providers with as few categorical restrictions as possible so that innovative programs can be implemented that address the needs of all homeless people.

Conclusions

As this report details, Housing First provides a life-altering opportunity for many individuals struggling with chronic homelessness. While the Housing First residences provide a first step out of homelessness for many, it is the final step for others. Content with living in SRO settings or sharing an apartment with another Housing First resident, these individuals expect to ultimately stay in their Housing First residences.

By design, Housing First in Quincy selects those who were homeless the longest and have co-occurring physical, mental health, and/or substance abuse. The experience of the first two years of Housing First in Quincy indicates that most of these individuals are able to remain in housing with appropriate supportive services in place. Those who needed to be evicted endangered the lives of their co-residents through their substance abuse-related behavior.

At this point, the question of which housing model works best for whom cannot be answered. Personal indicators coupled with a range of housing and support models need to be researched in larger random assignment control studies to advance our knowledge in this area. However, a plethora of research, including data in this study, points to Housing First as a cost-effective model that provides far superior services to chronically homeless individuals than the emergency shelter system.

As documented above, the social networks of Housing First residents consist for the most part of former and current homeless people and homeless service staff. In order to facilitate a wider re-integration into society, other support networks need to be tapped. Housing support services that integrate access to volunteer work or employment, and/or access to social clubs or religious institutions would benefit these men and women by providing an avenue to enter new social networks and encourage less reliance on just current or former homeless people and homeless service staff.

One disappointment in this Housing First experience is the lack of employment for its residents. Similar to initial reservations about the Housing First model itself, staff perceptions of the abilities of their formerly homeless clients to find and maintain employment can promote or hinder Housing First residents' access to work. "Housing readiness" (Meschede, 2004) or "work readiness" (Shaheen and Ria, 2007) often are conceptual constructs that impede programmatic efforts to help homeless persons to access housing and jobs. Staff training on successful housing and employment models for homeless persons is critical for counteracting such mindsets and for ensuring long-term success of Housing First. Additionally, staff needs access to training on service strategies that can effectively integrate clinical, housing, and employment supports into Housing First models to promote residents' long-term housing stability. This may include training in motivational interviewing and harm reduction strategies.

Flexibility in using housing funds and flexibility in choosing residents is an important ingredient for ensuring successful Housing First implementations. If the ultimate goal is to end all homelessness, then funding should not categorically restrict the selection of housing residents.

Everyone in society will benefit from ending long or short-term homelessness. Communities will be more attractive when visible homelessness is no longer part of the landscape, and those experiencing homelessness will be enabled to lead happier, longer, and more productive lives.

Recommendations

There is no way to end homelessness other than by providing housing to persons who have lost their homes and offering homelessness prevention resources to those who are at risk of losing their homes. Quincy should build on its successful implementation of Housing First and continue to provide different housing models in SRO and scattered site settings that provide different degrees of supports for tenants depending on the specific levels of need.

After successfully moving into Housing First and addressing issues that formerly chronically homeless people were not able to address during their homelessness (e.g. health care), access to daily activities outside the residence need to be addressed. Visiting social clubs, engaging in volunteer work, or finding employment are essential to promoting the expansion of social networks, improving self esteem, and leaving the homeless identity behind. Instituting more structured employment counseling and work preparation opportunities would be beneficial to all Housing First residents in their quest to reintegrate into society.

Living with persons with severe and un-medicated mental illness in SRO residences can be challenging for fellow residents. To address the needs of all Housing First residents, support of fellow residents on how to best interact with mentally ill individuals, as well as supports when behavior related to mental health issues surface is essential. Similarly, addressing substance abuse issues in Housing First needs to continue to be addressed in creative and innovative ways to allow housing options for all chronically homeless persons, even those with severe addictions.

As the Quincy and other Housing First implementations have demonstrated, Housing First is a successful and cost-effective model to end chronic homelessness. Funding levels for these models need to increase in Massachusetts to enable more chronically homeless individuals to leave the streets and reduce the number of people residing in crowded emergency shelters or outdoors.

In addition, there needs to be more flexibility in funding for homeless programs to allow local programs to decide on how to best use these funds in their vicinity. For example, funds for shelter beds could be much better used for innovative housing models. Similarly, funds restricted to certain populations, e.g. the homeless mentally ill, could be much better used to serve a broader range of individuals who may not exactly fit a narrow funding category.

Finally, research needs to be conducted to determine personal and programmatic factors for successful Housing First models as well as to test different Housing First models.

More knowledge of the challenges and achievements in transitioning from long-term homelessness to housing would help inform future policy and practice.

“I like it a lot, I am much happier here. I am more able to do things. I feel more useful and I am doing much better here.”
(Housing First resident)

References

- Calsyn R.J., & Winter, J.P. (2002). Social Support, Psychiatric Symptoms, and Housing: A Causal Analysis. Journal of Community Psychology, 30(3): 247-259.
- Coyne, J.C., & Downey, G. (1991). Social Factors and Psychopathology: Stress, Social Support and Coping Processes. Annual Review in Psychology, 42:401-42.
- Dean A., & Lin, N. (1977). The Stress-Buffering Role of Social Support: Problems and Prospects for Systematic Investigation. The Journal of Nervous and Mental Disease, 165(6): 403-416.
- Gulcur, L.; Stefancic, A.; Shinn, M.; Tsemberis, S.; & Fischer, S.N. (2003). Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programs. Journal of Community and Applied Social Psychology, 13(2):171-186.
- Hwang, S.W. (2000). Mortality among men using homeless shelters in Toronto, Ontario. Journal of the American Medical Association, 283(16):2152-2157.
- Kuhn, R. & Culhane, D.P. (1998). Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results From the Analysis of Administrative Data. American Journal of Community Psychology, 26(2):207-233.
- Lam, J.A., & Rosenheck, R.A. (2000). Correlates of Improvement in Quality of Life Among Homeless Persons With Serious Mental Illness. Psychiatric Services, 51:116-118.
- Massachusetts Housing and Shelter Alliance (2007). Home and Health for Good: A Statewide Pilot Housing First Program.
- Meschede, T. (2006). Moving Here Saved My Life: The Experience of Formerly Chronically Homeless Women and Men in Quincy's Housing First Projects (Interim Report). Boston, MA: McCormack Graduate School, University of Massachusetts Boston.
- Meschede, T. (2004). Bridges and Barriers to Housing for Chronically Homeless Street Dwellers: The Effects of Medical and Substance Abuse Services on Housing Attainment. MA: McCormack Graduate School, University of Massachusetts Boston.
- Picket-Schenk, SA, Cook, JA, Grey, DD, & Bulter, SB. (2007). Family Contact and Housing Stability in a National Multi-Site Cohort of Homeless Adults with Severe Mental Illness. The Journal of Primary Prevention, 28:265-279.

- Shaheen G., & Rio (2007). Recognizing Work as a Priority in Preventing or Ending Homelessness. Journal of Primary Prevention, 28:341-358.
- Stefancic, A., & Tsemberis, S. (2007). Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention. The Journal of Primary Prevention, 28:327-339.
- Tsemberis, S.; & Eisenberg, R.F. (2000). Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. Psychiatric Services, 51:487-493.

Appendix: Logic Model of Evaluation Framework

