

# Reducing Harm and Improving Outcomes in Community Responses to Homelessness



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This report represents work completed by undergraduate and graduate students at Humboldt State University and should be read in the context of a student research effort. It may therefore contain minor grammatical, syntactic, and/or typological errors. Balancing preservation of students' work with professional expectations was the responsibility of the Project Director, Ronnie Swartz, who is ultimately accountable for this report.



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## Part I: Introduction

Humboldt County, like most places in the world, struggles to house every community member who prefers to be housed. Diverse efforts can be identified in this region to address the complex needs of individuals and communities that face homelessness. Public agencies, private non-profit organizations, for-profit businesses, collectives of affiliated groups, and activists alike are working together and separately to minimize the risk of entering homelessness, decrease the amount of time people spend homeless, and reduce harmful effects of homelessness.

This report focuses on two aspects of homelessness services and supports. First is a review of professional, research, and scholarly literature on reducing homelessness-related harms. Second are findings from extensive interviews with Humboldt County community members who interact with homelessness. These people are primarily located in the Humboldt Bay area and include those who can be identified as business owners, government representatives, social service professionals, educational professionals, activists, law enforcement personnel, and volunteers.

We believe it is important to note that this report does not attempt to explain why people end up homeless, objectively evaluate the quality of local efforts to address homelessness, or present new demographic data about what is often referred to as “the homeless population.”

Though some people consider the definition too liberal or conservative, the McKinney-Vento Homeless Assistance Act is the definition of homelessness most frequently cited. A homeless person as described in the 2009 re-authorization is:

- (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and
- (2) an individual who has a primary nighttime residence that is
  - (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
  - (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or
  - (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

The definition also includes unaccompanied youth who have experienced a long-term period without living independently in permanent housing, have experienced persistent housing instability, and can be expected to continue in such status for an extended period of time (The Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009).

Recommendations presented in this report emerge directly from the research reviewed and the conceptualizations of community members who interact with homelessness. The focus is on immediate, substantial, evidence-based, cost-effective, and achievable strategies for reducing the harm that homelessness poses.

## Part II: Homeless Counts

Although many attempts have been made to count and describe people identified as homeless, no systematic method for tracking the homeless existed until relatively recently (US Department of Housing and Urban Development, 2001). In response to a directive from Congress, the Department of Housing and Urban Development (HUD) began to develop a tracking system calling for local communities and their service providers to gather information about homeless individuals and enter and store information into databases at the local level. In the time since Congress issued this directive there has been annual progress (US Department of Housing and Urban Development, 2001).

Attempts to count the number of people who are homeless and describe their characteristics have substantial limitations. For example, the transient nature of many people who are homeless presents serious obstacles to accurately ascertaining the number and characteristics of homeless individuals (Perl, 2007). The Urban Institute released an estimated number of homeless individuals in 2000 using data collected from the 1996 Census as part of the National Survey of Homeless Assistance Providers and Clients. This effort surveyed individuals who used services such as emergency shelters, transitional and permanent housing facilities, soup kitchens, food pantries, and drop-in shelters (Burt and Aron, 2000). Demographic, income, and other information was presented as well as a count. The U.S. Conference of Mayors has issued annual reports every year since 1984, in which 20-30 large cities survey their social service providers' efforts to reduce homelessness and provide housing (U.S. Conference of Mayors, 2011). The Department of Veterans Affairs (VA) publishes an annual report detailing the results of surveys from VA staff, service providers, and veterans themselves, in addition to a Point-in-Time estimate of the number of homeless veterans (Nakashima et al., 2007). In 2000, the Census Bureau conducted several one-day surveys of homeless individuals and reported basic characteristics of the homeless such as location, race, age and gender (Smith & Smith, 2001).

Point-in-Time (PIT) counts are a popular way to gather information on the characteristics of individuals who experience homelessness while estimating the number of homeless people in a single space on a single night during the year. This method is used to estimate both sheltered and unsheltered individuals. Despite being the method most often used to count homeless populations, it is far from accurate. There are limitations related to methodology and findings. Since these surveys are administered at a single location on a single day during the year, the demographic characteristics provided as data are not representative of the larger, unexplored population. These surveys provide static information and fail to regard people's transitional characteristics. They also tend to leave out questions that might elicit survival strategies and resilience. The U.S. Department of Housing and Urban Development continues to see the value in PIT counts, requiring them, for example, as a condition for receiving substantial federal dollars (US Department of Housing and Urban Development, 2004).

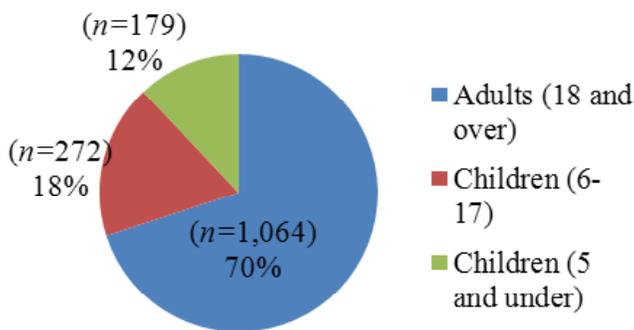
Point-in-Time counts in Humboldt County were conducted in 2009, 2010, and 2011. Perl (2007) describes the elements of federally qualified PIT counts. The data elements listed in the report include an unduplicated count of the homeless; characteristics such as age, race, sex, disability status, health status, and income; types of services that homeless clients received; and client outcomes such as length of stay in transitional housing, success in acquiring permanent housing, and employment status.

All participants must report on universal data elements, which include name, date of birth, race, ethnicity, gender, veteran's status, Social Security Number, prior residence, disabling conditions, amount and sources of income, receipt of non-cash benefits, physical and developmental disabilities, HIV status, mental illness, substance abuse status, and domestic violence status (Perl, 2007).

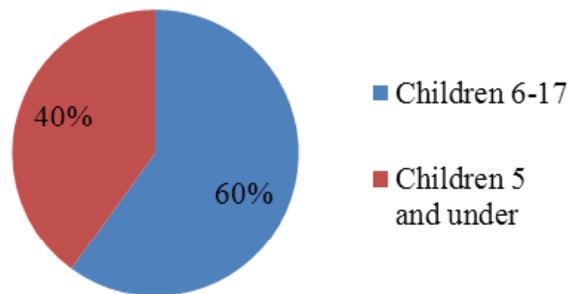
Humboldt County’s 2011 PIT count, like all PIT counts, pertains to a single geographic area and only includes those homeless individuals that surveyors were able to reach on the days the survey was conducted. The statistics found in Humboldt County’s PIT count cannot be applied to other areas in California or the United States. The following data is from the 2011 Point-in-Time count that was collected in a three day span on January 26-28, 2011, by the Humboldt Housing and Homeless Coalition (Humboldt Housing and Homeless Coalition [HHHC], 2011).

All surveys are confidential and voluntary. Respondents have the right to decline to answer any question asked in the survey. As a result, most questions do not have a 100% response rate. For example, when asked about gender, only 59% of the people surveyed responded. When asked about race only 54% responded, and 84% of surveys collected had a response to “Have you ever been in the military?” (HHHC, 2011).

**Figure 1a: Age**



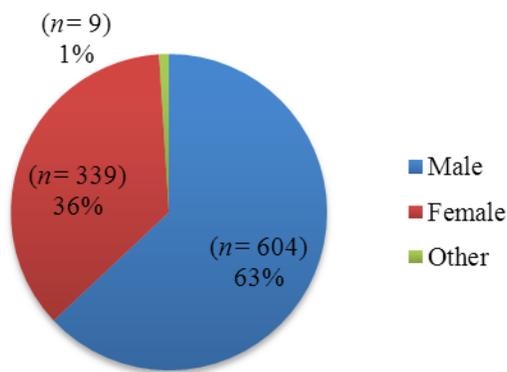
**Figure 1b: Children**



Of the 1,626 people identified as homeless in the 2011 Point-in-Time count a total of 1,064 (70%) were adults 18 and over, 272 (18%) were children between the ages of 6-17, and 179 (12%) were children under the age of five.

The average and median age of all people surveyed was approximately 30 years old. The average age of adults who were homeless was 40 years old. The youngest person reported from the survey was less than a year old, while the oldest was 88 years old. The average age reported for children (ages 0-17) was eight years old, and of the 30% of people surveyed who were children 40% were five years old or younger.

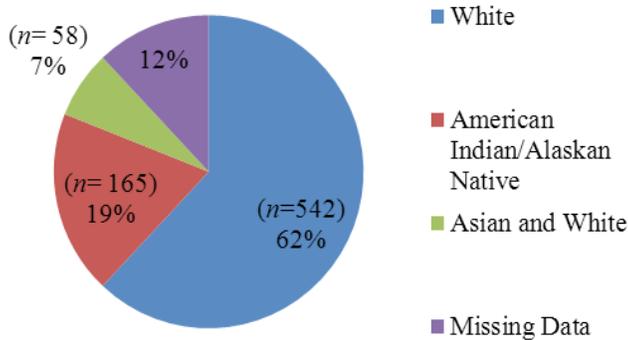
**Figure 2: Gender**



Only 59% (n= 952) of the total people surveyed reported their gender. Those who responded primarily

identified as male (63%,  $n = 604$ ) while 36% ( $n = 339$ ) identified as female. The remaining 1% ( $n = 9$ ) was coded as Other, Transgender, or Decline to State.

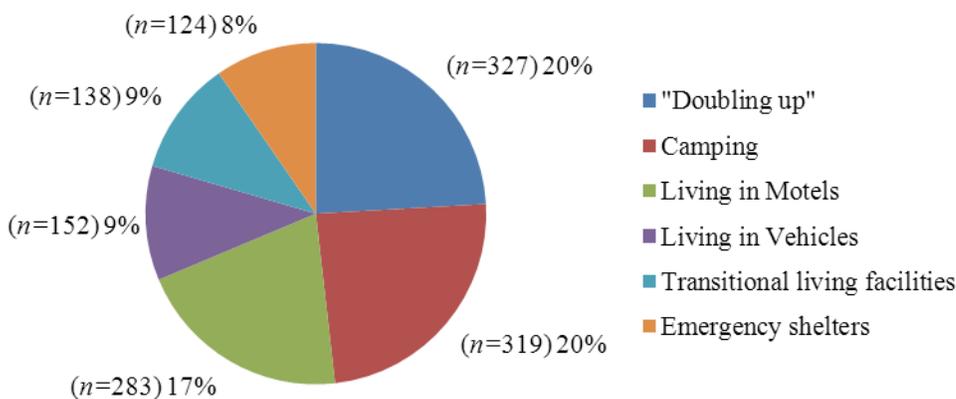
**Figure 3: Race<sup>1</sup>**



Of the individuals who reported race, 62% ( $n = 542$ ) identified as White. The largest “racial minority” represented in the survey, at 19% ( $n = 165$ ), were people who identified all or in part as American Indian. This suggests that people identifying as American Indian are disproportionately represented in the local homeless population count because the overall Humboldt County population of self-reported American Indians is 5.7% (United States Census Bureau, 2010).

It is unknown whether or not the category “White” included people of Hispanic origin because the 2011 Point-in-Time count treated ethnicity and race as two separate questions, following the United States Census Bureau classification system. Too few respondents who reported race also reported ethnicity. Therefore, there were not enough responses for this question to have adequate results for the category of Hispanic.

**Figure 4: Living Situation**



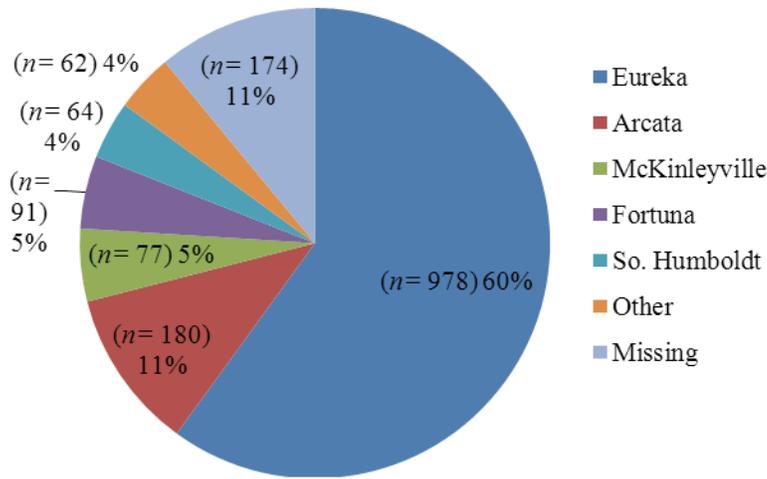
There were a variety of living situations reported. The most common was “doubling up” (20%,  $n = 327$ ). This is defined as a person or family who does not have a permanent place to live, but for the meantime is sheltered with friends or family. Just about as common was camping (20%,  $n = 319$ ). Camping refers to a self-report of sleeping anywhere “outside”. This was followed by living in motels (17%,  $n = 283$ ), living in vehicles (9%,

<sup>1</sup>The Point-in-Time count does not include “Missing Data” in overall percentages. “Missing Data” is primarily a result of questions not being answered. To provide a more complete picture of actual results and adequately represent categories of responses, this report chooses to include “Missing Data.”

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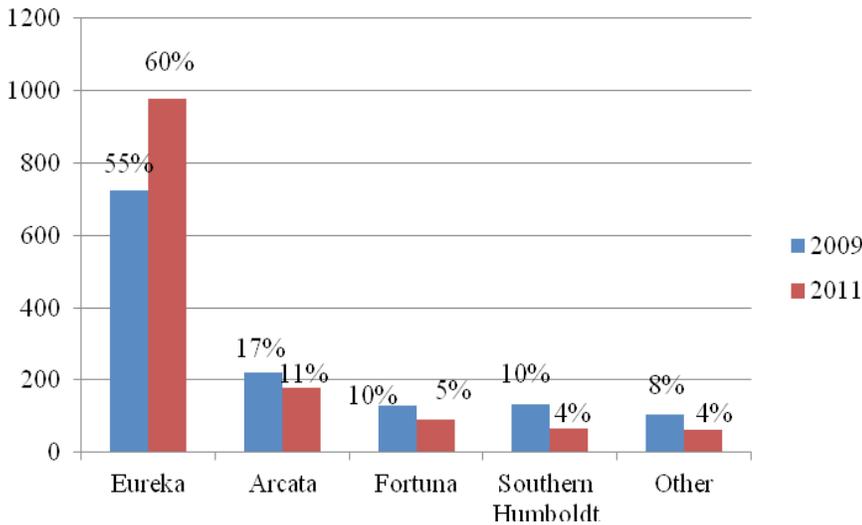
$n=152$ ), and staying in transitional living facilities (9%,  $n=138$ ). The least common living situation was people staying in emergency shelters (8%,  $n=124$ ).

**Figure 5a: Geography**



Most people identified as homeless in Humboldt County reported living in Eureka (60%,  $n=978$ ), while Arcata saw 11% of the population ( $n=180$ ). Fortuna ( $n=91$ ) and McKinleyville ( $n=77$ ) each saw 5% of the population. Southern Humboldt was counted as a region and included 4% ( $n=64$ ) of those surveyed. The remaining 15% ( $n=236$ ) included reports of *missing data* and *other* geographical areas.

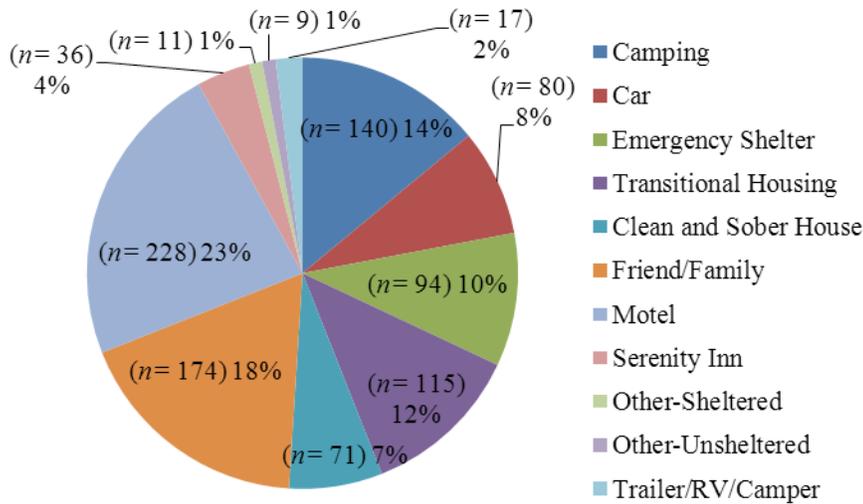
**Figure 5b: Comparative Chart 2009 and 2011**



The 2011 Point-in-Time count showed some changes compared to the last Point-in-Time Count in 2009. The number and percentage of people identified as homeless who reported living in Eureka increased from 55.3% ( $n=723$ ) in 2009 to 60% ( $n=978$ ) in 2011. Arcata saw a decrease from 17% ( $n=219$ ) in 2009 to 11% ( $n=180$ ) in 2011. In 2009, Southern Humboldt had the third highest percentage of people identified as homeless, with 10.2% ( $n=133$ ), which dropped to 4% ( $n=64$ ) in 2011. Fortuna saw a drop from 9.9% ( $n=130$ ) to 5% ( $n=91$ ). The 2009 category of “Other Areas,” which included Willow Creek, Honeydew, Kneeland, Alder point, Hoopa,

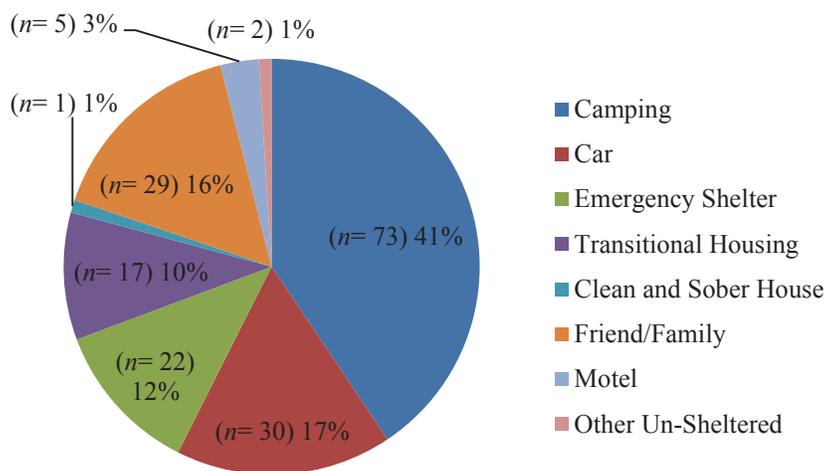
Orick, Orleans, and Trinidad comprised 7.9% ( $n= 103$ ) of the total population. In 2011, “Other” was down to 4% ( $n=62$ ). While there are several potential explanations for these shifts, one that is certain is the decision in 2011 to separate McKinleyville from Other.

**Figure 6: Living Situations Reported in Eureka**



With over half of PIT survey respondents reporting that they live in Eureka, data on people’s reported living situation is revealing. Twenty-three percent of people reported living in motels ( $n=228$ ) while 18% ( $n=174$ ) reported living with friends and family, 14% ( $n=140$ ) reported that they were camping, and 8% ( $n=80$ ) reported living in a car. Transitional housing, such as the Multiple Assistance Center and Bridge House operated by the Redwood Community Action Agency, was reported by 12% ( $n=115$ ) of respondents, while emergency shelter, such as the Eureka Rescue Mission, was reported by 10% ( $n=94$ ). Clean and sober housing, such as those facilities operated by Alcohol Drug Care Services, was reported by 7% ( $n=71$ ) of people surveyed. The Serenity Inn (also operated by Alcohol Drug Care Services) was reported by 4% ( $n=36$ ) of the population. Seventy-five percent of respondents were living in situations that were likely very temporary (i.e., camping, car, emergency shelter, trailer/RV/Camper, friend/family, motel).

**Figure 7: Living Situations Reported in Arcata**



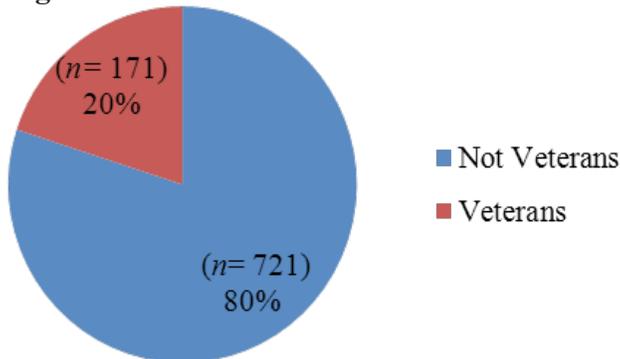
Arcata had the second largest percentage of people identified as homeless, twice as much as any other geographic area except for Eureka. Living situations differed from those reported in Eureka. For example, 41% ( $n=73$ ) of people reporting that they lived in Arcata said that camping was their primary means of shelter, compared to 14% in Eureka. Seventeen percent ( $n=30$ ) reported living in their car, compared to 8%. About the same number were staying with friends and family (16%,  $n=29$ ). Arcata’s emergency shelters, such as the Arcata Night Shelter operated by the All Faith Partnership, was reported by 12% ( $n=22$ ) of respondents, while 10% ( $n= 17$ ) were staying in Arcata’s transitional housing facilities such as the Arcata House. Other reported living situations, such as motels, were minimally reported. While living situations that were likely very temporary in nature were common in Eureka, they were even more pronounced in Arcata, with 91% reporting that they were camping, living in a car, emergency shelter, trailer/RV/Camper, friend/family, or motel.

**Table 1: Race and Shelter<sup>2</sup>**

	<i>White</i>	<i>Native American</i>	<i>Asian</i>	<i>Black/African American</i>	<i>Multiple Race Combinations</i>
<i>Un-Sheltered</i>	41% ( $n= 221$ )	35% ( $n= 57$ )	52% ( $n= 35$ )	42% ( $n= 11$ )	57% ( $n=25$ )
<i>Impermanent Housing<sup>3</sup></i>	14% ( $n= 75$ )	22% ( $n= 35$ )	19% ( $n= 13$ )	15% ( $n= 4$ )	14% ( $n= 6$ )
<i>Sheltered</i>	45% ( $n= 245$ )	43% ( $n= 70$ )	28% ( $n= 19$ )	42% ( $n= 11$ )	30% ( $n=13$ )

Differences are revealed when the categories of race and shelter status are examined. Those who identify as Asian or Multiple Race Combinations had the highest rates of being un-sheltered while those who identify as White reported the highest rate of being sheltered. Native Americans had the highest rate of impermanent housing.

**Figure 8: Veteran Status**



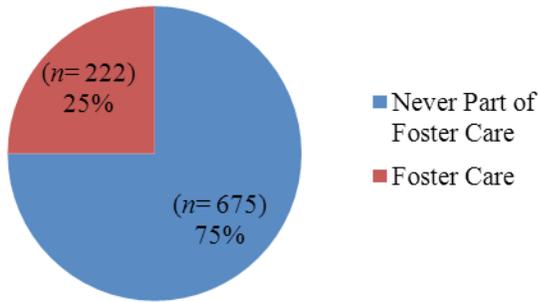
Twenty percent ( $n=171$ ) of the 892 people who responded to the question “Have you ever served in the U.S. Military,” said yes. Ten of these people identified as women, 158 identified as men, and the other three did not

<sup>2</sup>In recognition of the differential effects of people’s experiences based on racial/ethnic identification and *perceived* racial/ethnic identification, Native American, Asian, and Black/African American include those who identify as a single “non-white” race as well as those who identify as “white” and another race. The category Multiple Race Combinations includes those who identify as more than two races.

<sup>3</sup>The Department of Housing and Urban Development did not require “couch surfing”, which is defined as sleeping on somebody’s couch, or “doubling up” to be included in the sheltered or unsheltered categories. They remained a separate category altogether, which we called “impermanent housing”.

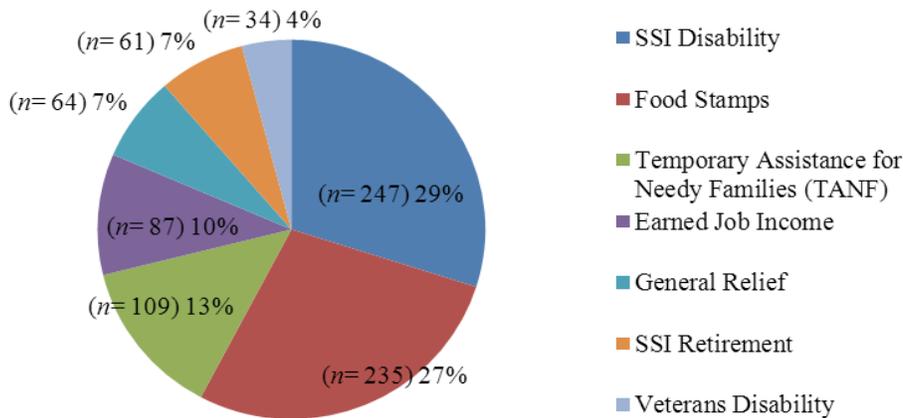
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respond to the question about gender identification.

**Figure 9: Foster Care**



When asked “Have you ever been in the foster care system,” 25% ( $n=222$ ) of the 897 individuals who responded said yes. This question included adults and children.

**Figure 10: Source of Income<sup>4</sup>**

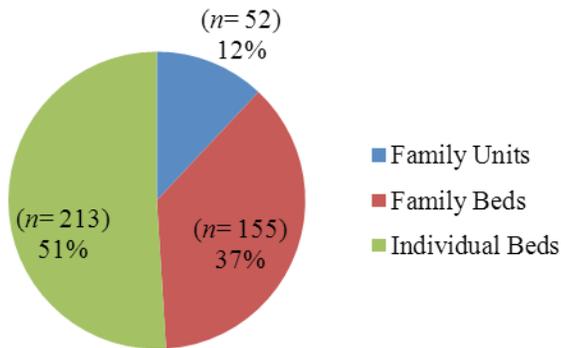


The most common sources of income reported were SSI/Disability (29%,  $n=247$ ), food stamps (27%,  $n=235$ ), and Temporary Assistance for Needy Families (13%,  $n=109$ ).<sup>5</sup> Earned income from a job accounted for 10% ( $n=87$ ) of those surveyed, 7% ( $n=64$ ) reported receiving general relief, 7% ( $n=61$ ) received SSI/Retirement, and 4% ( $n=34$ ) received Veterans Disability. This information is particularly relevant in the context of the State of California’s recent reductions to the Supplemental Security Payment (which is attached to SSI) and CalWORKs cash aid.

<sup>4</sup>It is likely that people reported more than one source of income. The totals here may equal more than the total individuals surveyed.

<sup>5</sup>Temporary Assistance for Needy Families (TANF) is a grant program, which provides financial assistance through the United States Department of Health and Human Services in order to turn welfare into a program of temporary assistance (U.S. Department of Health and Human Services, 2011).

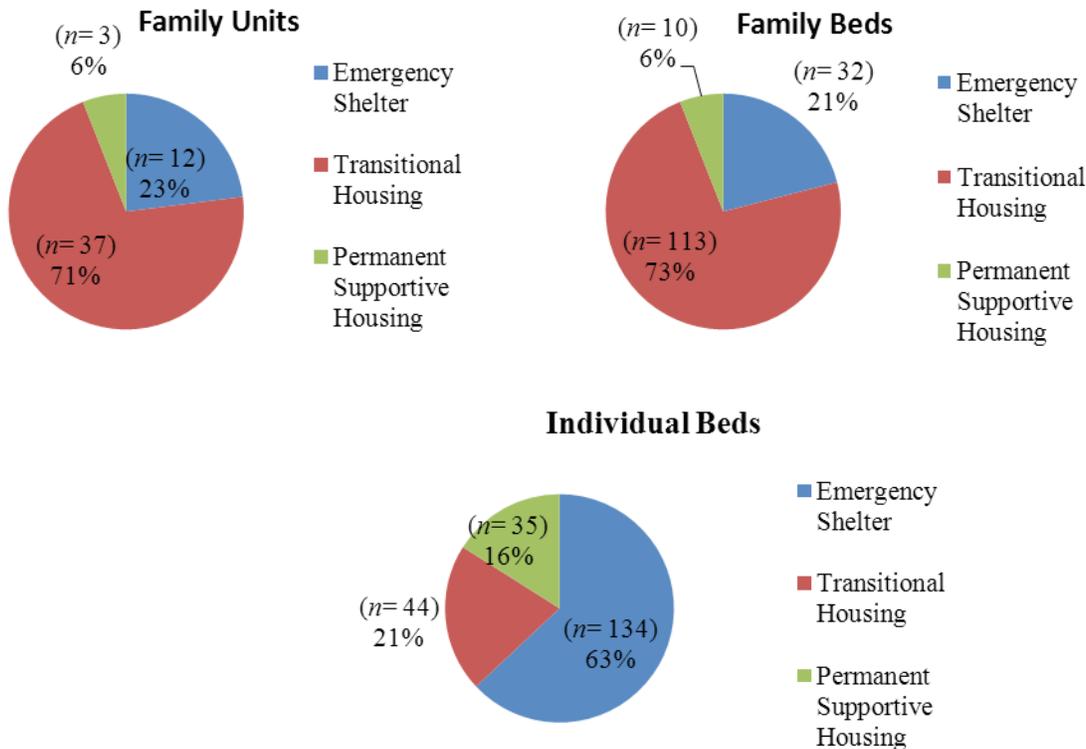
**Figure 11a: Beds in Humboldt County**



The U.S. Department of Housing and Urban Development’s 2010 Continuum of Care Housing Inventory Chart<sup>6</sup> reports on inventory of beds and family units available to the homeless in Humboldt County (HUD, 2010). This is separate from the Point-in-Time count but is likewise part of the federal requirements for receiving HUD funds. A “unit” refers to an apartment or living space that may include more than one bed.

Of the 420 available spaces, 51% (n= 213) were for single individuals, 37% (n= 155) were family beds, and 12% (n= 52) were family units. This may be compared to the 1,626 individuals reported homeless in the January, 2011 PIT count.

**Figure 11b: Beds by Program Type**



<sup>6</sup>The 2011 Continuum of Care Housing Inventory Chart has recently been released and can be found here: [http://www.hudhre.info/CoC\\_Reports/2011\\_ca\\_522\\_bed\\_inventory.pdf](http://www.hudhre.info/CoC_Reports/2011_ca_522_bed_inventory.pdf). Numbers are not comparable because of the time limited federal stimulus funds available for the Homeless Prevention and Rapid Re-housing Program (HPRP) through the American Recovery and Reinvestment Act of 2009.

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Of the 213 beds for individuals 63% ( $n= 134$ ) were in emergency shelters, 21% ( $n= 44$ ) were in transitional housing facilities, and 16% ( $n= 35$ ) were permanent supportive housing. Twenty-one percent ( $n= 32$ ) of the 155 beds allocated for families were in emergency shelters, 73% ( $n= 113$ ) were in transitional housing facilities, and 6% ( $n= 10$ ) were permanent supportive housing. Of the 52 family units provided in Humboldt County facilities for people who were homeless, 71% ( $n= 37$ ) were located in transitional housing facilities, 23% ( $n= 12$ ) were in emergency shelters, and 6% ( $n= 3$ ) were in permanent supportive housing. Permanent supportive housing trails other models for addressing homelessness in each of the categories.



Photo Source: Library of Congress, Prints & Photographs Division, FSA-OWI Collection, fsa 8b27229

## Part III: Literature Review

### *Methodology*

People experiencing homelessness are clearly exposed to multiple harms. These include health risks related to inadequate hygiene, trauma, accidents, victimization, infections, self-neglect, substance abuse, exposure to the elements and violence, poor nutrition, fatigue, and increased contact with communicable diseases such as Hepatitis, HIV, and TB (McNiekl & Binder, 2005; Nyamathi, Berg, Jones, & Leake, 2005; Nyamathi, Longshore, Galaif, & Leake, 2004; Palepu, Horton, Tibbets, Meli, & Samet, 2005; Stein & Nyamathi, 2004). Homeless adults experience health problems such as seizures and musculoskeletal disorders (Crowe & Hardill, 1993), chronic diseases like diabetes (Wilk, Mora, Chaney, & Shaw, 2002), respiratory tract infections (Martens, 2001), poor dental care (De Palma et al., 2005; Pizem, Massicotte, Vincent, & Barolet, 1994), skin and foot problems (Stratigos & Katsambas, 2003), mental illness (Ball, Cobb-Richardson, Connolly, Bujosa, & O’Neill, 2005) and substance abuse (Nyamathi, Leake, Longshore, & Gelberg, 2001).

In conducting a literature review that focuses on reducing harm and improving outcomes in community responses to homelessness, we concluded that key words associated with successful and collective community action was necessary rather than a focus on deficits and shortcomings. This allowed us to examine the many ways individuals, families, and communities address homelessness without needing to take a position on whether positive outcomes are related to character traits, specific services, or demographic characteristics. For example discrepancies abound regarding the conceptualization of resilience as a trait, process, or outcome. Nevertheless there are many ways to foster resilience (Jones, 2006).

The keywords we decided to match up with “homeless” or “homelessness” were developed with individual, organizational, and community contexts in mind using distinct concepts and their synonyms. The initial list included: accessibility, asset-based, best practice, building/fostering/ strengthening/developing resilience, capacity building, citizen, collectivist, community-building, coping, dignity, empowerment, evidence-based, follow-through, grassroots, harm minimization, harm reduction, help-seeking, inclusion/inclusive, integration, motivational interviewing, peer-support, persistence, protective factors, respect, rights, risk reduction, self-organizing, and vulnerability.

This inventory was narrowed down and refined to the keywords noted in Table 2, which lists the search terms entered into the three databases accessed (PsychInfo, Social Services Abstracts, and Sociological Abstracts), articles initially retrieved, and those determined as relevant for use in the literature review.

**Table 2: Literature review methodology**

<i>Keywords<sup>7</sup></i>	<i>Records Retrieved</i>	<i>Articles Reviewed</i>
“integration” + “homeless”	66	18
“includi*” + “homeless*”	19	6
“access*” + “homeless*”	48	14
“survival” + “homeless*”	47	6
“protecti*” and “homeless*”	34	8
“best practice” + “homeless*”	13	2
evidence based,” or “asset based” + “homeless*”	41	1
“community build*” + “homeless”	10	2
“coping” + “homeless*”	323	2
“empower*” + “homeless*”	228	6
“harm reduction” + “homeless*”	61	3
“risk reduction” + “homeless*”	54	1
“motivation*” + “homeless*”	183	2
“organiz*” + “homeless*”	56	2
“rights” + “homeless*”	76	1
“resilienc” + “homeless*”	134	2
“respect” + “homeless*”	181	5
“strengths” + “homeless*”	28	8
<i>Totals</i>	<i>1610</i>	<i>92</i>

### *Themes*

Eight themes that describe methods for reducing harms related to homelessness were identified across four broad categories. The four categories are: Structured Opportunities for Community Contributions, Relevant and Accessible Services, Social Support, and Attitudes. The eight themes are: giving back, vocational training, governance, community integration, peer-support opportunities, fostering family connections; responsiveness to immediate needs, and individualized services.

<sup>7</sup>Typically, when an asterisk is used to search a database, any sequence of letters can follow. For example “homeless\*” can include “homeless” and “homelessness,” while “includi\*” can include “inclusion,” “inclusive,” and “inclusiveness.”

**Table 3: Literature review categories and themes**

<b>Structured Opportunities for Community Contributions</b>	<b>Relevant and Accessible Services</b>	<b>Social Support</b>	<b>Attitudes</b>
<i>Giving back</i>	<i>Vocational training</i>	<i>Giving back</i>	<i>Governance</i>
<i>Vocational training</i>	<i>Peer-support opportunities</i>	<i>Governance</i>	<i>Individualized services</i>
<i>Community integration</i>	<i>Responsiveness to immediate needs</i>	<i>Peer-support opportunities</i>	
<i>Governance</i>	<i>Individualized services</i>	<i>Fostering family connections</i>	
<i>Peer-support opportunities</i>	<i>Fostering family connections</i>		

The first theme is that of *giving back*. The experience of giving back reflects acknowledgment of the experiences that helped individuals move out of homelessness and a wish to help others do the same. This theme includes settings where individuals who are presently experiencing or have formerly experienced homelessness provide services to current agency participants (Anker, 2008; Berkshire, 2007; Connor, Ling, Tuttle, & Brown-Tezera, 1999; Ovrebo, Ryan, Jackson, & Hutchison, 1994). This theme also includes informal and formal peer support among those experiencing homelessness, such as resource-sharing, outreach, and health education (Connor et al., 1999; Kidd & Davidson, 2007), as well as providing needed goods or services to the larger community (Brandt-Meyer & Butler, 1999). Research among individuals who have had such opportunities to give back report a sense of empowerment (Ovrebo et al., 1994); community and collective identity, contribution, and legitimacy; and usefulness of one’s knowledge and experience (Anker, 2008; Brandt-Meyer & Butler, 1999; Connor et al., 1999; Ovrebo et al., 1994).

*Vocational training* is the second theme, consisting of ways of providing skills, support for retention of skills, as well as employment. Vocational programs that have high levels of success go beyond education to include strategies for assisting people with utilizing their existing strengths (i.e., empowerment). There are opportunities to be peer educators (Connor et al., 1999), community advocates (Anker, 2008), and service providers (Brandt-Meyer & Butler, 1999; Kidd & Barker-Plummer, 2009; Novak & Harter, 2008). Such opportunities reportedly provide participants with a sense of purpose, competency, self-esteem, and pride (Brandt-Meyer & Butler, 1999; Connor et al., 1999). Legitimacy and recognition within the larger community and culture was a major outcome of such experiences, as was visibility and social connection and contact (Anker, 2008; Kidd & Barker-Plummer, 2009; Novak & Harter, 2008). A sense of ownership and accomplishment were also outcomes of vocational opportunities that included creating, producing, and distributing goods and services (Brandt-Meyer & Butler, 1999; Connor et al., 1999; Kidd & Barker-Plummer, 2009; Novak & Harter, 2008). Findings regarding retention include on-going and individualized case management and job support, stress-management training, (Camardese & Youngman, 1996; Goetz et al., 1996; Munoz, Reichenbach, & Witchger-Hansen, 2005), and entry-level positions as a starting point (Thompson, Pollio, Eyrich, Bradbury, & North, 2004).

The theme of *governance* reflects a structure where the people accessing services have a say in what those services consist of and how they are distributed. Some research emphasizes the range of ways that participants can be involved in organizational service development and provision, such as social action, advocacy, peer mentoring, committees, and client feedback (Anker, 2008; Karabanow, 2004; Wenger, Leadbetter, Guzman, & Kral, 2007). A component of governance is that people with unmet needs have the opportunity to lead the process of need-based planning based on their personal knowledge and lived experience. This legitimizes the experiences of participants and places some responsibility for their progress in their own agency (Albers & Paolini, 1993; Anker, 2008; Finley, 2003; Gray & Bernstein, 1994; Karabanow, 2004; ). Self-governance was also found to build community and collective identity for those involved (Anker, 2008; Finley, 2003; Wagner et al., 1991).

The ideas of community building and collective identity relate to the next theme, which is *community integration*. This theme includes connection to the larger community, region, or culture. The importance of connection and social support with both peers and one's larger community are emphasized throughout the literature as a source of survival and resiliency for individuals experiencing homelessness (Albers & Paolini, 1993; Applewhite, 1998; Brandt-Meyer & Butler, 1999; Camardese & Youngman, 1996; Kidd & Davidson, 2007; Letkemann, 2009; Magee & Huriaux, 2008; McCrea & Spravka, 2008; Novak & Harter, 2008; Rew & Horner, 2003; Rew, Taylor-Seehafer, Thomas, & Yockey, 2001; Smith, 2008; Yanos et al., 2004). Another aspect of integration for individuals experiencing homelessness is developing a sense of self-worth and usefulness, especially through opportunities to contribute to one's community (Anker, 2008; Brandt-Meyer & Butler, 1999; Connor et al., 1999; Finley, 2003; Kidd & Barker-Plummer, 2009). Finally, opportunities for community integration that are both accessible and relevant were highlighted, such as minimal requirements for engagement, a range of available resources through participation, and culturally-specific settings (Finley, 2003; Hoffman & Coffey, 2008; Magee & Huriaux, 2008; Wenger et al., 2007).

*Peer-support opportunities* as a source of strength, validation, understanding, survival, and resiliency for individuals experiencing homelessness is strong in the literature (Banyard & Graham-Bermann, 1995; Kidd & Davidson, 2007; McCrea & Spravka, 2008; Racine & Seigny, 2001; Smith, 2008). Peer-support provides an opportunity to learn and contribute via mentoring and role-modeling (Connor et al., 1999; Finley, 2003; Kidd & Barker-Plummer, 2009; Ovrebo et al., 1994; Racine & Seigny, 2001). The literature suggests that peer-support opportunities are most effective when they are paired with professional service provider support for structure and supervision—as long as the pairing allows for the relevance of local knowledge and lived experience of consumers (Anker, 2008; Connor et al., 1999; Karabanow, 2004; Lovell & Cohn, 1998; Magee & Huriaux, 2008; Moskowitz et al., 2006; Wenger et al., 2007).

*Fostering family connections* is about human contact and social support. Developing and strengthening people's support networks is critical because these connections often remain long after formal services end and may serve as a source of motivation (Banyard & Graham-Bermann, 1995; Lam et al, 1999; Lindsey, 2000; Lobo & Vaughan, 2003; Mitchell, 2003; Ovrebo, Ryan, Jackson, & Hutchison, 1994; Reed-Victor & Stronge, 2002; Smith, 2008). The literature also stresses the importance of agencies being inclusive by recognizing client-defined connections, such as extended family members and non-blood related individuals, as well as being flexible and relevant with family-related services (Badagliacco, 1999; Finley, 2003; Thrasher & Mowbray, 1995).

*Responsiveness to immediate needs* is defined as agencies providing survival services as well as more long-term, on-going support and treatment. Many distressing events precede homelessness. For example, Rew, Taylor-Seehafer, Thomas, & Yockey (2001) found that the top reasons for young people leaving housing and ending

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up homeless included: being thrown out by parents (51%), problematic use of alcohol or other drugs (37%), sexual abuse (31%), emotional abuse (27%), running away (25%), parental intolerance of sexual orientation (24%), and physical abuse (20%). Much of the research highlights the success of organizations that provide comprehensive services, from meals and showers to behavioral health and substance abuse treatment (Aviles et al., 2004; Brunette et al., 2004; Busen & Engebretson, 2008; Gordon et al., 2007; Lindsey, 2006; McGuire et al., 2002; Proehl, 2007; Neale & Kennedy, 2002; Reed-Victor & Stronge, 2002; Richards et al., 2006; Shin, Weitzman, Stojanovic, Knickman, Jimnez, Duchon, & Krantz, 1998; Williams, Lindsey, Kurtz, & Jarvis, 2001). The research supports such services being highly accessible to participants, with minimal requirements for engagement, and client choice about what services to access or not (Badagliacco, 1999; Bogard, 1998; Finley, 2003; Fitzpatrick, 2006; Gray & Bernstein, 1994; Magee & Hurliaux, 2008; Moore, Young, Barrett, & Ochshorn, 2009; Rowe et al., 1998; Wenger et al., 2007). The importance of responding to immediate needs, while simultaneously providing access to more in-depth services is evidenced through the success and cost-effectiveness of programs that follow the Housing First model (Larimer, Malone, Garner, et al., 2009; Stefanie & Tsemberis, 2007; Tsemberis, Gulcur, & Nakae, 2004).

*Individualized and consumer-driven services* refers to comprehensive resources that are relevant to people's unique needs and can be tailored to what the client chooses to engage in. This also speaks to the consumer-driven aspect of this theme: the idea of "client as expert" of his or her own life, a person who has the right to determine what services or treatments to access and utilize (Badagliacco, 1999; Bogard, 1998; Gray & Bernstein, 1994; Jones, 2006; Kidd & Davidson, 2007; Lindsey, 1996; Rew & Horner, 2003). Agency staff responsibilities are to recognize, validate, and foster people's strengths so as to support positive progress (Applewhite, 1998; Banyard & Graham-Bermann, 1995; Bender, 2007; Hoffman & Coffey, 2008; Karabanow, 2004; Lester, Milby, Schumacher, Vuchinich, Person, & Clay, 2007; Lindsey, 2000; McCrea & Spravka, 2008; Nebbitt, House, & Thompson, 2007; Smith, 2008; Taylor, Lydon, Bougie, & Johannsen, 2004; Thompson, Pollio, Eylich, Bradbury, & North, 2004; Williams et al., 2001). This also reflects the "meeting people where they are at" approach of harm reduction by supporting people in whatever steps they take toward a self-defined improved health or safety without any requirements for engagement (Busen & Engebretson, 2008; Cooper et al., 2005; Greenblatt et al., 1993; Lindsey et al., 2000; Luna, 1991; Magee & Hurliaux, 2008; Neale & Kennedy, 2002; Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006; Proehl, 2007; Wagner, 2001; Wenger et al., 2007).

The four main categories of recommendations emerging from an extensive review of literature related to homeless services are: Structured Opportunities for Community Contributions, Relevant and Accessible Services, Social Support, and Attitudes. Across these four categories were eight themes which can be actualized within the broader category: giving back, vocational training, governance, community integration, peer-support opportunities, fostering family connections; responsiveness to immediate needs, and individualized services.

## **Part IV: Community Conceptualizations Around Homeless Services**

### *Rationale*

A set of questions to ask people in the Humboldt Bay area related to conceptualizations of homeless services was developed as a result of the above literature review (see Appendix A). The intent was to collect information from people considered “key informants” who interact with homelessness services from a broad community perspective. In this research, a “key informant” was someone who was widely regarded as a principal influence in local homeless services and/or someone with longstanding or unique knowledge about historical and current homeless services in the community.

The collected wisdom of all respondents generated the themes noted below. In this way, people are not categorized by an affiliation (e.g., service provider, law enforcement, politician), but rather the voice of the local community is represented as a whole. Our hope is that by presenting community conceptualizations like this individuals and groups that have previously struggled to find common ground will continue their work from a place of community unification. These themes may seem like “common sense” to some people who have experience and/or opinions related to homeless services. Nevertheless, the themes presented below emerge from the aggregate data, the “voice of the community” instead of a position of advocacy or the disproportionate influence of one individual or group.

### *Methodology*

Twenty-seven key informants were identified to begin the qualitative research process. Each person was contacted by phone, email, or in person to participate in the research effort. The final question in the research instrument asked for additional names of people to contact. These additional names were pursued as potential research participants until the timeline for the research project required discontinuing additional interviews. Three people declined to participate and 13 people did not respond to the request. Thirty-nine interviews were conducted in total.

Interviews took place at a location convenient to the participant and ranged from about 15 minutes to over one hour. All interviews were recorded and transcribed. In order to increase internal reliability of the data analysis, a different research assistant transcribed the interview than the person who conducted it. This allowed the interviewer to separate from the interview itself and engage with the data set as a whole rather than from the perspective of the individual interview. Another strategy for increasing the strength of the research findings was to have the transcriber use speech recognition software in the transcription process. While listening to the interview, a research assistant spoke the responses of the person being interviewed into a headset microphone and corrected any errors made by the software. This allowed research assistants to immerse themselves more deeply in the data than if the audio interviews were sent to a third-party transcription service or if the research assistants typed the transcriptions themselves. By listening to the words of the respondents and repeating those words into a microphone, connections between researcher and data are strengthened.

After generating the transcripts, an iterative process was used to discern themes inherent in the data as a whole. First, research assistance read each transcript in sequence. Then, initial overall impressions of the combined data set (i.e., the group of transcripts as a whole) were noted, rather than impressions from a specific interview. Next,

each transcript was read again, but overall impressions and common themes from each transcript were noted at the top of the first page of each transcript before moving on to the next one. Then, each transcript was re-read with the overall impressions from the previous reading in mind so as to clarify, discern, and refine impressions from the interview transcript.

After the third reading of each transcript, a list of all the overall impression statements was generated. The list of impressions from each of the transcripts was organized so statements that seemed similar were grouped together into distinct “piles.” These “piles” were refined until all statements were organized into groups and single outliers were excluded. Each “pile” of impressions was then given a name or theme. Lastly, the impression statements for each theme were reviewed one last time to ensure proper grouping.

After the research assistants completed their analysis of themes, they gathered together with the Project Director to engage in further refinement. Each assistant presented their categories to the other members of the team. Discussion and negotiation ensued until the team agreed on one set of themes/categories. Finally, the Project Director, who had not yet interacted with the raw data, reviewed the entire set of transcripts with the themes in mind so as to determine whether they were appropriate and valid.

The research assistants conducted a norming session with the Project Director utilizing the above process with three transcripts before the full analysis took place so as to strengthen inter-rater reliability.

### *Limitations*

The categories of community conceptualizations reported below are best understood within the context of certain limitations. Some limitations are associated with the research method, others are related to analysis, while still others are common to qualitative research efforts in general.

The research team spent considerable time developing language for the survey instrument. Great care was given to write questions that were not “leading” in terms of the range of responses that might be provided. This was particularly difficult in relation to the question about “Continuum of Care” and “Housing First” models. The team assumed that many respondents would be familiar with practices consistent with the two models, but might not be familiar with the name of the models. The team wanted to provide definitions for the two models without judgment or evaluation. In the end, the decision was made to use definitions provided by organizations associated with each of the models. While the research was being conducted, the team noted that respondents’ understanding of the distinctions between “Continuum of Care” and “Housing First” differed greatly. Though the definition was provided to respondents in the form of the list of questions, the definitions were not read to all interviewees which may have led to some confusion or misunderstanding of the distinct models.

Other limitations should also be noted. Though the purpose of the research was stated in the consent form, some respondents were suspicious of the purpose of the research and may have withheld complete information. The word “duplication” used in the interview turned out to be problematic as some respondents considered this a “loaded” term related to funding scarcity.

Qualitative research in general is limited in the method for analyzing data and drawing conclusions. One way of strengthening reliability is to have the categories of description (i.e., the themes below), reviewed by an independent researcher (Åkerland, 2002). The degree to which multiple reviewers agree on which conceptions belong in which category can establish the quality of inter-rater reliability. This is why the team conducted a

norming process before analyzing the data set as a whole, independently developed the categories, engaged in a facilitated discussion about each researcher's categories to establish the final themes, and had the Project Director provide an independent final review of the themes in relation to the data.

### *Findings*

Each finding below represents one of the themes identified in the analysis of the data gathered in this study. Following each theme is a "recommended outcome" that logically follows from the theme identified. These outcomes are presented without judgment or evaluation of the current state of local affairs in relation to services for people who are homeless. These outcomes are based on the professional literature, built on existing community resources, strengths, and competence, and achievable.

***1. Homelessness is understood within multiple contexts. This includes individual behavior and problems, but it also includes economics, employment opportunities, laws, geography, and health. This understanding means successful interventions must address the same contexts.***

It is common to believe that only certain behavior leads to homelessness. In reality there is no all-encompassing reason for homelessness.

I think the reasons that people become homeless vary greatly. I think a common misunderstanding is that people become homeless because of a general choice to become homeless or some type of addiction issue. My understanding is that people [become homeless] out of different life experiences, not just those two things.

There are numerous causes of homelessness for different people. These can range from personal circumstances to national policies. They include individual behavior and dilemmas such as: fights with family members, alcohol and other drug dependencies, mental health conditions, and eviction. Other larger circumstances that may lead to homelessness are: unemployment, making less than a living wage, inability to access healthcare, lack of programs for people as they exit prison or the military, and lack of affordable housing. These larger circumstances that cause homelessness have become more apparent as our society changes.

There are more people in [homelessness] because of the economy, because of the job market being such as it is. I have been here a long time and when I first came here you could make a pretty decent living without a high school education working in a lumber mill or out in the woods and you could buy a home and you could support your family and you could make a living and have a career of it ... so a whole heck of a lot of people are finding themselves "eligible" for homelessness or absent career or vocational opportunities because the world has changed.

It is overwhelmingly agreed upon by research participants that people do not choose to become homeless.

A lot of the people on the street are there because they are afflicted. Not because they have chosen that lifestyle.

People, through no real fault of their own, find themselves in this situation [homelessness] or close to it.

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Whatever life circumstances that may have led to someone being in a position of homelessness were not chosen and it is not an ideal lifestyle.

When thinking about how best to help people who are homeless it is important that the community has in mind all of the reasons why someone may become homeless.

In terms of protecting people from homelessness in general, aside from having a booming economy and planning plenty of affordable housing, the other step is to have resources that can step in right when people are at the point of saying “I guess we are going to sleep in the car tonight.”

There data was clear that programs that address individual dilemmas such as drug addiction and mental health but there also must be programs that address larger issues such as lack of employment and affordable housing.

*Recommended Outcome: All stakeholders involved in efforts to minimize homelessness develop comprehensive strategies that, at a minimum, detail how the mission/purpose and specific practices of distinct groups relate to one another.*



***2. The risks people face when they are homeless serve as barriers to moving out of homelessness and contribute toward entering homelessness in the first place.***

Research participants identified many harms that people who are homeless face. Some of the most cited physical risks were exposure to weather, malnutrition, low personal hygiene, lack of healthcare, and risk of experiencing violence. These can lead to illnesses that affect people who are homeless differently than those who are housed.

You know if you or I get the flu we crawl into our warm bed and hide until we're better and if we don't come out often enough someone who cares about us is going to come in and force us to take fluids or take us to a doctor or whatever. This doesn't happen with people [who are homeless]. I mean they could get the flu or a bad sinus infection and die.

Chronic health conditions are also experienced differently.

If [people who are homeless] have complications like diabetes they can't take care of that condition in a timely way. Eat when they should eat, medicate when they should medicate. They experience consequences of diabetes much sooner and much worse than a housed population would.

The emotional harms of social isolation and developing a sense of hopelessness were mentioned as well. These harms are considered just as serious as physical harms.

The most significant harm is harm to the psyche, harm to the spirit if you will. I mean there's hunger, there's cold, there's disease, there is a whole gamut of things that can be defined as harms to people in that situation. It is a very significant harm to reach a point in your life where you have no hope.

There is this pervasive fear [while experiencing homelessness] so what you do is concentrate on your basic needs, just satisfying or trying to satisfy those. There is a little of that built in, not hopelessness, but an inability to see the future because you are so concentrated on taking care of your immediate needs.

These harms, both physical and emotional, make it extremely difficult to move out of homelessness. They, along with societal factors mentioned earlier, also may have contributed to someone becoming homeless in the first place. This can create a cycle of homelessness that is extremely difficult to break.

I see here the cycle of homelessness creating over and over because there are so many factors that contribute to it.

For example, a person may become homeless because they lose their job and no longer can afford rent. With nowhere else to go they begin camping somewhere. She/he would like to begin working again but there are limited employment opportunities. There is no guaranteed safe access to a place to take care of self-cleaning/hygiene. Without smelling and looking clean, presentation to a potential employer is compromised. Income is unsteady so it is difficult to attain stable housing. She/he may be living with a chronic health condition, as do almost 50% of all Americans (Centers for Disease Control and Prevention, 2009). Hunger and violence may feature into all this as well. Because this is a very difficult cycle to break with causal factors constantly piling one on top of the other it is important to develop service strategies that are able to step in at any point. Many

services may help this person's situation: a food program, a shower program, housing, job training, etc.

It's what you can provide for people. If you want to stop people from being chronically homeless ... then give them something in there that will break the cycle of homelessness.

Any of these services might be the one that can break the cycle of homelessness if they are easily accessible.

*Recommended Outcome: Service providers adopt a "no wrong door" approach in which all barriers to services are eliminated.*

***3. Awareness of homelessness is increasing which means the effects of stigma and bias need to be addressed.***

More citizens of this community are becoming aware of the issues of homelessness and more are invested to try and help.

[Homelessness] is a compelling social issue that affects a lot of us and we have a responsibility as the community, not just as welfare or social services or a church or a chamber but as a community to try and address it.

Now is an opportune time to increase education about dilemmas that people who are homeless face. Though respondents were clear that people do not choose to become homeless they believe that the larger community believes otherwise.

There's just a real lack of really good education about the fact that these are all our friends and neighbors.

Education to the larger community about homelessness could decrease biases. Part of education is building connections.

People should know that most people do not want to be homeless. That is not their desired choice in life. They are not criminals, or bad people. They have experienced some hard times and they need help. They are not throwaway people just because they are on the street. They still have dignity. They still need respect.

I think there could always be more of a connection between the larger population, or the non-homeless population, and the homeless population in understanding what is going on and what those systemic reasons for folks finding themselves there are ... education in the community can connect folks and remove those stigmas and misconceptions ... people feel really disconnected and in the dark about homeless issues in general.

Most importantly, local community education about homelessness could increase investment from citizenry to help people out of homelessness.

[People who are homeless] are humans. That is what a lot of people forget. People just like me and you. We are all dealt a hand at birth, so we play it. Sometimes your hand doesn't come out so well.

*Recommended Outcome: The group referenced in Recommended Outcome #4 develops, implements, and evaluates an educational campaign about the diversity of homeless experiences, struggles, and identities.*

***4. With increased awareness has come increased community and institutional involvement. Some of this is coordinated, some is in parallel, and some is contradictory.***

Diverse members of the community, not solely service providers, are invested in helping people out of homelessness.

In this community...more people are involved in trying to address the problem. I think that's a good thing. It seems like a lot of the people that are involved have a lot of different ideas how to accomplish the resolution or solution for homelessness, and that's fine too because there are a lot of reasons why people are homeless, so I'm hopeful.

This feeling is agreed upon by research participants--that we need investment from all areas of the community in order to be successful at minimizing homelessness.

There have been coordinated efforts by many different people in the community to assist in this issue. These efforts are considered useful because they allow the transmission of ideas from one invested person. They also allow for cross-agency training considered useful by many participants.

Every single time we meet we are constantly sharing information so I am always learning something about something that I didn't know about that helps me be a better [worker] and provide better services to the community.

The more training you can do between educators and nonprofits, education staff and social services or probation or tribal entities, then that kind of cross training around an issue like homelessness is really helpful.

The most important sentiment with regards to community collaboration is that different people are taking the time to just sit down together. This is considered intrinsically positive.

We got people to sit down together. It has evolved to the point now that there is actually movement to do some community education and to start building a network and the collaborations to start changing the perceptions.

Other groups of people have formed alternative organizations to discuss homelessness and help reduce harms. Sometimes the distinct organizations and collectives work in parallel—not with each other or against each other. Some participants described community groups that contradict one another in their work, highlighting such conflict as communication.

Communication can run poor and I think that a lot of times we are struggling for the same natural resources in our community when we could potentially be working together more, sharing more ideas, having more crossover and referral services.

*Recommended Outcome: People invested in helping minimize homelessness meet in consistent and inclusive gatherings. The group includes, at a minimum, service providers, chamber of commerce members, activists, and consumers of homeless services.*

**5. *A continuum of housing is necessary.***

Not to be confused with the “continuum of care” or “housing first” models, a continuum of housing provides a range of safe opportunities for people who are without stable housing. The data demonstrate that a significant range (or continuum) of housing options is necessary to best help people out of homelessness. The range goes all the way from safe ways for people to sleep outside to permanent supportive structures.

I think if you want people to not be homeless then let’s make housing ... and housing is going to look different. Maybe part of that housing will be a campground that is managed and is healthy and safe ... Does it have to look like a standard apartment or apartment building? No ... [in] my mind housing is our ultimate goal. That’s what we want ... It can be anywhere from a campground, to an institution, to the most amazing permanent housing cluster of homes with services.

The importance of housing was very clearly expressed by respondents.

Housing is one of Maslow’s primary needs. People need housing, or some type of shelter, to be healthy, safe, happy, and successful as they can be in their lives. I think that just getting people into housing and supporting them is one of the best ways to protect people.

Many research participants acknowledged that people who have become accustomed to sleeping outside might not be comfortable with transitioning into traditional housing options.

Not everybody wants to have a house with two bedrooms and a bathroom and a garage.

For people who might prefer to be outside some suggestions for housing include campsites, managed campgrounds, and simple structures for outside living. When thinking of how to shelter people it must be kept in mind to think beyond four walls and a roof.

I think that looking at different ways to house people and thinking outside the box and realizing that not everybody wants to live in an apartment.

Other housing that many research participants cited as useful are shelters and transitional living facilities. Both these options allow opportunities for engagement with service providers.

I think we do need more shelter. At least that could provide a bed and begin initial engagement to other services.

It is important to note that many research participants cited that often people who are homeless feel unsafe in shelter style housing.

It would be a shame not to have [shelters] but it doesn’t feel like enough people can use it and feel safe using it and so that’s why I would say it’s not very useful.

Some see shelter as a necessary alternative because of lack of other options and weather concerns. A solution mentioned would be to make shelters more personal.

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I would rather see us invest our energy and money into something more substantial. [It would be more beneficial to have] smaller shelters that are more homelike. They can still have a homelike setting where people feel individually cared for.

Transitional housing facilities allow people who are homeless to begin re-integrating into the traditional housing sector.

The longer you are homeless the harder it is to get into housing. So transitional shelters that teach those life skills help people move up the [housing] ladder which is very important and a missing step to helping people.

Single residence occupancies (also known as SROs) were frequently mentioned as an un-tapped housing source. SROs are small, affordable efficiency apartments intended to house a single person with limited and/or fixed income.

I have also been in favor of SROs, single room occupancy places because you need affordable housing. I think some of these homeless people, a lot of them are on SSI they could possibly afford a room in an SRO where they couldn't afford any other kind.

Participants in the research noted that the community has current property that could be converted into SROs to house single people who are homeless.

To take old motels in Eureka and change the ordinances that would allow them—most motel rooms are under 200 square feet—and change the ordinance to allow it to be an efficiency unit which would allow somebody to live in it. So we could convert old motels into efficiency units with the primary focus being the chronically homeless. You have stable housing and you have the support.

Other housing options mentioned by research participants include affordable housing and permanent supportive housing. Affordable housing is having traditional housing options available (apartments, single family homes, etc.) that people can afford on either fixed incomes (for example SSI) or with minimum wage jobs. Research participants mentioned often that there is not enough of this type of housing.

When you have people who could [receive] a Social Security Disability income of \$900 a month. If they could find a safe rental for \$300 a month then they could probably afford it. That's not really out there on the market right now, so I think we need to build a lot more affordable housing that can be accessed by people on fixed incomes.

Access to affordable housing might prevent homelessness in the first place because people would be living in homes that they can afford and would be less likely to fall behind on bills or rent.

If we had more low income housing ... more people could afford to live in a safe and healthy place. This could change the impact on their life significantly.

Permanent supportive housing refers to providing people who are homeless a place to live that includes provision of support services. This addresses the harms that can be linked to homelessness itself and delivers services to aid with dilemmas that may have contributed to becoming homeless in the first place and/or have served as barriers to leaving homelessness.

For people who are not necessarily capable of living by themselves or taking care of their needs, permanent supportive housing needs to be expanded because there are always going to be people who cannot live by themselves.

No matter how much housing you build, if you do not have the services to go with you are going to have a problem.

Many participants agreed that permanent supportive housing works and should be expanded in our community.

Conceptualizations about the social structure of housing were more complicated and reflected issues of community integration and exclusion that turned up in the earlier literature review.

A campground should never be built, and housing should never be built just for the homeless. Because that means that we are going to create special rooms for them. No. these are regular people...everyone in Humboldt County or passing through Humboldt County will have the same ability to stay at that campground because I believe the homeless population are not somebody to be feared. I don't believe that they are somebody that needs to be separated.

This inclusionary housing may decrease stigma and bias and allow people who are homeless to fully reintegrate into the larger community. Barriers were identified to this approach, however.

I'll tell you honestly, who wants them in their house or in their neighborhood? Go somewhere else. Where will they go? Nobody wants them. I hope [housing for people who are homeless] really happens but I don't see it. Nobody wants them in their neighborhood.

They are scattered. They are intermixed with other apartments and the problem with that what is hard to do from social services is your clients are all over the place and you have to go to them ... it is harder to monitor what is going on. But at the same time that is good because you are integrating them into the 'normal society'.

No matter which form of housing a participant might endorse, the data clearly revealed that there is not enough housing in the community.

The best thing is to have housing. I mean we really really need housing.

It was recognized that having adequate housing may be difficult but it is an important task to take on.

It is a very difficult issue and I think that looking at a variety of ways to provide housing and not making it a blanket solution and making services user friendly [is necessary].

*Recommended Outcome: A continuum of housing options is available including, but not limited to, affordable housing, single resident occupancies, encampments, structured and supervised facilities, humanitarian shelters, and mobile shelters.*

**6. Outreach and accessibility are critical and they are not the same.**

Often those who need to access services do not know where to begin or are worried that they will be unable to get the help that they need. One way to address this is to bring services to where people are at. This begins building a relationship with individuals and groups and allows for more timely help out of homelessness. Research participants pointed out that it may be overwhelming for people who are homeless to come into a building, wait till someone can see them, fill out paperwork, and then meet with a case manager. Often it seems too daunting to even try.

Their waiting room for people coming in and applying for benefits is pretty daunting if he's never had to ask for help before or even if you have. You walk in, you have to take a number, there are a lot of people around so you wonder if you're even going to be seen that day and how long it's going to be. You may be dealing with an intake worker who's on her 12<sup>th</sup> interview of the day ... [they feel like] just another number in line.

I sat there [at an agency] one time. I had just one simple question. I had to wait there an hour and a half. People that have mental [health] problems don't have the strength to sit there for that long.

Outreach services are more client/consumer friendly. As explained by one research respondent:

A lot of people are not able to articulate their needs ... if someone comes directly to them with food, clothing, shelter that motivates people to access the services rather than trying to seek them out. I think that all the outreach done...after a while that becomes motivational. When you begin seeing people there all the time who want to help you people's suspicion goes away and they become motivated to seek out services.

Research participants cited that the service providers who are currently engaged in outreach are very successful at reaching and helping people. They are also well liked and trusted by the client population because they are willing to go to where the clients are and begin building a relationship.

I think the outreach programs are one of the most effective and useful tools we have ... Everything that we do in the outreach has to be about getting people to a place where they are safe and comfortable.

Accessibility goes along with outreach by acknowledging that the process of accessing services (e.g., long waits, large amount of paperwork, etc.) can be an overwhelming process for people who are homeless. Accessibility is also defined as being able to access services right when someone needs them. Waiting periods and waiting lists are not conducive to helping people out of homelessness. The most cited example of this in our area was in relation to alcohol and other drug programs. There are waiting lists for treatment facilities and sometimes people must be sent out of the area to receive care.

By far we lack in this county drug and alcohol services both for youth and adults in a meaningful way ... Drug and alcohol services are key and having them immediate, an open door policy, having them spread out and having a continuum of services ... It has to be in this county, has to be kept as local as possible. But it's not.

By the time there is space in a facility for a person to receive care they may no longer be ready to access

treatment. Being able to access services right away when somebody is ready is crucial to helping people out of homelessness.

We do have mental health services but it feels like an older system that is not user-friendly. Again what our kids and families need are extremely user-friendly systems where the minute they are needed, or the minute they step forward and acknowledge that they have to do something the doors have to open for them. They have to be like, “Okay come on and let’s do it.” Not, “We have to fill out the paperwork and will get back to you in a week and then we’ll do an assessment in two weeks, then after that figure out [what to do].”

*Recommended Outcome: Services are available on-demand (i.e., services are available as soon as the person is ready to receive services) and nearby.*

**7. Individualization and coordination are critical and they are not the same.**

Research participants indicated that no two people, including people who are homeless, are the same.

Hopefully the different service providers are approaching the need to provide for people who are experiencing homelessness from different angles to reach different ... needs of [different] people.

This theme suggests a strong sentiment that services work best when they are tailored to the individual. What works for one person may not work for another—there is no “one size fits all” approach to helping people out of homelessness. While people dealing with homelessness share the condition of homelessness, their service needs differ from person to person.

I guess the traditional approach has just been to throw money at it. Let’s create a program. Let’s hire a bunch of social workers and we will write vouchers for housing or for meals. But that approach doesn’t really consider the individual, it considers only the demographic and that is part of why that fails.

Coordination relates to individualization. An individualized service plan may require coordination between different service providers. An effective and efficient way to accomplish this is the “one stop shop” idea. Instead of having the client commute to several different agencies, services are consolidated at one location with access to food, clothing, shelter, healthcare, and benefit eligibility processing

A lot of people get really overwhelmed with trying to keep an appointment. If they are on one end of town and they have to walk to the other end of town and it’s winter and they have boot rot...it would just be better to light a fire and try to dry out then try to go to an appointment at [several different agencies].

Coordination allows for easier access to services that the client needs.

I think historically the strategies have been ... a kind of one-size-fits-all approach ... it is a rather inflexible system where the client ... has to fit within the structure of the program as opposed to having the flexibility in the program itself to better respond to the individual circumstances or need that person has ... someone walks in the door they are engaged in a triage or intake process that really gets into needs and circumstances of the individual rather than okay this is our program see if you can find the doors to walk through that work for you.

*Recommended Outcome: Case managers have light enough caseloads that they may work towards individualizing and coordinating services for each person they serve.<sup>8</sup>*

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<sup>8</sup>Examples of field-tested assessment instruments can be found in Appendix B.

***8. Choice is essential and should not be confused with duplication.***

Freedom and choice are at the heart of American discourse. This preference for making choices does not go away when a person becomes homeless.

It's like when you go to Safeway and look at everything you can pick and choose. In the labor market you would love to have four job offers so you can say which one fits me best. It is the same thing for homeless people ... You need a range of possibilities and we are woefully short of possibilities.

Having only one available option for someone to receive services does not take into account those who may find accessing services easier somewhere else. Research participants agreed that allowing for choices should not be considered duplication. In fact, providing choices to people who access services is an excellent means to facilitate the experience of dignity to people who are homeless and to provide an opportunity for clients to make changes in their lives.

There are ways to deal with [homelessness] that are human, that respect an individual's choice and their situation.

Research participants also suggested that duplication of services is not present when so many people go without services. All the services available in our community are necessary.

I think that even though there are programs that do the same thing I think the need is so great that they don't overlap. I think the [current] programs serve different clientele and operate in two different geographic locations. I think that even though there may be some duplication of services in some ways it helps to have a diversity of programs. The need is so great that they are all necessary.

Until there are no waiting lists or gaps in services then duplication is not a strong concern.

*Recommended Outcome: Instead of being viewed as a problem to avoid, duplication is considered something to coordinate so all people are receiving the care they prefer based on their location, need, and individual choice.*

**9. Coordination is not the same as collaboration.**

Coordination and collaboration emerged as themes in the data, but as distinct phenomena. Coordination was presented as organizations letting each other know what steps they are taking in the community to serve people who are homeless. Then other organizations can fill in the gaps to try and increase the amount of care.

Service providers who might see similar demographics and offer similar services try really hard to coordinate services and work with each other. I think that is a really positive thing and shows the level of commitment of the people providing services in this community.

Collaboration brings organizations together to create a shared plan of service provision. The plan includes where people will go to access the service and which organization will do what in providing that service. For example, one respondent described a collaborative initiative this way,

I think it provided an opportunity for several homeless service providers to really work together on a single project. I think it has helped the collaborations among those agencies and I think there is better communication among the homeless service providers. [There was] an additional opportunity to get on the same page and really demonstrate a united front against homelessness. I think that was a really positive step for the community.

While coordination and collaboration have contributed to effective service provision, the data suggests a critique of these processes. They can be rather time consuming because of the large scale of program operations and the number of agencies involved. Agencies must meet ahead of time and work together to create a service plan. These meetings can involve hours of drafting and re-drafting in order to come up with a plan that satisfies all parties.

The problem is when we try to come together we become this monstrosity of a group. The group starts off with five or six people and we have this great idea and then we say, “Hey we have to go talk to these people and these people,” and then the group becomes unyielding. So, I don’t think there’s a way you can come up with an overall master plan. So that’s why I think going back and working with the local communities as best as you can is important.

This method can lead to a lot of time and energy spent before services are even available to people who are homeless.

We had something like 65 some odd public meetings in [the city] on homelessness issues and we did not get very far. We had a lot of talk, a lot of ideas, but what was finally accomplished was not much farther than what we have now.

Some members of the community view the process as “all talk and no action.”

We have had so many dialogues about what we could do and how we could do and that is all we ever do is talk about what we could do and how we could do and then nobody ever does anything.

*Recommended Outcome: To mitigate planning that delays action, organizations and institutions determine what steps they can take in conjunction with one another to address immediate needs.*

***10. There is a common skill-set for effective service providers and administrators.***

Service providers who are most successful in our community are the ones who are able to build trusting relationships with the people they serve. Traits of someone who can build these types of relationships with people who are homeless are: empathy, compassion, non-judgmentalness, respect, and a belief that people can change. They are also people who can listen to a person's story without evaluation.

I think to work with homeless and houseless folks you have to be dedicated. You have to be passionate. You have to be compassionate and empathetic and we can't be afraid to get dirty or to see where homeless and houseless people really live. I think you have to be persistent. You have to be able to really work with people to gain their trust and to build rapport.

I think you have to really be able to see the humanity in people. They deserve respect and they deserve to be treated as a human being and I don't always see that so I think that really requires having empathy and compassion and dedication.

I think being treated respectfully goes a long way and that includes being listened to.

Where I validate you as a homeless person but I am not looking at what you are. I'm looking at you the person and I say, "Hey I care about you." They respond to the care ... "You care about me and I am a person that most people ignore." That is the spark that starts the change.

You have to be incredibly nonjudgmental and just see the beauty and dignity that we all intrinsically have within us ... You just need to be an innately empowering person who sees the potential in everybody.

*Recommended Outcome: Workforce development efforts related to homeless services focus on developing empathy, compassion, respect, non-judgmentalness, and personal commitment.*

## **Part V: Conclusion**

This report is offered to the local community as a basis for unified and meaningful planning. Ending homelessness is an admirable goal. Reducing harm related to homelessness is achievable. The information presented here demonstrates the current knowledge-base related to professional and scholarly literature on homelessness. It also presents the wisdom of our local community *to* our local community. This report is shared with the hope that ongoing and new community efforts to address homelessness will be based on general evidence-based practice and local practice-based evidence.

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**Appendix A: Survey Instrument**



*Perceptions of Homelessness Service Strategies*

- a. Can we record this interview?
- b. Is it okay if I take notes to help me with the interview process? —They will not be included in our research.
- c. How do you think people experience homelessness differently in different areas of the community?
- d. What do you think are some of the most significant harms or risks people are subject to when they are homeless?
- e. There are a variety of ways to protect people from experiencing homelessness in general, chronic homelessness, and injury or death related to homelessness. Please share strategies you consider to be effective at protecting people from:
  - Homelessness in general
  - Chronic homelessness
  - Injury or death related to homelessness
- f. What responses/approaches that are currently happening in our community do you think are most useful?
- g. What responses/approaches that are currently happening in our community do you think are least useful?
- h. What responses/approaches that are not currently happening in our community do you think are most useful?
- i. What responses/approaches that are not currently happening in our community do you think are least useful?
- j. What do you think motivates people to access services?
- k. Where do you see gaps in our local or regional responses/approaches?
- l. Where do you see duplication in our local or regional responses/approaches?
- m. What shifts, if any, have you observed in homeless demographics?
- n. Have you observed any shifts in community responses/approaches to addressing homelessness? If Yes, explain.

## Reducing Harm and Improving Outcomes in Community Responses to Homelessness

- o. Are you familiar with the Housing First model?
  - o Housing First is an approach to ending homelessness that centers on providing homeless people with housing quickly and then providing services as needed. [National Alliance to End Homelessness]
- p. Are you familiar with the Continuum of Care model?
  - o The Continuum of Care model organizes and delivers housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency [HUD]. It begins with outreach, includes treatment and transitional housing, and ends with permanent supportive housing (Tsemberis, Gulcur, & Nakae, 2004).
- q. If you are familiar with the two, can you share your opinions of the differing models?
- r. What does it take to work with this population?
- s. Based on your direct experience interacting with homelessness, what do you think is important for people to know about the homeless population?
- t. Is there anything I should have asked that I didn't ask?
- u. Who else should we interview?

*Thank you for your time!*

**Appendix B: Field-Tested Assessment Instruments**



**Rural Arizona HMIS**

**Self-Sufficiency Matrix Entry**

**1. Matrix Summary**

**Intake Date** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      **Staff Name:** \_\_\_\_\_

**Agency Name** \_\_\_\_\_      **Program Name:** \_\_\_\_\_

**2. Client Information**

**First Name** \_\_\_\_\_      **MI** \_\_\_\_\_      **Last Name** \_\_\_\_\_      **Suffix** \_\_\_\_\_

**Client ID (ServicePoint Assigned)** \_\_\_\_\_      **SS#** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**3. Self-Sufficiency Matrix** (for the Arizona Homeless Evaluation Project)

Instructions:

- Complete this form for all clients at: 1) entry, 2) every 6 months while in the program for transitional housing and every 12 months for permanent supportive housing (if applicable), and 3) exit
- Select one and only one level in each of the 17 areas below by marking the box next to the appropriate level
- Level categories: 1 = In Crisis, 2 = Vulnerable, 3 = Safe, 4 = Building Capacity, 5 = Empowered

**Assessment Type (Point in Time - select one):**    Entry    Interim    Exit

**1. Income**

- 1. No Income
- 2. Inadequate income and/or spontaneous or inappropriate spending
- 3. Can meet basic needs with subsidy; appropriate spending
- 4. Can meet basic needs and manage debt without assistance
- 5. Income is sufficient, well managed; has discretionary income and is able to save

**2. Employment**

- 1. No Job
- 2. Temporary, part-time or seasonal; inadequate pay; no benefits
- 3. Employed full-time; inadequate pay; few or no benefits
- 4. Employed full-time with adequate pay and benefits
- 5. Maintains permanent employment with adequate income and benefits

**3. Shelter**

- 1. Homeless or threatened with eviction
- 2. In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable
- 3. In stable housing that is safe but only marginally adequate
- 4. Household is safe, adequate, subsidized housing
- 5. Household is safe, adequate, unsubsidized housing

**4. Food**

- 1. No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost
- 2. Household is on food stamps
- 3. Can meet basic food needs but requires occasional assistance
- 4. Can meet basic food needs without assistance
- 5. Can choose to purchase any food household desires

**5. Childcare**

- 0. N/A
- 1. Needs childcare, but none is available/accessible and/or child is not eligible
- 2. Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available
- 3. Affordable subsidized childcare is available but limited
- 4. Reliable, affordable childcare is available; no need for subsidies
- 5. Able to select quality childcare of choice



**6. Children's Education**

- 0. N/A
- 1. One or more eligible children not enrolled in school
- 2. One or more eligible children enrolled in school but not attending classes
- 3. Enrolled in school, but one or more children only occasionally attending classes
- 4. Enrolled in school and attending classes most of the time
- 5. All eligible children enrolled and attending on a regular basis

**7. Adult Education**

- 1. Literacy problems and/or no high school diploma/GED are serious barriers to employment
- 2. Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment
- 3. Has high school diploma/GED
- 4. Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society
- 5. Has completed education/training needed to become employable. No literacy problems

**8. Legal**

- 1. Current outstanding tickets or warrants
- 2. Current charges/trial pending; noncompliance with probation/parole
- 3. Fully compliant with probation/parole terms
- 4. Has successfully completed probation/parole within past 12 months; no new charges filed
- 5. No felony criminal history and/or no active criminal justice involvement in more than 12 months

**9. Health Care**

- 1. No medical coverage with immediate need
- 2. No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health
- 3. Some members (e.g. children) on AHCCCS
- 4. All members can get medical care when needed but may strain budget
- 5. All members are covered by affordable, adequate health insurance

**10. Life Skills**

- 1. Unable to meet basic needs such as hygiene, food, activities of daily living
- 2. Can meet a few but not all needs of daily living without assistance
- 3. Can meet most but not all daily living needs without assistance
- 4. Able to meet all basic needs of daily living without assistance
- 5. Able to provide beyond basic needs of daily living for self and family

**11. Mental Health**

- 1. Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems
- 2. Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent problems with functioning due to mental health symptoms
- 3. Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems
- 4. Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning
- 5. Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns

**12. Substance Abuse**

- 1. Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary
- 2. Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities
- 3. Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems that have persisted for at least one month
- 4. Client has used during last 6 months but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use
- 5. No drug use/alcohol abuse in last 6 months



**13. Family Relations**

- 1. Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect
- 2. Family/friends may be supportive but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect
- 3. Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support
- 4. Strong support from family or friends; household members support each other's efforts
- 5. Has healthy/expanding support network; household is stable and communication is consistently open

**14. Transportation/Mobility**

- 1. No access to transportation, public or private; may have car that is inoperable
- 2. Transportation is available but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.
- 3. Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured
- 4. Transportation is generally accessible to meet basic travel needs
- 5. Transportation is readily available and affordable; car is adequately insured

**15. Community Involvement**

- 1. No community involvement; in "survival" mode
- 2. Socially isolated and/or no social skills and/or lacks motivation to become involved
- 3. Lacks knowledge of ways to become involved
- 4. Some community involvement (advisory group, support group) but has barriers such as transportation, childcare issues
- 5. Actively involved in community

**16. Safety**

- 1. Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement
- 2. Safety is threatened/temporary protection is available; level of lethality is high
- 3. Current level of safety is minimally adequate; ongoing safety planning is essential
- 4. Environment is safe, yet future of such is uncertain; safety planning is important
- 5. Environment is apparently safe and stable

**17. Parenting Skills**

- 0. N/A
- 1. There are safety concerns regarding parenting skills
- 2. Parenting skills are minimal
- 3. Parenting skills are apparent but not adequate
- 4. Parenting skills are adequate
- 5. Parenting skills are well developed



**VULNERABILITY ASSESSMENT TOOL**

Client Name \_\_\_\_\_ Staff Name \_\_\_\_\_

**Survival Skills**

*Vulnerability, safety, dependency on others, ability to maneuver independently in safe manner, judgment*

<b>No evidence of vulnerability</b>	<b>Evidence of mild vulnerability</b>	<b>Evidence of moderate vulnerability</b>	<b>Evidence of high vulnerability</b>	<b>Evidence of severe vulnerability</b>
Strong survival skills; capable of networking and self advocacy; knows where to go and how to get there; needs no prompting regarding safe behavior	Has some survival skills; is occasionally taken advantage of (e.g. friends only present on payday); needs some assistance in recognizing unsafe behaviors and willing to talk about them.	Is frequently in dangerous situations; dependent on detrimental social network; communicates some fears about people or situations; reports being taken advantage of (e.g. gave \$ to someone for an errand and person never returned or short changed)	Is a loner and lacks “street smarts”; possessions often stolen, may be “befriended” by predators; lacks social protection; presents w/ fearful, childlike or helpless demeanor; has marked difficulty understanding unsafe behaviors	Easily draws predators; vulnerable to exploitation; has been victimized regularly (e.g. physical assault, robbed); prefers street to shelter; no insight regarding dangerous behavior (e.g. solicitation of sex/drugs) clear disregard for personal safety (e.g. walks into traffic)
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about survival skills: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Basic Needs**

*Ability to obtain / maintain food, clothing, hygiene, etc.*

<b>No Trouble Meeting Needs</b>	<b>Mild Difficulty Meeting Needs</b>	<b>Moderate Difficulty Meeting Needs</b>	<b>High Difficulty Meeting Needs</b>	<b>Severe Difficulty Meeting Needs</b>
Generally able to use services to get food, clothing, takes care of hygiene, etc.	Some trouble staying on top of basic needs, but usually can do for self, e.g. hygiene/ clothing are usually clear/good	Occasional attention to hygiene; has some openness to discussing issues; generally poor hygiene, but able to meet needs with assistance, e.g. prompting, I&R	Doesn't wash regularly; uninterested in I&R or help, but will access services in emergent situations; low insight re: needs	Unable to access food on own; very poor hygiene / clothing, e.g. clothes very soiled, body very dirty, goes thru garbage & eats rotten food; resistant to offers of help on things; no insight
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about basic needs: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For more information about this tool, or about DESC programs, please contact our Director of Administrative Services at 206-515-1514.**

Client Name \_\_\_\_\_

Staff Name \_\_\_\_\_

**Physical / Medical**

*Physical limitations or medical conditions that impact person's ability to function*

<b>No impairment</b>	<b>Temporary impairment</b>	<b>Significant medical or physical issue, or Chronic medical condition that is being managed</b>	<b>Chronic medical condition that is not well-managed or physical impairment</b>	<b>Totally neglectful of physical health, extremely impaired by condition</b>
	Cast x 4 weeks; recovering from surgery	Sight or hearing-impaired; Cerebral Palsy; smaller or larger stature/size making person vulnerable; seizure disorder	e.g. symptomatic & disabling physical illness	e.g. open wound, appears sickly, refusal to get treatment, missing limb
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about physical/medical health: \_\_\_\_\_

\_\_\_\_\_

**Organization / Orientation**

*Thinking, Developmental Disability, memory, awareness, cognitive abilities—how these present and affect functioning*

<b>No impairment</b>	<b>Mild impairment</b>	<b>Moderate impairment</b>	<b>High impairment</b>	<b>Severe impairment</b>
Good attention span; adequate self care; able to keep track of appointments	Occasional difficulty in staying organized; may require minimal prompting re: appointments; possible evidence of mild developmental disability; dementia or other organic brain disorder; some mild memory problems	Appearance is sometimes disorganized; has a significant amount of belongings making mobility challenging; occasional confusion w/ regard to orientation; moderate memory or dev. disability problems	Disorganized or disoriented; poor awareness of surroundings; memory impaired making simple follow-through difficult	Highly confused; disorientation in reference to time, place or person; evidence of serious developmental disability, dementia or other organic brain disorder; too many belongings to manage; memory fully or almost or absent / impaired
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about organization / orientation: \_\_\_\_\_

\_\_\_\_\_

**Mental Health**

*Issues related to mental health status, MH services, spectrum of MH symptoms & how these impair functioning*

<b>No MH issues</b>	<b>Mild MH issues</b>	<b>Moderate MH issues</b>	<b>High MH issues</b>	<b>Severe MH needs</b>
	Reports feeling down about situation, circumstances	Reports having MH issues, but does not talk about them or reports having service connection already in place, may be taking prescribed medications	Tenuous service engagement, possibly not taking medications that are needed for MH, not interested in services due to mental illness / low insight	No connection to services (but needed clearly), extreme symptoms that impair functioning (e.g. talking to self, distracted, severe delusions/paranoia, fearful/phobic, extreme depressed or manic mood), no insight re: Mental Illness
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about mental health: \_\_\_\_\_

\_\_\_\_\_

**For more information about this tool, or about DESC programs, please contact our Director of Administrative Services at 206-515-1514.**

Client Name \_\_\_\_\_

Staff Name \_\_\_\_\_

**Substance Use**

*Issues related to substance use, services, spectrum of substance use & how use impairs functioning*

<b>No or Non-Problematic Substance Use</b>	<b>Mild Substance Use</b>	<b>Moderate Substance Use</b>	<b>High Substance Use</b>	<b>Severe Substance Use</b>
No substance use or strictly social – having no negative impact on level of functioning.	Sporadic use of substances not obviously affecting level of functioning, is aware of Sub Use, still able to meet basic needs most of the time	Sub Use affecting ability to follow through on basic needs, has some support available for substance use issues but may not be actively involved, some trouble making progress in goals, e.g. could be a binge user	Sub Use obviously impacting ability to gain/maintain functioning in many areas, e.g. clear difficulty following through with appointments, self-care, interactions with others, basic needs (food, hygiene), not interested in support for substance use issues but this may be due to low insight or other reasons, e.g. mental illness	Obvious deterioration in functioning, e.g. MH, due to Sub Use, severe symptoms of both Sub Use & Mental Illness, low or no insight into Sub Use issues, clear cognitive damage due to substances, no engagement with substance use support services (and clearly needed)
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about substance use OR observed suspected signs of using drugs/alcohol: \_\_\_\_\_

**Communication**

*Ability to communicate with others, when asked questions, initiating conversations*

<b>No communication barrier</b>	<b>Mild communication barrier</b>	<b>Moderate communication barrier</b>	<b>High level communication barrier</b>	<b>Severe communication barrier</b>
Has strong and organized abilities; no language barriers; able to communicate clearly with staff about needs	Has occasional trouble communicating needs; language barrier may be an issue; occasionally reacts inappropriately when stressed	Some disorganized thoughts; poor attention span; withdrawn but will interact with staff/service providers when approached; pressured speech; very limited English	Physical impairment making communication very difficult ( e.g. hearing impaired & unable to use ASL); unwilling/unable to communicate w/ staff (e.g. shy, poor or no eye contact); doesn't speak English at all	Significant difficulty communicating with others (e.g. mute, fragmented speech) draws attention to self (e.g. angry talk to self/others) refuses to talk to staff when approached; may leave to avoid talking to provider
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about communication: \_\_\_\_\_

**For more information about this tool, or about DESC programs, please contact our Director of Administrative Services at 206-515-1514.**

Client Name \_\_\_\_\_

Staff Name \_\_\_\_\_

**Social Behaviors**

*Ability to tolerate people & conversations, ability to advocate for self, cooperation, etc.*

<b>Predatory behaviors, and / or no problems advocating for self</b>	<b>Mildly problematic social behaviors</b>	<b>Moderately problematic social behaviors</b>	<b>Highly problematic social behaviors</b>	<b>Severely problematic social behaviors</b>
Has a hx of predatory behavior; is observed to be targeting vulnerable clients to “befriend”; uses intimidation to get needs met (e.g. threatening and menacing to staff/clients); more than adequately advocates for own needs, if not overly so	Mostly “gets along” in general; if staff need to approach person, s/he can tolerate input & respond with minimal problems; may need repeated approaches about same issue even though it seems s/he “gets it”	Has some difficulty coping with stress; sometimes has angry outbursts when in contact with staff/others; some non-cooperation problems at times	Often has difficulty engaging positively with others; withdrawn and isolated; has minimal insight regarding behavior and consequences; has few social contacts; negative behavior often interferes with others in surrounding; often yells, screams or talks to self	Responds in angry, profane, obscene or menacing verbal ways; may come across as intimidating and off-putting to providers; may provoke verbal and physical attacks from other clients; has significantly impaired ability to deal with stress; has no apparent social network
<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>

Comments or observations about social behaviors: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Homelessness**

*Length of Time Homeless*

<b>Newly homeless</b>	<b>Moderate hx of homelessness</b>	<b>Chronically homeless</b>
Has been homeless less than 1 month; new to the area (e.g. moved here looking for work or only here for the season)	Has been homeless for 1-12 months; few prospects for housing at present	Has been homeless for 1 year + or has had at least 4 episodes of homelessness within the last 3 years; may have no options for housing due to history, ability to participate in process, etc.
<b>0</b>	<b>1</b>	<b>2</b>

Comments or observations about homelessness: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**For more information about this tool, or about DESC programs, please contact our Director of Administrative Services at 206-515-1514.**

**Appendix C: Findings and Recommended Outcomes**

<b>Finding</b>	<b>Recommended Outcome</b>
<p>1. Homelessness is understood within multiple contexts. This includes individual behavior and problems, but it also includes economics, employment opportunities, laws, geography, and health. This understanding means successful interventions must address the same contexts.</p>	<p>All stakeholders involved in efforts to minimize homelessness develop comprehensive strategies that, at a minimum, detail how the mission/purpose and specific practices of distinct groups relate to one another.</p>
<p>2. The risks people face when they are homeless serve as barriers to moving out of homelessness and contribute toward entering homelessness in the first place.</p>	<p>Service providers adopt a “no wrong door” approach in which all barriers to services are eliminated.</p>
<p>3. Awareness of homelessness is increasing which means the effects of stigma and bias need to be addressed.</p>	<p>The group referenced in Recommended Outcome #4 develops, implements, and evaluates an educational campaign about the diversity of homeless experiences, struggles, and identities.</p>
<p>4. With increased awareness has come increased community and institutional involvement. Some of this is coordinated, some is in parallel, and some is contradictory.</p>	<p>People invested in helping minimize homelessness meet in consistent and inclusive gatherings. The group includes, at a minimum, service providers, chamber of commerce members, activists, and consumers of homeless services.</p>
<p>5. A continuum of housing is necessary.</p>	<p>A continuum of housing options is available including, but not limited to, affordable housing, single resident occupancies, encampments, structured and supervised facilities, humanitarian shelters, and mobile shelters.</p>
<p>6. Outreach and accessibility are critical and they are not the same.</p>	<p>Services are available on-demand (i.e., services are available as soon as the person is ready to receive services) and nearby.</p>
<p>7. Individualization and coordination are critical and they are not the same.</p>	<p>Case managers have light enough caseloads that they may work towards individualizing and coordinating services for each person they serve [see Appendix B]</p>

Reducing Harm and Improving Outcomes in Community Responses to Homelessness

<p>8. Choice is essential and should not be confused with duplication.</p>	<p>Instead of being viewed as a problem to avoid, duplication is considered something to coordinate so all people are receiving the care they prefer based on their location, need, and individual choice.</p>
<p>9. Coordination is not the same as collaboration.</p>	<p>To mitigate planning that delays action, organizations and institutions determine what steps they can take in conjunction with one another to address immediate needs.</p>
<p>10. There is a common skill-set for effective service providers and administrators.</p>	<p>Workforce development efforts related to homeless services focus on developing empathy, compassion, respect, non-judgmentalness, and personal commitment.</p>