

Housing First in the Encampment Project

A Progress Report

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I. Introduction

The “Encampment Elimination Project” (hereafter simply the Encampment Project) in Tacoma coupled the removal of homeless individuals from multiple encampments in the city with the placement of some of these individuals into apartments following the Housing First approach. The research presented in this report is largely based on interviews with those placed into the Housing First program.

In summary, our main findings are the following.¹ Our research has found that most individuals experienced improvements in all measured dimensions of well-being and social support. Using self-report data we found reductions in the use of the emergency room and increases in the use of other healthcare services. We found reductions in both criminal victimizations and arrests. We also found that drug and alcohol use has changed little as compared to the levels during homelessness. The most troubling finding has been the high rate of evictions of clients by two of the three agencies involved in the project. The cause of this is left as a question for future research.

II. The Housing First Approach

Elements of the Housing First Model

There is no single model of Housing First. However, variations of this approach have been implemented by agencies across the country. The ideal Housing First model includes several components.² Consumers are placed into housing alone, with a partner, or with a few other roommates of their choosing. Placements are made in scattered sites throughout the community in order to promote social integration. Housing is protected in times of emergency, hospitalization, or inpatient treatment. The program utilizes a harm reduction model whereby housing is not contingent upon abstinence, enrollment in a treatment program, or a decrease in clinical symptoms. Case managers help clients to develop their own personalized goals using a motivational interviewing technique, a “client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence.”³ Rehabilitation programs are available and pursued only at the will of the individual. The program generally has two requirements: (1) if residents have income or benefits they must pay a percentage of their rent - usually 30% of their income and (2) they must meet with caseworkers twice a month.

The success of this new model has brought about a paradigm shift in the approach to coping with chronic homelessness – “Housing First” programs are replacing the traditional Continuum of Care in many cities across the United States. The Continuum of

¹ The first author wishes to acknowledge the important contributions of his research assistants, Allison Beller (co-author) and Ryanne Filbey, seniors at the University of Puget Sound. The project greatly benefited from their insights and efforts.

² Tsemberis, Sam and Sara Asmussen. 1999. “From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model.” *Alcoholism Treatment Quarterly* 17(2):113.

³ Motivational Interviewing Organization. 2007. “Motivational Interviewing Page.” Retrieved August 24, 2007. *Motivational Interviewing Organization*. (<http://www.motivationalinterview.org/>)

Care approach is recommended by the U.S. Department of Housing and Urban Development and remains the standard care for treatment of the homeless in most large cities in the United States.⁴ In this model treatment and rehabilitation are seen as a process whereby an individual travels up the hierarchal Continuum of Care which is set up by a patchwork collection of various service providers. Individuals are taken from the streets and put into a shelter or transitional housing where they undergo various treatment programs and classes to prepare them for labor and housing markets. They graduate the Continuum of Care when a service provider deems the individual “housing ready.” Any housing is contingent upon abstinence and enrollment in treatment programs to improve clinical status. At any point if an individual relapses, they start over at the bottom of the continuum. The goal of this approach is to teach the individual the skills they need to live independently before they are placed into housing. In contrast, the Housing First model is built on the assumption that “homeless adults need transitional and permanent housing in order to develop the daily living skills they either lost or never had.”⁵

Housing First in Other Localities

The above is Housing First in its ideal form. This model closely resembles the Pathways to Housing Program developed by Sam Tsemberis and implemented in New York City. Several studies have produced findings which suggest Pathways to Housing has been a success.

A longitudinal, experimental study compared New York’s Pathways to Housing with the Continuum of Care. The experimental consumer choice model resulted in 78% of participants living in stable housing after 2 years while only 38% of the participants in the control condition remained in housing. Researchers conclude that this study demonstrates that the harm reduction approach is effective. Tsemberis argues that one important feature of the Pathways program is that, upon initial contact with caseworker, clients are offered housing; this “fused several of the continuum steps - outreach, engagement, and housing – into a single desirable invitation.”⁶

One recent longitudinal experiment compared the Housing First model with the traditional Continuum of Care approach to rehabilitating homeless individuals with co-occurring disorders (mental health problems and chemical dependency). Findings indicate that “at the study’s end at 48 months, Housing First clients were stably housed 75% of the time during the previous 6 months compared to 50% of the time for treatment

⁴ U.S. Department of Housing and Urban Development: Community Planning and Development. 2007. “Homeless Assistance Programs.” *U.S. Department of Housing and Urban Development*. Retrieved August 25, 2007. (<http://www.hud.gov/offices/cpd/homeless/programs/index.cfm>)

⁵ Greenwood, Ronni Michelle, Nicole Schaefer-McDaniel, Gary Winkel, and Sam J. Tsemberis. 2007. “Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness.” *American Journal of Community Psychology* 35(3/4): 223.

⁶ Tsemberis Sam, L Moran, M Shinn, Sara Asmussen, and D Shern. 2003. “Consumer Preference Programs For Homeless Individuals with Psychiatric Disabilities: A Drop-in Center and a Supported Housing Program.” *American Journal of Community Psychology*. 32(4): 305-317.

first clients.”⁷ Reported drug use remained constant throughout the two year study and there were no differences in drug use between the experimental (Housing First) group and the control group.

One explanation for the success of the Housing First model is the consumer choice element: residents determine the kind of treatment they need. Sam Tsemberis and his colleagues examined data regarding personal choice from the same study described above. Results indicate that those in Housing First “perceived their choices to be more numerous than did participants in the control condition” and their perceptions tended to be more stable over time.⁸ This finding was true for control groups as well as the experimental group, but residents in the experimental group tended to have higher levels of perceived choice.

Increased choice was associated with better mental health in another study. Findings indicate there was “strong and inverse relationship between perceived choice and psychiatric symptoms.”⁹ The Continuum of Care model is built on the assumption that poor choices lead to homelessness and psychological problems. Thus this approach is focused on tightly regulating and monitoring the behavior of individuals. Researchers argue that “the results of this study challenge this assumption and suggest that, at least in part, a lack of personal control and choice, rather than too much of it is associated with the experience of psychiatric symptoms.”¹⁰ Researchers concluded that this evidence would support the consumer choice delivery system utilized by the Housing First program.

The Housing First model has been replicated and successfully implemented in other cities. In 2003 the Colorado Coalition for the Homeless created the Denver Housing First Collaborative. Findings indicate that this federally funded Housing First program was a success.¹¹ The program led to decreased social service use among individuals. On average, researchers found a 34% decrease in ER visits, an 80% decrease in inpatient nights, an 82% decrease in detoxification visits, and 84% decrease in the number of days of incarceration. The average resident’s income was increased from \$185 to \$431 per month. It is projected that these improvements equal \$31,545 in savings per person. Taking into consideration the cost of running the program, a net cost savings of \$4,745 per person is estimated. Perhaps the most important finding is that 64% percent of residents reported an improvement in their quality of life and more than half have

⁷ Padgett, Deborah K., Leyla Gulcur and Sam Tsemberis. 2006. "Housing First Services for People Who Are Homeless with Co-Occurring Serious Mental Illness and Substance Abuse." *Research on Social Work Practice*, 2006, 16, 1, Jan 16(1):74-83.

⁸ Tsemberis, Sam, Leyla Gulcur and Maria Nakae. 2004. "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis." *American Journal of Public Health* 94(4): 651-656.

⁹ Greenwood, Ronni Michelle, Nicole Schaefer-McDaniel, Gary Winkel, and Sam J. Tsemberis. 2005. "Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness." *American Journal of Community Psychology* 35(3/4): 224.

¹⁰ Ibid.

¹¹ Perlman, Jennifer and John Parvensky. 2006. "Denver Housing First Collaborative: Cost Benefits Analysis and Program Outcomes Report." *Colorado Coalition for the Homeless* December 11.

improved their health. Residential stability rates are equally as impressive: over 80% maintained housing for 6 months at the point in which the study was conducted.

A National Alliance to End Homelessness report states that San Francisco's Housing First program housed over 900 people in 2005. This large-scale program reports even higher cost savings. Social services cost the city \$61,000 each year for incarceration and hospitalization of each chronically homeless individual while permanent supportive housing costs only \$16,000 per year with a net savings of \$45,000 per year per person.¹²

In July of 2007 HUD reported the outcomes of a year long exploratory study on several Housing First programs which achieved different rates of housing stability.¹³ Clients were grouped into three categories, (1) "stayers" were clients that remained housed for a full 12 months with no disruption, (2) "intermittent stayers" were enrolled the entire 12 months but spent at least one night in another living environment and (3) "leavers" were disenrolled from the program in the first 12 months. Residents in Pathways to Housing in New York demonstrated the highest rates of housing stability with 62% stayers, and 31% intermittent stayers, compared to residents enrolled in a DESC Housing First program in Seattle of which 40% of residents were stayers and 40% were intermittent stayers. REACH, a San Diego housing program with some sobriety and treatment requirements, experienced much lower rates of housing stability with only 28% stayers, 54% intermittent stayers, and 21% leavers. Researchers conclude that "serving this population requires a long-term commitment to providing housing assistance ... while the housing provided by the programs increased housing stability and afforded the opportunity to receive treatment, substantial progress toward recovery and self-sufficiency often takes years."¹⁴

Housing First in the Encampment Project

The Housing First aspect of the Encampment Project was originally allocated over \$1 million, with the City of Tacoma contributing the single largest share of approximately \$500,000, for the housing of up to 100 persons. The administration of the housing was awarded to three agencies in Pierce County: Metropolitan Development Council, Greater Lakes Mental Health, and the Tacoma Rescue Mission.

Individuals in the encampments were contacted by members of the PATH team, who made offers of housing pending approval by a landlord or apartment manager. Those who expressed an interest in housing provided the information needed for a criminal background check with the assistance of the PATH members. This Housing First model relied upon the private housing market, that is, no publicly-owned housing was used for the placement of any individual removed from the encampments. Private landlords

¹² National Alliance to End Homelessness. 2005. "Community Snapshot: San Francisco July 2005. *National Alliance to End Homelessness*. Retrieved August 15, 2007.

http://www.endhomelessness.org/files/942_file_naeh_sanfrancisco_july05.pdf

¹³ U.S. Department of Housing and Urban Development Office of Policy Development. 2007. "The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness: Final Report." *U.S. Department of Housing and Urban Development*.

¹⁴ *Ibid.*, p. xxvii

reviewed the criminal records of the prospective tenants and had the right of refusal. Those accepted by the landlords were contacted by the PATH team and placed into their apartments after signing the lease. All (or nearly all) of the apartment units were located in Lakewood.

III. Research Methods

The primary source of data comes from multiple interviews with the Housing First residents. To date, most of the continuing residents have been interviewed two times. The initial round of the first wave of interviews occurred in February and March, 2007 although more recent entrants to the program have been interviewed since that time. A second wave of interviews occurred in the summer of 2007 for residents who have been housed at least six months. A third wave is scheduled for early 2008 for residents who have been housed at least one year. First and second wave interviews will also continue for new entrants and for those who have reached the six-month mark, respectively.

Each meeting consisted of a structured schedule of questions along with an open-ended interview, lasting about one hour. The structured questions asked about the respondent's background, physical and mental health, personal satisfaction and well-being, feelings of social support, satisfaction with the Housing First program, and contact with the criminal justice system. The open-ended questions followed up on several of these issues and explored in more detail the respondent's biography.

Thirty-nine residents in the Housing First apartments have been administered the first wave interview. A total of 58 individuals have, at one time, been housed by the program. The difference between the total number and the number interviewed is explained by two factors: Some individuals had already left the program prior to scheduling an interview and some individuals did not wish to participate.

Of the 39 wave 1 participants, 18 have been given the wave 2 interview. The difference here is largely explained by departure from the housing program of many residents in the interim and secondarily by the fact that the newer entrants have not reached six months of housing. No individuals were intentionally omitted from the study. That is, researchers intended (and still intend) to interview all residents who remain in the program and who agree to participate.

IV. Findings

Description of the Residents

Table 1 presents various characteristics of the participants. The table provides the data for both wave 1 and wave 2, which includes only those who were interviewed in the first wave and who have been housed for at least six months.

Table 1. Characteristics of the Encampment/Housing First Population.

		Wave 1 n=39	Wave 2 n=18
Sex	Male	61.5%	77.8%
	Female	38.5%	22.2%
Race	White	64.1%	72.2%
	Black	20.5%	22.2%
	Hispanic	5.1%	0.0%
	Native American	5.1%	0.0%
	Other/No Response	5.1%	5.6%
Median Residency in Pierce County		15.0 yrs.	20.5 yrs.
Mean Years of Schooling		11.7	11.9
Military Service		25.6%	38.9%
Chronically Homeless		92.1%	83.3%

The majority of the participants were men and white. Table 1 shows that most Housing First participants were long-term residents of Pierce County, with a mean length of residency of 15 years at wave 1. Approximately one-quarter of the original participants have served in some branch of the military.

The Department of Housing and Urban Development uses the following definition:

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. To be considered chronically homeless a person must have been on the streets or in an emergency shelter (i.e., not transitional housing) during these stays.¹⁵

Table 1 shows that over 90% of wave 1 participants satisfied the time requirements to be considered chronically homeless (the disabling criterion is not as easily assessed but will be considered next).

As discussed in the previous section, each meeting with the participants included a structured set of interview questions and an open-ended or semi-structured interview. These interviews were recorded so that the conversations could later be analyzed. Using the discussion of the participants' personal biographies from the open-ended interviews, researchers attempted to identify the presence or absence of various events or states prior to the participants' homelessness that might, at least in part, help to account for the

¹⁵ U.S. Department of Housing and Urban Development. 2007. "The Annual Homeless Assessment Report to Congress." p. v.

homelessness. Table 2 gives the rates at which researchers were able to identify these elements.

Table 2. Possible Causes of Homelessness Discussed in Personal Histories.

Possible Homelessness Factor	Rate of Occurrence n=39
Drug/Alcohol Abuse	76.9%
Mental Illness	64.1%
Layoff/Job Loss	35.9%
Divorce/Separation	33.3%
Abused as Child	30.8%
Physical Illness	25.6%
Crime/Incarceration	20.5%
Domestic Abuse	15.4%

Care must be taken in the interpretation of these results. As these discussions were only loosely structured, the participants were under no obligation to share anything about their pasts. The absence of any discussion of a topic does not necessarily indicate that it was truly absent. Thus the true rates of occurrence are probably higher than those presented here. The alternative bias – speaking about issues that were not actually present – seems much less plausible in this case.

We see very high rates of substance abuse and mental illness, as well as other difficulties in the biographies of the participants. Given the high rates, many of the residents reported multiple issues. We also note that the extent to which these possible factors were indeed true causes is probably unknowable, but it is no doubt true that many participants were disadvantaged by their prior experiences. To convey a sense of these interviews and the coding issues involved, the following quotes come from three of the participants, and reveal issues of drug use, crime/incarceration, mental illness, and child abuse:

They don't prepare you enough for society when you come out [of prison]. It's easier to get out and sell drugs and use drugs, steal and manipulate than to focus on a job when you are shot down all the time over your felony. It's much easier to get back into the same pattern without the proper support system.

Our family was very dysfunctional. My mother was very angry, not violent towards the kids but violent in her actions. There was probably some mental illness there. Some of my bi-polar disorder is from my family ... [My father] was a very heavy pedophile and he went for my sister more than any of the kids. He drank. He was very violent, physically and he had a way of making you feel very low with the verbal abuse and when I was seventeen I ran away

from home ... I met a man who pretty much tore my life apart because of his lifestyle and within two months he had taken \$6,000 of my savings. Within two months I had fallen apart emotionally and just gave up.

I actually dropped out in seventh grade. Then got a conviction as a juvenile ... My mother was an addict. She died when I was fifteen while I was in juvi. I went into a foster home. That's when I got my GED and had a job. Then my addiction caused me to do something crazy and I got locked back up. When I turned 18 the state cut me off and I was in the streets. I came to Washington getting high one night and I've been here ever since... fifteen years.

Effects of Housing First on Residents

The most important potential impact of any Housing First program is simply the maintenance of housing (i.e., prevention of homelessness) for its participants. Table 3 provides the rates of housing maintenance according to each agency. The most striking result is the extreme range across retention rates. MDC has successfully kept over 90% of their caseload in housing while Greater Lakes retained approximately one-quarter of their clients. Given the priority of housing stability as a criterion by which to judge the program, the variation in performance becomes an important question for policy-makers. The authors, in fact, are currently exploring this issue and hope to offer an explanation in a subsequent report.

Table 3. Caseload and Retention by Agency.

	Metropolitan Development Council	Greater Lakes Mental Health	Tacoma Rescue Mission*
Total Client	24	18	16
Current Clients	22	5	9
Number Evicted/ Removed	2	12	7
Retention Rate	91.7%	27.8%	56.3%

*The entire remaining caseload of the Rescue Mission was transferred to Metropolitan Development Council. The "Current Participants" value (9) reflects the number at the time of the transfer (July 2007).

Stable housing is predicted to have beneficial effects on various aspects in the lives of the participants. One way to consider the health of the participants is to examine visits to healthcare providers. We measured both visits to the emergency room as well as non-emergency visits to a doctor. An improvement for both the resident and for the public would be a decrease in E.R. visits and an increase in other healthcare appointments.

Table 4 presents the mean and median number of visits to the emergency room and to other healthcare providers both while homeless and while housed. In wave 1 the respondents estimated the number of visits during their last year of homelessness. In wave 2, respondents were only asked to estimate the number of visits during the last six months, as residents had been housed only between six and nine months. To adjust, the values presented for wave 2 in the table are twice the values actually reported.

Table 4. Participant Visits to Emergency Room and Other Healthcare Visits.

	During Homelessness (Total) n=39	During Homelessness (Continuing) n=18	While Housed n=18	Change from Homeless to Housed
	Mean	Mean	Mean	Mean
Emergency Room Visits	3.65	2.47	1.33	-1.14
Other Healthcare Visits	10.59	11.92	14.33	2.41
	Median	Median	Median	Median
Emergency Room Visits	2.0	2.0	0	-2.0
Other Healthcare Visits	2.0	2.5	9.0	6.5

The changes are in a beneficial direction both for the residents and for the healthcare system. Mean E.R. visits decreased by 1.14 while median visits decreased by 2. Visits to other doctors or healthcare providers increased by 2.41 for the mean and 6.5 for the median.

It is important to recognize that these are self-reported figures and that the respondents may not have accurately remembered the number of visits. We are seeking external data, especially from the local hospitals, to corroborate the self-reported figure and hope to have it in the wave 3 report in spring 2008.¹⁶

Stable housing is also predicted to affect both criminal offending and victimization. A reduction in criminal offending was clearly one of the goals behind the elimination of the homeless encampments. Less politically pressing, but likely just as serious, is the amount of crime perpetrated against the homeless. The interviews found large reductions in both.

A majority of the participants reported being victimized at least once during their last year of homelessness before entering the Housing First program. Focusing on the continuing participants, Table 5 shows that only 38.9% were not victimized in the last year of homelessness and this increased to 83.3% while in Housing First. These figures

¹⁶ Researchers are currently in the process of seeking formal consent from the participants to review their health records.

are not directly comparable, however, because residents have only been housed for 6-9 months while the homeless period was 12 months. We should again note that these are self-reported figures and what the respondent defined as victimization may not be treated as so by the criminal justice system (thus there is some reason to treat skeptically the report of 20 victimizations by a respondent). Additionally, almost all of these incidents were not reported to the police. Nonetheless, the researchers are confident that the majority of residents feel more secure and indeed are safer in the program.

Table 5. Frequency Distribution of Victimization while Homeless and Housed.

Number of Victimization	Homeless		Housed	
	Frequency	Percent	Frequency	Percent
0	7	38.9	15	83.3
1	6	33.3	1	5.6
2	2	11.1	1	5.6
3	1	5.6	0	0.0
4	1	5.6	0	0.0
5	1	5.6	0	0.0
20	0	0.0	1	5.6
Total	18	100.0	18	100.0

Table 6 shows the self-reported rates of arrests, again while homeless and housed.¹⁷ While homeless, 50% of the participants were not arrested and this increased to nearly 90% during the first 6-9 months of housing. Only two residents reported being arrested, and these were single incidents. Of course, there is a possible selection bias issue in that many of the evictions were related to criminal actions by the residents. It is difficult at this stage to determine whether housing reduces criminality or whether those who were most likely to offend were removed from the program. The official criminal records by the police department may help to answer this question.

¹⁷ Researchers have placed a request for the criminal records of the participants with the Tacoma Police Department. At the time of writing this request had not yet been completed. We hope to include these data in the wave 3 report in 2008.

Table 6. Frequency Distribution of Arrests while Homeless and Housed.

Number of Times Arrested	Homeless		Housed	
	Frequency	Percent	Frequency	Percent
0	9	50.0	16	88.9
1	5	27.8	2	11.1
2	2	11.1	0	0.0
3	1	5.6	0	0.0
No Response	1	5.6	0	0.0
Total	18	100.0	18	100.0

Residents also answered several sets of questions intended to measure their levels of personal satisfaction. In the first set, the question was “How _____ did you feel?” where the blank was replaced with the following terms: safe, lonely, happy, depressed, hopeful, angry, and tired. The respondents selected a number between one and five where one meant “not at all” three meant “somewhat” and five meant “extremely.” In the first wave interview the time period referenced was the last few weeks of homelessness; in the wave two interview the period was the last few weeks (and all had been housed for at least six months).

Table 7 shows the results of these questions. The first column of data shows the total sample, including many who have left the program and some who are not yet past six months in the program. The second column shows only those who were also interviewed in wave 2. The final column shows the difference between the second and third columns (column 3 – column 2). This reflects the comparison in well-being of the period of homelessness to that of housing in the program.

Table 7. Changes in Well-Being from Homeless to Housed (Scale 1).

	Mean while Homeless (Total) n=39	Mean while Homeless (Continuing) n=18	Mean while Housed (Wave 2) n=18	Mean Change from Homeless to Housed
Safe	2.82	2.83	4.22	1.39
Happy	2.27	2.22	3.28	1.06
Hope	2.74	2.56	3.44	0.88
Depressed	3.79	4.11	2.78	-1.33
Lonely	3.27	3.31	2.72	-0.59
Angry	3.28	3.33	2.89	-0.44
Tired	3.67	3.61	3.17	-0.44

All of the indicators of well-being are improvements. For example, while homeless the average level of safety was 2.83, meaning less than “somewhat.” It increased by 1.39 points to 4.22, where 5 means “extremely” safe. “Happy” and “Hopeful” also increased.

The decreases over time in the remaining categories – depression, loneliness, anger, and tiredness – are also improvements because each of these is a negative characteristic.

A second set of questions on well-being was asked during both waves of interviews, permitting another way to evaluate the effects of housing on the residents. The respondents were asked to assess the frequency of their agreement to the following statements:

- I felt calm and relaxed.
- I felt cheerful and in good spirits.
- My daily life was filled with things that interested me.
- I woke up feeling fresh and rested.
- I felt active and vigorous.

The possible responses were: “All of the time,” “Most of the time,” “More than half of the time,” “Less than half of the time,” “Some of the time,” and “At no time.” The responses were coded such that “At no time” equaled one and “All of the time” equaled six. The results are presented in Table 8.

Table 8. Changes in Well-Being from Homeless to Housed (Scale 2).

	Mean while Homeless (Total) n=39	Mean while Homeless (Continuing) n=18	Mean while Housed (Wave 2) n=18	Mean Change from Homeless to Housed
Calm and Relaxed	2.44	2.22	3.22	1.00
Cheerful	2.73	2.61	3.33	0.72
Daily Life Interesting	2.13	1.78	2.22	0.44
Woke up Rested	2.36	2.17	2.56	0.39
Active and Vigorous	2.79	2.50	2.86	0.36

Again all of the changes over time were beneficial. The largest improvement occurred with the statement, “I felt calm and relaxed,” increasing from just over “some of the time” to over “more than half of the time.”

In addition to these questions on personal well-being, we also used a set of questions to measure social support. Social support was measured by the frequency in which the respondent had someone who was connected to them in some way. The questions were the following:

- How often did you have someone to take you to the doctor when you needed to go? (Doctor)
- How often did you have someone who showed you love and affection? (Show Love)
- How often did you have someone to help you with your daily chores if you were sick? (Chores)

- How often did you have someone to turn to for suggestions about how to deal with a personal problem? (Suggestions)
- How often did you have someone to confide in or talk about yourself or your problems? (Confide)
- How often did you have someone to get together with for relaxation? (Relaxation)
- How often did you have someone to love and make you feel wanted? (To Love)

A one through five numerical coding was used for the responses: “None of the time,” “A little of the time,” “Some of the time,” “Most of the time,” and “All of the time.” The results are found in Table 9.

Table 9. Changes in Social Support from Homeless to Housed.

	Mean while Homeless (Total) n=39	Mean while Homeless (Continuing) n=18	Mean while Housed (Wave 2) n=18	Mean Change from Homeless to Housed
Doctor	1.59	1.33	2.11	0.78
Showed Love	2.90	2.78	3.28	0.50
Chores	2.33	2.56	2.83	0.27
Suggestions	2.72	2.94	3.17	0.23
Confide	2.90	3.00	3.22	0.22
Relaxation	2.74	2.78	3.00	0.22
To Love	2.69	2.89	3.06	0.17

As with the measures of individual well-being, all dimensions of social support were beneficial, although generally smaller in magnitude than those for well-being. The measures of well-being and support in tables 7-9 were attitudinal, reflecting respondents’ perceptions about their own lives. In a consumer choice model the beliefs and feelings of the participants are of great importance, in contrast to a more traditional model, which focuses on behavioral changes. Nonetheless, we might still be interested in program participation and substance use, considered next.

A tenet of Housing First is to provide, but not mandate, services, especially substance abuse and mental health treatment. We are therefore interested in the extent to which services have been provided by the agencies and utilized by the residents. Table 10 shows the rates at which respondents participated in programs over the month prior to the wave 2 interview. One-third of the residents participated in some form of substance abuse treatment. The rates of participation for other programs are much lower. Residents were also asked whether they knew that programs were available to them. Table 10 shows that the majority was aware of the availability of substance abuse and mental health programs suggesting that low rates of participation are individual choices. On the other hand, only around one-third believed that educational or vocational programs were available.

Table 10. Program Participation and Beliefs about Availability.

Program Type	Participated		Belief about Program Availability		
	Yes	No	Available	Not Available	Don't Know
Substance Abuse	6 33.3%	12 66.7%	15 83.3%	1 5.6%	2 11.1%
Mental Health	2 11.1%	16 88.9%	15 83.3%	0 0.0%	3 16.7%
Educational	1 5.6%	17 94.4%	7 38.9%	4 22.2%	7 38.9%
Vocational	0 0.0%	18 100.0%	6 33.3%	2 11.1%	10 55.6%

The nature of the availability of programs should be clarified. The Encampment Elimination Project was not allocated any revenue for programming, requiring first that participants secure benefits, typically through the Washington State Department of Social and Health Services (DSHS), for this purpose. Thus the first step toward putting a participant who has expressed an interest into a program is to apply for benefits. This process is generally cumbersome and time-consuming and, furthermore, not all participants are granted benefits. Given these barriers to placement into programming, the “Housing First” approach in Pierce County falls short of a genuine Housing First model.

Although it is not a criterion by which Housing First models should be judged, researchers asked the residents about their use of alcohol and other drugs. Table 11 shows that the use of alcohol was fairly constant when comparing the last year of homelessness to the most recent six months of housing. Not shown in the table is the fact that the quantity consumed by the most frequent drinkers had decreased. Respondents were asked how many drinks they typically consumed when they did drink. For those who reported drinking “3 to 5 times a week” or “every day or almost every day” the mean number of drinks while homeless was 4.7 and while housed was 3.5

Table 11. Frequency of Alcohol Consumption while Homeless and Housed.

	Homeless		Housed	
	Frequency	Percent	Frequency	Percent
Never in the recent period (year/6 months)	4	22.2	3	16.7
one time to once per month	6	33.3	5	27.8
1 to 3 times in a month	1	5.6	2	11.1
Once or twice a week	0	0.0	3	16.7
3 to 5 times a week	4	22.2	1	5.6
Every day or almost every day	3	16.7	3	16.7
Missing/No Response	0	0.0	1	5.6
Total	18	100.0	18	100.0

Table 12 shows that illegal drug use is also quite similar during the two periods, although the rate of those who reported to have completely abstained increased from one-third to one-half. Again, the limitations of self-report data clearly apply to this question.

Table 12. Frequency of Illegal Drug Use while Homeless and Housed.

	Homeless		Housed	
	Frequency	Percent	Frequency	Percent
Never in the recent period (year/6 months)	6	33.3	9	50.0
one time to once per month	4	22.2	3	16.7
1 to 3 times in a month	1	5.6	1	5.6
Once or twice a week	3	16.7	2	11.1
3 to 5 times a week	2	11.1	1	5.6
Every day or almost every day	2	11.1	1	5.6
Missing/No Response	0	0.0	1	5.6
Total	18	100.0	18	100.0

Satisfaction with Housing First

Regardless of the rate of participation in other services or in changes in drug or alcohol use, housing itself is the most significant improvement and most residents rate the Housing First project highly. Residents were asked to rate their satisfaction for 5 aspects of the project and the overall program on a 0-10 scale, where 0 was most unsatisfied and 10 most satisfied. The five aspects were (1) case managers, (2) physical aspects, like the heating and plumbing, (3) the ability to maintain social relationships, (4) the location, and (5) any transportation assistance. Table 13 provides the results.

Table 13. Participant Satisfaction with the Housing First Program on a 0-10 scale.

Housing First Element	Mean Satisfaction n=18
Case Managers	9.06
Physical Aspects	8.50
Social Relationships	6.33
Location	6.11
Transportation Asst.	5.78
Program Overall	9.03

Clients were very satisfied with the case managers and the apartments, and the program overall. According to the residents, the worst aspects of the program involve the location and transportation. Many residents spoke about the difficulties in changing their lifestyle when placed in neighborhoods with high crime and drug use. Even more prevalent was the problem with transportation. There are actually two problems here. First, residents are not given a monthly pass and instead are given individual passes on an as-needed basis by the case managers for reasons like doctor’s appointments. Second, the bus routes from certain parts of Lakewood to downtown Tacoma, where many appointments are located, run infrequently. Additionally, a number of residents mentioned that the trip is so long that transfers expire before they reach downtown.

To supplement the quantitative ranking of satisfaction, respondents were also asked to speak in their own words about the impact of Housing First on their lives. The following quotes are taken from the semi-structured interviews in the second wave:

There are drugs everywhere but you have a different outlook. You care about yourself. It matters to you if you’re passed out or strung out, you have a place to shower. It didn’t matter before you just sat and got high and passed out and covered up with a blanket and you were going to wake up that same way anyway. Now I can wake up with a shower and a new outlook and some direction. That gives me hope. It gives you hope to be able to have a place of your own.

The future is a lot brighter now - just having a home base to start from. When they did the emergency surgeries I was on the street. While I was waiting for approval for surgery I was in a wheelchair. I couldn’t get anywhere because I couldn’t walk at all. Food was scarce. It was tough. Having a home base provides a lot of the necessities people need to start over.

Basically it’s given me a peace of mind and a safe environment. It’s given me a chance to think about what I need to do to remedy the situation that I’m in. Before I can deal with other people I need to deal with myself ... I thank God for the chance that he has

provided for me to get my mind right. Me and my daughter have a better relationship.

As tough as it's been, [the case managers] have just stood right by me. And they have seen that emotional bi-polar side of me too and still stuck by me, knowing there is hope for me. And sometimes when you're out there on the street you feel like there isn't any hope, there is nobody. The apartment has been a big sense of security and belonging and responsibility.

It's given myself an opportunity to further enhance my life just because the housing is there. You do have a base and the base is not a tent. The base is an apartment therefore your opportunity is increased. The potential is there. I have a few other personal problems that need to be squared away and eventually, shortly I would hope ... things will change ... Without the program I would still be in the same situation ... If you're still homeless your attitude, your mental state is completely different.

We have our freedom to decorate and of course it's safe. It's well heated. ... just knowing you have a place to go home to helps you feel more positive about doing things ... It gives me something to be proud of.

If something like this was available while we had our children, the means for adoption would not have had to been made and I would still be with my children.

I thought that the homelessness was going to carry me through until I died.

V. Conclusion

The subtitle of this paper is meant in several ways. Firstly, a progress report is offered in the middle of a term, before all the evidence is in, leaving time for things to change as new data are gathered. The wave 3 report in spring 2008 will not only include new interviews with those who have been in the program for at least one year but will also include a larger number who have passed 6 months and will thus strengthen the findings reached here. Yet despite the small sample size and limited amount of time, we are beginning to see some patterns in the data.

Secondly, this report finds evidence that *progress* has occurred in the lives of the participants. Across many dimensions, the residents report improvements in their well being. Furthermore the self-report data indicate a reduction in emergency room visits and the number of arrests. Certainly the participants are highly satisfied with the overall

Housing First program. As of now, however, insufficient time has elapsed and an insufficient number of clients have been interviewed to make overly strong claims.

Finally, after an artless beginning, the institutional structure for the project is becoming more effective and stable. Many apartments were not filled. Many clients were evicted; only one of the three agencies contracted to provide housing had an acceptable retention rate, based upon Housing First models in other places around the country. Recent institutional changes will likely improve the outcomes over the next six months.

Based upon the evidence to date there are good reasons to continue Housing First in the Encampment Project. Researchers are continuing to track the residents over time so as to achieve greater confidence in the findings reported here. Additionally, we are expanding our investigation in several ways. First, we are in the process of obtaining data from the police and hospitals regarding arrests and emergency room visits, respectively. Second, due to the extreme variation in client retention reported in table 3, we are examining the organizations involved in administering the project. It is important to distinguish between the institutional failures to fill all the units and to keep clients in the units, and the beneficial effects, discussed in this report, on those who have been stably housed.