

**Rhode Island's
Housing First Program
First Year 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 preliminary report is based on 41 baseline interviews and 30 follow-up interviews with clients. A more complete report will follow in the summer of 2008.

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. We do not have complete data yet on the use of publicly-funded services. The data we do have, on 18 clients, indicates that there has been 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 apartment

Hospital overnights	= 149 X \$1,719 =	\$256,131
Mental health overnights	= 16 X \$1,300 =	\$20,800
Alcohol/drug overnights	= 43 X \$220 =	\$9,460
Emergency room visits	= 75 X \$640 =	\$48,000
Jail/prison overnights	= 149 X \$108 =	\$16,092
Shelter overnights	= 640 X \$25 =	\$16,000

Total = \$366,483/48 = \$7,635 per client + \$9,500 cost of supportive services + \$5,643 cost of housing subsidy = **\$22,778/per client**

¹ These tables involve extrapolating 6 months of data to 12 months and extrapolating 18 to 48 clients.

The estimated cost per client in institutional services use while in the program is \$7,635 per person per year. Adding program costs of \$9,500 per person for supportive services and \$5,643 per person for housing subsidies results in a total per client cost of \$22,778 per person per year. **This is \$8,839 per person less than the institutional costs of \$31,617 per person 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 \$424,272 less than the institutional costs of one year of homelessness.**

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 48 individuals housed by the program, 16 clients have left. Given that the program has been in existence for 18 months and assuming 48 housing slots at this point in the program, the turnover rate per year has been 22%. This is in line with national turnover rates for other supportive housing programs around the country.

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, 78% of clients reported being "Very Satisfied" and 12% "Somewhat Satisfied" with their housing situation at the time of our first interviews. 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.

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. 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 supportive services program has been extremely successful. Our recommendation would be to expand this program to include more chronically homeless Rhode Islanders, a population estimated to be approximately 650 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.

² National Alliance to End Homelessness Inc. "What is Housing First?" February 17, 2006

³ Dennis Culhane et al, "The Impact of Supportive Housing 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.

Program 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 assist in the evaluation, and Kate D'Addabbo was hired to type transcripts of recorded interviews. Due to the need for follow-up interviews, it is intended that this evaluation will be continue at least through the summer of 2008. This report is therefore preliminary. A more complete report will follow in 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 will have follow-up interviews every six months after that. A number of clients were also interviewed using a shorter form three months after the baseline interview. Clients are paid \$20 for the baseline interview and the 6-month follow-up

interviews and \$10 for the 3-month follow-up interviews. The goal is to have at least two 6-month follow-ups for each client. This preliminary report is based on 41 baseline interviews, 12 3-month follow-up and 18 6-month follow-up interviews with clients as well as five interviews with case managers and program directors.

Preliminary Results of the Evaluation

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 2005-2006⁴
% 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 hated being homeless.

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- Overall, 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 are either somewhat or very satisfied with their new housing. 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.

4- Six month follow-up interviews may indicate a slight decline in degree of satisfaction with clients' housing situation.

Very dissatisfied =	6%
Somewhat Dissatisfied =	6%
Neutral =	0%
Somewhat Satisfied =	28%
Very Satisfied =	61%
Total =	18

This result should be interpreted with caution since it is based on only the eighteen follow-up interviews that have been completed to date. It should also be noted that nine-tenths of clients are still satisfied with their housing situation, and clients do prefer even problematical housing situations to being homeless. For those who do express some dissatisfaction, the primary issue is the condition of their apartment, their building, and their neighborhood.

Client F

[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 G

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.

5- Clients feel they are making great 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.

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

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 follow-up interviews, only one-fifth felt their physical and mental health issues limited their interaction quite a lot, while more than half now felt these problems were not limiting them at all.

Limited ability to interact at time of 6-month follow-up?

Not at all =	56%
Very little =	13%
Somewhat =	13%
Quite a lot =	19%
Total =	16

6- Clients in the program are more likely to have income support, but relatively 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

This has led to a slight increase in income, 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

However, not as many clients are currently working as were while homeless. The decline has been from seven to two clients. The fact that fewer clients are working is due primarily to the fact that physical and mental health disabilities make it difficult or impossible for them to have success in the job market. However, several clients suggested that they did wish to work, suggesting the need for more job training and job placement services for clients.

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

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 follow-up interviews have allowed the collection of the same data for the six months following the baseline interview on 18 clients. Because we have only six months of data and because we have interviewed only 18 of the 41 clients, the following results should be considered preliminary estimates only. For the tables below, the data has been extrapolated to reflect one year's use of facilities and all 48 clients.

Year before entering apartment (N = 48)	Last 12 months follow-up interviews (N = 48)
Hospital overnights = 534	Hospital overnights = 149
Mental health overnights = 73	Mental health overnights = 16
Alcohol/drug overnights = 538	Alcohol/drug overnights = 43
Emergency room visits = 177	Emergency room visits = 75
Jail/prison overnights = 919	Jail/prison overnights = 149
Emergency shelter = 9,600	Emergency shelter = 640

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. Again, the final figures may show greater savings because self-report data is likely to underestimate use of these facilities, particularly while the client was homeless.

Estimated costs for year before entering program apartment

Hospital overnights = 534 X \$1,719⁵ =	\$917,946
Mental health overnights = 73 X \$1,300⁶ =	\$94,900
Alcohol/drug overnights = 538 X \$220⁷ =	\$118,360
Emergency room visits = 177 X \$640⁸ =	\$96,640
Jail/prison overnights = 919 X \$108⁹ =	\$84,780
Shelter overnights = 9,600 X \$25¹⁰ =	\$205,000

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

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

Estimated costs for year after entering program apartment

Hospital overnights = 149 X \$1,719 =	\$256,131
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Total = \$366,483/48 = \$7,635 per client + \$9,500 cost of supportive services + \$5,643 cost of housing subsidy = **\$22,778/per client**

The estimated savings per client in institutional services use is \$23,982 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 \$15,143 per person. When added to the \$7,615 person for institutional costs post housing placement, the total is \$22,778 per client \$8,839 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 \$424,272 less than the institutional costs of one year of homelessness.

8- The program's high initial turnover rate has declined through time.

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.

Out of the total 48 individuals housed by the program, 16 clients have left. Given that the program has been in existence for 18 months and assuming 48 housing slots at this point in the program, the turnover rate per year has been 22%. This is in line with national turnover rates for other supportive housing programs around the country.¹¹

The program's record with regard to turnover is better than that 22% figure might imply however. A large percentage of the program's turnover, eight of the sixteen, came from the House of Hope's Fran Conway House. Seven clients left the house between December of 2005 and November of 2006. The eighth left in May of 2007. One client left for a substance abuse recovery program and has moved back into the house. Two clients left in 2006 and returned to Riverwood Mental Health to be case managed. They have

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

found housing and so are not counted in the turnover figures. 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

The last client to leave the Fran Conway House left in May of 2007, which was the first client to leave since November of 2006, so the rate of leaving has slowed since its first year. It should also be pointed out that 2 of the 8 have moved into their own permanent homes. Since this program is closer to a group home setting, it took some time to find a group of clients who could live in the more restrictive environment that group living entails. In fact, the existing clients have now decided that Fran Conway House will be drug and alcohol free. They are very happy in their housing; 7 of 10 residents said they were very satisfied with their housing situation when we interviewed them for the 6-month follow-up survey while the other 3 said they were somewhat satisfied.

Congregate homes like Fran Conway House with their potential of communal support and the existence of house rules are an invaluable option within Rhode Island's permanent supportive housing inventory. The difficulty is in knowing who can thrive in such an atmosphere, and which clients will not, will leave, and will return to homelessness. In the next year of this evaluation, we will attempt to offer some guidance on the factors that may predict success in the scattered site model (Riverwood model) or the single site model of the Fran Conway House.

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

Riverwood reasons for discharge:

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

When turnover has occurred or clients are anticipating leaving the program, it may be because of the poor condition of the building and apartment unit they occupy. A small number of clients have mentioned problems such as lack of adequate maintenance, alcohol or drug use in the building, and the frequency of fights near their apartment as reasons why they may contemplate leaving their apartments and the program. 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 placement. On several occasions, Riverwood has actually switched clients between apartments in an effort to enhance residential stability. This strategy is crucial to the success of the Housing First model.

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.¹²

Client use of services

- Health services
- Mental health services
- Income support application
- Transportation
- Shopping
- Clothing
- Food
- Payee
- Dental care
- Job search
- Furniture
- Computer training
- Job search

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

¹² Data on access to services is based on self-reports. For the final report next year we expect to be able to obtain informed consent to access case management records. This will allow us to give more complete information on services accessed while in the program.

Client service needs

Dental care
Income support
Job
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. This may require the establishment of a more formal relationship with a mental health center for Fran Conway House residents.
- 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.
- 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. Tremendous 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 \$9,000 per client, over \$420,000 for the 48 clients combined. The turnover rate of clients is relatively low at 22%. 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.

Our recommendation would be to expand this program to include more chronically homeless Rhode Islanders, a population estimated to be approximately 650 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.