COSTS OF HOMELESSNESS: A STUDY OF CURRENT AND FORMERLY CHRONICALLY HOMELESS INDIVIDUALS ON CAPE COD, MASSACHUSETTS

Hands of the Homeless
Artist: David (Davio) Brown
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This study would not have been possible without the cooperation of the participating agencies and staff members who regularly provided follow up information, and of course all the individuals who were willing to be interviewed and consented to be part of this study. Since it's likely I'll leave someone out, I will not attempt to list the agency personnel who helped me throughout this project, but will acknowledge a special thanks to Tom Naples, a homeless street outreach worker, who was most helpful in introducing me to the streets and to potential study participants during the study recruitment period.

Special appreciation is noted for three people who provided technical assistance. Roman Mate has been the guiding force in both creating the Access data base and providing assistance throughout the analyses stage. He is an alumnus of Cape Cod Community College and is currently employed as a Computer Network Service Associate at the Marine Biological Laboratory, Biological Discovery in Woods Hole. Anne Foxx also provided some technical assistance regarding typing and data entry. She is a retired office manager of the Department of Sociology at the University of Massachusetts at Boston and has a MS in Human Services from the university where she has been consistently involved in Native American issues (she is a resident of Cape Cod and a Mashpee Wampanoag tribal member). Patricia Allen, a full-time instructor of English at Cape Cod Community College, provided proofreading in preparing the final version of this study.

A special appreciation goes to all the individuals who allowed me to interview them and track their cost activities over the course of the one year period. The recruiting process was probably the most memorable part of the study as it provided the opportunity to be out in the streets and hang out in areas where homeless individuals were known to be present in downtown Hyannis. In addition to the individuals who agreed to be interviewed and participate in the study, there were many others I engaged in conversation, however briefly, and learned a bit of their story.

My true heroes are both the individuals who survive the circumstances of homelessness and the numerous agency personnel who consistently do their utmost to assist individuals out of homelessness. Service providers who work with the homeless are truly compassionate people with an abundance of patience and determination to see the best in people and to help each individual in need.

Also, appreciation for special permission to use a copy of the original mural, Hands of the Homeless for the cover of this report (permission was granted by both the artist David (Davio) Brown and the co-founders of Homeless Not Hopeless, Inc., Mary Ann and Mark Halstead).

PARTICIPATING AGENCIES/ORGANIZATIONS

Health Care and Service Providers:

- Cape Cod HealthCare (Cape Cod and Falmouth Hospital; in and out patient, including Emergency Room, Psychiatric Center, C-Labs)
- Duffy Health Center and other services (case management, outreach, Project Hope)
- Gosnold on Cape Cod
- Hyannis Fire and Rescue
- Department of Mental Health
- Housing Assistance Corporation (NOAH Shelter, Housing First programs and Operation in from the Street)
- Community Action Committee of Cape Cod and the Islands, Inc. (Pilot House and Outreach)
- Cape Cod Council of Churches (Outreach)
- Vinfen Outreach
- Baybridge Clubhouse services
- South Coastal Counties Legal Services, Inc., Homelessness Outreach Program
- Nam Vets Association, Outreach
- Town of Barnstable Police Department
- Barnstable County Sheriff's Office, Barnstable County Correctional Facility

Permanent Supportive Housing/Housing First Programs:

- Duffy Health Center / Mass Behavioral Health Program and Housing Assistance Corporation (Housing First, Home and Healthy for Good, and Chase House)
- Department of Mental Health and Vinfen (Cape Cod Supportive Housing)
- Family Continuity Program and Department of Mental Health (Kit Anderson /Larry Doughty House)
- Housing For All Corporation (CHAMP Homes)
- Baybridge Clubhouse (Career House and Scattered Sites)
- Community Action Committee of Cape Cod and Islands, Inc. (Pilot Plus)

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EXECUTIVE SUMMARY

The purpose of the study was to document costs related to homelessness of individuals in order to compare costs associated with being homeless on the street versus those formerly homeless who resided in some type of Permanent Supportive Housing. The premise is that it is more costly for individuals to be on the street in comparison to supportive housing and that moving even the most chronically homeless individual[1] into supportive housing, especially into the 'Housing First' model that does not require individuals to be 'housing ready,' is not only more cost-efficient but more humane.

The study tracked 51 individuals over the course of a one-year period from September 1, 2006 to August 31, 2007. At the time the interviews were conducted 23 individuals were housed and 28 were homeless. During the course of the study 13 individuals consistently remained housed while 17 were consistently homeless while they remained in the study. The housing status of the remaining 21 individuals fluctuated as they moved out of or into housing while they remained in the study.

The study documented total costs of $2,255,354 over the study period ($992,369 for housed; $1,262,985 for homeless). The study documented that the annual average cost to house individuals was 12 percent less than the costs of the homeless subpopulation ($44,184 per year for housed and $49,308 per year for homeless): however, this was a smaller difference than that found in other studies. This outcome was mainly due to the high costs associated with some of the housed population coupled with the overall high health care costs of this population. In addition, some homeless individuals, even those definitely fitting the definition of chronically homeless, were surprisingly very low users of services.

The following identifies some of the characteristics of the study population: a lengthy history of residence on Cape Cod (average of 22 years) with 42 percent either having grown up on Cape Cod or spent some time here as a child; an average educational attainment level of just under high school; a majority identifying themselves as white, with the remainder (29%) reporting a minority status. While the majority of the individuals were never married, 65 percent reported having children, with 39 percent with children of dependent age.

The average length of time homeless was five years with a median of 2.5 years. The vast majority reported having physical health/injury issues (86%), mental health issues (78%) and either current or past alcohol and/or substance abuse issues (80%). Most individuals (71%) received some type of government benefit including health care coverage and although few were employed at the time of the interview, some did volunteer work in the community.

Based on self-reporting, the findings showed that factors leading to homelessness were multifaceted and included the following in order of most to least-frequently reported: alcohol

[1] The Department of Housing and Urban Development defines chronically homeless as "either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years." The disabling condition includes a substance abuse disorder. Available on line at http://www.hudhre.info/documents/DefiningChronicHomeless.pdf.

and/or drug use, financial issues, family issues, mental health issues, and health and physical injury issues. These factors were often interrelated.

As to be expected, when comparing costs between homeless and housed individuals, the homeless were more likely to use the majority of the costs associated with emergency room services (75%), rescue services (69%) police encounters (89%) and incarceration (100%). Surprisingly, at least one housed individual was also a frequent user of rescue services.

The finding of high health care costs (an annual average of $32,265 per person) associated with this population should not be surprising even for those who are housed, as having been homeless can have long term implications. Because this study attempted to seek out individuals fitting the definition of chronically homeless, this meant most individuals had some type of disability. For example, although the cost of emergency room usage was much higher for the homeless subpopulation, the other hospital costs were somewhat higher for the housed population.

The findings regarding housing status covering a one-year period showed that the population was more diverse and more fluid than anticipated as 21 individuals moved back and forth while they remained in the study. While the majority of the individuals in the study utilized services and therefore showed up in the tracking data, there were a few individuals who barely used the services, although most fit the definition of chronically homeless.

Since tracking a mobile population proved to be quite challenging, there was a small subset of individuals whose location at times was uncertain, and for whom some data may be missing. Despite this and other gaps in data collection, a substantial amount of data was gathered in the course of this study that provides a profile of this population and the researcher hopes this study proves useful for planning and policy purposes.

Since the sampling strategy was not randomized, the findings cannot be generalized beyond the study population, therefore, one cannot say that the study population represents the homeless population. However, the average age of 46 for the study population is just slightly older than the average age of the NOAH Shelter population (average age of 42) at the time the researcher was recruiting study participants. In addition, the ratio of male/female was coincidently the same as the NOAH shelter population for this same period (71% male).

While the region has been making progress in housing homeless individuals, especially in developing more Housing First and Permanent Supportive Housing units for the chronically homeless, the need is still great as the January 2008 point-in-time count identified 273 individuals either on the street, in shelters, or in motels. From 2006 - 2008, 28 homeless individuals died either on the streets or shortly after being placed into housing.[2] As a result of the findings and the researcher's observations, the study includes some policy recommendations: in particular the need for more supportive housing, and more resources for prevention and case management.

[2] The number of deaths has been provided by Alan Burt, an advocate for the homeless and Program Director of Homeless not Hopeless, Inc.

I. INTRODUCTION

Purpose of the Study

The purpose of the study was to document costs related to homelessness of individuals in order to compare costs associated with being homeless on the street versus those formerly homeless who resided in some type of Permanent Supportive Housing. The premise is that it is more costly for individuals to be on the street and that moving even the most chronically homeless[3] individuals into Permanent Supportive Housing, especially into the 'Housing First' model that does not require individuals to be 'housing ready,' is not only more cost-efficient, but more humane.

The movement toward a Housing First model represents a paradigm shift from emphasis on shelter to emphasis on getting the most chronically homeless into housing. This approach has been promoted by Philip Mangano, the executive director of the United States Interagency for the Homeless (USICH); the National Alliance to End Homelessness; and the Massachusetts Housing and Shelter Alliance, among others. The emphasis on decreasing the numbers of street homeless by placing them into housing without first getting them housing ready stemmed from Dennis Culhane's research documenting that a small proportion of homeless individuals (10%-15%) utilize most of the services.[4] The premise is that if these individuals were to be housed, the public costs for emergency shelter, acute health care, public safety, and corrections would substantially decrease.[5]

The philosophy behind Housing First is that homeless persons do not have to be "housing ready," and they, in fact, need housing first (hence the title) before they can stabilize. This has been the approach of Philip Mangano and USICH for some time.[6] Another important component of the Housing First philosophy is that residents are not required to accept services, but once

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[3] As noted in the Executive Summary, the Department of Housing and Urban Development defines chronically homeless as "either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years." Available on line at http://www.hudhre.info/documents/DefiningChronicHomeless.pdf.

[4] Culhane's U.S. Congressional Testimony to the Committee on Senate Banking, Housing and Urban Affairs, Subcommittee on Housing and Transportation Hearing, March 30, 2006.

[5] The New Yorker published an article titled, "Million Dollar Murray*"* about a homeless individual whom service providers estimate used around $100,000 in health care and other expenditures within a one-year period. Since Murray had been homeless for ten years, they estimated that costs reached around one million dollars to keep him homeless (see Conclusion for additional discussion - The New Yorker: "Million Dollar Murray," by Malcolm Gladwell – Issue of 2006-01-03 and 20; accessed on line on 2/28/2006 at www.newyorker.com/printables/fact0260213fa_fact).

[6] Mr. Mangano has appeared on Cape Cod as the keynote speaker for the *Homelessness Summit*: *The Grand Community Effort to End Homelessness on Cape Cod and the Islands*, held on October 25, 2003, co-sponsored by the Cape Cod Council of Churches and the Leadership Council; and the public forum to release the Ten Year Plan on February 11, 2005. He also spoke at the public dedication for Bridgeport, on July 2005 (Bridgeport is an eight unit permanent supportive housing complex partly funded through the HUD CoC application). Mr. Mangano has made recent appearances on the Cape to offer support and advice as the Leadership Council moves forward to address the concerns of residents and business owners regarding inappropriate behaviors of a small subset of street homeless in the downtown Hyannis area.

stabilized into housing, services should be slowly introduced. This is a drastic change from the Department of Housing and Urban Development (HUD) Permanent Supportive Housing model, which requires support services be designed into the program. In fact, HUD mandates that Shelter Plus Care applications are matched dollar-for dollar (50/50) in support services.

The annual HUD Continuum of Care (CoC) Homeless Assistance application (McKinney Vento funds) also began to strongly emphasize placing chronically homeless individuals into housing while also encouraging CoCs to develop ten year plans to end homeless with an emphasis on chronic homeless individuals. The Leadership Council to End Homelessness on Cape Cod and the Islands, formed in 1995 as the regional CoC, oversees the annual HUD application; in 2005 the Council also published a regional ten year plan to end homelessness.[7]

Hence, the concept of this study developed out of discussions at the Leadership Council meetings during this period of change when it was suggested we should conduct a similar study to document costs. The study was one of the tasks in the work plan of the ten year plan. After examining two studies and communicated with others doing research on costs associated with chronically homeless individuals,[8] the researcher submitted a proposal to the Cape Cod Commission. The Leadership Council approved the concept of this study, and the researcher was awarded funding through the Cape Cod Commission through the Affordable Housing Department. Additional funding was also awarded through the Cape Cod Foundation's Great Expectations Fund.

This study is an attempt to document the overall costs as comprehensively as possible. While the original goal of the study was to document whether it was more cost-efficient to house individuals in Housing First units in comparison to the costs of being on the street, since there were very few Housing First programs when the study began, it was not possible to emphasize this comparison. Therefore the additional purpose of the study, to develop a better understanding of the use of services, and consequently the needs of the population based on tracking the costs/charges of the two subpopulations over a one-year period, was actualized to the best of this researcher's ability.

[7] The plan was published in February 2005. While written by this researcher, it was the result of a unified Leadership Council effort, which included a broad range of community members.

[8] Dr. James O'Connell, executive director of Boston Health Care for the Homeless and members of his staff, especially Jill Roncarti, communication on February 17, 2006; and Edward Castillo, Serial Inebriates Program Utilization of Healthcare Resources study at the Institute for Public health, San Diego State University, communication on February 9, 2006).

II. RESEARCH METHODOLOGY

Introduction

This is a descriptive study utilizing a convenience sample of the study population. This study was intended to track two subsets of chronically homeless individuals: those living on the street and those formerly homeless who resided in some type of permanent supportive housing over a one year period – from September 1, 2006 to August 31, 2007. The tracking consisted of documenting an array of costs, such as medical (including emergency room visits, psychiatric care, and detoxification stays), involvement in the criminal justice system, case management, and costs related to transporting individuals. The tracking also included documenting the costs of supportive housing programs, including support services, as well as any additional costs, such as that of housing vouchers, transportation, and so forth, if the information was available.

Research Design

Institutional Review Process

Cape Cod HealthCare Institutional Review Board/Protocol Process
Since this study included collecting data from Cape Cod HealthCare (CCHC), this required approval of their Institutional Review Board (IBS). A required protocol presented at a board meeting on August 2006 and was approved with minor revisions. Each time changes were made to the original protocol and/or an extension was requested, a revised protocol was submitted for the IRB's approval. The original protocol was revised five times.

Department of Mental Health Process
The study also included programs that contract with the Department of Mental Health (DMH), requiring approval by the state headquarters and fulfilling their IRB requirements. The study was also reviewed and approved by the Southeastern Area Headquarters.

Solicitation of Participating Agencies/Organizations

Once a list of key participating agencies was created, the executive directors or appropriate persons with authority to approve their participation were contacted. Agencies and organizations that appeared interested in participating in the study were sent a cover letter and a Memorandum of Understanding (MOU). While some MOUs may have been slightly altered at the agency's request, in most cases the generic version was used (see Appendix A). The MOU required a signature by the executive director (or head of agency), and the name of a person/persons designated to provide the required tracking information was requested. The MOU also stipulated that the researcher would not report findings from one agency to another.

Health care agencies participating in the study required specific forms in order to abide by the Privacy for Individually Identifiable Health Information (HIPAA) guidelines. Cape Cod HealthCare approved of a form to be used specifically for their services, while the other health care providers (Department of Mental Health, Duffy Health Center, Gosnold on Cape Cod and Hyannis Fire and Rescue agreed to one form listing all four providers (see Appendix C).

Interview Guide

The interview guide was intended to capture demographic information (educational attainment, age, gender, marital status), as well as some geographic background of the study participants (where they were born, where they resided prior to becoming homeless), and their homeless history, including why they became homeless and where they stayed. The researcher also inquired about each participant's physical and mental health including substance and alcohol abuse. The interview also inquired into the type of services they utilized and if they were employed and/or received any government benefits.

Strategy for Sampling of Study Participants

Recruiting study participants required working with an array of agencies, including outreach workers, shelter staff, permanent supportive housing providers, and other persons working with individuals fitting the study criteria. A flyer was widely distributed and was used as a recruitment tool and to ensure consistency regarding information passed on to potential participants, both housed and homeless (see Appendix B). In order to make the study more manageable, the geographic area of recruitment was primarily the Village of Hyannis in the Town of Barnstable, Massachusetts.

Homeless individuals were recruited out on the streets and in areas where the homeless were known to congregate. While potential study participants were often referred to the researcher by service providers, some individuals were approached directly and in the course of conversation, the researcher determined whether they fit the study criteria or not. During this recruitment period, a number of locations and agencies were visited, such as the Village Green, Main Street, NOAH Shelter and the Salvation Army.

Recruiting permanent supportive housing residents required working with service providers and visiting programs that agreed to be part of the study. This process included speaking directly to the residents, sometimes in groups, to determine those willing to participate and whether they fit the study criteria or not. It should be noted that this population was somewhat self-selected, as for the most part, only those willing to consider participating met with the researcher.

Determining refusal rate presents challenges because, for the most part, those not wanting to participate chose not to speak to the researcher. While some individuals made it very clear that they did not want to participate, others just passively made themselves unavailable. However, two persons residing in permanent supportive housing declined participation, as did one person at the NOAH Shelter. At least three persons on the street refused to discuss possible participation in the study, although a few individuals also approached the researcher and asked questions about the study and/or offered to be interviewed (not all volunteers fit the study criteria).

Interview Process

Regardless of how participants were recruited, individuals were met with privately and assured that participation was voluntary and their choice to participate did not have any impact on their eligibility for or use of services. Each interview was conducted as privately as possible. For those homeless at the time of the interview, Community Action Committee of Cape Cod and the Islands, NOAH Shelter and the Salvation Army provided private space. Some interviews were

conducted on the Village Green in Hyannis and in the researcher's vehicle. For those housed at the time of the interview, both congregate living facilities, Champ Homes and Larry Doughty House, provided private space and others were either interviewed at an agency or at the person's residence.

The first two interviews were conducted on October 27, 2006 and the last interview was conducted on March 3, 2007. Initiating the interview process was delayed due to the necessity of the DMH approval process. It also became necessary to extend the recruitment process past the original end of December, 2006 deadline in order to capture some of the most frequent users of services.

Each person interviewed was required to sign a copy of the Informed Consent Forms (ICF) and the Medical Release forms. Because it was not usually convenient to make copies of the original, duplicate copies were signed and each person received copies of all forms. Two persons asked that their copies of the signed forms be turned over to a particular agency person for safekeeping and this was done, noting their request on the form (see Attachment C for copy of the consent forms). The interviews were timed once the consent forms were explained and signed by both parties; the length of interviews ranged from 10 minutes to 53 minutes with an average of 21 ½ minutes. If a person listed services not included on the ICF, a separate ICF was signed and the above process was followed. Each person also received a $10 grocery certificate to either Shaws or Stop and Shop supermarket.

Although 55 persons were interviewed, three persons were immediately taken out of the study and no data was collected as they were determined to not fit the study criteria. One person requested to be taken out of the study and none of this data was included. Two persons who moved into independent housing during the course of the study were removed from the study once their housing status changed. Because the costs related to their independent housing was not collected, any additional costs related to other services was also excluded from the analysis from that period on although the data up to that point remained as part of the study. Four individuals left the region and since it was impossible to continue to collect data for them, they were taken out of the study from that point on. At least two individuals left the region but returned, thus providing gaps in their services.

Justification for Use of Special Subject Population

The researcher acknowledges that homeless individuals are a vulnerable population. However, since the goal of the study was to document expenditures related to experiences of unsheltered/street homeless individuals in order to compare these costs to formerly homeless individuals in supportive housing, it was necessary to try to capture their experiences, both from their perspective during the interviews and through documented data regarding utilization of services. The researcher treated each participant with respect and dignity and attempted to capture their stories to the best of her ability. The study does not identify any participants in order to protect their anonymity.

Data Collection and Analysis

Since the study participants were concentrated in the Village of Hyannis, Massachusetts area, services in Hyannis pertinent to this population were included in this study. Therefore, data were collected from the following. Health care providers included Cape Cod HealthCare, Duffy Health Center, Gosnold on Cape Cod and Hyannis Fire and Rescue. Other services captured in the study were expenses related to encounters with the Barnstable Police Department, the Barnstable County House of Corrections, and South Coastal Counties Legal Services.

Other programs providing emergency shelter included Housing Assistance Corporation's NOAH Shelter, Operation in From the Street (although a collaborative program, HAC provided fiscal management at that time), and Community Action Committee's Pilot House. Permanent Supportive Housing and Housing First programs consisted of the Family Continuity Program's Larry Doughty House/Kit Anderson , Housing for All Corporation's CHAMP Homes, Department of Mental Health/Vinfen's Cape Cod Supportive Housing, and Housing First programs, including Chase House and Home and Healthy for Good: both collaborative programs with Housing Assistance Corporation and Duffy Health Center. Additional case management and outreach programs consisted of Duffy Health Center, Community Action Committee, Department of Mental Health, Council of Churches and NamVets Association (see Acknowledgment Section for list of participating programs and Housing Section for definitions of some of these programs).

The data was analyzed utilizing an Access database: each study participant was assigned a code and names and dates of birth were not included in the database. All documented expenditures were logged and while every attempt was made to document actual costs and/or charges whenever possible; when actual costs were not available, estimated costs of the expenditure were compiled by using existing charges/costs when available. To determine an estimated charge for emergency room physicians' fee, knowledgeable health care providers were consulted.

After consulting with the fiscal officers at Duffy Health Center and Cape Cod HealthCare, the decision was made to collect the actual billing charges for all health care activities in order to keep the data consistent across service providers. Therefore, the analysis included the actual billing charges while noting this would be higher than the actual reimbursement. Most of the study participants were covered through MassHealth (the state Medicaid program). The Duffy Financial Chief Officer reports that their overall reimbursement rate is about 72 percent (86% of medical charges and 45% of Mass Behavioral Health Program charges).

Numerous Access queries were conducted in the process of analyzing the data, including controlling for length of time homeless and housed for the comparison of monthly average charges/costs (see Table 24).

Responses to the open-ended questions were coded into categories to enhance the analyses.

Limitations of the Study

It should be noted that since random sampling was not utilized, the findings cannot be interpreted as representative of the homeless subpopulations represented in this study (formerly homeless individuals in housing and homeless individuals).

Since it was impossible to predict all of the services individuals would use in advance, as the study progressed, this researcher became aware that there were programs that this study would not be able to capture.

Estimated health care charges were utilized to provide some of the missing data in comparing two subpopulations: those on the streets or emergency shelter and those in permanent supportive housing. The estimated charges cannot be viewed as reliable in comparison to actual charges reported by the health providers who participated in the study.

Persons residing in permanent supportive housing were more likely to have a personal primary care physician and less likely to utilize Duffy Health Center and in most cases, less likely to use the emergency room at Cape Cod Hospital. Therefore, information provided by both the residents and the permanent supportive housing staff on frequency of medical visits were used to calculate estimated charges based on Duffy Health Center rates.

If study participants were sectioned[9] by the Barnstable Police Department, this information was noted in the data but whether they were sent to a detoxification or mental health unit or their length of stay was not specified. Therefore the estimated charges, based on an average detox stay, most likely underestimates charges as mental health unit charges are much higher.

Unless specific information was available regarding stays in detoxification and mental health units outside of Barnstable County, this data was not included in the study and when it was included it was based on estimated amounts. At times information was provided by study participants regarding medical procedures (both off and on Cape), but estimates for these procedures were not included since it was impossible to determine estimated charges.

The original study design included three interviews – the original interview, a mid-point interview and a final interview. Due to the delay in completing the interview recruitment process, mid-point interviews were not possible. While a limited number of final interviews were conducted, follow-up was also done based on observation, agency information and the tracking data itself, which relayed particular services participants received.

Nonetheless, the inability of this researcher to conduct the final interviews presented a limitation to the study, since the researcher could not be 100 percent certain about the status of a few of the study participants at the end of the data collection period. Therefore, the status of individuals at the conclusion of the study period was determined to the best of the ability of this researcher, while noting some individuals left the region.

[9] See Part III, Barnstable Police Department for further discussion on sectioning individuals.

III. FINDINGS

Introduction

The findings showed that the study population was more diverse and more fluid than anticipated. While the majority of the individuals in the study utilized services and therefore showed up in the tracking data, there were a few chronically homeless individuals who barely used the services. While some individuals remained in housing through the course of the year, others moved in and out of housing and some moved out of the region; some stayed and some returned.

Three category of users emerged from the study with some categories having subsets. This section is further analyzed in the final discussion of the findings.

- Minimal usage of services
- Moderate users of services
- Heavy users of services

The Demographic Profile section serves to provide not only basic demographic information but other background material to help better define the study population. Thus, additional information on housing and homeless history, physical and mental health conditions, and alcohol and substance abuse history, helps define this population and also serves to better understand the linkage between these variables and the usage of services, including health care.

The demographic data show a population just a bit older than the NOAH Shelter population at the time of the study recruitment period (average age, 46; NOAH, 42) with a gender breakdown (male/female) exactly equal (71% male) to the NOAH Shelter population at that time. Regarding race/ethnicity, while the majority of the study population was white, minorities were overly represented among this population in comparison to the general population in Barnstable County.[10] While the majority of the study population reported never having been married (55%), they also reported having children (65%). While the majority reported having at least a high school education or more and also having some technical training, the average educational attainment was just under the 12th grade due to the low education level of some of the study participants.

Residential information showed that most of the study participants had a lengthy history of residing on Cape Cod with 22 years as the average length of residency. The average length of time homeless was over five years with the majority reporting having been homeless more than once. Factors related to why individuals became homeless showed that the cause was usually multifaceted and included problems with alcohol and/or substance abuse, financial crisis, separation from family and physical and/or mental health issues.

Considering that the vast majority of the study participants reported physical and/or mental health issues as well as either a current or past alcohol and/or substance abuse problem, it should

[10] Both the 2005 American Community Survey Data for Barnstable County based on race and ethnicity for households and the 2000 Census data shows that whites represent 95 percent of the population in Barnstable County (http://www.epodunk.com/cgi-bin/popInfo.php?locIndex=22284 and http://www.bchumanservices.net/docs/thc2001IRORFAV2apx1aa.pdf respectively).

not be surprising that most individuals received some type of government benefit including health care coverage and few were employed at the time of the interview (this is also linked to the fact that the study intentionally sought out chronically homeless individuals which meant that they would have some type of disability). Monthly average benefit amounts were relatively low, emphasizing the impossibility of living in any type of housing solely on this income without receiving a housing subsidy.

While not everyone in the study used the Cape Cod HealthCare/ Hospital's Emergency Room, the majority (n=41) made a total of 272 visits and 12 of these persons made over ten visits over the course of the one year period (the most frequent usage was 19 visits). Hyannis Fire and Rescue made 144 transports during this one year period with up to 16 rescue calls for one individual.

The majority of the health care charges (64%) were related to those who were homeless at the time (Cape Cod HealthCare, Hyannis Fire and Rescue, Duffy Health Center, Gosnold on Cape Cod and Estimated Health Care Charges). However, a comparison of the Cape Cod HealthCare Emergency Room charges to the other non-Emergency Room (ER) usage charges shows that the majority of the ER charges (76%) were utilized by those who were homeless, while the majority of the non-ER charges (56%) were utilized by those who were housed. This finding is most likely related to the fact that that the population under study suffers from chronic health conditions as noted above.

The majority (93%) of the criminal justice/legal services costs were utilized by the homeless participants. The criminal justice component includes the Barnstable Police Department and the Barnstable County Correctional Facility. The majority of the Barnstable Police Department costs were associated with those who were homeless at the time and also showed that most of the expenditures were utilized by a handful of individuals. All of the expenditures for the Barnstable County Correctional Facility were attributed solely to six individuals who were homeless at the time they entered the facility. The South Coastal Counties Legal Services costs were relatively low in comparison with a slight majority of the expenditures going toward those who were housed at the time they received services.

Regarding the shelter and housing findings, 34 individuals were in some type of Permanent Supportive Housing/Housing First units during the course of the study period: 13 individuals were consistently housed; an additional seven individuals were housed at the end of the study period; and the remainder went in and out of housing and/or left the region or moved into independent housing. Fourteen individuals were consistently homeless throughout the course of the one year period; three additional persons were homeless while they remained in the region and/or until moving into independent permanent housing.

Although 31 individuals used the shelter system over the course of the one year period, there were a handful of individuals among the consistently homeless subpopulation who did not come into shelter and/or barely used the shelter services. The drastic range in costs for the housed population was due to those who were housed and received subcontracted services through the Department of Mental Health (DMH), which substantially increased the case management costs for this small subset of the population, especially in comparison to the costs associated with the

other Permanent Supportive / Housing First programs. Mainly due to the high costs associated with the Permanent Supportive Housing programs with DMH clients (and possibly the low costs associated with Housing First units), 77 percent of the overall shelter/housing costs were associated with the housed population.

When merging all the costs/ charges together, including some homeless street outreach costs, the final analyses comparing the monthly average costs of the two subpopulations shows a difference in expenditures with 56 percent going toward homeless individuals.

An additional comparison analysis was conducted by calculating the average monthly costs associated with the different service categories for four subpopulations (housed full-time, housed part-time, homeless full-time, and homeless part-time). While the subcategories of the different type of services for the most part showed higher monthly average costs associated with the homeless subpopulation subcategories, the exceptions were the housing /shelter categories and Cape Cod HealthCare charges, mainly due to the non-ER charges.

The overall monthly average for this analysis showed a 12 percent difference between the housed and the homeless subpopulation with higher charges/costs associated with the homeless subpopulation.

While the overall findings do not show a large difference in the total charges/costs between the housed and homeless subpopulations, the findings document that the homeless subpopulation are more likely to use the emergency services such as the emergency room, Hyannis Fire and Rescue and Barnstable Police Department, as well as Gosnold's alcohol and substance abuse services and costs associated with incarceration.

Part I.
Profile of Participants

Introduction

The demographic findings provide some background information, such as housing history (where the individual grew up, length of time residing on Cape Cod), and other demographic information consisting of age, gender, race, race/ethnicity, educational attainment, marital status, whether individuals had children or not, and if any of these children were of dependent age (under 18). It also covered homelessness history, self-reported factors leading up to becoming homeless, and what individuals considered their most pressing unmet need at the time of the interview (see Table 1 on the following page).

Demographic Profile

Age – Age of study participants at the time of the interview showed that the average age was just slightly over 46, with a range of 19 to 67 and a median of 47. Since the interviews covered just over a five month period, the age of study participants at the mid-point of the study (February 28, 2007) was also calculated, showing an average of 46 and a range of 20-67. According to NOAH Shelter data during the study recruitment period, the average age of residents during this time period was slightly under 42, with a range of 19 to 81 and a median of 43.[11]

Gender - The majority of the study participants were male (71%) which was also consistent with data from NOAH Shelter for the study recruitment period, which coincidently had the same ratio of males to females.

Marital Status – The majority of the individuals, 28 persons (55%) reported having never been married, 13 reported being divorced, seven reported being separated, two reported being widowed and one person reported being currently married at the time of the interview although separated from spouse. While a few persons may have reported more than one status over time, the most current status was recorded.

Children - While 18 persons reported not having children, the majority (65%) reported having children ranging from one to 11 children. Of those reporting having children, 16 men and four women reported children of dependent age (under the age of 18) at the time of the interview and three reported paying monthly child support for at least one dependent child. None of the dependent-aged children were living with the study participants although a few reported visitation with their children.

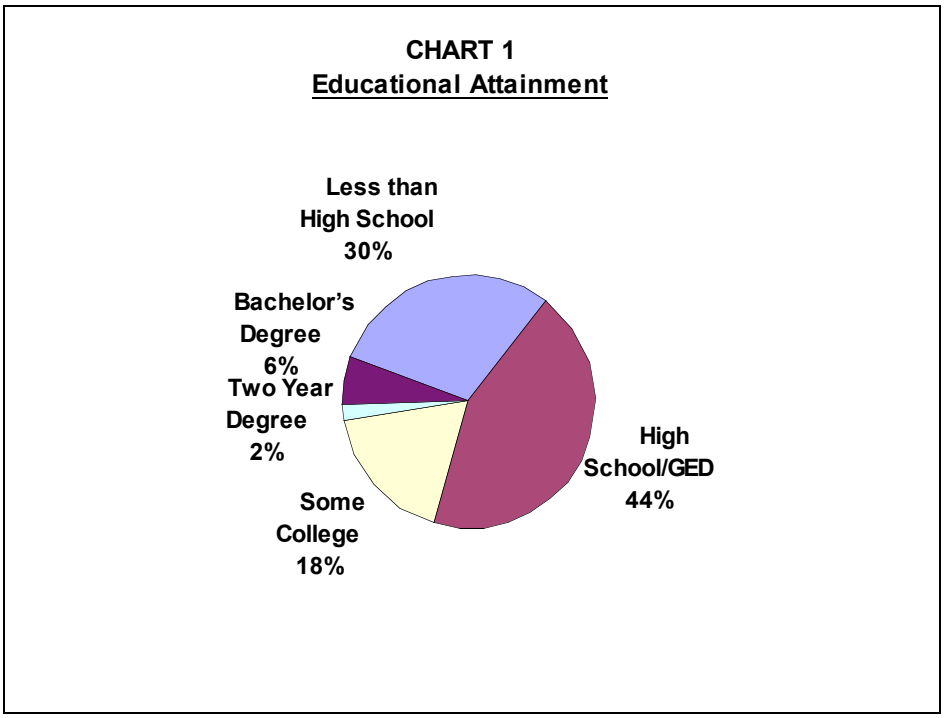
Race/Ethnicity – The majority of the study participants (71%) were White/ Caucasian while the remainder fell into an array of minority categories such as African American, Cape Verdean, Hispanic, Native American and an additional eight reporting being of mixed race/ethnicity.

Educational Attainment - The average educational attainment level was 11.66. Fifteen persons had less than a high school education, ranging from completing grade six to right up to grade 12 without graduating; and 22 persons reported either completing high school or a General

[11] NOAH Shelter data provided by Marc Israel at Housing Assistance Corporation based on the Homeless Management Information System (HMIS) which he coordinates).

Educational Development (GED) certificate. While 13 persons reported having attended college, only four persons completed a degree (one completed a two-year program while three had bachelor's degrees). Twenty-eight persons also reported having some formal technical training.

TABLE 1 Demographic Profile (N=51)		
Demographic Category	Percent	Number
Average Age = 46 (Range 19-67) Average Age at midpoint of study (February 28, 2007) = 46 (Range = 20-67; Median = 47)		
Gender		
Male	71%	36
Female	29%	15
Race/Ethnicity		
White	71%	36
Minority Category (African American, 3; Cape Verdean,1; Hispanic, 2; Native American, 1; Mixed Race, 8)	29%	15
Marital Status at Time of Interview		
Single/Never Married	55%	28
Separated/Divorced	39%	20
Widowed	4%	2
Married	2%	1
Children		
Have Children	65%	33
(Number of Children, n=52)		
Have Children of Dependent Age, under 18	39%	20
(Number of Children of Dependent Age, n=34)		
Do Not Have Children	35%	18
Educational Attainment (N=50)		
Average Educational Attainment = 11.66, Range, 6-16)		
Less than High School (3 persons had 8th grade or less)	30%	15
High School/GED	44%	22
Some College (averaged at 12.5 years of education)	18%	9
Two Year Degree	2%	1
Bachelor's Degree	6%	3
Technical /Vocational Training		
Reported Technical Training	55%	28
Military Service		
Did Not Serve in the Military	84%	43
Served, but not in Military Combat	12%	6
Served in Military Combat	4%	2
Categories may not add to 100% due to rounding		



Military Service – While the majority of the study participants (84%) reported not having served in the military, eight reported military service, with two of these persons having served in combat.

Housing and Homeless History

Residential History: Eight persons reported having been born on Cape Cod; an additional 25 reported having been born in other parts of Massachusetts. Of the remainder, two were born in other New England states, 16 in other parts of the United States, and one person was born outside of the United States (see Table 2 on page 15).

Eleven persons reported having grown up on Cape Cod, and an additional eight persons reported residing on Cape Cod at least part of the time during their growing up years. Twenty-three persons grew up in other parts of Massachusetts, two in other New England states and seven in other parts of the United States.

The majority of the study participants (n=30) reported having resided in the town of Barnstable (primarily Hyannis but not solely limited to the Village of Hyannis) before becoming homeless, and an additional six persons also resided in other Mid-Cape towns. An additional 12 persons reported residing in towns either in the Upper-Cape (9 persons) or Lower-Cape (3 persons)[12]. Four individuals reported not residing on Cape Cod before becoming homeless. Further analysis

[12] Cape Cod (Barnstable County) consists of 15 towns divided into three regions as follows: Upper Cape (Sandwich, Mashpee Falmouth and Bourne): Mid-Cape (Barnstable, Yarmouth and Dennis); and Lower Cape (Harwich, Brewster, Chatham, Orleans, Eastham, Wellfleet, Truro and Provincetown).

would have to be conducted to determine whether those on the verge of homelessness are drawn to the Hyannis/ Barnstable area due to the availability of affordable housing and/or services as this detail was not captured in this study.

The average length of time residing on Cape Cod prior to becoming homeless was 22 years (range from less than one year to 59 years), thus representing strong roots on the Cape for the majority of the study participants.

Homelessness history: Measuring length of time homeless presented challenges because sometimes individuals reported going in and out of homelessness with intermittent short stays either with other persons (what is often referred to as couch-surfing) or having some temporary housing stay. The participants who reported being homeless most of the time with very short intermittent stays with others, were counted as homeless during that period (even if this didn't quite fit HUD's definition of homelessness). If individuals reported having had a stay either in a permanent supportive housing unit or having their own place, they were not considered homeless during that period of time. Given the difficulty gathering this self-reported history, the analysis of the length of time of time individuals were homeless most likely under-represents the actual time homeless for this population.

Nonetheless, length of time homeless averages over five years, with a range of two months to 28 years; 30 persons reported having been homeless before (see Table 3). Ninety-two percent of the study participants fit the HUD definition of chronically homeless. Ninety-four percent of the individuals in the study fit the HUD definition of Homeless (originally lived on the street, shelter or a place considered inhabitable) either at the time of the interview or prior to entering permanent supportive housing. There were a few exceptions where it appeared that two individuals may have been doubled-up most of the time during the course of the study period and one person who went right into permanent supportive housing from independent housing, but had experienced a prior homeless episode.

While housing status changed for a number of the study participants over the course of the study, at the time of the interview, 28 persons were homeless and 23 persons were residing in some type of permanent supportive housing unit.

TABLE 2 Residential History (N=51)		
	Percent*	Number
Where Born		
Cape Cod	16%	8
Massachusetts (Other than Cape Cod)	47%	24
Other New England State	4%	2
Other part of U.S.	31%	16
Outside of U.S	2%	1
Where Grew Up		
Cape Cod	26%	11
Combination of Cape Cod & Other	16%	8
Massachusetts (Other than Cape Cod)	45%	23
Other New England State	4%	2
Other part of U.S.	14%	7
Residence Before Becoming Homeless		
Town of Barnstable	57%	29
Other Mid-Cape Town	12%	6
Upper-Cape Town	18%	9
Lower-Cape Town	6%	3
Massachusetts (other than Cape Cod)	2%	1
Outside of MA	6%	3
Length of time Residing on Cape Cod before Homeless Average = 22 Years; Median = 17 Years (Range = Less than one Year to 59 Years)		
Under 1 Year and Less Than 10 Years	33%	17
10 Years and Less Than 20 Years	20%	10
20 Years and Less Than 30 Years	18%	9
30 Years and Less Than 40 Years	14%	7
40 Years and Less Than 50 Years	6%	3
50 Years Plus	10%	5
Figures may not add to 100% due to rounding.		

TABLE 3 Homeless History (N=51)		
	Percent	Number
Length of Time Homeless* Average = 5 Years; Median = 2.5 Years (Range = less than one year to 28 years)		
Less than 1 Year	14%	7
1 Year and Less Than 5 Years	51%	26
5 Years and Less Than 10 Years	20%	10
10 Years and Less Than 20 Years	8%	4
20 Years Plus	8%	4
Fit HUD Definition of Chronically Homeless	92%	46
Been Homeless Before	59%	30
Been Homeless Before and also fit Definition of Chronically Homeless	49%	25
Homeless/Housed Status at Time of Interview		
Street/Shelter	55%	28
In Permanent Supportive Housing/Housing First	45%	23
*Figures may not add to 100% due to rounding.		

Why Became Homeless – Individuals were asked what they considered to be the most important factors leading up to either their current status of homelessness or having been homeless in the past. The question read as follows: *What do you consider the most important/primary reasons for being (or having been) homeless?* More than one response was noted.

While analyzing these open-ended responses, it should be noted that categories are most likely interrelated, such as reported "separation from a partner" or "need to leave the family" was also impacted by a change in financial status and loss of residence. In addition, admitted substance abuse and/or alcoholism most likely also exacerbated the financial situation.

The following Table 4 shows the responses to this question, and although the numbers for the subpopulations (housed/homeless) at the time of the interview is displayed, only the percentages for the total numbers are calculated. Of those who were homeless at the time of the interview the most frequent response was the link to alcohol and/or drug use, followed by both financial and family, with physical health and mental health issues reported less frequently. In comparison, the housed population, although reporting alcohol and/or drug use as frequently as financial

causes, reported mental health issues as more prevalent,[13] followed by physical health issues and fewer family issues.

The 'Other' category shows one response in each subpopulation stating "nowhere to go upon release of prison," and a few other responses more difficult to categorize (and perhaps too personal).

TABLE 4
Why Became Homeless
(N=51)

	Percent**	Numbers		
Responses			Homeless* n=28	Housed* n=23
Alcohol and/or Drugs	43%	22	12	10
Financial (lost housing, couldn't afford housing, no income)	37%	19	9	10
Family (separation, death of family member, domestic violence/abuse)	22%	11	9	2
Mental Health Issue	22%	11	3	8
Health/Physical Injury	20%	10	5	5
Other	10%	5	2	3

*Percentages are not provided for the subpopulation categories because the base numbers are too low.
**Since most individuals provided more than one response, the total percent adds to more than 100%.

Unmet Need

The open-ended question, *What do you think your biggest unmet need is right now?* was intended to determine what individuals felt they needed the most. For those who were homeless at the time of the interview, the most frequent comment was the need for housing. Although three of the responses did not quite specify housing but instead stated "shelter," "a warm place to stay" or "a place to sleep," they were included within the "housing unmet need" category. Among the housed subpopulation, four persons also specified the desire to have more independent or stable housing.

Other reported unmet needs were to improve finances and/or for employment (one response in each subpopulation included improve education/return to school and one response in the housed subpopulation was to earn a decent wage); to get and or stay clean and/or sober; and to improve physical and or mental health. There were some responses unique to the particular

[13] This was also due to the fact that some of the housed individuals were also in programs overseen by DMH and therefore had a mental health/illness diagnosis.

subpopulation. For example, four participants in the homeless subpopulation identified basic needs (food, shower, etc.) as unmet needs, while four participants in the housed subpopulation identified the need for a vehicle and/or to restore driver's license as an unmet need. In addition, four participants of the housed subpopulation reported they did not have any unmet need, while no one in the homeless subpopulation's responses fit this category.

TABLE 5
Reported Unmet Need
(N=51)

	Percent**	Numbers		
Responses			Homeless* (n=28	Housed* (n=23)
Stable Housing	45%	23	19	4
Employment /Improved Finances including education	28%	14	6	8
Get /Stay Sober /Drug Free)	22%	11	5	4
Improved Physical/Mental Health	16%	8	4	4
Basic Needs	8%	4	4	-
Vehicle and/or Driver's License	8%	4	-	4
None	8%	4	-	4
Other	6%	3	2	1

*Percentages are not provided for the subpopulation categories because the base numbers are too low.
**Since most individuals provided more than one response, the total percent adds to more than 100%.

Physical, Mental Health and Substance Abuse Issues

Physical Health Issues

The analysis of the response to questions on physical health shows that the vast majority, 86 percent of the study participants suffered from either serious injuries or other chronic heath conditions. Physical health problems included, in most cases very serious injuries resulting in long term damage, and other serious health conditions ranging from diabetes; heart condition including treatment for high blood pressure; Hepatitis C and/or liver damage; respiratory problems, including asthma; serious vision problems, including being legally blind; memory and/or head injury; and the 'other' category which included allergies, and health issues too identifying to specify. The categories with percentages are outlined in Table 6 on the following page. In addition to the categories, the analysis shows that 67 percent reported having at least two health issues or more.

TABLE 6 Physical Health and Injury Issues Reported (N=51)		
	Percent	Number
Reported Physical Health Issues (includes Physical Injuries)	86%	44
(Reported Health Issues, n=43; Reported Physical Injuries, n=28)		
Number of Health Issues Reported*		
Reporting at least One Health Issue	41%	21
Reporting Two Health Issues	24%	12
Reporting Three or More Health Issues	22%	11
No Health Issues Disclosed	14%	7
Types of Physical Health Issues Reported*		
Physical Injury (most were quite serious injuries) (Reported More than one Physical Injury)	55%	28 (7)
Diabetes	16%	8
Heart Condition and/or High Blood Pressure	16%	8
Hepatitis C /Liver Damage	16%	8
Respiratory (including asthma)	16%	8
Serious Vision Problems (Legally Blind, etc.)	12%	6
Memory/Head Injury	10%	5
Other (includes cholesterol, arthritis, and other)	27%	14
* The figures add to more than 100% because individuals report more than one category.		

Mental Health Issues

Individuals were very forthcoming in reporting whether they had a mental health issue or not; the majority of the study participants (78%) reported this information. The following represents what was reported at the time of the interview (see Table 7).

The majority of persons disclosing a mental health issue also reported more than one disorder (n=21). Of the 16 persons reporting a diagnosis of bipolar disorder, nine also reported an additional disorder and two of these persons also reported a diagnosis of schizophrenia. Other psychological disorders were depression, anxiety and post traumatic stress disorder (PTSD). Eleven persons reported having both anxiety and depression. All nine persons reporting PTSD also suffered from anxiety, depression and/or had a psychological disorder: four had a psychological disorder and anxiety and one person had two psychological disorders. Three persons chose not to disclose the specific diagnosis and one person was unclear on the diagnosis.

Eleven persons did not report any mental health concerns.

TABLE 7 Mental Health Issues Reported (N=51)		
	Percent	Number
Reported Mental Health Issue(s)	78%	40
Mental Health Issues Reported		
Reporting One Mental Health Issue	29%	15
Reporting Two Mental Health Issues	24%	11
Reporting at least Three Mental Health Issues	12%	6
Reporting Four or Five Mental Health Issues	8%	4
Mental Health Issue but Diagnosis not disclosed	8%	4
No Mental Health Issues Disclosed	24%	11
Types of Mental Health Issues Reported*		
Bipolar	32%	16
Schizophrenia	10%	5
Depression (includes Chronic Depression)	37%	19
Anxiety (includes Panic Attacks/ Panic Disorder)	35%	18
Post Traumatic Stress Disorder (PTSD)	18%	9
Other (includes Undisclosed)	18%	11
*The figures add to more than 100% because some individuals reported more than one category.		

Alcohol/Substance Abuse Issues

Since questions asking about alcohol and other substance abuse issues only captured what the person reported at the time of the interview, this status may have changed over the course of the data collection for some individuals, as noted by the type of services utilized such as detox units. While some individuals remained clean and sober and stabilized in housing (at least during the period of the study), others had relapses and went in and out of detox units and/or ended up back out on the street/shelter.

The majority of the study participants, 80 percent, reported either a current or past alcohol and/or substance abuse problem. Four persons reported having both an active alcohol and substance abuse problem: in addition12 persons acknowledged an alcohol problem and two reported an active substance abuse problem. Seven persons reported having a past alcohol and substance abuse problem: in addition, six persons acknowledged a past alcohol problem and 11 reported a past substance abuse problem (six persons in recovery for substance abuse also reported being on some type of maintenance program[14]). For those housed at the time of the interview, if acknowledged alcohol and/or substance abuse problems, most reported past problems.

[14] Two persons also reported problems with extensive marijuana use and were therefore included in the substance abuse category.

TABLE 8 Alcohol / Substance Abuse Issues Reported (N=51)		
	Percent*	Number
Reported Either Current or Past Alcohol and/or Substance Abuse Problem	80%	41
Alcohol / Substance Abuse Issues Reported		
Reported Active Alcohol & Substance Abuse Problem	8%	4
Reported Active Alcohol Abuse Problem	24%	12
Reported Active Substance Abuse Problem	4%	2
Reported Past Alcohol & Substance Abuse Problem	14%	7
Reported Past Alcohol Problem	12%	6
Reported Past Substance Abuse Problem (this includes 6 persons on some type of a maintenance program such as methadone or other medications)	22%	11
Not Reporting any Alcohol and/or Substance Abuse Problem	20%	10
*The figures add to more than 100% both due to rounding and because one individual reported an active alcohol problem but past substance abuse problem.		

Combination of Physical Health, Mental Health and Substance Abuse Issues

Twenty-five individuals reported issues in all three areas, meaning they currently had a physical health issue, a mental health issue, and an active or past issue with alcoholism and/or substance abuse. Only one person did not report any concern for any of the three categories, while three persons reported at least one issue, and 22 persons reported issues in at least two categories (six individuals with mental health and physical health; seven individuals with mental health and substance/alcohol issues; and nine individuals with physical health and substance/alcohol issues).

Prescription Medications

Forty-one individuals (80%) reported taking prescription medications at the time of the interview. Although this study was not able to collect the costs associated with prescription drugs because of the difficulty in consistently capturing this information, it is noted that some individuals reported numerous prescriptions and one person reported that one prescription alone cost $1,800 (frequency of refill was not gathered). The types of prescription drugs varied depending upon the health condition, but also included psychotropic drugs. A few individuals stated that although they should be taking a prescription medication, they did not follow up on this and/or they refused to take the medication. Everyone on prescription medication had MassHealth or other coverage which paid for all or most of the costs (some had a small co-payment amount). The number of medications taken (for the 39 individuals who reported this information) ranged from one to 20 prescriptions.

Benefits, Income and Volunteerism

Benefits and Income

The analysis shows that 71 percent of the study participants reported they received some type of cash benefit and 63 percent received food stamps at the time of the interview. The following list provides a brief definition of the benefit programs and Table 9 displays the specific finding for each category.

- Supplemental Security Income (SSI) - based on financial need to the aged, blind and disabled.
- Social Security Disability Insurance (SSDI) – based on having worked and paid social security taxes and also fit the definition of disabled.[15]
- Emergency Aid to Elders, Disabled and Children (EAEDC) – a Massachusetts state-funded program that provides cash and medical assistance. Eligibility guidelines: limited income, ineligible for other cash assistance programs, and Massachusetts and U.S. citizenship residency or eligible non-citizen.
- Food Stamps – a federal program administered by the state and provides an access card to purchase food, based on income and other eligibility requirements.[16]

TABLE 9
Benefits Received by Study Participants
(N=51)

	Percent	Number
Received Income Benefit	71%	36
Type of Benefits Received		
SSI	29%	15
SSDI	22%	11
Social Security	2%	1
EAEDC	16%	8
Received both SS & SSI	6%	1
Received Food Stamps	63%	32
Health Care Coverage		
MassHealth/Medicaid	77%	39
Both Medicaid and Medicare	16%	8
Other Subsidized Health Care Coverage	2%	1
No Health Care Coverage	6%	3

[15] Both SSI and SSDI are administered by the Social Security Administration. For more information on eligibility requirements visit the Social Security Administration's website at http://www.ssa.gov/disability/

[16] Both EAEDC and Food Stamps are administered by the Massachusetts Department of Transitional Assistance. For more information on eligibility requirements visit www.mass.gov and search for Health and Human Services, than search for Department of Transitional Assistance (the direct web link is extremely long).

The fact that 94 percent of the study participants at had health care coverage is perhaps representative of how integrated the individuals are with service providers who assist them through the application process, coupled with the fact that anyone receiving EAEDC, SSI and/or SSDI would be automatically income eligible (but would still need to apply).

While 36 individuals[17] received some type of cash benefit at the time of the interview, a few reported they were applying for benefits. Applying for SSI and/or SSDI can be a very lengthy process taking up to two years. Some individuals receiving EAEDC were also in the process of applying for either SSI or SSDI as the average EAEDC monthly benefit of $260 was very low. Table 10 below shows the range and average of the monthly benefit amounts and the total monthly benefit amount per program at the time of the interview.

As noted in the shelter and housing section to follow, some individuals contributed their full food stamp allotment to their permanent supportive residency while others contributed a portion.

TABLE 10
Monthly Benefit Amount Received by Study Participants
(N=36)

Monthly Benefits	Range	Average	Total amount of Benefit per Month
SSI	$547 to $737*	$657	$9,857
SSDI	$564 to $973 ($250)	$757	$8,575
Social Security	$633* ($300)	$633	933
EAEDC	$96 to $304	$260	$2,082
Food Stamps	$10 to $159	$95	$3,033
Total Monthly Amount			**$24,480**

*One individual received both SSI and SS but because the amount of each benefit was lower than usual (amounts noted in parentheses). This was not calculated into the average benefit amount but was added to the total amount of benefits.

Employment – Seven persons reported some type of employment, four of whom for which this was their primary source of income. Three of these persons remained employed throughout the course of the study, and the fourth was uncertain. Three individuals reported some employment to supplement their benefits. One person reported being employed off and on but not at the time of the interview and did not have any income to report. There were two additional cases where individuals did not report any source of income, and it was unclear how they survived. Some reported doing temporary work or odd jobs.

[17] One person received a temporary small monthly stipend from a nonprofit organization which is not counted in the above figures.

Volunteerism

At least nine of the study participants also donated their time to either the agency they currently were affiliated with or had previously received services from. Sometimes volunteering and/or community involvement was a program requirement, but this did not account for everyone who donated their time. The specific details regarding the type of volunteer work will not be noted because this information would be too identifying. Most individuals viewed this as a way of giving back to the organization; they took their involvement very seriously and expressed pride in their contribution. For the most part, individuals who gave of their time were very reliable and consistent in their participation.

Part II.
Health Care Charges and Usage

Introduction

The health care providers participating in the study consisted of Cape Cod Healthcare (CCHC), Duffy Health Center, Gosnold on Cape Cod, and Hyannis Fire and Rescue. As noted in the methodology section, the actual billing charges were used in order to keep the data collection consistent across health care providers.

Because the permanent supportive housing residents were more likely to utilize private care, it was impossible to track their usage to the extent of those in Pilot House or those living on the street because the majority of the homeless subpopulation was more likely to utilize Duffy Health Center and emergency care at Cape Cod Hospital. Therefore data was compiled of estimated charges based on what the individual and/or agency reported on health care usage. Note, the amount of charges was based on the rate reported by Duffy Health Center ($130 for a medical visit and $100 for therapy). Estimated medical data was analyzed separately.

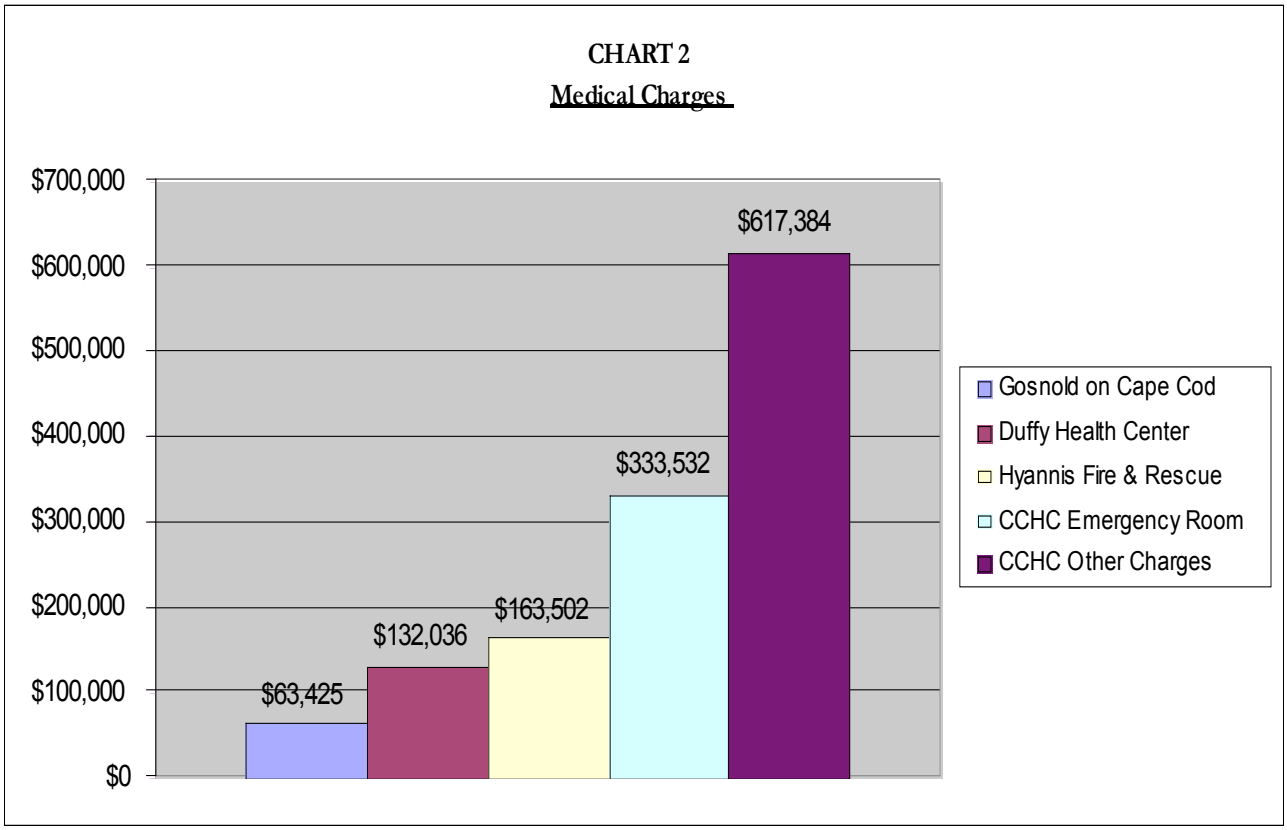
Additional missing health care costs included off Cape medical visits and/or surgeries and visits to medical specialists (some of these circumstances were revealed during the interview process). Therefore, this section, while perhaps using charges and not specific reimbursement amounts, might overestimate the exact costs, it also drastically underestimates the usage due to the inability to capture all known expenditures.

Since usage of rescue services and emergency rooms are considered overly utilized by chronically homeless individuals living on the street, this was an important part of the analysis. The study was only able to collect data from the Hyannis Fire and Rescue as the Hyannis area was the focus of the study. Therefore if a person utilized another rescue service, unless this was reported at the time of the interview, this data was not included.

The documented health care charges for the four major participating providers is noted below in Chart 2. The Cape Cod Healthcare's charges are broken down separately: Emergency Room and Other Charges to emphasize the high emergency room usage among this population. Additional charts are also provided which display the comparison in usage of those who were housed or homeless at the time of the service.

Cape Cod HealthCare

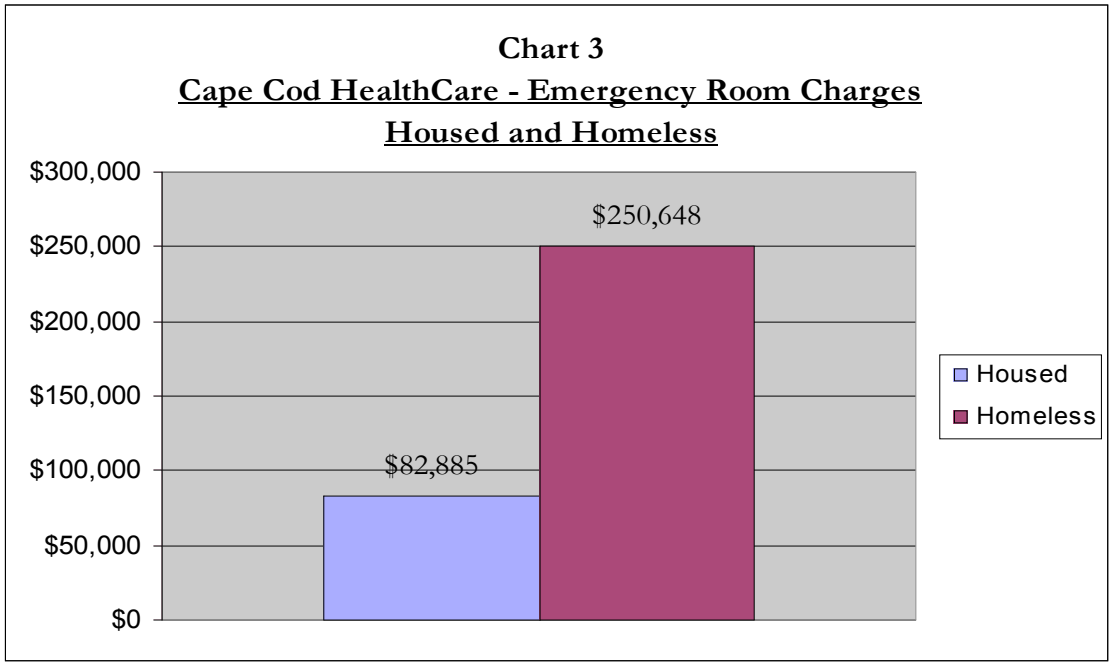
The data included charges for Cape Cod Hospital, Falmouth Hospital, C-Labs, the in and out-patient care, emergency room visits and the Psychiatric Center. Of the 51 persons in the study, 49 used Cape Cod HealthCare Services at least once over the course of the one year period. The total amount of charges for CCHC equaled **$950,916**: the average expenditure per individual was $19,406 and the median was $10,944 with a range from $537 to $85,675 per total cost per individual. Since the CCHC data does not contain physicians' fees, including radiologists and surgeons' fees, the actual charges, especially for in-patient care and out-patient surgery would be higher. A slight majority of the expenditures (55%) were for those who were housed at the time of the service.



Emergency Room Charges

Forty-one persons used the CCHC Emergency Room (ER) at least once during the study period with a total charge of **$333,532.** This consisted of 291 ER visits with 19 of these visits not accruing any charge because the person left without being seen. The charges per visit for the 41 individuals ranged from $86 to $11,218 while the total charges per individual ranged from $86 to $26,127. The average charge for the total costs per individual at $8,135 was most likely skewed higher due to 12 users with total individual charges of over $10,000 – therefore the median (the midpoint of occurrences of $5,242) is probably a better comparison figure.

As noted below in Chart 3, 75 percent of the ER charges ($250,648) went toward those who were considered homeless at the time of their usage.



The following Table 11 displays the ER usage per person over the one year period. This analysis shows that for those who used the ER, the majority had from one to five visits while the remainder had from six to 19 ER visits. This analysis was based only on the visits where the person was seen by a physician and there was a charge involved.

TABLE 11
Emergency Room Usage
(N=41)

Number of ER Visits per Person *(Based on 272 visits)*	Percent	Number
1-5 Visits (1-2 Visits = 13) (3-4 Visits = 6) (5 Visits = 4)	56%	23
6-10 Visits	15%	6
11-15 Visits	22%	9
16–19 Visits	7%	3

Estimated Emergency Room Physician's Charges

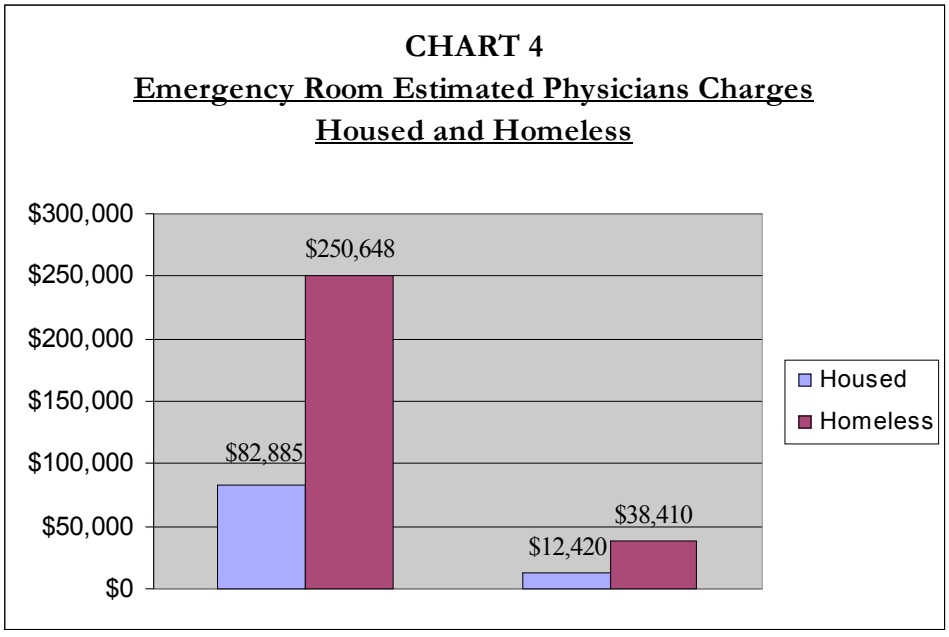
An attempt was made to calculate an average charge for the ER physician's fee since this was billed separately and not included in the above. Based on the limited information available, treatment would be categorized into different levels of care depending upon the health crisis with a minimal starting fee of $115. The five tier categories were developed based on the observation of the distribution of charges and multiplied $115 for each additional tier of care based on the

assumption that the higher the ER cost, the more complicated the care (see Table 12 below). It should be noted that since there was no way to know if a specialist was called in, this most likely underestimates the actual charges associated with the visit.

TABLE 12
Estimated Emergency Room Physician's Charges
(N=41)

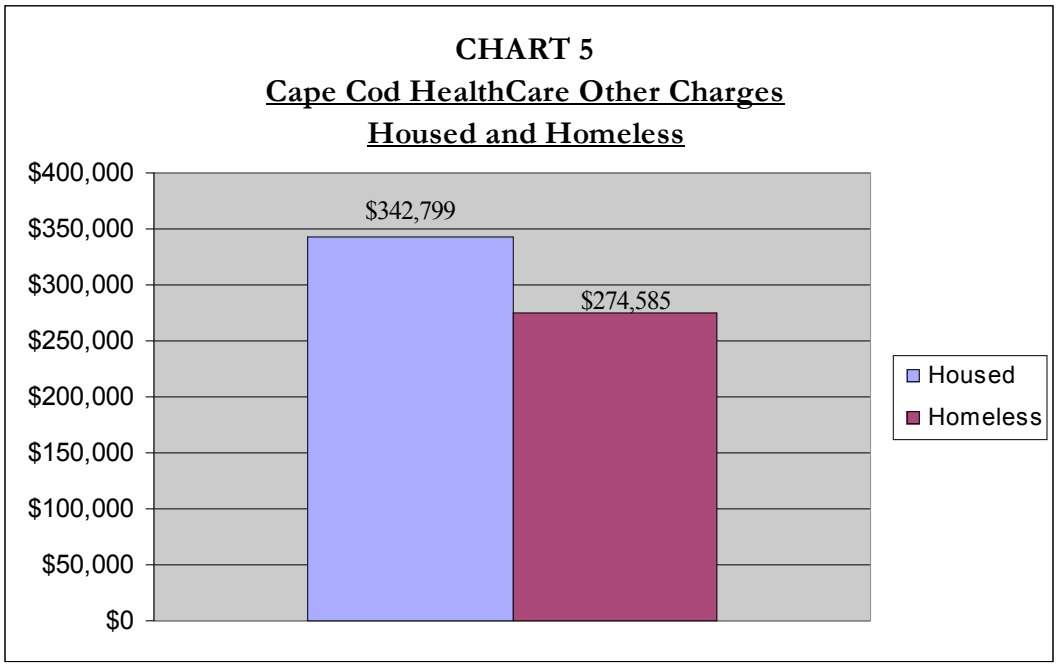
Number of Occurrences	Range of Charges	Estimated Charge	Total Estimated Charges
155	$85 to $999	$115	$17,825
82	$1,000- $1999	$230	$18,860
20	$2,000 - $3,999	$345	$6,900
12	$4,000 - $5,999	$460	$5,520
3	$6,000 plus	$575	$1,725
Total = 272			**Total = $50,830**

The following Chart 4 displays both the ER Charges and the Estimated Physicians' Charges for the two subpopulations, housed and homeless. As to be expected, the majority of the Estimated Physicians charges for those who were homeless accounts for 76 percent of the **$50,830**.



"Other" Cape Cod HealthCare Charges

The following chart shows the comparison between the Housed and Homeless subpopulations for the "Other" (non ER) Cape Cod HealthCare (CCHC) charges totaling **$617,384.** A slight majority of the expenditures (56%) were for those who were housed at the time of the service.



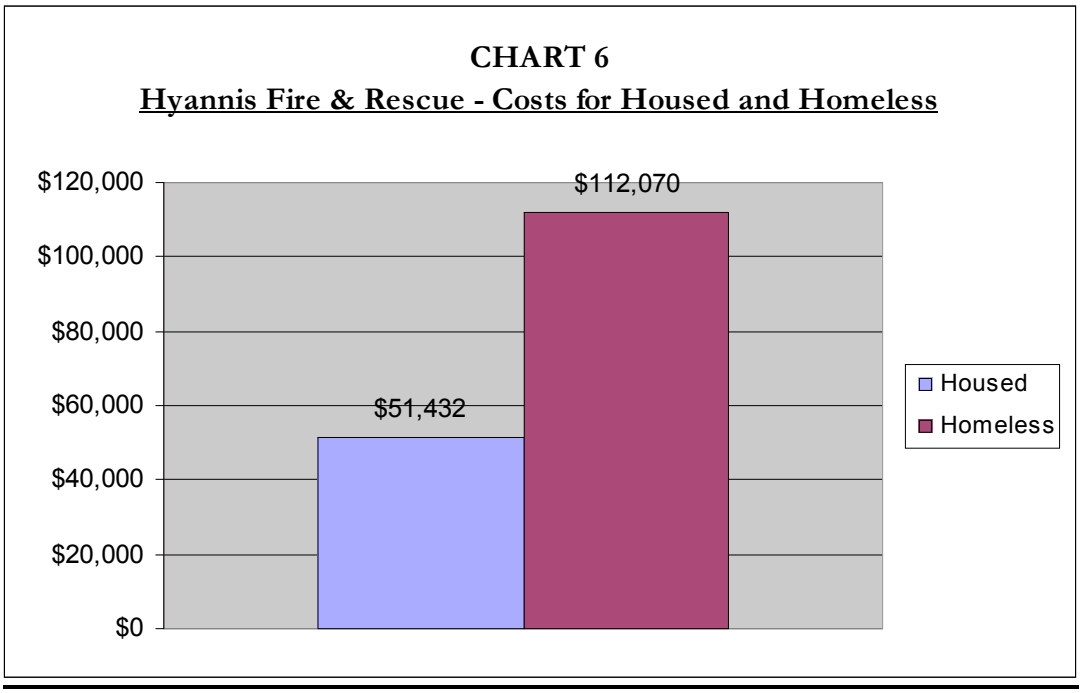
The majority of the "Other" CCHC charges were for hospitalization and/or or surgery (both in and out-patient) and psychiatric in-patient stays at the Cape Cod Hospital Psychiatric Center. Eighteen individuals had 29 hospital stays and/or in out-patient surgery: the charges totaled $375,034, with a range of $1,444 to $45,679 for each stay and a range of $1,444 to $77,635 for total charges per individual.

Four persons had a total of six stays at the Psychiatric Center at Cape Cod Hospital totaling $91,033 for a total of 57 days: the costs per person ranged from $12,249 to $30,503. When comparing those housed and homeless, the majority of the charges (67%) were utilized by those who were housed at the time. The remainder of the CCHC 'Other Charges' was utilized for testing and lab work and will not be broken down further because of the risk of identifying individuals.

Hyannis Fire and Rescue

Thirty-one persons utilized Hyannis Fire and Rescue at least once over the course of the study period with the total charges of **$163,502** for rescue calls. There were 165 calls with 144 transports (91 basic life supports and 47 advanced life supports). The charges per call ranged from $376 (a non-transport fee) to $1,458 for advanced life supports. The total costs per individual ranged from one non-transport call at $376 to 16 calls totaling $15,644 over the course of the year. The average total cost per person was $5,274 and the median was $2,357.

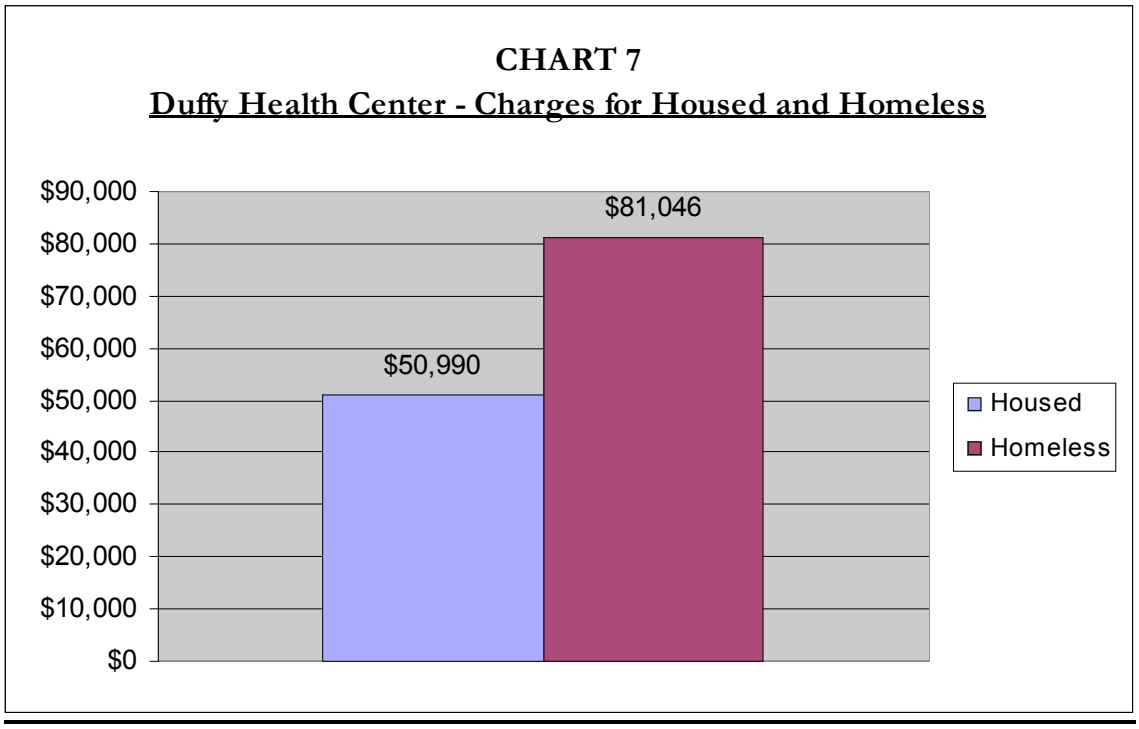
While the majority of the costs (69%) were among persons who were considered homeless (see Chart 6 below), the data also revealed that the third highest user of Hyannis Fire & Rescue services was housed throughout the duration of the study.



Duffy Health Center

The total charges for Duffy Health Center equaled **$132,036** with 39 persons receiving services, with a range of charges from just under $28 to $130 per visit. The total charges per individual ranged from $130 to $13,570. The Duffy charges include medical tests, medical visits, medical case management and group and individual therapy. There is also an array of services provided without an additional charge attached, such as urine screening as well as respite care (this allows someone a resting spot), referrals and check in with Pilot House residents. The majority of the charges ($82,165) were for medical visits; $49,021 was for group and/or individual therapy utilized by 23 individuals. The small remainder went toward medical case management and other fees.

When comparing the two subpopulations, housed versus homeless, the results show that 61 percent of the Duffy Health Center charges went toward those who were homeless at the time of the service (see Chart 7 below).



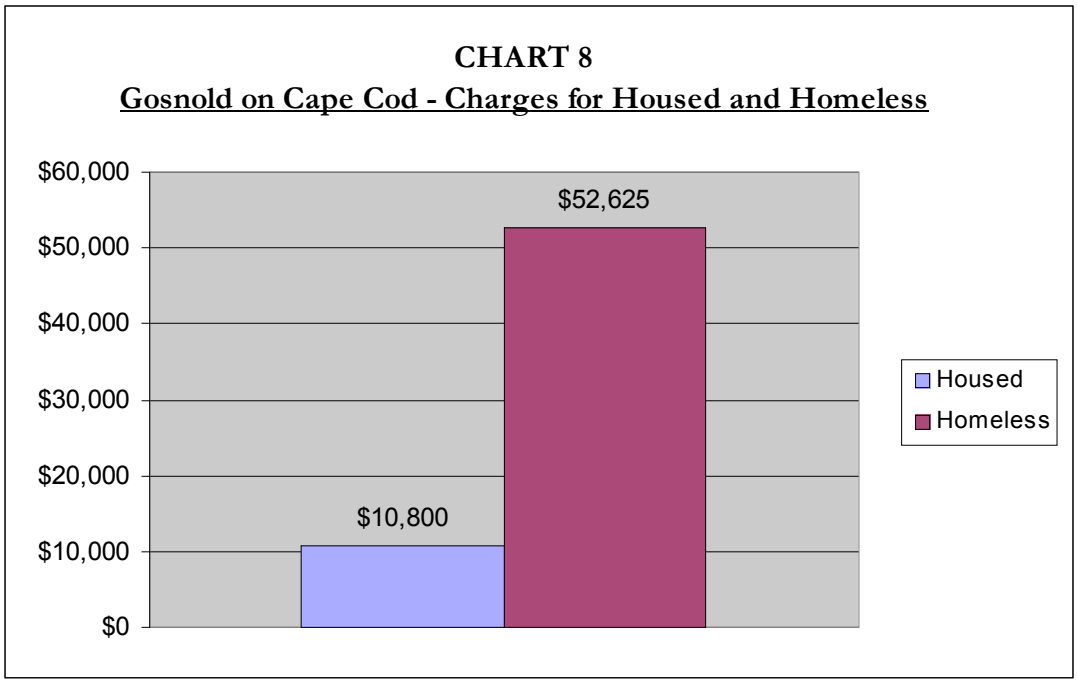
Gosnold on Cape Cod

The total charges for Gosnold services equaled **$63,425** with 17 persons receiving services including medical visits, counseling, evaluations, and in-patient detoxification and halfway house stays. The majority of the charges ($40,050) went for in-patient care for 12 persons. This consisted of 24 stays at $450 per day: one person had five separate stays. The length of stay ranged from one to seven days per stay; for total days of stay per person, the length of stay ranged from one to17 days.

The second largest expenditure was for a residual half-way house stay at $145 per day for a total charge of $17,835. Five persons had half-way house stays: one person had three stays and two persons had two stays. The length of stay ranged from two days to 30 days per stay with a range of 2 days to 51 days per individual for a total of 123 days.

The remaining balance of $5,540 went toward outpatient medical and therapy visits for eight persons – two of these persons also received inpatient and residential care.

Chart 8 below, which compares the subpopulations, shows that 83 percent of the charges were utilized by those who were homeless at the time of the service.



Combining all Health Care Charges

The total health care charges for the four major providers included in this study came to $1,309,879: this included 49 persons with a range from $717 to $99,766 of total expenditures. The average expenditure was $26,732 and the median was $11,184.

Estimated Health Care Charges

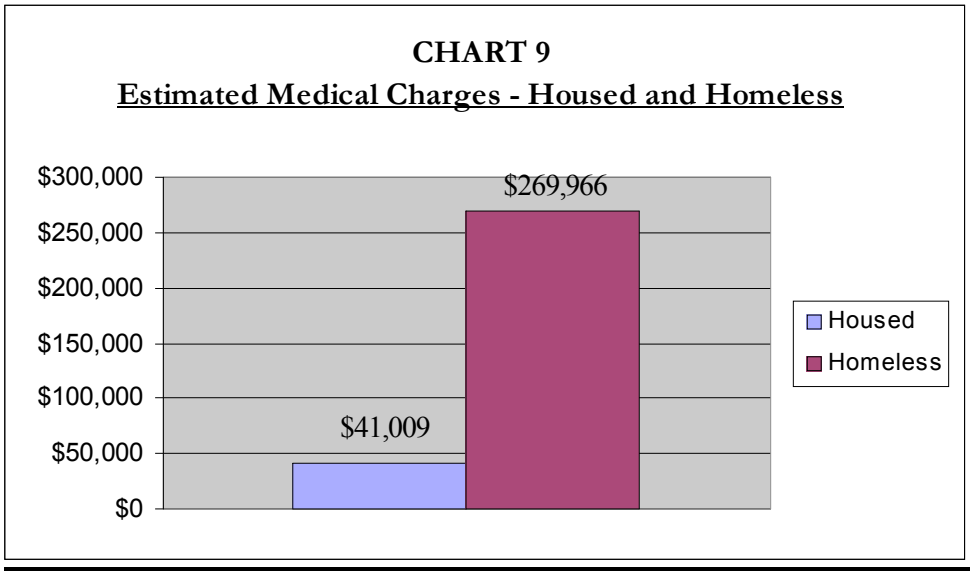
Estimated medical charges were based on information provided by individuals and/or organizations noting specific medical events and/or ongoing medical care. This estimate included routine visits to a private physician, therapy and/or psychiatrist visits either provided through the agency but billed separately or independently, detox stays and ongoing methadone treatment (this is based on a few individuals who acknowledged they were receiving this treatment at the time of interview). For the few cases where individuals were sectioned (see Barnstable Police Department section below), an estimated three week stay for detoxification was used, even though the sectioning could be for a stay in a mental health hospital which is much more costly. Estimated psychiatric stays were for the most part based on self-reporting information. In addition, if transportation expenditures showed that someone was transported off Cape, the assumption was made that the person was transported to a detox unit.

The estimated amounts were based on Duffy Health Care charges, Gosnold's daily rate for inpatient detox, and Cape Cod HealthCare's Crisis Center's rate for inpatient care, unless reported otherwise by the supporting agency. The amount for daily methadone treatment was based on a rate of $19 per day (general information provided with no relation to individual use by Habit Op) and calculated based on self-reported information.

In order to control for duplication of services before estimated medical costs were added, the database queries were checked to see whether the person utilized other services during the estimated dates. The estimated date of services and/or length of stay were based on this cross reference.

While the data in this section cannot be viewed as reliable as the other health care charges previously noted which were based on data reported directly from the health care providers, nonetheless, it attempts to fill in some of the gaps of known health care costs. However, this data is not conclusive as the physician's fees for inpatient and outpatient care at Cape Cod Hospital are not included in this estimate, nor are the charges for other medical procedures reported to the researcher (surgeries and other medical expenditures too complicated to attempt an estimate).

The total estimated health care cost came to **$284,825** with the vast majority of the expenditures, 85 percent, for those who were considered homeless at the time (see Chart 9 below).



A breakdown of the estimated medical expenditures shows that the majority of expenditures were for detox and mental health stays.

TABLE 13
Estimated Medical Charges (N=31)

Type of Care	Total Estimated Charges
Therapy & Psychiatrist	$26,800
Private Physician & Specialist	$9,810
Detox & Mental Health Stays	$231,172
Methadone Treatment	$15,865
Self Reporting Ambulance Usage	$1,178
Total Estimated Charges	**$284,825**

Part III.
Criminal Justice And Legal Services Costs and Usage

Introduction

The criminal justice category includes encounters with the Barnstable Police Department and incarceration at the Barnstable County House of Corrections. This researcher acknowledges that although there may have been involvement among the study participants with other police departments and/or corrections facilities, she is confident that this data most likely captures most of the activities of the study population since they were selected to be part of the study based on their primary concentration in the Hyannis area. Also included in this section was any involvement with South Coastal Counties Legal Services.

Barnstable Police Department

The data for the Barnstable Police Department (BPD) during the one year period shows that 69 percent of the study participants (n=35), had at least one encounter and some had numerous encounters with one individual having 39 encounters over the course of the year (see Table 15 on the next page).

The total cost to the Barnstable Police Department for these encounters came to **$36,980.** The costs were calculated based on an average of $40 per hourly rate for the police officers involved[18] and included the following: interactions, non-arrest encounters (victimization and other), arrests, and protective custody. The costs associated with the encounters also include reporting time when appropriate, station time, and included an estimated cost for each police officer when multiple officers/cruisers were involved in the same encounter.

The data shows that the total cost per individual ranged from a low of $10 to a high of $5,480 with an average total cost per person among those having contact at $1,057. However, the average is most likely skewed by the higher users as the median (the midpoint of occurrences) is substantially less at $390. The following Table 14 provides a breakdown for total cost per individual which relays this skewed distribution (7 individuals per quintile). While this shows that the majority of the expenditures were utilized by a small subset of the population, this does not take into consideration the numerous short-term contacts among some individuals, which while not fitting into the heavy user cost-wise category, certainly absorbed time and energy of the Police Department. It also shows that there were some minimal users with very few costs.

TABLE 14
Barnstable Police Department – Total Cost Per Individual by Quintiles (N=35)

Quintiles	Total Amount	Range	Average	Median
1st Quintile	$350	$10-$80	$50	$40
2nd Quintile	$1,390	$90-$290	$199	$240
3rd Quintile	$2,720	$300-$460	$389	$390
4th Quintile	$8,890	$490-$1,950	$1,270	$1,430
5th Quintile	$23,630	$2,240-$5,480	$3,376	$3,080

[18] This researcher considers this a conservative estimate as the figures are only calculated based on the average salary of police officers and does not account for additional costs such as benefits, any overtime, maintenance of vehicles and the overhead costs for police headquarters.

At times, multiple police cruisers responded to the same call: of the 283 individual encounters throughout the course of the one-year period, 552 cruisers were involved. On one occasion, there were seven cruisers involved in one call, and on a couple of occasions four to six cruisers were involved in the same call. Twenty-two times there was more than one incident regarding the same person on the same day: while the majority of these encounters consisted of one additional encounter on the same day, there were six cases with three return encounters and one case with four encounters with the same person on the same day.

The average and median figures for the variables, "number of cruisers" and "total time spent" also relays the distribution of this population as the median (the midpoint of occurrences) in both categories is substantially lower than the average, again signifying that the average is skewed higher by the subpopulation of heavy users.

TABLE 15
Barnstable Police Department
(N=51)

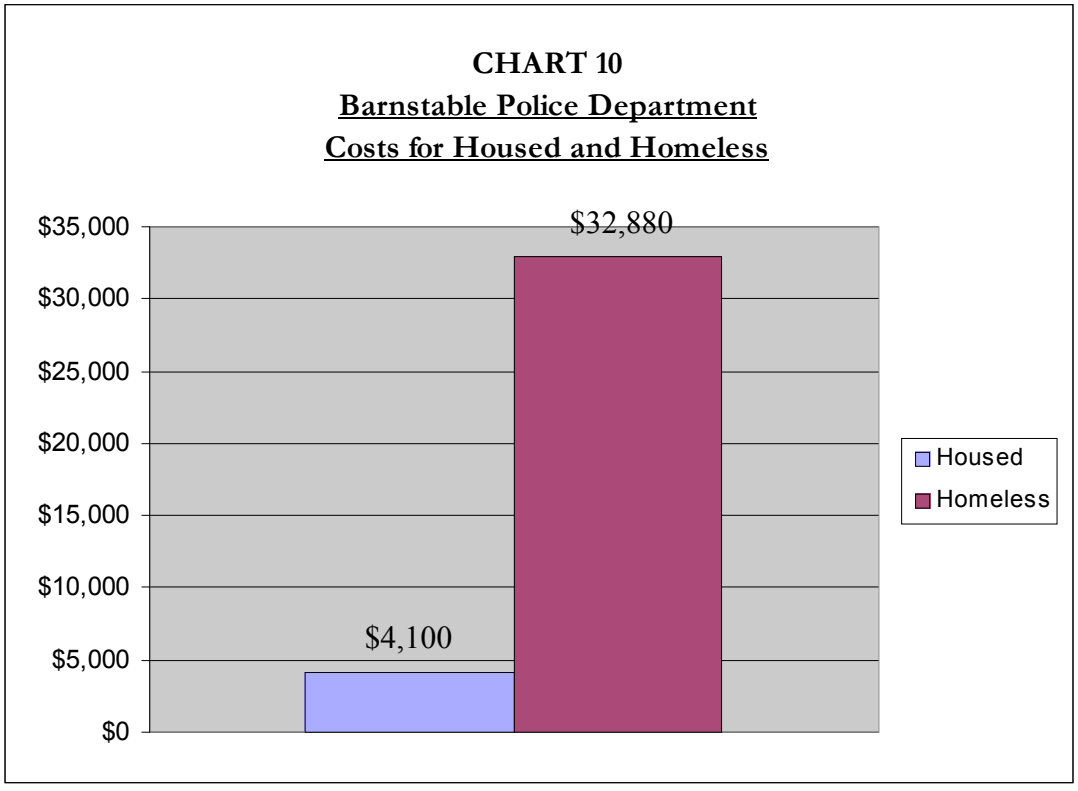
Type of Incident	Number of Persons/Incidents
At least one Encounter	35 persons
Number of Contacts (Range per Person) Average = 8; Median = 5	283 Contacts (1 to 39 Contacts)
Number of Cruisers Involved Range, per Person, Individual Encounters Range, per Person, Total Encounters Average = 16; Median = 8	552 Cruisers (1 to 7 cruiser per call) (1 to 74 cruiser, total usage per person)
Total Time Spent (Range, Total Contact per Person) Average = 26 hours Median = 10 hours	925 hours (15 minutes to 137 hours)
Protective Custody (Number of Persons and Range)	64 Incidents (16 persons with 1 to 13 incidents)
Arrests (Number of Persons and Range)	22 Arrests (14 Persons with 1 to 5 Arrests)
Sectioned (Number of Persons)	5 Persons (Sectioned One Time Only)
Repeated Calls (for the same person on the same day)	22 Persons (Range, 2 to 4)

Protective Custody (PC) is a process utilized by the police department to bring people in to get them temporarily off the streets to prevent injury while that person is intoxicated (this can only involve intoxication and not drug use): the person can be held for up to 12 hours and the police are required to watch the person every 15 minutes. During this study period, 16 participants

were taken into PC involving 76 incidents ranging from one to 13 incidents per person among this group (an average of 8 hours per PC was calculated).

The police can also appeal to the court to Section people considered a danger to themselves by petitioning the judge to send the person to either a detoxification unit (Section 35) or to a mental health unit (Section 12). Five persons were sectioned. Information was not available as to where the persons were sectioned to and their length of stay. Since the stay can range for up to 30 days for detoxification and a mental health unit, the costs were estimated based an average of 21 days and based on a daily charge of $450 per day (Gosnold's inpatient rate was used for this analysis) and are included in the estimated medical data in the previous section. In a few cases, unless the person reported otherwise, the average costs per day for inpatient treatment for Gosnold on Cape Cod was used.

When comparing the two subpopulations, homeless versus those housed, 89 percent of the Barnstable Police Department's expenditures went toward those who were homeless at the time of the interaction (see Chart 10). While most of the expenditures ($22,890) were utilized for protective custody, it should not be surprising that the vast majority of these costs (92%) were utilized for those who were homeless. Since this figure only includes the costs of the actual PCs (officer and station time), it undercounts the actual costs as this usually involved a number of calls and/or officers/cruisers leading up to the person being taken into custody. Nonetheless, the costs per individual for the 16 persons who were PC'd during the study period, ranged from $340 to $4,320 (as noted above, the costs were based on an average of eight hours although the person may be held for up to 12 hours).



Barnstable County House of Corrections

Six of the study participants (12%) were incarcerated within Barnstable County sometime during the one-year study period: two of these persons were incarcerated more than once – one person twice and the other four times. This study was not able to track if someone was incarcerated outside of Barnstable County.

The length of stay of incarceration ranged from a low of four days for one stay (this person had multiple stays) to a high of 148 days. It should be noted, however, that the length of stay does not accurately reflect the full incarceration period as four persons were still incarcerated at the end of the data collection period on August 31, 2007.

Based on an average cost of $75.00 per day, the costs ranged from a low of $300 to a high of $11,100 per stay with the average per stay based on 11 days at $3,518 (the average cost per person was $6,450) The total cost of incarceration for this population for this one year period was **$38,700** (see Table 16 below). All six persons were homeless at the time of incarceration.

TABLE 16
Barnstable County House of Corrections
(N=6)

Percent of Population Incarcerated (N=51)
- 12%

*Length of Stay**
- Each separate stay per person = Range, 4 -148 days
- Total stay per person = Range, 28 -148 days
- Average stay per person = 86 days
- Total number of days = **516**

Costs (based on $75 per day)
- Average cost per stay (based on 10 stays) = $3,870
- Average cost per person (based on 6 persons) = $6,450
- Total Costs = **$38,700**

Homeless versus Housed
- Homeless at time of Incarceration **= 100%**

*Note, four persons were incarcerated at the end of the study period so the data do not truly represent length of stay.

Interrelationship of Barnstable County, House of Corrections, and Barnstable Police Department

While one person incarcerated did not have any noted contact with the Barnstable Police Department during the course of the study period, the remaining five had a total of 86 encounters

ranging from five encounters to 27 encounters. While not a question that was systematically asked, eight persons mentioned their former incarceration experience.

South Coastal County Legal Services

The Homeless Legal Services Project provides outreach and legal services to homeless persons (both individuals and families). While the costs are smaller in scale in comparison to the Barnstable Police Department and House of Corrections, seven persons used this service for a total of **$2,580**. This cost was calculated at $100 per hour and included 32 interactions, ranging from 20 minutes to over eight hours: the costs per person served ranged from $50 to $810 for the seven persons.

When comparing the two subpopulations, homeless versus those housed, 57 percent of the expenditures ($1,480) went toward those who were housed at the time of the interaction.

This study was not able to gather data on court costs and probation expenses. A visit with the Clerk of Courts at the Barnstable First District Criminal Court determined that it was not possible to determine estimated court costs since some indigent clients receive a court appointed lawyer and others may not, depending upon the circumstances. The court does not have an estimated cost per person served. While it would have been possible to capture data on the frequency of use of the criminal court system, since costs were not available this data was not collected. The Barnstable County Department of Probation was not able to participate in the study.

Part IV.
Shelter, Street and Permanent Supportive Housing Programs – Costs and Usage

Introduction

While this study is not intended to be an evaluation of services and/or programs, it is important to briefly outline the specific shelter and permanent supportive housing programs as they consist of an array of different services which has a substantial impact on costs.

Description of Shelter and Housing Programs

NOAH Shelter, a Housing Assistance Corporation program, provides 60 emergency shelter beds. Also, at the time of the study NOAH provided employment, housing search and case management. The shelter also provides breakfast and dinner to its guests. At the time the study was conducted, clients had to leave for the day, but were able to come back into the shelter for appointments with the housing search and employment search staff. They could also come in to check for mail and use the telephone during certain times. The exception to having to leave for the day is when the shelter remained open on the weekends during some of the coldest winter days with certain restrictions (persons couldn't come and go at will but had to stay for the day except to go outside to receive lunch delivered by volunteers in the parking lot). The shelter also offered art classes one afternoon a week conducted by community volunteers. While clients were in residence in the evening, counselors were available, and two nights a week the adjoining Duffy Health Center outreach clinic was open. Anyone requesting shelter for the first time was required to go through an intake process. Guests were not expected to pay toward their stay, although some may have volunteered at the shelter and/or performed certain services.

Pilot House, run by Community Action Committee of Cape Cod and the Islands (CAC) in partnership with Duffy Health Center, is a 'dry' shelter in that the residents are expected to work on their sobriety and stay clean and sober. They provide 17 shelter beds and residents also have reserved space which is distinct from other shelters. Case management and self sufficiency skills training are provided to each resident. In addition, residents are expected to work with a substance abuse counselor and nurse who visit the shelter regularly, and receive ongoing monitoring in cooperation with Duffy Health Center where they may receive regular urine screening to determine drug/alcohol use, along with comprehensive medical care and individual and/or group therapy. While residents may occasionally 'slip,' their space can be reserved while they go to a detoxification unit and/or receive further treatment. Residents pay toward their stay and also contribute food stamps. During the course of the study, shelter residents, with the exception of those living on the second floor, were required to be out for the day and could return at 2:00 PM, unless they had some other schedule approved. However, during the winter months, the shelter stayed open as a respite from the cold, including during the weekends.

Operation in from the Street [19]– this is a collaborative program which started in January 2006. Although Housing Assistance Corporation was the fiscal coordinator at the time the study was initiated, that responsibility was later transferred to Duffy Health Center. However, during the course of the study, both Housing Assistance Corporation and Duffy Health Center equally

[19] The program name transitioned from *Operation in from the Cold* to *Operation in from the Street* when the decision was made to make the program year round. However, during the course of the study period, funding was not available to make that a reality.

shared responsibility in assessing individuals and providing the follow-up case management and/or working with the collaborative on follow-up. This program continues to be a collaborative effort consisting of an array of key players, including Duffy Health Center, Cape Cod Council of Churches, Community Action Committee of Cape Cod and the Islands, the Human Services Committee of the Town of Barnstable, Vinfen, Nam-Vets Association, Cape Cod Hospital, landlords and community members (including members of the faith based community). During the course of the study, the town contributed $10,000 per year toward this program.

While not an emergency shelter, this program placed "hard to reach" individuals most at risk of dying on the streets during the winter months into motel units. Once individuals are housed in a motel unit, workers also gradually plug in services in order to stabilize the individual by working with the clients to define their needs. This could consist of helping individuals obtain benefits, referrals to Duffy Health Center clinic or other health care, and getting individuals into Housing First units and so forth. While the program was striving to become year round, during the study period the funds were not available.

Pilot Plus is also run by CAC. Over the course of the study period, CAC developed permanent supportive housing units on the second level of Pilot House, providing five units, funded through a HUD Continuum of Care Shelter Plus Care (SPC) grant through Barnstable Housing Authority. Shelter residents may graduate and move into the SPC units. These residents pay one-third of their income toward rent to the housing authority overseeing the subsidy. The SPC residents were not required to be out for the day. Case management is provided by both CAC staff and Duffy staff.

CHAMP Homes, Housing For All Corporation (HFAC), at the time of the study, ran Permanent Supportive Housing programs for formerly homeless individuals with an average of 44 units in three separate dwellings within their complex. They provide case management, life skills counseling, transportation when necessary, and meals, along with other services. All basic necessities are provided, such as telephone, cable (although residents may pay extra to have cable in their room), laundry rights and certain household supplies. Residents pay a residential fee. During the course of the study period, HFAC added a four-unit transitional housing unit, Bayside Cottage, for women transitioning from prison, but this population was not recruited as part of the study.

Cape Cod Supportive Housing is run by the Department of Mental Health (DMH) in collaboration with Housing Assistance Corporation (providing housing vouchers) and Vinfen (providing support services). At the time the study started this program provided 20 scattered site units for formerly homeless individuals. By the end of the data collection period, DMH had revised the program, thus affecting some of the residents as their services changed. Because residents are DMH qualified, they also receive additional DMH services: Vinfen is contracted to provide ongoing case management with oversight from DMH. However, clients in this program are able to live independently and resided in scattered site subsidized units and pay rent based on their income/benefit amount as determined by the program overseeing the subsidy (Housing Assistance Corporation oversees housing vouchers paid through an annual HUD CoC Shelter Plus Care grant). Clients of this program, once stabilized in housing, are expected to participate

in treatment based on their individual needs. The treatment plan may include involvement in structured activity, educational/vocational opportunities, substance abuse treatment, symptom management skills or learning basic activities of daily living (ADL) skills. They also may be required to volunteer four hours per week depending upon their other activities.

Kit Anderson /Larry Doughty House is run by the Family Continuity Program and also works in collaboration with the Department of Mental Health. This complex provides 12 beds with six of these beds reserved for formerly homeless and the remainder for other individuals primarily coming out of institutions. Again, because the residents must fit the DMH criteria, there are additional services available to this population. These clients live in a residential setting, not an individual setting, with case management and extensive services available on site, including 24/7 staff providing supportive counseling for mental health and substance abuse issues and full-time nursing support to meet the clients' medical needs. Residents pay toward their stay and also contribute the full amount of their food stamps to the house. As people complete their treatment program, they have the opportunity to transition into the Supported Housing Apartments for greater independence with continued staff support.

Chase House, a Housing Assistance Corporation program, is located on the grounds of the NOAH Shelter complex and provides six units for formerly homeless individuals. At one time, these units were considered transitional housing (thus requiring a time limit to length of stay), but during the study period had already converted to permanent supportive housing.

Housing First – While there were few units that fit this category, one complex with funding through a HUD CoC grant intended to house up to six individuals converted to six scattered site units early into the study. Additional Housing First units utilized housing vouchers, coupled with case management and additional services through Duffy Health Center. The Housing First approach is often coupled with the following Home and Healthy For Good program.

Home and Healthy For Good – None of these units existed during the interview period, but 12 units were developed as the study progressed. This program is run by Housing Assistance Corporation through state funds that come through Massachusetts Housing and Shelter Alliance (MHSA) via HUD. It's basically a Housing First model that provides up to 70 percent of rent and minimal funds for case management. The bulk of case management comes through a partnership with the Duffy Health Center and the program also utilizes other mainstream resources and support services available within the community.

While no one was specifically recruited from the *Operation in from the Street* and *Home and Healthy for Good* programs, individuals in the study may have utilized these services over the course of the one year period.

Comparison of Subpopulations: Shelter/Street and Permanent Supportive Housing/ Housing First

Over the course of the one-year period the study population proved to be very fluid and for some, their status changed from being on the street/shelter to moving into some type of Permanent Supportive Housing/Housing First units and/or independent housing and vise versa, and for some this was a temporary stay as noted in the following patterns:

- Stayed in of Permanent Supportive Housing/Housing First throughout the course of the study period;
- Stayed homeless/out on the street/shelter throughout the course of the study period;[20]
- Was homeless until moved directly into Independent housing;[21]
- Status Fluctuated:
    - Housed at the beginning of study period but lost housing;
    - Placed into housing during the study period and either lost housing or maintained the housing through to the end of the study period;
    - Placed into housing and then transitioned into independent housing;
- Left region – these persons fit into all but the first category.[22]

The following Table 17 displays the housing status over the course of the one-year period.

TABLE 17
Homeless and Housing Status Over the Course of the One Year Period
(N=51)

Homeless and Housing Status	Percent	Number
Homeless Consistently While Participating in the Study [23]	33%	17
• Homeless Consistently During the One Year Period		(14)
• Homeless Consistently While Either Remaining in the Area or Up Until Moving into Independent Housing		(3)
Housed Consistently During the Course of the Study Period	26%	13
Homeless and Housing Status Fluctuated	41%	21
• Housed at the Beginning of the Study Period But Not Housed at the End of the Study period		(6)
• Housed Sometime During the Course of the Study Period and Either Did Not Remain Housed or Did Not Remain in the Study[24]		(8)
• Housed at the End of the Study Period, But Not Housed at the Beginning of the Study Period		(7)

[20] If the person was homeless prior to imprisonment, they were counted as homeless during the incarceration period.
[21] Once a person moved into independent housing data was no longer collected on them and they were no longer included in the study.
[22] Four individuals permanently left the region.
[23] While there was some uncertainly about the status of a few cases, these individuals were low users of services and therefore had a minimal impact on the overall costs.
[24] This includes three persons who left the region and /or moved into independent housing.

Homeless - Shelter and Street Population

Fourteen persons remained homeless throughout the course of the study period.[25] Two additional individuals were homeless until they left the region late into the study and an additional person moved directly from homelessness into independent housing (without support services).[26] For those who were not consistently homeless during the course of the study, some moved into permanent supportive housing and then went back into homeless and vise versa as noted below.

Permanent Supportive Housing Population

Table 17 (page 42) shows that the majority (n=34) of the study participants were housed for at least part of the study period. Of the 19 individuals residing in permanent supportive housing at the beginning of the study period (September 1, 2006), 13 were consistently housed over the course of the year. The six individuals who left housing did so either by choice or were evicted.

An additional 15 individuals were placed into some type of housing (the individuals came from Pilot House, NOAH Shelter and some came from the street). One person graduated into independent housing and seven other individuals remained in housing at the end of the study period. For the remaining seven persons who were temporarily housed for part of the year, two left the region, two were evicted, and the others just left. Length of stay ranged from two weeks to ten months for those who were not housed for the full year.[27]

Status at the End of the 12 Month Period

When combining those in housing who stayed throughout the course of the study and those placed in housing during the course of the study – 20 persons resided in some type of permanent supportive housing unit and it is assumed that two persons remained in independent housing at the conclusion of the data collection period. The following lists what is known about the homeless subpopulation:

- A few individuals were thought to be doubled up for at least part of this period.
- Four individuals were incarcerated at the end of the study period.
- Five persons left the region toward the later part of the study collection period but two returned to the area after varying times away creating gaps in services.
- The remaining individuals went in and out of shelter and/or other services although not everyone utilized these services.
- The whereabouts of a few individuals remained uncertain as they were infrequent users of services and therefore more difficult to track.

[25] Since it was impossible to completely track each individual's activity, it was suspected that three of these persons may have been doubled up during most of this duration, and a few others may have gone in and out of doubled up situations over the course of the year.

[26] Once a person moved into independent housing they no longer fit the study criteria and from that point on were no longer included in the analysis.

[27] Noting the length of time for those who stayed is somewhat artificial since counting ended as of August 31, 2007.

Shelter & Street Costs and Usage

NOAH Shelter - Twenty-two persons stayed at the NOAH Shelter over the course of the study period. Calculated at $45 per night (the costs include support services, including housing specialist, employment specialist and case management services), the costs ranged from $45 to $10,305 for a total of 1,554 nights of stay for a total cost of **$69,930**. Although some individuals were either banned from the shelter and/or made the decision to not utilize the shelter services and some were known to be staying outside, some individuals still came to NOAH for a meal even if they were not allowed to stay or chose not to stay overnight. These costs are not included. As noted above, shelter residents are not required to pay toward their stay.

Pilot House - Eight persons stayed at Pilot House during the course of the study period with a range of lengths of stay from 14 to 234 days. The costs were calculated to $32 per day for the month of September 2006 and at $21 for the remainder of the study period. Based on this rate, the total costs per individual ranged from $294 to $4,907 with a total of 1,092 days of stay. The total costs equaled **$23,296**. Residents usually pay around $200 per month for their stay and also contributed around $100 in Food Stamps if able, although they can contribute less if not employed or receiving inadequate benefits such as EAEDC.

Case management for Pilot House residents was provided by the program director who often does this on her own time and, therefore, there were no billable hours to add to the costs. Duffy Health Center's substance abuse counselor and nurse provided services and supervision to residents. In addition, Duffy case managers, CAC and the Council of Churches outreach workers also provided case management and other services to residents. These costs equaled **$4,290** as noted in the following Table 18.

As noted earlier, Pilot House operates as a dry shelter and partners with Duffy Health Center who also provides a part-time substance abuse counselor and a nurse for Pilot House residents for a total of $13,500 in additional costs per year. Based on a total number of 17 residents, this calculated to $66 per month per resident and was factored into the overall costs for the study participants (this did not duplicate other Duffy health charges for this population). In addition, residents also receive intensive health care services from Duffy Health Center (Duffy also provides an outreach clinic two nights a week adjunct to the NOAH Shelter: most of these clients receive follow-up treatment at the main clinic at Park Street).[28] When examining the costs of Duffy Health Center medical-related charges for Pilot House residents during their length of stay this came to **$43,932** with a range of $780 to $11,440 for the eight individuals. However, since these medical charges were calculated elsewhere, they were not directly added to the Pilot House costs as this would duplicate these charges.

[28] Since NOAH residents do not have a reserved bed and come and go, it did not make sense to attempt to provide a comparison analysis of Duffy Health Center charges for those who utilized NOAH Shelter stays.

TABLE 18 Shelter and Operation in from the Street - Stays and Costs (N=31)			
Shelter	Number of Persons Served*	Total Number of Days	Total Costs
NOAH (case management included in nightly rate)	22	1,554	$69,930
Pilot House Case Management & Medical CM[29]	8	1,092	$23,296 $4,290
OIFTS Case Management	11	348	$15,706 $4,390
Totals	**41**	**2,612**	**$117,611**
*The total of the number of persons in each categories is higher than the total number of persons served due to duplication.			

Operation in from the Street (OIFTS)
Eleven individuals utilized this program during the study period, and one person had more than one stay. The total costs came to **$15,486** with a range per individual from a low of $49 to $5,806. The length of stay ranged from one night to 98 nights for a total number of 348 nights. Even though this program does not fit the definition of an emergency shelter, it is included in the table above for comparison purposes. Case management and transportation expenditures for the OIFTS residents came to $4,390. Most of the documented case management was provided by staff of the Duffy Health Center's case management program.[30]

Permanent Supportive Housing Costs and Usage

Because some of these programs are relatively small with low numbers of study participants residing in each of the program, instead of providing detailed information on each program, the data will be merged together which will display the vast range of costs. Also because this report was not intended to be an evaluation of services, some of the specifics such as daily case management rates for specific programs will not be revealed.

The following Table 19 displays the range of total costs for housing. The daily rate for case management costs ranged from just under to $20 to just under $145. Some programs had more

[29] As noted on the previous page, this includes the Duffy substance abuse counselor and nurse who provide services to the shelter residents.
[30] Since it was difficult documenting the case management expenditures for this program this researcher feels certain that this figure drastically undercounts these costs as a number of agencies played a role in helping to stabilize individuals once they were taken off the street and placed into a motel.

than one funding source/provider of case management. This particularly pertained to the two programs which were part of the Department of Mental Health system: Vinfen provided case management for Cape Cod Supportive Housing residents while DMH also had oversight and therefore, an additional monthly case management fee. Larry Doughty House also had DMH funds for case management and additional funds through an annual HUD CoC grant for support services. The differences in total costs is related to the availability of funding sources for particular programs and the varying length of time individuals stayed in the housing unit. The total cost for the housing programs equaled **$313,569**.

TABLE 19
Permanent Supportive Housing Costs
(N=34)

Program	Number of Persons Served	Overhead Costs	Case Management Costs	Other Costs (Transport/ Misc.)	Total Cost per Agency
Pilot Plus	2		$2,492	$158	$2,650
CHAMP Homes	8	$6,469	$39,517		$45,986
Kit Anderson/ Larry Doughty House Case Management: DMH = $138,606 HUD CoC = $10,860	3		$149,466		$149,466
Cape Cod Supportive Housing Case Management: Vinfen = $29,118 DMH = $20,204	4		$49,322	$3,405	$52,727
Housing First (Includes Chase House and HHG)	14		$50,960	$647	$51,607
Baybridge	3		$10,809	$324	$11,133
Total	**34**	**$6,469**	**$302,566**	**$4,534**	**$313,569**

In addition to the agency costs, the housed individuals either paid a tenant share if they had a housing voucher or paid a determined rental amount to the agency. If an individual had a very limited income they may not have paid a tenant share, but most residents did pay a rental amount.

The following two Tables (20 and 21) display the total costs for the two categories of housing units: those with and without a subsidy.[31] For those receiving a housing subsidy, the tenant rental share amount, based on income, ranged from zero to $327. For those without a subsidy, the rental amount ranged from $373 to $477.

TABLE 20
Permanent Supportive Housing - With Subsidy
(N=24)

Program	Number of Persons Served	Total Tenant Rental Amount*	Total Subsidy Amount*
Pilot Plus	2	$567	$2,024
Champ Homes	1	$223	$1,752
Baybridge Housing	3	$3,047	$7,860
Cape Cod Supportive Housing	4	$8,216	$27,713
Chase House, Housing First and Home & Healthy for Good	14	$10,710	$38,937
Total	**24**	**$22,763**	**$78,286**
*Figures have been rounded.			

People living in scattered-site housing had their own kitchen and only paid their rental share, which, in most cases, included utilities. However, one congregate living program required residents to contribute all or most of their food stamp allotment to the house since meals were provided. Residents may have contributed food stamps to the other congregate living facility listed below, but doing so did not seem to be a requirement.

TABLE 21
Permanent Supportive Housing - Without Subsidy
(N=11)

Program	Number of Persons Served	Tenant Rental Amount	Food Stamp Contribution
Champ Homes	8	$27,033	0
Kit Anderson/ Larry Doughty House	3	$15,023	$4,193
Totals	**11**	**$42,056**	**$4,193**

[31] The total number of individuals in the two tables is greater than 34 because one Champ Homes unit was converted to a subsidy.

Additional Costs – Outreach, Case Management and Transportation for Homeless Individuals

At the time the study was conducted, the following case management and outreach services were available for homeless individuals.[32]

- Vinfen had one outreach worker who provided services to DMH eligible clients.
- Community Action Committee had one full-time outreach worker.
- Cape Cod Council of Churches also had case mangers conducting some outreach to the street homeless and in March 2007 hired a full-time street outreach worker.
- NamVets Association had a full-time outreach worker.
- Duffy Health Center's Project Hope staff provided outreach to assist individuals to apply for benefits. The case management and nursing staff also conducted outreach to encampments and other areas utilized by the homeless and also provided both medical and other case management services to the street homeless population.

This analysis does not truly represent the outreach expenditures dedicated to the street homeless due to the difficulty in gathering this data as the amount of time spent with the street homeless was not always recorded.[33] If records were not kept regarding time spent with individuals, transportation expenses and time spent on transport was captured. Community Action Committee of Cape Cod, Cape Cod Council of Churches and NamVets outreach workers all provided transportation on and off Cape for homeless individuals. While Duffy Health Center staff did not provide transportation off Cape, they provided a voucher for cab or bus fare (the information for off-Cape transportation was not available due to the difficulty in retrieving this data). While not providing outreach services, Baybridge Clubhouse provided case management prior to placement into housing.

Therefore, this section drastically undercounts the expenditures in this area, especially when noting the above mentioned agencies with staff personnel dedicated to street outreach. Regarding the documented expenditures this came to **$20,794 -** this included case management and outreach services, either direct transport expenditures or vouchers to cover transportation costs (if information was available) and other minor miscellaneous costs.

Although shelter residents are considered homeless, because case management costs were included in the *Shelter & Operation in from the Street Costs* (see Table 18 above) it was therefore excluded from the following Table 22 to avoid duplicating costs.

TABLE 22
Costs of Case Management, Outreach and Transportation
for Homeless Individuals (N=18)

Total Case Management Costs	Total Transportation/ Misc. Costs	Total Costs
$19,362	$1,432	$20,794

[32] There may have been other outreach services this researcher was not aware of at the time the study was conducted, but the above listed agencies seemed to be the primary providers.

[33] It wasn't until into the analysis stage that the researcher realized this data was missing so it was very difficult to obtain at a later date.

Part V.
Comparison Analyses of All Expenditures

Introduction

This section includes totals of all expenditures with a breakdown for the three major categories; medical, criminal justice and shelter and housing for both housed and homeless. It also contains a comparison of monthly average charges/costs for four subcategories: housed full-time and part-time and homeless full-time and part-time.

Comparison of All Expenditures for Housed and Homeless

The following Table 23 shows the grand total of all expenditures at **$2,255,353**

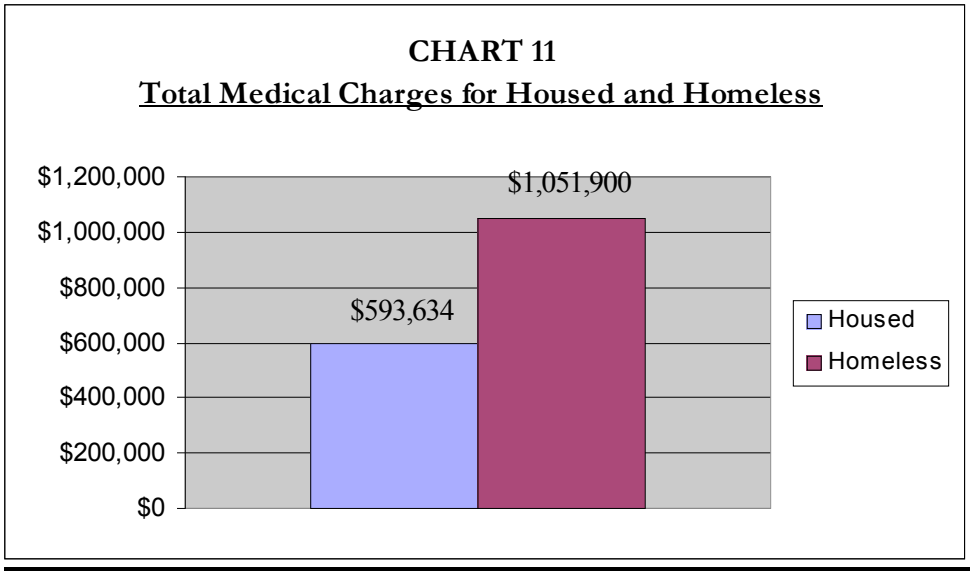
TABLE 23
Comparison of All Expenditures for Housed and Homeless (N=51)

	Number Persons Served*	Total Costs Housed	Total Costs Homeless	Total Costs/ Charges
Medical Charges				
Cape Cod HealthCare	49	$425,684	$525,233	$950,916
Hyannis Fire & Rescue	31	$51,432	$112,070	$163,502
Duffy Health Center	39	$50,990	81,046	$132,036
Gosnold on Cape Cod	17	$10,800	$52,625	$63,425
Estimated ER Physicians' Charges	41	$12,420	$38,410	$50,830
Estimated Other Medical Charges	30	$42,309	$242,516	$284,824
Subtotal		***$593,635***	***$1,051,900***	***$1,645,535***
Criminal Justice/Legal Services Costs				
Barnstable Police Department	35	$4,100	$32,880	$36,980
Barnstable County Correctional Facility	6	-	$38,700	$38,700
South Coastal Counties Legal Services	7	$1,480	$1,100	$2,580
Subtotal		***$5,580***	***$72,680***	***$78,260***
Shelter and Housing Costs				
Shelter Costs (Noah, Pilot & OIFTS) Case Management Costs (Note, NOAH CM costs are included in the nightly amount)	41	-	$108,931 $8,680	$108,931 $8,680
PSH - Agency Overhead, Case Mgmt	8	$6,469	-	$6,469
Housing Subsidy Costs	25	$78,286	-	$78,286
Case Management, Transportation & Misc. Costs (Homeless Outreach)	Housed, 35 Homeless, 19	$308,399	$20,794	$329,193
Subtotal		***$393,154***	***$138,405***	***$531,559***
Total		**$992,369****	**$1,262,985**	**$2,255,354**

**Due to duplication of individuals utilizing different services within categories, this column has not been totaled.*
*** There is a slight difference in the final total amounts due to rounding.*

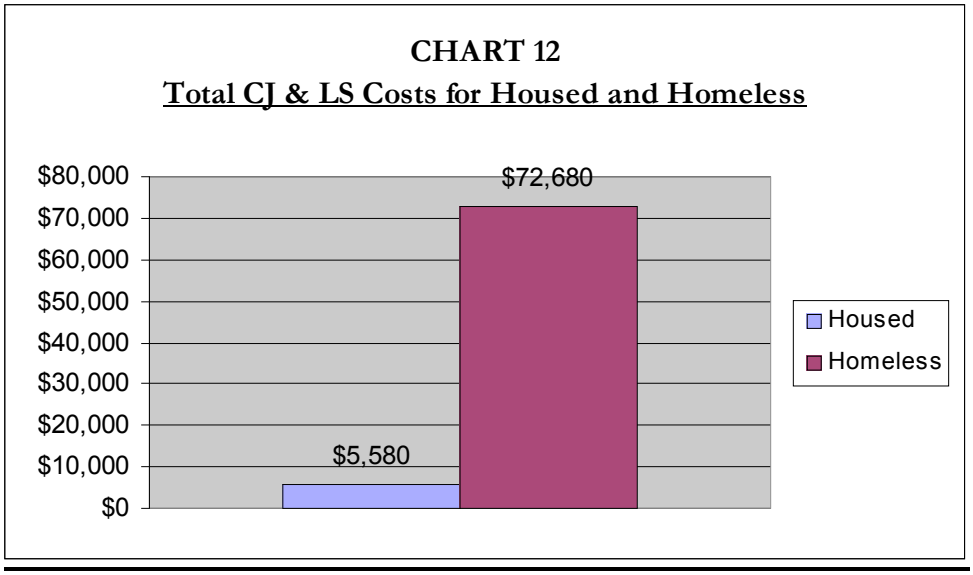
Total Medical Charges for Housed and Homeless

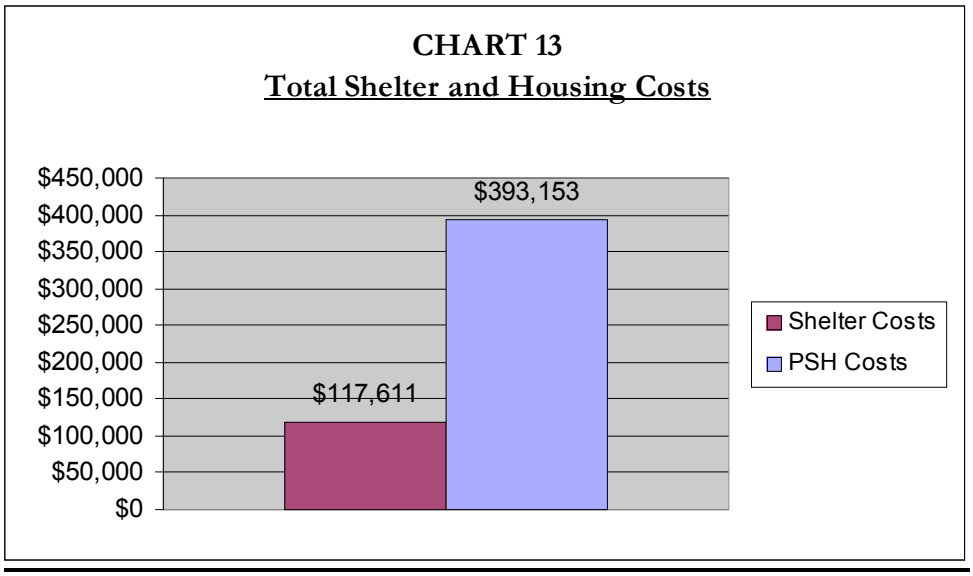
The following Total Medical charges chart includes all the health care charges, including estimated medical charges. This shows a total of **$1,645,535** with 64 percent of the charges utilized by homeless individuals.



Total Criminal Justice and Legal Services Charges for Housed and Homeless

The following chart shows the total expenditures for Criminal Justice and Legal Services activities which included the Barnstable Police Department, Barnstable County House of Corrections and South Coastal Counties Legal Services. This shows that of the total expenditure of **$78,260** the vast majority, 93 percent was utilized by homeless individuals.





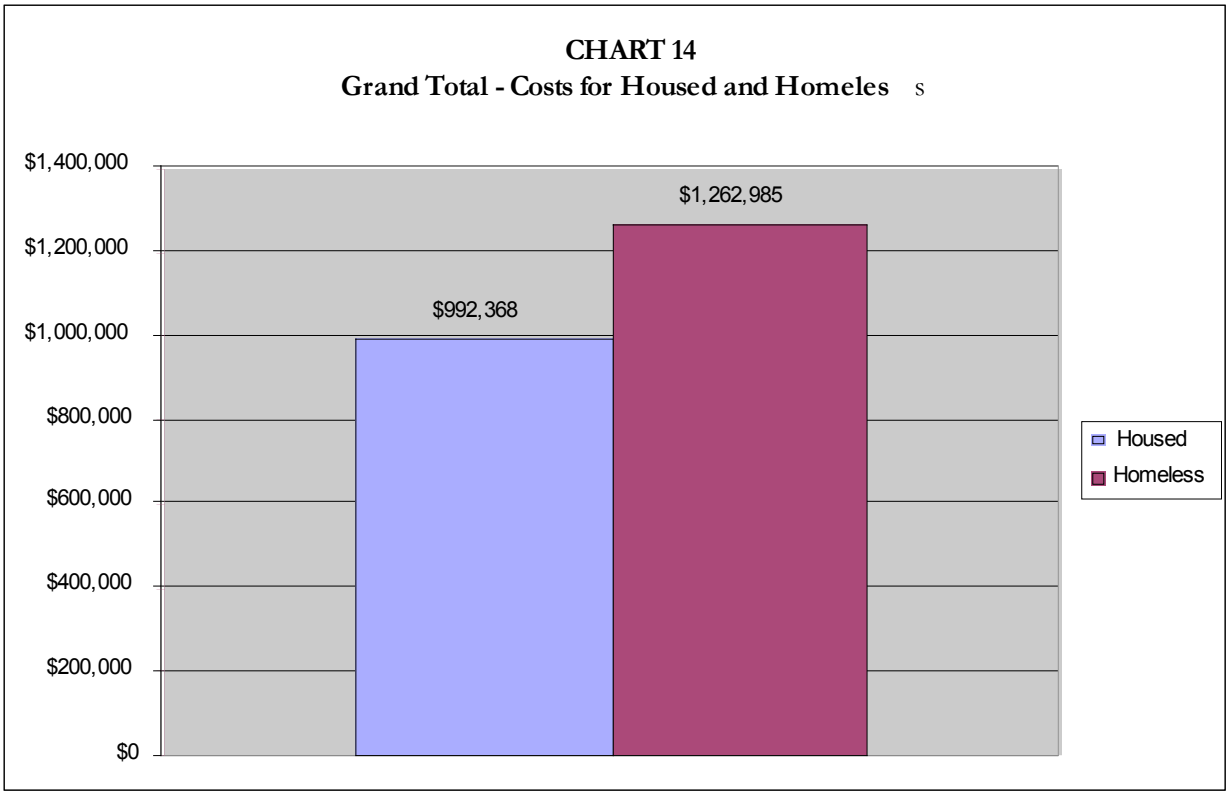
Total Shelter and Housing Charges for Housed and Homeless

The above chart, Total Costs for Shelter and Housing shows that the majority of the total expenditure of **$510,764** went toward those who were housed at 77 percent. This analysis also includes the value of the public housing voucher in the amount of $78,286. As already noted in the above section, defining the programs (see pages 39-41), the sheltered population also included units that contract with the Department of Mental Health which substantially increased the case management costs.

Additional costs, not represented in the above table but added to the final comparison of all expenditures for housed and homeless (see Chart 14 below) included costs for case management and outreach, and transport costs for those on the street at **$20,794**. As previously noted, it was very difficult to gather some of the case management and outreach costs for the street homeless population, perhaps partially since some of the agencies do this work without additional funding and, therefore, recordkeeping is not required. In addition, time spent with individuals on the street can be irregular with short interactions, thus keeping track of these encounters presented difficulties for street outreach workers and others conducing outreach.

Grand Total for All Charges/Costs for Housed and Homeless

The following Chart 14 shows that for all the charges/costs, the total amount equals **$2,255,354**, and that 56 percent of the overall expenditures ($1,262,985) went toward homeless individuals.



Comparison of Monthly Averages for Four Subcategories

This section analyzes the housed and homeless subpopulations into four subcategories to examine the monthly average charges/costs for health care, criminal justice/legal services and housing and shelter usage. It also analyzes the costs for outreach and case management for the street homeless population. This calculation is based on adjusting for length of stay, thus allowing for a more accurate calculation of the average monthly rate (see Table 24). The total number of months for all categories came to 581.6 months (269.5 for housed and 312.1 for homeless). The subcategories are based on the following calculations: housed full-time, 156 months; housed part of the time, 113.5 months; homeless full-time,[34] 183.2 months; and homeless part of the time, 128.9 months.

While the two full-time categories, housed (13 individuals) and homeless (17 individuals) are mutually exclusive, the other two categories reflect individuals who either moved from housing to homeless or vice versa during the course of the study period, and therefore fall into both categories (21 individuals). The analysis calculated the average monthly costs for all four subcategories based on the individual housing status at the time they used each service listed in the following Table 24. The total averages for each of the four housing and homeless subcategories are also included and the final overall monthly average for housed and homeless is also provided.

[34] This category includes one person who although counted as homeless full-time, moved into independent housing and then came out of the study.

TABLE 24 Comparison of Monthly Average Charges/Costs for Housed and Homeless (N=51)				
Type of Service	Housed FT Monthly Average (based on 156 months) n=13	Housed PT Monthly Average (based on 113.5 months) n=21	Homeless FT Monthly Average (based on 183.2 months) n=17	Homeless PT Monthly Average (based on 128.9 months) n=21
CCHC Charges (Emergency Room) Est. ER Phy. Fee	$1,861 ($306) $43	$1,193 ($310) $50	$2,001 ($1,019) $145	$1,231 ($497) $92
Gosnold on Cape Cod	$31	$53	$179	$154
Duffy Health Center	$111	$296	$229	$304
Hyannis Fire & Rescue	$249	$111	$375	$336
Medical Estimate Charges	$199	$100	$849	$674
Medical Subtotal Average	***$2,494***	***$1,801***	***$3,778***	***$2,791***
Criminal Justice/Legal Services (Barnstable PD)	$15 ($6)	$28 ($28)	$236 ($135)	$229 ($63)
Housing/Shelter (includes Case Management)	$1,803	$986	$290	$494
Homeless Street Outreach & Case Mgmt	–	–	$111	$161
Total Averages	$4,312	$2,817	$4,415	$3,674
Total Monthly Averages[35]	Housed (based on 269.5 months) $3,682		Homeless (based on 312.1 months) $4,109	

The analysis shows, as expected based on the earlier analyses, very little difference in some types of services but quite a bit of difference in others. For example, while the Cape Cod

[35] The monthly averages equals $44,184 for housed and $49,308 for homeless annually (multiplying by 12).

HealthCare charges for full-time subcategories (housed and homeless) show similar averages, and the part-time subcategories (housed and homeless) also show similar averages with the costs higher for the full-time categories, the monthly average costs for emergency room usage is much higher for both homeless subcategories in comparison to the housed subcategories with the full-time homeless subcategory substantially higher.[36]

The average monthly charges for Gosnold on Cape Cod are substantially higher for both homeless subcategories, with homeless full-time being the highest. It should not be surprising that the analysis shows a lower monthly average for Duffy Health Center for housed full-time as most of the housed individuals had a private primary care physician. Nor should it be surprising that the homeless full-time subcategory reflects the lowest monthly average as this includes individuals who do not come in for services.

While Hyannis Fire and Rescue shows the highest monthly average charges for the homeless full-time and the lowest for the housed part-time subcategories, the fact that the housed full-time subcategory had a higher average monthly charge than housed part-time was an unexpected finding.

Medical estimated charges were highest for both homeless subcategories even though the housed full-time estimated costs were also included in this data (estimates for those in housing and reported frequency of medical visits to a private physician which more than likely undercounted actual charges).

The overall monthly averages for all health care charges/costs shows a substantially higher monthly average for homeless full-time, followed by homeless part-time and housed full-time, with the lowest monthly average for those housed part-time.

As expected, the monthly average costs for the criminal justice services[37] were substantially higher and practically equal for the two homeless subcategories. The monthly average calculated solely for Barnstable Police Department usage shows the highest monthly average among the subcategory of homeless full-time.

As noted previously (see Part IV.) the findings regarding housing and shelter cost is skewed by the higher costs associated with some of the permanent supportive housing programs, thus showing the average monthly cost for those housed full-time close to twice as high as the monthly average housing costs for those housed part-time (individuals in the higher cost Permanent Supportive Housing tended for the most part to also stay throughout the year).

[36] Please refer to Charts 3 and 5 which display the findings that the homeless population used the majority of the charges for emergency room usage (75%) while the housed population used a slight majority of charges for the other/non-emergency room charges (56%) while the overall Cape Cod HealthCare expenditures were higher for the homeless population.

[37] As noted in Part III, Criminal Justice and Legal Services Costs and Usage, the legal services cost totaled $2,580 so most of the expenditures in this area were based on the cost for incarceration and interaction with the Barnstable Police Department.

The shelter costs, while substantially lower in comparison to the monthly average costs for the housed population, nonetheless, shows a higher monthly average for homeless part-time in comparison to a much lower monthly average for those homeless full-time. Those homeless part-time includes individuals who either came out of housing or went into housing, and as a result, were more connected to the network of shelter and outreach services as noted in the higher average monthly costs for homeless street outreach and case management for this subcategory as well. In comparison, the subcategory of those homeless full-time includes individuals who do not use the services and are less likely to come into shelter and therefore have a lower monthly average for both shelter usage and homeless street outreach/case management.

The total monthly averages for all four subcategories shows very similar monthly average cost for the full time subcategories (housed and homeless), and is higher in comparison to the monthly average for the part-time subcategories of housed and homeless part-time with the housed part-time subcategory being substantially lower.

The total monthly averages for housed and homeless[38] showed a monthly average of $3,682 for the housed population in comparison to $4,109 for the homeless subpopulation. Overall, the monthly average cost of the housed individuals was 12 percent less than those who were homeless.

As previously noted, the findings in this study and the overall costs for unsheltered homeless individuals are impacted by: 1) some of the missing data; 2) a few folks who were not consistently in the region; and 3) some chronically homeless individuals who barely used the services.

[38] This calculation required adding the subcategory totals together and multiplying by number of months for both housed categories and homeless categories and divide the total by the total number of months. This final calculation was off by $33 out of an overall total of over 2.2 million dollars.

IV. DISCUSSION AND POLICY RECOMMENDATIONS

Discussion of the Findings

This study set out to examine if there was a substantial difference in cost between the two subpopulations, those housed and formerly homeless and those homeless, with the belief that homeless individuals would have higher costs and it would be cheaper and certainly more humane to work toward developing more permanent supportive housing, and in particular, more units following the Housing First models in the region.

While this proved to be true overall and in some predicted areas, the findings are still somewhat mixed. As anticipated, the costs of the criminal justice service included in the study showed that the majority of the expenditures (93%) were utilized by homeless individuals. Also the majority of the health care charges (64%) were also utilized by homeless individuals, even when excluding the estimated medical charges (59%). However, the Cape Cod HealthCare charges showed that the majority of the non-emergency room expenditures (56%) went toward those who were housed, while the vast majority of the emergency room charges (75%) were utilized by the homeless subcategory. However, the majority of the combined overall Cape Cod HealthCare charges (55%) were utilized by the homeless.

The high cost of housing individuals, particularly if they received services from the Department of Mental Health, was an unexpected finding. The study found that 77 percent of the costs went to those in supportive housing. When including the additional case management and outreach costs for the homeless subpopulation, this was decreased slightly to 74 percent. However, as previously mentioned, this researcher is convinced that she was unable to document additional costs associated with the homeless population.

Due to the timing of this study, which was implemented when the region had very few Housing First units, a comparison of homeless costs with the Housing First model costs was not possible. Irregardless, it does reflect the reality of the variety of supportive housing programs as they existed in this region at the time the study was implemented (and still exist for the most part).

Also, this researcher is convinced that there are numerous hidden costs related to serving the homeless population that this study was not able to document (note the policy recommendations section below).

When thinking through the diversity of usage and population, the following categories emerged from the findings regarding usage of the services.[39]

- Minimal usage of services
- Moderate users of services
- Heavy users of services

[39] Appreciation to Arlene Crosby, director of case management at Duffy Health Center for suggesting these categories based on a general conversation about the findings and the researcher's struggle to make sense of the diversity among this population.

Minimal Users - This category is divided into two subgroups. The first is those who do not need the services and therefore use services minimally. These individuals not only choose to remain independent, but genuinely do not have many needs (or at least that appears to be the case, as those fitting this category did not report alcohol and/or substance abuse and/or mental health problems).

The second category of minimal users would be those who kept a very low profile and hardly used any services, even though they definitely fit the definition of chronically homeless. It is the researcher's conclusion that, this subgroup intentionally chose this option as they did not want to get caught up in the "system." Some expressed the concern of not wanting to be medicated, and they also valued their independence. Although they might not show up in the high expenditures category, this small subset definitely had some very serious needs and, for the most part, remained homeless. They did not use the shelter, seldom showed up on the police reports and had other minimal usage.

Moderate users - This category includes individuals who may have used some services but not others and were the moderate users of most services. For example, they may have had some involvement with the Barnstable Police Department, but were not the frequent users.

Heavy Users -This category again contains two groups. The first represents the most chronically and long-term homeless. They appear more difficult to stabilize and have the most difficulty maintaining sobriety, as noted in the movement in and out of detox, and therefore, more difficult to house and to maintain housing. This category includes the most frequent users of the Emergency Room, Barnstable Fire and Rescue, the Barnstable Police Department, and also includes individuals frequently taken in for protective custody. However, this category was not solely limited to the homeless subpopulation as an unexpected finding was that at least one frequent user of rescue and emergency room services was also housed throughout the course of the study period.

Also included in this category but separate from the above is the small subset with high health care costs which is related to the overall study population – the definition of being chronically homeless, includes having a disability. For this group, even if housed, the impact of both age and prior homelessness experience, coupled with having a disability (in some cases the health/disability issues were related to becoming homeless in the first place) increased the usage of health care services.

The findings, while displaying use and costs of particular services, need to be used cautiously and with care because the researcher was not able to obtain certain costs such as medical care obtained from private physicians and detoxification programs not included in the study, including health care obtained off Cape, as well as all the costs associated with street outreach for the homeless.

Policy Recommendations

The following policy recommendations are based on both the analyses of the findings and research observation. The findings are objectively stated throughout the report. The observations are based on the entire research process: during the course of the study, this researcher spent quite a bit of time on the street and met with many service providers and visited service programs. In addition to the individuals interviewed for the study, other homeless individuals were engaged in conversation. The observation is based on this component of the research even if more difficult to quantify.

The recommendations are divided into two parts: short term recommendations and long term recommendations and are not necessarily mutually exclusive.

Short Term Goals

Enhance Stabilization/ Case Management and Tracking for Individuals Once Housed

This researcher noted that not everyone in housing had case management costs attached to their housing. Perhaps this was an oversight or a failure of this researcher to obtain this information, but there were a few incidences where it was certain there was no formal follow-up. It is important that when chronically homeless Individuals are placed into housing they receive case management services for at least one year in order to enhance their stabilization. Duffy Health Center believes that "intensive case management associated with Housing First is the critical component to housing stability" and reports a retention rate of 83 percent for Housing First residents.[40]

The stabilization/case management service providers should develop a system to track the services individuals receive in addition to their housing related costs, and to document length of stay to analyze whether they are able to stabilize in housing or not. The goal of this component would to be to intervene and help prevent the loss of a unit if at all possible. This would include making sure clients receive all mainstream resources they might be entitled to (most of this work is being done by the agencies included in this study as soon as the person becomes a client).

The following are services this component might include

- Financial management workshops
- Tenant /landlord relations training (responsibilities of both tenant and landlord)
- A fast track reporting system with landlord and/or housing authority should any problems arise
- Availability of prevention intervention if an individual appears to be at risk of losing housing

If an agency case manager is currently working with homeless individuals, there is a tendency to concentrate on the current crisis and the stabilization piece for those housed is not always consistent. Therefore, agencies providing additional services other than case management to

[40] Email communications with Claire Goyer, the Executive Director of Duffy Health Center on January 6, 2009.

housed individuals should assign a separate worker to solely concentrate on the stabilization/case management component in order to eliminate this conflict.

Establish Discharge Planning Policies
Develop a system to track when individuals are released from hospitals and other institutional stays, including detox units. While the researcher is aware that service providers have a working relationship with the social service program at Cape Cod Hospital, this does not seem to be the case for other facilities, even if the agency staff were involved in getting the person into the program. The Duffy Health Center worked with Barnstable County's House of Corrections with an Inside Out program to facilitate the transition of homeless inmates from the facility to the community until recent budget cuts eliminated the funding. Duffy has also been having conversations with detox program providers to work on individual transition plans.

Policies could be established to work within the confidentiality concerns, such as creating forms to be signed by the agency and client to allow for the release of this information. Agencies should work with the array of health care providers in designing acceptable forms for all parties concerned.

The goal is to develop a process to intervene once individuals are released to help them stabilize, if possible. Placing someone into OIFTS or another program depending upon funding and space availability should be a priority (the researcher is aware that this is already being done at times, but is also aware that providers do not always know when someone is being discharged).

Improve Record Keeping of Costs Associated With the Street and Shelter Population
This researcher would recommend establishing a method to document the time spent with the street homeless to more accurately reflect the amount of time and related costs, such as providing transportation, meals and so forth which remain some of the hidden costs utilized by this population. There were additional costs associated with this population, such as the daily lunch at the Salvation Army soup kitchen, which were not included in this study.

Long Term Goals

Expand Prevention Funding Programs for Individuals
While the region does a wonderful job in preventing family homelessness, the funding sources for homeless individuals has been more limited in comparison. Project Prevention at Housing Assistance Corporation provides prevention funds for individuals, as do other programs on the Cape, such as the Falmouth Service Center, Salvation Army, Interfaith Council for the Homeless of Lower Cape Cod (recently renamed as the Homelessness Prevention Coalition), Hands of Hope Outreach Center, and Harwich Ecumenical Council, to name a few. However, funding for individual prevention is limited in comparison to the funding available for families. For example, in fiscal year 2008[41] Project Prevention spent **$36,646** and helped 106 individuals for an average payment of $346. In comparison, Project Prevention[42] expended close to a million

[41] The agency's fiscal year runs from July 1, 2007- June 30, 2008.
[42] This program has recently experienced severe budget cuts of the state legislated funds for families due to cutbacks at the state level.

dollars during this same period with an average cost of $2,038 per family assisted (this includes some state finding specifically to get families out of shelter).

- Expand funding for homelessness prevention for individuals and network with agencies across the Cape to promote the program.

Expand Opportunities for Homeless Individuals for Employment and/or Community Involvement

NOAH Shelter receives funding from the South Middlesex Opportunity Council's Mobile Resource Team (MRT) to provide housing search and employment services to individuals fitting the HUD definition of homelessness. The housing search program has a full-time employee and the employment program has a part-time (20 hour a week) employee. The Career Opportunities program in Hyannis is the local One Stop Career Center funded through state and federal money and also offers services to homeless individuals.

Some programs, such as Homeless not Hopeless, also provide computer and internet access to residents and outreach clients while also teaching them basic computer skills. CHAMP Homes also has a computer available for residents. (This list is not conclusive.)

While some individuals may never be able to be economically self-sufficient due to their disability, it was this researcher's observation that the few individuals who were involved in volunteer work and/or gave back to their community in some way seemed to take great pride in these accomplishments and felt a sense of self-worth.

This researcher also observed the pattern of homeless individuals having to be out of the shelters during the day and the congregation of these individuals in sometimes less than desirable locations. For some individuals, it became difficult to stay clean and sober if their main support network on the street were other homeless individuals with substance and/or alcohol abuse problems. During the interview process, it became clear that some individuals were cut off from family and developed an extensive network of friends on the street, sometimes with negative consequences. This researcher witnessed one incident where a group of individuals were attempting to find another homeless individual because they were aware that the person just received his/her benefit check and they wanted to tap into that resource.[43]

Further clarity on what expanding employment and/or community involvement might look like would require further exploration, but some type of cottage industry and/or gardening opportunities similar to what the HAC housing and farm program in Sandwich might entail (once The Community Green project, originally named Dana's Field, gets up an running), or programs similar to Cape Abilities,[44] which provides employment and training to individuals with disabilities are possibilities. Agencies could develop a collaborative program in conjunction with or modeled after Cape Abilities. An example is the collaborative art exhibit which took place during the spring of 2008, and provided an opportunity for Duffy and Cape Abilities clients to create and display their original artwork. This researcher also observed how individuals took great pride in their art and their participation both at this showing and at another event when

[43] It was not uncommon for individuals to rent a motel room for a night or two when they received their benefit check, especially if they did not utilize the shelter either because they were banned or by choice.
[44] Cape Abilities programs are further explained on their website (www.capeabilities.org/).

artwork was exhibited at a church as part of the NOAH Shelter program and how this appeared to enhance self esteem.[45]

This recommendation is based on the belief that everyone has a need to be needed and feel that they are making a contribution. There are homeless individuals with skills and training that are currently not being utilized. The question remains how to tap into these skills while not jeopardizing benefits if individuals must maintain this financial support.

Enhance Education and/or Training Opportunities

This recommendation is intertwined with the above but also notes the limited technological and computer skills among this population. Service providers might partner with the Cape Cod Community College's downtown campus to help individuals develop basic computer skills. It might be that some agencies help their clients become computer literate as does Homeless not Hopeless, but this researcher was not fully aware of such services.

Housing, Housing, and More Housing

More affordable housing units on Cape Cod and more Housing First/Permanent Supportive Housing units to move homeless individuals into housing must be developed. The 2008 HUD Continuum of Care for Homeless programs application included projects to develop five new beds for chronically homeless individuals, and there are two projects in the pipeline from the 2006 and 2007 HUD CoC awards to develop 17 new leased housing units and the possibility of another project based on reallocating HUD funds awarded in 2003 (this has yet to be approved locally and to work its way through the HUD Boston Field Office process) . While every new unit counts, this does not come close to meeting the need.

Limitations of the Study

While this study consists of some very valuable data, the design was overly ambitious and it was difficult for one person to follow through with the original design of the study. Thus some data, such as all the costs associated with street outreach, was not able to be collected. Also the inability of the researcher to conduct most of the follow up interviews also may have hindered gathering some valuable data regarding undocumented services/health care.

The study was also dependent on the accuracy of data collected from an array of participating agencies. When at times data seemed contradictory, this researcher did her best to verify the data to correct any discrepancies and/or at times needed to make an informed decision to resolve discrepancies in the data.

It was also dependent on study participants reporting accurate information. While there did not appear to be any genuine intention toward dishonesty, and for the most part individuals seemed forthcoming with some very personal information, it is noted that this was self-reported information and was not checked against agency records.

[45] The cover of this report was part of a Homeless Not Hopeless project to make visible homelessness at the December 2007 Homelessness Memorial.

As mentioned in the methodology section, this study was not able to document all the costs associated when persons were sectioned (to either a detoxification unit or mental health unit); expenditures outside of Barnstable County, especially due to medical care; and other medical expenditures within the region. Estimated costs were calculated to compensate for some of the missing expenditures (off Cape medical/surgeries were not included due to the difficulty in making any type of accurate estimation).

In addition, this study was not able to conduct a comparison between Housing First and street homeless where the costs of housing would most likely be certainly be lower especially in comparison to some of the costs found in this study due to the inclusion of congregate housing for Department of Mental Health clients.

Conclusions

A New York Times article about a homeless individual named Murray in the city of Reno, Nevada, has resulted in the phrase "Million Dollar Murray" that is now used as a buzzword for frequent flyers – homeless individuals that frequently use emergency and safety services.[46] Two police officers who had frequent contact with Murray gathered information and estimated that based on $100,000 in costs over a one year-period, since Murray had been homeless for 10 years the costs ran over a million dollars.

While for the most part this study emphasized aggregated data, it should be noted there is one study participant who fell well above the $100,000 in expenditures for the one year period and another, who had that person remained homeless for the remainder of the year, would have far exceeded the $100,000 amount. [47] Two additional individuals' expenditures were approaching $100,000 for the one year period (five additional individuals had expenditures over $50,000). While Murray's expenditures were mostly medical, the expenditures for this study's participants included shelter, interaction with the Barnstable Police Department, Department of Corrections, and use of an array of health services, including Hyannis Fire and Rescue, Cape Cod HealthCare, including emergency room and other health care services (Duffy and Gosnold as well as estimated health care costs which this researcher believes was a conservative estimate).

While the comparison of the monthly average costs for the different services captured in this study does not show an overall drastic difference, one particular case shows a substantial difference in expenditures between being homeless and housed. This particular case makes for a neat comparison because the person became housed during the course of the study: the analysis shows that the costs for this individual were substantially reduced in every category once housed with the overall costs at least half as less in comparison to when homeless. This reduction also

[46] This phrase is based on an article about an homeless individual who service providers estimated accrued $100,000 in health care, substance-abuse treatment costs, and other expenses for a one year period (Gladwell, Malcolm, "Million Dollar Murray" The New Yorker (February 13 and 20, 2006) [online] 2/28/2006 at www.newyorker.com/printables/fact0260213fa_fact).

[47] Although one individual was placed into housing during the course of the study, this person's costs approached $80,000 during the period of homeless with the majority of the expenditures in the health care area.

included a reduced cost for shelter since the housing subsidy amount was less than half of the emergency shelter costs (this, however, does not count the tenant's share of the subsidy). Both rescue and emergency room usage was substantially decreased along with other medical costs. While this is only one case, it represents a substantial savings given that this particular person's expenditures were extremely high while homeless.

Based on the above, even though there were individuals in the study who were frequent users of at least some of the services, the most surprising finding was that some of the most chronically homeless individuals barely used services, or at least services that were able to be documented within this study. Therefore, the question remains on how to provide services to members of the most chronically homeless of the street population.

As of this writing, the Leadership Council has formed a subcommittee to address the concerns regarding the street homeless in the Hyannis area: they have organized meetings with representatives of the business district and residents to design plans to move forward toward solutions regarding most likely a very small subset of homeless individuals who exhibit unacceptable and unlawful behavior in the Hyannis business district area (most of the complaints including urinating in public and other disruptive behaviors). This well may be an opportunity to move toward solutions while also including a segment of the community not previously involved in the work of the Council.[48]

A comparison of the point-in-time count, conducted by the Leadership Council to End Homelessness on Cape Cod and the Islands over the past two years shows that the number of homeless individuals slightly decreased from 2006 to 2008. While any decrease is positive, the fact that 161 individuals were either on the street or in emergency shelter on the date of the count (January 30, 2008) and an additional 112 individuals were temporarily living in motels because they had no where else to go, is still too high.

As previously noted, from 2006 - 2008, 28 homeless individuals either died on the street or shortly after going into housing. It is unknown whether more available housing units would have prevented these deaths. It was also the observation of this researcher that agency staff who work with the homeless shelter and street population are extremely caring and conscientious, as are the staff in the permanent supportive housing projects and would do everything in their power to assist individuals. Thus, service providers within Barnstable County and other regions across the country will continue to develop Housing First units in the quest to get the most vulnerable of the homeless off the streets to save lives while also perhaps saving money. However, it should be noted that chronically homeless individuals come with serious health problems as documented in this study[49]

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[48] The policy recommendation that homeless individuals need a place to go during the daytime seems particular astute right now given the concern expressed by business owners and residents in the Hyannis area.

[49] When developing a Housing First complex for chronic inebriates in Seattle Washington, the social worker commented that the costs would be higher than anticipated because the residents had more serious health problems than anticipated (Kowal, Jessica, "Homeless Alcoholics Receive a Permanent Place to Live, and Drink," The New York Times, July 5, 2006 on line available July 11, 2006 at http://www.nytimes.com/2006/07/05/us/05homeless.html?_r+1&oref+slogan&pagewanted).

This project was an incredible experience, and much more complex than anticipated. While noting some of the limitations, this researcher is confident that this study will add to the knowledge of the chronically homeless population in this region by documenting their demographic profile as well as the costs associated with services utilized over the course of a one-year period. This study is the first of its kind in the region providing as much rich detail about homeless and formerly homeless individuals and hopefully should prove useful for the region's planning and policy efforts to end homelessness.

APPENDIX A

AGENCY CORRESPONDENCE

COVER LETTER & ENCLOSURES
MEMORANDUM OF UNDERSTANDING
LIST OF POTENTIAL PARTICIPATING AGENCIES/ORGANIZATIONS

PO Box 655
Lee M. Hamilton, Ph.D. **South Dennis MA 02660**
Research Consultant **508-398-2333/lhamilton@capecod.net**

TO: **Name of Agency/Organization**
DATE:
SUBJECT: Memorandum of Understanding for Cost Benefit Analysis Study of Chronically Homeless Individuals on Cape Cod

Dear _____:

You are being asked to participate in a study of homeless individuals on Cape Cod because you provide services and/or have contact with either homeless street individuals and/or formerly homeless individuals now living in permanent supportive housing. The goal of the study is to document and compare the costs associated with the different experiences of the two subpopulations. This study is being supported by a grant through Cape Cod Commission and has been endorsed by the Leadership Council to End Homelessness on Cape Cod and the Islands. Also note, in order to pursue this study this research has passed Cape Cod HealthCare's Institutional Review Board to ensure the protection of human subjects.

If your agency/organization is willing to participate in this study, you are required to sign the attached Memorandum of Understanding (MOU). It is important that this form be reviewed by persons in leadership positions able to make such decisions and/or reviewed by Board of Directors if appropriate.

The first stage in the implementation of this study requires the involvement of appropriate agencies to help with the selection of study participants from the two categories: either living on the street without stable shelter or living in permanent supportive housing. If you fit these criteria you may have already been approached with a tentative request.

The second stage of the study is the ongoing tracking of individuals selected to be part of the study. This is dependent upon the participation of an array of agencies/organizations providing services to the study population. The tracking will cover a one-year period from September 1, 2006 to August 30, 2007 and can be done retrospectively if study participants are signed on after September 1st. The findings will be compiled into a report and released to the public and will protect the confidentiality of the study subjects.

If you would like additional information, please feel free to contact me. Once you have had the opportunity to review this material, I would be glad to meet with you to discuss this further.

Sincerely,

Lee M. Hamilton, Ph.D., Research Consultant
Enclosure: Memorandum of Understanding
List of Potential Participating Agencies/Organizations

Lee M. Hamilton, Ph.D.
Research Consultant

PO Box 655
South Dennis MA 02660
508-398-2333

COST BENEFIT ANALYSIS STUDY OF CHRONICALLY HOMELESS INDIVIDUALS ON CAPE COD

Memorandum of Understanding
between
Lee M. Hamilton, Ph.D., Research Consultant
and
Name of Agency/Organization

This agreement is made on this date of _____ between **Lee M. Hamilton, Ph.D**. Research Consultant and **Name of Agency/Organization.**

This Agreement outlines the commitments made by both parties during the one-year period of the study (September 1, 2006 – August 30, 2007). During this one-year period the researcher will track a subset of homeless individuals living on the street and another subset of individuals living in permanent supportive housing with the criteria that they had to have been homeless to qualify.

The Researcher will:

1. Upon approval of the agency, meet with residents to solicit participation in the study, if appropriate.
2. Provide a copy of the signed Informed Consent Form to the participating agency/organization of all participants willing to be involved in the study.
3. The researcher will interview each participant three times (at the beginning of the project which is also when the Informed Consent Form will be signed, mid-way into the study, and at the conclusion of the study).
4. The researcher will treat each participate with dignity and respect.
5. The researcher will take every precaution to protect the anonymity of all participants in the study –no names will be used in reports or included in databases. Only the researcher and possibly a research assistant will have access to the data. Participating agencies will receive a copy of the results of the study in a final report with the aggregated data only and will not receive information based on any individual participant.
6. The researcher agrees to provide a $10 supermarket/gift certificate to each participant at the initial interview and at each following interview.
7. The researcher, with the cooperation of the participating agency/organization, will track each study participant over a one-year period to determine costs associated with their experiences. Please see the attached list of potential agencies/organizations participating in this tracking. With assistance from participating agencies/organizations, the researcher will determine rates/estimates for certain services, such as the use of volunteers.

8. The researcher has passed the Institutional Review Board (IRB) at Cape Cod HealthCare in order to gather health care costs. If you are an agency subject to HIPAA standards this process should serve to affirm that this study will protect the rights of human subjects and personal health information. You may also want to use the same or similar form used by CCHC, just altered with your agency information (see attachment if relevant to your agency).

The participating organization/agency will:

1. If appropriate, agree to let the researcher meet with persons in your program to ask if they are willing to participate in the study with the understanding that it will be made clear to each person that participation is voluntary. Each potential participant will be informed that participation or non-participation will not impact on any services that they might receive.
2. The agency/organization understands that clients/residents agreeing or not agreeing to participate is solely their decision and that the information gathered is for research purposes only and will not negatively impact on client services.
3. Agree to provide ongoing information as requested by the researcher and possibly a research assistant on at least a monthly basis with the understanding that this tracking will cover a one-year period (September 1, 2006 – August 30, 2007).
4. Appoint person(s) responsible to serve as an ongoing contact for the researcher and/or her research assistant to assist tracking of individuals within the agency/ organization. This person(s) will also assist the researcher in determining costs related to the services. Please specify contact person(s) _____

   _____
5. All parties understand that the researcher will not disclose data gathered on individual participants from other organizations and will therefore not report back to participating agencies on information gathered for any of their clients/residents.
6. Agree to not publicly disclose the names of the study participants to anyone outside of their agency and only person(s) within the agency who need to know this information for tracking purposes will have access to this information.
7. Understand that once the study becomes public, the report will include a list of participating agencies, but will not specify where specific data and clients came from other than for comparison purposes between homeless individuals on the street and individuals living in permanent supportive housing.
8. The undersigned has discussed this project within their agency/organization and have reached approval to participate as signified by the authorized signature below.

Researcher	**Agency/Organization**
_____	_____
Signature	Authorized Signature
_____	_____
Date	Title
	_____
	Date

APPENDIX A
LIST OF POTENTIAL PARTICIPATING AGENCIES/ORGANIZATIONS

Participating Health Care and Service Providers:

- Cape Cod HealthCare (Cape Cod and Falmouth Hospital (in and out patient including Emergency Room, Psychiatric Center, C-Labs)
- Duffy Health Center/O'Neill Clinic and other services (case management, outreach, Project Hope)
- Gosnold on Cape Cod
- Hyannis Fire and Rescue
- Department of Mental Health
- Habit OPCO
- Housing Assistance Corporation (NOAH Shelter and Operation in from the Street)
- Community Action Committee of Cape Cod and the Islands, Inc. (Pilot House and outreach)
- Cape Cod Council of Churches (including outreach)
- Vinfen Outreach
- Baybridge Clubhouse
- South Coastal Counties Legal Services, Inc.
- Nam Vets Association
- Town of Barnstable Police Department
- Barnstable County Sheriff's Office/ Barnstable County Correctional Facility

Participating Permanent Supportive Housing/Housing First Programs:

- Housing First & Home and Healthy for Good Projects (Duffy Health Center/ Mass Behavioral Health Program and Housing Assistance Corporation)
- Cape Cod Supportive Housing (Department of Mental Health, and Vinfen)
- Kit Anderson /Larry Doughty House (Family Continuity Program and Department of Mental Health)
- Housing For All Corporation / CHAMP Homes
- Baybridge Clubhouse / Career House and Scattered Sites
- Chase House (Housing Assistance Corporation and Duffy Health Center)
- Community Action Committee of Cape Cod and the Islands, Inc. (Pilot Plus)

APPENDIX B
RECRUITMENT FLYER

RESEARCH ON LONG TERM HOMELESSNESS ON CAPE COD

CONSIDER BEING PART OF A STUDY ON HOMELESSNESS ON CAPE COD
IF YOU ARE EITHER:
Living on the street or don't have permanent shelter OR
Living in permanent supportive housing but were homeless before
YOU MAY BE ELIGIBLE TO TAKE PART

WHAT IS THE PURPOSE OF THIS STUDY?

- This study compares the costs of living on the street to living in permanent housing. By understanding the costs related to the different experiences, the research might help to support the need for more permanent supportive/Housing First units.

HOW CAN YOU FIND OUT MORE ABOUT THE STUDY?

- If you are interested in being part of this study, you can attend a group information session and/or meet individually with the researcher.

WHAT HAPPENS IF YOU AGREE TO BE PART OF THE RESEARCH?

- If you take part, a researcher will track the costs of services related to homelessness that you use over a one-year period.
- If you participate, you will be asked to sign an informed consent form.
- You will receive a $10 supermarket/gift certificate during your initial interview. You will receive additional certificates for any other interviews.
- Agreeing or not agreeing to be part of this study will not influence any services you receive now or in the future.
- If you do agree to be part of the study, your name will be protected and you will not be identified

WHO IS CONDUCTING THE STUDY AND WHAT WILL HAPPEN TO THE FINDINGS?

- This study will be conducted by Lee M. Hamilton, Ph.D., a local research consultant who has lived on Cape Cod for the past 34 years. She is dedicated to affordable housing/homelessness issues and has worked on a number of research projects in the region.
- The Cape Cod Commission is funding this study. The study is also endorsed by the Leadership Council to End Homelessness on Cape Cod the Islands.
- The findings from this study will be used in a public report.

HOW TO TAKE PART??

- Agree to attend an information session and/or agree to meet with the researcher. You can do this through the person handing you this form.
- You can contact the researcher at 508-398-2333 to set up a meeting to discuss the study.

APPENDIX C
CONSENT FORMS

- Informed Consent Form[50]
- Cape Cod Health Care
- Other Health Care (Duffy Health Center, Hyannis Fire and Rescue, Gosnold on Cape Cod, and Department of Mental Health)

[50] While there was a second consent form participants were required to sign if they listed a program not on the list, since this copy is exactly as the first form and just included room to list other agencies, it did not seem necessary to include that copy.

APPENDIX C
CONSENT FORMS
Informed Consent Form

Study Contact
Lee M. Hamilton, Research Consultant
P.O. Box 655, S. Dennis MA 02660
508-398-2333

INFORMED CONSENT FORM #1

For: *Cost Benefit Analysis Study of Long-Term Homelessness On Cape Cod*

You have been asked to take part in this research on homelessness on Cape Cod because

- You live on the street and don't have permanent shelter **OR**
- You live in permanent supportive housing and you were homeless before you entered this Program.

Purpose of the Research
The research compares the costs of services for individuals living on the street and individuals living in permanent supportive housing. This comparison will help us to better understand the different experiences and costs related to these experiences. It will also help us understand some of the hidden costs of homelessness.

Research Sponsors
The Cape Cod Commission funded this research through a grant. The Leadership Council to End Homelessness on Cape Cod and the Islands has also endorsed this research.

Expected Duration of Research Participation
The research will last from September 1, 2006 through August 31, 2007.

The research will consist of a brief interview with the researcher at the beginning of the research. There may be a second interview after six months. There also may be a final interview after one year.

Number of Research Participants
About 50-60 individuals will take part in this research. This will include about 25-30 individuals in each group (being on the street or being in permanent supportive housing)

Personal Information the Researcher Would Like To Gather
The research will track the amount of services received and costs related to the services you receive over this one-year period. This covers a range of services such as housing support services, volunteer assistance, physical and mental health care and other programs as listed below.

The research will document costs related to these services.

The agencies/ organizations participating in the research will have access to the list of the study participants for tracking purposes only. Only the researcher and perhaps a research assistant will have access to the overall data collected. This information will be kept confidential.

List of Potential Participating Agencies/Organizations (some agencies may have you sign a separate authorization form in order to release your information)

- Cape Cod HeathCare facilities, including Cape Cod Hospital, Falmouth Hospital, C-Labs and VNA services
- Town Ambulance/Ambulance Company
- Independence House
- Gosnold on Cape Cod
- Highpoint in Plymouth
- Street Outreach workers: Department of Mental Health/Vinfen, CACCI Main Street Outreach Worker, and Duffy Health Center/Outreach Workers
- Duffly Health Center and the O'Neill Health Center
- NOAH Shelter and other Housing Assistance Corporation services
- Overnights of Hospitality program
- Operation in from the Cold
- Cape Cod Council of Churches
- Salvation Army services
- Legal Services of Cape, Plymouth and Islands, Inc.
- Barnstable Police Department
- Barnstable County Department of Corrections
- Any incarceration/probation or court related experience
- Possible Participating Permanent Housing Programs and their related service providers:
    - Bridgeport/Falmouth Housing Corporation and Cape Cod Council of Churches
    - Cape Cod Supportive Housing/ Department of Mental Health, Vinfen and Housing Assistance Corporation
    - Kit Anderson II/ Housing Assistance Corporation and Duffy Health Center
    - Kit Anderson I/Family Continuity Program and Housing Assistance Corporation

If you receive other services or care, you might be asked to sign an additional consent form listing those agencies or services.

Foreseeable Risks and Benefits of Participating in the Research:
There are no immediate known risks and/or benefits from participating in this research**.**

Risks
While there are no serious risks identified, you may experience some discomfort during the interview process when being asked questions about your homeless experiences (either current experience or prior experience).

You may also experience some discomfort after the research is released (the researcher will protect the anonymity of the research participants and names will not be used in any report).

Benefits
There are no immediate known benefits for participating in this research.

While you may not personally benefit, it is hoped that the research findings will contribute to the body of knowledge in the field of homelessness. The researcher hopes this research will document the hidden costs of homelessness. The researcher hopes to identify the need for more permanent supportive housing.

You will receive a $10 supermarket/gift certificate to participate in the research. You will also receive an additional $10 supermarket/gift certificate at any other interviews during the research period

Voluntary Participation
Your participation in the research is completely voluntary.

Your decision whether to participate or not participate will not affect any services you may currently receive, or might receive in the future.

You are free to not answer any questions during any interviews.

You may withdraw from the research at any time by informing the researcher, Lee M. Hamilton either by telephone or mail (the researcher's name, address and telephone number is on the front page of this form).

You will be removed from the research if you relocate outside of Barnstable County.

You also may ask more questions about the research at any time.

If during the research or anytime later, if you wish to discuss your participation in this research with someone who is not directly involved, or if you feel undue pressure to enroll in this research or to continue to participate in this research, contact Spiros Thomas RPh, MBA, a representative of the Institutional Review Board (or Ethics Committee) at Cape Cod HealthCare at 508-862-5351.

Confidentiality
The information gathered is for research purposes and will be put into a report and released to the public and possibly published. Your name or any other individually identifiable information will not be used in any reports or included in any computer database. Your identity will be protected. Only the researcher and possibly a research assistant will have access to this data.

This research has passed the Cape Cod HealthCare's Institutional Review Board to make sure that the research process protects human subjects.

The researcher will not disclose data gathered on individual participants from other organizations and will not report back to participating agencies on information gathered for any of their clients/residents.

I HAVE READ THE CONSENT FORM//OR THIS FORM HAS BEEN READ TO ME. THE RESEARCHER HAS ALSO EXPLAINED THE RESEARCH.

I UNDERSTAND THIS INFORMATION AND WILLINGLY AGREE TO PARTICIPATE IN THIS RESEARCH.

I UNDERSTAND THERE IS NO COST TO MY PARTICIPATING IN THIS RESEARCH.

I ALSO UNDERSTAND I CAN WITHDRAW FROM THE RESEARCH AT ANY TIME.

I HAVE BEEN INFORMED THAT PARTICIPATING AGENCIES/ORGANIZATIONS MAY NEED A COPY OF THIS CONSENT FORM FOR THEIR RECORDS. I GIVE PERMISSION TO RELEASE THIS FORM.

_____ _____

Participant's Signature **Date**

I have received a signed copy and agree to the above.

I understand that I may withdraw from the research at any time and my identity will be protected.

I have also received a $10 supermarket/gift certificate.

_____

Printed Name of Participant

_____ _____

Researcher's Signature **Date**

Lee M. Hamilton, Ph.D.
Printed Name of Researcher

APPENDIX C
CONSENT FORMS
Cape Cod Health Care

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

Principal/Overall Investigator: ***Lee M. Hamilton, Ph.D., Research Consultant***

Protocol Title: C*ost Benefit Analysis Study of Chronically Homeless Individuals on Cape Cod*

AUTHORIZATION TO USE OR RELEASE INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES

Federal law requires Cape Cod Healthcare, Inc. ("CCHC") and its affiliated hospitals, researchers and other health care providers to protect the privacy of information that identified you and relates to your past, present or future physical and mental health and conditions ("protected health information"). If you decide to be come a subject in the research described in the attached consent form, your protected health information will be used and shared with others as explained below.

If you agree to the described uses within CCHC and the sharing of your protected health information outside of CCHC, then after reading this entire document, please sign your name at the end of the line provided. If you have questions, you may ask the researcher who is reviewing the informed consent form with you. You can also contact the researcher listed under Study Contacts in the attached consent form.

1. What protected health information about me will be used or shared with others during this research?

Bills for health care services during the time period of the study (September 1, 2006 – August 30, 2007), which may contain information on reason for visit.

2. Why will protected health information about me be used or shared with others?

The main reason is to conduct the research as described in the attached consent form.

3. Who will use or share protected health information about me?

Only the researcher and possibly a research assistant will have access to individual health information. No one else will have access to this information.

Although the Cape Cod Commission has provided partial funding for this project and the affordable housing specialist chairs the ongoing Oversight Committee of this project, personal health information of study participants will not be shared in this group, nor will it be shared with any additional funding sources should they later be identified.

4. For how long will protected health information about me be used or shared with others?

Once information is entered into a coded database that will not contain any names, the information received from CCHC will be destroyed, thus not leaving any trace to link the data with names. However, once entered into a coded database, this information will be used for research purposes.

This research has no expiration date.

5. Statement of Privacy Rights:

a. You have the right to withdraw your permission at any time and for any reason for the researchers and participating CCHC entities to use or share your protected health information. We will not be able to withdraw all of the information that already has been used or shared with others to carry out the research or any information that already has been used or shared with others to carry out related activities such as oversight, or that is needed to ensure the quality of the study. If you want to withdraw your permission, you cannot participate further in the research. If you want to withdraw your permission, you must do so in writing by contacting the researcher listed as the Study Contact on the attached informed consent form; and the Cape Cod Healthcare Privacy Office at 88 Lewis Bay Road, Hyannis MA 02601.

b. You have the right to request access to your protected health information that is used or shared during this research and that relates to your treatment or payment for your treatment; but you may access this information only after the study is completed. To request this information, please contact the researcher listed under Study Contacts on the informed consent form.

I have received a copy of the Cape Cod Healthcare Notice of Privacy Practices.

I understand that if I withdraw my authorization, Cape Cod HealthCare will not condition treatment, payment or enrollment eligibility for benefits on whether I sign or not.

SIGNATURE:

_____	_____
Print Name of Subject	**Date of Birth**
_____	_____
Signature of Subject	**Date**

APPENDIX C
CONSENT FORMS
Other Health Care

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR RESEARCH PURPOSES

Principal/Overall Investigator: ***Lee M. Hamilton, Ph.D., Research Consultant***

Study Title: C*ost Benefit Analysis Study of Chronically Homeless Individuals on Cape Cod*

AUTHORIZATION TO USE OR RELEASE INDIVIDUAL HEALTH INFORMATION FOR RESEARCH PURPOSES

Federal law requires ***Duffy & O'Neill Health Centers, Hyannis Fire-Rescue Department, Gosnold Treatment Center of Cape Cod, and the Department of Mental Health*** and its affiliated hospitals, researchers and other health care providers to protect the privacy of information that identified you and relates to your past, present or future physical and mental health and conditions ("protected health information"). If you decide to become a subject in the research described in the attached consent form, your protected health information will be used and shared with others as explained below.

If you agree to the described uses within the above listed providers and the sharing of your protected health information outside of their agencies, then after reading this entire document, please sign your name a the end of the line provided. If you have questions, you may ask the researcher who is reviewing the informed consent form with you: this person is also listed under Study Contacts in the attached consent form.

1. **What protected health information about me will be used or shared with others during this research?**
   Bills for health care services during the time period of the study (September 1, 2006 – August 30, 2007), which may contain information on reason for visit.

2. **Why will protected health information about me be used or shared with others?**
   The main reason is to conduct the research as described in the attached consent form**.**

3. **Who will use or share protected health information about me?**
   Only the researcher and possibly a research assistant will have access to individual health information. No one else will have access to this information.

   Although the Cape Cod Commission has provided partial funding for this project and the affordable housing specialist chairs the ongoing Oversight Committee of this project, personal health information of individual study participants will not be shared in this group, nor will it be shared with any additional funding sources should they later be identified.

4. For how long will protected health information about me be used or shared with others?

Once information is entered into a coded database that will not contain any names, the information received from Duffy & O'Neill Health Center, the Hyannis Fire-Rescue Department, Gosnold Treatment Center of Cape Cod, and Department of Mental Health will be destroyed, thus not leaving any trace to link the data with names. However, once entered into a coded database, this information will be used for research purposes. This research has no expiration date.

5. Statement of Privacy Rights:

a. You have the right to withdraw your permission at any time and for any reason for the researchers and participating **health care providers** listed below to use or share your protected health information. We will not be able to withdraw all of the information that already has been used or shared with others to carry out the research or any information that already has been used or shared with others to carry out related activities such as oversight, or that is needed to ensure the quality of the study. If you want to withdraw your permission, you cannot participate further in the research. If you want to withdraw your permission, you must do so in writing or by telephone by contacting the researcher listed as the Study Contact on the attached informed consent form; and the following **health care providers for which you have received services**:

- **Duffy & O'Neill Health Centers –** Claire Goyer, Executive Director
  105 Park Street, Hyannis MA 02601 (508-771-9599)
- **Hyannis Fire-Rescue Department,** Dean L. Melanson, Deputy Fire Chief
  95 High School Road Extension, Hyannis MA 02601 (508-775-1300)
- **Gosnold Treatment Center on Cape Cod,** Raymond Tamasi, Executive Director
  200 Ter Huen Drive, Falmouth MA 02541 (1-800-444-1554)
- Department of Mental Health**, Deborah Bainton, Director of Homeless Services**
  77 High School Road Extension, Hyannis MA 02601 (508-957-0917)

b. You have the right to request access to your protected health information that is used or shared during this research and that relates to your treatment or payment for your treatment; but you may access this information only after the study is completed. To request this information, please contact the researcher listed under Study Contacts on the informed consent form.

SIGNATURE:

_____	_____
Print Name of Subject	**Date of Birth**
_____	_____
Signature of Subject	**Date**

APPENDIX D
INTERVIEW GUIDE

Date of Interview: _____
Time Interview Started: _____
Participant Code # _____

COST BENEFIT ANALYSIS RESEARCH INTERVIEW GUIDE #1

NAME: _____
(Get full name including any middle initial- clarify spelling)

DATE OF BIRTH: _____

DO YOU HAVE A LOCATION WHERE YOU RECEIVE MAIL? (POST OFFICE BOX, RELATIVE, AGENCY) PSH RESIDENTS (get address):

_____

_____

CAN YOU PROVIDE A NAME OF SOMEONE (FRIEND, FAMILY, AGENCY PERSON) WHO MIGHT KNOW HOW TO LOCATE YOU?

_____

HOW MIGHT I CONTACT THIS PERSON?

_____

PSH RESIDENTS: Ask if they have a telephone # _____

STREET POPULATION: Ask if they have a cell phone # _____

HOW LONG HAVE YOU BEEN ON CAPE COD? _____

- **What town have you lived in most recently? _____**
- **Where did you grow up? _____**
  City/town State
- **Where were you born? _____**
  City/town State

DO YOU CURRENTLY RECEIVE ANY OF THE FOLLOWING? Check if <u>YES</u>

☐ **SSI** **Monthly Amount? _____**
☐ **SSDI** **Monthly Amount? _____**
☐ **Social Security** **Monthly Amount? _____**
☐ **General Public Assistance / General Relief** **Monthly Amount? _____**

☐ **Veterans Benefits** **Monthly Amount? _____**
☐ **Veterans Health Care**

☐ **Medicaid /MassHealth**
☐ **Medicare**
☐ **Veterans Health Care**
☐ **Private Health Insurance** **Provider? _____**

☐ **Do you have a regular health care provider or clinic that you use?**
If so, who is this? _____

☐ **Food Stamps** **Monthly Amount? _____**

☐ **Employment** **Weekly Amount? _____**
(Any work you get paid for)
Type of Employment _____

☐ **Unemployment Benefits** **Weekly Amount? _____**

☐ **Other: _____**

IF NOT CURRENTLY EMPLOYED, IF EMPLOYED IN THE PAST, WHAT TYPE OF WORK HAVE YOU DONE?

HAVE YOU PARTICIPATED IN ANY PROGRAMS/SERVICES FROM THE FOLLOWING IN THE PAST THREE MONTHS? (Check if YES)

☐ **NOAH Shelter**
☐ **Overnights of Hospitality**
☐ **Operation in from the Cold**

☐ **Duffy Health Center**
☐ **O'Neill Health Center**

☐ **Cape Cod Hospital**
☐ **Falmouth Hospital**
☐ **Visiting Nurse Association**
☐ **C-Labs**

☐ **Salvation Army**
☐ **Vinfen Outreach**
☐ **Main Street Outreach /Tom Naples**
☐ **Duffy Health Center Outreach**

☐ **Any other Street Outreach Worker (specify name/agency of worker)**

☐ **Legal Service of Cape, Plymouth and Islands, Inc.**
With Kathleen Navin the Homeless Outreach Worker?
In the office with other staff?
☐ **Independence House**

☐ **Gosnold**
☐ **Highpoint in Plymouth**

☐ **Baybridge Clubhouse**
☐ **Nam Vets Association**

☐ **Food Pantry**
What pantry to you use?
How frequently do you go there?

☐ **Soup Kitchen**
What soup kitchen do you attend?
How frequently do you go there?

☐ **Have you had to use the services of a rescue squad or ambulance in the past three months? If yes, how often**?

☐ **Are there other service/agencies you have had contact with recently? Please Specify:**

☐ **Are you a military veteran?**

IF NOT IN PSH, WHERE HAVE YOU SLEPT WITHIN THE PAST WEEK?

_____

- **Where do you usually stay at night? _____**
- **Do you sometimes stay in local motels temporarily? Yes/No.**
  - **If yes, what town do you usually stay in? _____**
  - **Have you received financial assistance from any agency to help pay for the motel stay?**
    Name of Agency? _____

IF IN PSH, HOW LONG HAVE YOU LIVED HERE? _____

- **Type of unit?**
  ☐ **Congregate** ☐ **Complex** ☐ **Scattered site**
- **If you pay toward, rent how much is this amount? _____**

WHAT DO YOU CONSIDER THE MOST IMPORTANT/PRIMARY REASONS FOR BEING (OR HAVING BEEN) HOMELESS?

#1.

#2.

#3.

DO YOU HAVE ANY PHYSICAL/ MENTAL HEALTH AND/OR PHYSICAL INJURY ISSUES? YES / NO

Do you have a disabling condition? HUD defines this as "a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." A disabling condition limits an individual's ability to work or perform one or more activities of daily living.

- **If yes, what is the nature of the disability or disabilities? _____**

- **Does your condition require medical treatment?**

- **Do you take any medications on a regular basis for this or other conditions?**

- **If on any medications on a fairly regular basis, how are you able to obtain the medication (paid for through MassHealth, free samples from a clinic, purchase on own)? Do you know what the medications costs and frequency of prescription refill?**

<u>STREET POPULATION ONLY:</u>
CAN YOU TELL ME HOW LONG YOU'VE BEEN HOMELESS FOR?

- **Have you been continuously homeless for a year or more? (This means living on the streets and/or in an emergency homeless shelter.) If yes, were you on your own (unaccompanied) <u>and</u> were you also disabled at this time?**

AND/OR

- **Have you had at least four episodes of homelessness in the past three years? (This also means living on the streets and/or in an emergency homeless shelter.) If yes, were you on your own (unaccompanied) <u>and</u> were you also disabled at this time?**

PERMANENT SUPPORTIVE HOUSING POPULATION ONLY:
CAN YOU TELL ME HOW YOUR HOMELESS EXPERIENCE BEFORE YOU ENTERED THIS PSH UNIT?

- **Were you continuously homeless for a year or more? (This meant living on the streets and/or in an emergency homeless shelter.) If yes, were you on your own (unaccompanied) and were you also disabled at this time?**

AND/OR

- **Did you have at least four episodes of homelessness in the past three years before you came into this unit? (This also meant living on the streets and/or in an emergency homeless shelter.) If yes, were you on your own (unaccompanied) and were you also disabled at this time?**

LET RESPONDENT KNOW NOTING GENDER: MALE or FEMALE

WHAT IS YOUR CURRENT MARITAL STATUS?

- ☐ **Never Married**
- ☐ **Married**
- ☐ **Separated**
- ☐ **Divorced**
- ☐ **Widowed**

DO YOU HAVE ANY CHILDREN? Y/N

- **Number of children? _____**
- **Whereabouts of children? _____**

HOW WOULD YOU IDENTIFY YOUR RACE/ETHNICITY?

- ☐ **White/Caucasian**
- ☐ **African American**
- ☐ **Cape Verdean**
- ☐ **Hispanic / Specify _____**
- ☐ **Native American**
- ☐ **Asian /Specify _____**
- ☐ **Mixed/Other Please Specify _____**

WHAT IS THE HIGHEST YEAR YOU COMPLETED IN SCHOOL?

- ☐ **Less than High School - Circle year completed: 7 8 9 10 11**
- ☐ **High School Diploma or GED Equivalent**
- ☐ **Some college, but no degree**
- ☐ **Community or Junior College (two year degree)**
- ☐ **Bachelor's Degree**
- ☐ **Master's Degree**

- ☐ **Technical Training - Specify**: _____

ASK BOTH STREET AND PSH:
WHAT DO YOU THINK YOUR BIGGET UNMET NEED IS RIGHT NOW?

THANK YOU VERY MUCH FOR LETTING ME INTERVIEW YOU AND FOR PARTICIPATING IN THE RESEARCH.

- **If you have identified other services/programs you use, I need to ask you to sign an additional consent form to allow me to add that program/service to the permitted list of contacts.**

ARE YOU WILLING TO LET ME BRIEFLY INTERVIEW YOU SIX MONTHS INTO THE RESEARCH AND AT THE CONCLUSION OF THE RESEARCH? YOU WILL BE PROVIDED WITH A $10 GROCERY/GIFT CERTIFICATE AT THE TIME OF EACH INTERVIEW.

YES/NO

JUST TO REMIND YOU, THE ABOVE INFORMATION YOU SHARED WITH ME WILL SOLELY BE USED FOR RESEARCH PURPOSES. YOUR NAME WILL NOT BE USED IN ANY REPORT AND YOUR IDENTITY WILL BE PROTECTED.

AGAIN, THANK YOU FOR YOUR TIME!

Time Interview Ended: _____

Location of Interview: _____