1-1-2011

Outcomes, adaptations and performance: a local evaluation of shelter plus care

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OUTCOMES, ADAPTATIONS AND PERFORMANCE: A LOCAL EVALUATION OF SHELTER PLUS CARE

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THESIS

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

MASTER OF SOCIAL WORK

2011

MAJOR: SOCIAL WORK

Approved by:

_____

Advisor Date

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Chapter 1: Introduction
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Homelessness is a persistent and pervasive social problem that has substantial negative implication on urban and rural communities across the United States. Few structural or material belongings can impact the human experience more so than a home, therefore, having access to one's own home is a conversation about human rights, equity and personal fulfillment (Padgett, 2007; Padgett, Gulcer & Tsemberis, 2006; Van Wormer & Van Wormer, 2009). People experiencing homelessness are acutely disadvantaged; they face complex struggles to earn a steady income, locate safe shelter, and attend to other primary needs. (Noee & Patterson, 2010). There is a vast body of literature linking psychological risk factors and consequences associated with episodes of homelessness (Baynard & Graham-Bermann, 1998; Barber, 1994; Burt & Cohen, 1993; Calsyn & Roades, 2006).

This study approaches homelessness from a biopsychosocial framework that combines individual and structural factors to better understand pathways to homelessness. This work proceeds as follows. First, the study reviews prominent studies that explore risk factors for homelessness. Next, the study analyzes the abysmal consequences that homelessness can have on individuals.

To begin, the risk factors associated with individual episodes of homelessness are interlaced with the consequences that result from a state of homeless. Nooe and Patterson (2010) craft an ecological mapping of

biopsychosocial risk factors that illustrates the pathways leading to homelessness and explores individual and social consequences that result from such episodes of homelessness. The author's suggest (2010), "homelessness can be understood as the result on interactions among risk factors ranging from individual conditions to socio-economic structures and environmental circumstances" (p. 105). Shelton, Taylor, Bonner, and van den Bree (2009) found that among young adult males experiencing homelessness, risk factors were related to early childhood experiences within dysfunctional families, poverty, and breached relationships with parents or caregivers. Michigan's Campaign to End Homelessness (2007) identified "loss of family support systems, lack of income, debt, lack of employment or underemployment, disabilities, and a lack of affordable housing" as major factors leading to homelessness.

By employing an ecological perspective to explain the risk factors and consequences associated with homelessness, Nooe and Patterson (2010) dismiss the dichotomous argument of individual vs. structural causes. Instead, a subset of authors and researchers include individual and social factors in a biopsychosocial interplay of risk factors and outcomes associated with homelessness (2010; Baynar & Graham-Bermann, 1998; Barber, 1994; Burt & Cohen, 1993; Calsyn & Roades, 2006). As Nooe and Patterson explain, "The concept underscores the complexity of interactions on different systems levels and encourages analysis of homelessness as resulting from individual and family

risks or vulnerability within a social context" (pg. 107). Chart 1 below "Nooe & Patterson: Biopsychosocial Risk Factors for Episodes of Homelessness – Structural" outlines the fundamental structural risk factors associated with homelessness as defined by Nooe and Patterson.

Table 1: Nooe & Patterson: Biopsychosocial Risk Factors for Episodes of Homelessness – Structural

Nooe & Patterson: Biopsychosocial Risk Factors for Episodes of Homelessness - Structural		
Structural	**Poverty**	*Limited resources reduce the likelihood that individuals and families can afford housing.*
	Underemployment/ Unemployment	*Part-time or Full-time work providing insufficient wages increases the likelihood that individuals and families will be unable to maintain housing.*
	Welfare Reform	*Reduced Public Benefits limit available resouces to pay for housing.*
	Shortage of Affordable Rental Housing	*The demand for affordable housing units exceeds the supply, leaving many with housing costs that exceed their means.*
	Housing Instability	*Lack of income and supportive housing; housing discrimination are risk factors for homelessness.*
	Discrimination	*Women and minorities face lower wages and other discriminatory practices that increase the risk of homelessness.*
	Deinstitutionalization	*Over 16% of single adults experiencing homelessness suffer from Serious Mental Illness.*
	Healthcare costs	*Healthcare costs for those without insurance can reduce available resources to pay for housing.*

Chart 1 developed by author from content presented by Nooe & Patterson, 2010.

Factors that lead to homelessness cannot be reduced to simple, singular explanations. The chart provided below - "Nooe and Patterson: Biopsychosocial Risk Factors for Episodes of Homelessness – Structural" -outlines the comprehensive individual risk factors associated with homelessness as defined by Nooe and Patterson. Nooe and Patterson astutely point out the complexity of risk factors as well as their complex interactions which compound and increase the likelihood of homelessness (2010). A clear understanding of the ecological

complexities of homelessness provides the policy community, administrators and direct service providers with the tools to craft and implement policies and programs that effectively respond to the unmet needs of people experiencing homelessness and help diminish homelessness across the country.

Table 2: Nooe & Patterson: Biopsychosocial Risk Factors for Episodes of Homelessness – Individual

Nooe & Patterson: Biopsychosocial Risk Factors for Episodes of Homelessness - Individual		
Individual	**Age**	*Age is a risk factor for both children and people over 50 years of age.*
	Marital Status	*48% of homeless individuals have never been married.*
	Social Support	*People who experience homelessness tend to have lower levels of social support and elevated levels of relationship conflict (when compared to non-homeless groups).*
	Foster Care	*History of foster care is highly correlated with increased episodes of homelessness.*
	Family Conflict & Violence	*Particularly among homeless youth, family conflict is commonly linked to the onset of homeless episodes.*
	Sexual Abuse	*Childhood sexual abuse is a risk factor for adult homelessness.*
	Maltreatment	*Maltreatment includes sexual, physical, and emotional abuse; neglect family conflict, and an inability to cope with trauma.*
	Incarceration	*Incarceration for people with limited resources and social support can result in isolation from family and community, therefore reducing the likelihood of reintegrating into the community.*
	Mental Illness	*Severe and persistent mental illness increases the difficulty associated with accessing resources and poses additional challenges to the cognitive tools necessary to achieve and maintain employment and housing.*
	Domestic Violence	*Domestic Violence is a primary risk factor for homelessness, particularly among women and children.*
	Health Status	*Medical problems often increase the risk of homelessness.*
	Education	*Poor education is a risk factor for homelessness.*
	Military Service	*An average of 41% of homeless men are veterans.*
	Substance Abuse	*Persistent heavy substance abuse is cited as a major risk factor for homelessness.*
	Minority Status	*Minorities are more likely to be poor and at greater risk for homelessness.*

**Chart developed from content presented by Nooe & Patterson, 2010.*

Furthermore, the solution to ending homelessness must incorporate a response to the individual and structural challenges that commonly lead to loss of housing (Michigan's Campaign to End Homelessness, 2007). In particular, the individual and social consequences of homelessness present significant barriers to individuals' reentry into mainstream community living (Padgett, 2007). These

repercussions can include emotional, psychological, physical and relational distress.

On any given night, about 643,067 people experience homelessness across the nation; an estimated half is mentally ill (The National Alliance to End Homelessness, 2009). Nooe and Patterson (2010) emphasize the danger and stress that homelessness causes for the mentally ill; it can promote additional mental trauma and compromise an already fragile state of health. In fact, the stressors associated with homelessness can aggravate existing disorders and generate new disorders previously undetected (The National Alliance to End Homelessness, 2009). Additional negative effects of homelessness include –but are not limited to – social isolation, substance abuse, sexual abuse, criminal activity, criminal victimization, and suicidal ideation (Caton, Dominguez, Schanzer, Hasin & Shrout, 2004). Moreover, people experiencing homelessness typically have limited access to shelter and accommodations that support good hygiene. Thus, a minor medical problem, in combination with a lack of medical care, can easily become a major medical matter (Nooe & Padgett, 2010) and even result in loss of skill, impaired health, damaged self-confidence and self-esteem, feelings of loneliness, and isolation (2010; Federal Task Force on Homelessness and Severe Mental Illness, 1992).

Over the course of 2008, over 85,000 people in Michigan experienced homelessness at least once (MSHDA, 2009). In Detroit, the homeless crisis is

staggering. In 2009, Detroit led the nation with the highest concentration of homelessness per capita; close to twenty thousand people were homeless in the City, and for every 10,000 residents, over two hundred had been homeless at least one time that year (HAND 2010; The United States Conference of Mayors, 2009). Given this severe problem, social work practitioners, service providers and the community have a social responsibility to practice due diligence and work more effectively to identify ways to improve permanent supportive housing programs.

Despite increased efforts to reduce homelessness in Detroit, service provision has been limited by reduced discretionary funding, fragmented funding streams and disjointed services. As a result, the homeless service sector has been unable to reduce homelessness. Between 2008 and 2009 in Detroit, the rate of homelessness increased by an estimated 11%. Only four other cities in the United States documented an increase in homelessness at a rate over 10% (The United States Conference of Mayors, 2009).[1] The soaring incidence of homelessness continues to stress mainstream and specialized service providers in the City of Detroit. Without an assigned city government office to oversee homeless issues for the City, the non-profit service sector must fill the gaps.

A multilayered response to this enduring problem has resulted in strategic plans to end homelessness at the national, state and local levels. In 2010, the national strategic plan, *Opening Doors,* was developed by the United States

[1] These cities include Charlotte, NC, Charleston, SC, Norfolk, VA and Nashville, TN.

Interagency Council on Homelessness (USICH) with the goal of eradicating homelessness in the United States by 2020 (USICH, 2010). The Michigan State Housing Development Authority (MSHDA) drafted a statewide plan to end homelessness in Michigan (Michigan Coalition Against Homelessness, 2010); concurrently, the Homeless Action Network of Detroit (HAND) developed its local plan to respond to concentrated city-wide needs in Detroit (HAND, 2010). These state and local plans to end homelessness rely heavily on federal funding designated to provide housing and support services to individuals experiencing homelessness.

Shelter Plus Care it is one of six housing programs outlined by *Opening Doors; it* combines support services with permanent housing. Moreover, it is one of two programs designed to provide long-term housing solutions to homeless persons with disabilities (USICH, 2010). In addition, since Shelter Plus Care is not defined by regulations that restrict the eligibility of these hard-to serve consumers, it is reportedly the most comprehensive program designed to meet the needs of 'hard-to-serve' consumers, including individuals with serious mental illness (SMI), chronic problems with alcohol and/or drugs and acquired immunodeficiency syndrome (AIDS) or related diseases. Consumers in the program are provided individualized attention and extensive support services when transitioning into housing such as an individualized care plan overseen by a case manager, substance abuse and mental health treatment (HUD, 2009). As one of few programs designed to provide permanent supportive housing to

extremely vulnerable homeless groups, the effectiveness and reach of this program may have important implications for the goal of eradicating homelessness by 2020.

Research Question and Approach

In order to determine the factors that impede or facilitate Shelter Plus Care's capacity to reduce homelessness in Detroit, this study conducts an exploratory program evaluation of Shelter Plus Care in Detroit, Michigan. The fundamental research question guiding the thesis is whether Shelter Plus Care effectively reduced the incidence of homelessness. To answer this research question, the researcher investigated whether the number of consumers serviced by the program could be increased. Moreover, the study investigates whether organizations are reproducing the program in accordance with programmatic goals outlined by HUD. Thus, the research examines the implementation of Shelter Plus Care among six Detroit-based organizations that execute the program in order to determine whether there are variations in service delivery and program provision. Subsequently, the study also explores whether these variations are correlated with discrepancies in consumer outcomes between agencies. Finally, the researcher explores the limitations faced by organizations seeking to expand the program by providing additional housing units and helping to house more people.

To achieve the research objectives, the researcher analyzed survey responses, focus group feedback and aggregate data from the Homeless

Management Information System (HMIS). In particular, the study analyzed responses and reports from case managers and administrators in each of the six Detroit organizations that implement Shelter Plus Care.[2] Twenty-four respondents completed the survey and an additional four participants provided individual reports of their experience with Shelter Plus Care from administrative and case management perspectives in a focus group.

Findings

Based on the exploratory research, the researcher concludes that the Shelter Plus Care program is achieving several of its main objectives that correspond to specific guidelines outlined by HUD. According to HMIS data, the program's introduction of a permanent supportive housing intervention is correlated with increased housing stability. Put differently, the intervention seems to improve the length of time consumers remain in housing. In particular, the program appears to increase housing stability for hard-to serve consumers, improves their self-sufficiency, and helps them acquire income. In some instances, individuals in the program have advanced to housing alternatives with fewer support services suggesting increased self-sufficiency. Furthermore, the data suggests very little variation in service delivery and organizational success rates among the six organizations that implement Shelter Plus Care in Detroit.

However, housing needs for individuals with severe mental illness and ongoing substance abuse problems exceeds the units supplied by the six

[2] Due to limited data and financial restrictions, a rigorous impact analysis of the program effect is beyond the scope of this study (see Chapter 3).

organizations. Originally, the researcher predicted that organizations were unable to increase the supply of Shelter Plus Care units due to funding limitations and an insufficient supply of Fair Market Rents (FMRs) in Detroit. Indeed, limited funding seems to play a significant role in the limited supply of Shelter Plus Care units; however, respondents reported that Detroit has a sufficient supply of FMRs priced at a rate deemed affordable by HUD based on the regional cost of living.[3]

Accordingly, the findings highlight several aspects of the program theory and implementation guidelines that prevent the program from serving the maximum number of participants. In particular, the program requires that funding be channeled through an additional state or county entity equipped to oversee mental health programs, compared to similar programs that do not require a 'sponsor'. In Michigan, the Michigan Department of Community Health (MDCH) and Wayne County Community Mental Health (WCCMH) serve as sponsors for Shelter Plus Care grantees.

Additionally, an absence of funding for case managers results in limited staff time to care for consumers with challenging needs. Without funding to staff case-managers, organizations utilize flexible dollars from other sources to provide services required by Shelter Plus Care guidelines. Participants report that the product of this programmatic limitation is limited staff; this leads to high staff turnover, overburdened case managers and reduces the quality of care for consumers.

[3] HUD requires monthly unit rentals for Shelter Plus Care match the Fair Market Rents established for Detroit.

Finally, HUD developed vague guidelines to give organizations the flexibility to meet their community's specific needs. Because of the overwhelming number of individuals in Detroit meeting the general Shelter Plus Care eligibility guidelines, it is difficult for organizations to select consumers for the program and deny others given the absence of explicit standardized eligibility guidelines. Study participants suggest more restrictive eligibility requirements may help organizations select consumers that HUD deems most appropriate for the program.

Research Contribution

This study contributes to the Social Work literature on the supply side of housing and homeless service provision. To date, Shelter Plus Care has failed to attract the attention of independent evaluators. This results in a lack of industry knowledge about the program in Detroit, along with a failure to investigate policy-relevant and practice-relevant issues influencing programmatic delivery for persons with severe mental illness and chronic substance abuse problems (Padgett et al, 2006) Hence, this research identifies ways to improve the impact of the program. Moreover, there remains a tremendous gap between the experience of policy-makers and front-line workers that can only be filled through conscientious investigation and information sharing.

Consequently, this research adds to the conversation regarding the effectiveness of permanent supportive housing programs. The study contributes a front-line, ground level perspective of Shelter Plus Care for people shaping

policy and developing programmatic guidelines; future researchers can build on the findings of this study to generate a more rigorous research design that will be better suited to test the impact of Shelter Plus Care. Based on the research findings, several innovative and pragmatic recommendations are developed to help increase the capacity of Shelter Plus Care, thereby reducing the occurrence of homelessness in the city of Detroit.

Roadmap

Chapter 2 briefly outlines the history of strategic programs to end homelessness and presents relevant background information on Shelter Plus Care. It also lays out the research hypotheses regarding the influence of the program. Chapter 3 describes the research methods employed to evaluate the program. The chapter also discusses the strengths and limitations of the research design. Chapter 4 presents the research findings and examines the successes and failures of the Shelter Plus Care program. It identifies and discusses challenges to the ability of implementing organizations to produce the desired outcomes, as well as obstacles to securing housing units. Chapter 5 explores the implications of the research. The researcher identifies and recommends several direct and efficient pathways for increasing the supply of Shelter Plus Care housing units in Detroit.

Chapter 2: Background & Problem Analysis

This chapter begins by discussing the importance of housing stability. Next, it moves into a discussion and comparison of the two primary service delivery models/plans to end homelessness, generally referred to as the treatment first and housing first models. The models explain the divergence in thought behind two distinct approaches utilized to care for individuals experiencing homelessness. Particular attention is paid to the theoretical forces driving each service approach. Understanding the foundational elements of treatment first and housing first models will help to determine a method that can best assist city, state and national objectives to end homelessness. Finally, the chapter moves to a specific discussion of the Shelter Plus Care service delivery model, which follows a Housing First theoretical approach.

The Importance of Housing Stability

Research suggests a relationship between housing, and physical and psychological wellbeing, while also providing a protective structure from inclement weather and danger (Shaw, 2004). Padgett identifies the psychological benefits housing provides when identified as 'home'; this sense of home is correlated with a feeling of self-determination, comfort in daily routines, privacy and agency to construct an identity, and a safe space to reduce harmful behavior (Padgett, 2007). The authors of *Opening Doors,* the federal plan to end homelessness, referred to one's home as "an essential platform for human and community development." The authors maintain, "Stable housing is the

foundation upon which people build their lives" (USICH, 2010).

Consequently, living without a home produces great uncertainty and substantial threats to physical and psychological wellbeing (USICH, 2010). As Nooe and Patterson illustrate, the individual and social impacts of homelessness are devastating. Stigmatization and blame potentially represent the most negative individual psychological consequences associated with homelessness. These challenges add hopelessness to the physical and psychological hardships associated with episodes of homelessness. Rejected and stereotyped by other community members, the homeless population suffers disproportionately from acts of violence and is more likely than housed individuals to participate in "survival-sex," or the trade of sex for money to pay for food, shelter and other basic needs (2010; Caton, C. L., Dominguez, B., Schanzer, B., Hasin, D. S., Shrout, P. E., et al., 2004)

In addition to the negative outcomes homelessness has on individuals, homelessness has a direct impact on communities. Untreated mental illness, in conjunction with substance abuse, community rejection, and an absence of social support, can result in desperate behavior. A study conducted in 2008 by Greenberg and Rosenheck discovered that homeless inmates are more likely to be charged with a violent offense. These results do not imply that persons experiencing homelessness are more prone to violent crime. Instead, they suggest that criminal behavior is likely the consequence and manifestation of unmet needs that may reduce public safety.

Intervention Models

The early 1980s marked the start of an uphill battle to end urban homelessness in the United States. Despite substantial funding directed toward services for the homeless population, service providers only managed the problem and failed to find a sustainable solution to end homelessness (Padgett, 2007). Unable to reduce the incidence of homelessness, a small number of homeless services providers, such as Pathways to Housing in New York, began examining and implementing housing first delivery models.

Treatment First Model

Treatment first was the dominate service delivery model of the 1980s and 1990s. As the name suggests, treatment first models generally require the fulfillment of substance abuse treatment and psychiatric rehabilitation requirements prior to consumer access to housing. The approach is based upon the notion that people experiencing homelessness should reach a pre-determined state of "readiness" before receiving access to housing. Nevertheless, scholars argue that this assumption fails to recognize the important role played by a safe place in various types of recovery (Padgett, Gulcer & Tsemberis, 2006; Van Wormer & Van Wormer, 2009).

Treatment first requires that consumers abide by an established set of rules and regulations designed by the organization; hence participants must comply with a predetermined treatment model. Gaining access to housing and

support services is contingent upon treatment compliance (Padgett, et al., 2006). Consumers in a treatment first program are required to abstain from drug and alcohol use, obey strict curfews, and/or observe limited visitation rights when living in a shelter or a transitional housing facility. Thus, consumers can be denied access to housing until they meet behavioral standards outlined by programmatic goals (Padgett, et. al., 2006; Van Wormer, & Van Wormer, 2009; Padgett, 2007). Again, treatment plans vary and are often designed by a case-manager or follow general treatment plans outlined by an organization. Regardless of the institution designing and implementing the treatment plan, the consumer is typically unable to access housing until he or she demonstrates a certain level of capacity to comply with the plan (2006; Van Wormer & Van Wormer).

For those consumers who adhere to the behavioral requirements, additional demands must be met prior to receiving housing. In particular, consumers move through multiple temporary housing placements, beginning with a drop-in shelter where they are provided a cot or chair, typically with access to meals and a washroom. The next stage of housing is often supervised dormitory-type housing followed by a shared room in a supervised group home. To advance into housing with fewer controls, consumers must exhibit readiness or sobriety, appropriate behavioral modifications and adherence to curfews enforced by housing supervisors (Van Wormer & Van Wormer, 2009; Padgett, et.

al., 2006; Padgett, 2007). An inability to adhere to such guidelines is punishable by expulsion from the program.

Opposition to the Treatment First Model

Strict regulations imposed by this model, in addition to the lack of privacy and self-determination associated with temporary housing placement, result in high expulsion rates, high attrition and countless cases in which consumers are reluctant to go to emergency shelters (Padgett, 2007). Treatment first presents particularly complex hurdles for individuals with serious mental illness (SMI) and for those with chronic alcohol or drug-use problems (Padgett et al, 2006; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003).

Recognition of the unmet needs of this "hard-to-serve" sub-population motivated the development of a new consumer-centered approach to homeless services. Pathways to Housing, a New York non-profit, took the lead by re-tooling housing program guidelines and by re-defining priorities and successful outcome measures. The new "housing first" model sought to abolish the ladder of activities required for housing privileges in treatment first programs (Padgett et al, 2006; Gulcur, et al, 2003).

Housing First Model

In contrast to treatment first, the primary programmatic objective of the housing first model is to connect individuals with housing. The philosophical core of housing first is based on the belief that consumer self-determination is integral to improving individual outcomes (Gulcer, et al, 2003). Weeks, months, and

even years of homelessness can contribute to feelings of helplessness and worthlessness. By including consumers with severe disabilities in treatment planning, the model seeks to actively engage participants and encourage ownership of the recovery process (HUD, 2009; Padgett, 2007; Van Wormer & Van Wormer, 2009).

Housing First and Harm Reduction

A significant number of homeless people have mental illness and co-occurring substance related disorders. Housing First addresses the needs of these individuals by helping to reduce risk-taking behavior through "harm reduction" interventions instead of forcing consumers to stop the behavior entirely (Marlatt & Tapert, 1993). Such interventions may include educating individuals about the damaging consequences of drug-use, encouraging less frequent use, and helping people increase healthy behaviors. Long-term goals may include eliminating drug-use altogether, but harm reduction interventions provide positive reinforcements to consumers who reduce drug use and increase healthy behavior (HUD, 2009; Padgett, et. al., 2006). The primary goal is to alleviate the social, legal and medical consequence associated with uncontrolled addiction and substance use (Van Wormer & Davis, 2008). When coupled with housing, harm reduction provides individuals with SMI and drug addiction the flexibility to gradually reduce dangerous behaviors in a private home environment with appropriate and helpful support services.

Opposition to the Housing First Model

The housing first model is not without opposition. Conservative backlash has coined housing first as a 'bunks for drunks' program (Van Wormer & Van Wormer, 2009). The primary criticisms come from elected officials seeking to eliminate funding for programs that serve the "undeserving" poor (2009). Opponents to programs rooted in the housing first philosophy blame individuals for being homeless rather than investigating the structural and human misfortunes that lead to homelessness. Some conservative thinkers have designed a narrative that suggests it is too costly to house certain categories of the homeless population. However, recent evaluations indicate that one year of permanent supportive housing is less expensive than the costs people accrue while living on the streets. In fact, housing first and permanent supportive housing programs produce significant cost savings by helping to reduce the disproportionate use of emergency medical services by individual's experiencing homelessness. In particular, due to the transient nature of homeless people, inadequate shelter, malnutrition, and absence of preventative care, people experiencing homelessness are often disproportionate users of emergency services (Molnar, et al., 1990). For example, a study conducted within Maine's Greater Portland area investigated 70 Shelter Plus Care participants and compared the costs associated with emergency and mainstream services during one year of homelessness to the costs associated with housing and services during one year in housing provisioned through Shelter Plus Care. The study

concluded that Shelter Plus Care yielded an annual cost savings of $600.00 per person (Wheeler and Mondello, 2008).

Shelter Plus Care

The Shelter Plus Care program combines permanent supportive housing within a Housing First delivery model. It is designed to meet the needs of individuals with severe mental illness, problems with drug and alcohol abuse and/or HIV/AIDS (HUD, 2011). It was developed as a component of the National Affordability Act of 1990, amended by the Stewart B. McKinney Act, and expanded by the Housing and Community Development Act of 1992. The provision of housing and support services in tandem is expected to improve housing stability and produce greater individual outcomes. Therefore, many advocates claim that the program has components that make it a viable key player in the fight to end homelessness by 2020 (HUD, 2011).

As outlined by The U.S. Department of Housing and Urban Development (HUD), Shelter Plus Care is a long-term program that “provides rental assistance for hard-to-serve homeless persons with disabilities in connection with supportive services funded from sources outside the program.” The program’s target population includes homeless persons with disabilities, together with their families who face a lack of adequate housing. This “hard-to-reach” population primarily includes individuals with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome [AIDS] (or

related diseases). A variety of housing choices are offered through the program, along with supportive services funded by other sources (HUD, 2011).

Six organizations operate Shelter Plus Care in Detroit. The organizations vary in capacity, location, structure, and the type of housing and service programs they provide. Rental assistance for Shelter Plus Care in Detroit is distributed from HUD through two distinct conduits - Michigan Department of Community and Wayne County Community Mental Health (HAND, 2011).

Guidelines set forth by HUD for program implementation are intentionally vague to allow local organizations the maneuverability to adjust programmatic components to meet their consumers' specific needs (HUD, 2011).

Program Components: Range of rental assistance

Shelter Plus Care rental assistance is distributed to eligible applicants including States, local government units, Indian Tribes and public housing agencies (PHAs). In Michigan, the Michigan Department of Community Health (MDCH) and Wayne County Community Mental Health (WCCMH) are recipients of Shelter Plus Care funding. Local non-profit organizations cannot apply for Shelter Plus Care funding directly from HUD; instead, the non-profit must apply for funding through one of the above-mentioned sponsors. Therefore, Shelter Plus Care funding requires an added level of administration not required by other HUD housing programs (HUD, 2011).

The rental assistance is to be used for permanent housing at FMR as established by HUD. HUD subcontracting rules designate specific entities as

overseers of four types of rental assistance: Tenant-based rental assistance (TRA), Sponsor-based rental assistance (SRA), Project-based rental assistance and (PRA) Single Room Occupancy dwellings (SRO) (2011).

For tenant-based rental assistance, non-profits request funding from MDCH or WCCMH in order to assist program participants with the selection and acquisition of housing. Rental assistance is linked to the participant. Thus, it provides individuals with the freedom to move and or transfer assistance to a new unit (2011).

Sponsor-based rental assistance works through a contract with a sponsor such as a non-profit organization or community mental health center. Housing units owned by the sponsor are rented to program participants and rental assistance is linked to the building. Individuals generally have less flexibility to move into a different building unless the sponsor has multiple properties (HUD, 2011).

Project-based rental assistance requires applicants to contract with building owners for 5 or 10 years. In this version of Shelter Plus care, program participants must live in designated properties. In contrast to tenant-based rental assistance, there is less flexibility to move to a different unit (HUD, 2011).

For organizations to be considered for Shelter Plus Care, rental assistance grants must be matched by supportive services equal in value to the amount of rental assistance. In Detroit, six organizations receive rental assistance funding to implement Shelter Plus Care. These organizations include:

Coalition of Temporary Shelters, Detroit East Community Mental Health, Development Centers, Inc., Neighborhood Services Organization, Southwest Housing Solutions Corporation and Traveler's Aid Society. To maintain each organization's confidentiality, they will remain anonymous throughout the report.

Chapter 3: Research Methods

Overview

The research is based on the analysis of qualitative data from surveys, aggregate data analysis and focus groups. The primary research design used in the study is a One-Shot Case Study, which involved data collection from a single group of case managers and administrators. The majority of the data was collected in Detroit from February - March 2011.

An analysis of the qualitative data allows the researcher to examine service providers' assessment of the effect of the Shelter Plus Care program. In addition, the research methods enable the researcher to locate potentially problematic themes with the program theory and/or implementation; survey responses and focus groups provide a unique perspective of the complex nature of service provision and the barriers that hinder the realization of programmatic goals. Thus, the recommendations made in this report are directly guided by personal input from services providers working on the front line.

Data Collection and Analysis

The One-Shot Case Study used for this research project involved the collection of data in three phases: survey data collection, focus group data collection and data collection from the Homeless Management Information System (HMIS), an information management system database.

Phase 1: Survey Project

In the first phase of data collection, the researcher distributed surveys to case managers in all six Detroit organizations managing Shelter Plus Care. Administrators from those six organizations agreed to participate and distribute surveys to case managers overseeing Shelter Plus Care consumers. A total of 25 respondents completed the survey questions. The survey respondents represent nearly 100% of the Detroit administrators and case managers executing Shelter Plus Care.

Table 3: Survey Participant Breakdown

Organization	**Case Managers**	**Administrators**	**Total # of Participants**
Organization 1.	4	3	7
Organization 2.	1	1	2
Organization 3.	4	1	5
Organization 4.	1	1	2
Organization 5.	2	1	3
Organization 6.	5	1	6
Total Participants:			**25**

The survey consisted of closed and open-ended questions eliciting individual reports of program efficacy, barriers to successful outcomes, and constraints that prevent capacity building. Before crafting the survey, I met with three stakeholders to gather background information on the program and to identify the fundamental dependent and independent variables that should be collected by the survey instrument. These stakeholders included a Neighborhood Service Organization administrator, the director of the Homeless

Action Network of Detroit (HAND), and a senior project manager from the Corporation for Supportive Housing. [4]

Administrators and case managers were invited to participate in the current research by completing a survey and/or by participating in a focus group. Surveys were distributed to each organization and took less than thirty minutes to complete.

Analysis

Closed-ended survey responses were entered into the SPSS software management program and descriptive statistics were generated for each survey question. Due to the small survey N, the researcher reduced response categories with four categories to two categories. For example, questions questions with a possible outcome of (strongly agree, agree, disagree, strongly disagree) were reduced to (agree, disagree).

The researcher identified themes that emerged from the survey, which correspond with outcomes and questions of interest to the survey project. In particular, respondents' assessment of the impact of Shelter Plus Care, programmatic operations analysis, and a section that identified opportunities to improve the program were of particular interest for the research objectives.

For open-ended questions, the researcher conducted a close reading of respondents' answers to identify patterns and/or important anecdotal evidence. The themes that emerged from open-ended questions were grouped to match

[4] A copy of the survey can be found in Appendix A.

the respondents' assessment of Shelter Plus Care, programmatic operations analysis, and a recommendations section to advance the study into a form of participatory research.

Phase 2: Focus Group

A one-time focus group represented the second method of data collection. Once surveys were completed, case managers were invited to participate in a one-time focus group that was held on April 8, 2011 at the Housing Resource Center in Detroit, Michigan. Of the twenty-five survey respondents, only four participated in the focus group. Representatives from Organization (1) and Organization 6 (3) were present.

Table 4: Focus Group Participant Breakdown

Organization	Case Managers	Administrators	Total # of Participants
Organization 1.	1	0	1
Organization 6.	2	1	3
Total Participants:			**4**

Due to the low participation rate, the qualitative data gathered from the focus group is limited. There were two, male, Caucasian participants. One was in his mid-twenties, while the other was in his late-thirties. There were two, female, African American participants, both in their mid-twenties.

The focus group questions were designed to build on themes identified from the survey data. In particular, questions sought to: determine the barriers that prevent the program from housing more people, build on the respondent assessment of the SPC portion of the study, identify capacity constraints and

expose additional challenges associated with achieving the outcomes outlined in HUD guidelines.

The researcher facilitated the focus group while a co-facilitator monitored the discussion and recorded the commentary. The open-ended questions allowed participants to speak freely about Shelter Plus Care, the efficacy of the program, and circumstances that prevent organizations from housing additional people.

Analysis

In particular, participant responses shed light on funding constraints, bureaucratic barriers to bringing the program to scale, and compared SPC to similar programs such as Supportive Housing Program. The focus groups represented an important method for identifying and investigating programmatic guidelines that challenge organizations' ability to achieve the desired HUD outcomes.

The qualitative nature of open-ended questions provided participants with the opportunity to openly voice their perspectives. Responses were grouped into thematic findings and themes were analyzed through line-by-line coding. The session was audio recorded to facilitate analysis.

Phase 3: Secondary data collection

For the third phase of data collection, data was collected from the Homelessness Management Information System (HMIS), a HUD regulated online database designed to collect and record data on consumers experiencing

episodes of homelessness in the City. The total system involves data collection from 33 agencies. Data is collected for the following indicators: homeless counts, demographics of the homeless population, patterns of homeless service use, evaluations of service effectiveness, and improvements in care. For the purpose of this study, the researcher commissioned the Detroit based HMIS staff to run a report on the six organizations of interest from January 1, 2009 through December 31, 2009.

Analysis

Given the focus of this project, the researcher was interested in the analysis of several specific indicators from the HMIS Report for the six Shelter Plus Care including organizations' length of stay, and consumer destination upon exiting the program. These indicators are expected to shed light on programmatic efficacy at an organizational level and correspond with HUD's performance measures for Shelter Plus Care.

Chapter 4: Findings

Summary of The Key Findings

Overall, the research suggests that Shelter Plus Care has the expected positive effect on individuals in the program. In particular, the findings indicate that Shelter Plus Care has increased housing stability and income for consumers. Moreover, the program has improved the general self-sufficiency of its clients.

Individual Outcomes

The original research plan was to analyze the way organizations implement Shelter Plus Care and to identify variations in service/program provision that result in greater outcomes for program participants. However, the study did not find any notable differences between the organizations. This is due, in part, to the limited data collected on this topic. Nevertheless, the overall results from my analysis of the survey responses, focus group discussion and HMIS data suggest a positive program impact on housing stability, income and self-sufficiency measures.

Housing stability

The results suggest that Shelter Plus Care improves housing stability for people who had previously lived on the streets for months or years. Individuals suffering from addiction, serious mental illness, physical disabilities and/or HIV/AIDS are successfully transitioning into permanent supportive housing and staying.

HMIS Findings

The examination of the HMIS data suggests that in 2009, four hundred thirty nine (439) individuals[5] were enrolled in Shelter Plus Care. At the end of 2009, 337 individuals remained in the program; the other 106 exited to various destinations.[6] An HMIS report tabulated the length of stay, or time in housing, for those 439 participating in Shelter Plus Care throughout the year. Of those 439 individuals living in Shelter Plus Care rental units, an estimated 95%, or 415 individuals had a length of stay greater than 12 months. Furthermore, 90% of consumers had a length of stay over 18 months (369 consumers).

Of the 106 consumers discharged throughout the year, only 67 were adult consumers, while the remaining 40 were family members of clients. An estimated 39% of the 67 clients exited to permanent or semi-permanent housing, 25% exited to stay with a family or friend, and 31% (26 consumers) exited to unknown or undesirable places (i.e. jail, emergency shelter). An estimated 5% of consumers died. In short, of the 439 consumers participating in the program in 2009, only 26 consumers, or 6%, exited to unknown or undesirable destinations, therefore, these outcomes indicate that the program is having the intended effect on housing stability and improved individual outcomes.

Survey Findings

Furthermore, a survey distributed to 25 practitioners (administrators, case managers, and others involved with Shelter Plus Care management) measured

[5] This figure, 439, includes adults and their children.
[6] Destinations are described in the following paragraph.

the perceived impact of Shelter Plus Care. Survey questions were analyzed to determine practitioners' perceptions of the impact of the program. Regarding the indicators pertinent to housing stability, responses suggest that the practitioners believe the program has a positive impact. These survey results support the findings from the HMIS data.

In particular, an estimated 86% (19 respondents) agree that programmatic guidelines are suitable for hard-to-serve homeless. When asked to reflect on the impact of Shelter Plus Care, 100% (25 respondents) agree "Shelter Plus Care offers long-term solutions to homelessness".

Limitations associated with the research design exclude the prospect of identifying a counterfactual. However, survey participants were asked to report a perceived counterfactual by reflecting on the comment, "Outcomes for Hard to Serve homeless would be similar without the program"; 78% (18) disagreed or strongly disagreed with the statement. Finally, respondents were asked to reflect on the statement, "As participants acclimate to permanent supportive housing, for many, their overall condition can improve over time", an estimated 92% (22 respondents) agreed or strongly Agreed with this statement. Despite the absence of a counterfactual in the study, respondents suggest that outcomes for participants would not have been the same without the program.

Focus Group Findings

The tone of the conversation during the focus group osculated from glowing reports about consumers' lives being transformed to frustrating accounts

of overworked and underpaid caseworkers. More specifically, case managers relayed stories of consumers entering the program in a state of depression with an utter loss of hope. After several months participating in the program, participants were often observed to exhibit a new found optimism and signs of hope that were absent prior to having a place to call their own. One respondent reported:

> The housing first approach, I think, makes a big difference because…where as in a lot of situations especially outside of [the] supportive housing context the move would be to evict right away for some of the things that go on, but that's really last resort for most of the cases with Shelter Plus Care. (Anonymous, Focus Group, April 8, 2011).

Another respondent reported:

> I think one of the other factors [for increased length of stay] is that most of our Shelter Plus Care are sponsor-based that allow client choice in where they want to live. (Anonymous, Focus Group, April 8, 2011)

In these statements, the respondents articulate the program's theoretical foundation, which is based on the housing first model, along with the individual consumer benefits associated with a program that prioritizes housing stability over behavioral misconduct. In short, each mode of data collected during the study found evidence that supports the claim that the program is improving housing stability.

Income

As outlined by HUD, increased individual income is an important metric through which to measure the success of the program. Upon entry, case

managers link consumers to Social Security Insurance, and other resources to improve quality of life. In fact, a small subset are able to earn an income through job placement.

HMIS Findings

According to the HMIS data-set outlined in the previous section, of the 67 adult consumers exiting the program in 2009, 43% (29 participants) had an increase in income from the time of entry to the time of exit from Shelter Plus Care. Nine consumers had an income upon exiting the program. Of those nine, four consumers (an estimated 6%) increased their income through earned income sources (i.e. job placement) and their average income change was $835.44; the average income at intake $965 and the average income at exit was $1,664.00).

An estimated 22% of consumers (15 consumers) experienced an increase in income as the result of acquiring Social Security Insurance; the average income increase was $303.47. In particular, their average income at intake was $742, while it had increased to 928 at exit. The focus group and survey questions did not request income information since the HMIS data presented the most effective means by which to collect income data.

Survey Findings

The survey findings fail to explain the link between improved consumer income and participation in the program.

Focus Group

Little time was spent directly discussing income during the focus group. Instead, practitioners discussed the effect of current economic challenges on Shelter Plus Care consumers seeking employment. One practitioner reported, "[We are] sending employees to get jobs, but no jobs are available. [This creates] problems with self-esteem" (Anonymous, Focus Group, April 8, 2011).

It appears that organizations are less likely to encourage consumers to pursue a new job during a difficult job market. The researcher concludes that this is done in order to protect consumers from external challenges that may have negative implications for their recovery, etc.

Self-sufficiency

Self-sufficiency is an abstract term that can be defined as one's capacity to satisfy his or her basic needs with limited external assistance (HUD, 2011). In this study, improving self-sufficiency is the process of growing increasingly self-reliant with an ability to live in a setting with fewer support services. However, caution must be taken when discussing self-sufficiency, because for many eligible consumers for Shelter Plus Care, living with fewer support services is not and should not be an objective.

HMIS Findings

Due to the qualitative nature of self-sufficiency, HMIS reports were not suitable to measure individual improvements in this category.

Survey Findings

When survey respondents where asked to report on the likelihood that individuals would advance from Shelter Plus Care, a service rich program, to alternative housing with fewer support services, 63% (14 respondents) reported customers are unlikely to advance, while 37% (8 respondents) reported consumers are likely or extremely likely to advance. Although these figures may seem insignificant, they are more impressive when considering the severity of conditions faced by many consumers upon entry into the program. The fact that 37% of respondents report that consumers are likely to advance to a program that provides fewer services suggests improved self-sufficiency. An estimated 48% of respondents reported that they help consumers apply for alternative housing subsidies once consumers have reached a perceived level of improvement in self-sufficiency.

Finally, when asked to indicate the extent to which respondents agree with the statement, “As participants acclimate to permanent supportive housing, for many, their overall condition can improve over time,” over 91% of respondents agreed or strongly agreed with the statement.

Focus Group Findings

One focus group respondent reported that she had great success transitioning from Shelter Plus Care Consumers to Section 8 Housing (a program disconnected from service provision). She stated:

> I transitioned almost half my group to Section 8 and I can say, no one has lost their section 8. And that is a wonderful thing – it's going on a year. I do like the program because it provides an opportunity for consumers to grow (Anonymous, Focus Group, April 8, 2011).

Again, caution must be used in interpreting this data, as not all consumers are prepared to live alone without support services. First, the consumer must fully exhibit a capacity to live alone. Should that consumer move into Section 8 and fail to meet the consumer requirements established by the Section 8 Voucher program, he or she could lose access to housing subsidies indefinitely. Nonetheless, the transition of consumers from Shelter Plus Care to Section 8 points to the program's capacity to help consumers reach greater levels of self-sufficiency.

Three Primary Implementation Problems

Although the program appears to be working for consumers, particularly with regard to HMIS data, the survey and focus group analysis emphasizes the challenges administrators and case managers experience when implementing the program. Case managers report fatigue, failure to provide sufficient and comprehensive care, and challenges associated with navigating loosely defined HUD guidelines. In Detroit, the pervasiveness of homelessness translates into a formidable demand for housing programs. The process of selecting certain participants for the program and rejecting others was expressed as a

considerable burden for some case managers. Participants were forthcoming, sharing openly the challenges and assets of the Shelter Plus Care program.

The focus group conversation and survey responses identified three primary implementation challenges that face the organizations and case managers responsible for executing the program. First, there are significant bureaucratic barriers that prevent the program from expanding and serving a greater percentage of the homeless population. Because organizations are reliant on a sponsor for program expansion, internal inefficiencies that burden the sponsor pose problems for organizations operating Shelter Plus Care. Second, the program is devoid of funding for case managers to oversee relationships with landlords and supervise support services. Third, the guidelines crafted by HUD for Shelter Plus Care are vague and fail to provide a firm framework to guide decision-making concerning consumer selection into the program. These three implementation challenges will be discussed in more detail throughout this chapter.

Obstacles to Program Implementation

The current research identified three major obstacles to program implementation. The focus group served as the primary method for collecting information on these challenges. Due to the quantitative nature of the HMIS system, the data offered little explanation for the following findings. As is the case with many discretionary funding programs, funding, or the lack thereof, was a major issue that surfaced repeatedly during the study. Additional key findings

include challenges arising from splintered funding streams, complicated application processes, lack of funding for case management, and loosely defined HUD programmatic guidelines.

Bureaucratic barriers to Program Expansion

Survey Findings

The survey did not provide information concerning barriers to program expansion. The majority of the data that is relevant to programmatic elements that interfere with program expansion emerged from the focus group.

Focus Group

Initially, the researcher predicted that organizations were unsuccessful in increasing the supply of Shelter Plus Care housing units because of an insufficient supply of Fair Market Rents (FMRs) in the city. A Free Market Rent is a housing unit priced at a rate deemed affordable based on the regional cost of living. HUD requires that monthly unit rentals for SPC be equal to or less than the FMRs established for Detroit.

In contrast to the researcher's original expectation, there is a sufficient supply of FMR units in Detroit. Instead, the challenges preventing organizations from increasing the supply of Shelter Plus Care units, as reported by study participants, are cuts to discretionary funding and barriers that emerge along complex multi-tiered funding streams. To procure funding for Shelter Plus Care rental units, non-profit organizations and small local units of government are required to apply to a sponsor who, in turn, applies to HUD. The Michigan

Department of Community Health (MDCH) and Wayne County Department of Community Mental Health (WCDCMH) are 'sponsors' for all Shelter Plus Care funding that is filtered into Detroit.

Focus Group participants were highly critical of this funding model. In particular, it was described as an inefficient process that raises barriers to increasing the supply of Shelter Plus Care units in the city of Detroit. One participant reported:

> To apply for Shelter Plus Care you must have the County or the State sponsor you. So we asked the state to sponsor us this past year and they said 'no,' because they don't have the resources to manage all of the Shelter Plus Care in the state that they have to manage. Application comes through the state, it can't be our agency applying for it… So every time they need to be reviewed every year, really the state should be doing the renewal application, [but] they don't have the staffing so I get a letter that says you need to get that completed. The county is the same way, the county mismanaged our contracts for so long that they were almost threatened to be terminated by HUD - to where the county has hired an outside contactor that manages those [contracts] so they are done right. Those are a piece of cake for us. An independent contractor over sees the process (Focus Group, April 8, 2011).

The process of utilizing a sponsor, instead of having direct access to apply to HUD, has not only stunted the growth of Shelter Plus Care units in the City, but has also been associated with a shift in some organizations' willingness to participate in the convoluted Shelter Plus Care application process. One participant reported:

> [We have the] option to go with the state as [a] sponsor, but the state [MDCH] is so short staffed and overwhelmed that they know they aren't managing things the way they should. We apply for Supportive Housing

> Program [funding] instead because we don't need a sponsor [to get funding] (Anonymous, Focus Group, April 8, 2011).

The above mentioned barrier is particularly salient in the face of such a tremendous need for additional housing units in Detroit. The evidence from this study suggests that Shelter Plus Care is effectively increasing individuals' housing stability, but the program, it seems, is the victim of its own success. The consequence of long-term housing stability manifests itself in limited unit turn over. In other words, the sum of units provided by Detroit-based organizations are occupied with long-term residents, inhibiting the uptake of new residents, thereby effectively failing to continue to reduce the number of people living on the streets at a steady pace. Shelter Plus Care is listed in *Opening Doors*, *the Federal Plan to End Homelessness*, as a key program that could help in the fight to end homelessness. Its demonstrated power to take people from the streets into permanent housing is wasted when deliberate steps are not taken to increase the number of units and, in turn, expand the impact of the program.

Lack of Funding for Case Management

Survey Findings

Responses to three survey questions inform and support the need for an improved funding strategy. Over 54% of respondents reported that funding was insufficient to pay for the time and resources required for locating and securing housing. A second question asked if funding to pay for the resources required for developing and maintaining relationships with landlords is adequate, over 58% reported that it was not. Finally, when asked to demonstrate the extent to which

respondents agree that funding is sufficient to support the staff and work needed to coordinate support services, over 75% of respondents disagreed with the statement.

Focus Group Findings

Similar to many programs with a mental health component, Shelter Plus Care does not allocate funding for case managers. Instead, organizations utilize other funding sources to compensate case managers. Stretching other resources to fund case management positions can stress an organization and put pressure on staff to carry a large caseload with limited compensation. Staff turnover, although not fully investigated in this study, could prevent Shelter Plus Care from coming to scale by limiting institutional knowledge of Shelter Plus Care.

During one focus group conversation, nearly every case manager mentioned a need for additional funding to help improve the level of care provided to consumers. For example, one participant stated:

> Now the downside of Shelter Plus Care is that there is no money to provide the support services, if we didn't have grants in other areas to cover that, we'd be talking a really different ballgame here (Anonymous, Focus Group, April 8, 2011).

The focus group was utilized to garner a more comprehensive understanding of the inner workings of the program. When asked, "If you could wave a magic-wand and change one thing about the program, what would that one thing be?" a different participant stated:

> I'm not sure if you are familiar with the VASH program for Veterans, but for every 25 VASH vouchers, [there is] funding for a full-time caseworker. If I had a wish, I would say that SPC should be set up similarly, so that there is guaranteed funding for the services to be provided and then that enables people to provide a full range of service (Anonymous, Focus Group, April 8 2011).

Another case manager reported on her limited ability to provide adequate services to consumers on her caseload:

> If we were able to provide other services, a lot of people in the program may need bus tickets, or things like that, and we aren't really able to provide them with the bus tickets or to provide referrals to other places where they can get assistance (Anonymous, Focus Group, April, 8 2011).

Funding limitations continue to limit the impact and reach of the non-profit and governmental sectors. Although funding influences nearly all programs, the direct challenge to the program's ability to provide adequate case management demands that this topic be included in the analysis. Funding limitations for staff and housing units will be explained further in the following chapter.

Loosely defined HUD guidelines

The guidelines for Shelter Plus Care are intentionally vague for three main reasons: to give organizations the agency to identify unmet needs of people experiencing homelessness in local communities; to design community-driven eligibility criterion; and to develop localized organization-based standards for success.

There was a consensus among focus group participants regarding the challenges associated with ambiguous eligibility criterion guidelines. Perhaps the greatest challenge to the pervading homeless problem in Detroit is the vast number of people experiencing homelessness with co-occurring disorders. Because the population is so large, participants report, the process of determining those who should participate in the program and those who should not presents a fundamental challenge.

Cuts to discretionary spending over the past decade have encouraged service providers to collect data that documents the impact of the services they provide. Those figures are often compared with national standards to determine the extent to which programs and organizations are effective. In turn, those organizations that produce the greatest impact are more competitive and more likely to continue to receive funding. The Shelter Plus Care guidelines require organizations to establish internal standards and measurements for success on an individual basis. One participant expressed her perspective on Shelter Plus Care goals and objectives:

> [It is difficult] establishing goals and objectives in the face of unclear, unstandardized HUD guidelines. Shelter Plus Care should have some standardized objectives. Instead every agency writes their own [guidelines] (Anonymous, Focus Group, April 8, 2011).

Shelter Plus Care is designed so that organizations can craft organization-based standards of success for the number of individuals housed, length of stay

and improved individual outcomes (i.e. increased income, fewer hospital stays, adherence to treatment plan, etc.). One participant explained a negative consequence linked to that freedom:

> Agencies are establishing their own goals, those goals may be easily achievable and make it appear as if the organization is successful, but there is no way to compare one organization against the other (Anonymous, Focus Group, April 8, 2011).

Conclusion

The general findings from analysis of the survey responses, focus group discussion and HMIS data indicate positive program effects for housing stability, income and self-sufficiency measures. However, the study identified three primary implementation challenges that negatively impact the organizations and case managers executing the program. Several bureaucratic barriers limit the expansion of Shelter Plus Care. To study proposes three recommendations to increase the number of available housing units each year. In addition, the absence of funding makes it difficult for organizations to secure funding to staff case managers and, once secured, makes it difficult to find sufficient funding to keep staff employed long enough to develop institutional knowledge that could help bring the program to scale. Finally, the guidelines designed by HUD for Shelter Plus Care are vague and fail to provide an effective tool for case managers to choose eligible program participants. These challenges with

implementation have strong implications for changes that could be made to improve the program.

Research Limitations

Due to a lack of data, funding restrictions and strict time limitations, a One-Shot Case Study of Shelter Plus Care was employed to achieve the research objectives. Since this case study lacks a control group and pre-test data on outcomes of interest, it cannot be used to determine the causal impact of Shelter Plus Care (Mohr, 1988).

In particular, for the purposes of a rigorous program evaluation, our aim would be to determine the causal effect of the program on a series of outcomes. This means that we would need to assess whether the outcomes for Shelter Plus Care recipients would have been different if these recipients had not been exposed to the program. In order to achieve this objective, we would need to locate a comparable control group for Shelter Plus Care recipients and gain access to a sufficient amount of pre-treatment and post treatment data on the outcomes of interest. A sufficiently large amount of quantitative data would be required to conduct a retrospective analysis of the causal effect of the program because statistical methods are needed to compensate for the non-experimental implementation of the program.[7]

[7] Due to the non-random assignment of recipients to Shelter Plus Care, there is a serious threat of "selection bias" to the validity of the study results. Selection bias means that the program selected recipients that were *systematically different* from those not selected for the program. In particular, we are concerned that SPC selected individuals that would perform better on certain outcome variables of interest to the program evaluation.

In the context of this study, “internal validity’ refers to confidence in one’s assessment of the actual effects of Shelter Plus Care on variables of interest. Given the lack of a comparison group in the research design, threats to internal validity – which arise due to history, selection bias, maturation, testing, instrumentation and regression – are not minimized because we cannot reasonably assume that these threats do not affect the outcomes of interest. Therefore, these threats could explain positive outcomes that are attributed to the program.

Regarding external validity, or the generalizability of the research findings, the limits to internal validity discussed above imply serious limitations for the external validity of the study. Moreover, it is important to highlight the fact that the study is limited to those six organizations providing Shelter Plus Care within the City of Detroit boundaries. To assess the nation-wide impact and implications for Shelter Plus Care, data collection would need to be expanded to gather sufficient information on a representative sample of Shelter Plus Care organizations and recipients.

In summary, in order to *isolate* the true program effect, a stronger research design should be employed. Therefore, this work can best be characterized as an exploratory study and the results should be interpreted as suggestive.

Chapter 5: Implications

Summary

One of the primary missions of the social work profession is to attend to and seek to resolve the damaging individual consequences that result from poverty, racial injustices, marginalization, and systems that disproportionately benefit privileged groups (Shulman, 2009). The profession's mission is to confront and transform systems of inequity by empowering entire communities to improve the quality of life for each of its members, particularly those who suffer from discrimination, and all other forms of oppression (Lee, 2001). Among the most oppressed people in our society are people experiencing homelessness. The implications of this study highlight opportunities for the homeless service sector to increase the Shelter Plus Care housing units, thereby reducing the incidence of homelessness in the city of Detroit.

Barriers to Implementation

Based on data gathered from the current research, three known barriers to program implementation were determined. Bureaucratic barriers, lack of funding for case managers, and loosely defined HUD guidelines all inhibit Shelter Plus Care Program implementation. Bureaucratic challenges are most apparent in fragmented funding streams that add to the time and resources that are required to apply for new funds. Case managers and administrators from Shelter Plus Care organizations report an absence of City Government support (Anonymous,

Focus Group, April 8, 2011). Consequently, Detroit organizations struggle to develop innovative and experimental means through which to strengthen the impact of the program.

Data collected in this study indicates that Shelter Plus Care is producing positive outcomes for people formerly experiencing homelessness. Due to limited research and evaluation, however, we know little about the program itself and the national metrics associated with housing stability. In 1997, HUD conducted a National Evaluation of Shelter Plus Care of Shelter Plus Care (1997). The findings distinguished major strengths and challenges that the program faced, but because the investigation took place in the program's start-up years, few of the findings are comparable today. Additionally, Shelter Plus Care is relatively new in Detroit. The most senior Shelter Plus Care program is known to have started in 1998, one year after the publication of the national evaluation. Additional research is required to build upon this study's findings and to support organizations that administer Shelter Plus Care by reducing barriers to implementation.

According to the focus-group responses, evidence suggests that case managers are stressed. Intentional programmatic changes that are targeted to reduce case manager and administrator stress could improve the impact of the program. Moreover, it is evident that the limited volume of Shelter Plus Care units troubles administrators and case managers. First hand, administrators and case managers encounter the program's capacity to transform consumers' lives, but

due to limited resources - human or financial - the program serves a finite number of people. Both case managers and administrators are disturbed by the burden of rejecting eligible applicants from the program when limited housing units and limited case managers are the only barriers to housing. This challenge is particularly salient in Detroit, where organizations are faced with a vast homeless population that altogether transcends the supply of units.

Importance of Housing

Few structural or material belongings are as vital as housing; therefore, having access to one's own home is a conversation about human rights, equity and personal achievement. Homelessness impacts every aspect of a person's life – from meeting basic needs to damaging interpersonal relationships and causing aversive interactions with community members and police enforcement. More specifically, social isolation and the absence of social support combined with ridicule from the community make homelessness a pervasive challenge. The success of permanent supportive housing programs alongside the development of city, state and federal strategic plans to end homelessness have highlighted a national recognition of the importance of housing.

This study sought to evaluate Shelter Plus Care, a program to end homelessness for hard-to-serve populations based on the housing first philosophy. The study findings indicate that the program is successfully achieving its primary objectives. Nevertheless, the program continues to face several significant implementation barriers, which mitigate the positive effect of the

program. More specifically, limited capacity, multi-tiered funding streams, and vague programmatic guidelines prevent Shelter Plus Care from producing a powerful impact.

The evidence from this study suggests that Shelter Plus Care is effectively increasing individuals' housing stability, but the program, it seems, is the victim of its own success. The consequence of long-term housing stability is limited unit turn over. In other words, the sum of units provided by Detroit-based organizations are occupied with long-term residents, inhibiting the uptake of new residents, thus effectively failing to continue to reduce the number of people living on the streets at an increased rate.

Shelter Plus Care is trumpeted in *Opening Doors*, the federal plan to end homelessness, as a key program in the fight to end homelessness. Its demonstrated power to take people from the streets and into housing is wasted when communities lack innovative means to increase the number of available units, thereby expanding the impact of the program.

With the highest per capita homeless rate in the nation, social work practitioners, service providers, and the community have a social responsibility to practice due diligence and dig deeper to identify new and innovative ways to grow and improve permanent supportive housing programs.

Recommendations

Summary

The recommendations included in this section are designed for Detroit, based on the contextual basis of the evaluation study. Further research should be conducted to determine the generalizability of each recommendation to programs in other cities and rural areas. Bear in mind, this evaluation is place based and therefore differs from national evaluations of the program.

The research has identified four distinct yet overlapping recommendations; three of which are centered on a greater involvement of the Homeless Action Network of Detroit (HAND) in the organizing and oversight of Shelter Plus Care programs. HAND is an elected governing body with a membership made up of local organizations that provide various services to individuals experiencing homelessness. The Board of Directors is made up of homeless direct service providers and executives, formerly homeless individuals, and intermediary technical assistance experts oversee and direct HAND's activity as the homeless sector trade association. HAND is Detroit's Continuum of Care (CoC), which is a relatively new concept established by HUD. In HAND's case, the COC is a nonprofit that works directly with organizations providing homeless services. The organization seeks to increase collaboration and information sharing among organizations, and between HUD and direct service providers. An ambitious and driven staff has taken on many of the responsibilities that cities often employ public departments to manage.

Recommendation I: Overcoming Bureaucratic Challenges and Building the Supply of SPC units

Every year, the six organizations implementing Shelter Plus Care craft an agreement with HUD to procure and oversee a designated number of housing units for the respective year. The six organizations are responsible for locating and securing housing units,[8] and employing outreach strategies to locate and recruit consumers who meet eligibility requirements for the program. In Detroit, some organizations struggle to grow the program to a size that can satisfy the relative demand. Nevertheless, if Shelter Plus Care is to participate in the fight to end homelessness by 2020, deliberate steps should be taken to increase the number of people housed by Shelter Plus Care rental assistance. Limited funding opportunities clearly reduce the number of new units procured each year. Additionally, MDCH reportedly lacks sufficient capacity to change the contracts and handle the administrative oversight needed to increase housing units in Detroit. Essentially, this is a funding issue that requires added leverage to attract more dollars that can expand the supply of permanent supportive housing in Detroit.

The six organizations that operate Shelter Plus Care could attract additional funding by applying for rental assistance as a collaborative. A joint application for new project dollars could improve the competitive stance of each individual organization by leveraging their collective assets and combined

[8] There are three parts. Project-based, sponsor based and tenet based. There is a different contract for each of those.

capacity. The ideal outcome associated with this recommendation would be an increase in the number of new Shelter Plus Care units in Detroit and a shared city-wide responsibility for the program.

To summarize, Shelter Plus Care providers need more units, but to grow their supply they must work together to leverage their capacity and organizational strengths to secure additional funding. The recommendation is that HAND increases its scope to play a more active role in bringing these six organizations together to develop a partnership amongst the organizations to craft joint grant proposals.

Recommendation II: Improving funding for case management by streamlining funding

Currently funding streams for Shelter Plus Care begin at HUD, and are then funneled through state and county entities, and eventually land at local non-profits and community mental health providers. Federal funding is purportedly available on a competitive basis, but MDCH reportedly lacks the capacity to effectively compete for these resources. HAND, it was conjectured, would be a more successful applicant for the funds. Ideally, funding would move first from HUD to HAND, and then from HAND to private non-profits and community mental health providers. With HAND at the helm, applying for funding would be overseen by an organization with a stronger leverage point, thereby displaying the capacity to apply for funding more effectively.

In addition, HAND can organize its membership and use its collective voice to advocate and bid for funding that would be designated for case

management. Funding for case managers could reduce the stress administrators experience when trying to secure flexible dollars not linked to the program, while also reducing large case manager caseloads.

Recommendation III: Refining Shelter Plus Care Guidelines

Shelter Plus Care administrators and case managers voiced concerns about the challenges associated with determining which consumers are best fit for the program versus those who are not. The HUD guidelines are extremely vague and in light of a vast demand for Shelter Plus Care housing units, the decision making process is critical. The recommendation is that HAND requires organizations to utilize a Vulnerability Index to help case managers select consumers for the program. Further, HAND could outline particular consumer characteristics of the hard-to-serve population to include in the program.

Recommendation IV: Improving Data Management

As discretionary funding continues to decline, competition for funding becomes more competitive. Organizations that are able to demonstrate a positive impact through measureable outcomes appear to be more competitive when applying for funding. The recommendation to improve data collection and management is one designed to reinforce the three preceding recommendations.

The data collected by HMIS is not collected in a way that organizations can easily utilize the data to tell the story of their organizations' accomplishments. If the data were user-friendly, organizations could manage and evaluate it to leverage more funding to create additional housing units.

Future Research Objective

There are several ways to improve the current research study. Most importantly, the current research was scoped to include a consumer-based focus group, but due to short research deadline to complete the project, the focus group was never held. First and foremost, future research will include a focus group to garner consumer feedback on programmatic effectiveness. Presently, the researcher has only 2009 statistics from HMIS, but the plan is to request specific reports for 2008 and 2010 to bolster the argument. Also, the researcher will request for HMIS to run a few reports from programs similar to Shelter Plus Care in order to develop a semi-controlled comparison.

Given these improvements in the research methods and data collected, the researcher will confirm and/or update the findings and finalize the recommendations for Shelter Plus Care implementers and HAND.

APPENDIX A

Shelter Plus Care Survey Tool

1. City, State of Organization _____

2. Title/Position of Respondent _____

3. How long have you been operating the Shelter Plus Care Program?

_____ (In years)

4. How many unduplicated S+C consumers did you house in FY2009?

_____

5. How many unduplicated S+C consumers did you house in FY2010?

_____

6. What form of Shelter Plus Care rental assistance does your organization provide? Please check those that apply. If you respond 'Tenant-Based' please answer questions 7 & 8. All responses other than 'Tenant-Based' please skip to question 9.

__ Sponsor-Based Rental Assistance
__ Tenant-Based Rental Assistance
__ Project- Based Rental Assistance
__ Single Room Occupancy (SRO)- Based Rental Assistance

7. Are tenants required to live in particular structures or units during the first year?

__ Yes
__ No
Please explain:

_____
_____
_____

8. Are tenants required to live in a particular structure or unit during the subsequent year?

__Yes
__No
Please explain:

_____
_____
_____

9. Which entity below distributes your Shelter Plus Care dollars to your organization?

__ Wayne County
__ The State of Michigan

__ Other: _____

10. When thinking of the average ratio of consumers to case manager's in the Shelter Plus Care Program, please fill in the figures that represents the ratio in your organization:
____:____

In the following section, you will be asked to provide information on Shelter Plus Care consumers:

11. Thinking about your organization, what percentage of Shelter Plus Care Consumers enter the program through each of the following possibilities (Should approximate 100 percent):

__ Clients enter through internally operated emergency shelter
__ Clients referred from alternate organizations
__ Clients recruited through organization-run outreach program

12. Thinking about the condition of consumers just before they begin receiving Shelter Plus Care services from your organization, how often does the following occur? Please indicate whether the following occur always, frequently, rarely or never by checking the appropriate box.

	Always	Frequently	Rarely	Never
Consumers entering the program are chronically homeless.				
Consumers entering the program are **severely disabled;** compared to other homeless consumers.				
Consumers entering the program have some form of cash assistance (for example, stipends, bridge cards, SSI/SSDI, veteran's benefits, etc.).				
Consumers entering the program have some form of employment (for example, seasonal or part-time work).				
Consumers entering the program have a support system (for example, friends, family, etc.).				
Consumers entering the program have access to transportation.				
Consumers entering the program have outstanding warrants/unresolved legal issues.				

Consumers utilize emergency services for help with a physical problem				

In the following section, you will be asked to provide your opinion about the impact of Shelter Plus Care Programs. Instead of indicating how frequently things occur, you will be asked to indicate how strongly you agree with provided statements.

13. When thinking of the Shelter Plus Care Program, please indicate how strongly you agree with the following statements. Please indicate whether you strongly agree, agree, disagree, or strongly disagree by checking the appropriate box.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Participant transition into Shelter Plus Care requires many supportive services-more than any other time, except crisis.				
Program guidelines are suitable for 'hard-to-serve' homeless.				
Shelter Plus Care offers long-term solutions to homelessness.				
Outcomes for 'hard-to serve' homeless would be similar without the program.				
Outcomes for 'hard-to-serve' homeless are greatly improved by the program.				
When participants return to homelessness, your organization aims to re-enroll participants who leave the program.				

14. When thinking of administrative costs to operate the Shelter Plus Care Program, please indicate how strongly you agree with the following statements. Please indicate whether you strongly agree, agree, disagree or strongly disagree by checking the appropriate box.

	Strongly Agree	Agree	Disagree	Strongly Disagree
Funding to cover the effort and resources required to locate housing is adequate.				
Funding to cover resources required to develop/maintain relationships with landlords is adequate.				
Funding to cover resources required to coordinate				

support services is adequately funded.				

You will now be asked to answer a series of questions concerning the length of time associated with securing housing for a consumer.

15. On average, how long does it take to deem a consumer eligible for Shelter Plus Care Services?

_____

16. After deemed eligible for housing, what percentage of your Shelter Plus Care consumers wait the following time-spans before being housed (Total should approximate 100%):

__ Less than two weeks
__ 2-4 weeks
__ 4-6 weeks
__ 6-8 weeks
__ 8-10 weeks
__ 10-12 weeks
__ 12 weeks or more

17. What percentage of consumers who are deemed eligible for the Shelter Plus Care program do not get into housing due to loss of contact between your organization and the consumer?

_____%

18. How many consumers did you lose contact with within the last year before your organization was able to situate them in housing units supported by Shelter Plus Care rental assistance?

__ 1-5
__ 5-10
__ 10-15
__ 15-20
__ 20-25
__ 25 or more

Please answer the following about housing unit capacity:

19. Is there a sufficient supply of Fair Market Rents in your area to meet the demands of your client base?

__Y
__N

20. Based on your agreement with HUD, How many Shelter Plus Care Units have you agreed to supply?

_____

21. How frequently does your organization exceed the number of units specified in your grant agreement with HUD? Please circle always, frequently, sometimes or never.

Always	Frequently	Sometimes	Never

22. How many units make up your housing reserve for Shelter Plus Care consumers?

23. Do you currently have vacancies in these units?

__Y
__N

24. Do you frequently have Shelter Plus Care consumers on a waiting list?

__Y
__N

25. What is the average time-span people wait to get into housing once they are on that list?

___

26. On average, how many consumers make up your Shelter Plus Care waiting list? __ _

Please answer the following concerning client outcomes:

27. What percentage of consumers remain in housing units supported by Shelter Plus Care rental assistance for the following time-spans? (Total should approximate 100%)

__ Less than 1 month
__ 1-6 months
__ 7-12 months
__ 13-18 months
__ 19-24 months
__ 25-30 months
__ 30 months or more

28. Thinking about consumers who do not complete the first year of the program, please indicate to what extent you agree with the following statements. Please indicate whether you strongly agree, agree, disagree or strongly disagree by checking the appropriate box.

	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
Consumers do not complete the first year because program rules are too strict					
Consumers do not complete the first year due to problems associated with chronic drug or alcohol use.					

Consumers do not complete the first year because of behavioral problems associated with mental illness.					
Consumers do not complete the first year because of behavioral problems NOT associated with mental illness.					
Consumers do not complete the first year due to an untimely demise.					
Consumers do not complete the first year because they need more support than Shelter Plus Care can provide					

29. How likely are Shelter Plus Care consumers to move on to each of the following housing categories upon exit of the program? Please indicate whether each of the following is extremely likely, likely, unlikely or extremely unlikely by checking the appropriate box.

	Extremely Likely	Likely	Unlikely	Extremely Unlikely
Section 8				
Unsubsidized market rate housing				
Alternative housing plan with fewer services				
Housing with friends or family				

30. The Department of Housing and Urban Development (HUD) explains that Shelter Plus Care Grants are reserved for 'hard-to-serve' persons experiencing homelessness with disabilities (primarily those with serious mental illness, chronic problems with alcohol and/or drugs, and acquired immunodeficiency syndrome [AIDS]). Please explain specific outreach strategies your organization employs to recruit this 'hard-to-reach' population.

_____
_____
_____

31. Thinking of the time-span that takes place between meeting eligibility and being housed in a Shelter Plus Care unit, please explain consumers primary place of residency. For example, do consumers stay on the streets or do they stay in a temporary shelter before a housing unit is secured?

_____
_____
_____
_____

32. Please indicate how strongly you agree with the following statement. Indicate whether you strongly agree, agree, disagree, or strongly disagree.
"As participants acclimate to permanent supportive housing, for many, their overall condition can improve over time."

Strongly Agree	Agree	Disagree	Strongly Disagree

33. Please explain how you handle consumers who, overtime, require fewer support services. (For example: Are they transferred to other Rental Subsidy Programs with fewer support services?)

_____
_____
_____
_____

34. How does Shelter Plus Care compare to other programs designed to assist persons experiencing homelessness?

_____
_____
_____
_____

35. Does your organization provide furniture for Shelter Plus Care consumers? If so, how and to what extent?

_____
_____
_____
_____

36. In the following space, please list any additional concerns you would like to address.

_____
_____
_____
_____

I want to thank you for taking the time to fill out the above survey. Should you have any questions or concerns, feel free to contact the principal investigator at 803-226-1870

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ABSTRACT

OUTCOMES, ADAPTATIONS AND PERFORMANCE: A LOCAL EVALUATION OF SHELTER PLUS CARE

by

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December 2011

Advisor: Dr. Bart Miles

Major: Social Work

Degree: Master of Social Work

Individual outcomes and barriers to program implementation for Shelter Plus Care are presented from an exploratory study investigating the impact of the permanent supportive housing program in Detroit, a city that faces unique challenges and has complicated needs. Individual outcomes including improved housing stability, increased income and reports of enhanced self-sufficiency suggest the program is achieving the goals projected by the U.S. Department of Housing and Urban Development (HUD). Despite positive outcomes for individual consumers, barriers to program implementation emerged as thematic problems for organizations running the program. Recommendations aimed at increasing the number of Shelter Plus Care units while simultaneously increasing the number of individuals exiting homelessness; streamlining fragmented funding streams; refining loosely defined HUD guidelines; and improving data collection procedures are made as participatory suggestions to help Detroit bring Shelter

Plus Care to scale.

AUTOBIOGRAPHICAL STATEMENT

An mélange of life experiences have influenced the person I am today. I was privileged to have been able to absorb all the wonderful things from my exposure to people from all walks of life, living in a number of cities, and absorbing a broad range of cultural diversity. My hunger for lifelong learning has been strengthened and expanded by the amazing people I have met along the way. Additionally, living in different cities taught me to be amenable and to adapt to the world around me and to new experiences.

I spent many years searching for my place in a large, sometimes intimidating, world. Never have I felt so at home than I do right now. Working to improve the lives of the isolated and marginalized has given me more satisfaction than I ever hoped to have gained. My goals are always responding to a changing environment and new opportunities, but one thing remains constant. I am driven to continue to live a life in which I feel inspired everyday to work towards the common good, protect those in need, and to help rebuild the places that have restored my hope in myself and in society.