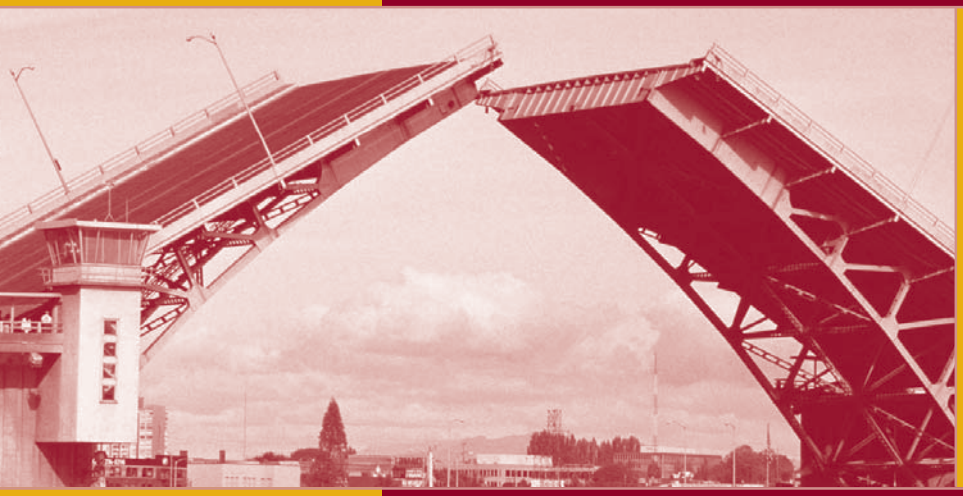
Bridges and **Barriers** to **Housing** for **Chronically Homeless Street Dwellers**



The Effects of Medical and Substance Abuse Services on Housing Attainment

October 2004

Tatjana Meschede, Ph.D.
Center for Social Policy
John W. McCormack Graduate School of Policy Studies
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I am also deeply indebted to the current and former homeless street dwellers who shared their stories with me, as well as those providing services to them. They are truly the champions in this effort to better understand bridges and barriers to housing for homeless street dwellers, and it is my hope that this work will help create better services and most importantly housing opportunities for those still on the streets.

"She never in her life could save that kind of money that she needs to get back on her feet, and she has no skills to be able to market herself to be able to make more money in that sort of situation. So what happens is that she is stuck in that cycle until somebody intervenes with authority, like the way we are trying to get DMR to help her get suitable housing that will be subsidized. Unless somebody steps in to do that she's always going to be in that sort of place where she is cycling around and that doesn't change her desire, it doesn't change what she wants. She dreams of the same things all of the rest of us dream, which is going some place in the evening and being able to get into a warm bed or to a place where the rain is not going to hit you on the head. Or where somebody is not going to rape you because you are outside, or any of the other things that she has to deal with having to live outside. It makes perfect sense to me when I think of the scenario how easily she could become discouraged. It makes sense to me that the woman goes out and does drugs." ***(Service Provider)***

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Executive Summary

Between 2000 and 2002, the Boston Health Care for the Homeless Program (BHCHP) street outreach team assessed 174 chronically homeless street dwellers at High-Risk of death and provided them with continuous intensive medical care on the streets. At the end of 2002, 42 of these individuals were housed or in a long-term treatment program, 19 died, and 92 remained at high risk on the streets. The remaining 21 individuals were either lost to follow-up, moved out of state, were jailed or in a shelter.

This research project explores the ways in which medical and substance abuse services succeeded and failed in helping to connect these homeless high-risk street dwellers to the broader homeless continuum of care and ultimately to housing. The study analyzes a unique dataset of health and substance abuse service use, and also incorporates 36 interviews with service providers (BHCHP street outreach team, respite care, detoxification staff) and current and formerly high-risk street dwellers. By combining quantitative and qualitative methods, this study uncovers bridges and barriers to housing and has important implications for the homeless service system and homeless policies.

Major Findings

Needs and Services

- ***Multiple needs:*** Most high-risk individuals had severe medical conditions, mostly related to life on the streets, and the extent of substance abuse and mental illness was high. Of the 174 high-risk street dwellers, 94% had substance abuse problems, and 82% had a major mental illness.
- ***Extensive use of health and substance abuse services:*** High-risk street dwellers used health and substance abuse services extensively. During the three years, 77% accessed respite care, 54% accessed the Boston Medical Center Emergency Room (BMC ER), and 31% used BMC's inpatient units. In addition, 60% were seen in detoxification programs, 20% in short-term and 11% in long-term substance abuse treatment programs. Many high-risk individuals had numerous admissions to these programs, resulting in enormous public costs.
- ***A service gap:*** Cycling between these service programs and the streets was widespread, pointing to a service gap for high-risk street dwellers between respite or detoxification and the next step program in the continuum of care. Programs with fewer rules and realistic expectations tailored to the needs of street dwellers (e.g., Safe Haven or Housing First programs) may help to fill this gap.
- ***Providers and street-dwellers disagree on needs:*** In the 36 qualitative interviews with service providers and high-risk cohort members, service providers expressed

more concern with the service needs of the high-risk cohort, while high-risk individuals themselves stressed the need for housing options.

Bridges and Barriers to Housing

- ***Demographics and outcomes:*** Women, those older, and white, and those with health insurance coverage had better chances of obtaining housing.
- ***Service use and outcomes:*** Contrary to expectations, health and substance abuse service use did not predict better housing outcomes. The only service that impacted better access to housing was extended stay at respite care of 292 days or more, which was significantly beyond the average stay of 30 days.

Policy Implications

- ***Strengthening homeless services:*** Implications for homeless services include focusing on housing rather than service needs, continuous support during transitions from the streets to housing, and educating staff, especially in mainstream service settings, on the effects of homelessness on their clients.
- ***Reassess the Continuum of Care model:*** The linear continuum of care model does not work for high-risk individuals, especially the requirement of moving through transitional housing programs to access permanent housing. Rapid re-housing may be a better approach to solve the problem of "chronic" street homelessness.
- ***Creation of accessible, affordable and diverse housing projects****:* Policy recommendations focus on the need for creating affordable housing options for high-risk street dwellers, such as SRO type apartments, supportive housing and Housing First programs, and the need for fewer housing eligibility requirements.

"This is a guy who had extreme, extreme paranoid schizophrenia; he did not want to talk to people or have any eye contact with people. He was really frightened and I met him and started working with him while he was at McInnis House [the Boston respite care program]. He stayed at McInnis for almost 10 months while he waited for his fingers to resolve and almost all of them resolved except two. But in the course of time that he was there we were able to take him up to get major services. He got hooked up to psychiatric services; he is now medicated; he is now on a regular treatment program. They put him in housing in the DMH single occupancy housing, so he is housed now and this was not a straight process. We had lot of failed attempts with this guy where they tried to put him in halfway houses and he could not function in a halfway house, he was not a man who could function in a closed environment like that. He has paranoid schizophrenia and didn't want to be that close to people. He works perfectly in a single occupancy room. He stays almost all day in his room but he is not drinking in his room. He is watching movies or TV or whatever." ***(Service Provider)***

Introduction

In the winter of 1998/99, after the deaths of 16 homeless people in the streets of Boston attracted wide attention by the media, the Commissioner of the Massachusetts Department of Public Health (MDPH), Dr. Howard Koh, convened a group of stakeholders serving the homeless street population. The goal of this MDPH Homeless Taskforce was to reduce the number of homeless people dying on the streets as well as to improve service delivery to those homeless individuals most at risk of dying. A wide range of individuals serving or encountering the homeless street population, including homeless outreach teams, law enforcement personnel, and homeless advocates, were invited to participate in the task force.

"Our assumption at that point [when 16 street death occurred in the winter of 98/99] was that people had died because they had fallen through the cracks, because they have not received health care. In fact what happened is that they found out of the 16 people who died, 12 of them had been in and out of a hospital emergency room or in a detox within six weeks of the time they died. And what started to emerge was this pattern that they saw, that in fact people were coming in but they were getting very disconnected care at lots of different emergency settings. And nobody was doing any coordination between any of those things. So people were not getting any continuity of care." ***(Service Provider)***

Contrary to common beliefs that the homeless do not want to accept services and help (Boston Globe, 2/13/2002), an investigation into the lives of those who died in the streets of Boston in the winter of 1998/99 by members of the MDPH homeless taskforce indicated that service providers knew most of them. This fact clearly demonstrates that homeless people use services when they are available, and that street deaths can be attributed, at least to some extent, to the failure of the homeless service delivery system (Hwang, Lebow, Bierer, O'Connell, Orav, & Brennan, 1998). It is therefore important to evaluate the homeless service system as it pertains to the homeless street population. Due to a lack of consistent and coordinated data collection among service agencies, little is known about the overall service utilization of Boston's homeless street population, and this study begins to fill this gap.

Starting in January 2000, the Boston Health Care for the Homeless Program (BHCHP) implemented an intensive medical care plan for a group of street dwellers identified at high risk of death. Many of these "chronically" [1] homeless individuals on the streets do not move along the homeless continuum of care (CoC) as planned, but remain on the streets for long periods of time. This study documents their health and substance abuse service utilization pattern, demonstrates their movement through different service agencies and documents where these services fail.

While this study was being conducted, the federal government unveiled its plan to end "chronic" homelessness in ten years. Several federal funding opportunities geared

[1] Homeless advocates have voiced their concern regarding the use of the term "chronic" as stigmatizing because it distorts the causes and nature of homelessness, pointing to mental illness and substance abuse as causal agents instead of more structural causes. Therefore, this term will be used in quotation marks throughout this report to remind the reader of the controversy around its use.

toward reducing "chronic" homelessness were issued, and many localities have created ten year plans to end "chronic" homelessness. Findings of this study have policy implications for achieving this goal.

Research Questions

Partnering with the Boston Health Care for the Homeless Program (BHCHP), the major purpose of this study is to assess the contribution of medical and substance abuse services in connecting homeless street dwellers at risk of death to the homeless CoC or other types of housing, thereby enabling them to leave their life on the streets.

Related questions include:

- What are the specific residential benefits for homeless street dwellers at risk of death based on these services?
- What are homeless service providers' theories of homelessness and assumptions about how services may improve the housing, health, psychiatric disability and employment of the street homeless?
- What factors enable homeless street dwellers to move along the CoC and attain housing?
- What are the barriers to connecting homeless street dwellers with services so that they can move along the CoC and attain housing?
- What changes in the service delivery approach for homeless street dwellers at risk of street death would improve housing and other outcomes?

High-Risk on the Street

In January 2000, the BHCHP street outreach began providing intensive medical services to a cohort of 120-140 street dwellers identified at high-risk of death based on factors identified in prior research (Hwang et al., 1998; Hwang, 2000). Street dwellers sleeping regularly on the streets for six months or more are assigned to the high-risk street cohort when one or more of the following symptoms are present:

- A triple diagnosis of a medical illness, substance abuse, and a major mental illness;

"People give me food sometimes but I don't trust it, it could be poisoned. It's a Zoo out there, absolutely crazy! I get $550 a month in SSI. I buy food and clothing, alcohol. I sometimes stay at a motel to clean up, take a shower, do laundry." *(Current High-Risk Street Dweller)*

- A major medical illness requiring acute care hospital admissions, multiple emergency room visits, or admission to respite care during the previous year;
- Three or more visits to the emergency room during the prior three months;
- Age above 60;
- A diagnosis of cirrhosis, heart failure, or renal failure; and/or
- A history of frostbite, hypothermia or immersion foot.

"They have their own community, I sleep under this bridge, you sleep under that one, we are neighbors and friends, and it's amazing how if I see a couple of the street women together, it almost like "oh yesterday when I was at your spot and borrowed a cup of sugar...", like a community of let me knock on your door and borrow a cup of sugar. They take what they have and they work it, and they survive. ... Even though it's on the streets, even though it is their drinking buddies or their drug buddies, it's their family." *(Service Provider)*

Individuals identified at High-Risk of dying on the streets are enrolled on an ongoing basis in an intensive care management program, and are followed closely by the BHCHP street outreach team. The number of individuals has changed over time, as some depart the group due to housing, death, or incarceration, and others are added to the group. Initially enrolling about 60 individuals, the total sample size of the high-risk cohort averages 130 per calendar year, for a total of 174 individuals at the end of 2002. This group constitutes about 15 percent of the total street population served by BHCHP. This group of "chronically" homeless and difficult to serve individuals was intentionally picked for this study, which aims to demonstrate failures and achievements of services attempting to reach those most likely to be left out of the service delivery model.

Methodology

This case study utilizes a combination of qualitative and quantitative data collection methods to analyze the ways in which medical and substance abuse services, including extensive medical street outreach, contribute to connecting homeless street dwellers at risk of death to the homeless CoC and housing. To document service use and associated outcomes for Boston's high-risk homeless street dwellers in calendar years 2000-2002, secondary data analyses were conducted on merged data from BHCHP's medical and MDPH BSAS's substance abuse service databases. This unique database is the first of its kind as it combines information on high-risk chronically homeless individuals across two separate systems of care: the health and substance abuse service systems.

Qualitative data were collected via 36 semi-structured interviews with key informants to document views on service delivery and service goals, as well as successes and barriers in connecting the street homeless to the CoC and housing. This purposive sample in-

cluded: six BHCHP street outreach workers; eight respite care providers; four detoxification staff; and nine current as well as nine former high-risk street homeless individuals. All interviews were conducted after permission was granted. These taped interviews were transcribed and analyzed for recurring themes using qualitative data analyses software (NVIVO).

The High-Risk Street Cohort 2000-2002

The high-risk street dwellers were significantly more likely to be Caucasian and older than the non high-risk street population and sheltered homeless individuals, but there were no significant difference between the high-risk group and the other two groups in terms of gender (see Table 1).

"I went to a shelter temporarily but I never got out of the system at the shelter because they couldn't help me find an apartment and stuff. Now I stay on the streets with my boyfriend. Sometimes we go to the ATM bank, sometimes we sleep on the stairs, or wherever we can find a nice spot with the blankets that we get from the night van." *(Current High-Risk Street Dweller)*

Table 1
Comparison of Demographic Characteristics Between the High-Risk Street Cohort, Non High-Risk Street Dwellers, and Boston's Homeless Shelter Population, 2000-2002

	High-Risk Cohort	Non High-Risk Street Dwellers	Boston's Shelter Population[2]
Total N	**174**	**1,258**	**15,057**
Gender	(N=174)	(N=1,237)	(N=13,800)
Male	74%	77%	73%
Female	26%	23%	27%
Race	**(N=172)**	**(N=582)**	**(N=10,983)**
White	76%**	65%	45%
African American	13%	24%	33%
Hispanic	4%	7%	17%
Native American	7%	2%	1%
Asian	0%	1%	1%
Other	0%	1%	3%
Age	**(N=171)**	**(N=419)**	**(N=11,150)**
Under 18	0%	<1%	1%
18-24	0%	9%	8%
25-34	3%	15%	18%
35-44	34%	28%	32%
45-54	37%	27%	29%
55-64	17%	15%	11%
65-74	5%	6%	1%
75+	4%	0%	0%
Average Age	**50****	**44**	**41**

*** Significant differences p < .001*

[2] Unduplicated count of individuals accessing the following shelter programs: Boston Rescue Mission, Long Island Shelter, Long Island Annex, Pine Street Men's Inn, Pine Street Women's Inn, Shattuck Shelter, Woods Mullen. Please note that some of the non high-risk street dwellers may also be among the sheltered homeless population. Due to lack of identifying information, unduplication between the two samples could not be conducted.

Burden of Illness, Mental Health and Substance Abuse

High-risk cohort members suffered from a variety of medical conditions, of which many are related to life on the streets. Most common were infectious and parasitic diseases (41 percent), problems related to the circulatory system (34 percent), and respiratory diseases (24 percent).

The BHCHP street outreach team assessed 82 percent of the high-risk cohort with a major psychiatric disability. For those who had a specific psychiatric diagnosis, most were diagnosed with a depressive disorder (37 percent), followed by a psychotic condition (22 percent), or a bipolar disorder (10 percent). Others suffered from anxiety disorders (nine percent) or Post Traumatic Stress Disorder (PTSD; five percent).

"I am getting old. I can't do that anymore. I am tired. ...The streets are hard. ... You have to find a place to sleep. You have to find something to eat. ... It wears you out." *(Current Street Dweller)*

Of the 174 high-risk cohort members, 116 (67 percent) were also admitted for substance abuse treatment during calendar years 2000-2002, with one of the programs tracked by the Massachusetts Department of Public Health Bureau of Substance Abuse Services (BSAS). Of the 58 high-risk individuals not treated for substance abuse problems, 47 were diagnosed with a substance abuse problem by the BHCHP outreach team. As such, only 11 individuals (6 percent) of the entire high-risk homeless street cohort did not exhibit evidence of a substance abuse problem.

Given the high rates of psychiatric disability and substance abuse, it was not surprising that most high-risk individuals were dually diagnosed with a major psychiatric disability and substance abuse (76 percent). Seventeen percent were diagnosed with a substance abuse and no major psychiatric disability, and five percent with just a psychiatric disability[3]. Only two individuals did not have a diagnosis of either one.

Utilization of Health and Substance Abuse Services

At the end of 2002, more than half (58 percent) of the 174 high-risk individuals were served by BHCHP for more than five years. The length of time on the high-risk cohort list varied from less than one month to 36 months for an average of 22.61 months. Many individuals (22 percent) were classified as high-risk for the three years of the study period; another 26 percent were diagnosed as high-risk for less than one year, and 21 percent from one to under two years.

Of the 174 high-risk individuals, 134 (77 percent) were served by BHCHP's respite care program during 2000-2002 (see Table 2). The number of admissions ranged between

[3] Percents do not total 100 due to rounding.

one and 31 during this period, with an average of 5.23 admissions. Fifteen percent of all high-risk individuals were admitted only once, another 11 percent twice, and 18 percent three to five times. Very few (11 individuals or six percent) were admitted more than ten times. Measured in days, the length of stay in respite care ranged from one to 621 days with an average of 103.75 days during the three years. Of those who utilized respite care, 28 percent stayed less than one month, and 17 percent used the program between one and two months. Seven individuals stayed for over one year.

Thirty-one percent of all high-risk individuals received inpatient care at Boston Medical Center (BMC) during the study period, ranging from between one and 17 inpatient visits for an average of three visits. Most received inpatient care once during the time period (23 individuals or 43 percent of all receiving inpatient care); three individuals received inpatient care ten or more times. The number of days spent in inpatient care ranged from one to 103 days, for an average of 13.80 days. Half of those receiving inpatient care stayed at BMC for up to one week, another 20 percent from more than one week up to two weeks, and 13 percent for more than two weeks up to three weeks. Fifty-four percent of all high-risk individuals visited BMC's ER, ranging from one to 47 ER visits for an average 7.33 times. Most visited the ER once (19 percent), two (14 percent), three (13 percent), or four (12 percent) times.

Table 2
High-Risk Cohort Medical and Detoxification Service Utilization, 2000-2002

Service Program	Number of Individuals Using Service[a]	Percent of Cohort Using Service
Medical Services		
Respite	134	77%
BMC ER	94	54%
BMC Inpatient	54	31%
Substance Abuse Services		
Detoxification	104	60%
Short Term SUD	35	20%
Long Term SUD	19	11%

[a] *More than one response possible*

"I have been not treated because I was dirty. Some of the hospitals, they won't treat you. If the insurance is not correct, they kick you out." *(Former Street Dweller)*

The overall number of substance abuse treatments ranged from one to 72 visits during the 2000-2002 study period, for an average of 15 treatment stays. Most of the substance abuse treatment services attended by high-risk individuals were detoxification programs which accounted for 89 percent of all admissions. A total of 104 high-risk individuals (60 percent of all high-risk street dwellers) were admitted to these services (see Table 2). Post-detoxification residential services accounted for seven percent, and the remainder of services were provided in outpatient treatments, supportive housing, Section 35 (involuntary commitment to substance abuse services), and correctional facilities. The number of detoxification admissions ranged from one to 49 over the three-year study period, with an

"It seems I have done it [detox] 100 times. They take your street clothes and have you stay in pajamas and gowns – I don't know what the hell that was for. It's only five days, the government must be out of their minds if they think five days will cure one's alcohol or drug addiction. Detoxing someone does not help with the overall substance abuse problems. ...My liver gave me problems and I stopped by myself. I have been sober for over a year." ***(Former Street Dweller)***

Table 3
Combined Use of Medical and Detoxification Services

Service Type	N	Percent
No Services Used	9	5%
Respite Only	22	13%
ER Only	4	2%
BMC Inpatient Only	2	1%
Detoxification Only	15	9%
Respite and ER	16	9%
Respite and BMC Inpatient	2	1%
Respite and Detoxification	30	17%
ER and Inpatient	2	1%
ER and Detoxification	3	2%
Respite, ER, and Inpatient	13	8%
Respite, Inpatient, and Detoxification	1	1%
Respite, ER, and Detoxification	20	12%
ER, Inpatient, and Detoxification	5	3%
Respite, ER, Inpatient, and Detoxification	30	17%
Total	**174**	**101%[4]**

average of 11.46 admissions. The number of days spent in detoxification ranged from one to 273 days, with an average of 44.34 days during the study period.

A total of 35 high-risk street dwellers were successfully referred to short-term residential substance abuse treatment programs for 34 days on average. As such, many stayed for the anticipated duration of these programs, which normally lasts for one month. A total of 19 high-risk street dwellers were served in long-term substance abuse treatment programs, close to three months on average.

Combined Use of Medical and Detoxification Services

As displayed in Table 3, only nine individuals did not use any medical or detoxification services. Another 25 percent used only one of the four services types, and many (17 percent) were served by all. A combination of respite and detoxification services was also common (17 percent), as were respite care alone (13 percent), and respite, detoxification, and ER (12 percent).

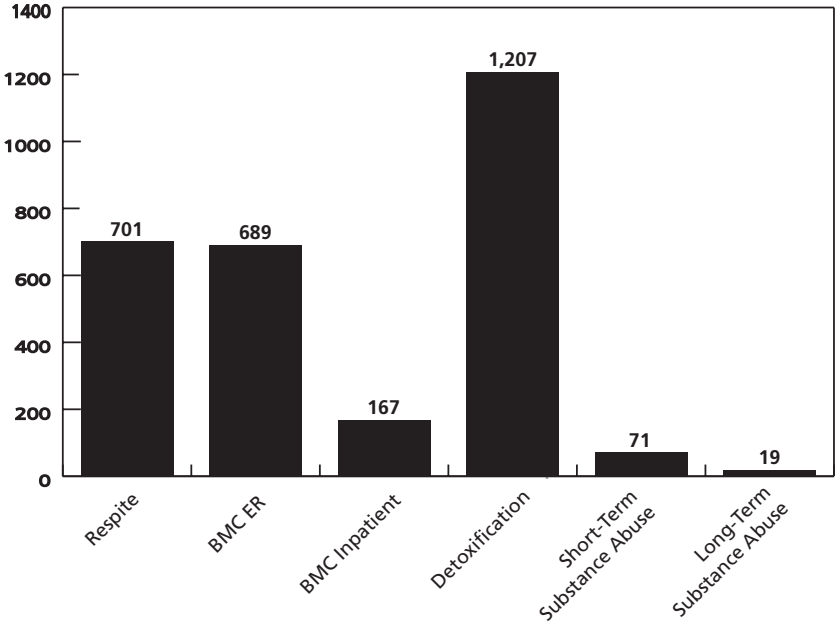
Most of the high-risk individuals using services did so numerous times. As depicted in Figure 1, the whole cohort used health and substance abuse extensively over the three years of this study, exerting tremendous costs for the overall service system. The total number of admissions for both respite care and BMC ER reached about

[4] Percents do not total 100 due to rounding.

700, admissions to BMC inpatient care were at 167. In addition, individuals of this cohort of 174 were treated in detoxification 1,207 times, with an additional 71 admissions to short-term substance abuse treatment as well as 19 admissions to long-term substance abuse treatment.

Figure 1

Total Number of High-Risk Cohort Admissions to Health and Substance Abuse Service, 2000-2002



Referrals from Respite and Detoxification

In addition to documenting service use patterns, this study also focuses on the intersection between different service systems and continua of care in providing care for high-risk street dwellers. As summarized in Tables 4 and 5, most of the high-risk street dwellers for whom program exit information was available (81 percent of all in respite care admissions, 83 percent of all detoxification stays)[5] exited from either respite care or detoxification on their own volition, leaving respite against medical advice from respite care or indicating no interest in further treatments after completing detoxification. About 22 percent of those exiting respite care entered the hospital, a long-term treatment program, moved in with family or friends, or their own apartment.

"We try to get them into a shelter, or just getting them to a point where they are safe upon discharge from here . . . [but] More than half of the people end up back on the streets" ***(Respite Care Provider)***

About half of all detoxifications were ended by the individual dropping out, while another half were completed. Of all high-risk individuals who completed detoxification, most (42 percent) left without a referral to a next step longer term treatment program. A little more than one quarter were referred to a transitional or residential program (Table 5).

[5] The percentages presented in tables 4 and 5 are based on number of stays, not individuals.

Table 4
Destination/Referrals from Respite Care, 2000–2002

Destination	2000–2002
Against Medical Advice	38%
Shelter	20%
Away Without Leave (Disappeared)	16%
Hospital	10%
Treatment Program	4%
Family/Friends	4%
Street	2%
Own Plans	3%
Apartment	2%
Nursing Home	1%
Transitional Shelter	<1%
Halfway House	<1%
Jail	<1%

Table 5
Destination/Referrals from Detoxification for Program Completers, 2000-2002

Destination	2000–2002
Referral not Wanted	42%
Transitional	17%
Residential	10%
Outpatient	9%
Shelter	5%
Referral not Needed	4%
Hospital/Health Care	3%
Other	10%

"Sometimes I would get sick, and I learned how to take care of myself. Then I ended up in the hospital, and from the hospital I went to Betty Sneads. Then back to the streets, and then after another couple of months I was back at the Snead House or McInnis." ***(Former Street Dweller)***

"Lack of resources is a huge issue. All the cuts, you know compounded with the fact that we have to discharge people based on their medical stability. And sometimes it's impossible to get a good plan in place. That's a big issue." ***(Respite Care Provider)***

High-Risk Status at the End of 2002

Of the 174 homeless individuals classified as high-risk during 2000-2002, 92 individuals (53 percent) were still living on the streets at the end of 2002. Almost a quarter had moved into housing (N=35), or were in a long-term treatment program leading to housing (four were stable in a long term program, three in a nursing home). Nineteen individuals (11 percent) died during the three years, and another 15 were either lost to follow-up or left the state. The remainder were in jail or prison, or staying at a homeless shelter.

"BMH [Barbara McInnis House] was most helpful in leaving the streets. I still go there once in a while to say 'hi' to everyone down there." *(Former Street Dweller)*

Outcomes were also studied for the 101 individuals assigned to the high-risk cohort during the first six months of the study period. As these individuals were among the first enrolled into the new model of intensive medical care on the streets, and therefore were the longest served in this new service approach, outcomes were expected to differ. In fact, those who were assigned to the high-risk group early on had slightly better outcomes. Of these 101 individuals, relatively fewer were still on the streets (45 percent), while relatively more were housed (30 percent). Not surprisingly, a higher proportion was deceased (15 percent).

Over the three years of this study, six individuals left the high-risk cohort for some time (ranging from six to12 months) and then returned to the streets. At the end of 2002, three of them were in housing, and three remained high-risk on the streets.

Table 6 depicts the demographic characteristics and service use for the high-risk cohort by three outcomes at the end of 2002: housed/stable in a long-term program, remaining high-risk on the streets,

Figure 2
Comparison of Outcomes Among All High-Risk Individuals and Those Diagnosed as High-Risk Between January and June, 2000

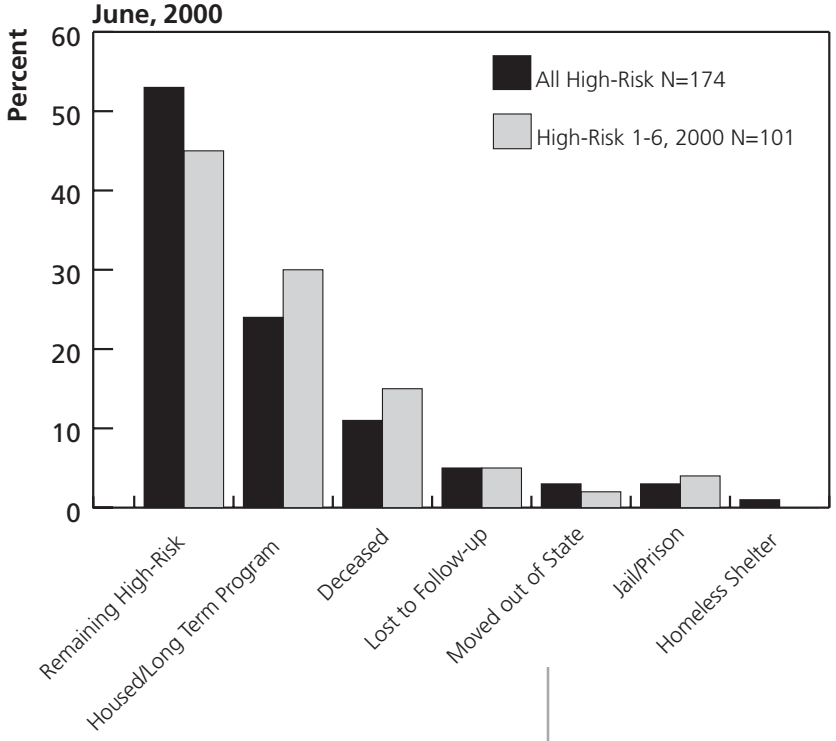


Table 6
Comparison of Individuals Who Were Housed, Remained High-Risk on the Streets or Had Died at the End of 2002

	Housed/ Program N = 42	High Risk N = 92	Died N = 19
Demographic Characteristics			
Male	57%*	80%	90%
White	83%*	73%	74%
Average Age	51*	50	51
Health			
Health Insurance	91%*	83%	74%
Psychiatric Disability	81%	89%	58%
Substance Abuse (SUD)	93%	97%	90%
Psychiatric Disability and Substance Abuse	76%	89%	53%
BHCHP Client			
Months as BHCHP patient	59	59	57
Months on High-Risk cohort	19	24	14
Health Service Utilization			
Admissions to Respite Care	64%*	87%	79%
Avg. LOS[6] Respite Care (days)	132 *	114	56
ER Admissions	45%*	61%	53%
Inpatient Admissions	24%*	36%	47%
Avg. LOS Inpatient (days)	7	13	27
Substance Abuse Service Utilization			
Admissions to Detox	60%	64%	63%
Avg. LOS Detox (days)	40	53	26
Admissions to Short-Term SUD	21%	22%	5%
Avg. LOS Short-Term SUD (days)	31	40	4
Admissions to Long-Term SUD	10%	13%	5%
Avg. LOS Long-Term SUD (days)	58	104	29

**Significant differences yielded in regression analyses between those housed/in program over one or both of the other groups*

and died during the 3 years of the study period. This information indicates that proportionately, fewer men and more white high-risk individuals were housed at the end of 2002. Fewer of those who died had health insurance coverage or a diagnosis of a psychiatric disability. There were no differences in the length of time served by BHCHP among the three groups. Those who were housed had lower rates of accessing medical care, pointing to the stabilizing effects of housing on health status. However, once in respite care, those housed stayed longer on average. There were no notable differences in accessing substance abuse services between the three groups, but those who died stayed in these treatment programs for shorter periods of time.

In sum, high-risk street dwellers used health and substance abuse services extensively over the three years of the study period. However, as statistical analyses indicate[7], except for exceptionally long stays—those exceeding 292 days—at respite care, the extent of service use did not predict better housing outcomes. A major reason may be that these services did not see it to be their role to address housing issues. Philosophically, staff in these programs may also feel mental health and substance abuse issues need to be addressed first, as some of them indicated. On the other hand, street dwellers who were not able to access housing may have been sicker or more disorganized.

Demographic characteristics were found to be more important in predicting leaving the streets for this cohort of street dwellers. Women were consistently found to be more likely to move into housing. As evidenced in the interviews, high-risk female street

[6] Length of stay
[7] For details on multi-nominal and survival analyses, please refer to the complete doctoral dissertation under the same title.

dwellers were more troubled by their life on the streets, therefore possibly more likely to leave the streets when such opportunities opened for them. Mentioned by one provider and supported by prior research, women on the streets were also more willing to accept care then men (Calsyn and Morse, 1990). In addition, as one former high-risk woman described in her interview, homeless women on the streets were perceived as more vulnerable than homeless men, and therefore may receive more attention by service providers.

"But it's nasty, not nice. Especially for a woman. It makes you hard, mean, it makes you a hard woman. It's a hard life. It makes you hard, it makes you mean. I had fights with men, grown men, punched them in the stomach, punched them in the face. I look at people different now. I used to be pretty trustworthy, and now I don't trust anybody. It's hard to trust when you are out there." *(Current Street Dweller)*

Those older and those identified as white were also more likely to have left the streets. Elderly high-risk individuals may have more housing options due to their age, or, as some pointed out in the interviews, may realize that they are too old to continue to live on the streets. Further, racial discrimination may be ingrained in providing services and accessing housing, explaining why those who identified as white had a higher probability of accessing housing. However, interview data overall did not point to racial discrimination in receiving services, except for one individual who felt that whites did not have to wait as long as those of color to receive services. Other factors may impede successful housing attainment for high-risk individuals of color, possibly previous incarceration, as incarceration rates are higher for the non-white population.

"It was kind of weird because everyone would look out for me a little more than they did for other people. I think that's because I was a woman on the streets." *(Former Street Dweller)*

Health insurance coverage was also consistently found to increase the odds of housing. Health insurance coverage may improve access to services, which in turn provide housing opportunities. On the other hand, data did not provide information of when health insurance coverage was granted. As such, it is possible that high-risk individuals in housing accessed health insurance during or after their transition to housing.

"And I think they [the women] are also much more prone to accept help to even think about it. Men tend to think macho, I can do this on my own. I have not found that too much in women." *(Service Provider)*

Perspectives

Service Provider Perspectives

Eighteen service providers expressed their views about the reasons that homeless people live on the streets, the immediate and larger purpose of their work, and the role of their program in connecting the high-risk street cohort with services and helping to the end their client's homelessness. Below is a summary of these interviews.

Service Needs

As expected, many providers talked more about the service needs rather than the housing needs of homeless street dwellers. Respite care providers and detoxification staff focused mostly on substance abuse and psychiatric problems. According to their theories, "chronically" homeless individuals end up in a cycle of street life and short-term program attendance, due to substance abuse and psychiatric disability. While some acknowledged structural barriers such as lack of affordable housing and service program rules that create barriers to moving from one step to the next, most focused on individual factors as preventing successful transitions to housing. The street outreach team also alluded to the failure of the service system in providing adequate support to prevent street homelessness. Individuals, then, get stuck on the streets due to limited resources leading to discouragement and substance abuse.

"But it is really, really important we establish that trust relationship. So that means we never promise anything that we can't deliver. We are really consistent and if we say we are gonna be at some place, then we are there. Whether or not the person comes. … Because I think that a lot of our people have been in relationships that have been very conditional, and our goal is not to make that judgment, that's not what we are about. Our goal is provide support and care and to really not do that with a judgment, and realizing that we cannot change somebody. But we can support them." *(Service Provider)*

Service Processes

Aside from offering medical care and detoxification, all service providers stressed the importance of developing trusting relationships with individuals from the high-risk cohort. Most providers did not support forcing individuals off the streets during severe weather conditions as a general policy; but many also struggled with assessing circumstances when such an intervention may be warranted. Concerns centered on determining when individuals were incompetent to make their own decision about staying on the streets.

Housing Readiness

Contrary to the views of respite care providers and detoxification staff, most street outreach team members thought that most high-risk individuals are ready to be housed, as long as there is sufficient support and the housing matches their needs, thereby backing a "Housing First" approach. Respite care providers and detoxification staff, for the most

part, noted that by adapting to years on the streets, "chronically" homeless individuals lack the ability to live indoors and follow rules. As such, they need to relearn daily living skills in addition to attending to substance abuse and/or psychiatric problems before moving into housing. According to respite care providers, this skill development can only be achieved in long-term treatment programs. All provider groups agreed on the need for ongoing support systems once an individual has moved into housing, in order to continuously provide social supports and guidance.

"I think if you ask people: 'Can I help you with housing,' they will say 'yes.' But some people choose to be out on the streets, they want to be housed, but when it comes down to the necessary steps they need to take, like do clean time, they choose to be out on the streets as oppose to being in a program. If you ask any of our patients whether they want an apartment, they would say yes, but if you asked them that they would be required to stop drinking: 'No, I opt for the street.'" *(Service Provider)*

Barriers to Housing

Respite care providers listed many psychological barriers to housing for "chronically" homeless street dwellers, mostly associated with the change from surviving on the streets to adapting to a very different indoor lifestyle. These psychological barriers include fear of change and the unknown, lack of self-worth, need for creating trusting relationships, and lack of hope that change is possible.

"I think the biggest hurdle we have is the limitation that other programs are finding themselves in, limiting the amount of beds, closing shelters because of the lack of funds. Post detox treatment programs are not available when you need them to be available. And that puts that patients in just the biggest vulnerable area of their lives that they can look and say very easily 'there is no bed, I am out of here' and run. And so they go and repeat the same substance abuse problem." *(Service Provider)*

On a more structural level, all provider groups discussed a lack of programs for continuous care and treatment of "chronically" homeless street dwellers. While the members of the street outreach team were open to a "Housing First" approach, respite care providers and detoxification staff, for the most part, believed that such an approach would not be successful with "chronically" homeless street dwellers due to the psychological and skills barriers discussed above.

Homeless Street Dweller Perspectives

A total of nine current high-risk cohort members shared their stories about living on the streets, the services they have accessed, and their plans for moving to housing. Their homeless experiences varied, ranging in length from just over two years, to up to twenty. In addition, nine former high-risk cohort members shared their experiences about living on the street, and transitioning to housing. The length of prior homelessness varied from four to 16 years, and their time spent in housing ranged from two months to two years.

"I can't deal with shelters. I have tried but I like my freedom. I like to be able to make choices to the best of my abilities. I don't want to be told what to do." ***(Current Street Dweller)***

Homeless Causes and Service Needs

A combination of various causal factors led these street dweller interview participants to street life. Most often, these were a combination of economic factors, such as lack of skills to earn an income necessary to afford the high rents in the Boston area, and psycho-social issues such as domestic violence, family break-ups, and substance abuse. Most had accessed homeless shelters when they first lost their housing, but could not tolerate the crowds and rules. As a result, life on the streets was the only option remaining. It was not surprising to learn that all street dweller respondents pointed to housing as the foremost service need; but they also reported needing help with medical, substance abuse, and psychiatric issues.

"I really don't like it [shelters]. It was a nerve wracking experience. You are treated like a lot of us get treated, like a criminal. There are too many people in there. You can get robbed. So it's like a prison without the guards." ***(Former Street Dweller)***

Street Life

All street dweller interviews entailed many accounts of the harshness of street life and the desire to have a place to live. Even though life was tough in the streets, high-risk homeless street dwellers felt a sense of self determination, which they did not feel in the homeless shelter system or other service programs. Former high-risk cohort individuals tended to be slightly more supportive of removing individuals from the streets against their will at times of extreme weather conditions.

Accessing and Maintaining Housing

High-risk individuals assessed the services from BHCHP street outreach and respite care as very helpful, most often going beyond the provision of medical care. A few former high-risk cohort members stayed at the respite program for many months, much longer than the average program stay of three weeks. Most likely this occurred due to their initial medical needs, and after recuperation, in order to await housing placement. Detoxification services, in general, were assessed as not valuable in promoting soberness, but two individuals were in long-term substance abuse programs they rated as very helpful in their recovery process. These programs also helped them to move off the streets.

"They really help me out a lot. If I don't come for my appointment, they ask: 'Where were you?' and they come out looking for me. They know that something is wrong when I don't show up, 'she must be back on the streets or something.' When I am in the hospital, they know about it. I can't hide from them [laughs]. All the trouble they went through to get me better again. I owe them a lot. And I was thinking that I don't know how to thank them. And then I said, yeah, by being sober and staying off the streets, getting my own place. Stuff like that." ***(Former Street Dweller)***

The personal connections that some high-risk individuals developed with service providers were also important to accessing and remaining in housing. Continuous support by service providers after having moved into housing was also valuable to many. Those who had moved into housing were very pleased with their new living environments.

Barriers to Housing

Former and current high-risk individuals listed numerous obstacles to leaving the streets. Most importantly, the lack of access to affordable housing was noted by many. Given the high rents in the Boston area, none of the high-risk group members could afford housing without subsidies. However, the complex application process for affordable housing is an insurmountable obstacle for many on the streets. In addition, the long waits, often entailing many years, for Section 8 or public housing, were very discouraging.

"I rather pay rent than sleeping in the streets. … With the economy and the government – the governor is cutting everything out. They are making more hotels and everything else instead of making more affordable housing. … I only get $582. You can't do much with that. You can't pay for an apartment. That's why I am waiting for my Section 8. Section 8 is on freeze right now. As soon as they unfreeze it I can get my Section 8." ***(Current Street Dweller)***

The need to attend long-term programs as a common prerequisite for housing was helpful for some, but also rejected by many. Again, sharing space with other individuals and following program rules are major hurdles for many on the streets. Recommendations to

better help "chronically" homeless street dwellers attain housing included putting resources into affordable and supportive housing, providing services that help with transition from the streets into housing, and empowering homeless street dwellers in their use of services.

"There [at the shelters] they want you to go to a program before you get housing. That would have not worked for me." ***(Former Street Dweller)***

"Housing. The number one priority in my lifestyle is my health. When I have a home, I can maintain my health." ***(Current Street Dweller)***

In sum, there were very few differences between current and former high-risk street dwellers regarding homeless causes, decisions to live on the streets, and assessments of services available to them. Information gathered in these interviews points to the need to increase the affordable housing stock, support service providers linking individuals to housing, provide long-term support once an individual has moved off the streets, and empower homeless individuals in assisting them with choices and opportunities.

Bridges and Barriers to Housing

This section portrays major themes from the interview information across interview groups, thereby contrasting important differences on interview participants' assessments on bridges and barriers to housing for high-risk street dwellers.

Program Capacities and Interagency Collaboration

The extent of program capacities and resources, as well as referral and interagency collaboration, was among the most important issues facilitating as well as hindering high-risk street dwellers' movement off the streets (see Tables 7 and 8). In theory, successful referrals from respite or detoxification were expected to link individuals with long-term service programs, providing help with achieving secure and permanent housing for street dwellers. However, as presented earlier, many high-risk street dwellers have cycled between the streets and respite care, as well as the streets and detoxification, numerous times. This was true for current street dwellers as well as former street dwellers. To better understand the causes and nature of these cycles was one focus of this study.

At the service system level, the numerous cycles between short term residential treatments (respite and detoxification programs) and the streets could be explained, to some extent, by the lack of program capacities at respite and detoxification programs as well as lack of follow-up long-term treatments. State budget cuts have affected services at both, respite care and detoxification. The detoxification system lost close to half its beds in early

2003[8]. The effects of consolidating two respite care programs into one were described by this street dweller:

> *"When we were at the Snead House we had 9 on each floor, they had more time. [Now] they have no time, they need more people, volunteers asking questions: Do you need any help? They need to take action and help us get there. Help us with the process to apply for housing. Go with us, help us go through with it. People need help to go." (Current Street Dweller)*

Due to the recent human service budget cuts in the state, options for referrals from respite care and detoxification have been drastically reduced as well. Long waits to obtain long-term services and housing have made referral from respite care and detoxification more challenging. Consequently, the continuum of care, either in the substance abuse treatment system, or the system of care available after respite, fell apart with detrimental effects for homeless street dwellers.

As respite care and detoxification providers indicated, many programs do not accept homeless individuals, reducing the number of available referral options. Barriers include past criminal records and medical needs that programs feel ill-equipped to attend to. In addition, the types of program available for homeless street dwellers often do not address the service needs of this group, such as providing medication and supportive services, or do not want to admit individuals that were homeless for long periods of time.

Access to Housing

Another barrier to leaving the streets is the lengthy housing application process, including the long waits until a housing placement becomes available. Successful housing placement most often occurred among those interviewed when street dwellers stayed at the respite care program for extended periods of time, and they were then able to attain housing upon leaving respite care. Respite care service provider interviews and results of the quantitative analyses supported this reality. Providers stated that housing placements were most successful when exceptions with respect to the length of stay at respite care were made and individuals were allowed to stay much longer.

> *"I ended up in Barbara McInnis House; I was there for 14 months. … From McInnis I went straight to PSI Paul Sullivan Housing. They got my name in when I was at McInnis. It took them about a year before I got housing." (Former Street Dweller)*
>
> *"… there are some special circumstances with patients that we give one on one attention that do actually go from here into housing, … ." (Service Provider).*

One avenue to achieve housing for the high-risk cohort is to connect those eligible with services of the Massachusetts Departments of Mental Health (DMH) or Mental Retar-

[8] Please note that most interviews took place in summer 2003, after the end of the study period for service use data which were collected between 2000 and 2002. As such, the drastic cuts in detoxification beds did not impact service utilization analyses.

dation (DMR), shortening the long waits for housing imposed by applying for Section 8 housing vouchers, which are open to all low income individuals. The recent addition of three psychiatric outreach workers to the BHCHP street outreach team raised hopes to have better access to the various DMH housing programs such as DMH shelters and the Safe Haven project, as well as more traditional DMH housing options.

"There [at the shelters] they want you to go to a program before you get housing. That would have not worked for me." *(Former Street Dweller)*

Detoxification programs successfully referred a few high-risk street dwellers to long-term treatment programs. Most of those who were sober at the time of interviews reported having stopped abusing substances on their own, without going through detoxification and a substance abuse treatment program. For the most part, they attributed their beginning of sobriety to having reached a point of experiencing severe medical problems and facing the possibility of death.

"I want a home. I just need to get going. I don't know what am I going to do. I really don't know what am I going to do. ... I need to be walked through the whole process. I am thinking someone needs to listen to me; but no one really is paying attention to where I am going next. They want me to move into a shelter for abused women, and I really don't want to go." *(Current Street Dweller)*

The Homeless Continuum of Care

It was apparent from most interviews that the linear service model promoting a stepwise progress, ingrained in most continua of care, including the homeless CoC, does not work for many. Of the former street dwellers now in housing, only one individual went from short-term to long-term treatment to attain housing. Further, some former street dwellers explicitly stated that the stepwise CoC model would not have worked for them.

Those providers who were more critical of the current service system also shared their concerns with a service system that is set up in too much of a 'lock step' manner and has too few options. In addition, prior negative service experience in shelters, hospitals or other programs can function as a barrier to service use and linkage to housing. Both providers and consumers talked about many instances when home-

"Getting people to feel more comfortable asking for help. Very many times our patients have been stigmatized and just been treated horribly so just going out there and showing compassion, and having them feel comfortable coming to us for their health care, is really a huge accomplishment." *(Service Provider)*

less individuals were treated disrespectfully when accessing mainstream services, or, even worse, denied services.

Personal Factors

Even though the service system poses great challenges for placements of homeless street dwellers, many service providers at respite and detoxification attributed psycho-social factors as reasons for street dwellers remaining on the streets, and not solely program factors. Untreated mental illness and substance abuse, and the inability to take on responsibilities that come with housing placements, were some of the examples given by respite care providers. Fears of the unknown and leaving friends on the streets were cited as major barriers for successfully leaving the streets by other providers

Street dwellers had a different view. When prompted for reasons of why people cycle between respite care and the streets, one former street dweller explained:

> *"It's easier, it's because of low self-esteem, it's because you feel like it's never going to get better. People feel hopeless and helpless. Sometimes you feel like what's the difference. It's not a big deal, you know. I am not going to get any help; I am not going to get any housing. That's when you end up not doing anything." (Former Street Dweller)*

Providers also presented the lack of housing skills as a barrier. Skills that were important for survival on the street were considered maladaptive for indoor living. Consequently, preparation for housing needs to include relearning of skills for successful housing transition and retention. Some were able to use the long waiting period at respite to get accustomed to indoor living. Current and former high-risk street dwellers disagreed that training and developing more skills would be useful. While acknowledging the need for continuous support during their transition to housing, as well as during the initial period in housing, they did not support long-term training to relearn housing skills.

"The thing we try to do is to follow up with support, because some of those who lived on the street, and all of a sudden being in their own apartment is really hard. We have an older man he is in his early 70's and he had lived on the street for 15 years. I don't think he really had bad substance abuse, but he does have a mental issue. He was in McInnis House for two months, got into elderly housing. And now that he is in elderly housing he doesn't even know what to do. He has not even hung up his clothes, has not even made the bed. He just lay on the couch because that's all he has known. ... So what we try to do is to follow up to bring over food, to see if someone has come in, try to address his medical condition. But we end up doing a lot of other things, like moving people, all kinds of things." *(Service Provider)*

Table 7
Number and Percentage of Each Respondent Group Indicating Bridges to Housing

Bridges to Housing	Street Outreach Team (N=6)	Respite Care Providers (N=8)	Detoxification Service Providers (N=4)	Current High Risk Street Dwellers (N=9)	Former High Risk Street Dwellers (N=9)
Service Coordination					
Within Own System of Care	2 (33%)	4 (50%)	3 (75%)	2 (22%)	4 (44%)
With Other Homeless Programs Providing Housing	3 (50%)	5 (63%)	3 (75%)	0	5 (56%)
With Mainstream Agencies (DMH/DMR)	3 (50%)	5 (63%)	0	1 (11%)	2 (22%)
Service Processes					
Provider-consumer relationships	4 (67%)	3 (38%)	2 (50%)	5 (56%)	5 (56%)
Consistent support/ Continuity of Care	3 (50%)	5 (63%)	0	0	4 (44%)
Client Centered Approach/ Consumer Involvement	3 (50%)	2 (25%)	2 (50%)	1 (11%)	2 (22%)

Impetus for Leaving the Streets

The impetus for contemplating moving off the streets was most often motivated by consumers becoming very sick and facing the possibility of death.

During such low points in their lives, life on the streets was no longer an option, and long-term treatment a necessity. It was mostly the supportive continuous relationships with service providers, and the willingness of programs to keep individuals for long periods of time that then enabled street dwellers to successfully make the transition into housing.

"Those people who have had so much suffering come to a point where they realize that they cannot take it anymore are more ready to get into treatment programs."
(Service Provider)

"I finally got sick and tired of living the way I was living. Now I have my own place, and I love it. I gained so much this time, you know."
(Former Street Dweller)

Table 8
Number and Percentage of Each Respondent Group Indicating Barriers to Housing

Barriers to Housing	Street Outreach Team (N=6)	Respite Care Providers (N=8)	Detoxification Service Providers (N=4)	Current High Risk Street Dwellers (N=9)	Former High Risk Street Dwellers (N=9)
Lack of Funding					
Lack of Program Capacity	0	3 (38%)	2 (50%)	1 (11%)	0
Lack of Referral Options	5 (83%)	6 (86%)	2 (50%)[9]	7 (78%)	3 (33%)
Lack of Housing	0	2 (25%)	0	4 (44%)	3 (33%)
Housing Application Process	2 (33%)	2 (25%)	0	3 (33%)	2 (22%)
Insufficient SSI Income	2 (33%)	1 (13%)	0	2 (22%)	2 (22%)
Service Provision					
Unskilled Staff	1 (17%)	2 (25%)	2 (50%)	2 (22%)	0
Service Eligibility					
Eligibility Rules	2 (33%)	2 (25%)	1 (25%)	0	0
Criminal Records	0	2 (25%)	1 (25%)	1 (11%)	0
Health Insurance	1 (17%)	1 (13%)	2 (50%)	0	0
Personal Factors					
Untreated MH and/or Substance Abuse	2 (33%)	4 (50%)	0	0	1 (11%)
Lack of Skills	2 (33%)	2 (25%)	2 (50%)	0	0
Fear of Change	1 (17%)	3 (38%)	2 (50%)	1 (11%)	0

Depending on the nature of consumer-provider relationships, respondents felt these relationships can be both a facilitator and a barrier to continued service use and housing. Developing a trusting relationship can be a major facilitator of successful service delivery and promoting movement off the streets. On the other hand, both street dwellers and providers talked about some staff not being responsive to their clients' needs, thereby hindering the process of helping individuals move off the streets.

[9] Shortage/cuts of TSS programs

Implications and Recommendations

Implications for Changes in the Homeless Service System

Interview respondents shared a variety of suggestions for improving services and housing "chronically" homeless street dwellers. These ranged from structural changes geared toward increasing the affordable housing stock to addressing more interpersonal issues such as educating service staff and the larger public about homelessness. Current and former high-risk individuals focused on the need for affordable housing and more client centered services, while providers spoke more of the need to create service programs tailored to the high-risk cohort.

Focus on Housing

Street based service delivery is successful in engaging high-risk street dwellers as well as attending to their short-term needs such as food, clothing, and medical care. Building on this successful model of engaging difficult to reach street dwellers in services, service programs should take on a more active role in addressing the housing needs of the street population. In addition, the inclusion of housing assistance at detoxification programs and expansion of housing services at respite care may help limit repeated cycles between these services and the streets. Of course, adding a credible housing focus to these programs hinges on the production of affordable housing for street dwelling individuals and commitment of resources towards this end.

Creation of Different Housing Programs

The need for a variety of program and housing options for street dwellers became evident in the interviews. The linear continuum of care model in homeless, medical, and substance abuse services has not worked for the high-risk street population, and many providers discussed the need for more flexible programs addressing specific needs of street dwellers. However, as the linear continuum of care is ingrained in the current service provision models, most providers thought of it as the only model of change; very few spoke of the necessity of changing this service approach. For example, the belief that substance abusers cannot succeed, and thus should not attain housing, was widespread. Consequently, changing to a housing first approach would require focusing on staff education and garnering support for such an approach.

Continuous Care After Accessing Housing

The need for continuous service support after moving to housing was documented in the many stories of former street dwellers' failure to maintain housing, as well as by those who transitioned successfully. Some members of the street outreach team took on responsibili-

ties beyond providing medical care. Support services during the transition to and throughout housing, if necessary, should be developed to increase the chances of high-risk homeless street dwellers' success in housing.

Staff Education on Homelessness

Another suggestion derived from the interviews was for more education on the issues of homelessness for staff in both homeless and mainstream programs. A better understanding by staff of the issues homeless individuals face would contribute to alleviating some of the often negative service experiences that hinder street dwellers' future engagement in care. In addition, client input into their treatment and service plans can support passage to more independent living.

"I would like to see more people who are more in tuned with their clients. They are not so judgmental; they are so mean. Like people who have been homeless, they know how it feels. We are not stupid. I am educated. Get more in tuned with the people. Get closer to the people you are dealing with; get to know them; understand their pains." *(Current Street Dweller)*

Sufficient Financial Supports

Lastly, the provision of sufficient financial support is critical. Many current and former high-risk individuals were benefiting from SSI income; however these income amounts were not at levels sufficient to meet housing expenses. As this former high-risk individual explained,

> *"And I am moving into a new room which costs me $475 a month. And I am getting $585 in SSI. How can you live on $110 a month? I also get food stamps for $100 a month." (Former Street Dweller)*

Policy Recommendations

In order to meet its goal of ending "chronic" homelessness by 2012, the current federal administration advocates: increasing access to mainstream benefits, entitlements, and services; training and employment; and planning long-term housing for individuals released from prisons, hospitals, and treatment centers (U.S. Department of Health and Humans Services, 2003). The provision of affordable housing is conspicuously absent from this list of key strategies. However, as the findings of this research project demonstrate, access to services and benefits alone cannot solve the homeless crisis. The long-term goal of ending "chronic" homelessness can only be achieved with sufficient resources to address the housing needs of this population, in addition to their service needs. As such, no services to the "chronically" homeless street population should be delivered without the focus on permanent housing.

"It's not easy. Programs are so strapped. What they need to do is to start looking at this homelessness, not the shelters and the programs, look at the problem. Stop putting your money into your damn profits and start putting it into housing. Like the Beacon Street people, they don't want any of us homeless people there. But yet, they won't fork the money to trying to help them. They rather run them out of there, and that's not fair. There is so much you can do for a homeless person. You can teach them and point them in the right directions to their own home, own apartment, to get a job, learn skills. Give them the tools to accomplish all these things. I don't care who you are on the streets, because when you are on the streets you know a little bit about many things." ***(Former Street Dweller)***

The sequential nature of the homeless CoC, which promotes housing stability by requiring movement from phase to phase, has not been successful for the "chronically" homeless street population. HUD has acknowledged the limitations of the homeless CoC in connecting chronically homeless street dwellers to housing, and has begun promoting Housing First models. At the same time, despite its goal of ending "chronic" homelessness, the federal government has incongruously proposed extensive cuts to the Section 8 housing voucher program. The Administration's request for 2005 to renew housing vouchers is more than $1 billion below the amount provided in 2004 and, given rent increases and other factors, more than $1.6 billion below the amount needed to maintain the current level of assistance. (Center on Budget and Policy Priorities, July 9, 2004). In addition, voucher assistance has been repeatedly threatened by new federal formulas for calculating inflation and fair market rents. In Massachusetts, only a direct appeal by Governor Mitt Romney to HUD Secretary Alphonso Jackson secured additional funding and avoided the immediate termination of vouchers for 600 families because of revised inflation-adjustment formulas. Despite this stop-gap measure, the long-term projections for Massachusetts look bleak. Currently receiving 71,093 vouchers, Massachusetts' projected loss of housing vouchers would reach 8,617 by the end of 2005, and a total of 20,681 by 2009 (Center on Budget and Policy Priorities, March 17, 2004). Without sufficient housing supports, the federal initiative to end "chronic" homelessness cannot succeed.

Locally, the creation of the DMH funded Safe Haven project in Boston, which currently provides eight beds for "chronically" homeless individuals with a dual diagnosis of a psychiatric disability and substance abuse, is a first step to addressing the housing needs of street dwellers. However, the number of beds provided in this small housing project is by no means sufficient to meet the needs of the street population. In addition, the eligibility criterion of a dual diagnosis of mental health and substance abuse problems pits one needy population against another, rather than offering an inclusive solution addressing the needs of all "chronically" homeless street dwellers.

Ending "chronic" homelessness in Boston and Massachusetts also requires a major modification in the way services are delivered to the homeless. As Burt et al. (2004) summarizes,

> *"A serious commitment to ending chronic street homelessness necessitates a paradigm shift, part of which involves the willingness of a community and its homeless assistance providers to consider approaches that have been proven to work even though they, at least initially, represent a significant departure from traditional programs". (p.xxii)*

As such, successful implementation requires addressing service providers' reluctance to support a Housing First model, as well as the creation of different types of housing, with a variety of levels of supportive services. Housing has been demonstrated to reduce hospital and detoxification admissions (Gulcur, Stefancic, Shinn, Tsemberis, and Fischer, 2003). Consequently, the enormous costs associated with the frequent use of medical and substance abuse services (see Figure 1) could be diverted into the creation of affordable and supportive housing.

Because high-risk individuals have so many different service needs professionals should be trained across disciplines. For example, the ability to address medical and substance abuse issues, while simultaneously being knowledgeable about housing needs, would enable service providers to offer a more integrated system of care to high-risk street dwellers. Alternatively, teams across professional specialties might be better able to address these holistically. A less fragmented system of care that supports long-term supportive relationships between providers and consumers, regardless of where consumers are in the process between the streets and housing, could be beneficial in ending homelessness for this population. It is also critical that the system allows for client input.

"The ultimate goal is housing and recently we got a grant to work with Mass Mental [Health Center] and that is one of the overall goals, why we are partnering with them. Hopefully we can get them in the DMH system to eventually get them housing and it has happened for some people. DMH has housing available and the same case with DMR and you can get other services a long with that. It's easier to get housing this way than through Section 8." *(Service Provider)*

Lastly, the federal strategy of diverting entry into homelessness by referring individuals released from the criminal justice system and psychiatric hospitals to appropriate settings other than shelters can only be successful if these individuals are offered realistic housing options, rather than long-term treatment. In addition, rapid re-housing once individuals become homeless is key to preventing them from becoming accustomed to life on the streets, adapting skills that are not suitable to housing, and thus complicating the

transition back into housing. Interventions at the homeless shelter system, for most the first point of entry into the homeless service system, need to address both service and housing needs of those newly entering homelessness. Shorter shelter days and rapid re-housing are important mechanisms to ending "chronic" homelessness.

Study Limitations

This study was limited to data on health care utilization based on just one hospital, and substance abuse services. It did not include information on admissions to the other hospitals in Boston and mental health services. Though attempts to include this information were made, it could not be accessed in the timeframe of the study. Future studies should include this information to portray a more complete picture of health, substance abuse and mental health service utilization patterns.

This study also focused on a defined group of "chronic" street homeless individuals in Boston, which may differ from "chronically" homeless street dwellers in other communities where service provision and delivery may also differ. As such, generalizability of findings may be compromised.

In addition, only a small group of individuals was selected for qualitative interviews. Qualitative research focuses on understanding the essentials of the experience of the phenomena, looking at the depth in the information gathering process, not breadth. However, the issues of service delivery, service needs, and service outcomes are relevant for other municipalities struggling with reducing the number of street homeless, and improving service delivery to this group. Lessons learned from this Boston based study can inform the homeless service delivery systems in cities across the country.

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"The outside assumptions of people choosing to live on the streets come from, 'I don't want to think about this issue too much because if I think about it too much I might actually think I have to do something.' Like be responsible socially or vote accordingly or have my tax paying dollars going up or actually feel the suffering that the person feels and that's too much for many people to have to deal with. So it's easier just to blame the victim, because if I blame you I don't have to think about it." *(Service Provider)*

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