From Street Life to Housing: Consumer and Provider Perspectives on Service Delivery and Access to Housing

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Abstract

The goal of this qualitative study was to demonstrate the achievements and failures of services that attempt to reach those most likely to be left out of the homeless-services delivery model—the chronically homeless street population. In 36 interviews with current and former chronically homeless street dwellers and the people who serve them, this study analyzed the service needs of chronically homeless street dwellers and the successes and failures of street-based medical and substance abuse services intersecting with the predominant continuum-of-care (CoC) model for homeless individuals, thus connecting chronically homeless street dwellers with services and housing. Using Grounded Theory as the guiding principle for analysis (Strauss and Corbin, 1998), the results of this study emphasize important differences between providers' and consumers' perceptions and theories on homelessness, service needs of homeless street dwellers, and service provision. Program and policy recommendations for ending chronic homelessness include the need to increase the affordable housing stock, enhance support systems for successful transition to housing and continuous support, and reduce bureaucratic barriers to housing.

Introduction

A large proportion of the homeless population (about 80 percent) is able to move back into housing within a short time (Kuhn and Culhane, 1998). But some among them struggle for many years, adapting their lifestyle to the streets and facing numerous barriers to leaving their homeless plight behind. Years of life on the streets, accompanied by malnutrition, lack of health care, and most often also extensive substance abuse, take a toll on their health and place them at increased risk of death (Hwang, 2000). Because of the multiple problems these chronically homeless individuals face, as a group, they use up to one-half of all homeless-services resources (Kuhn and Culhane, 1998). The prominent public policy response is incremental: providing services aimed at reducing the harm evoked by experiencing homelessness for unsheltered individuals rather than comprehensively addressing its root causes. Similar to other U.S. social policies, U.S. programs for homelessness lack a comprehensive system of care (DiNitto, 2000).

Focusing on street-based medical and substance-abuse services, the primary purpose of this qualitative study was to assess the contribution of these services in connecting chronically homeless street dwellers at risk of death to housing. Although the quantitative analysis of this research project points to a very small effect of these services on housing outcomes (Meschede, 2010), this qualitative research aims to answer the following four questions to illuminate the experience of providers and street dwellers contributing to these small effects:

1. What are homeless-services providers' theories of homelessness and assumptions about how their services may improve the housing, health, psychiatric disability, and employment of the street homeless?
2. What factors enable homeless street dwellers to attain and maintain housing?
3. What are the barriers to connecting homeless street dwellers with services so that they can better attain and maintain housing?
4. What changes in the service delivery approach for homeless street dwellers at risk of death would improve housing and other outcomes?

Literature Review

When street life becomes the norm, chronically homeless street dwellers are preoccupied with immediate survival needs (food and a safe place to sleep) and not with long-term service or housing needs. Street-based relationships provide social support but fail to provide the resources needed to move off the streets. Accepting housing or shelter often means a departure from known structures and street friendships (Snow and Andersen, 1993). Co-occurring health, substance-abuse, and mental-health problems, which are often untreated, pose additional challenges for these individuals. Thus, access to housing is rare and the risk of dying while living on the streets is high.

The dominant approach to homeless services, the continuum-of-care (CoC) model, has not been successful in moving street dwellers into housing. This model specifies the need for local and regional planning and the implementation of a coordinated homeless-services system to move

homeless-services consumers out of homelessness. This service integration approach is based on the theory that the coordination of public services increases efficiency, effectiveness, and quality of service delivery, thereby leading to better consumer outcomes (Rowe, Hoge, and Fisk, 1998). Theoretically, a CoC comprehensive system of care for homelessness entails a network of housing and service programs for homeless people, including street outreach, intake and assessment, shelter and services, transitional housing and services, and permanent supported or unsupported housing, depending on individual needs. The homeless-shelter system provides the link to transitional housing but has had little success in housing chronically homeless individuals (Burt et al., 2004), who, for the most part, avoid the shelter system due to shelter rules, overcrowding, and lack of personal safety. In addition, these individuals are often required to go through lengthy treatment programs as a prerequisite to attain housing, which many of them are not able to handle due to the rules and restrictions of these programs.

Outreach to homeless people, the first step in the CoC model, attempts to contact, assess, and engage individuals (mostly street dwellers) in services for homeless individuals, especially those who are underserved or unserved or those who are unable, unwilling, or reluctant to seek services. Outreach workers look for homeless people in the streets and parks, under bridges, in abandoned buildings or lots, and in other places where they may settle down for the day or night. The short-term goal of this work is to connect with homeless people and provide care for their immediate needs. Long-term goals of the effort are to connect street dwellers to available services and housing options and to link them to the safety-net programs for which they are eligible. "Outreach is foremost a process of relation-building" (Erickson and Page, 1999: 6-2), aimed at developing a trusting relationship between the outreach worker and the homeless individual. Because this is potentially a lengthy process, success depends on the homeless individual's ability to establish trust with a service provider and overcome past negative service system experiences. The study described in this article focused on medical outreach to homeless individuals, which has been integrated into providing medical services to individuals living in the streets and follows the same principles discussed previously.

Outreach to homeless street dwellers, whether general or medical, reaches individuals who are more severely impaired (Lam and Rosenheck, 1999). Street dwellers agreeing to enroll in the federally funded ACCESS (Access to Community Care and Effective Services) demonstration project for mentally ill homeless individuals had more severe medical problems, had a higher degree of substance abuse and psychotic challenges, exhibited greater health and social services needs, and received fewer services before enrolling in ACCESS than their sheltered counterparts. Street dwellers who enrolled in the ACCESS program showed equivalent outcomes after 3 months in the program, when compared with sheltered homeless individuals (Lam and Rosenheck, 1999). Further, positive housing outcomes have been linked to successful outreach services (Erickson and Page, 1999).

A positive association between the number of service contacts and housing outcomes has been consistently demonstrated (Morse et al., 1994; Pollio et al., 1997). In addition, the timing of an intervention and improved personal relationships between providers and consumers have contributed to better housing outcomes for mentally ill homeless individuals (Jones et al., 2003; Pollio et al., 2000). Further, coordination of service needs and service system integration is important (Goldman et al., 2002; Pollio, 1990; Rosenheck et al., 1998).

Another promising approach for housing chronically homeless individuals is the Housing First model, which attempts to move the most disabled homeless people directly to housing before treatment, using housing as the transforming element to support participation in treatment. This approach does not require sobriety or participation in long-term treatment programs unlike the traditional CoC approach. Promising results have been demonstrated in a number of projects using the Housing First model (Tsemberis and Eisenberg, 2000). In sum, housing for chronically homeless street dwellers who, for the most part, also have substance abuse and psychiatric disability problems can be successful when affordable housing programs match their service needs (Clark and Rich, 2003; Lipton et al., 2000).

Although the mechanisms for positive housing outcomes for street dwellers have been widely researched, the link that medical services to homeless individuals can provide to connect chronically homeless street dwellers to the CoC and housing has received less attention. Medical outreach to homeless people in Boston uses this same street outreach approach. Respite care is put in place to help homeless individuals recuperate from medical illness. Residential substance-abuse services are designed to help with addressing substance abuse problems. Referral services for both service types aim to connect the homeless street dwellers at risk of death to the CoC to foster movement to more permanent housing. For many, however, it may take numerous cycles between moving off the streets into respite or substance abuse treatment and returning to the streets before they are ready to contemplate housing options (Meschede, 2010). To what extent, then, can medical outreach, medical respite care, and substance abuse treatment services connect homeless street dwellers at risk of death to the homeless CoC? Is the theory of change proposed in the CoC model salient to homeless street dwellers and those providing them with medical and substance abuse services?

Because the goal of this study was to assess the contribution of medical and substance abuse services to connecting chronically homeless street dwellers to the CoC and housing, perspectives of current and former homeless street dwellers are a critical part of the analysis. Before this research, however, few studies have attempted to assess the needs of homeless individuals from their own perspectives. An early study of mentally ill homeless individuals found that consumers of services for the homeless point to the lack of access to basic resources, rather than the lack of access to social services, as the major cause of their homelessness experience, rather than the lack of access to social services (Ball and Havassy, 1984, cited in Culhane, Metreaux, and Hadley, 1999). In a more recent homeless consumer needs assessment, conducted as part of the national ACCESS program, long-term housing was the most frequently cited need (91 percent). Access to psychiatric, dental, and medical services and to public assistance ranked high as well, ranging from 78 percent for psychiatric disability treatment to 70 percent for public assistance. More than one-half of the participants also indicated they needed employment assistance (56 percent). Access to substance abuse treatment ranked the lowest (28 percent) (Rosenheck and Lam, 1997). Access to housing and living wage jobs were also underscored as the most important service needs by homeless shelter users in San Francisco (Martin et al., 2000).

Consumers of homeless programs and their case managers often do not agree on the medical service needs of homeless individuals. The greatest differences between consumer and provider regarding perceived levels of need were for dental care (73 percent of consumers and 44 percent of providers), medical services (72 percent of consumers and 55 percent of providers), substance

abuse services (28 percent of consumers and 44 percent of providers), and psychiatric disability services (78 percent of consumers and 93 percent of providers) (Rosenheck and Lam, 1997). Providers saw a greater need for psychiatric disability and substance abuse services, but consumers valued dental and medical services more highly.

Consumers of homeless programs stated that barriers to needed services include the lack of knowledge regarding where to go for services and the inability to pay for services (Rosenheck and Lam, 1997). They also cited previous negative service experiences, such as long waits, confusion during service delivery, feelings of being hassled during services, and denial of services. In sum, the lack of clarity about where to obtain services, how to pay for services, and previous negative experiences when receiving services were factors that prevented homeless individuals from seeking care.

In a survey of 400 homeless people in San Francisco (Martin et al., 2000), many expressed their dislike of homeless shelters. Complaints included dirty and insufficient facilities, high noise levels, and disrespectful shelter staff. In addition, they said that shelters did not provide a comprehensive service system centered on helping individuals with exiting homelessness as they had hoped for. As such, homeless individuals stressed the need for comprehensive case management that focuses on access to housing and employment.

In Boston, the site of this study, outreach to the homeless street population began in 1986, when the city's largest homeless shelter began operating a night outreach van. Since that time, this van has been searching the streets of Boston for homeless people settling down for the night, checking in with each of them, and providing food, clothing, and blankets. In the early 1990s, several day outreach teams operated by three different homeless services agencies complemented this night outreach team. This study's partner, the Boston Health Care for the Homeless Program (BHCHP), has been a visible force on the streets, serving chronically homeless individuals. BHCHP began providing services to the homeless population in Boston in 1985 by integrating the delivery of healthcare services into mainstream services for the homeless at places such as homeless shelters and soup kitchens. In 1986, to reach those homeless people not using any of these services, members of the BHCHP medical team started to accompany the night outreach team. When other day outreach teams started to operate in different parts of the city, either a nurse or a nurse practitioner from BHCHP began to accompany each of those teams. In 1985, BHCHP employed a team of eight medical professionals. Today, it has expanded to more than 230 employees, including 12 doctors, 3 dentists, 24 nurse practitioners and physician assistants, and more than 40 nurses.

The BHCHP respite care program "… is a major component of Boston's service delivery model and offers an opportunity to divert emergency room visits, avoid acute care hospital admissions, and minimize hospital lengths of stay. In calendar year 2000, BHCHP's medical respite program cared for 969 individuals over 1,600 admissions, with an average length of stay of between two and three weeks" (BHCHP, 2001).

The BHCHP's street team provides intensified primary medical care to a group of street dwellers identified as being at high risk of death. Their multidisciplinary team of nurses, nurse practitioners, and medical doctors has become a consistent and dependable presence over the years to these individuals living on the streets of Boston (BHCHP, 2001). BHCHP street outreach services encompass three goals: improved primary care; increased access to shelters, detoxification units, hospitals, and other programs; and decreased mortality on the streets (BHCHP, 2001).

In January 2000, the BHCHP street outreach team began providing intensive medical services to a cohort of 120 to 140 street dwellers identified as being at high risk of death based on factors identified in previous research (Hwang, 2000; Hwang et al., 1998). Street dwellers sleeping regularly on the streets for 6 months or more are assigned to the high-risk street cohort when one or more of the following symptoms are present:

- A triple diagnosis of a medical illness, substance abuse, and a major mental illness.
- A major medical illness requiring acute-care hospital admissions, multiple emergency room visits, or admission to respite care during the previous year.
- Three or more visits to the emergency room during the previous 3 months.
- Age above 60.
- A diagnosis of cirrhosis, heart failure, or renal failure.
- A history of frostbite, hypothermia, or immersion foot.

Individuals identified as being at high risk of dying in the streets are enrolled on an ongoing basis in an intensive care management program and are followed closely by the BHCHP street outreach team. Constituting about 15 to 20 percent of the total street population, most high-risk individuals are enrolled based on carrying a triple diagnosis of chronic medical illness, severe mental illness, and substance abuse. The use of medical services and substance abuse treatment is very high among high-risk street dwellers, with most cycling between respite or detoxification and the streets numerous times; however, use of these services does not predict better housing outcomes (Meschede, 2010). This group of long-term homeless and hard-to-serve individuals was intentionally picked for this study, which aimed to demonstrate failures and achievements of those services that attempt to reach those individuals who are most likely to be left out of the traditional CoC model.

Focusing on the interview data of this mixed-method case study of Boston's high-risk street cohort, this article seeks to answer the following research questions in four broad areas:

1. What are homeless service providers' theories of homelessness and assumptions about how their services may improve the housing, health, psychiatric disability, and employment of the street homeless? How do homeless street dwellers assess these services?
2. What factors enable homeless street dwellers to attain and maintain housing according to service providers and former street dwellers' experiences?
3. What are the barriers in connecting homeless street dwellers with services so that they can attain and maintain housing based on service providers and current and former street dwellers' assessments?
4. What changes in the service delivery approach for homeless street dwellers who are at risk of street death would improve housing and other outcomes for these individuals?

Methodology

Researchers in this study collected qualitative data through 36 semistructured interviews with key informants to document views on service delivery and service goals, as well as successes and barriers in connecting homeless street dwellers to the CoC and housing. This purposive sample, by program type for providers, by housing status, gender, and race for consumers, included six BHCHP street outreach workers, eight BHCHP respite care providers, four detoxification staff of programs collaborating with BHCHP, and nine current and nine former high-risk homeless individuals (see exhibit 1).

Clinicians from the BHCHP street outreach team approached current and former members of the high-risk cohort and informed them about the study. After individuals agreed to participate in the study, a team member introduced them to the interviewer. Most interviews took place at a walk-in clinic for the homeless; some took place at the homes of former high-risk street dwellers. Consumer participants were reimbursed for their time by providing them with supermarket gift cards. After the participants granted consent, the interviewer taped all consumer interviews and transcribed them. Among the consumer interviewees were five women (28 percent); most were White (72 percent) and closely resembled the overall high-risk street cohort (see exhibit 2).

Analysis of the 36 interview transcripts first used an open-coding approach (Strauss and Corbin, 1998). The initial coding list was expanded during this process, yielding close to 200 free codes. The next step of the qualitative analyses combined these free codes into major themes for each interview transcript, including properties and dimensions (Miles and Huberman, 1994). After creating these tree codes, researchers grouped and compared themes relevant to the research questions across interview groups. This step also included quantifying the extent of themes on theory

Exhibit 1

Positions of Provider Interview Participants

Position	BHCHP Street Outreach	BHCHP Respite Care	Detoxification Staff
Medical	3	1	—
Psychiatric/social work	2	2	—
Case manager	—	3	2
Program director	1	2	2
Total	**6**	**8**	**4**

BHCHP = Boston Health Care for the Homeless Program.

Exhibit 2

Characteristics of Consumer Interview Participants

	Current High-Risk Homeless on the Streets	Current High-Risk Street Homeless in a Program	Former High-Risk Street Homeless Housed
White male	3	1	4
White female	3	1	1
Minority male	2	—	1
Minority female	1	1	—
Total	**9**	**3**	**6**

of homelessness, service needs, and program logic, as well as successful practices and barriers to housing across interview groups. Finally, based on the interview themes, recommendations for ending chronic homelessness are presented.

Results

This section returns to the four research questions on the effects of homelessness theories on service delivery, bridges and barriers to housing, and recommended changes to the service delivery system. Major themes from the interview information are portrayed across interview groups, thereby contrasting important group differences.

Service Providers' Theories of Change and Role of Their Programs

The complexities of reasons for homelessness, as well as the interaction of causal factors that range from economic factors to substance abuse, were well documented by both providers and consumers. Although service providers alluded to the complexity and variety of causes of homelessness, they mainly attributed their clients' homelessness to problems with mental health, substance abuse, and medical issues rather than lack of affordable housing and insufficient incomes.

> I think the top two reasons are substance abuse and mental illness. There are a few people who would otherwise choose to live on the streets but substance abuse certainly leads people to very drastically change their lives. They abandon their families, jobs, losing jobs and homes, and mental illness also causes that decline. The patients I work with who have been on the street for a long time are usually more severely mentally ill and/or more serious substance abusers. (service provider)

This viewpoint is not surprising, given the high rates of health problems and substance abuse in the high-risk street cohort.

Consumers did not discuss the role of mental health as a causal factor for their homelessness but supported in their testimonies the prominent role of substance abuse in contributing to losing their home. Consumers, however, also tended to talk about the lack of sufficient income to afford housing more than providers, thus pointing to structural causes such as high rents and loss of jobs as the main contributors to their becoming homeless. Both providers and consumers also alluded to family breakup as another factor that contributed to the homelessness of high-risk street dwellers.

> I think people become homeless because they become estranged from support systems that they have and they sort of lose their way. … There are many things that can get in the way of somebody. It could be that they have been in an abusive relationship, they have sort of maneuvered away from all these support systems that they have. There is no one reason, but I think the bottom line is that people become separated from support and they get separated from connections with other people who can help them to stay in the path. (service provider)

Overall, there were no major disagreements between providers' theories of homelessness and the reasons consumers attributed to their homelessness (see exhibit 3).

Exhibit 3

Percent of Each Respondent Group on Theories of Homelessness, Service Needs, and Program Logic

Homelessness Theories	Street Outreach Team (N = 6) (%)	Respite Care Providers (N = 8) (%)	Detoxification Service Providers (N = 4) (%)	Current High-Risk Street Dwellers (N = 9) (%)	Former High-Risk Street Dwellers (N = 9) (%)
Lack of affordable housing	17	13	0	11	22
Insufficient income	67	0	50	22	22
Mental health	100	63	75	0	22
Substance abuse	50	63	75	56	89
Medical problems	17	13	0	0	0
Trauma/abuse	17	38	25	22	0
Prison/jail	17	25	25	22	0
Unstable family/loss of or breakup with spouse	50	38	50	22	33
Major Service Needs					
Housing	17	38	25	100	56
Mental health	83	38	75	0	11
Substance abuse	33	50	75	56	33
Medical problems	50	25	50	44	44
PTSD	0	13	0	0	0
Life skills training/job training	17	13	25	0	0
Consistent support	17	13	0	0	0
Program Logic					
Developing provider-consumer relationships	100	50	50	89[a]	89
Access to medical services	67	100	50	67	89
Continuity of care	50	38	75	11[b]	0
Decreasing mortality	33	0	0	11	11
Linkage to housing	33	25	75	11	44

PTSD = post-traumatic stress disorder.

[a] *Developing relationships with Boston Health Care for the Homeless Program (BHCHP) outreach team.*

[b] *Receiving continuity of care from BHCHP outreach team.*

Service providers and consumers strongly disagreed regarding their assessments of major service needs of high-risk street cohort members. Providers stressed the need for mental health and substance abuse services, but consumers focused more on housing and medical concerns. It was evident that providers thought of substance abuse as a major barrier to achieving housing, whereas consumers, although they acknowledged the need to address substance abuse problems, were much more focused on their lack of housing as a major service need. For some, substance abuse was directly linked to the hopelessness of street life and the lack of resources to enable individuals to leave the streets.

> I was more in the streets, doing a lot of drugs; I was drinking. I didn't care; I had nothing to live for. Life wasn't worth living. 'Poor me.' I was feeling like why was I handed this hand of cards. I had nothing but losses in my life. My parents passed

> away, my grandfather died, it was why me? What did I do to deserve all this? And thinking, if I deserve all this, I might as well keep going with it. (former street dweller)

Although service providers thought that clinical issues needed to be addressed first, it became evident in the interviews that it is necessary to address both housing and clinical needs in conjunction with one another to support high-risk street dwellers' move off the streets.

Service providers listed several domains of their program theory and underlying assumptions about how their services facilitate housing (see exhibit 3). These assumptions included developing trusting relationships with consumers, providing access to medical and other services, providing continuity of care, decreasing mortality on the streets, and working toward breaking the cycle of homelessness. For the most part, service providers viewed providing access to medical services and forming trusting relationships with the high-risk homeless street population as their primary role. Addressing housing needs was viewed as secondary. As such, service delivery by the street outreach team and respite care providers was dominated by addressing short-term medical needs, rather then long-term residential concerns.

Street outreach workers, who often make the first service contact with street dwellers, described developing trust and providing primary care medical services as their foremost goal. Establishing trusting relationships with high-risk street cohort individuals was seen as the foundation for addressing both short- and long-term needs.

> But it is really, really important we establish that trust relationship. So that means we never promise anything that we can't deliver. We are really consistent and if we say we are gonna be at some place, then we are there. Whether or not the person comes…. Because I think that a lot of our people have been in relationships that have been very conditional, and our goal is not to make that judgment, that's not what we are about. Our goal is provide support and care and to really not do that with a judgment, and realizing that we cannot change somebody. But we can support them. (service provider)

Because the high-risk cohort was identified out of the need to decrease mortality on the streets, it was not surprising that street outreach workers also named the reduction of mortality as a goal of their services. When prompted about linking street dwellers to housing programs, street outreach workers did not view this need as the focus of their work, referring to other programs with that mission. However, connecting street dwellers with respite care or linking them with services from other state departments, such as the Department of Mental Health (DMH) or the Department of Mental Retardation (DMR), was regarded as an important first step in helping individuals move off the streets.

Respite care providers also stressed the importance of establishing trusting relationships with their clients and providing access to medical care. Although discharge planning is integral to the respite program, very few talked about connecting clients to residential programs or housing. In reality, more than 50 percent of clients return to the streets from respite care (Meschede, 2010). As such, respite care staff members seem to accept this pattern of high-risk street dwellers' numerous cycles between the streets and respite care.

> We try to get them into a shelter, or just getting them to a point where they are safe upon discharge from here. More than half of the people end up back on the streets. (service provider)

Detoxification staff focused on the narrower task of providing medical detoxification and then referring residents to other programs within the substance abuse CoC, and linking them with medical and mental health care. They reported working closely with clients while they are in detoxification but not maintaining contact afterwards.

Consumers described the services they received from the street team and at respite care primarily as medical; however, many also underscored the caring and respectful relationships with the street outreach team, which were extended to providing support during and after moving into housing. Some of those who had moved into housing viewed the services they received from respite care as helpful in attaining housing. They were often allowed to exceed program length limitations to enable them to move from respite care directly into housing. Respite care can be a valuable bridge to housing for high-risk street dwellers by keeping individuals in the program until a placement has been secured.

> To tell you the truth, most of that [individuals in housing] has to do with us making exceptions, like us keeping somebody here for ten months to get them into an ideal placement. (respite care provider)

Service providers who identified housing as a major service need also mentioned that their work should include providing linkages to permanent housing. Conversely, those who were more concerned with substance abuse and mental health needs tended to focus more on treatment-related services and were less optimistic about high-risk individuals succeeding in housing without such prior treatments. As one provider explained, "I have never seen anyone go from the streets into housing and survive [remain in housing]."

Services on the streets, at respite care, and at the detoxification programs were guided by a consumer-focused approach to providing care to high-risk individuals. The predominant philosophy centered on letting the consumer be in charge of addressing housing needs, including waiting until they introduce the topic. The steps necessary to facilitate movement from the streets were addressed only at that point. Some respite care providers shared their frustration with this approach. It is hard "watching people make poor decisions," one service provider said. Providers' theories of change, however, were also guided by a belief that housing can be achieved only in a certain way, most often through placement in long-term treatment programs. Those who are involved in referral decisions, such as the case managers at respite care, supported this theory of change.

Successful Practices Accessing Housing and Barriers to Housing

The extent of program capacities and resources and of referrals and interagency collaboration were among the most important issues facilitating and hindering high-risk street dweller's movement off the streets (see exhibit 4). In theory, successful referrals from respite care or detoxification were expected to link individuals with long-term service programs that would help them achieve secure and permanent housing. Most current and former high-risk street dwellers, however, frequently cycled between the streets and respite care and between the streets and detoxification.

Exhibit 4

Percent of Each Respondent Group on Successful Practices and Barriers to Housing

Successful Practices Accessing Housing	Street Outreach Team (N = 6) (%)	Respite Care Providers (N = 8) (%)	Detoxification Service Providers (N = 4) (%)	Current High-Risk Street Dwellers (N = 9) (%)	Former High-Risk Street Dwellers (N = 9) (%)
Service coordination					
Within own system of care	33	50	75	22	44
With other homeless programs providing housing	5	63	75	0	22
With mainstream agencies (DMH/DMR)	50	63	0	11	22
Service processes					
Provider-consumer relationships	67	38	50	56	56
Consistent support/continuity of care	50	63	0	0	44
Barriers to Housing					
Lack of funding					
Lack of program capacity	0	38	50	11	0
Lack of referral options	83	86	50	78	33
Lack of housing	0	25	0	44	33
Housing application process	33	25	0	33	22
Insufficient Social Security income	33	13	0	22	22
Service provision					
Unskilled staff	17	25	50	22	0
Service eligibility					
Eligibility rules	33	25	25	0	0
Criminal records	0	25	25	11	0
Health insurance	17	13	50	0	0
Personal factors					
Untreated mental illness and/or substance abuse	33	50	0	0	11
Lack of skills	33	25	50	0	0
Fear of change	17	38	50	11	0

DMH = Department of Mental Health. DMR = Department of Mental Retardation.

At the service system level, these numerous cycles between short-term residential treatments (respite and detoxification programs) and the streets can be explained, to some extent, by the lack of program capacities at these programs and the lack of follow-up at longer term treatment centers. State budget cuts have affected services at both respite care and detoxification centers and have reduced options for referrals from respite care and detoxification programs. Long waits for longer term services and housing have made referrals from respite care and detoxification programs more challenging, and they are discouraging for consumers. One former street dweller explained that a sense of hopelessness contributed to his returning to the streets after his health status had improved at respite care.

> It's easier [to go back to the streets]; it's because of low self esteem; it's because you feel like it's never going to get better. People feel hopeless and helpless. Sometimes you feel like, 'what's the difference.' It's not a big deal, you know. 'I am not going to get any help; I am not going to get any housing.' That's when you end up not doing anything. (former street dweller)

Consequently, CoC, either in the treatment system or the system of care available after respite care fell apart with detrimental effects for homeless street dwellers.

As respite care and detoxification providers indicated, many programs do not accept homeless individuals, which further limits the number of available referral options. Barriers to access include past criminal records and medical needs that program professionals feel ill equipped to manage. In addition, the types of programs available for homeless street dwellers often do not address their service needs, such as providing medication and supportive services, or do not admit individuals who have been homeless for long periods of time.

Another barrier to leaving the streets is the lengthy housing application process, including the long waits until a housing placement becomes available. Successful housing placements most often occurred among those interviewed when consumers stayed at the respite care program for extended periods of time and were then able to move directly to housing. Both respite care provider interviews and the quantitative analyses supported this contention. Providers stated that housing placements were most successful when exceptions were made regarding length of stay at respite care and individuals were allowed to stay much longer.

> I ended up in [respite care]; I was there for 14 months…. From [respite care] I went straight to … housing. They got my name in when I was at [respite care]. It took them about a year before I got housing. (current street dweller)

> There are some special circumstances with patients that we give one-on-one attention that do actually go from here into housing. (service provider)

One avenue to achieve housing for the high-risk cohort is to connect those eligible with Massachusetts DMH or DMR housing services, thereby presenting an alternative to the long waits imposed by applying for Section 8 housing vouchers, which are available to all low-income individuals. The recent addition of three psychiatric outreach workers to the BHCHP street outreach team raised hopes for better access to the various DMH housing programs, such as DMH shelters, Safe Haven and Housing First projects, and more traditional DMH housing options.

Detoxification programs successfully referred a few high-risk street dwellers to long-term treatment. Most of those who were sober at the time of the interviews reported having stopped abusing substances on their own, without going through detoxification and substance abuse treatment programs. For the most part, they attributed attaining sobriety to having reached a point of experiencing severe medical problems and facing the possibility of death.

From most interviews, it was apparent that the linear service model ingrained in most CoCs, including the CoC model for homelessness, does not work for many. Of the former street dwellers now in housing, only one individual went from short-term to long-term treatment to housing. Some former street dwellers explicitly stated that the stepwise CoC model would not have worked for them.

> There [at the shelters] they want you to go to a program before you get housing. That would have not worked for me. (former street dweller)

Those providers who were more critical of the current service system also shared their concerns that the system is too inflexible and has inadequate options. In addition, previous negative experience in shelters, hospitals, and other programs can function as a barrier to service use and the accompanying linkages to housing. Both providers and consumers cited many instances in which homeless individuals were treated disrespectfully when accessing mainstream services, or, even worse, were denied care.

Although the service system poses great challenges for placing homeless street dwellers in housing, many respite and detoxification providers attributed psychosocial factors, and not solely program factors, as causes of street dwellers remaining on the streets. Respite care providers cited untreated mental illness and substance abuse as factors, as well as the inability to take on the responsibilities that come with housing placements. Other providers spoke of fear of the unknown and not wanting to leave friends on the streets as major barriers to successful housing outcomes.

Consumers had a different view. When prompted for reasons that people cycle between respite care and the streets, one consumer said the following:

> But it's a mess, it's confusing. … I want a home. I just need to get going. I don't know what am I going to do. … I need to be walked through the whole process. I am thinking someone needs to listen to me; but no one really is paying attention to where I am going next, and that's why I am back on the streets. (current street dweller)

Providers also presented the lack of housing skills as a barrier. Skills that were important for survival on the street were considered maladaptive for indoor living.

> I think that for some people living inside is too difficult to manage because they don't have the skills to do it, like if they get any income and can't manage the income on their own, or being inside and not losing connections with the outside world. So that they just isolate themselves and can't figure out how to go grocery shopping, or get a phone, and actually connect with people outside. So I think that there are a bunch of skills that need to be in place for somebody to stay in. (service provider)

Consequently, preparation for placing street dwellers in housing needs to include relearning the skills necessary to successfully make the transition to and retain housing.

Some were able to use the long waiting period at respite to get accustomed to indoor living. Current and former high-risk street dwellers disagreed that training and developing more skills would be useful. Although consumers acknowledged the need for continuous support during their transition to housing and during their initial period in housing, they did not support the need for long-term training to relearn housing skills.

Many street dwellers also stressed the importance of sufficient time to successfully make the transition from the streets to housing.

> It's a slow process. You can't expect immediate results, which is what people want to see. You can't transform a homeless person into this clean sober person, that doesn't work. It takes time. Homeless people don't trust people. It takes a long time for homeless people to start to trust people. (former street dweller)

Depending on the nature of consumer-provider relationships, respondents thought these interactions could serve both as facilitators and barriers to continued service use and housing. As presented earlier, trusting relationships can be major facilitators of successful service delivery and can promote movement off the streets. On the other hand, both consumers and providers talked about staff who were not responsive to their clients' needs, thereby hindering the process of helping individuals to move off the streets.

> What strikes me dealing with the homeless population is how powerless they are in the system. How the system is not responding to any of their needs. … But when push comes to shove, I think the homeless are being kicked to the curb. And our services are lacking, there is a general sense from the people who come in here and talk about … [that] … There are very few [services they trust] in the system overall. Consequently, that makes our job much more difficult to lead them onto further treatment, hook them up with services. (service provider)

The impetus for contemplating moving off the streets most often was sickness and the possibility of death.

> I got tired of it. Tired of being out there drunk, punched up, sick. And because of my liver problems. (former street dweller)

> Those people who have had so much suffering come to a point where they realize that they cannot take it anymore, and they are more ready to get into treatment programs. (service provider)

At such low points, life on the streets was no longer an option, and long-term treatment became a necessity. Supportive, continuous relationships with service providers and the willingness of programs to keep individuals for longer periods of time is what enabled street dwellers to successfully make the transition into housing.

Implications for Changes in the Homeless Service System

Interview respondents shared a variety of suggestions for improving homeless services and for housing chronically homeless street dwellers. These suggestions ranged from structural changes geared toward increasing the affordable housing stock to addressing more interpersonal issues, such as educating service staff and the larger public about homelessness. Current and former high-risk individuals focused on the need for affordable housing and more client-centered services, but providers spoke more of the need to create service programs tailored to the high-risk cohort.

As discussed previously, street-based service delivery is successful in engaging high-risk street dwellers and attending to their short-term needs, such as food, clothing, and medical care. Building on this successful model of engaging difficult-to-reach street dwellers in services, services should take on a more active role in addressing the housing needs of the street population. In

addition, the inclusion of housing assistance at detoxification programs and expansion of housing services at respite care may help limit repeated cycles between these services and the streets. Of course, adding a credible housing focus to these programs hinges on the production of affordable housing for street dwelling individuals and a commitment of resources toward this end.

The need for a variety of program and housing options for street dwellers became evident in the interviews. The linear CoC model in homeless, medical, and substance abuse services has not worked for the high-risk street population, and many providers discussed the need for more flexible programs addressing specific needs of street dwellers. As the linear CoC is ingrained into the current service provision models, however, most providers thought of it as the only model of change; very few spoke of the necessity of changing this service approach.

> There are halfway houses, and those are wonderful things. They can be a great place for skill building. Folks who make it through an entire detox, who make it through a 28-day program or even 90 days, make it to the halfway house. All the challenges they are presented with, by the time they finish that halfway house, they may at that point be able to make enough money to be able to afford a room. (service provider)

The belief that substance abusers cannot succeed, and thus should not attain housing, was widespread among service providers.

Contrary to the views of respite care providers and detoxification staff, street outreach providers thought that all high-risk cohort members would be ready for housing. Most street outreach team members thought of the high-risk street cohort as being ready to be housed, along with sufficient support and housing that matches their needs, backing a Housing First approach. Respite care providers, for the most part, noted that by adapting to years on the streets, chronically homeless individuals lack the ability to live indoors and follow rules. As such, these individuals would need to relearn daily living skills in addition to attending to substance abuse and psychiatric problems before moving into housing. According to respite care providers and detoxification staff, this skill development can be achieved only in long-term treatment programs. Consequently, changing to a Housing First approach would require focusing on staff education and garnering support for such an approach.

The need for continuous service support after moving to housing was documented in the many stories of former street dwellers' failures to maintain housing and by those individuals who made the transition successfully. Some members of the street outreach team took on responsibilities beyond providing medical care, such as regularly checking in with former street dwellers and helping them with basic chores in their new home. Support services during the transition to and throughout housing, if necessary, should be developed to increase the chances of high-risk homeless street dwellers finding success in housing.

Another suggestion derived from the interviews was to provide more education on the issues of homelessness for staff in both homeless and mainstream programs. A better understanding by staff of the issues that homeless individuals face would contribute to alleviating some of the often negative service experiences that hinder street dwellers' future engagement in care. In addition, clients' input into their own treatment and service plans can support passage to more independent living.

For example, this former street dweller describes empowerment of homeless people and unconditional support by staff as key elements to a successful transition from the streets to housing.

> I think that homeless programs should basically not push people to do things but rather try to let them know. We can see what you can do, but you need to be in charge. I can be there to help you in any way you want me to. That type of thing, and I think that's the key to everything…. But I think too, that people need to have a say in what they want. They would say, this is what I want, and how do I go about getting there. People don't know how to do that. Just being there, just letting people know that you are there. If you need something, I am here. Treating them like a normal person. (former street dweller)

Last, the provision of sufficient financial support is critical. Many current and former high-risk individuals were benefiting from Social Security income; however, these income amounts were not at levels sufficient to meet housing expenses. One former high-risk individual explained:

> And I am moving into a new room which costs me $475 a month. And I am getting $585 in SSI. How can you live on $110 a month? I also get food stamps for $100 a month. (former street dweller)

Summary and Recommendations

This study about differences in perceptions of service needs between providers and consumers highlights potential areas of intervention for homeless service delivery and policies. Interview respondents shared a variety of suggestions for improving services and access to housing programs for chronically homeless street dwellers. These suggestions ranged from structural changes geared toward increasing the affordable housing stock to addressing more interpersonal issues, such as educating service staff and the larger public about homelessness. Current and former high-risk individuals focused on the need for affordable housing and more client-centered services, but providers spoke more of the need to create service programs tailored to the high-risk cohort, and many among them did not believe that street dwellers could successfully move from the streets directly into housing. These findings have several implications for homeless policies.

Policy Recommendations

In 2002, the federal administration set the goal of ending chronic homelessness in 10 years by increasing access to mainstream benefits, entitlements and services, and training and employment and by planning long-term housing for individuals released from prisons, hospitals, and treatment centers (HHS, 2003). Although the provision of affordable housing was absent from this list of key strategies, local vicinities began to plan for and implement Housing First programs to address the housing needs of their chronically homeless populations with great success and reduction in public costs (Larimer et al., 2009; Meschede, 2007; MHSA, 2010). The sequential nature of the CoC model for homelessness, which promotes housing stability by requiring movement from phase to phase, has not been successful for the chronically homeless street population. HUD has also acknowledged the limitations of the CoC model for homelessness in connecting chronically homeless street dwellers to housing and has begun promoting Housing First models.

With this shift in focus to housing provision through Housing First programs, the numbers of chronically homeless individuals have begun to decline in many regions. Much work lies ahead in meeting the goal of ending chronic homelessness by 2012, however. As the findings of this research project demonstrate, access to services and benefits alone cannot solve the homelessness crisis. The long-term goal of ending chronic homelessness can be achieved only with sufficient resources to address the housing needs of this population, in addition to their service needs. As such, no services to the chronically homeless street population should be delivered without a focus on permanent housing.

Ending chronic homelessness in Boston and Massachusetts also requires a major modification in the way services are delivered to the homeless.

> A serious commitment to ending chronic street homelessness necessitates a paradigm shift, part of which involves the willingness of a community and its homeless assistance providers to consider approaches that have been proven to work even though they, at least initially, represent a significant departure from traditional programs. (Burt et al., 2004: xxii)

As such, successful implementation of new housing models such as Housing First requires addressing service providers' reluctance to support such model and the creation of different types of housing with a variety of levels of supportive services. Housing has been demonstrated to reduce hospital and detoxification admissions (Gulcur et al., 2003). Consequently, the enormous costs associated with the frequent use of medical and substance abuse services (Meschede, 2010) could be diverted into the creation of affordable and supportive housing.

Because high-risk individuals have so many different service needs, service providers need to be trained across disciplines. For example, the ability to address medical and substance abuse issues while simultaneously being knowledgeable about housing needs would enable service providers to offer a more integrated system of care to high-risk street dwellers. Alternatively, teams across professional specialties might be better able to address these issues holistically. A less fragmented system of care that supports long-term supportive relationships between providers and consumers, regardless of where consumers are in the process between the streets and housing, could be beneficial in ending homelessness for this population. It is also critical for the system to allow for client input.

> It's not easy. Programs are so strapped. What they need to do is to start looking at this homelessness, not the shelters and the programs, look at the problem. Stop putting your money into your … profits and start putting it into housing. Like the people [living in upscale inner city neighborhoods], they don't want any of us homeless people there. But yet, they won't fork the money to trying to help them. They rather run them out of there, and that's not fair. There is so much you can do for a homeless person. You can teach them and point them in the right directions to their own home, own apartment, to get a job, learn skills. Give them the tools to accomplish all these things. I don't care who you are on the streets, because when you are on the streets you know a little bit about many things. (former street dweller)

Finally, the federal strategy of diverting entry into homelessness by referring individuals released from the criminal justice system and psychiatric hospitals to appropriate settings other than shelters can be successful only if these individuals are offered realistic housing options, rather than long-term treatment. In addition, rapid rehousing after individuals become homeless is key to preventing them from becoming accustomed to life on the streets, adopting skills that are not suitable to housing, and thus complicating the transition back into housing. Interventions at the homeless shelter system, for most the first point of entry into the homeless services system, need to address both the service needs and the housing needs of those newly entering homelessness. Shorter shelter stays and rapid rehousing are important mechanisms to ending chronic homelessness.

> The ultimate goal is housing and recently we got a grant to work with Mass Mental [Health Center] and that is one of the overall goals, why we are partnering with them. Hopefully we can get them in the DMH system to eventually get them housing and it has happened for some people. DMH has housing available and the same case with DMR and you can get other services along with that. It's easier to get housing this way than through Section 8. (service provider)

Significance of Study

Assessing outcomes of the homeless services delivery system has moved to the forefront at the federal level and in the state of Massachusetts. In 2001, the 107th Congress stated the following goals:

> The conferees reiterate and endorse language included in the Senate report regarding the need for data and analyses on … the effectiveness of McKinney Act [the major source of federal funding for homeless programs] programs …" and "… analyze their [homeless people's] patterns of use of assistance, and document the effectiveness of the systems. (U.S House of Representatives, 2001: 110)

Outcomes associated with current policies regarding homelessness and programs derived from these policies are of utmost interest to many program administrators and public officials at the local, state, and national levels. In addition, several Massachusetts departments, by uniting their efforts to address homeless services in the state, have voiced the need for evaluations of homeless services. Because this study evaluated the effectiveness of the first step in the homeless CoC—homeless outreach—it added to a body of knowledge informing federal and local policymakers on current homeless policies, especially for the chronically homeless.

Many jurisdictions at the city, county, and state levels have been creating new plans to end homelessness in 10 years, focusing in particular on the chronically homeless. To qualify for federal funding under the McKinney Act, the main source of financial support for most homeless programs, every local CoC program for the homeless has to specify plans to address chronic homelessness in their jurisdictions. Many, if not all, of the individuals identified at high risk of dying—the target group of this study—have been homeless for many years and most of them have multiple barriers to successful transition to more permanent living situations. Learning more about their service-use patterns and assessing the service delivery system will add to the understanding of what it might take to end chronic homelessness. In that, the findings from this study will contribute to a better understanding of how homeless people decide to use services offered to them, which services they use, and what outcomes are associated with service use.

Study Limitations

This study focused on a defined group of chronically homeless street dwellers in Boston, which may differ from chronically homeless street dwellers in other communities where service provision and delivery may also differ. As such, the generalizability of this study's findings may be compromised.

In addition, only a small group of individuals was selected for qualitative interviews. Qualitative research focuses on understanding the essentials of the experience of the phenomena, emphasizing depth, rather than breadth, in the information gathering process. The issues of service delivery, service needs, and service outcomes are relevant, however, for other municipalities that are struggling with reducing the number of chronically homeless street dwellers and improving service delivery to this group. Lessons learned from this Boston-based study can inform the homeless services delivery systems in cities across the country.

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