HOMELESSNESS TO PERMANENT SUPPORTIVE HOUSING:
PROMOTING HOUSING AS HEALTHCARE IN RURAL COMMUNITIES

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ABSTRACT

HOMELESSNESS TO PERMANENT SUPPORTIVE HOUSING:
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Programs and federal resources aimed towards homelessness have historically been geared towards providing emergency assistance instead of long-term housing. The advent of permanent supportive housing (PSH) initiatives over the last two decades supports the Housing First theory, which recognizes housing as a form of harm-reduction and healthcare to those who are chronically homeless. Permanent supportive housing provides stable housing to those with co-occurring disorders, and also offers services to address client medical conditions. Although permanent supportive housing efforts have gained recognition for successfully re-stabilizing many chronically homeless individuals who reside in sprawling urban cities, this model has only recently been applied to serve rural homeless communities. As a result, current research has been overwhelmingly focused on urban models of permanent supportive housing, while largely ignoring the examples of this model as applied in rural dwellings. With an increase in rural-based PSH efforts, this project aims to address this gap in literature by comparing the impacts of both housing models.

As there are no existing studies that examine the impacts of both PSH models, the purpose of this project is to evaluate the effect of permanent supportive housing to rural
homeless communities compared to that of urban communities. This exploratory research analyzes pre-existing survey data collected by a rural PSH non-profit agency as well as archival sources to measure the impact of urban models.
ACKNOWLEDGEMENTS

For my Dad.
# TABLE OF CONTENTS

ABSTRACT .......................................................................................................................................................... ii

ACKNOWLEDGEMENTS ........................................................................................................................... iv

TABLE OF CONTENTS ................................................................................................................................... v

LIST OF TABLES ........................................................................................................................................ vii

LIST OF FIGURES ........................................................................................................................................ viii

LIST OF APPENDICES ................................................................................................................................... ix

CHAPTER 1: AN INTRODUCTION TO THIS THESIS .................................................................................. 1

CHAPTER 2: A SOCIO-HISTORICAL PERSPECTIVE OF HOMELESSNESS IN THE UNITED STATES ......................................................................................................................... 6

   Framing the Emergence of Homelessness ...................................................................................... 6

   Defining the “Old” and the “New” Homeless ......................................................................... 10

   The Effect of Deinstitutionalization ......................................................................................... 12

   Trends in Media Coverage .................................................................................................. 16

   Criminalization of Homelessness ......................................................................................... 18

CHAPTER 3: PERMANENT SUPPORTIVE HOUSING FRAMEWORKS AND DESIGN ................................................................. 21

   Background of Issue ........................................................................................................ 21

   Theoretical Framework .................................................................................................. 23

      Permanent supportive housing .................................................................................. 24

      The harm-reduction model ....................................................................................... 25

      Housing first ............................................................................................................. 27

      Urban model ............................................................................................................. 28
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single-site</td>
<td>28</td>
</tr>
<tr>
<td>Rural model</td>
<td>29</td>
</tr>
<tr>
<td>Scatter-site</td>
<td>30</td>
</tr>
<tr>
<td>Permanent Supportive Housing Research</td>
<td>32</td>
</tr>
<tr>
<td>Cost effectiveness</td>
<td>32</td>
</tr>
<tr>
<td>Design considerations</td>
<td>34</td>
</tr>
<tr>
<td>Service provision</td>
<td>36</td>
</tr>
<tr>
<td>Other benefits for individuals and the community</td>
<td>39</td>
</tr>
<tr>
<td>CHAPTER 4: SURVEY RESEARCH METHODOLOGY AND RESULTS</td>
<td>42</td>
</tr>
<tr>
<td>The Case Study</td>
<td>42</td>
</tr>
<tr>
<td>Survey Analysis</td>
<td>43</td>
</tr>
<tr>
<td>Results</td>
<td>44</td>
</tr>
<tr>
<td>Satisfaction with services</td>
<td>45</td>
</tr>
<tr>
<td>Perception of health</td>
<td>47</td>
</tr>
<tr>
<td>CHAPTER 5: DISCUSSION OF FINDINGS AND CONCLUSIONS</td>
<td>56</td>
</tr>
<tr>
<td>Discussion</td>
<td>56</td>
</tr>
<tr>
<td>Perceived frequency of substance/alcohol use of residents</td>
<td>57</td>
</tr>
<tr>
<td>Perceived physical and mental health of residents</td>
<td>60</td>
</tr>
<tr>
<td>Perceived emotional health of residents</td>
<td>62</td>
</tr>
<tr>
<td>Conclusions</td>
<td>64</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>70</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1: Average client score on their satisfaction with services by year ......................... 46
Table 2: Average client score on their satisfaction with staff by year .............................. 46
Table 3: Average client score on their satisfaction with programming by year ................. 47
Table 4: Average client score on their perceived physical health by year ....................... 49
Table 5: Average client score on their perceived mental health by year .......................... 50
Table 6: Average client score on their perceived substance/alcohol use by year ............. 52
Table 7: Average client score on their perceived emotional health by year ..................... 53
LIST OF FIGURES

Figure 1: Permanent supportive housing theoretical model ............................................. 23
Figure 2: Average client score on their perceived physical health by year ...................... 49
Figure 3: Average client score on their perceived mental health by year ......................... 51
Figure 4: Average client score on their perceived substance/alcohol use by year............ 52
Figure 5: Average client score on their perceived emotional health by year............... 54
LIST OF APPENDICES

Appendix A: Placement Activities................................................................. 79
Appendix B: Apartments First 2011 Survey Instrument ............................... 82
Appendix C: Arcata House Apartments First! Program Objectives............... 88
Appendix D: A Brief History of the Arcata House........................................ 90
A great deal has been written about homelessness over the last century. As long as wage-labor has existed, there have been people out of work and without steady income or housing. Often the result of economic inequality, homelessness has been experienced over the centuries by a great variety of people. The archetypal images of the homeless in American culture range from the vulnerable, to the mentally disabled, to the adventurous traveler (Bloom 2005). Policy on the problem of homelessness has often been dependent on, and shaped according to, public attitudes toward those who deviate from society’s mainstream. Generally the disabled and truly impoverished have been viewed more compassionately than able-body wanderers without permanent housing.

During the advent of industrialization, the terms “hobo” and “tramp” were colloquialisms describing the demographic of migratory workers in search of employment. In this postindustrial economy, the demographics of the homeless populations have been altered substantially, as have the migratory patterns of the homeless. These terms were eventually redefined to incorporate the socio-economic status of poverty in defining the social role of its participants (Bloom 2005).

The rise of capitalism and the emergence of homelessness in urban areas have long paralleled economic and political social trends. By the late 1970s, an increasing frequency of people without homes, wandering city streets and sleeping in doorways began to emerge. First apparent only in large cities, this era of homelessness penetrated
rural and suburban areas coast to coast and across the heartland of the United States as well.

Today, about 1.6 million Americans experience homelessness in a given year (USDHUD 2009). The continued existence of large numbers of homeless individuals can, in large part, be attributed to housing market dynamics that have created an affordability problem so severe that 5.5 million very low-income households are forced to spend more than 50 percent of their income on housing (USDHUD 2007).

However, the homeless assistance systems themselves have also played an unintended role in the persistence of homelessness, and of chronic homelessness in particular. Chronically homeless individuals are long-term shelter users or “street homeless,” the vast majority of whom have a serious mental illness, substance abuse disorder or physical disability, and often a combination of these. According to the Federal definition shared by HUD (Housing and Urban Development), HHS (Health and Human Services) and VA (Veteran Affairs), a chronically homeless person is defined as “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years” (USDHUD 2006).

In recent years, an increasing number of government officials and advocates for the homeless across the country are arriving at the conclusion that long-term homelessness can be solved. Many believe that the approach which will bring us there is permanent supportive housing (PSH), which is affordable housing linked to accessible mental health, substance addiction, employment, and other support services. This
approach recognizes housing as a form of health care for those who suffer from chronic homelessness.

Permanent supportive housing models have seen well-chronicled success in large-scale urban cities, such as Seattle and San Francisco (Pearson et al. 2007; Shore 2010). Although advocates cite this as an effective model in such environments, what is not well known is how these models have impacted rural communities.

This begs the question, what are the impacts of PSH on rural communities, as compared to impacts of PSH on urban communities?

Urban communities have not only come to be familiar with the concept of permanent supportive housing but also how it has impacted the lives of formerly homeless tenants, their neighbors and local businesses. In this sense urban PSH has an identity that rural PSH efforts so far do not. Characteristics that define permanent supportive housing impacts largely center on efficiency of service provision. If this is true, for example, how may these services be provided in environments lacking the centrality and resources of an urban city?

Researching the impacts of PSH on rural communities could be important for many reasons. First, if PSH models have already been implemented in rural communities nationwide without the longitudinal studies that supported implementation in urban communities, there should be as much research as possible conducted by these programs to generate their own understandings of its impact. Since these efforts have been implemented in urban communities, public policy has undoubtedly been affected.
Decision-making in rural communities needs to be just as informed, for the potential to benefit local government and residents.

Research on this subject could also be significant to those homeless populations living in rural cities. Since the phenomenon of homelessness in rural areas is seen as less prevalent to that of urban environments there is a perception that it is not a social problem. Since scholarly research has ignored the topic of PSH in rural communities almost completely, many are unaware it exists. This would pose as a significant problem to a homeless individual unaware these services were even an option.

This topic is lastly important to the discipline of sociology, because while this thesis provides an overview of PSH and a basis of study on rural PSH impacts, it should serve as a launching pad for further research that explores this research question using different measures and resources. This thesis is, nonetheless, the first of its kind to address the research question: what are the impacts of PSH on rural communities, as compared to impacts of PSH on urban communities?

The contents of this thesis are organized in five chapters. Chapter 2 looks at representations of homelessness throughout history to gain a broader understanding of the policies that have led to the implementation of permanent supportive housing. This information is crucial in understanding the perpetuation of homelessness and the eventual emergence of housing as a response. Chapter 3 explores PSH literature as a response to homelessness as it exists in urban communities. A theoretical model is provided to illustrate the relationships between both urban and rural supportive housing modes. Chapter 4 explores permanent supportive housing impacts in rural communities by
analyzing existing data collected by a non-profit organization that applies the PSH model. Lastly in Chapter 5, discussion centers on major themes represented in the results of the study. Descriptive analysis is implemented in discussing survey results as they relate to mainstream PSH literature. Limitations of study and future research suggestions are also explored in this chapter. As it stands, nobody has used a case study of a rural PSH program to compare overall impacts against mainstream PSH literature that examine only urban models. This thesis analyzes themes found in the urban-focused literature as they compare to findings of this case study of rural settings.
CHAPTER 2: A SOCIO-HISTORICAL PERSPECTIVE OF HOMELESSNESS IN THE UNITED STATES

To understand the history of permanent supportive housing it is necessary to explore the broad history of general policies and principles that have affected homeless populations over the last century. Upon conducting preliminary research, four main themes began to emerge: how outdated perspectives of homelessness have shaped current perspective; the initial and continued effect of de-institutionalization on the population; media coverage; the criminalization of homelessness through vagrancy laws. These four themes, gathered through an extensive review of existing literature, illuminate the social history of homelessness in American culture.

Throughout this chapter, the research questions will continue to be explored as they relate to these themes.

Framing the Emergence of Homelessness

It may be helpful to begin by acknowledging that homelessness is not any sort of recent phenomenon; as long as jobs have existed, there have been people unemployed and without housing. Characteristics that defined the role of the homeless culture during the Progressive Era are far different than the descriptors used to explain homelessness in the modern world and may help to explain how public sentiment towards the condition of homelessness has changed repeatedly over time.
During the Progressive Era of American history, the homeless served as seasonal workers used to strengthen Midwestern harvesting communities and rural industries, collecting work in logging and railroad construction. In this regard, the homeless community of this era was admired for their strong work ethic and reliability. Although homelessness was prevalent in urban epicenters, the same populations would migrate to rural communities in times of employment, usually via railroad. The same people would generally settle in larger cities during winter slack seasons where they lived on their accumulated earnings or made ends meet through short-term service and industrial jobs. Members of this population became known as ‘hoboes’ (Bloom 2005).

The “hobo” was often contrasted with the “tramp,” which was taken to mean a person who sometimes worked to facilitate travel but for whom travel was of primary importance. The “bum,” on the other hand, describes a derelict person who neither travels nor works. Though these labels formed the dominant characterizations of the ‘wandering poor,’ this is not to say the term homeless did not already exist (Bloom 2005).

From the 1830s to the 1850s, the term homeless became more common in the United States. Simultaneously, the label homeless – as well as the concept of homelessness – increasingly emerged as responses to the extreme cases of those who did not maintain the new middle-class norm of domesticity. The concept of homelessness was in flux as people weighed whether their status encompassed separation from a domestic unit as well as lack of shelter (Bloom 2005).
This period of time also saw a shift of public sentiment in regard to the homeless population that is difficult to understand without examining the history of urban and rural migratory work over the Progressive Era.

The complex and shifting seasonal labor market of the western United States drew together a diverse workforce of farm owners, homesteaders and farm laborers mingled with displaced industrial workers, men who migrated from one side of the country to the other seeking work, as well as criminals, marginally employable drunks, addicts, and disabled men (Higbie 2004). Irish and German immigrant laborers often took harvest jobs digging canals through open farm country. As grain production spread across states like Minnesota, Iowa, Illinois and Wisconsin in the 1870s, an early migrant stream followed the harvest from south to north (Schob 1975).

Over the course of the 1910s and 1920s labor market patterns continued to change in ways that rank-and-file workers were able to perceive. The mechanization of construction, for example, undermined a crucial part of the seasonal workload, as the steam shovel revolutionized the process of ditch digging. Although farmers in some states, like the Dakotas, were slow to adapt to this new model of technology, migrants could no longer depend on earning their winter stake from ditch digging or wheat harvesting (Higbie 2004).

The indispensable outcast was the connective tissue that helped bind together the city and the countryside (Bloom 2005). But, as in the Midwestern states where these transients were – at least temporarily – viewed as useful and hardworking, those who lived in urbanized dwellings had their own impression of homelessness. Spectacular
urban growth gave new visibility to the kinds of social problems, such as crime, poverty
and disease that became the natural foci of policy (Schneider 1989). Cities served as
receptacles for vast numbers of migrants moving between regional margins and played a
major role in the process of modernization. As regional centers, cities incorporated new
socioeconomic, institutional and cultural patterns.

This concept of “new homelessness” forced itself onto the urban policy agenda
beginning around 1850, as great numbers of a highly mobile working class began to
populate American cities as a result of foreign immigration, western development and
industrialization. Although they served only a fraction of the amount that the private
housing market did, most migratory and unemployed workers found this lifestyle to be a
more practical day-to-day solution than cheap lodging houses (Bloom 2005). Others
found their needs satisfied with inexpensive lodging in areas that occupied a greater
variety of people. At the time, housing as shelter existed for lower class populations, as
the concept of ‘ends meet’ was still attainable through perseverance. This would not last
long.

The collapse of the American economy that accompanied World War One and the
postwar years between 1916 and 1921 marked a decisive reorganization of the labor
markets. As many opportunities for rural-industrial employment declined, the
availability of inexpensive used automobiles, and the expanding network of rural
highways created a more decentralized and less visible migration for the “hobo.” As the
geography of job opportunity shifted, the figure of the hobo dropped out of social science
discourse. In due time, new migrants would take the hobo’s place in the labor reserve and the social scientific imagination (Higbie 2004).

At the same time in urban areas such as New York and Boston, police stations overflowing with nightly lodgers made the homeless problem inherently a housing one. In response, there were attempts at building model tenements between 1850 and 1920, though policy-makers and reformers generally avoided such innovative projects in favor of restrictive legislation. These model tenements were costly undertakings that were not profitable enough to maintain without raising rents beyond what the lowest classes could afford. As a result, these tenements were only erected based on the “philanthropic spirit among the developers” (Schneider 1989:93). Furthermore, “supporters and administrators of the municipal lodging facilities saw it first as a weapon against unwanted tramps and the demoralized unemployed and only second as a service to a legitimate sector of the laboring population” (Schneider 1989:96).

Defining the “Old” and the “New” Homeless

Although the elaboration of categories, such as migratory laborer, hobo, tramp, and bum served to end terminologically stabilizing the seasonal labor force, “terminology has presented other limitations” (Bloom 2005:908). In order to understand the recent manifestation of homelessness, social scientists have created a paradigm that contrasts the “old homeless” with the “new homeless” (Barak 1991). Although the terms are defined very broadly, the “old homeless” includes the population of hobo on the move and men
on skid row from the 1870s to the 1970s (Bloom 2005). These people had no homes, but may have found nightly residence in SROs (single-room occupancy hotels). In contrast, the “new homeless” of the late 1970s literally had no shelter and their numbers contained more families, women, and children than the “old homeless.” Some literature also suggests that the “new homelessness” population contains more minorities (Bloom 2005).

This categorization proves to be problematic through the majority of the research. The term “old homeless” offers a limited historical perspective because it collapses the entire history of pre-1970s homelessness into one catchall phrase (Bloom 2005). A major problem with this distinction is that it assumes that the image of the “old homeless” would not carry over to characterize the “new homeless.”

“The first wave of homelessness in the twentieth century was a product of the mass unemployment characterizing the Great Depression. That era’s thousands of itinerant would-be working-men were dubbed “rail-riding hobos,” “tramps,” “vagrants,” “bums,” and “derelicts” by those who recorded their plight. These images, with their connotations of eccentricity, resourcefulness, hard-drinking independence, and disenfranchisement, remained in the popular imagination long after the men who gave rise to them had all but disappeared to the war and to postwar prosperity. When homelessness reappeared as a social problem in the late 1970s and early 1980s, we turned first to these images to characterize the “new” homeless” (Bogard 2003:425).
Since these stereotypes survived the socially constructed transformation from “old homelessness” to “new homelessness,” public understanding of the condition came to reflect outdated and irrelevant stereotypes of a previous era. In this way, the framing of “old homeless” served to perpetuate modern homelessness. This presented an individualized, freewheeling representation of a condition that had in actuality always been chronic and widespread. To first characterize the old homeless in terms of independence and work drive and then to define them as separate from “new homelessness,” actually “others” members of the “new homeless” community. Since modern homelessness is visibly a vast and collective concern, it is unfair for this homogenous representation to be applied to a heterogeneous reality. Attributing a condition such as homelessness to reflect individual choices and decision debunks the plight of poverty by fixating responsibility/blame on the homeless community for their own misfortunes. This process symbolically distances homelessness from society’s mainstream by establishing a norm and a deviance, without accounting for the socioeconomic inadequacies of the system. Since modern representations of homelessness no longer reflect the older image of the free-wheelin’ hobo, perception must continue to shift to reflect a structural and economic understanding of the issue.

The Effect of Deinstitutionalization

The source of homelessness among persons with a long-term mental illness is commonly described as being primarily both the result of deinstitutionalization and the
outcome of a critical shortage of low-income housing. The introduction of antipsychotic
drugs in the 1950s made it possible for many people with mental health issues to leave
their hospitals, as these new medications helped control the voices, delusions, and mood
swings that often accompany these diseases. The patients often did well as long as their
medication was continued, but this was not always the case. State mental health
administrators began discharging patients and closing down wards. In 1955, there were
552,150 patients in public mental hospitals. By 1985, there were only 109,939, an 80
percent decline (Torrey 1989:11-12). Given the advent of effective antipsychotic
medication, most patients who were discharged from the hospitals or who were never
hospitalized in the first place could have made a successful transition to the community if
the needed programs had been implemented (Torrey 1989). For this reason, it is
generally agreed that deinstitutionalization has not been a success.

In most cases, patients were discharged to their families, transferred to nursing
and boarding homes where treatment and rehabilitation were not available, or were
released on their own without supportive services to aid their rehabilitation into society.
In many areas, the system of community care has been underfunded and fragmented in
such a way that no agency receives ultimate responsibility for the patient (Linhorst 1990).
Finally, the system has been inaccessible to many patients, creating the young adult
chronic population that has not responded to traditional mental health services. These
inadequacies have resulted in the condition of homelessness among people who suffer
from mental illness, as it exists today: a shift in representation the “experts” have labeled
“new homelessness.”
More of the seriously mentally ill reside in shelters and on the streets than in public hospitals. Many of the seriously mentally ill are also confined in prisons, and it is estimated that 5 to 20 percent of the nation’s 2.3 million in jails and prisons exhibit these chronic symptoms. Note this estimation was from 1989. Approximately one-third of the total population of homeless adults are seriously mentally ill, while another third are alcoholics and drug addicts and the remaining third are homeless for economic reasons (Torrey 1989:11).

Torrey (1989) believes there were a series of central mistakes that were made during the deinstitutionalization process including initial misconceptions made about the causes of illnesses. This may be because thirty to forty years ago, much less was known about schizophrenia and manic-depressive psychosis. Sociologist Erving Goffman even argued the symbolic interaction perspective: that being in the hospitals caused these diseases, while psychiatrist Thomas Szasz claimed that the diseases were mythical and that there was nothing wrong with these people that discharge from the hospital would not cure (Torrey 1989). But more recently people are coming to realize that most patients require continuing medication, and a stable system of support (i.e. aftercare), rehabilitation and eventual housing.

Likewise, Linhorst (1990) recognizes the decline in low income housing to be the most significant variable in the growth of the homeless mentally ill. He proposes a redefinition of homelessness among people with chronic mental illness, noting the greatest need is access to affordable housing. There is considerable evidence indicating that until persons with mental illness have a stable living situation that offers them some
measures of dignity, rehabilitation services are of limited value (Linhorst 1990).

Furthermore all homeless people, and not just homeless individuals with mental illnesses, share the need for affordable housing. Therefore the mental health system is no longer solely responsible for the solution. Now the question becomes whether the federal government takes on a leadership role in the development of affordable housing.

These attitudes toward housing are seemingly beginning to change and some mental health departments are beginning to take on that leadership role in the coordination and development of low income housing, because in many instances, they have the legal responsibility to see that persons with a chronic mental illness have appropriate housing options (Ridgeway and Carling 1987). The Position Statement of the National Association of State Mental Health Program Directors calls for public mental health systems to exercise leadership in the development of housing and emphasizing the need to coordinate and negotiate roles played by the mental health authorities, public assistance and housing authorities, the private sector, and consumers themselves (Linhorst 1990).

Since the early 1990s the literature surrounding deinstitutionalization dried-up, suggesting it is no longer the issue it once was. Obviously many people on the street are mentally ill, but this is not true to all. Furthermore they do not necessarily attribute their condition to the same cause. If it can be agreed that each cause is unique, each proposed housing solution should be as well.
Trends in Media Coverage

Media interest in homelessness has largely focused on one-on-one interviews with people who are homeless, presenting individualized representations of poverty, and failing to account for the overwhelming majority of low-income, no-income families who comprise the majority of the growing homeless population. Indeed, there has long been a media misrepresentation of homelessness that correlates with the public’s average perception of life on the streets. This is why homelessness is a social issue, rather than an individual phenomenon. This considered, media coverage in regard to homelessness, whether in a newspaper or on TV, has long been under criticism from the academic sociology community. Although such research is important and may help to determine individuals’ vulnerability to homelessness, it can also lead to inappropriately interpreting individual deficits as the causes of homelessness (Buck, Toro and Ramos 2004).

To understand how homelessness is generally perceived one must either assess public attitudes toward homelessness and homeless people (Link 1995). Alternatively, one can examine media and professional coverage of homelessness in order to identify how the social problem is portrayed (Buck, Toro and Ramos 2004). The latter approach is what has been extensively discussed through the literature, and indicates a relationship between media framing of homelessness and how those who are not homeless perceive it.

Although homelessness has received attention for decades from historians and social critics alike, it was not until the mid-1980s that the mass media focused extensively on the hardships of homelessness as a devastating social problem. Between
1986 and 1989, The Center for Media and Public Affairs analyzed several stories from national evening newscasts and newspaper articles, which revealed coverage in the 1980s tended to be very sympathetic. The majority focused on programming and descriptions of people who are homeless, rather than the causes of homelessness.

After peaking in the late 1980s, the total amount of coverage in the printed media began to decline (Lee 1991). Similarly, the homeless received little attention in television and radio media between 1993 and 1996. Buck, Toro and Ramos (2004) indicate that compared with stories published between 1980 and 1983, those published from 1988 to 1990 tended to be more negative. This data is inconsistent with the previous study. The stories printed at this time on average focused more on the deviant characteristics of those who are homeless along with critiques of existing programs and services. Buck et al. also point to a content analysis of nationally syndicated comic strips conducted between 1989 and 1992 that reported 57% could be categorized as placing the blame on the homeless for their own plight. Much like with these findings, it is proposed that in the late 1980s and early 1990s there was a negative shift in attitudes toward homeless people in the media (Blasi 1994). Furthermore, an increasing number of newspaper, magazine, and television news stories in the 1990s have suggested that Americans are growing impatient, and even hostile toward the plight of people who are homeless.

While media coverage of homelessness has declined in the 1990s, perhaps due to the amount of excessive coverage in the 1980s, the sympathetic feelings toward homelessness among the public has been maintained, and the theory that media has lost
sympathy of the homeless in recent years is only supported by the fact there is less coverage. The sympathetic portrayal of homelessness in the media during the 1980s may have influenced policy implications and public sympathy.

Criminalization of Homelessness

A great body of literature has alluded to the relationship between law and vagrancy (Jenness 2004; Amster 2004; Boyle 2002; Garland 2001; Aulette and Aulette 1987). This may have first been expressed in William Chambliss’s classic work on the social forces that enabled vagrancy laws to emerge in the fourteenth century (1967), although in the modern context a more useful method for measuring the engagement of perceptions of vagrancy into criminalized law would be to study specific political and economic relationships within the realm of decision-making. Homeless policy has been shaped by levels of priority, different to each large city, county, region. More specific to the overall concept of criminalization, systematic explanations point to a growing number of factors that provide its impetus and sustain the factors over time. Recent work suggests these factors must be considered in combination and with temporal sensitivity to fully explain criminalization as a specific form of social control connected to larger processes of institutionalization and modernization (Boyle 2002; Jenness and Grattet 2001; Garland 2001).

We might then ask why are certain behaviors and conditions, like homelessness, defined as criminal? In the aforementioned classic study, Chambliss (1967) explained
vagrancy laws as a function of changes in other parts of the social structure, notably in the economic organization of society. He believed vagrancy laws emerged in 1348 England in response to the Black Death, which had disastrous consequences on the social structure, economy, and health of its citizens, decimating the labor force. As a result of this dramatic decline in surplus labor, wages rose considerably and vagrancy laws emerged (Chambliss 1967). This was meant to stabilize an otherwise mobile workforce by preventing laborers from moving, thus requiring those laborers to accept low wage employment landowners could more easily afford. Even more recently in history, the redevelopment of central cities, in combination with changing views of the homeless (the emergence of the very label of homeless implies it was an attempt to redefine the “hobo” label to encompass economic status and class) led to laws criminalizing homelessness in the United States. This criminalization portrays those who have been cast off of a failed economic system as bands of misfits and vagabonds, living outside the system and threatening those who live within the system (Jenness 2004; Aulette and Aulette 1987).

Increasingly, communities are using the criminal law to cleanse their streets of human survivors (Smith 1994). This is widely attributed to the view of homelessness as a threat to the social order and its maintenance. Whereas the depiction of disease leads to the imposition of regimes of sterility and sanitization, images of moral decay and social disorder set the table for legislative efforts aimed at regulating street people and criminalizing homelessness (Amster 2004).

This suggests a strategy of targeting behaviors that characterize certain social classes peculiar to the target group, then criminalizing it. Examples of this, like
panhandling and sleeping in public, further prove it is clear that by targeting conduct and not status, conduct still attaches to specific groups and that attacking the conduct (like sitting on the street) criminalizes the category (homelessness) making life for homeless people practically impossible.

Vagrancy laws have been enforced in efforts to “get the homeless off the street,” but in doing so these individuals enter into an already overcrowded prison system that can end up costing just as much as PSH options where available. If PSH options were to find funding in either rural or urban areas, the issue could be addressed in a way that meets the need of the individual, while also being cost efficient.

Housing can be seen as a possible response to all four topics of discussion in this chapter. Recognizing homelessness as an issue of health, increased allocation of funding on permanent supportive housing as a potential solution could 1) work to provide wraparound services not available since before de-institutionalization that address mental illness, 2) re-frame media representations to be more compassionate to the issue and solution-based, 3) effect the enforcement of vagrancy laws, and 4) show that many perceptions of homelessness are now very outdated and do not properly reflect the times.

The next chapter will explore permanent supportive housing as it was originally conceived as a response to urban homelessness, theories and frameworks around PSH to help address the research question.
CHAPTER 3: PERMANENT SUPPORTIVE HOUSING FRAMEWORKS AND DESIGN

Recognizing housing is a crucial component to health and is becoming the common response to encountering homelessness, permanent supportive housing services that implement the harm-reduction model have found it to be a practical way of providing shelter and treatment to those who often need it most.

Background of Issue

Permanent supportive housing is a strategy that not only provides stable housing to persons with co-occurring disorders, but also offers services to help address these conditions. It is defined as “decent, safe, and affordable community-based housing that provides residents with the rights of tenancy under state/local landlord tenant laws and is linked to voluntary and flexible supports and services designed to meet residents’ needs and preferences” (SAMHSA 2002:1-2). Permanent supportive housing can make an important contribution to ending homelessness for persons with co-occurring disorders and help them recover.

Permanent supportive housing can be provided in a variety of settings. Many individuals with co-occurring disorders are best served in regular housing (similar to other housing in the community) where they can also receive intensive, coordinated supports and services. Housing should be affordable and chosen by the tenant, accessible to tenants with co-occurring disorders regardless of their readiness to change or their
progress in recovery for either disorder, and combined with services that have sufficient depth to assist people with significant functional impairments (CSAT 2010).

Some believe permanent supportive housing is most effective when delivered with devotion to the best practice model developed from the SAMHSA (Substance Abuse and Mental Health Services Administration) Supportive Housing Study conducted in the 1990s (Rog and Hornik 2002). These suggested characteristics include choice in housing and living arrangements for clients who suffer from homelessness, a functional separation of housing and services, safe and affordable housing, community integration and rights of tenancy, access to privacy, as well as flexible, voluntary, and recovery-focused services (CSAT 2010).

Much of the research pertaining to harm-reduction and permanent supportive housing encouraged the adoption of the Housing First initiative (Kertesz et al. 2009; McGray 2004; Tsembris, Gulcer and Nakae 2004). Kertesz and colleagues (2009), for example, review Housing First as well as more traditional rehabilitative recovery interventions, focusing on the outcomes obtained by both approaches for homeless individuals with addictive disorders. The authors noted that Housing First documents report excellent housing retention, despite the limited amount of data pertaining to homeless clients with active and severe addiction. Other research pertaining to Housing First emphasized respect for homeless individuals as consumers entitled to make choices while condemning homelessness itself as a social evil that, like slavery in the nineteenth century, should have no place in the United States today (McGray 2004; Tsembris,
Gulcer and Nakae 2004). In short, Housing First represents an important break from traditional models that focus on “fixing” clients to make them “housing ready.”

Theoretical Framework

The theoretical framework will outline the foundational concepts used in this thesis. The purpose of this section is to highlight the core theoretical concepts that contribute to the analysis and interpretation of the data. It explains the conceptual variables and relationships between them. This model (Figure 1) depicts the experiences of participants/tenants of PSH programs and how the characteristics of the environment in which they live have a direct association to the type of housing support he or she receives. Urban models implement the single-site model, while rural models employ a scatter-site approach. The PSH model has been developed through the Housing-First initiative, which itself has been supremely influenced by the harm-reduction approach to case management and service provision. This model serves as a visual representation of the following section.

Figure 1: Permanent supportive housing theoretical model
Permanent supportive housing

Permanent supportive housing for homeless people is meant to prevent various types of crises and provide much needed health services to those who suffer from chronic homelessness. Properly run permanent supportive housing provides these services in a manner catered to the needs of each individual in the program in order to help disabled people live independently. Possible and common services include case management, medical and psychiatric care, housekeeping, home health assistance, medication and appointment reminders, addiction treatment, meal programs, and life coaching. The idea is to stabilize tenants, both for their own sake and to save public dollars by avoiding the more expensive institutions such as jails, hospitals, and homeless shelters.

In framing permanent supportive housing policies, programs should not be established in response to asking important question such as “what works?” but as “what works for whom?” (Caton, Wilkins and Anderson 2007). These questions have shaped the course of more recent research involving housing and homelessness, which are favoring factors like compatibility, more than they have in the past. Homelessness had not been traditionally viewed as an issue of health in decision-making and policy until earlier in this decade. The result of this realization has been influenced by public health studies from large major cities where of homelessness is prevalent such as San Francisco and first operationalized in large urban areas as well. Past policy surrounding homelessness favored shelters and transitional housing, but unfortunately, these approaches did little to reduce the number of the long-term homeless and even less to
reduce the potential harms associated with homelessness by providing adequate health services.

The permanent supportive housing rectangle begins this model because it has become known as the most well-known and effective approach to minimize the harms related to homelessness, primarily the problem of not being housed.

The harm-reduction model

Harm-reduction refers to a range of public health policies designed to reduce the harmful consequences associated with recreational drug use and other high-risk activities. Harm reduction is put forward as a useful perspective alongside the more conventional approaches of demand and supply reduction (Marlatt 2002).

Many advocates argue that prohibitionist laws criminalize people for suffering from a disease and cause harm, for example by obliging drug addicts to obtain drugs of unknown purity from unreliable criminal sources at high prices, increasing the risk of overdose and death (Inciardi and Harrison 2000). Its critics are concerned that tolerating risky or illegal behavior sends a message to the community that these behaviors are acceptable. However, the potential benefits to the individual addict and to society mirror one another, as the rejection of prohibitionist law in order to improve the safety, and in many cases health of the population at risk.

The harm-reduction approach was first designed for these drug related issues, but has been acclimated as a set of practical strategies that reduce negative consequences associated with both drug use and sexual practice as well. Since both substance abuse
and sexual victimization are common factors to homeless communities, a spectrum of strategies has been incorporated to reduce these risks, ranging from safer use, to managed use, to abstinence. Harm-reduction strategies must address conditions of use along with the use itself (Marlatt 2002). Because harm-reduction demands that interventions and policies designed to serve drug users reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

Harm-reduction is directly linked to the mission of Housing First programs due to the common acceptance that licit and illicit drug use is part of our world. The Housing First program adopts the principles of harm reduction and chooses to work to minimize the harmful effects of drugs rather than simply ignore or condemn them. In doing that, advocates and Housing First staff come to realize some ways of using drugs are clearly safer than others (Inciardi and Harrison 2000). The harm-reduction model also calls for a non-judgmental provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm. The model also affirms drugs users themselves as the primary agents of reducing the harms of their drug use. By doing this, harm-reduction strategies seek to empower tenants to come up with solutions that meet their actual conditions of use. Lastly, and perhaps most importantly, harm-reduction recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities increase people's vulnerability to dealing with drug-related harm (Marlatt 2002; Inciardi and Harrison 2000).
Housing first

When applied to chronically homeless individuals, Housing First refers to the rapid and direct placement of homeless individuals into permanent housing with supportive services available, but without service utilization or treatment required as a condition of receiving housing (Tsemberis, Gulcur and Nakae 2004). By separating the participation in or success of treatment from the provision of permanent housing, Housing First programs target individuals who have declined rehabilitative treatment or those who experienced treatment and had been unsuccessful (Tsemberis, Gulcur and Nakae 2004). The Housing First approach also has been used with homeless families in the past but many of those characteristics and outcomes differ from those of individuals.

While the Housing First model presents a vast array of treatment options for those who experience homelessness, characteristics and demographics of those in need cannot be homogeneously determined. There are a variety of factors that may influence a case manager to reference one type of housing model over another. Factors would include the socialization of the individual, their diagnoses, and perhaps mobility as well. These factors as well as consideration for the physical location of the person in need would influence what type of Housing First model they would enter. While permanent supportive housing initiatives and the Housing First model itself originated in and was developed for urban communities, homeless individuals living in rural environments also benefit from the services offered through this approach. The next sections this chapter of will elaborate on the similarities and differences of permanent supportive housing models as they relate to their urban and rural settings.
Urban model

Most research regarding urban homelessness does not explicitly label it as such. Most homelessness is assumed to be urban-based. In this sense, the perception of homelessness as a social problem is most often ascribed to those who are most noticeable. Rural homelessness, on the other hand, is often less visible because the areas that exhibit this type of condition are typically smaller in scale and population. This results in homeless individuals having a stronger sense of community, thus allowing them to foster more connections and have greater potential success in finding a place to sleep on any given night.

Urban homelessness is greater on a visible scale due to the fact that urban areas have more job opportunities than rural environments and thus also have a larger amount of people out of work as well. Demographically, homelessness in urban areas is often a racial issue, as there is a disproportionate number of minorities to those of whites. Though never causally studied in-depth, research has found African Americans face this problem more often than many others (Faniel 2009).

Homelessness in urban areas is also often housing or shelter-centered, at least partially in response to the large visibility of the issue. It thus makes more sense Housing First model programs are piloted in urban areas with great financial support.

Single-site

Single-site permanent supportive housing has more recently become the premier response to ending long-term homelessness. Single-site residences often come in the
form of a renovated hotel or apartment complex and are almost exclusively located in urban areas. One reason these residences appear to characterize only urban housing efforts is that such large and unused buildings are often not available in rural environments. From a policy standpoint, homeless populations that reside in large cities are usually far more noticeable than those who do not, which may result in them receiving greater attention. Urban cities like San Francisco have led the way in single-site permanent supportive housing policy (Kertesz 2009; Pearson et al. 2007). Due to the lack of affordable housing in urban settings like this, renovating an old hotel or apartment building is a more attractive choice both in availability and affordability than independently contracting a property management company to lease scatter-site apartments.

Single-site residences are often most appropriate for those who realize they need the extra services and want to help themselves to receive them (Shore 2010). This is due to the fact that single-site permanent supportive housing usually provides health and case management services on-site, thus defeating any need for tenants to seek services themselves (Pearson et al. 2007; CMHS 2007).

Rural model

Many of the rural homeless have traditionally stayed in overnight shelters, just like their urban counterparts, but some counties don't even have shelters. This forces those who experience homelessness to live in encampments, abandoned buildings, barns or cars. Many move from place to place, sleeping on the couch of a friend or relative, or
on the floor until they move on to the next person willing to take them in for a while (Tsemberis 2004). Rural homelessness is characterized by transient culture in this sense (Bridegam 2007). Even if these groups of rural homeless never leave their community, they are often mobile and determine where they will sleep on a night-to-night basis.

Nationally, there are about 675,000 homeless people on any given night. Of that figure, an estimated 9 percent, or just over 60,000 people, live in rural areas (Bridegam 2007:2-3). Rural homelessness presents challenges because there is less transitional housing, fewer employment programs, fewer social service agencies and fewer health care programs than in cities. At the same time, finding solutions for homeless people can be easier in rural areas, in part because the numbers are not quite as overwhelming as in urban settings (Bridegam 2007).

Permanent supportive housing programs for these rural communities differ from those of urban communities. Rather than provide single-site service to these communities, advocates and staff working in rural housing programs often have little choice but to opt for scatter-site accommodations, due to the limited availability of other options.

Scatter-site

Scatter-site permanent supportive housing sees “a growing second wave of supportive housing thinking that recognizes the scatter-site model as a hopeful alternative to big-box practices of segregating the tenants” (Bridegam 2007:8). This point references the different lifestyles attributed to each type of permanent supportive housing model.
Scatter-site models are most often applied to PSH models in rural areas. While ‘big-box,’ or single-site residences may provide both flexible services and case management under one roof, these sites can force clients that exhibit serious mental or physical disabilities that affect their social skills to interact and engage with each other in problematic and disruptive ways. Though it is not always an option for those who live in urban environments, some clients may be better suited in a more individualized setting.

In scatter-site models, supportive services are based upon the individual’s needs as well as the existing resources of the provider. Services may center on a person’s disability or their need for skills development around living independently in their own housing. Together with wrap-around supportive services, a tenant-based scatter-site housing model provides many benefits to program participants, housing providers and the communities that they are operated in (Shore 2010).

Whether intentional or not, the scatter-site model as applied in rural environments supports the argument for separating housing from mental-health and addiction treatment. Tsemberis (2004) notes when people are placed in situations where housing and treatment are dependent on one another, they have a tendency to revert to behaviors such as hoarding, withdrawal, and drug abuse. They begin a cycle that can eventually get them evicted, and that only adds to their suffering (Tsemberis et al. 2004). This sentiment is too broad and seems to forget that the availability of local housing in these areas is the real determinant to whether in-house treatment services can be made available. Another argument is that these in-house services would benefit many of those
who suffer from mental health disorders and have poor histories of accessing or even seeking these treatment options.

Permanent Supportive Housing Research

Permanent supportive housing literature addresses the cost effectiveness of such programs in providing long-term shelter for those who encounter homelessness (Burkholder and Hexler 2002; Snow 2001; Culhane et al. 2001; Shore 2010; Bridegam 2007), model design considerations (FWDH 2009; CSH 2008; Culhane et al. 2009), service provision (CMHS 2007; CSAT 2010; NAMI 2008; CMHS 2003), and other benefits for both homeless individuals and the greater community (CSH 2001 and 2004; Burkholder and Hexler 2002; Bridegam 2007; SAMHSA 2010; Shore 2010).

Cost effectiveness

Homelessness causes or exacerbates many conditions that lead the homeless to utilize the health, mental health, and corrections systems at high rates and at taxpayers’ expense (Burkholder and Hexler 2002; Salit et al. 1998). Many homeless individuals with long-term needs cycle between shelters, hospitals, residential treatment centers, and prison (Snow 2001). These are expensive settings never intended to function as housing and do not provide the stability these individuals need to rebuild their lives. For example, in a study released in the New England Journal of Medicine, researchers found that homeless individuals were more likely to be admitted to public hospitals, and once there, tended to stay 36 percent longer than other patients. It found that better access to
supportive housing for currently homeless patients could ultimately save taxpayers $5,000 per individual per year (Salit et al. 1998). With these considerations, the claim that permanent supportive housing is a cost-effective alternative to shelters, hospitals, treatment centers, and prisons grows stronger.

In another example, a comprehensive study of almost 5,000 formerly homeless in New York who were severely mentally ill concluded that this population could be placed in service-enriched housing for almost the same amount of public funds spent every year in psychiatric and medical care, emergency shelters, and other services (Culhane et al. 2001).

Other research that involves permanent supportive housing costs stresses the financial difference between scattered-site supportive housing and single-site supportive housing. A scattered-site supportive housing program is one in which a monthly rental subsidy is provided to an individual or family to assist them in renting a privately owned dwelling unit in the community. It is not necessary that participants be employed or have another income source, as their contribution towards the rent is based on their income (Shore 2010). A tenant-based, scattered-site supportive housing program is usually most prevalent in rural settings and is far less costly in the short-term to launch and administer (Shore 2010; Bridegam 2007). The program only requires funding for the ongoing monthly rental assistance payments. Different funding sources may also provide funding for additional important activities, including security deposits, tenant-caused damages and vacancy loss (FWDH 2009).
The cost of the monthly rental assistance may also decrease over time as program participants’ incomes increase, whether through the attainment of employment or through receipt of benefits such as Social Security disability benefits. These programs provide housing assistance to 1,100 households on a monthly basis for approximately $7 million annually, or about $530 per household per month. This figure represents the cost of the housing only, and does not include the cost of providing supportive services (Shore 2010).

In comparison, Burkholder and Hexler (2002) discuss a single-site supportive housing development that was about to break ground in Phoenix, Arizona around the time the article was written. The Phoenix single-site development had an estimated price tag of just over $15 million. The development was set to have 65 units and not all of them were targeted for people experiencing homelessness.

Design considerations

Concerns about the design of supportive housing typically fall into the categories of compatibility, location, size and aesthetics (FWDH 2009). Modern codes, zoning and architectural standards insure that new multi-family housing developments must be roomy and supportive of a high quality of life.

As a subset of affordable and accessible housing, permanent supportive housing is unique due to its often strategically located and dispersed sites throughout their community (CSH 2008). Permanent supportive housing site selection is often governed by zoning ordinances, is subject to development standards, and is also subject to all
applicable building and fire codes (FWDH 2009). The operation of multiple units of permanent supportive housing is also subject to rental registration and inspection (CSH 2008).

Developers of permanent supportive housing may practically choose locations most likely to contribute to the success of their clients. Thus, proximity to public transportation, groceries, medical services and employment would likely be preferred (FWDH 2009). Dispersing quality, affordable housing also provides more choices to renters who want to live close to family, friends and other supports (Culhane et al. 2009).

A single-site setting usually takes the form of a multi-unit apartment building of any size where formerly homeless individuals or families occupy all of the units. In these settings, services to support the tenants’ recovery, employment activities and reintegration into the community are typically available on site (FWDH 2009). Larger buildings usually include a 24-hour front desk. While it is conceivable to build very large projects, newly constructed, single site permanent supportive housing developments will typically be fewer than 150 units and generally 80 units or less (CSH 2008).

Wherever possible, scattered site units are grouped geographically to achieve management and service economies of scale. The supportive housing project may hold a master lease for the units and sublet to the tenants or the tenants may rent directly from the landlord in an arrangement facilitated by the supportive housing sponsor (FWDH 2009). Services usually include some home visits, but most service provision occurs outside the tenant’s home (Culhane et al. 2009).
Whether the project is the renovation of an older building or a new design, aesthetics are an important feature. Classic designs that incorporate accessibility and energy efficiency are generally preferred by both neighborhoods and the lenders who underwrite the projects (FWDH 2009).

Service provision

Permanent supportive housing literature often discusses the diversity of services that often accompany these programs. Much of the literature discusses specific programs, often segmented to specific cities and states. Therefore, literature in this category was only examined if it came from national reports discussing generalized services. The services have been implemented in many nation-wide samples for the purposes of providing tenants with a flexible array of case management programs to choose from and other services that help them move towards recovery.

The following list of common support services to permanent supportive housing was compiled by The Center for Mental Health Services (2007):

- Integrated treatment for co-occurring disorders;
- Inpatient, residential, and outpatient substance abuse treatment;
- Psychiatric assessment and treatment;
- Psychotropic medications;
- Health care, including dental care;
- Skills training;
- Habilitation and rehabilitation services;
• Case coordination services; and
• Direct provision of or links to additional services, such as individual and family counseling, HIV services, crisis intervention, child care, medical care, vocational counseling, and job placement (CMHS 2007:29).

A unique feature for tenants in permanent supportive housing is that they are most likely to benefit from services when they see them as necessary. As discussed earlier, this works against the notion that housing programs are types of imprisonment and encourages tenants to empower themselves through harm reduction models. Consumers should be asked about their needs and preferences regarding program services, and the program should be prepared to deliver a sufficient number and variety of services to respond to the needs and preferences that are most important to the client (CSAT 2010). These services are most effective when they are well coordinated and convenient for the client.

Although people with co-occurring disorders want and use supportive services, many of them do not want to live in settings in which services are required or delivered as part of the housing program (CSAT 2010). They may prefer scattered-site housing, if available, because in these models staff members travel to meet with their clients. This however, is not always an issue of choice, and is usually determined by whether the client lives in a rural or urban setting. But the physical design of permanent supportive housing is not always important when it comes to issues of service provision. Intensive case management, integrated dual diagnosis treatment and assertive community treatment
especially, have proved most helpful for clients, and particularly for those with co-
occurring disorders (CSAT 2010; NAMI 2008; CMHS 2003).

In intensive case management, the case manager can help coordinate multiple
services in keeping with the client’s needs and preferences. Case management that
includes an assertive outreach approach has been shown to engage and retain clients at a
high rate, while case management that does not include outreach results in more “lost”
clients (CSAT 2010). Meeting at the client’s residence, for example, can be an effective
strategy (NAMI 2008). Integrated dual diagnosis treatment refers to the integration of
mental health and substance abuse treatments in one approach. The same clinicians or
teams of clinicians working in one setting, provide both mental health and substance
abuse interventions so that the consumer does not get lost, excluded, or confused going
back and forth between two different programs (CMHS 2003). Assertive Community
Treatment (ACT) is a team-based approach to delivering treatment, support, and services.
These teams consist of 10 to 12 staff with experience in psychiatry, social work, nursing,
substance abuse treatment, and employment support (CSAT 2010). ACT teams can
support individuals with co-occurring disorders in permanent supportive housing, serving
as a convenient way of receiving treatment for those who otherwise may not have.
Intensive case management is crucial in helping their clients meet their goals, whether
employment, wellness or housing.
Other benefits for individuals and the community

Supportive housing is not only effective for the public in cost and design; it is effective at helping the formerly homeless rebuild their lives as well. Somewhat recent studies compiled by the Corporation for Supportive Housing (2001) show that, because of their new-found housing stability coupled with supportive services, formerly homeless people in service-enriched housing use expensive alternatives at a much lower rate than the homeless (Burkholder and Hexler 2002). Once in permanent supportive housing, most of these individuals experienced significant decreases in emergency room visits, inpatient hospital days, incarcerations, detoxification services, and use of residential mental health facilities (Burkholder and Hexler 2002). The housing stability and supportive services provided by permanent supportive housing could also positively affect residents’ employment status. A study by the Corporation for Supportive Housing shows that when employment services are provided in supportive housing, participants’ rate of employment went up 40 percent and their earned income increased 50 percent (CSH 2004).

In comparison to the savings, permanent supportive housing produces benefits to the community. Many neighborhood residents are initially resistant to proposals for permanent supportive housing in their “backyard.” But a study of the Connecticut Supportive Housing Demonstration Program shows that supportive housing improved neighborhood safety and beautification and increased or stabilized property values in most communities (Bridegam 2007).
Scatter-site supportive housing programs provide positive financial impacts to communities. Scatter-site permanent supportive housing provides rental assistance to different apartment communities, property management companies and independent rental property owners. These programs provide landlords with a stable stream of tenants and rental (Bridegam 2007).

Positive relationships with private landlords are a crucial component of a successful program, not only to maximize housing choice but also to provide participants with supportive environments where landlords work as partners in the program. Many program landlords take a relaxed approach to reviewing tenant selection criteria for applications, reducing or waiving required deposits, and working proactively with tenants to support participants in their housing (SAMHSA 2010).

This includes counseling participants in tenant matters related to compliance and behavior as well as cooperating with supportive service providers to allow appropriate intervention when necessary. This alternative produces positive results rather than the old model that often ended in tenant eviction. This assistance and cooperation increases the rate of housing retention for program participants and also contributes to community building among tenants and staff (Shore 2010).

As the success of permanent supportive housing in urban environments has been well chronicled in scholarly research and has since entered into the realm of public discourse, questions remain regarding this model’s reliability in rural communities. The lack of scholarly literature surrounding permanent supportive housing in rural areas was exacerbated by the absence of research that compared urban and rural models.
To address the lack of scholarly literature surrounding permanent supportive housing in rural areas, pre-existing survey data was analyzed to measure the impact of a rural PSH program on its participants. Respondents’ level of satisfaction within this program serves as a case study to measure the impact of PSH on rural communities. The Results described here evaluate the survey respondents’ level of satisfaction with this rural PSH program as compared to impacts understood through urban PSH literature. This process will support the mission and direction of this non-profit agency, while simultaneously addressing the research question: “what are the impacts of PSH on rural communities, as compared to the impacts on urban communities?”
CHAPTER 4: SURVEY RESEARCH METHODOLOGY AND RESULTS

As discussed earlier, existing literature on permanent supportive housing tends to concentrate on programmatic outcomes of large-scale urban models. There is no research that examines rural PSH models and how they compare to urban PSH models. To help address this gap in research, survey data is evaluated that measures the impact of a rural non-profit PSH agency. Since 2007, surveys have been annually administered to measure client satisfaction with services. The results serve as a case study to measure the impact of PSH on rural communities in comparison to the impact of PSH on urban communities.

The Case Study

The case study is an approach capable of examining simple or complex phenomenon, with units of analysis varying from single individuals to large corporations and businesses; it entails using a variety of lines of action in its data-gathering segments and can meaningfully make use of and contribute to the application of theory (Creswell 2007; Yin 2003). The case study described here uses a “constructivist” methodology, that is, a research technique that uses key actors’ and close observers’ understandings and interpretations of the implementation (Guba and Lincoln 1985). The research methods used in the case study are traditional ones, in which the researcher acts as the observer and interpreter of events (Felton 2003).

Research is focused on Arcata House’s Apartments First program and how it operates within the larger national movements toward permanent supportive housing.
The success of this scatter-site PSH program will be evaluated based on the findings generated through pre-existing survey data.

Survey Analysis

The Arcata House Apartments First program started collecting data in 2007 at the request of its funders. Many clients have participated in the survey since the beginning of the program’s conception. Because of the program’s success, the program has expanded over the years to include a larger client base. The Arcata House Apartments First program implores a scatter-site approach to house their clients, partnering with local landlords as housing providers. At the time of this study, The Apartments First program was providing housing to clients in three local cities: Arcata CA, Eureka CA and Mckinleyville CA.

In 2007, the program staff worked to develop a client satisfaction survey, called the “Client Experiences Questionnaire” (See Appendix B). It was first developed as a 31-item, self-report instrument meant to collect data in 5 different domains: 1) the program and its services, 2) clients’ experiences with the program, 3) clients’ lives in general, 4) clients’ health in general, and 5) comparison of current and past health status. Likert Scale response categories were established that used either a 5-point scale from “1=Never” to “5=Most of the Time” or a 10-point scale from “1=Terrible” to “10=Great” or from “1=Never” to “10=All Day, Every Day.”
For the four survey administrations periods examined in this sample (May 2007, May 2008, May 2009, March and April 2011), clients were encouraged to complete the questionnaire on their own but were offered assistance, if needed. Questionnaires were administered on an individual-basis during home visits with clients urged to respond within a two-week window of time. Clients were allowed to complete the questionnaire and return it to the staff member immediately or to complete it and send it back to the evaluator in a self-addressed, stamped envelope. Most respondents answered by mail, utilizing a stamped and addressed envelope provided by The Arcata House to return the questionnaire.

For the last evaluation period examined, the survey questionnaire was delivered to the nineteen (19) current residents in the Apartments First Program. One household completed their survey together, moving the sample size from nineteen (19) to eighteen (18). Five (5) clients completed the questionnaire on their own, and thirteen (13) completed it with assistance. During these four years program participants have changed in number (2010 \(n=18\), 2009 \(n=14\), 2008 \(n=14\), 2007 \(n=12\)). The average time in the program for the clients was 2.89 years.

Results

This section contains the results of the survey research. The format presented is a data analysis that identifies the most relevant results of these findings. Responses for the most recent year 2010 were compared to those of previous administration periods in
order to measure client satisfaction with the program over this 4-year period of time. During these four years program participants/survey respondents have changed in number (2010 \( n=18 \), 2009 \( n=14 \), 2008 \( n=14 \), 2007 \( n=12 \)).

Likert Scale response categories were established that used either a 5-point scale from “1=Never” to “5=Most of the Time” or a 10-point scale from “1=Terrible” to “10=Excellent” or from “1=Never” to “10=All Day, Every Day.” From these responses, mean values were generated then divided by question asked and year of administration. Throughout this section, survey results are identified and evaluated based on knowledge of PSH literature and according to the relevance to the research question, *what are the impacts of PSH on rural communities, as compared to impacts of PSH on urban communities?*

**Satisfaction with services**

Overall, clients (survey respondents) were very satisfied with Arcata House Apartments First services. Clients from the 2010 evaluative period (\( n=18 \)) reported uniformly high scores on the satisfaction of services they received (4.8) and on the performance of staff in providing these services (4.57) on a scale from 1 to 5, with 5 being “most of the time”. This expresses that clients in the Apartments First program found the services they received were 96% effective and clients found that the performance of staff in providing these services were 91% effective.

As expressed in Table 1, these results are consistent with responses from previous years, indicating that in this four-year period of time Apartments First clients have been
overwhelmingly successful in the eyes of their clients in both the services provided and the performance of the staff in providing these services. Clients report their satisfaction with services they received in 2010 (96%) is slightly lower (100%) than in 2009 \((n=14)\) and the cumulative mean average \((n=40)\) of the three previous years (98%).

Table 1: Average client score on their satisfaction with services by year

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<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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</thead>
<tbody>
<tr>
<td>Average score</td>
<td>5</td>
<td>4.71</td>
<td>5</td>
<td>4.8</td>
</tr>
</tbody>
</table>

Clients reported their satisfaction with performance of staff in providing these services in the 2010 evaluative period (91%) is also slightly lower than in 2009 (100%) and the cumulative mean average of the three previous years (99%), as noted in Table 2.

Table 2: Average client score on their satisfaction with staff by year

<table>
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<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average score</td>
<td>4.92</td>
<td>5</td>
<td>4.86</td>
<td>4.57</td>
</tr>
</tbody>
</table>

As noted in Table 3, clients also reported very high scores indicating that they liked the program (5), that the program was providing the kinds of services they needed (4.7), and that their lives had improved as a result of being in the program (4.7) on a scale from 1 to 5, with 5 being “most of the time”. This expresses that clients in the Apartments First program found themselves 100% satisfied with the program itself, that
94% of clients found that both the services provide the kind of services they felt they need and that their lives have improved as a result of being in the program.

Table 3: Average client score on their satisfaction with programming by year

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>4.75</td>
<td>4.86</td>
<td>4.93</td>
<td>5</td>
</tr>
<tr>
<td>Services needed</td>
<td>5</td>
<td>5</td>
<td>4.93</td>
<td>4.7</td>
</tr>
<tr>
<td>Lives improved</td>
<td>4.75</td>
<td>4.86</td>
<td>5</td>
<td>4.7</td>
</tr>
</tbody>
</table>

These results are also consistent with responses from previous years. In 2010 clients liked the program (100%) slightly more than they did in 2009 (99%) and the cumulative mean average of the three previous years (97%). Clients reported the program provides the kinds of services they need (94%) less than the 2009 year (99%) and the cumulative mean average of the three previous years (99%). Lastly, clients reported their lives have improved as a result of being in the program in 2010 (94%) at a lower rate than they felt in 2009 (100%) and the cumulative mean average of the previous three years (97%).

Perception of health

In addition to gaining a more complete understanding of client satisfaction as it connects to service provision in this program, survey results also highlighted broad themes gathered by questions related to the health of respondents. Clients responded to questions related to health in four domains: physical health, mental health, substance use,
and emotional health, which is meant to measure a client’s personal sense of well-being and happiness. For each survey administration, clients have been asked to rate their currently perceived health status since being a program participant along with their perceived health status before entering into the program. Clients responded on a Likert scale format from 1 to 10, with 1 meaning “terrible” and 10 meaning “excellent.” However, questions regarding current and past substance use are scaled differently in this format from 1 to 10, with 1 here meaning “never” and 10 meaning “all day, every day.”

Results indicate a generally positive impact on the perceived health status of clients in the Arcata House Apartments First program. Respondents rated their health improved in 2010 in three out of the four health domains by a significant amount. These results fall in line with results from previous survey administrations from 2007-2009 and imply that individuals who live inside are generally healthier than individuals who live outside. Only when measuring the perceived frequency of substance/alcohol use reported this year, is there a major outlier to the data collected in previous administrations.

As expressed below in Table 4 and Figure 2, Apartments First clients have reported their perceived overall physical health has improved since being in the program each year the survey was administered from 2007-2010. Though these numbers fluctuate slightly by year, responses indicate the perceived current physical health status of individuals in the program is “average” to slightly “above-average,” compared to a “below average” perceived physical health status before entering the program.
Table 4: Average client score on their perceived physical health by year

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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</thead>
<tbody>
<tr>
<td>Today</td>
<td>5.58</td>
<td>5.07</td>
<td>6.23</td>
<td>5</td>
</tr>
<tr>
<td>Before program</td>
<td>4.42</td>
<td>3.57</td>
<td>3.57</td>
<td>3.94</td>
</tr>
</tbody>
</table>

Figure 2: Average client score on their perceived physical health by year

Nevertheless, findings in 2010 indicate a slight dip in the perceived physical health status of program participants from previous administrations. Figure 2 also shows the current perceived physical health of clients in the program spiked in 2009. While there was a marked improvement in these results from 2008-2009, results from 2010 show the perceived physical health status of respondents more similar to the 2007 and 2008 administrations than the 2009 survey administration.
In response to questions about their perceived current mental health status, survey respondents reported their perceived overall mental health has improved since being in the program each year the survey was administered from 2007-2010, depicted in Table 5 and Figure 3. Clients have generally perceived their mental health status before entering the program as much worse than it is since becoming a program participant, with numbers reflecting a “below average - poor” status prior to program entry and an “above-average – great” status since entering the program. This represents a seemingly vast improvement in the lives of program participants when it comes to their perceived mental health.

Table 5: Average client score on their perceived mental health by year

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<tbody>
<tr>
<td>Today</td>
<td>6.91</td>
<td>7.36</td>
<td>7.79</td>
<td>7.55</td>
</tr>
<tr>
<td>Before program</td>
<td>4.73</td>
<td>3.29</td>
<td>3</td>
<td>3.5</td>
</tr>
</tbody>
</table>
As stated above, themes regarding perceived substance/alcohol use generated through the data were measured on a 10-point scale different from the scale that is used to compare current and past physical health, mental health and emotional health categories. Clients were asked to respond to questions regarding perceived frequency of substance/alcohol use using a scale from 1-10, with 1 meaning “never” and 10 meaning “all day, every day.” Results expressed in Table 6 and Figure 4, thus, appear to indicate an overall negative response to the perceived impact of substance/alcohol use in this program and that these clients are worse-off now than they reported before entering in the program. This relationship, however, actually expresses a positive impact housing has had on reducing perceived levels of substance use and/or alcohol use.

Figure 3: Average client score on their perceived mental health by year

As stated above, themes regarding perceived substance/alcohol use generated through the data were measured on a 10-point scale different from the scale that is used to compare current and past physical health, mental health and emotional health categories. Clients were asked to respond to questions regarding perceived frequency of substance/alcohol use using a scale from 1-10, with 1 meaning “never” and 10 meaning “all day, every day.” Results expressed in Table 6 and Figure 4, thus, appear to indicate an overall negative response to the perceived impact of substance/alcohol use in this program and that these clients are worse-off now than they reported before entering in the program. This relationship, however, actually expresses a positive impact housing has had on reducing perceived levels of substance use and/or alcohol use.
Table 6: Average client score on their perceived substance/alcohol use by year

<table>
<thead>
<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today</td>
<td>2.64</td>
<td>2.93</td>
<td>4</td>
<td>7.94</td>
</tr>
<tr>
<td>Before program</td>
<td>3.36</td>
<td>5</td>
<td>6.08</td>
<td>5.88</td>
</tr>
</tbody>
</table>

Figure 4: Average client score on their perceived substance/alcohol use by year

Except 2010, survey results for this question indicate client levels of substance and/or alcohol use has steadily declined since starting the program. In 2010 clients reported their perceived frequency of substance/alcohol use was higher than it was before beginning the program, indicating PSH through Apartments First may have had a negative effect on their health. This is the only survey result that reflects a negative effect of housing on the health status of clients.
Lastly, in response to questions about clients’ emotional health (sense of well-being and happiness), survey respondents reported significant improvement in their perceived status since being in the program, as depicted in Table 7 and Figure 5. For 2010, clients rated their perceived emotional health at an average of 8.5, a near-excellent score. This number is similar to what clients rated their perceived current emotional health in the 2007 survey administration, when the advent of housing was still fresh for program participants. Scores across the board also reflect the biggest yearly variances in clients’ self-evaluations, with a mean-average perceived current emotional health rate of 81% and a mean-average of 31% before entering the program. This represents a 50% margin of difference and best illustrates the effect housing has on perceived emotional wellness.

Table 7: Average client score on their perceived emotional health by year

<table>
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<tr>
<th></th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today</td>
<td>8.81</td>
<td>7.43</td>
<td>7.85</td>
<td>8.5</td>
</tr>
<tr>
<td>Before program</td>
<td>4.17</td>
<td>3.07</td>
<td>2</td>
<td>3.11</td>
</tr>
</tbody>
</table>
These results seem to follow the general understanding that PSH is an effective response to chronically homeless individuals. General responses to the questions asked in this survey were very positive, reflecting client satisfaction with the services and support provided by the Arcata House Apartment First program.

Clients’ satisfaction with services was a dominant theme in these results, showing these satisfaction rates to be significantly high year in and year out. Although these numbers reflect positively for the Arcata House Apartments First program, there is little variance in these numbers to suggest any dissatisfaction in the four year sample.

Results garnered for the perceived health status of clients were far more substantive. In 2010 clients rated their perceived physical, mental, and emotional health statuses as uniformly better since entering into the program. These results are consistent with those of previous years, reflecting a sustainable and long-term impact of housing on
clients’ perceived health status. A significant finding was that while from 2007-2009, clients reported using substances and/or alcohol less often since being in the program, in 2010 clients reported using more frequently than before entering the program. Another significant finding is the sustained positive impact housing had on the perceived emotional health of the program participants. This category shows the largest variance in percentage measuring clients’ perceived emotional health status before entering the program and since entering the program. These findings show clients feel housing has made the most significant impact on their perceived emotional well-being, or sense of happiness.

While these findings elicit useful data in analyzing the effectiveness of a rural PSH program, the real impact of the study can only be fully understood by its relationship to other PSH models. The next chapter serves as a discussion and analysis of these findings, rooted in the understanding of PSH effectiveness, as it exists in urban areas. This discussion sheds new light on formally held notions of PSH in rural areas, and how/if this model impacts a broader understanding of this housing approach.
CHAPTER 5: DISCUSSION OF FINDINGS AND CONCLUSIONS

While the overall characteristics, design and implementation of PSH models certainly differ based on location, seemingly their impact of success does not. This study’s survey findings were similar to themes that came up in the urban-centered literature. Results support the Housing First initiative that recognized homelessness as an issue of health and housing as the answer. The results of these programs reflect the satisfaction and health of its residents. Two general themes arose in the findings: “feelings toward services and provisions of PSH program” and “perceived effects on health.”

For the purposes of this study, the results related to “feelings toward services and provisions of PSH program” are not used in this analysis, as questions concerning the validity of results were immediately raised. The clients responding to these questions may have felt pressure to answer positively, in fear of losing their housing. Also recognized as a barrier in analysis, is that the majority of respondents in PSH programs have little to no basis of comparison when answering questions related to housing satisfaction/service satisfaction.

Discussion

Themes discussed reflect those prevalent in the survey results presented in chapter 4. Since the Permanent Supportive Housing Initiative was spawned through the adoption of a harm-reduction policy, Housing First, recognizing housing as a form of healthcare, it
is relevant that the results indicate the effectiveness of this strategy in both rural and urban environments. More specifically, and in agreement with existing literature, results found that PSH has had positive impacts on the perceived physical and mental health of residents, perceived frequency of substance and/or alcohol use among residents and lastly the perceived emotional health of residents.

Perceived frequency of substance/alcohol use of residents

In agreement with existing literature, this study found that permanent supportive housing has had a positive perceived impact on the substance/alcohol use of residents (Podymow et al. 2006). In a number of instances PSH programs have lead to the reduction of use in residents over time (Podymow et al. 2006; Padgett, Gulcur and Tsemberis 2006). Housing First was an approach crafted to recognize many homeless individuals are actively addicted to drugs and alcohol (Padgett, Gulcur and Tsemberis 2006), by offering stable housing first without requiring treatment adherence or sobriety, thus practicing harm reduction policies regarding substance use and consumer choice as a key operating principle (Tsemberis et al. 2004).

Survey results regarding frequency of substance/alcohol use of residents in the Apartments First program indicate perceived client levels of substance and/or alcohol use have steadily declined since starting the program. In the 2010 administration, however, clients reported they thought their frequency of substance/alcohol use higher than it was before beginning the program, loosely implying PSH through Apartments First has had a
negative effect on their health in this regard. As stated earlier, this is the only survey result that reflects a negative effect of housing on the perceived health status of clients.

A possible reason for the spike may be that the reporting scale confused respondents. Since themes regarding perceptions of substance/alcohol use generated through the data were measured on a 10-point scale different from the scale that is used to compare perceived current and past physical health, mental health and emotional health categories, respondents may not have paid close enough attention to notice the difference. Clients were asked to respond to questions regarding frequency of substance/alcohol use using a scale from 1-10, with 1 meaning “never” and 10 meaning “all day, every day.” Results expressed on Figure 4, thus, first appear to indicate an overall negative response to the perceived impact of substance/alcohol use in this program and that these clients are worse-off now (in 2010 evaluation period) than they reported before entering in the program. This relationship, however, actually expresses a positive impact housing has had on reducing perceived levels of substance use and/or alcohol use.

Taken over a four-year period, these results indicate a perceived reduction in average frequency of substance/alcohol use. This implies rural PSH has had a long-term effect on reducing the perceived substance/alcohol use of its residents. This is also an indication that, although residents continue to use alcohol and/or substances, they have still retained housing up to the point of the last reported study.

According to reviews of comparative trials and case series reports, Housing First reports, all centered on urban examples, document excellent housing retention, despite
the limited amount of data pertaining to homeless clients with active and severe addiction (Kertesz et al. 2009).

No studies have compared a Housing First with a non-Housing First approach for clients recruited on the basis of having severe addiction, although a case series from a Seattle housing program, known as 1811 Eastlake, published preliminary findings from seventy-five severe alcoholics who were permitted to drink in their rooms (Downtown Emergency Service Center 2008). The program's services included voluntary medical and chemical dependency treatment, and of the seventy-five entrants, fifty (66%) remained housed for a year. The clients were reported to have accrued $2.5 million less in public service expenditures compared with the year preceding admission, although a formal calculation of program and capital costs is not publicly available. The Seattle report, as well as reports from a Canadian shelter with on-site alcohol provided to refractory alcoholics (n= 17) (Podymow et al. 2006), suggests that some long-term refractory alcoholics can be housed and may even drink less if alcohol is permitted indoors in a secure setting.

Although survey results indicating that PSH has had a positive impact on perceived reduction in frequency of substance and/or alcohol use are compliant with results of similar studies with data gathered from urban models, there are significant limitations. Most literature/urban studies regarding substance use of the homeless while in PSH only measures alcohol habits, not broader topics of substance use. Based on what is available, survey results indicate PSH has helped reduce levels of alcohol use in the perceptions of residents, supporting the existing literature. There seems to be no
difference in the impact of PSH on residents’ substance/alcohol use in rural environments and in urban environments; both support the theory that housing is an effective form of health care, empowering tenants to work towards less substance use.

Perceived physical and mental health of residents

This study also found that permanent supportive housing has had a positive impact on the perceived physical and mental health of respondents in rural and urban areas alike. Results suggest a relationship between PSH and a perceived sense of mental and physical wellness of PSH residents. The best outcomes for housing stability were found for programs that combined housing and support (Kessell et al. 2006).

Survey respondents reported their overall perceived mental health has improved since being in housing through the Arcata House Apartments First program. Clients have generally perceived their mental health status since entering the program as much better than it was before becoming a program participant, with numbers reflecting a “below average - poor” status prior to program entry and an “above-average – great” status since entering the program. This suggests a perceived improvement in the lives of program participants when it comes to their mental health.

Apartments First clients have reported their overall perception of physical health has improved since being in the program as well. Though these numbers fluctuate slightly by year between 2007-2010, responses indicate the perceived current physical health status of individuals in the program is “average” to slightly “above-average.”
compared to a “below average” perceived physical health status before entering the
program

The Housing First and related permanent housing interventions reported in the
literature generally have supplied housing for persons whose primary problem is a non-
adiction psychiatric disorder (Kessell et al. 2006; Rosenheck et al. 2003; Tsemberis,
Gulcur and Nakae 2004). New York's ‘Pathways to Housing’ program in particular has
produced several studies demonstrating its success with severely mentally-ill clients
(Gulcur et al. 2003; Tsemberis and Eisenberg 2000; Tsemberis, Gulcur and Nakae 2004).

According to an analysis of eighty participants in Housing First programs,
including some from New York's ‘Pathways to Housing’ and two other programs
(Pearson et al. 2007), 91% carried a major psychiatric diagnosis, and nearly all received
federal disability benefits. Roughly half were judged by case managers to still be using
drugs or alcohol, although “severe impairment” from substance use was uncommon
(20%). Sixty-seven residents (84%) remained successfully housed for twelve months.

In addition to empirical evidence showing greater housing stability and choice
(Greenwood et al. 2005), PSH as applied through Housing First can assist in recovery
from substance abuse. This, in turn, can lay the groundwork for achieving the full
promise of mental health recovery.

The Housing First model aligns closely with the recovery movement that is
currently driving mental health reform in the United States (Anthony 1993; Deegan 1996;
SAMHSA 2002). It also provides a valuable example of how structuring services in
innovative ways enables recovery-oriented practices that include harm reduction
tolerance rather than abstinence enforcement. Without the rules and restrictions of mainstream programs, providers can genuinely engage with residents and respond to them individually instead of having to offer a “take it or leave it” proposition bundling temporary housing with services.

As found in this study, permanent supportive housing has had positive impacts on the perceived physical and mainly mental health of its residents in rural environments and urban environments with no decipherable difference in success as based on location.

Perceived emotional health of residents

Lastly, this study found that permanent supportive housing has had a positive impact on the emotional health/perceived levels of happiness of respondents. Results suggest a relationship between PSH and a heightened sense of happiness in PSH residents. Survey results representing the rural PSH model show a mean-average perceived emotional health rate of 81% since entering the housing compared to and a mean-average of 31% before entering housing. In 2010, the same respondents reported an 85% perceived sense of happiness, even higher than average. PSH has had a similarly effective impact on residents’ sense of happiness and emotional health in urban environments (Yanos, Barrow and Tsemberis 2004).

In response to questions about clients’ emotional health (sense of well-being and happiness), survey respondents reported significant improvement in their perceived status since being in the program. In 2010, clients rated their perceived emotional health at an average of 8.5, a near-excellent score. This number is closest to what clients rated their
current perceived emotional health in the 2007 survey administration, when the advent of housing was still fresh for program participants. Over a four year period of evaluation, scores also reflect the biggest yearly variances in clients’ self-evaluations, with a 50% margin of difference and best illustrates the perceived effect housing has on emotional wellness.

PSH literature illuminates these findings, as effective large-scale efforts aimed at therapy, training/education, social networking, or even life skills within these programs have seen a rise in clients’ self-reported levels of happiness (Rimmerman et al. 1992). Psychosocial rehabilitation services were positively related to the outcome of symptomology, therapeutic goals, and social integration. In another study, social supports were seen to have a direct buffering effect on the health and well-being of the client (Ogilvie 1997). Increases in the number of social supports led to decreases in symptoms, and shortened spans of illness and depression as reported by clients (Ogilvie 1997).

How clients feel about the services they are being offered or obtaining is of great importance to the success of their housing stability. HUD previously performed an evaluation of a program using a Housing First model. They reported that within the Housing First program housing, clients experienced month to month changes in levels of impairment but over 12 months no downward trends developed in terms of changes in psychiatric systems or drug and alcohol use (Pearson et al. 2007). They also found improvements in financial situations of the residents (Pearson et al. 2007). It was noted that income was increased and residents managed their money more successfully,
however, this was due to increases in entitlements and not employment (Pearson et al. 2007). Housing stability was the only real outcome the Housing First model shown in this report (Pearson et al. 2007). Nevertheless, these results reflect the satisfaction of program participants with services.

Permanent supportive housing, as represented in this thesis, has played a significant role in the perceived emotional health/happiness of these formerly homeless residents who live in rural settings, just as it had been reported in urban settings.

Conclusions

Much of the existing research on the impact of permanent supportive housing examines its impacts when applied in urban environments. The findings of this thesis mainly support the existing data on PSH outcomes in urban communities, showing a close relationship linking housing to health. In revisiting the research question – what are the impacts of PSH on rural communities, as compared to impacts of PSH on urban communities? – the biggest impact that PSH in rural communities as explored in the case study of Arcata House’s Apartments First program, is on its clients perception of health being improved since having housing. More specifically, respondents reported feeling an improved sense of physical health and mental health, a perceived reduction in substance and/or alcohol use and an improved sense of happiness. Research regarding PSH in urban environments indicates there is also a strong relationship linking housing to improved wellness. Overall how clients of the program perceive the impacts of PSH on
rural environments is quite similar to its reported impacts on urban environments.

The difference in models is primarily an issue of design. Since Housing First
PSH initiatives were piloted in urban environments that focused on a single-site design
mode, rural models have had to adapt by instituting a scatter-shot housing approach.
Scatter-shot designs in these environments only work if the agency of operation has a
strong relationship with local landlords. These agencies must lease out apartments
individually, and in an often-widespread landscape, without the luxury of leasing vacant
hotel buildings in more service-centered environments. For these very reasons they must
also offer outreach services to their clients, as to be able to get whatever services each
individual may require.

By uncovering that PSH as it exists in rural areas is a topic of study that has
largely been ignored in the literature, this thesis aimed to explore its impact, and whether
or not this is at all similar to the impact of PSH in urban areas. Results indicated a
similarity in perceived health outcomes. Although this is an important outcome of the
study, it does not necessarily answer the research question or support the claim that
Housing First has been effective in its approach to harm-reduction. This doesn’t suggest
that housing as an approach to ending chronic homelessness can’t work effectively in
urban and/or rural environments, but that these data tell us about how clients perceive
the impact of their services. Nothing more. The measures of client satisfaction with
different types of services can’t be interpreted as showing “impacts” or “effects” as the
narrative may suggest.

Although this was the first known study of its kind to attempt to measure the
perceived impact of permanent rural supportive housing as it relates to the impact of urban PSH, there are more limitations that must be addressed. Since early on in researching this topic it became clear literature pertaining to PSH in rural environments was scarce and outcome-oriented literature was non-existent, it is no surprise this study suffered several sample-size issues. There was a small sample of existing data pertaining to rural PSH efforts in the literature and a relatively small sample size of respondents in the survey study. This issue could not be remedied due to a lack of other local options; this agency was the only one of its kind in the community. To elaborate on this limitation, a four-year sample of survey data was analyzed. Results of this study, of course, must not be viewed as representative of rural PSH efforts in general. This study was never expected to yield profound results or add a significant contribution to the field of PSH research, but rather highlight the importance of exploring this topic further. The gap in research on rural PSH must be bridged as to inform best practices to the future efforts of non-profit agencies like the Arcata House.

Another limitation of study is related to the administration of the survey. Some surveys were administered with assistance from a staff member of The Arcata House, in cases where clients needed extra support either filling out the surveys due to poor writing proficiency or comprehension of the questions asked. In these situations where survey questions are read aloud to program clients, anonymity of the study was potentially compromised. Although the surveys were returned in unmarked sealed envelopes, they may have felt pressure to answer positively to all questions at the time the survey was being administered. For fear of losing housing or other services there may have been a
fear these survey would be used to evaluate client gratitude rather than client satisfaction. There were also fairly significant limitations related to the survey instrument itself. A major weakness of the survey is that demographic information was ignored completely. In this survey variables including “age,” “gender,” and “length of time in services” are completely ignored, unfortunately limiting the level of analysis when interpreting the data. In addition to excluding demographic information from this survey instrument, this survey clearly links the concepts of satisfaction and wellness to a vague understanding of the term “success.” While the Arcata House program measures their effectiveness based on the success of clients, there is no clear definition of “success” given. What is successful to one PSH agency may not be a success to another. Perhaps there are different measures of success to rural PSH programs when compared to urban PSH programs, but without first defining success research on the subject will always be incomplete. Defined measures of success may include “sustained tenancy,” “employment,” “education” or perhaps “overall wellness.”

This study can be replicated using different methods than those implemented in this thesis, such as in-depth interview research. It would be beneficial to see future studies continue to explore the contrast between urban and rural housing models to prove if outcomes really are that similar? The major outcome of this study is that residents in both urban and rural PSH programs have felt healthier since they began the program, but these results were indicative of perceived health status and not actual health status. With this, future studies should also deal with more complicated metrics than what was used in this study. Although it is important to the resiliency of program clients to feel healthier
now than they did prior to entering program, an exploration of objective measures of behavior could highly support the validity of this study. An example would be rather than measuring only perceived health of client, data could also be gathered that on objective information, such as the researcher checking hospital records of the client, tracing 911 calls to the house and exploring a client’s police records. In depth interviews could also be conducted with program staff, front-line workers from different agencies, neighbors and other experts who are not the clients themselves.

In the time since primary research was conducted on this thesis, homeless policies and advocacy efforts have continued to have major impacts on both rural and urban communities. Recently in Humboldt County, where the Arcata House and other rural homeless and housing services operate, there has been an effort to occupy Eureka’s Palco Marsh. Recently a group of homeless individuals organized to form the Palco 11 – a group of marsh residents attempting to sue the city in Federal Court for wrongful eviction. The city so far is offering to relocate these individuals into shipping crates in Eureka harbor as an alternative, making these efforts geared toward eliminating the sight of homelessness to residents but not doing anything to improve the lives of the homeless.

As examples of indignity and discrimination continue to homeless communities who live in all environments, the need to promote housing as healthcare is as important now as ever. In this case, shipping crates are not viable alternatives. Continuing to research the positive impacts of PSH in both rural and urban communities brings us closer to a public understanding that housing as healthcare is an effective approach in
addressing the needs of homeless individuals and families.

For the purposes of this study, the implementation of somewhat basic measures seemed both appropriate and necessary to lay the groundwork for future research. Within this framework, results show that PSH has been perceived as beneficial to the health of program residents in both urban and rural settings. This outcome was achieved in part through an exploratory approach, first generating a complex literature review related to homelessness, as it has existed in the US over the last century. The contents of this literature review comprise the contents of Chapter 2, identifying main themes (inc. criminalization, deinstitutionalization, media coverage) and conclusions that point toward housing as a possible solution to homelessness. This literature also introduces the concepts of harm-reduction and Housing First initiatives. In Chapter 3, these concepts are further investigated, as are characteristics of differences in design and implementation based on issues of location. Both rural and urban models are explored, with urban centered options carrying far more weight in research breadth. To address this lack of detail, a survey analysis was conducted, with findings explored in Chapter 4, and broader results discussed in Chapter 5.

What was discovered is that PSH has helped formerly homeless individuals feel healthier than they did while they lived on the street or in shelters, and that this is true no matter where you are.


Corporation for Supportive Housing—Southern New England. 2004. “Building successful relationships between service providers and property managers in
scattered site supportive housing.” New York: Corporation for Supportive Housing.


Podymow, Tina, Jeff Turnbull, Doug Coyle, Elizabeth Yetisir and George Wells. 2006. “Shelter-Based Managed Alcohol Administration to Chronically Homeless People Addicted to Alcohol.” *Canadian Medical Association Journal* 174: 45–49.


Substance Abuse and Mental Health Services Administration. 2002. “Supported housing study.” Center for Mental Health Services, Homeless Programs Branch, Rockville, MD.


Appendix A: Placement Activities

The mission of Apartments First is closely linked with personal interests of seeking effective ways of providing people who are disabled and homeless with the support they need to secure and keep permanent housing. The Apartments First program believes that social services that enhance individual and family well-being can be more effective when people are in their own home. This sentiment reflects the goals embedded in the Housing First model, centering on the provision of housing on an immediate basis and adding services when needed.

The goal of this project placement with the Arcata House was to use research skills as an applied sociologist to assist Arcata House in documenting the success of their Apartments First program. Involvement would both seek to highlight the progress the program has made over the last several years and serve as a record that the program could use for its own advancement in receiving future grants. Placement in The Arcata House’s Apartments First program serves to be the heart of this thesis, which will be grounded and developed through my personal involvement working with the program.

Community Meetings

In order to develop a well-rounded understanding and perspective of homelessness and help satisfy placement hours, Humboldt Housing and Homeless Coalition (HHHC) meetings connected experience in this placement to larger conversations and group efforts in Arcata. Attending HHHC meetings shed new light on
community sentiment of local homelessness work, drawing themes to my on-site experiences with the Arcata House. Seven meetings were attended during the time period of this placement.

Film Showing

Among the first activities was to accommodate two screenings of the documentary film “The Empress Hotel,” which stands as a strong example of how the permanent supportive housing model can be successfully applied to communities in need. The film provides a rich history of the Empress Hotel through chronicling the experiences of its clients.

First Viewing

The first screening of the film took place at the Hotel Arcata. The purpose of this specific screening would be to raise awareness of homelessness and educate the local community to the concepts of supportive housing and harm reduction. This experience helped raise awareness of The Arcata House in the local community as well, strengthening relations with businesses and nearby residents.

Former Empress Hotel Executive Manager turned filmmaker Roberta Goodman traveled from San Francisco to host the film showing and answer questions of her experience working in an SRO.
Second Viewing

The second screening of the film would be held on campus in Humboldt State University’s BSS Building. This was a personal suggestion to the Arcata House administration after seeing another opportunity to screen the film. This intern accommodated this showing with HSU administration and advertised the film with flyers in weeks leading up to the showing.

Roberta Goodman once again lent support, leading a discussion and brief question and answer dialogue following the screening.

Data Collection from Charts/Records

When initially being introduced into The Arcata House, it was decided as part of the placement fulfillment, a chart audit of services would be conducted and analyzed to support research findings as well as satisfy a grant requirement to program stakeholders. Between 2007 and 2008, in consultation with the Program Evaluator, the Executive Director developed a set of 14 Program Objectives (Attachment C) and an abstracting tool facilitates collection of client-related data that can be used to evaluate Program Objectives 1 through 14. The data has since been collected periodically and is used to evaluate progress toward the stated Program Objectives.

While performing the annual chart audit, further research was garnered necessary for statistical significance. It was decided survey research would be conducted to strengthen this study.
Appendix B: Apartments First 2011 Survey Instrument

HMIS # ___  ___  ___

Dear Friends,

Apartments First, Humboldt County’s first permanent supportive housing project, is over five years old. We appreciate your willingness to participate in the program.

We want to make sure we are on the right track and are hoping you will be willing to share your experiences with us. Please complete the following survey and mail it back to our evaluator in the enclosed envelope, or you can put it in the envelope and give it to the evaluator. The information you provide in this survey will be kept completely confidential and there are no right or wrong answers.

When we receive your survey, the evaluator will send you a gift certificate for Safeway. Thank you for helping us!

How long have you been in Apartments First!? ________________

Did you fill out this survey in the summer of 2009?  Please check: ☐yes  ☐no

About the Apartments First Program and the services you receive

1. The services I receive through the program are just what I need. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>(5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. The staff is doing a good job of gathering most of the information they need to help me. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. The staff explains what they want me to do. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. I understand what the program/staff wants me to do. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

5. I get all of the services I need to stay housed. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

6. The staff keeps me informed so I don’t have to worry about things. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

Please provide any additional comments:

**About your experiences with the program**

1. Do you like being in the program? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

2. Are you getting the kind of help that you feel you need? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

3. Do you feel like you can maintain housing without case management?

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

4. Do you think the program has improved your life? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>
### About your life in general

1. Are you happy with your apartment? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

2. Do you think you would like to continue living where you are for a long time? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

3. Do you think you are doing better with money than you did before you were housed? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

4. Are you enjoying the activities you do? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

5. Do you think you have enough time to relax and enjoy life? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

6. Do you enjoy television and/or radio? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

7. Do you enjoy the time you spend with other people? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

8. Do you spend as much time as you would like with other people? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>
9. If you live with members of your family or significant others, do you spend enough time with them? Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

Please provide any additional comments:

### About your health

1. Overall, my health is good. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

2. I am able to get medical care when I need it. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

3. I am able to get dental care when I need it. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

4. Using alcohol and other drugs affects my life in a negative way. Please circle one:

<table>
<thead>
<tr>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Neutral</th>
<th>Not very often</th>
<th>Never</th>
</tr>
</thead>
</table>

Please provide any additional comments:

On the questions that follow, 1 is the lowest (my health is terrible) and 10 is the highest (I am very healthy)

1. **Today** I think that my physical health is …

<table>
<thead>
<tr>
<th>1 Terrible</th>
<th>2 Not great</th>
<th>3 Not too bad</th>
<th>4 Neutral</th>
<th>5 Fair</th>
<th>6 Good</th>
<th>7 Very good</th>
<th>8 Great</th>
<th>9 Very good</th>
<th>10 Great</th>
</tr>
</thead>
</table>
2. **Before I started the program** my physical health was …

<table>
<thead>
<tr>
<th></th>
<th>1 Terrible</th>
<th>2 Not great</th>
<th>3 Not too bad</th>
<th>4 Neutral</th>
<th>5 Fair</th>
<th>6 Good</th>
<th>7 Very good</th>
<th>8 Great</th>
<th>10 Very good</th>
<th>10 Great</th>
</tr>
</thead>
</table>

3. **Today** my mental health is …

<table>
<thead>
<tr>
<th></th>
<th>1 Terrible</th>
<th>2 Not great</th>
<th>3 Not too bad</th>
<th>4 Neutral</th>
<th>5 Fair</th>
<th>6 Good</th>
<th>7 Very good</th>
<th>8 Great</th>
<th>10 Very good</th>
<th>10 Great</th>
</tr>
</thead>
</table>

4. **Before I started the program** my mental health was …

<table>
<thead>
<tr>
<th></th>
<th>1 Terrible</th>
<th>2 Not great</th>
<th>3 Not too bad</th>
<th>4 Neutral</th>
<th>5 Fair</th>
<th>6 Good</th>
<th>7 Very good</th>
<th>8 Great</th>
<th>10 Very good</th>
<th>10 Great</th>
</tr>
</thead>
</table>

5. **Today** my frequency of using alcohol and other drugs is …

<table>
<thead>
<tr>
<th></th>
<th>1 (most) All day every day</th>
<th>2 Daily</th>
<th>3. two to three times per week</th>
<th>4 Neutral</th>
<th>5 Two to three times a month</th>
<th>6 Only on special occasions</th>
<th>8 Never</th>
<th>9 Very good</th>
<th>10 Great</th>
</tr>
</thead>
</table>

6. **Before I started the program** my frequency of using alcohol and other drugs was …

<table>
<thead>
<tr>
<th></th>
<th>1 (most) All day every day</th>
<th>2 Daily</th>
<th>3. two to three times per week</th>
<th>4 Neutral</th>
<th>5 Two to three times a month</th>
<th>6 Only on special occasions</th>
<th>8 Never</th>
<th>9 Very good</th>
<th>10 Great</th>
</tr>
</thead>
</table>
7. **Today** my life is …

<table>
<thead>
<tr>
<th>1</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Not great</td>
</tr>
<tr>
<td>3</td>
<td>Not too bad</td>
</tr>
<tr>
<td>4</td>
<td>Neutral</td>
</tr>
<tr>
<td>5</td>
<td>Fair</td>
</tr>
<tr>
<td>6</td>
<td>Good</td>
</tr>
<tr>
<td>7</td>
<td>Very good</td>
</tr>
<tr>
<td>8</td>
<td>Great</td>
</tr>
</tbody>
</table>

8. **Before I started in the program**, my life was …

<table>
<thead>
<tr>
<th>1</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Not great</td>
</tr>
<tr>
<td>3</td>
<td>Not too bad</td>
</tr>
<tr>
<td>4</td>
<td>Neutral</td>
</tr>
<tr>
<td>5</td>
<td>Fair</td>
</tr>
<tr>
<td>6</td>
<td>Good</td>
</tr>
<tr>
<td>7</td>
<td>Very good</td>
</tr>
<tr>
<td>8</td>
<td>Great</td>
</tr>
</tbody>
</table>

9. How many times **in the past year** have you gone to the hospital emergency room?

____________________

10. **In the past year**, have you experienced any of the following?

- [ ] Mental Health Issues
- [ ] Substance Abuse
- [ ] Chronic Health Issues
- [ ] Been in Debt
- [ ] Had Involvement with Child Welfare Services (CWS)
- [ ] Had Involvement with Adult Welfare Services (AWS)
- [ ] Been Evicted
- [ ] Traumatic Life Event
- [ ] Institutional Care
- [ ] Neglect

Please check all that apply.
Appendix C: Arcata House Apartments First! Program Objectives

Objective 1: Each client will receive at least one encounter each week with the Care Coordinator.

Objective 2: Each adult client will receive a complete bio/psycho/social assessment.

Objective 3: Clients will receive benefits counseling.

Objective 4: Clients enrolled in mainstream benefits.

Objective 5: At the start of the program the clients will have a Primary Care Provider.

Objective 6: Clients will sustain their relationships with Primary Care Provider.

Objective 7: The majority of clients will rate their health status as improved at 1 year post admission.

Objective 8: Clients will be assessed for mental health and/or counseling services at the beginning of program. Clients will receive mental health services on an ongoing basis if needed.

Objective 9: Clients will be assessed for substance abuse treatment at the beginning of program. Clients will receive substance abuse treatment on an ongoing basis if needed.

Objective 10: Clients will self-report an assessment of their own health status in client interview.

Objective 11: Each client will receive at least one encounter each week with the Housing Specialist.
**Objective 12:** Each client will be assessed for legal issues and referred to the appropriate legal services, if needed.

**Objective 13:** Each client will be assessed for credit/debit issues and will be referred to the appropriate credit services, if needed.

**Objective 14:** Each client will engage in meaningful daytime activities at least two days a week.
Appendix D: A Brief History of the Arcata House

The Arcata house was founded in 1991 by a group of citizens concerned about the local homeless epidemic. Their goal was to provide transitional housing and to educate the community about homelessness. Before that time the only transitional shelter in Arcata had been a short-lived project that had used a donated trailer in a downtown parking lot. After six months of operation, that project was closed in the spring of 1989, but at the same time the Arcata City Council committed to seeking a more viable shelter program.

A single family home was located by the city and purchased in January of 1992. Arcata House was incorporated as a California Nonprofit Public Benefit Corporation that same year and has been providing transitional housing to homeless families and individuals ever since. The initial residence was able to house up to six people at a time.

With the help of grant funds through the City of Arcata, a second home in the North Town section of Arcata was purchased and renovated between 1995 and 1996, allowing Arcata House to double the number of homeless people housed to twelve. In 2000, ongoing structural and flooding problems at the original house led to a decision to instead purchase and renovate a larger home in better condition located on Janes Road. In 2001, Arcata House purchased the old Eagles Hall in downtown Arcata and completed its reconstruction into a six bedroom, handicapped accessible residence plus office headquarters.
In 2005, with funding from the Emergency Housing Assistance Program, the North Town house was renovated with the installation of thermal windows, new doors, smoke alarms and remodeling the bathroom.

To be eligible to apply for federal funding, a community must bring all stakeholders together in an ongoing organization that develops a Continuum of Care plan to end homelessness and analyzes and prioritizes local service needs. In March 2004, Arcata House convened an all-day conference of local stakeholders interested in the issues of housing and homelessness. From that meeting a new group, the Humboldt Housing and Homeless Coalition (HHHC), was formed. Arcata House has been and continues to be an active participant in the Coalition.

With the HHHC in place, the Arcata community was able to apply and receive federal HUD funding to begin the Apartments First Program, a direct response to the federal government’s goal of getting chronically homeless people off the streets. Arcata House took an innovative approach to this goal by providing permanent supportive housing at sites scattered throughout the community. This approach has proved to very successful in helping the homeless re-integrate into the community. Arcata House continues to take an active role in the countywide process of planning and developing services for homeless people. The Arcata House was responsible for organizing the first Housing Conference and served on Arcata’s Homeless Services Plan Task Force.