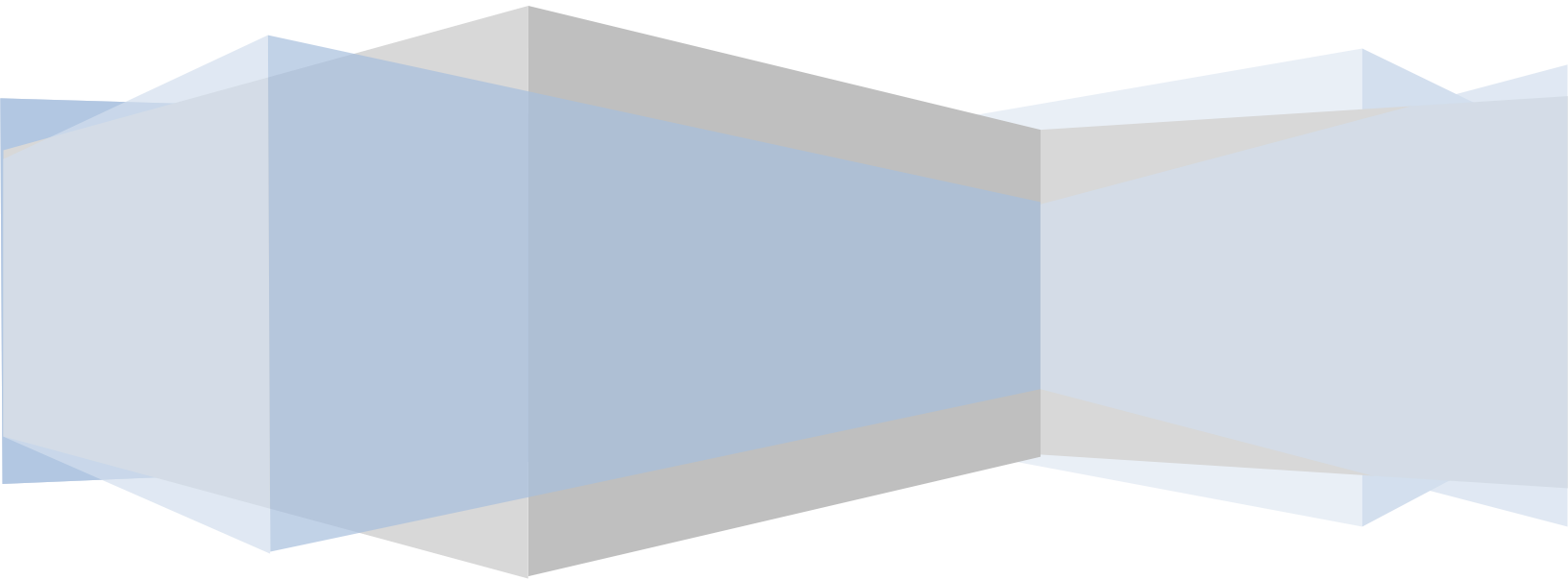
Ending Homelessness for Single Adults in Metrowest: One Year So Far

A Report on Phase One of the South Middlesex Opportunity Council's Plan to End Homelessness

November, 2007



Overview: *A Look Back*

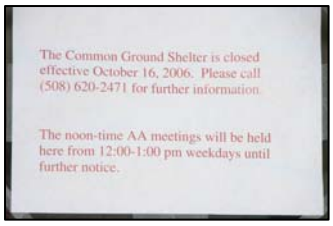
It has been 20 months since SMOC's Executive Director, Jim Cuddy issued a challenge to begin the process of closing homeless shelters. SMOC – the South Middlesex Opportunity Council—is a Community Action Agency that was founded in 1964 as part of the Federal War on Poverty. At the heart of the mission of all Community Action Agencies is to meet the basic needs of economically disadvantaged adults and families living in the community while also working to alleviate poverty. SMOC's mission statement is "mobilizing resources for social change and economic independence." Homeless individuals are the most economically disadvantaged among us – often suffering from mental health issues, addiction, severe histories of trauma, significant medical issues and more. SMOC took the Community Action mandate of community-based solutions and applied it to the issue of homelessness.

Cuddy: SMOC official issues challenge to close homeless shelters
By **James T. Cuddy / Guest Columnist**
Sunday, January 22, 2006 -
In Framingham recently, a woman burned to death in a dumpster. Her life ended in a container, on a side street adjacent to downtown, within walking distance of the Common Ground Shelter. Police were not immediately able to identify the body, did not suspect foul play, and theorized that "Jane Doe" was...

In June 2006, SMOC called a meeting of staff and stakeholders where the **Plan to End Homelessness** in the region was laid out. Each phase would be marked with the closing of a shelter or the conversion of shelters to supported housing. Phase One would also launch the new service delivery system and the conversion from a shelter-model with housing for shelter "graduates" to a housing-based model with homeless prevention, triage and rapid re-housing as the focus. At the heart of the new system is the Common Ground Resource Center which opened on the same day as the shelter was closed. Serving as the hub for the housing continuum in the Metrowest region, the Resource Center is staffed by an interdisciplinary team of service providers with an integrated use of data and technology to facilitate client flow and outcome management.

This paper will provide an overview of the planning process and implementation of SMOC's plan to end homelessness. It will highlight some of the outcomes of the first year and lay the foundation for phase II.

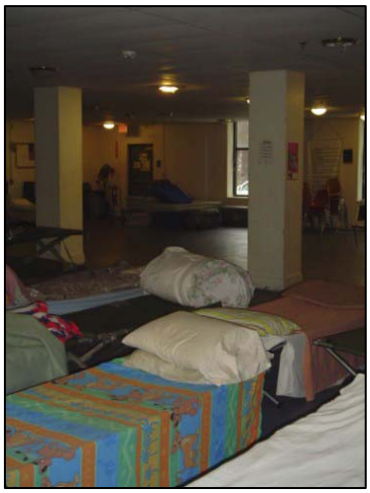
Overview: *Where We Were Before:*



On October 16th, 2006, the first phase was implemented and the Common Ground Overflow shelter was closed – 40 shelter beds were taken "off-line."

There had been a steady climb in the number of people seeking shelter and services since the late 1980's. The demand in the Metrowest region peaked in 2004, after the closing of the Framingham Detoxification Center. In 2005 nearly 1000 clients received emergency shelter in the four programs for single adults in

Metrowest. Many people became "stuck" in shelter because they lacked sufficient income to afford rent and / or were unable to meet the sobriety thresholds that had been required for the bulk of SMOC housing which is within our sober housing program.



Prior to last October, SMOC's continuum of housing and care was coordinated but not integrated. This resulted in a fragmented system with multiple access points and highly individualized programs. Referring agencies made multiple phone calls to access programs and these referrals with subsequent intakes at the program level – each program maintaining its own intake, wait list and discharge plans. Although shelters have always met a need, SMOC has joined the chorus of voices and researches that assert that the system is fundamentally flawed and that people are more likely to obtain and maintain self-sufficiency once housing has been secured.

Overview: *Shelter to Housing*

SMOC never had just shelters. For more than 20 years, there has been a robust housing continuum with a variety of housing program and geographic options. The housing has always been supported by other programs within SMOC. Specifically, behavioral health, employment, education, fuel assistance and domestic violence support and counseling have always been available to program participants.

At the heart of SMOC's continuum has been a culture of recovery. As an agency, SMOC embraces sobriety and abstinence from drugs and alcohol. The staff generally believes that being sober is the healthiest and safest way to live. Prior to the closing of the Common Ground, 54 of 94 shelter beds (57%) were in sober environments and three of the four shelters as sober environments. In addition, sober housing continues to be the bulk of SMOC housing.

Planning Process:

For six months, the staff met, planned and implemented the initial tasks towards ending homelessness in the region. Planning was both logistical and cultural – each aspect was complex and difficult. The staff was challenged to think about their programs differently and took on an extensive oral history project with program participants in the shelter and in the sober housing program. There was also a research project that involved in-depth interviews within the shelters and sober housing.

Staff began planning for a complete integration of shelter and housing programs. As they talked through the various elements of closing a shelter, they were forced to rethink broader issues that apply to the entire continuum. The Common Ground shelter had been a "refuge of last resort" – the only emergency shelter that was open to people – regardless of income or current sobriety. Staffed by a dedicated team, it was, for countless individuals, the beginning of a journey towards recovery and self-sufficiency. The police brought people there. Throughout the spring of 2006, there had been an average of 40 people sleeping there each night. Although a vital resource in the community, the shelter also contributed to a downtown environment that was troubled. It had

become a source of tension between the community and SMOC. Its closing would alleviate problems but would also be complicated.

The planning process also required a review and evaluation of all of those individuals that were living in shelter and in some of the housing environments. The intake and referral process was going to be centralized through the new resource center. The new system would put housing and tenancy at the center and integrate intensive housing-based services when needed. As people would be moving into housing more rapidly then they had been, the continuum would need additional supportive housing programs – including **Housing First**.

The result was a complete integration of the shelter and housing programs and a collaborative investment in the success of clients throughout the continuum with a focus on housing, stabilization and self-sufficiency. In the "old model," relapse would often result in a discharge to the overflow shelter for respite care. This was done primarily as a mechanism to maintain integrity and "safety" in recovery-based environments. As we planned to close the shelter and integrate the continuum, it became clear that all of the programs would have to work with relapse differently as there would be no shelter to use as respite care.

In keeping with latest evidence-based practices, the new system of housing placement and tenancy preservation requires incorporating relapse sensitive and harm reduction principles. This new model put pressure on the entire housing continuum, requiring staff to work differently, especially with treatment-resistant clients. At the crux of the culture change is forcing a shift from a strictly abstinence-based model to one that is sensitive to relapse for those people that are living in recovery from drugs and alcohol and implementing a harm-reduction model for those clients that are not able to be sober. As change can be difficult, there were disagreements and frustration but also humor, collaboration and partnership.

Pioneering of Program and Practices:

"The effort to eliminate poverty, as outlined by Lyndon B. Johnson, has seen its day but I witnessed every step of the process. Now 42 years later the goal has been revised – we will end chronic homelessness in 10 years. I believe I may have seen it all." – Margaret Davitt, Director of the Turning Point and employee for 42 years.

More than forty years ago, President Johnson launched the war on poverty. That effort focused on community-based solutions and the creation of Community Action Programs – of which SMOC is one. Forty years later, SMOC has expanded the mission to include ending homelessness within the Metrowest region. As SMOC maintains significant housing and social service resources in the community, the Agency was well positioned to find a meaningful solution to homelessness.

Over the last decade, there has been significant focus on the causes and costs of homelessness. In recent years, communities have begun to act – creating a groundswell of plans, policies and programs. Throughout the country, there are more than 300 such plans to end homelessness. Virtually all of them are led at the executive level of government – mayors and governors. The City of Worcester, for example, in partnership with all of the stakeholders, including social service agencies, just passed their plan to end homelessness. Governor Patrick recently appointed a Commission to End Homelessness and has created an interagency task force to implement the

Commission's recommendations. In states and municipalities, elected leadership acknowledges that there is a real problem of poverty and homelessness and they ask to partner with nonprofit agencies – as well as businesses and community organizations – to develop solutions-oriented policies to effectively solve the problem of homelessness.

In early November, the Federal Government released National data indicating that there has been a 12% decline in the number of people experiencing chronic homelessness - from 175,914 in 2005 to 155,623 in 2006. The data are based on reports from a single day from 3,900 cities and counties of which more than 1,500 reported a decrease over one year where local and state-wide efforts have had a dramatic impact. This was the first decrease in homelessness in the history of contemporary homelessness. As the primary provider of services to homeless adults and families in the region, SMOC took the bold step to forge ahead and adapt national best practices to our own delivery of housing and services in this community.

Common Ground Resource Center:

Plans and policies to end homelessness throughout the country all contain elements of homeless prevention, triage, emergency placements and rapid re-housing. Each plan operationalizes these tenets. Systems of referrals, intakes and reporting have to be balanced with the need to collect program fees that are necessary to preserve tenancy and maintain programs. Case Managers and Housing Coordinators wear many hats in order to facilitate the self-sufficiency goals of our program participants and work towards ending homelessness.

All referrals from other agencies as well as walk-ins are now centralized for the Metrowest continuum and are triaged daily by the staff. Housing and program placements are based on individualized assessment as well as client choice. Individualized wrap-around services are provided to program participants living throughout the continuum. These services are provided by a variety of SMOC programs as well as Framingham Community Health Center, the Salvation Army, Advocates, Wayside Youth and Family Services, Health Awareness, South Middlesex Legal Services and others.

The Resource Center houses staff that were physically relocated and whose jobs evolved into this collaborative team. That staff includes: Housing Coordinators, Behavioral Health Services clinicians, (in expanded management roles), Shelter Coordinator (now CGRC Director), Benefits Coordinator (in expanded role), Voices Against Violence counselor, Mobile Resource Team Housing and Employment Specialists.

Other members of the team that are located in off-site programs include shelter managers and housing coordinators. In addition, new positions were created including a Triage / front-door worker, stabilization worker for SMOC Sober Housing, Early Recovery Specialist, Data and Outcome Manager (working with entire Agency), case managers for Housing First Program and

expanded staff for young adult program. This interdisciplinary team is continually collaborating on client and system matters to continually evolve the program.

Engaging seriously in a process of ending homelessness requires new ways of working. Managers and line staff of SMOC's housing continuum have been able to glean some of the best practices as developed in other parts of the country. We have also committed to on-going training. Training topics have included effective case management guidelines, substance abuse treatment philosophy, stages of change, motivational interviewing, cognitive counseling strategies, and uniform delivery of services, evolving treatment approaches, harm reduction and more.

Recently, the single adult continuum, along with the rest of the Agency, has launched an effort to become "trauma-informed." At its core, trauma-informed services recognize the impact of violence and victimization on development and coping strategies and therefore has shown to be more effective in the field of addiction and mental health. Studies have shown that trauma impacts on all areas of functioning including physiological, cognitive, skill deficits, feelings, beliefs and relationships.

To implement best practices across the Commonwealth, The Bureau of Substance Abuse Services (BSAS) contracts with the Institute for Health and Recovery to train and consult with all BSAS-funded programs to become trauma-informed. The Institute for Health and Recovery worked with SMOC to go beyond our BSAS-funded programs and train and consult with our *entire* Agency towards becoming trauma-informed.

There is significant evidence that trauma is pervasive among people seeking services, including shelter and housing. In the general community, less than 30% of men have experienced physical assault and 4-24% of men have experienced sexual assault. However, among those seeking services such as mental health, addiction and homelessness, 86% have experienced physical assault in their lifetime and 30-35% experienced childhood sexual assault and 25% experienced sexual assault as an adult *(Fallot and Freeman, 2004)*

For women, the numbers are more staggering. Women in community samples report a lifetime history of physical & sexual abuse ranging from 36 to 51%. However, women with substance abuse problems report a lifetime history ranging from 55 to 99% *(Najavits et al., 1997).* Virtually all (97%) of homeless women have experienced severe physical and sexual abuse and 87% of homeless women have experienced abuse both as children and as adults *(Goodman et al., 1997).* Finally, 70% of homeless women had been physically abused by a partner *(Goodman et al., 1995.*

Understanding the prevalence and impact of trauma provides valuable insight for staff in interacting with clients and understanding client's behavior – especially when it is difficult. It

allows staff to intervene more effectively while still using a recovery-based approach. The approach and understanding supplements the 12-step model and enhances the entire continuum by helping people succeed in housing.

SMOC has adopted the following principles regarding becoming a trauma-informed agency:

Guiding Principles for SMOC's Trauma-Informed Services

Trauma is the human experience of violence - including physical abuse and assault, sexual assault, domestic violence, child abuse or neglect, and / or the witnessing of violence, terrorism, war and natural disasters.

SMOC recognizes that trauma is pervasive, may be experienced by any individual regardless of race, color, national origin, gender, sexual orientation, socioeconomic status or disability, and can be fundamentally life-altering.

All SMOC services are provided in a sensitive, confidential and culturally competent manner that recognizes the prevalence and impact of violence, abuse and other traumatic events - whether these events are part of a person's past or current experience.

Trauma may significantly impact people's lives in ways that are not readily apparent and may affect how individuals seek services.

SMOC views women and men with lived experience as the experts on recovery. To this end, SMOC staff focuses on the strengths of each individual and family and collaborates with and empowers clients to make healthy choices.

This philosophy of service-delivery incorporates an understanding of the prevalence and impact of trauma across the life span and the complex paths to healing and recovery.

SMOC strives to implement *best practices*, as backed by research, in our effort to end homelessness. Our work is outcome-oriented and evaluated based on rigorous data collection and analysis.

Resources: *Housing Development*

At the heart of ending homelessness is the capacity to house people. This requires a development model with grants and low interest rates in order to keep housing that is affordable for individuals at or below 30% of the area median income. For more than 20 years, SMOC has been operating a subsidiary corporation for housing development. SMOC's Non-Profit Housing Corporation relies on The Department of Housing and Community Development (DHCD); the Community Economic Development Assistance Corporation (CEDAC); Federal partners such as HUD and Federal Home

Loan Bank as well as local banks for grants and low-interest loans. Housing development is rooted in rehabilitating old buildings – many of which had been condemned or otherwise marginally inhabitable rather than new construction. Backed by robust management and good neighbor policies, through the SMOC housing department, there has been significant neighborhood improvement in many communities.

Resources: *Housing Subsidies*

Yet, even with low operating costs of $90 - $100 per week, finances are still a significant barrier for many people staying in shelters. Subsidies are required. Some people that are on a fixed income and unable to work may need a shallow subsidy for an indefinite amount of time. Others may be able to work and afford the rent in time, but at the moment cannot afford anything. These individuals may require a short-term full subsidy. Yet others may require something else. In short, subsidies must be flexible – short and long term, shallow and full.

In addition to rearranging some existing programs, SMOC received new housing and services resources. Of particular significance were the addition of housing subsidies for those individuals that had been chronically homeless as well as the creation of a "1st step" housing program using existing shelter-based programs and converting them to housing-based programs.

Using research results that had started to be published on the cost-savings and overall social benefits, the Massachusetts Department of Mental Health recognized that some of their long-term homeless clients should be housed as a first step towards recovery. To this end, in 2005, they transferred money to the Department of Transitional Assistance (DTA) to be used as housing subsidies as a pilot "housing first" model. SMOC opened fifteen units as part of this pilot. Eight of the original people are still living in that program. Several of the others either went on to long term care environments or moved out on their own. As Housing First programs throughout the country began to prove themselves as effective at helping people get better, as well as saving tremendous costs, the Massachusetts Housing and Shelter Alliance (MHSA) received additional support through the Department of Transitional Assistance to provide new subsidies through a pilot program called Home and Healthy for Good. As part of the allocation and to support the closing of the shelter, SMOC

"It's good… I am just like them," Freddie said. Freddie has been the resident-manager of one of the First Step houses which offers stable living to individuals living with multiple issues including substance abuse and mental health for more than a year.

"It was time for me to do something different with recovery. I wanted to take it to the next level," he said. His position is challenging and requires a lot of balance, patience and integrity. Three years ago he began with nothing but the clothes on his back and was able to turn it around and give back to others.

"My plan was to get clean for a little while." He said. Once his "head got clear" he decided to stay a little while longer. As a member of a local recovery group and as the role model for newly-sober individuals, Freddie has responsibility today, a meaning and a purpose to his sticking around. "The guys respect me. "It refreshes me everyday." "I see it and I don't want to go that route."

Reporting daily to his recovery group, it is Freddie's job to make the coffee and to setup for the meeting. Usually he is accompanied by two or three residents from his house. Freddie has many goals in-store for his future. He dreams of his own place and possibly a part-time job while he continues in his recovery. Regardless, one thing is certain for Freddie, "[I'm] not roaming the streets, I have places to be."

opened 32 additional slots for chronically homeless individuals – many of whom had been staying at the Common Ground shelter and others that had been living outside. This year's (fy08) State allocation to Home and Healthy for Good was expanded and SMOC will be able to increase this program by 15 slots.

In addition to the new subsidies, SMOC was able to convert several existing shelter-based grants into housing-based grants. Specifically, DTA allowed SMOC to take their Emergency Services Grant (ESG) and use it to fund beds in a housing environment for homeless clients. Some of the clients living in recovery were able to use these slots which were combined with another existing program – the post-detox / post-relapse program for homeless individuals (also funded through MHSA). These combined programs were rolled right into the housing continuum as a newly designed supportive housing program.

Resources: *Home and Healthy For Good/ Housing First*

Housing subsidies for chronically homeless individuals was paired with case management support from the Massachusetts Behavioral Health Partnership through the CSPECH *(Community Support for People Experiencing Chronic Homelessness)* program to house some of the most difficult-to-house individuals. MHSA recently completed a cost analysis state-wide. The people that have been living just in SMOC's 32-funded slots in Metrowest had generated a total cost of service use of the jails, emergency room, inpatient hospitalization, detox, shelter and respite care in the six months prior to being housed an average cost per person per month of $2720.88. *After* being housed, service usage cost among those same individuals dropped to $395.30 per month or an 85% savings throughout systems of care.

On average, the annual health care cost for individuals living on the street was $28,436, compared to a $6,056 for individuals in the population who obtained housing.

Housing First represents a significant paradigm shift in the phenomenon of homelessness. This strategy demonstrates impressive outcomes when people are supported in a permanent, housed environment, rather than targeted for intensive services in shelters or streets. Tenants live in leased, independent, apartments or congregate-living homes that are integrated into the community and they continue to have access to a broad-range of comprehensive services, including medical and mental health care, substance abuse treatment programs, case management, vocational training, and life skills. The use of these services, however, is not necessarily a condition of ongoing tenancy. Housing First represents a shift toward "low-threshold" housing, which focuses on the development of formerly homeless persons as "good-tenants" as opposed to "good-clients."

Home and Healthy for Good: A Statewide Pilot Housing First Program
Preliminary Report - 2/2007

Resources: *Case Management and Other Services:*

In addition to housing subsidies, there was enhanced integration of client-centered support services and case management. This occurred through existing staff, in new and expanded positions as well as newly created staff positions.

The MetroWest Community Healthcare Foundation funded three new positions – a Triage Worker; an Early Recovery Specialist and a Sober Housing Stabilization Coordinator. These are three new staff positions that are central to the team at the Resource Center.

As mentioned earlier, the Massachusetts Behavioral Health Partnership (MBHP) created the Community Support for Persons Experiencing Chronic Homelessness program (CSPECH) – a case management program for the new Housing First tenants. MBHP is the mental health and substance abuse provider for the MassHealth program which is the State Medicaid plan. When SMOC initially closed the shelter, MBHP funded forty slots for people experiencing chronic homelessness to receive housing-based case management services.

The Middlesex Savings Bank, Framingham Cooperative Bank and the United Way of Tri-County provide funds for general operations. Finally the Department of Public Health and the Department of Mental Health provide support for services.

Program Resource: *Ready, Willing and Able*

As a lack of available income is the primary cause of homelessness as well as barrier to housing, SMOC launched the Ready, Willing and Able, temporary ("day") labor program that enables people to work and get paid a portion of their earnings on the same day. This program has been critical not only to tenancy issues facing many clients but also as an opportunity for people to get acquainted (or reacquainted) with work habits and skills.

Richard (rear) – has been an RWA employee since March 3/07. Although Richard had been homeless for many years, he moved from SMOC housing into his own apartment in October '07.

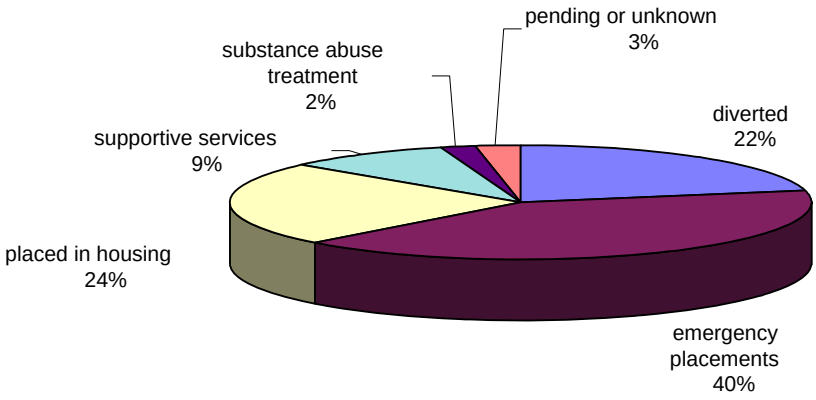
Mike (front) – An RWA employee learning maintenance and painting trades on the job.

Carolyn lives in SMOC housing. She had been an RWA clerical employee and is now employed

Common Ground Resource Center: *Outcomes so far*

Each individual that is referred or walks in for services goes through an assessment process. For referrals, this process is initiated with a referral form and additional information from the referring source. Between October 16th, 2006 and September 30th, 2007, 1421 people were assessed through the Resource Center. It is significant to note that nearly a quarter were placed directly into a housing program.

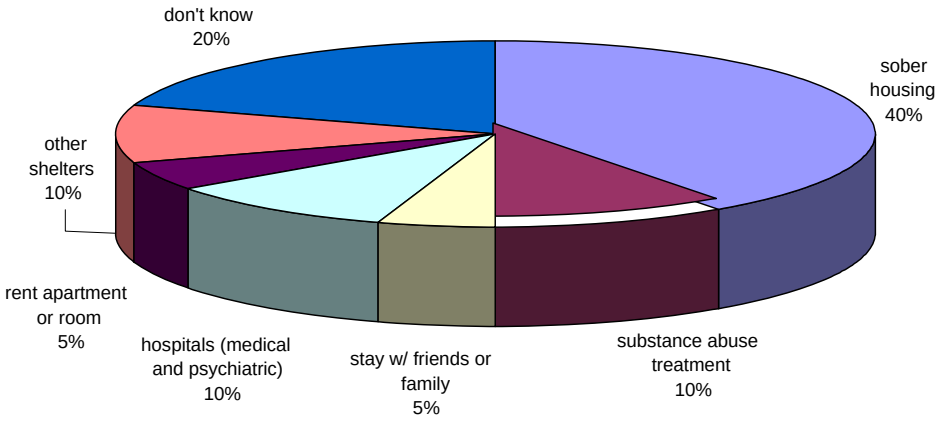
Common Ground Resource Center Assessment Outcomes



Although 40% were referred for shelter placement, this number is significantly smaller than it would have been in the old system and the amount of time spent in shelter has been reduced. Since implementing the new system, the average length of shelter stay was reduced from 90 to 30 days. From October 2006 through September 2007, 641 people received shelter services from compared with 1000 for fy05 for an overall 46% reduction in homelessness.

From when we changed the system, through September 2007, 549 Individuals left shelter. As this is a very transient population by definition, it is not surprising that 20% left to whereabouts unknown. It is significant to note that 40% went on to SMOC sober housing.

Shelter Leaving Destinations



Preparing for Phase II

Phase II will be focused on the conversion of Roland's House. Currently a shelter located in Marlboro and already sharing a building with Single Room Occupancy units, the shelter units will be converted to permanent supported housing. Marlboro is strategically located halfway between Framingham, SMOC's headquarters, and Worcester where SMOC owns and operates an emergency shelter for single adults as well as approximately 117 units of housing within the City and an additional 124 units in the surrounding communities. Therefore, the Marlboro conversion will launch a deeper integration of the Metrowest and Central Mass Continuums.

In addition to expanded housing and services capacity, SMOC also looks forward to expanding our use of data collection and expanding the number of outcomes that we measure and track. Assessments and self-sufficiency plans will be even more comprehensive, individualized and outcome – oriented. Areas that will be explored in a comprehensive manner include: Housing, health, employment, education, mental health, substance abuse, trauma histories, income and savings, social networks and legal issues.

Additional Resources and Support Needed

Although SMOC is doing more than we have ever been able to do to support homeless individuals, there is a need for additional services and housing subsidies. To end homelessness, the State must expand access to substance abuse treatment. Shelters often become de facto holdings for people waiting for slots in residential treatment programs or detox facilities. A complete substance abuse treatment continuum that does not use shelters as a step is necessary to permanently reduce the need for shelter.

"Looking forward, I believe that we're helping many formerly-homeless individuals sustain permanent housing but there is room for better and stronger resources." Margaret Davitt (Director of Turning Point Shelter)

There needs to be support to make the work easier not harder through meaningful partnership with local and State officials to address the underlying causes of, and remedies for, poverty and homelessness. This is true for siting new programs and adequate levels of support that is streamlined to reduce the burden of extremely complex and duplicative reporting.

Epilogue: *A Match Made*

Katie was 24 years old and enrolled in college when her life took on an unexpected direction. She began seeing hallucinations – sporadically in the beginning and more prevalent later on. “At school, I didn’t know what was wrong,” explained Katie. Her best recourse – and most likely a popular choice for a college student – was to self-medicate using a lot of alcohol, and all the time. This self-therapy took away the hallucinations and temporarily corrected a rather disabling condition. She was able to complete her degree but then promptly asked to leave to campus. She was broke, homeless, hallucinating and an alcoholic by necessity.

In October 2006 she contacted the Common Ground Resource Center for assistance. Katie was referred to Shadows in Ashland and was given temporary shelter until a more substantial plan was made. After a very short stay Katie arranged a placement in a psychiatric hospital in rural Western Massachusetts. She was admitted, treated and released but with no place to go. Still vigilantly trying to maintain her psychiatric care and survive on her own, she began to drink. “I never really saw myself as someone who could be homeless,” she recalls. Time passed and Katie, by some means or another, contacted the Common Ground Resource Center for assistance. Given her current living situation, she was quickly referred again to the Shadows until she moved into a First Step Housing program. This was a milestone for Katie. Katie was scared but optimistic. “It has been really nice to live with sober people in a sober house.”

A year has now passed since Katie entered the First Step Housing program. She is connected with behavioral health providers and a day program which she attends regularly. Katie isn’t alone either. She recently was prescribed some puppy time – with her new friend Annie. Annie is a young, energetic Cockapoo who was prescribed for her as a psychiatric-aid-dog. Katie and Annie start their day promptly with a walk at 6am. “Annie keeps me busy and happy,” she said, “all the time.”

When asked “where do you think you would be today if you hadn’t entered the program?” Katie hesitated and couldn’t put together an answer. She then replied, “probably in and out of other shelters.”