Rhode Island's *Housing First* Program Evaluation

Research supported by the United Way of Rhode Island

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Executive Summary

In 2005, the state of Rhode Island and the United Way of Rhode Island created a program to address chronic homelessness in the state by housing 50 homeless single adults in subsidized apartments and by providing those clients with the services they needed to stay housed. The program was designed according to "Housing First" principles which involve rapid access to permanent housing with voluntary access to a variety of services. The program was implemented with the first client accessing housing in late 2005 and the 48th client being placed in April of 2007. An evaluation of the program by Eric Hirsch, PhD and Irene Glasser, PhD was begun in July of 2006. The primary evaluation tool was in-depth interviews with clients in the program. This report is based on 41 baseline interviews and 63 follow-up interviews with clients.

The results of this program have been very positive. The program is clearly serving its intended *chronically homeless* population. At the time of our interviews, clients in the program had been homeless for an average of 7.6 years. Most importantly, placing clients in permanent housing with supportive services has resulted in a dramatic decline in the use of government-funded services, as shown in the tables below.[1]

Estimated costs for year before entering program apartment

Hospital overnights = 534 X $1,719 = $917,946
Mental health overnights = 73 X $1,300 = $94,900
Alcohol/drug overnights = 538 X $220 = $118,360
Emergency room visits = 177 X $640 = $96,640
Jail/prison overnights = 919 X $108 = $84,780
Shelter overnights = 9,600 X $25 = $205,000

Total = $1,517,626/48 = ***$31,617 per client***

Estimated costs for year after entering program

Hospital overnights = 137 X $1,719 = $235,503
Mental health overnights = 58 X $1,300 = $75,400
Alcohol/drug overnights = 75 X $220 = $16,500
Emergency room visits = 81 X $640 = $51,840
Jail/prison overnights = 190 X $108 = $20,520
Shelter overnights = 384 X $25 = $9,600

Total = $409,363/48 = $8,528 per client + $9,500 cost of supportive services + $5,643 cost of housing subsidy = ***$23,671/per client***
Savings = $7,946 per client X 48 clients = $381,408

[1] These tables involve extrapolating from follow-up surveys of 31 clients at 6 months and 21 clients at one year after placement.

These cost savings can only be realized if clients remain in their new homes. A return to a life in the street or in shelters is destructive to the client's health, mental health, and level of social integration. And it dramatically increases the costs to the government and taxpayers due to increased use of health, mental health, corrections, and shelter facilities. Out of the total 41 individuals interviewed for the evaluation, 38 have remained in permanent housing either in the program itself or elsewhere in other permanent housing situations. Of the three remaining residents, one died of a drug overdose and the whereabouts of the other two clients is unknown. This extremely high success rate, with 93% of clients remaining in permanent housing, is unprecedented in programs of this type where 33% turnover rates per year are common.

The clients themselves consider this program to be very successful. 93% of clients reported being "Very Dissatisfied" with their housing situation the year before entering their apartment. By contrast, 62% of clients reported being "Very Satisfied" and 29% "Somewhat Satisfied" with their housing situation after a year in the program. Those in the program also feel they are making great progress on health, mental health, and social goals. While homeless, nearly half of participants rated their health as "Poor" or "Very Poor" and two-thirds of participants said that physical or mental health disabilities had limited their ability to interact with those they felt close to. Once in the program nearly half rated their health as "Good or "Very Good" and only one third felt that their disabilities limited their social interaction. However, after a year some of this progress was lost, with only one-third of clients continuing to rate their health as "Good" or "Very Good" and one half feeling that their disabilities were limiting their social interaction.

Program case managers have been very effective in getting their clients on income support programs such as Supplemental Security Income (SSI). This has resulted in a slight increase in their incomes. They have been less effective in promoting work. This is due to the fact that the great majority of those participating in this program have mental and physical disabilities that make it very difficult or impossible for them to work in part-time or full-time jobs.

This Housing First program has been extremely successful. Our recommendation would be to expand this program to include more chronically homeless Rhode Islanders, a population estimated to include over 1,000 individuals. This would result in cost savings for the state and its citizens, and it would dramatically improve the lives of those benefiting from the program.

The Housing First Program

In 2005, the state of Rhode Island and the United Way of Rhode Island initiated a pilot program to address the problem of chronic homelessness. The intention was to house 50 homeless single adults in subsidized apartments and provide the clients with whatever services were needed in order to enable them to stay housed. The pilot was explicitly designed according to the *Housing First* model. That model has several features.[2]

1) Homeless individuals are given access to housing as quickly as possible. Generally, clients are given standard lease agreements and need only to meet the requirements of that agreement in order to continue their tenancy.

2) Housing is considered permanent, not transitional.

3) A variety of services are delivered following housing placement to help the individual stay in permanent housing.

4) Use of services by clients is on a voluntary basis.

The assumption under which Housing First programs operate is that clients are better able to benefit from services related to mental health, substance use, health, vocational or educational goals if they have their own home as opposed to living in a homeless shelter or on the street. Advocates of the *Housing First* approach argue it will generate the following benefits.

1) The fact that the services provided are accessed voluntarily as well as the lack of restrictive policies surrounding tenancy will limit turnover of residents. Clients will tend to stay in their apartment or move on to other permanent housing settings.

2) Homeless people cost taxpayers more money than clients served in *Housing First* programs. This is because homeless people utilize a variety of government funded services including shelters, emergency rooms, hospitals, mental health facilities, jails and prisons, and drug/alcohol treatment facilities. Putting chronically homeless people into permanent housing with access to case management and services will reduce their use of these other more expensive facilities.[3]

3) Once permanently housed, formerly homeless people will enjoy better health and mental health, will have higher incomes and better access to jobs, will be more socially integrated into the community, and will be happier.

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[2] National Alliance to End Homelessness Inc. “What is Housing First?” February 17, 2006

[3] Dennis Culhane et al, “The Impact of Supportive Houisng on Services Use of Homeless Persons with Mental Illness in New York City,” University of Pennsylvania, 1998; Massachusetts Housing and Shelter Alliance, “Home and Healthy for Good; A Statewide Pilot Housing First Program,” June 2007

Implementation of the Program

The Housing First Pilot Program was implemented with the first client accessing housing in late 2005. The program has housed clients over eighteen months with the 48th client accessing housing in April of 2007. The first 11 clients were housed in late 2005 and early 2006 at Fran Conway House, a program sponsored by the House of Hope Community Development Corporation. At that time, the case management team, Riverwood Mental Health Services, had not yet been hired, so case management was provided by House of Hope for these initial clients. Fran Conway House, a former convent, is self-contained. Each resident has their own living room/bedroom, bathroom and small kitchen. There are also a variety of common areas including a large communal kitchen, dining area, and lounge.

Riverwood Mental Health Services began housing clients in May of 2006 and by April of 2007 had 37 clients in apartments. Most are in scattered site apartments throughout the Providence metropolitan area in Providence, Pawtucket, Central Falls, and North Providence. Rent is paid for by 25 Shelter plus Care vouchers provided by the Department of Housing and Urban Development or by state programs such as the Neighborhood Opportunities Program. Riverwood employs five case managers plus a director to provide supportive services to their clients. Initially, Riverwood took over case management of Fran Conway House residents, but now case management has reverted back to House of Hope staff for the eleven residents at that location.

Evaluation Design

Professor Eric Hirsch PhD, Professor of Sociology at Providence College, was hired in the summer of 2006 to evaluate this Housing First program. Irene Glasser PhD, an anthropologist with extensive experience in homelessness research, was hired to conduct the evaluation of the House of Hope part of the project, and Kate D'Addabbo and Jessica Cigna were hired as research assistants. The evaluation continued with six month and one year follow-up interviews through the summer of 2008.

The primary evaluation tool was in-depth interviews with clients in the program. Interviews have also been completed with program staff members. The baseline interview form includes demographic questions, scales to evaluate health, mental health, social interaction patterns, income levels, work histories, use of publicly funded facilities such as hospitals, mental health facilities, jails and prisons, and so on. There are open-ended questions on such topics as reasons for homelessness, level of satisfaction with the client's housing situation, and goals for the client in the program. Responses to the open-ended questions were tape-recorded and verbatim transcripts were produced in order to use client responses for this evaluation. Each client was interviewed using the baseline form and then had follow-up interviews every six months after that. Clients were paid $20 each time they were interviewed. This report is based on 41 baseline interviews, 12 3-month follow-up, 30 6-month follow-up interviews, and 21 one-year follow-up

interviews with clients as well as seven interviews with case managers and program directors.

Evaluation Results

1-The program is serving its intended population.

This program was designed to serve chronically homeless single adults, that is, single people over the age of 18 who have experienced either long-term or repeated episodes of homelessness. The program is serving this population. The mean number of days homeless the year before entering the program's housing for the 41 clients we interviewed was 335 days. Clients spent a mean of 200 days in shelter, 47 days on the street, and 77 doubled-up with friends or family during that year. In addition, 85% of clients had been homeless for a year or more, while 83% had had at least four episodes of homelessness in the last three years.

Another way of measuring chronic homelessness is to consider how long it had been since the client first became homeless. At the time of the baseline interview, clients in the program had been homeless for an average of 7.6 years. It should be understood that this does not mean that the typical client had been continuously homeless for eight years. As indicated above, most of the program's clients have had multiple episodes of homelessness.

It is clear that the program has drawn participants from the ranks of the literally homeless. 56% stayed in shelters the night before moving into their apartment, while 20% had been doubled-up with friends or family and 12% came directly from the street. Finally, except for being older on the average, the 41 clients interviewed for this evaluation closely match the characteristics of chronically homeless adults in the Rhode Island shelter system as the following table shows.

		Supportive Services Program	Rhode Island Shelters 2005-2006[4]
	% Male	73%	73%
Age	**18-30**	6%	21%
	31-40	19%	22%
	41-50	46%	31%
	51-60	24%	21%
	61+	5%	5%

[4] Eric Hirsch, *Rhode Island Shelter Information Project Annual Report 2005-2006*, Rhode Island Emergency Food and Shelter Board 2007

	Supportive Services Program	Rhode Island Shelters 2005-2006
Race/Ethnicity		
% White	63%	65%
% Black	17%	22%
% Hispanic	7%	9%
% Other	13%	4%

2-Clients were very dissatisfied with their homeless condition.

Program clients hated being homeless. This runs counter to the idea that homeless people "choose" to be homeless or enjoy the freedom and lack of responsibility that comes with being homeless. When asked how satisfied they were with their housing situation the year before entering this program, clients responded this way.

Level of Satisfaction with Housing Year before Entering Apartment

Very Dissatisfied =	93%
Somewhat Dissatisfied =	2%
Neutral =	2%
Somewhat Satisfied =	0%
Very Satisfied =	2%
Total =	41

Here are some of the comments made by clients about their experiences while homeless.

Client A

[Being] homeless [is] dull and miserable. I was on the street. I did what they wanted me to do. You get up, you are out at six, and you are back at five. You are out at six o'clock in the morning I'm out, I'm on the road. The thing is because I was in my accident; I couldn't be out on the road looking for a job so that I could get an apartment…. I couldn't financially get another apartment because of the financial situation… It was basically street life. What do you do? You get up, you eat, you walk around, you come back, and you get ready to go spend the night. That's it.

Client B

[Being homeless is] Long. Cold. Lonely and lost.

It is tough to live when my gas and heat were shut off. The new owner bought the house that we were renting and he turned the gas and electric off. I went to court and they told us not to pay the rent so the landlord shut the gas and electric off and we were really cold. Until they turned it back on and then back off. I lived like that for almost a year. Then I moved….before that I went from friend to friend.

Client C

[Being in a shelter] wasn't very good. The showers were not cleaned and they never cleaned them. They did not have curtains that hung over some of the showers. They never cleaned the toilets. There was not a curtain in front of some of the toilets. They had no toilet paper in some of the bathrooms. You would always have to bring your soap in with you, that type of thing. When people took a shower before you and you would take one after them, they would never pick up after themselves and they just left it for someone else to do. They didn't care. You had to deal with their mess. Then there was this whole thing about bed bugs, well…I tended to put a plastic sheet over the mattress.

I mean it's hard to carry all the stuff. And up the flights of stairs, they had 16, 32 stairs. Those stairs were hard to carry all your things up. I mean everyone was going to have a wrist problem. And the food wasn't that good, but what are you going to do? And some people would drink out of the faucets who had a terrible cough. It kept everybody up in the room all night long. And the people didn't think anything of drinking out of the faucet, coughing into the faucet.

3-Clients were very satisfied with their housing situation at the time of the baseline interview.

Very dissatisfied =	5%
Somewhat Dissatisfied =	2%
Neutral =	2%
Somewhat Satisfied =	12%
Very Satisfied =	78%
Total =	41

Ninety percent of clients were either somewhat or very satisfied with their new housing when they first entered the program. Here are some of the comments clients made about participating in this housing program.

Client D

Eternally grateful for this place being here. As far as the hierarchy of needs goes, it satisfies all the most important, eating, roof over my head, it gives a place where people who want to give to people who need clothing or food, it gives them a place for people to come to and give that type of things to people and actually see the people instead of not knowing where it goes. It provides all of my basic needs.

Not only that, the staff that is here now is very wonderful. You can approach them at any time they are here five days a week and then you have Saturdays and Sundays which are kind of more relaxing. If you need services or if there is something going wrong, of course the staff is there.

Client E

I'm satisfied because like I said, it is a home; it is a place I can go. They are not restrictive as you can't come in at any particular hour or not. I am happy because no matter what little bit has happened—I have had my stuff stolen here and there--but the fact that it is a safe neighborhood, [and] there is something you can go and do... And I know I can be where I want to be. If I want to be on my own. Do my meal in my own room.

Client F

Living here is good, let's put it this way. You get your own apartment. You are not on the street. You have the ability to leave the building when you want to and you can come back when you want. You don't have to report to anyone when you were living or coming. You have your own mailbox. You can't have overnight guests, however, if I had company and it was a snowstorm I bet they would let me let them stay over. We have a back porch. It is like any other place. You can have coffee. People are not nosy enough to get into your business. If you want to talk to someone you can, but you don't have to… It is a clean place and safe. It is a kind of place where if I had to come back at 10pm at night, I could feel safe coming back to this area. They drop you off and as long as you have your key in your hand you're okay. You aren't near the ACI [state prison] or anything where someone could pop up and knock you in the head or something.

Client G

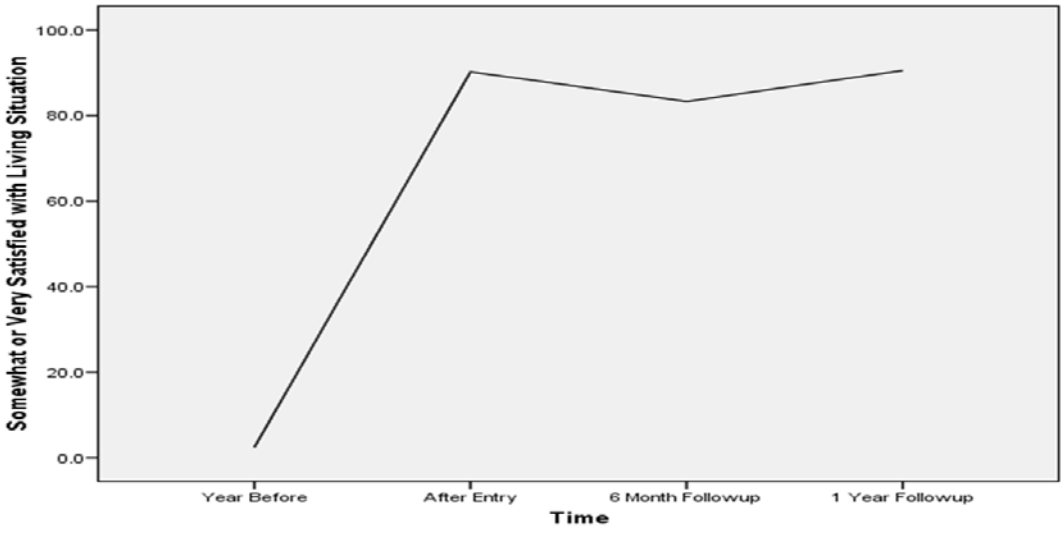
It's a house to live in. Feels good to be out of the cold. Not getting up in a shelter, staying out there from 6 in the morning waiting to 5 at night to go back in. Carrying a bag with clothes with you. I don't even carry a bag anymore.

4- Six month and twelve month follow-up interviews indicate that clients were somewhat less satisfied with their housing situation.

Clients continue to be satisfied with their housing situation as they progress through the program. However, through time, an increasing percentage of clients are "Somewhat Satisfied" as opposed to "Very Satisfied". Whereas 78% of clients were very satisfied with their housing situation at intake, only 60-62% were very satisfied at the six month and one year follow-up interviews.

	Six Month	One Year
Very dissatisfied =	10%	5%
Somewhat Dissatisfied =	7%	5%
Neutral =	0%	0%
Somewhat Satisfied =	23%	29%
Very Satisfied =	60%	62%
Total =	30	21

Figure 1- Degree of Satisfaction with Housing Situation Over Time



Initial satisfaction with their new apartment has diminished for some, usually due to the condition of the apartment and/or negative features of their building or neighborhood.

Client H

> [This place is] not really different than the shelter. I hear noise all the time up and down the halls. People are dealing drugs all over the place. Matter of fact yesterday afternoon I was laying on that couch over there and umm I didn't have the door locked and uh I have hearing aids no so I can hear good now you know and they came into my bathroom and stole all of my toilet paper.
>
> There's no way would I go back to a shelter. I appreciate the fact that they put me in here. I do appreciate that fact, but it is just not my style you know?

Client I

> One good thing is that it is better than being in the street. It is better than being in a shelter. That's all I can say about here. The people who live here, a lot of them do not have any motivation and are very negative. The floors are negative. There are a lot of drugs and a lot of alcohol. I can't complain because it is better than what I have had. But overall I do not like it here.

Client J

> I like the apartment. It's just the neighborhood. I'm around liquor stores, bars, clubs, tricks, drug dealers. …I'm still fearful of being in the basement, people climbing in the windows, I don't know if its paranoia or what, you know, but I never had the fear before. I don't want to open my shades 'cause I don't want people looking in my house.

Over nine-tenths of clients are still satisfied with their housing situation, and clients do prefer even problematical housing situations to being homeless.

Client K

It's an amazing relief of stress that I'm always going to have the security, the knowledge that I know that I have somewhere to come home to. That I have a safe, a secure living environment. A roof over my head; relieves an enormous amount of stress. To not be living out of plastic tubs. Where I'm going to be, what's going on next? What's going on. The aspect of it, having people around is also very healthy.

5- Clients feel they are making progress on health, mental health, and social goals.

One of the suggested benefits of this kind of supportive housing program is that clients will enjoy better health, mental health, and greater integration into the broader community. Results from the baseline and follow-up interviews indicate that this has occurred. However, over time progress has been partially reversed particularly with regard to self-rating of physical health status.

When asked to rate their physical health while they were homeless, that is, the year before entering their new apartment, nearly half of clients rated their health as "poor" or "very poor" while only 22% rated their health as "good" "very good" or "excellent".

Excellent =	2%
Very good =	5%
Good =	15%
Fair =	32%
Poor =	34%
Very poor =	12%
Total =	41

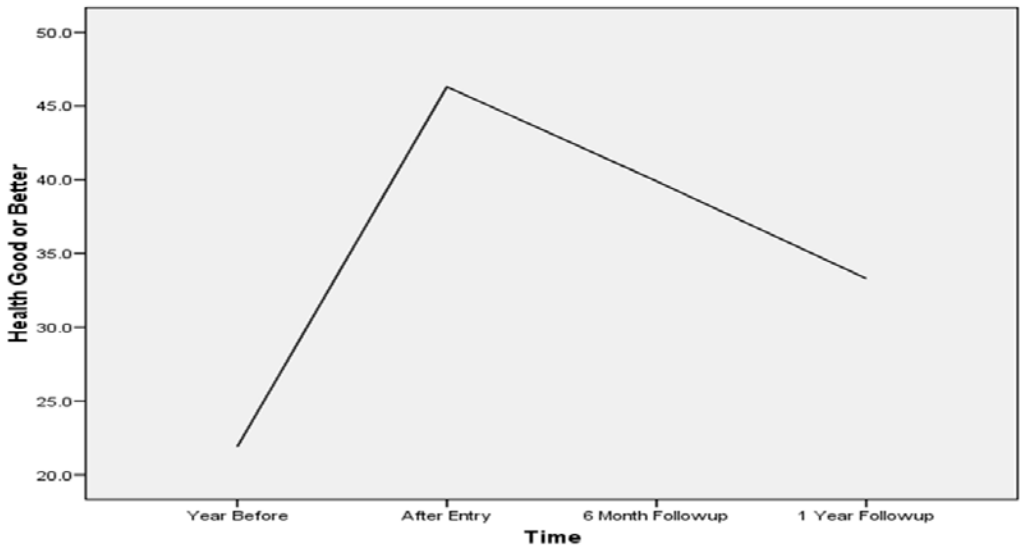
By the time of the baseline interview, these percentages were reversed, with 21% of clients rating their health as "poor" or "very poor" and 47% rating it as "good" or better.

Excellent =	5%
Very good =	15%
Good =	27%
Fair =	32%
Poor =	19%
Very poor =	2%
Total =	41

However, through time program participants have increasingly rated their health as fair or poor. This may be due to the fact that clients now have better access to primary health care and may now be more aware of chronic health conditions that they were not focusing on while they were homeless.

	Six Month	One Year
Excellent =	3%	0%
Very good =	3%	10%
Good =	33%	24%
Fair =	43%	48%
Poor =	13%	19%
Very poor =	2%	0%
Total =	30	21

Figure 2- Clients Self-Rating of Health Through Time



We also asked clients whether physical or mental health issues had limited their ability to interact socially with friends and family. While homeless, two-thirds felt that these problems had limited their ability to interact “quite a lot” while only one-tenth felt that they were not limited at all.

Limited ability to interact the year before entering apartment?

Not at all =	10%
Very little =	3%
Somewhat =	18%
Quite a lot =	67%
Total =	39

When interviewed in their new apartment, clients felt much more confident about their ability to interact with friends, family, and neighbors. Only one-third felt physical and mental health issues had limited their ability to interact "quite a lot" and one third now felt that they were not limited at all.

Limited ability to interact at time of baseline interview?

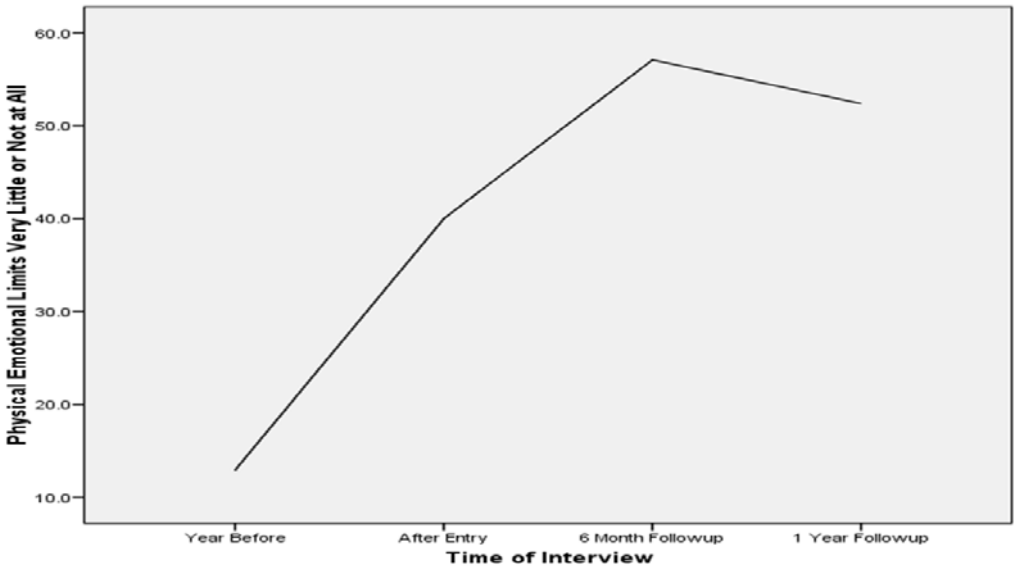
Not at all =	33%
Very little =	8%
Somewhat =	25%
Quite a lot =	33%
Total =	40

Finally at the time of the six month and one year follow-up interviews, about one-third felt their physical and mental health issues limited their interaction quite a lot, while more than half now felt these problems limiting them very little or not at all.

Limited ability to interact at time of 6-month and one year follow-ups?

	6-Month	One Year
Not at all =	46%	24%
Very little =	11%	29%
Somewhat =	7%	14%
Quite a lot =	36%	33%
Total =	30	21

Figure 3- Physical/Emotional Limits on Social Interaction through Time



The fact that progress has been made by clients in these areas is reflected in our interviews.

Client L

Well, I'm more at ease, I have more confidence, and I'm just, I just feel better about myself, like an normal person. I feel normal again. I feel like I'm a contributing decent human being now. 'Cause before I didn't feel too good about myself you know. I just feel safe, I feel a lot better.

Client M

How has your life changed since we talked last, which was about six months ago?

Well, I'm still maintaining my sobriety. And that's going well. …I'm trying to not be depressed all the time. When I get into the depression I try to tell myself instead of thinking about the stuff you don't have or wish you had or whatever turn around and be thankful for the things that you do have. And that does work. You know, not all the time, but most of the time that works out well.

Client N

They got me, ah, well since I've been here I've stopped drinking and stopped doing drugs. Due largely to this place because they have substance abuse counseling and they would be little things here and there. When I was still getting high I was getting to the point where I didn't want to do it anymore. So I gone a year and a half without alcohol and five and a half months without cocaine.

From not spending money on cocaine, (Laughs) I got a brand new LCD TV. I mean it's the first TV I actually ever bought in my life. It's always a good feel to be able to buy it. This year for Christmas I went hog wild because I had so much extra money. Cause when I first stopped doing the coke I started putting aside the money, I was hiding the money next to my fridge. And I wouldn't buy anything except stuff that I really needed and I just put it away 'cause I wanted to see how much money I would end up with not doing the coke. That was a big reason I stayed off it, too. Cause I saw how much money I'd been spending. So for Christmas I went hog wild I bought everybody everything.

It's nice to be able to buy to see somebody at Christmas and have a present for them. Past years I never got presents for anybody they always used to have stuff for me but I never had, I was too busy buying a bottle of vodka or $50 piece of coke or. It was nice to be able to give presents back this year.

Client O

Yes, it's gotten, like my uh…I don't want to say attitude, but my whole being feels a lot better, I don't feel anxious and depressed as I was, staying away from drugs and alcohol that's great too. That's going on 14 months.

And uh, that's an eye opener right there. I mean, a real eye opener because you know when you live in a ….cloud ….for 25 years or so and then you stop and all of a sudden the cloud lifts from ya it's like wow look at all this. So it's been good.

…If you're depressed it's nice to turn around to know that you have somebody to talk to, to complain about, to look for advice to. To me I think that's the greatest. I call up, I need a ride, to a doctor's appointment. If my case manager can't do it they get someone else who can. Which is real nice, it really is…. This place is great. I wish there were more places like this.

The group setting at the House of Hope program particularly appears to foster greater social interaction among the residents. When asked about friends in follow-up interviews, most of the residents counted as their close friends the other residents.

Client P

Well, I just moved in four days ago but the neighbors here are terrific everyone gets along well. Everything is so well organized. And you know, I go through sewing lessons downstairs twice a week. And tomorrow I'm volunteering at an Easter Party. We're giving an Easter Party to some of the kids from Hope development, some of the family places. We're going to have about 20-25 kids tomorrow.

…The party's here and we have games and candy and tomorrow I'm going to be the bean bag lady. I'm going to run the bean bag games. (Laughs) As a matter of fact I even sewed the bean bags downstairs.

Do you cook in your apartment?

We can use the microwave and use crockpots upstairs. We eat downstairs four nights a week. Monday-Thursday. And Friday-Sunday the kitchen is open and we can come downstairs and cook. And last Sunday was my first day here and one of the men upstairs made homemade baked beans downstairs and everybody was invited in. And I hadn't had homemade baked beans in 25 year. It was so good.

But not all clients have experienced gains in their ability to socialize. Some are relatively isolated.

Client Q

I don't have nothing to do all day. Lay down, watch television, fall asleep on the couch, get up eat something, go back and lay down, fall asleep, get up eat, do that all day longer. Sometimes I wonder why I can't get to sleep at night.

And this client is making gains in self-sufficiency, although it was perhaps at the expense of sociability:

Client R

How has your life changed since we talked last which was about six months ago.

Has it been that long? How has it changed? Um. I think I'm more recluse, I'm more in the house. I think I'm more recluse.

Why do you think that is?

I get agitated very easily and quickly, I can't seem to tolerate people for too long (Laughs) God it's so true. So I just stay around. I made myself the most wonderful meal yesterday which is amazing because all I've been eating is bologna and cheese sandwiches. Peanut butter. But I actually cooked a whole meal I'm really impressed with myself.

What did you make?

I made baked chicken, stuffing, corn, rice, mac and cheese with cranberry and apple sauce. And I didn't die. I didn't get sick or nothing. I ate a lot. I'm very impressed with myself.

6- Clients in the program are more likely to have income support, but few are working.

Program case managers have been successful in assisting clients in applying for and ultimately receiving disability support programs such as Supplemental Security Income (SSI) and Social Security Disability Income (SSDI). The process of applying for these programs involves detailed applications, doctor's appointments, correspondence, and telephone calls, and is often daunting when an individual is homeless. As shown in the following table, while homeless, two-fifths of clients were receiving disability payments. Now, over half of clients are receiving such payments.

	Job status year before moving into apartment	**Job status at baseline**
On disability =	42%	54%
Unemployed, not looking for work =	24%	27%
Unemployed, looking for work =	15%	15%
Working part-time =	15%	5%
Working full-time =	2%	0%
Total =	41	41

Participating in the program for a year has not resulted in significant employment gains for clients. About one-fifth of clients are either employed or looking for work. This is not surprising since a large majority of clients in this program have mental or physical health disabilities that make it extremely difficult or impossible for them to work. However, several clients suggested that they did wish to work, suggesting the need for more job training and job placement services for clients.

	Job status at 6 Months	Job status at 1 Year
On disability =	60%	57%
Unemployed, not looking for work =	20%	19%
Unemployed, looking for work =	7%	10%
Working part-time =	10%	5%
Working full-time =	3%	5%
Total =	30	21

A few clients have gotten jobs however.

Client S

How has your life changed since we talked last?

I have a little job now.

How did you get that job?

I just went and applied for it. I knew Christmas time was coming and I went to some places, I went to Kmart, Sears, grocery stores, and I went to Walmart and applied and they called me for an interview and I was like "Yeah", I'm happy about that.

And how has the job been.

It's been alright. I mean it's job. There are tons of people there, tons of associates so different personalities and stuff like that but its alright I have good days and bad days. I'm hoping today will be a good one.

The ability to get nearly all clients on income support programs has led to a slight increase in income, as shown in the increase in percentage of clients in the $7,500 to $9,999 income category.

Income year before moving into apartment		**Income at baseline**	
None =	18%	**None =**	12%
$1-$4,999 =	25%	**$1-$4,999 =**	27%
$5,000-$7,499 =	15%	**$5,000-$7,499 =**	15%
$7,500-$9,999 =	30%	**$7,500-$9,999 =**	38%
$10,000-$12,499 =	7%	**$10,000-$12,499 =**	3%
$12,500-$14,999 =	2%	**$12,500-$14,999 =**	5%
$15,000 + =	2%	**$15,000 + =**	0%
Total =	40	**Total =**	40

Income at 6 Months		**Income at 1 Year**	
None =	3%	**None =**	5%
$1-$4,999 =	33%	**$1-$4,999 =**	33%
$5,000-$7,499 =	17%	**$5,000-$7,499 =**	14%
$7,500-$9,999 =	40%	**$7,500-$9,999 =**	38%
$10,000-$12,499 =	7%	**$10,000-$12,499 =**	10%
$12,500-$14,999 =	0%	**$12,500-$14,999 =**	0%
$15,000 + =	0%	**$15,000 + =**	0%
Total =	30	**Total =**	21

Those clients who are a year into the program have not seen significant income gains. 41% of clients had income of $7,500 or more while homeless; 48% of clients have incomes of $7,500 or more a year after entering the Housing First program. This is not a program that can be considered to be a success in increasing client's very low incomes, mainly because most clients continue to be supported by inadequate monthly SSI or General Public Assistance payments as shown below.

Sources of income year before		Sources of income at baseline	
Social Security =	17%	**Social Security =**	17%
SSI =	34%	SSI =	42%
Bridge =	5%	**Bridge =**	2%
GPA hardship =	5%	**GPA hardship =**	10%
Vets benefits =	5%	**Vets benefits =**	5%
Food stamps =	29%	**Food stamps =**	34%
Total =	41	**Total =**	41

Sources of income at 6 Months		Sources of income at 1 Year	
Social Security =	17%	**Social Security =**	14%
SSI =	50%	SSI =	43%
Bridge =	0%	**Bridge =**	5%
GPA hardship =	17%	**GPA hardship =**	29%
Vets benefits =	0%	**Vets benefits =**	0%
Food stamps =	40%	**Food stamps =**	25%
Total =	30	**Total =**	21

7- Clients have dramatically reduced use of publicly-funded services

The interviewing process allowed us to gather self-report data on use of services such as hospitals and emergency rooms, mental health facilities, alcohol and drug rehabilitation centers, jail and prison, and homeless shelters for 41 clients. Six month and one year follow-up interviews have allowed the collection of the same data for the year following program placement. For the tables below, the data has been extrapolated to reflect all 48 clients.

Year before entering apartment (N = 48)		Year after entering apartment (N = 48)	
Hospital overnights =	534	**Hospital overnights =**	137
Mental health overnights =	73	**Mental health overnights =**	58
Alcohol/drug overnights =	538	**Alcohol/drug overnights =**	75
Emergency room visits =	177	**Emergency room visits =**	81
Jail/prison overnights =	919	**Jail/prison overnights =**	190
Emergency shelter =	9,600	**Emergency shelter =**	384

Obviously, according to these figures, the program has resulted in a dramatic reduction in the use of these public facilities. But this reduction will be associated with cost savings

only if the program costs plus the yearly public facility costs are less than the costs while clients were homeless. Here are the cost estimates.

Estimated costs for year before entering program apartment

Hospital overnights = 534 X $1,719[5] =	$917,946
Mental health overnights = 73 X $1,300[6] =	$94,900
Alcohol/drug overnights = 538 X $220[7] =	$118,360
Emergency room visits = 177 X $640[8] =	$96,640
Jail/prison overnights = 919 X $108[9] =	$84,780
Shelter overnights = 9,600 X $25[10] =	$205,000

Total = $1,517,626/48 = ***$31,617 per client***

Estimated costs for year after entering program

Hospital overnights = 137 X $1,719 =	$235,503
Mental health overnights = 58 X $1,300 =	$75,400
Alcohol/drug overnights = 75 X $220 =	$16,500
Emergency room visits = 81 X $640 =	$51,840
Jail/prison overnights = 190 X $108 =	$20,520
Shelter overnights = 384 X $25 =	$9,600

Total = $409,363/48 = $8,528 per client + $9,500 cost of supportive services + $5,643 cost of housing subsidy = ***$23,671/per client***
Savings = $7,946 per client X 48 clients = $381,408

The estimated savings per client in institutional services use is $23,089 per person. Adding program costs of $9,500 per person for supportive services and $5,643 person for housing subsidies results in a total per client cost of $23,671 per person. When added to the $8,528 per person for institutional costs post housing placement, the total is $23,671 per client $7,946 per person less than the institutional costs while these individuals were homeless for a year. For these 48 clients as a whole, the costs while in this Housing First program are approximately $381,408 less than the institutional costs of one year of homelessness.

[5] Kaiser Family Foundation, *Rhode Island Hospital Expenses per Inpatient Day, 2005*, State Health Facts
[6] State of Rhode Island, Department of Mental Health, Retardation, and Hospitals, 2007
[7] SStarr of Rhode Island, Cost of de-tox bed night, 2007
[8] Blue Cross Blue Shield Medical Cost Estimator for Massachusetts, 2004
[9] State of Rhode Island, Department of Corrections, Cost per Offender, 2006
[10] State of Rhode Island, Department of Housing and Community Development, 2006

8- The program keeps clients in permanent housing.

Complete benefits from a Housing First program can be realized only if program administrators can keep the turnover rate as low as possible. Dollars spent on housing subsidies and supportive services are well spent only if clients stay in permanent housing. A return to a life in the street or in shelters is destructive to the client's health, mental health, and level of social integration. And it dramatically increases the costs to the government and taxpayers due to increased use of health, mental health, corrections, and shelter facilities. Some studies have indicated that turnover rates can be as high as 33% per year.[11] However, these rates may be misleading. The key to achieving cost savings and benefits for clients is to keep them in permanent housing. In many cases, clients leave the program for what they consider to be better permanent housing, particularly if they do not believe they will continue to need to access program services.

The initial turnover rate in the program was relatively high. Out of the total of 48 individuals originally housed by the program, 16 clients left their housing placements. Eight of the sixteen left the House of Hope's Fran Conway House, seven leaving between December 2005 and November 2006 and the eighth in May 2007. One client left for a substance abuse recovery program and has moved back into the house. Two clients returned to Riverwood Mental Health to be case managed and subsequently have found permanent housing. Here are the reasons why clients left the House of Hope part of the program.

House of Hope reasons for discharge:

Drug/alcohol use =	3
Left voluntarily =	1
Found own place =	2
Left for doubled-up situation =	1
Removed by mental health agency =	1
Total =	8

Turnover at the Fran Conway House slowed dramatically after the first year. In fact, only one client has left the program since November of 2006. Since this program is closer to a group home setting, it took some time to find a set of clients who could live in the more restrictive group environment. In fact, the existing clients have now decided that Fran Conway House will be drug and alcohol free. Congregate homes like Fran Conway House that can offer communal support are an invaluable option within Rhode Island's permanent supportive housing inventory. However, it is more difficult to maintain them as points of entry into a Housing First program because restrictive rules such as drug and alcohol bans are not consistent with the Housing First philosophy. "High demand" settings lead to high rates of moving out of permanent housing for this population of

[11] Yin-Ling Irene Wong et al, *Predicting Staying in or Leaving Permanent Supportive Housing that Serves Homeless people with Serious Mental Illness*, U.S. Department of Housing and Urban Development, March 2006

chronically homeless clients. And, given a group home setting, it often takes some time to find the right mix of clients that will allow for the lowest possible turnover rate.

The Riverwood Mental Health Services part of the program has had a very low turnover rate. Only eight clients were discharged from a program that originally had 37 housing slots. Here are the reasons why Riverwood discharged eight clients.

Riverwood reasons for discharge:

Died =	3
Left voluntarily =	2
Left for doubled-up situation =	1
Hospitalized =	1
Incarcerated =	1
Total =	8

Riverwood has avoided client discharge in all but a few cases due to the persistence of Riverwood case managers and administrators in *rapidly re-housing* clients who have difficulties in their apartments. Two clients are actually currently living in their third placements and several others are in their second placements. On several occasions, Riverwood has actually switched clients between apartments in an effort to enhance residential stability. The House of Hope has also welcomed back at least two clients who at one time had left their program.

The real measure of the success of the Housing First program is whether clients remain in permanent housing. Out of the total 41 individuals interviewed for the evaluation, 38 are still in permanent housing. This is an extremely high success rate with over 90% of clients remaining in permanent housing. This is due to the persistence of program managers and case managers at re-housing clients. Of the three remaining residents, one died of a drug overdose and one is in a shelter program run by the House of Hope. The whereabouts of two clients is unknown.

Why did three clients fail to stay in permanent housing? What these four clients have in common is severe disabilities.

a) Client 1 was convicted of murder and spent 30 years in state prison. As he acknowledged himself, he found it extremely difficult to adjust to life outside prison walls once he was released.

> Actually, from day one, it was very difficult for me, transitioning from prison into society after thirty years. It was a culture shock. Sometimes I find myself with my back against the wall. I worry about someone doing something to me. I don't trust many people out here. I am always worried that someone is going to stab me or

> I am going to end up in another fight and then I will end up back in prison. A whole bunch of stuff like that basically. I think my biggest worry is economically, finances, no money no job. No place to stay, struggling with housing. Being homeless.
>
> …The worst thing that could happen to me right now is that I get kicked out to the street for whatever reason, I would be devastated I would be sick and in the hospital.

In fact this client was unable to cope with life at Fran Conway House. In addition, he had a terminal illness. He used addictive drugs heavily and eventually died of a drug overdose.

b) Client 2 is a male veteran with a severe physical disability and is supported by a pension from the Veterans Administration. He has not worked in 30 years. He was a very heavy drinker while at Fran Conway House and as a result caused conflicts in the house. He left on his own and his whereabouts are unknown.

c) Client 3 is a female who was enrolled in the Riverwood scattered site program. She continued to use addictive drugs, particularly heroin. She enrolled in a methadone program but was unable to avoid returning to heavy use of heroin. This made it impossible for her to continue in the program. She was removed from the program and her whereabouts are unknown.

In all three cases, the client used drugs and/ or alcohol at such a high level that they were unable to stay in housing. In one case this was due to a drug overdose and in the others an inability to live in the group home setting of Fran Conway House and in the other such a heavy use of heroin that the client was unable to function on a day to day basis in her apartment. It is important to note that many clients in this program continue to use alcohol and addictive drugs but are able to function at a high enough level to stay in their housing.

9- Clients are accessing a variety of services through their program case managers.

The success of the Housing First model is predicated on the ability of clients to access whatever services they need to remain in their new housing. Clients are indeed accessing a variety of services through their case managers, as shown in the table below. 80% of clients are accessing physical health care while 54% are accessing mental health care.

Client use of services

Health services
Mental health services
Income support application
Transportation
Shopping
Clothing
Food
Payee
Dental care
Job search
Furniture
Computer training
Substance abuse group meetings
Medical assessment and follow-up
Medication management
Criminal justice system advocacy
Moving assistance
Discharge planning from institutions including hospitals and prisons

A number of clients also mentioned service needs that they had that so far had not been fulfilled by the program.

Client service needs

Dental care
Income support
Jobs
Schooling/training services
Psychiatric services
Furniture
Air conditioning
Eyeglasses
Listing of food pantries
More case manager visits
Drug counseling
Transportation

Recommendations for Improving the Program

While the Housing First program has been remarkably successful, we do have suggestions for improving it.

1- The success of Housing First programs is due in part to the ability of clients to readily access mental and physical health services. Case managers should have mental health training and clients should be able to meet with psychiatrists or counselors whenever they need to. There should be a formal relationship with a mental health center for any Housing First program.

2- While most clients are on disability, a number express the need and willingness to work part-time. Case managers need to connect clients with jobs and with effective job training where feasible.

3- Clients who are not working need daytime and evening activities. These could include group trips and/or organized adult activities in the community as a whole.

4- Dental care is a special need that must be addressed.

5- All clients, even those who appear to be self-sufficient, need regular case manager visits, at least on a bi-monthly basis.

6- The scattered site apartment program run by Riverwood is working well overall. However, the program could use more high quality apartments. Maintenance problems, as well as drug/alcohol use and fighting are issues in a few buildings. Case managers must be vigilant to be sure that these problems do not lead to program exits.

7- Since many clients have been homeless for a long period of time, there is a need for life skills training, particularly to orient clients to apartment living.

8- There is a need for a more adequate furniture allowance since many clients do not have adequate furniture, nor access to funds to acquire it.

Conclusions

This Housing First supportive services program has been extremely successful. We believe that a program like this should be a crucial part of the answer to the problem of homelessness in Rhode Island. It is serving the intended population, chronically homeless single adults. Clients were very unhappy while homeless and are now generally very happy with their housing situation. They are very grateful for this program. Progress has been made with respect to client health, mental health, and ability to interact socially with family and friends. Clients have higher incomes due to the ability of program staff to get them onto disability support but few are working.

The program more than pays for itself. Cost savings due to reduced use of expensive facilities such as hospitals, emergency rooms, mental health facilities, and prison are dramatic, nearly $8,000 per client, over $380,000 for the 48 clients combined. The percentage of clients no longer in permanent housing is extremely low at 7%. Much of the turnover that did occur was due to high initial turnover at the House of Hope program, where the congregate setting necessitated managing the resident mix to achieve long-term safety of the house residents. Riverwood Mental Health Services has used rapid re-housing methods to retain clients in permanent housing. Both programs have followed clients closely and move them back into housing even after they have left the program for some time.

Our recommendation would be to expand this program to include more chronically homeless Rhode Islanders, a population estimated to be over 1,000 individuals. This would result in cost savings for the state and its citizens, and it would dramatically improve the lives of those benefiting from the program.