Outreach and the "Housing First" Model:

Offering Housing during the First Contact by Outreach Workers

An Edited Transcript of the PATH National Presentation

March 9, 2004

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This telephone/Internet presentation was supported by a technical assistance contract with the Substance Abuse and Mental Health Services Administration (SAMHSA). However, the content of this teleconference does not necessarily reflect the views of SAMHSA or the U.S. Department of Health and Human Services.

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Welcome and Speaker Introductions

Tom Lorello

Welcome, everyone, to this PATH national presentation called Outreach and the "Housing First" Model: Offering Housing during the First Contact by Outreach Workers. I'm Tom Lorello from Advocates for Human Potential in Sudbury, Massachusetts. We're the technical assistance contractor for the PATH program, and I'll be the moderator for today's presentation. There are more than 200 people participating on this call from all over the country, including staff from PATH-funded agencies and representatives of State and Federal government. Many are listening to the presentation over the telephone and many others are listening via the Internet. Welcome to all of you, and a very special welcome to our expanded audience in the National Resource Center network.

We're pleased to have three nationally recognized experts with us today who have prepared a presentation specifically for the PATH audience. I'd like to introduce our featured experts in their order of appearance. First, we have Dr. Sam Tsemberis with us, who is a nationally recognized advocate of the Housing First approach. He's a clinical psychologist and a professor of psychiatry at the New York University Medical Center and is also the founder and executive director of Pathways to Housing in New York City, an agency based on the belief that housing is a basic right for all people.

Pathways to Housing offers immediate access to independent, permanent apartments to individuals who are homeless and who have psychiatric disabilities and substance use disorders. Dr. Tsemberis has received honors for his work from the Center for Mental Health Services, the National Alliance to End Homelessness, and others. He's been profiled by National Public Radio's All Things Considered, Public Broadcasting Systems' The News Hour with Jim Lehrer, and has been featured in the *New York Times, New York Daily News, Christian Science Monitor,* and others.

We also have Sheryl Silver with us today, who is currently a team leader of a PATH-funded outreach team with Pathways to Housing. Sheryl has worked with people experiencing homelessness since 1987 and those with psychiatric disabilities since 1993. She's the co-founder of the organization Alliance for Human Potential in Denver, Colorado, where she provided HIV education and prevention services. Sheryl brings the unique perspective of having worked on an outreach team earlier in her career that did not have immediate access to housing and is now working on the Pathways team that does have this capability. We'll ask her a little later to comment on the difference in those experiences.

Finally, we have Ann Denton, of Advocates for Human Potential, who has 20 years of experience as a leader in housing for people with mental disabilities. She currently directs a contract with the Center for Mental Health Services to provide comprehensive assessment of State and local provider performance of PATH programs. She's also provided technical assistance and training to more than 50 communities regarding the HUD Continuum of Care

planning process. She assists providers with implementation issues related to *Olmstead* as well as PATH. Prior to coming to AHP, Ann was the director of the Austin office of The Enterprise Foundation and was also the Texas State PATH contact when she served as the Coordinator of Housing and Residential Services for the Texas Department of Mental Health and Mental Retardation.

Welcome to all of you. Thanks so much for taking the time to be with us this afternoon.

To kick things off, I'm going to direct my first question to Sam. Sam, I assume that many of our listeners have heard the term "Housing First" but may not be entirely clear about exactly what that is. I wonder if you could talk about exactly what Housing First is and what its essential components are.

Housing First

Sam Tsemberis

Sure, Tom. Thank you for inviting me. Housing First is actually quite simple. It's direct provision of permanent, independent housing to people who are homeless. In our case, everyone we work with is a person who has psychiatric disabilities or substance abuse issues. We provide people who are homeless and have co-occurring disorders with housing of their choice, which is typically an independent apartment, before we do anything else.

Now, that's the way we define it. I know that there are a number of variations now around this definition of Housing First. Some people call a Safe Haven program a Housing First program or believe the idea that you're going to get housing right away or we're focused on giving you housing are also called Housing First programs. As far as I'm concerned, Housing First means you provide the person direct and immediate access to housing.

Do you want me to say more about this?

Tom Lorello

Yes, please describe some of the components of the Pathways program, especially what you think works.

Chronic Homelessness

Sam Tsemberis

Let me say first how we came to this idea of Housing First. Even though I'm credited as being the founder of Pathways to Housing, I certainly am not the person who thought that Housing First was the way to go. Housing First is really a consumer-driven idea. Like Sheryl and many people out in the audience who do outreach, I was also an outreach worker for many years.

The target population I am talking about is that group of homeless people that are mentally ill, living on the streets primarily or in drop-in centers or in and out of shelters, jails, emergency rooms, and so on. Nationally this group has come to be called the chronic homeless population.

They've come to national attention for a number of reasons. One of them, not insignificantly, is that this is the group that we're failing. People go in and out of homelessness quite a lot in this country—mostly, they're homeless episodically, and we don't hear about them because they don't show up when we're counting homeless people. The group that I'm talking about is the group that stays homeless. This group is believed to comprise about 10 percent of the homeless population, but accounts for somewhere around 40 percent or 50 percent of the service utilization.

So it's like we're spinning our wheels over and over again and people are remaining homeless. Dennis Culhane certainly brought that to our attention in New York City when he found that 10 percent of shelter users account for 50 percent of the resources in the shelter system and never find permanent housing. This is the chronic homeless group with multiple problems.

Since this recent epidemic of homelessness that is going on now almost 25 years, the concern was first voiced by people in the mental health system or substance abuse system that among the people on the street were people with mental illnesses. So the innovative thing that we did then was to send clinicians out to the street to do outreach. Outreach was a very unique program when we first started because it got clinicians out of the office, going to the street, making these sidewalk house calls, and trying to get people into the system.

The idea of outreach was to engage the individual and figure out their survival needs. Are they going to be okay? Are they able to cope? Are they able to fend for themselves? Do they have physical health problems that are pressing? Do we need to take them to the hospital right away or can we just refer them to the next step in the system? The next step in the system is typically a treatment step, perhaps a drop-in center or Safe Haven where we can get people stabilized, because we don't want them to be psychotic and we don't want them to be suffering from the cravings of addiction. We want to treat their clinical conditions. As clinicians, the focus has always been to treat the clinical conditions first and in that way, get the person ready for housing.

There's a sort of co-conspiracy there because the housing provider waiting to admit these people into the program wants people to be what they call "housing ready," which means they're clean and sober, they're on medication, and they look like they're going to be able to fit into the residential program like the other residents do now.

That is the typical continuum of care, that step-by-step process that goes from outreach to drop-in or Safe Haven to transitional housing to permanent housing. That's the housing-ready model.

Tom Lorello

I think that's the part that a lot of people struggle with, the idea that you would not require sobriety or treatment first. In case that wasn't clear from your opening remarks, the Pathways program does not require sobriety or mental health treatment. Is that correct?

Continuum of Care vs. Housing First

Sam Tsemberis

Yes, we don't require treatment first. It's not because we wouldn't like it; it's just that we can't get people to be clean and sober and we can't get them to see a psychiatrist because from their perspective, that's not the problem. People we typically meet on the street who are mentally ill and/or addicted do not see the clinical problems as their main problems. From their perspective, they were mentally ill before they were homeless. They were living somewhere sharing a room or renting a room in some place before they became homeless, but they had symptoms. Maybe their symptoms are worse, maybe their addiction is worse now that they're on the street, but their sense of urgency is not about the treatment of their illness.

The other thing that happens to people is that they have a good relationship with an outreach worker. Then they go to the next step, let's say a Safe Haven, and they have to give up that relationship with that worker. Sometimes that's not the easiest thing to do. Then they have another relationship with the person at the Safe Haven; they have to give up that relationship to go to transitional housing. For people who have psychiatric disabilities, making any friends at all is difficult, and it is especially difficult to request that every 180 days they switch emotional allegiances.

The other thing that is problematic is that when people relapse, and we know relapse is just part of addiction or it's part of mental illness, they would lose their step on that housing conveyor belt and be back down to step one because they would be considered not housing-ready.

It's not that we didn't try to put people on that conveyor belt, on their way to permanent housing, or try to get them to see that the clinical conditions were keeping them out of housing. It's just that they were in disagreement about it. Even if they agreed with us, they could not get to permanent housing.

Then the experience of the outreach team was one of complete frustration and exasperation with all the effort and time and energy it took to get people housed. People would fail, the team would feel bad for the person, the person was devastated, and the situation would just go around and around and around.

The sequence I've been describing is treatment then housing maybe, because maybe people make it into housing after all that treatment, and maybe they don't.

The Housing First approach is housing then treatment maybe, meaning for sure you get housing and then you can get treatment if you want to. It was a leap of faith to trust the people we were

working with. It really meant what they wanted was housing and that we were going to be willing to give it to them.

What people wanted for housing was not program housing. They didn't want to go into some residential, multi-unit, SRO-type place with other people who had psychiatric disabilities living there. They wanted a little inexpensive apartment, just a simple place like they used to have. They wanted to live by themselves and come and go as they wish. They didn't want to live in treatment. They wanted to live in a house and go to treatment, if they wanted to do so.

So the supported housing, scattered-site model fits very well with what people wanted because it is in scattered sites throughout the neighborhoods where we can find affordable housing. The person goes right from the street into one of those apartments.

Tom Lorello

Are there any strings attached?

Housing First Program Requirements

Sam Tsemberis

There are no clinical strings. The person doesn't have to see the psychiatrist or take medication or be clean and sober. They do have to pay 30 percent of their income toward the rent. The supported housing contracts are set up that way. Typically, their income is from SSI. If people don't have SSI, we'll help them get it.

The other requirement is that somebody has to visit the apartment twice a month. Not to make you take medication or anything, but just to make sure that the housing is okay, that you're okay in there, that you're managing, that there's food in the fridge. Some people are so comfortable with isolation after years of isolation on the street or under the bridge that they'd go into an apartment and then isolate again. We didn't want to be in an argument with them about the fact that we are going to visit; we wanted them to know we're not just going to leave them there.

Those are the two requirements, and we're actually flexible about that. If the person is too paranoid to sign over an SSI check, we'll wait. If they don't agree to the two visits up front, and we think we can finesse the relationship, we'll go ahead and house them anyway. Most people, knowing the options they face with other housing providers, are glad to agree to our requirements. We haven't had much difficulty in getting a buy-in on those two conditions.

Tom Lorello

Sam, to what extent are people more interested in things like treatment after they're housed?

Treatment after Housing

Sam Tsemberis

Well, it's a remarkable thing in the sense that we have about 70 percent participation in treatment. We started with 50 people being housed in apartments. Now we have 450 and we have another new ACT team starting up. We're going to be up to about 500 scattered-site apartments. Typically, people get into the apartment and after some period of time, approximately 70 percent of the people in the apartments are in treatment. It's not because we require it. I think people felt that many of their symptoms were somehow related to the fact that life is so dangerous and scary when you're living on the street. Then people get housed and they're still feeling very anxious or very depressed. They meet the psychiatrist who's part of the ACT team, which is what I'm going to describe next, and they say, "Maybe it would be helpful to take some medication."

Other people, I've noticed, move into the apartments and they want to stop drinking or using so they can hold onto the apartments. They recognize that there's a connection between being out of control and losing housing. We would spend all of this energy ahead of time getting people to be clean and sober so they could get housed, and it turns out that once they're housed they want to be clean and sober to stay housed.

So there is a good bit of participation in treatment. What people also want just as much, if not more than, treatment is jobs. People want something to do. That's where supported employment and other kinds of supports come in to get people working or back to school or having some way of spending their time productively.

The third dimension is that people start to reconnect with their families. They're alone when we meet them on the street, and they seem like isolated individuals. Once they're housed, they have a phone and they can make calls out and get calls back. They begin to reconnect with their families.

Also, many people don't want their families to know they're on the street. They feel it can be upsetting for their families to see them in that condition. They're humiliated, so they avoid the contact. Once they have a place, there's something dignified about that. They feel more comfortable about making that call.

Those are the kinds of ways life immediately begins to develop for people. It's not that you house people and then your job is over. You house people and then your job actually begins. I think Sheryl will speak to this better than I can in terms of the incredible complexity of services, offered by the ACT team, which is an interdisciplinary mental health team that includes psychiatry, social work, and vocational rehabilitation. We also have a nurse practitioner on our team because people come in with a lot of physical health problems. Substance abuse counselors, vocational counselors, and job developers are consultants to the team. So whatever services the person wants next after housing are available to them, in no particular sequence other than the sequence that the consumer chooses. This is consistent with what we've been doing right from the Housing First part. Housing First is not actually a sequence that we insist

on. It's the consumer saying, "I want housing first." We just developed a program model that provides that.

Their choices don't end with housing. Then we say, "What do you want next?" So what they want next could be mental health, it could be a job, it could be family, so that's what's next for that particular person. It's individualized. There seems to be a great unanimity, a chorus of voices when everybody's homeless. When you ask, "What do you want?" everybody says, "housing." Then when you ask, "What do you want next?" there's a range of options that come from the consumer. The ACT team takes over and helps the individual and continues the passage to recovery, as the person begins to be part of their apartment, building, and neighborhood, and their life gets back together.

There's also a belief that people can and do recover. We haven't talked much about what it takes to set up a program like this, but there is a philosophy and a belief system that supports the hopefulness of a message which says, "I believe in you and you can do it." That leap of faith is based on a true belief in others. It's based on the belief that people with psychiatric disabilities or other conditions are able to do just as much as the rest of us. Believing that, and conveying that hope, helps people to realize that dream. For the people that have been beaten down and abused, really, by the mental health system and other systems, you have to help them rekindle the belief in themselves.

Tom Lorello

Can you say a little bit about what helped you to make that leap of faith? There are probably a lot of folks out there for whom that leap is going to be a big step. For some people it may seem irresponsible to put people in housing who are not sober or who are refusing treatment. Where does that faith come from? Sheryl or Ann, please jump in if you want to.

Sam Tsemberis

I'm just preaching here, Tom. I'm not really saying I found it easy to make that leap of faith.

I had to be sort of beaten into submission after years of failed experience. I was trained as a psychologist. When people on the street would say to me, "I'm hungry and I need a place to live," I would say, 'What does that mean?" I was trained to interpret. I wasn't trained to listen. I tried to go step by step by step for years—including taking people to the hospital involuntarily if necessary—and I was really trying to get them onto that conveyor belt and into housing, but it was just too frustrating.

After thousands of efforts like that, I said, "Well, maybe people really mean what they're saying. Maybe they really want housing first. I'm going to try this." I tried it in complete trepidation and fear, not knowing how it would turn out. What convinced me that it's absolutely doable are the outcomes. People went in and they stayed in. They thrived. They flourished. That's how I was convinced.

Tom Lorello

Nothing does it like a successful outcome. Actually, I'd like to ask you about some of the supporting research. Before we move onto that, Sheryl or Ann, did either of you have anything you wanted to say about this?

Ann Denton

I would just say that my experience is the same. I think there's a group of people for whom what we're doing now in most of our public mental health systems is not working. Recognizing what is not working for people makes communities more likely to choose to do something different. One of the things you have to have to do this is decision maker buy-in or community buy-in, and the recognition that things are not working is one of the sources of that. That's why I think the research that Sam's program has done is so important, because it's not an anecdotal story. It's firmly grounded in data.

Tom Lorello

Let's move onto that now. Sam, can you speak to the supporting research? We've made these claims that it works.

Housing First Outcomes

Sam Tsemberis

Let me describe the two programs that were compared in this research. I've already said a little bit about our program, which is a supported housing program with scattered-site apartments, where the individual is given a choice about what apartment they want and whether they want to live independently or with others. Most people choose to live independently. The person is housed without any prerequisites in terms of their clinical status. There are two program requirements, which I discussed previously.

The ACT team, which is interdisciplinary, is an evidence-based practice. There's a huge literature on ACT, described very well in terms of the 18 or 20 fidelity dimensions. We are pretty consistent with that, except that we're more consumer-driven than the national model. The team is available 24/7. ACT is a very intensive support for people in the scattered-site apartments. We don't leave people in their apartments and go away. That's our program, and that's the experimental program, I would say.

The control group was people in the continuum of care program, either in the drop-in center or what we call in New York a reception center, which is like a Safe Haven. Then people move along the continuum to a transitional community residence and then to permanent housing. The study itself was of 225 people who were literally homeless 15 of the last 30 days and who had a history of housing instability over the last 6 months.

The study was funded by the Substance Abuse and Mental Health Services Administration. What we wanted to know was, basically, would it work. Before the research, we really were, as Ann said, left to tell stories about successes. This study, though, included 225 people who were homeless and had a major Axis 1 diagnosis of severe mental illness, like schizophrenia or bipolar illness. The average age was 41.5 years old, about 67 percent were men and 23 percent women. Most were not married.

The time spent homeless was 6 months to 12 years; the median was 3 years. This was a group that had been homeless a long, long time. Forty percent of the group was African American and 28 percent was Caucasian. Ninety percent of the sample had co-occurring disorders—either active or a history of substance abuse disorder—which was either drugs or alcohol. When the people were randomly assigned to either Pathways or control, 99 went to Pathways and 126 went to control.

The clinical and demographic characteristics of those two samples were not different. They were virtually the same person going into program one or program two, and that's very, very important in this kind of a random assignment design. You don't want to find differences in your samples because you want to attribute the outcomes to the program differences rather than to the participant differences.

We were able to follow 86 percent of these people for 36 months, hovering around 90 percent for the first 2 years and then dropping to 86 percent in the third year, which is a great follow-up rate. We had a very active research team that was headed up by Beth Chen at NYU and her students.

I guess the most compelling thing I want to tell you about is that 58 percent of everybody in the sample started out as literally homeless, on the street when we met them as opposed to a shelter, drop-in center, or coming from a hospital. By the end of 12 months, in the control group, that 58 percent had dropped to about 25 percent, which was a good drop, and then it stayed there. Because people agreed to participate in the research, we gave them a boost to move them along in the system. Twenty-five percent, though, remained literally homeless for the duration of the study.

When you look at the Housing First approach, by 12 months only 3 percent of the sample remained literally homeless; from 58 percent to 3 percent. That's where that number stays pretty much throughout the 36 months of the study. That says that when you provide the housing, people get off the street and they stay off the street. The Housing First approach does end literal homelessness.

The other way of saying that is we used something out of Dartmouth called the Residential Follow-back Inventory, and we looked at the number of days people spent in stable housing over that time. Looking at the first year of data, people at the beginning of the study were spending about 3 percent to 6 percent of their time in stable housing, staying with friends or other arrangements. When we met them, they were homeless. Now looking at the continuum of care group, in 6 months they went from spending 6 percent of their time in stable housing to about 18

percent, and then by 12 months they had gone up to about 23 percent. So they'd gone from 6 percent to about 23 percent in 12 months.

The Housing First group went from 6 percent to 80 percent. It's almost four times the amount of time spent in stable housing. People go into housing and with the support services of this Assertive Community Treatment team they stay there. It's a whopping effect. It's not like something subtle that you need a magnifying glass to see.

Tom Lorello

Wow. It's very, very impressive. If I can shift gears here, I can imagine that some listeners may be excited by these results, but feel that it might be difficult to imagine it happening in their particular community. Perhaps they don't really know how to get started. Ann, you've helped stakeholders in many communities to adapt these principals. What can you tell us about what those communities have done to get started?

Developing a Housing First Model

Ann Denton

You have to have three things to do this, and one is you have to have some way for people to pay for the apartment. Sam's talking about people paying 30 percent of their income. Well, 30 percent of an SSI check isn't going to be adequate in most communities, so you're looking for rental subsidies. That's the first piece.

The second piece is you have to find a way to pay for the services. A lot of our service delivery systems are not set up to deliver services at the intensity or depth that an ACT team is. So you have to look at the way that your services are configured.

The third thing you really have to have is a way to convince the decision makers that this is worth doing. I think it's clear to all of us that it's worth doing, but there are some specific things you can do. I'll elaborate a bit on each of these.

In terms of housing assistance, I would say that the main thing I want people to know is that there's money out there to do housing. You may not be familiar with where it's coming from, and it may not seem like an easy thing, but it is there. There are three major sources of dollars that will support the housing piece of Housing First. First, Public Housing Authorities have the lion's share of the affordable housing resources in this country. The second biggest pot of money is the Consolidated Plan. Finally, the one that probably most of us on this call are familiar with is the Continuum of Care, or McKinney Homeless Assistance Funds.
Tenant-based rental assistance is what you want from any of those resources; you want the voucher or the assistance to attach to the person because that facilitates choice. Choice is such an essential element of how this program works for people.

So, for Public Housing authorities, you're looking at the Section 8 list. There are things that you can do even if your Section 8 list is closed. You can advocate with the Public Housing Authority to get preferences on the Section 8 list, so you can ask them to tinker with how they're doing business. Also, if they're a Housing Authority in good standing, they have the ability to apply for additional funds that you could use for rental assistance. Mainstream housing vouchers is an example of a program that a Housing Authority in good standing can apply for. All of a sudden they have the resource to help you with your housing piece.

The second largest pot is the Consolidated Plan. The HOME Program—the Home Investment Partnership Program—is typically used to do development of affordable housing. That's a wonderful thing. You can also use it for tenant-based rental assistance. In communities where the Housing Authority is either unfriendly or so overcommitted in terms of what little resources they have, the Consolidated Plan HOME Program is a source of rental assistance. I know a lot of communities where advocates have been successful in getting that.

Finally, Continuum of Care is the one we're all familiar with. When Shelter Plus Care is awarded as tenant-based rental assistance, it is a perfect, made-in-heaven match for a Housing First program. That covers the housing piece very quickly.

Remember, you have to have housing money, you have to have services money, and you have to have buy-in. Regarding services, many of our States, despite the fact that we have budget crunches in most States, are experimenting with evidence-based practices. So you're looking at either new dollars for evidence-based practices or a reconfiguration of the service delivery system to support evidence-based practices.

As Sam said, ACT teams are perfect for this activity. I don't want to dispute that, but I would also say I think there are ways to use service delivery dollars in other ways to achieve the same results. You can do things like continuous treatment teams or other interventions that will work. You just have to have sufficient capacity and the ability to provide services 24/7.

One of the opportunities for services funding is either new funding for evidence-based practices or the reconfiguration of service delivery systems that's happening in many States.

A second one that's widely used for a variety of things is for States that have the Medicaid Rehab Option. In your State plan, depending on how it's written, you can either bundle services and call it supported housing or Housing First, or you can piece together a menu of services, reimbursable under the Rehab Option, that will support Housing First activities. Again, it's not so much that the money's not there, it's that the system may not be set up to facilitate it right now, but it's possible to make that happen.

Finally, and this is related to the last issue of buy-in, many States are seeing that what they're doing for people is not working. So they're doing State or provider-funded initiatives. This could include new money or it can just include a restructuring of what they have.

Tom, as you alluded to earlier, Housing First is a bit of a leap for some people. The idea that people are going to go into Housing First and that you're not going to put all these requirements on them is counterintuitive for those of us who had clinical training. I certainly had my share of clinical training, as well. I think for me there are three very persuasive arguments. One is it works and it's the right thing to do. The whole notion that people with serious mental illnesses can and will recover, given the proper conditions, is the number one reason to do this. There are a lot of people out there in decision-making positions who went into this business because that was their belief.

A second argument we've talked about a couple of times. What we're doing right now isn't working for some of the people who are our responsibility to serve. When you look at homelessness in a community, you can say there's nothing wrong with what's going on for some of the people, but for some other people, the housing-ready model is not working at all. Those people for whom it's not working, the 10 percent who are chronically homeless, are using enormous resources in our systems. So let's take a look at doing something different for that group. I found that in dealing with the decision makers, if they don't think you're trying to change the world, but you're trying to create an initiative for a specific group of people, that really helps them go ahead and make that leap.

The final persuasive argument that we haven't really talked about is that Housing First is cost-effective. There are a lot of people out there who are talking about doing affordable housing development and are doing a lot of different kinds of things for people, but Housing First is cost-effective on the housing level and it's cost-effective on the service level. On the housing level, rental assistance is always cheaper than development—always. I think that if you take a look at the data on what it takes to get a housing development project off the ground in terms of upfront capital and then what it takes to keep it going in terms of debt service, rental subsidies on a per-person basis are always going to be cheaper.

Sam Tsemberis

Can I chime in something about that? I know in New York City, for example, running the program that we run with scattered-site housing and an ACT team costs about $22,000 per person per year. For a municipal shelter cot in New York City with services, it costs $25,000 to $30,000 per person per year.

Ann Denton

That's not even counting the data that Sam referenced earlier, which talks about the emergency services that people are using; jail time, emergency rooms, and all of that. When people are in a Housing First program, that chaos in people's lives really dies down. That's what Sam's data is about. So you make the argument that that's best for those individuals. It's also best for the system. It costs less. Emergency room visits, police calls, ambulances, court costs, everything, you cannot beat that in terms of savings. There's data out there that supports that.

To summarize my three points, there's housing money out there, and you must have housing assistance dollars to do this. People can't afford housing on SSI. The second point is there are service dollars available in your community. You may not have new dollars, but you need to look at what you're doing or how you can use your Medicaid resources more creatively to do this. Finally, for getting the buy-in, hope and recovery are powerful messages. Also, what we're doing now isn't working for some people and it costs less to do it this way.

Tom Lorello

I think the data, such that that Sam offered, is very powerful. I find the idea that so many people seem to be willing to accept things like treatment after the fact also says something.

Ann Denton

Absolutely. People will say, "Well, they're going to have drug parties or something in their apartments." I think the experience of providers who are doing this indicates that's not the case at all.

Sam Tsemberis

I don't want to give the impression that people move into the apartment and they live happily every after. It's not like that. It's gritty and it's real. I'm sure when Sheryl talks you'll get a flavor of that.

I want to say one other thing about replication in other places. You can work hard to do it locally, but I know nationally, and probably as many of you know, the Interagency Council on Homelessness has been championing this idea and they put out $35 million to support it. Now Fort Lauderdale, Chattanooga, Denver, Philadelphia, and another program in New York, among others, are funded to do exactly this program that I just described to you. The Federal partners involved in this initiative hope to fund additional programs. You can persuade from the ground up or you can persuade people that have money, and then the money is out there and people are writing proposals to implement the program.

It is not so radical or so difficult to persuade people that this works. Clearly, there's been a lot of persuasion happening in all of those counties and cities.

Tom Lorello

I would like to segue now to the issue of outreach, since so many of our PATH-funded programs come at the issue from that angle. Sheryl, you have the unique perspective, as we mentioned in the introduction, of having worked in two different PATH-funded outreach programs in your career. The one that you worked on earlier in your career did not have immediate access to housing at the time. You now work in the Pathways program in which that's the emphasis. I wonder if you could talk a little bit about the differences between doing outreach in these two programs.

Outreach and Housing First

Sheryl Silver

The differences are really quite remarkable. I just want to go back to almost the beginning of the call when Sam was speaking about believing and what we believe the folks that we work with can do. I remember doing outreach where housing wasn't really an option at all for our folks and I came to believe there wasn't really any hope. It will just take so long to get these people housing, if it even does happen. You almost accept that this nice little camp that they set up down by the river where they serve coffee is really great and that's probably how it's going to be for quite some time.

So, you almost get a little bit brainwashed by the system that is telling you that the folks you're working with will never get housed, and you accept it. In a loving way you accept it, but you accept it nevertheless, whereas now I see folks and when I look at them I think, "Oh, I can't wait to see how their apartment looks and how they set up their kitchen and what they're going to cook for lunch for us." It's a completely different way of looking at it.

They feel that right up front, I believe. The folks that we work with get that feeling from us in the beginning, that we have this hope and this belief that their lives can be different, that we're not resigned to the fact that they will be as they are right now.

I also think that the idea of not giving them a lot of requirements that they have to meet prior to getting a place to live is really the key to everything. I used to see the same people for years and years on the street. Really, if someone had said to them, "We have a place for you to go. You have your own key. The requirement is that you pay rent and we see you twice a month," they wouldn't have been there for more than a week on the street, where I saw them year after year after year. Now I still keep in touch with folks from where I was working. A lot of these folks have died on the street. I am convinced, had they been given a place to live, they would be living now and would be cooking lunch for somebody in their apartment.

Tom Lorello

It must be extraordinary to go out there to talk to somebody, knowing that you have something real and concrete to offer them as opposed to a blanket and coffee. That must help to go out there with a little more hopeful attitude.

Sheryl Silver

Absolutely. A lot of folks don't quite believe it at first. They are looking for all the reasons why they shouldn't accept what you're offering, waiting for the catch. So it still takes the same skill that outreach workers have to have in terms of the engagement process. However, the engagement process doesn't need to take quite as long. You meet them one time and offer them something and then engagement happens while they're in their apartment and it continues like that. Engagement doesn't need to happen on the street for 3 months, 6 months, a year, and then you move to some kind of action. It's a very similar skill, but you're able to offer so much more.

Tom Lorello

When you are out on the street and you meet someone for the very first time, at what point do you offer housing? Is it literally, "Hello, I'm Sheryl. Do you want an apartment?"

Sheryl Silver

For the most part we have an idea of who we're going to be seeing. So yes, that's about it. We have a small housing stock, and if we don't have that housing stock available at the time, we have funds to put someone in the YMCA, if that's what they choose. Some people say, "No, I'll stay where I am for a few days." Then, as quickly as possible, we show them the actual place. Some folks don't want to leave their spot and they don't quite trust us enough initially to go look at the place, so we'll take a Polaroid® picture and show it to them wherever they are. Then they'll see it's for real and they'll come with us to see it in person.

So, yes, it can be a very speedy process if everything goes as planned. Within 2 weeks we can have someone in their own apartment.

Tom Lorello

Do you have in mind, or do any of our presenters have in mind, an example of someone you have housed? When I imagine this I just imagine it being a completely mind-boggling experience, to have people offer you blankets for years and then literally have somebody offer you an apartment and you move in. Can you describe what someone's reaction might be?

Housing First Challenges

Sheryl Silver

For many people it's very similar; it's complete disbelief that what you're offering is really what's going to happen. So there's a similar disbelief. Then it depends on who the person is. People have different levels of trust based on their own personal experiences within the system, or perhaps their psychiatric symptoms will allow for them to be more or less trusting of what you're saying.

There are folks who are ready right away and they say, “Let’s go” and that’s great. There are other people with whom you have to take a gentler approach. Really, the end result is the same, that we have folks in their places pretty quickly. Once they’re in their places, that’s when you really see who the person is and how they choose to set things up and how they choose to decorate things.

Even though we said earlier that it’s not always a bed of roses for folks, what happens is that people take ownership of their homes remarkably fast. Initially, there may be situations where people are taken advantage of by the local crack dealers or old friends who took advantage of them on the street and are going to take advantage of them again while they’re in their home. We have folks who call us and whisper on the phone, “Sheryl, you have to come over here and get these people out, but don’t let them know I’m telling you.” They want us to get these people out of their apartments and they want to save their homes in any way they can. We’ve come up with some creative stories on how to get folks out, and we’ll maneuver it so they’re not in the apartment when we go. Folks become so invested in keeping their homes.

There are times when the vultures in the neighborhood have gotten so bad that we’ve had to move somebody to a different apartment in the dark of night. Then we’ll move someone else into that apartment and go from there. In the majority of the situations where we have had to move people, it’s been because they have come to us and said, “I don’t want to lose my place. These folks have come in.” It’s amazing how quickly that happens.

Tom Lorello

Are there other types of challenges that people would need to be prepared for if they move to this model? I am aware of the fact that when we talk about this, sometimes it does sound like this is an easy thing to do. Having people take advantage of folks, that’s one challenge that you need to be prepared for. Are there others?

Sheryl Silver

It’s a lot of hard work. What we all talk about here on our team is that you have to love the people that you’re working with, and you have to really, really believe, as we all do, that anything is possible for them. That makes these really hard days seem not quite so difficult.

Again, we’re on call 24 hours a day, 7 days a week. We have folks who call us and ask us how to cook pork chops. You know what? That’s okay. They need someone to call and ask how to cook pork chops or whatever it is. Some people just call every night. The person on call knows to expect a call from Aaron every night at 7 p.m. because he just needs to check in and let us know how his day went. He’s been with us for probably about 2 months now. He actually isn’t calling every day anymore; he’s calling maybe four or five times a week. That’s what he needs to do and that’s okay because it’s keeping him in his place and keeping him feeling safe and good about where he is. He’s 42 years old and this is the first home he’s ever had. It’s important for him to let someone know how he’s doing.

I'd say it's time intensive. There's a lot of time and there's a lot of emotion that goes into it, but I guess I really don't think it's that much more in terms of time and emotion than when I was doing outreach on the street. It's just the positive emotion you get at the end of the day because you actually are leaving people in their apartments and not down by the river; it leaves you with quite a different feeling.

We're helping people stay housed as opposed to stay alive on the street.

Folks have said to me at different times and in different ways, "People were helping me get by before," and they are very indebted and they're very grateful for the help that they received on the street, but now they say, "I'm really living." When we ask them what they mean by that, they say, "I can go home at night. I can go home whenever I want, really. I can go home at 2 p.m. in the afternoon and take a nap if I want. I have a place to shower where I'm not around 60 other men. I can go to the bathroom behind a closed door and not have 20 other men watch me." These are important things.

Question and Answer Period

Q. Can someone address the issue of people without Axis 1 diagnoses but with major drug and alcohol addictions and their chances for the Housing First model? These folks tend not to be eligible for SSI. Do you take the leap of faith with these individuals, hoping that they'll stop their addiction and gain employment once they move into housing?

Sam Tsemberis

I think the New York program that's going to do a Housing First model is about to take exactly that leap of faith. Actually, in our own work there are somewhere around 15 percent of the people who are housed in the apartments who don't have an Axis 1 disorder that qualifies them for SSI. They may have a personality disorder or a substance abuse disorder that just doesn't qualify, but their behavior is such that they can't quite get it together and they've been street homeless for a long time.

What happens there at least in terms of the rental part is that public assistance in New York City pays something like $215 a month toward the rent directly to the landlord. Being able to afford to house them under this kind of a model works well.

I have not really found this group of people to be so different than people with severe mental illnesses. In fact, the severe mental illness is really code for the person who has SSI. That I understand. The person has SSI. Severe mental illness I actually don't understand because I'm very, very hard put to explain it. Fifty percent of the people in the program have something called schizophrenia, and you can look it up in the *DSM IV* but you cannot tell what symptoms will emerge or how the person will manage their apartment. Will they line up their books all in a row or sideways or will they be messy or neat? Will they call their family first or want a job first? This diagnosis tells you nothing really about the person.

Except for the economics of it, that the people on public assistance get $215 and the people on SSI get $640 and pay 30 percent of that, we haven't really noticed any appreciable differences in the outcomes.

Tom Lorello

So this is a population that you do have some experience with. You would say the leap of faith is worth it.

Ann Denton

I think also that it's all combined with different ways of believing the work should be done, and that includes harm reduction and motivational interviewing. When someone gets a place to live it equals the playing field. How can we expect people to make these incredible changes in their lives when they're living in such incredibly horrid situations?

By providing someone with a place to be, now the work can begin.

Sam Tsemberis

Two reasons why we didn't start that way is, one, everyone on the street we were dealing with was severely mentally ill. We were largely funded to do outreach through programs that were focused on people with severe mental illnesses. Two, to start a housing program where you don't have control or can't guarantee that the person is going to be able to pay 30 percent of the rent was too risky for me from a management perspective if we just went with the group that's on public assistance. They could be off it next week. It was, from a business perspective, risky. I still think that risk is there for people just starting out.

You can have 15 percent of 500 people, that's 75 people not on SSI, because you have a cushion of steady rent payers. To me, it's the business of it that makes me nervous about starting out with just the group who is not on SSI.

Tom Lorello

To me, I find the motivation issue very interesting. When we're providing outreach in a service system in which we don't have the capacity to give people direct, immediate access to housing, sometimes we call them unmotivated. They need to be prepared. We assume that we have to work somehow to build motivation. Somehow, people become much more motivated when we lower the barriers to getting into housing.

Sam Tsemberis

Absolutely. I think that treatment resistance, as it's sometimes called, *is* treatment resistance. It's resistance to being in treatment because people don't want treatment. They don't have

housing resistance. Housing resistance is not actually a barrier. If you offer people what they want, whether it's housing or some type of immediate services, this idea of resistance evaporates.

Tom Lorello

How would this model apply to families that are homeless?

Sam Tsemberis

I think it would be great for families. You'd have to have a slightly different ACT team, but families typically have much less in the way of clinical needs and much more in the way of support service needs. I think that it would be wonderful to put a single parent family with kids right into an apartment. I know they've actually tried this in Westchester. Heavy users of their shelter system were moved directly into scattered-site apartments. It works very well with families.

Sheryl Silver

I think, also, it's a big barrier to a lot of our folks who are on the street to access housing because they're in relationships with people. For some reason, we don't think people who are homeless and who have mental health conditions can have lovers or partners or children. So a lot of folks have a boyfriend or girlfriend and no one will take them in the program because of that. We have folks who have partners who are living together. It's pretty amazing what kind of homes they are able to make. My experience is that it works very, very well.

Tom Lorello

Would the funding mechanisms be any different for families?

Ann Denton

I don't think so. Maybe on the services side.

Sam Tsemberis

Definitely the ACT team would have to be modified. You wouldn't need such emphasis on mental health and substance abuse. You would need family systems, child development, vocational, and educational services, nurses, nutritionists, that kind of thing. You'd have to scale the services, and it's totally doable, actually, to a team that represents the needs of the new population.

Sheryl Silver

We had a young man in his 20s who just couldn't imagine living anyplace without his mother. So we were able to get them a two-bedroom apartment. She doesn't receive any of our clinical services, but she contributes toward the rent. They're doing very, very well.

Q. What has been your chief strategy for creating jobs or accessing jobs? What has your success rate been?

Sam Tsemberis

We started with jobs very early on in the program because people were housed and immediately wanted something to do. As the agency has grown, we've grown positions that are filled by consumers, either directly on the team or if we have a vacancy for an administrative assistant or a messenger or accounting clerk, whatever the skill level, we try to hire people right from the program. We do employ about 15 percent of the people we house in our program.

Then we have recently participated in a supported employment model where we have a person in charge of supported employment and a job developer on each of our six ACT teams who consults with individuals to get people jobs in the community. We place a huge emphasis on employment. In hindsight, we could have done better but we're very focused on what happens now.

One of the conversations going on here is, "What happens to outreach when you have a Housing First model?" I would say when the agency decides to do Housing First, the outreach workers become part of the ACT team. Then the services very quickly would have to focus on this issue of vocational and educational services because that's what people want next. People who are living on $640 a month are still living in incredible poverty. There's very, very high motivation to get some work just to make a little more money. I think that we're trying harder to get more people employed in the community.

Tom Lorello

Do you raise the issue of jobs in the same way that you would housing, when you're on the street, or is that generally something that comes up after people are housed?

Sam Tsemberis

First of all, we never accept no for an answer when the person is homeless. People have been told for years, "Come with me and I'll get you housing, because I know that's what you want," and then it's used in this coercive way, like, "First you have to see the psychiatrist and then you have to do this." When we go and say, "Come with me, we'll get you housing," they may say, "Yeah, yeah, I've heard that before."

After people are housed they'll say, "I need something to do," so the motivation does come from them. If it doesn't, we will suggest it in the same way that we go back to the person on the street and don't take no for an answer. We really mean it about the housing. Then we say, "Do you want to do something? We can help you with that. Whatever it is you want to do, we can help you with that."

It is an interactive relationship, where you're raising the person's hope and expectations for themselves. People have sometimes been in the system a long time. They've been told they have a mental illness and they can't do anything, just take medication and be quiet and don't bother the staff. This is really the only message they've been getting, especially if they are an inpatient. So now you're telling them, "You could live in the community, you could see your family, you could have a job." That's a lot of what the motivational interviewing is about.

Tom Lorello

Would you think a similar principal applies to jobs as is true of housing? In other words, immediate access without a lot of preparation and jumping through hoops is what works with housing. Would you see a similar principal applying to jobs?

Sam Tsemberis

The only vocational assessment question we use is, "Would you like to work?" If the person says yes, then we say, "Where?" and try to help them to find whatever job they're trying to find.

Tom Lorello

It's not necessarily months of preparing for jobs? It's right into real jobs?

Sam Tsemberis

Yes, absolutely. It's totally real jobs, just like it's real apartments.

Q. Are you requiring a representative payee for people to enter housing?

Sam Tsemberis

For the rent, yes.

Q. What amazes me about that is I work as a PATH provider and if there's one thing people hold precious, it's control of their money. How do you manage to have people give you that control?

Sam Tsemberis

When the person gets an apartment, they know they have to pay rent. That's a reality. I think it's hard to get a payeeship when there's nothing being offered. You want control of their money, but for what? So the "for what" we're able to offer is to say to people, "We're going to be paying the bulk of the rent on this apartment, but we have to make sure that your 30 percent is paid. This is the best way we have figured out how to do that." They do have control of the rest of their money. We're not controlling all of their money; we're controlling just that 30 percent. If the person manages well we give them the rest of the money back. It's just a smaller percentage after the rent is taken out.

Q. We've tried that. I guess people are extremely reluctant. We do a Housing First approach, and we do not require payeeship because we have found that people would choose to live in the street versus tell you where their bank is.

Sheryl Silver

I think that Sam would probably agree that this issue is not a deal breaker. Right now, on our team, we have a few people for whom we are not a payee. They're actually, in many cases, better with their money than most of us are with ours.

The goal, of course, even when we become their representative payee from the beginning, is to have that responsibility returned to them. I think the conversations really start with the folks who do not have a payee because most of the folks who come to us who have had SSI already have a payee, so it's just a matter of transferring payeeship. For those who did not have a payee, the conversation goes like this: "We'll agree to a certain amount of money that you'll give us each month in a money order. That will cover your rent. If you'd like, we can also pay the bills out of that money. The rest of the money you keep. As long as you give us that money order and the rent is paid and the utilities are paid, then I'm good. The less money I have to control the better."

Sam Tsemberis

It is applied individually. It's not a deal breaker. We request it, but if the person is too suspicious to sign forms, we'll house them and work later to figure it out.

Q. I'm from Contra Costa County in Martinez, California, and we have one of the Interagency Council on Homelessness grants. A couple of questions we have are regarding the Public Housing Authority. First, you mentioned that for the Section 8 list, the Housing Authority can make a preference for our folks. We tried to work with our Housing Authority to identify our population as a preference and they refuse to do that. We're interested in how you've done that.

Second, you mentioned that you house people in 2 week's time, which means that somehow your Housing Authority is processing them pretty quickly. We're housing people in a 60-day period. We're wondering how you're able to do that.

Sam Tsemberis

I can answer the second part of that. We have some people on Section 8, but most of the people we have are either Shelter Plus Care or supported housing dollars. That's much quicker than Section 8. When we've had the vouchers, the agency pays the rent until the voucher gets processed. When you put in your Interagency Council grant, was that with the Section 8 vouchers as the rent piece?

Q. No, it's not. It's actually Shelter Plus Care. I agree with you that Shelter Plus Care is the typical way to go. However, what we're trying to do is alleviate the bottleneck for people we have in Shelter Plus Care over the years who don't need the intensive services anymore. We'd like to move them into Section 8, thereby opening up Shelter Plus Care vouchers for other people who will be coming in off the streets and who will need the more intensive services, but our Housing Authority refuses to create a preference for that. They said that their list is closed and they would have to reopen the entire list again.

Sam Tsemberis

It would have to come from a commissioner or other top level person. It would have to be a policy decision. You'd have to persuade someone to make them do it.

Q. In fact, we actually met with our HUD CPD department and Public Housing Department to see if we could move it that way, and there was absolutely no movement at all. I was curious to see whether you had some magic.

Sam Tsemberis

No, no magic.

Ann Denton

I think that there are going to be some Public Housing Authorities who simply will not play. You're right, HUD has traditionally taken the stance of not making them do that. It sounds like you've done everything you can. Because Shelter Plus Care is 5 years of assistance, if people get on those lists, by the end of 5 years many of them should have transitioned to Section 8. Even people who have closed lists occasionally open them. Five years is a pretty long time. You should be able to get some people on the Section 8 list.

I would say the other alternative for communities that have a Housing Authority that cannot or will not play is the HOME funds—look at tenant-based rental assistance under HOME. That counts. In the Continuum of Care planning they're really pushing communities who transition

people to mainstream resources. It's yet another bridge subsidy because it only lasts for 24 months, but it's a way to get people into mainstream services and it helps with your continuum planning.

Q. I have one more question. Most of our funding is from the Federal government, and we can't use Federal dollars for the Medicaid match. How do you put the whole grouping of dollars together, where you use Medicaid but you have match dollars that are non-Federal?

Sam Tsemberis

That's difficult for me to answer. The way I understood the Interagency Council application was that the SAMHSA share was contract funded to pay for your services. Over time, in the 3 years of that grant, you would be enrolling more and more people into your Medicaid provider program. The SAMHSA funds would be pretty much spent down by the end of year 3, but at that time everybody would be receiving and being paid for services under Medicaid.

It's like a transition that they're offering you. It doesn't matter if they overlap Federal funds to Federal funds because those were the terms of the agreements.

Q. Yes, that's true for that program. However, we are looking at the people who are Shelter Plus Care housed now who are not part of this new grant, because there are about 200 vouchers out there for people who are not part of the Interagency Council grant. We have been receiving services in the past from State funds, which are all going away as of June of this year. Some of our Federal PATH funds are some of the dollars that are going away, also.

So we're moving toward more of a system of using Medicaid as our billing source for services. However, trying to find a match is difficult because again, the dollars that we do have are through HUD McKinney-Vento, which are Federal dollars, and you can't use that as match. I was wondering what you were doing for your match.

Sam Tsemberis

I think Medicaid plays out differently State-by-State. Our ACT teams are funded by Medicaid so we don't have these issues.

Q. We have the housing for the folks that are not in this new chronic homeless initiative, but we don't have services anymore. How do you pay for services?

Sam Tsemberis

In the past we've had contract-funded services through the local Department of Mental Health (DMH), the State Office of Mental Health (OMH), and HUD. We've used a kind of mosaic of funding sources so that we have a coherent ACT team, but this has been an accounting nightmare because when they come to audit they want to know which clients are the DMH clients and which are OMH and which are HUD.

Leaving that aside, this year the State is licensing ACT teams and we're going to be billing Medicaid for the ACT services. It's a transition to that funding source.

Q. You've mentioned that the optimal housing is scattered site.

Sam Tsemberis

Let me correct that. The optimal housing is the housing the consumer wants. That's the optimal housing. It just so happens that about 95 percent of the people we work with want a place of their own that is best described as the scattered-site supported model.

Q. My question is related to the impossible housing market. What is your view of providers getting into development of housing? Would that then be better off being mixed housing?

Sam Tsemberis

There are so many things that have to be done around the issue of housing. I think that in terms of getting people off the street, we can always find apartments to rent for a small number of people. In terms of a real solution to homelessness overall, we're going to have to have quite a few strategies going on at the same time, including refurbishing of buildings and building new buildings. Because of the recovery focus and trying to get people what they want, I personally would not build more SROs. To me, from the consumer's perspective, they are mini-institutionalized settings in the neighborhood.

I like the models that come out of Boston and other cities, where regular affordable housing is built, and they put together a percentage of those units, let's say 20 percent or 15 percent, for people with special needs. You could offer tax breaks with that, but you'd need multiple strategies, I would think, to really address the big issue of homelessness. For the street-to-apartment kind of approach, there's always a few apartments that you can rent. Landlords like renting from programs because they know the rent is going to be paid on time.

Q. I have a question with two parts. I want to know how you were able to get around the crime-free neighborhood dilemma. Who covers the utility deposit costs for those apartments? When the word got out about the Housing First, how did you handle the overload of people coming in just for the housing?

Sam Tsemberis

Those are very good questions. First, about the NIMBY issue, because it's scattered-site apartments we don't have to go to the block association or to the community board meetings and say, "We're going to rent an apartment in your neighborhood and it's going to be inhabited by someone who has a disability." We just go and rent the apartment. There's no clearance or announcement required in any particular neighborhood. This is off the radar screen of the usual procedural things that get constituents' attention.

All of the deposits, including the rent deposits and often the broker's fee and utility costs—we call that set-up for the apartment—is paid for by the agency. We anticipate paying that and we have requests in our rental contract to have that available for people because there's no way somebody with no money is going to be able to afford that. You have to build that into your start-up costs, including the costs for furniture and the security deposit, which are really the bigger costs.

Sheryl Silver

It also takes quite a bit of creativity with the utility companies, the phone companies and the like. You sometimes have to go up the ladder and speak to supervisor after supervisor, but one little letter oftentimes gets deposits waived very quickly if you get to the right person. So I think all of us team leaders and office managers have gotten very creative with the utility companies and with the language that we speak in terms of getting things waived and not having to pay full fees for installation and other services.

Sam Tsemberis

You're doing things on volume. You do develop relationships with everybody, whether it's the phone company or Consolidated Edison here. At the furniture store, you can get better deals if you buy in bulk.

The third part of your question was about the people who want the housing only. It would be wonderful if we could just offer everyone who was homeless a place, but at the outreach level we do select people who have severe mental illnesses because that's what our funding is for. We know ahead of time that the person meets the criteria from those street outreach interviews.

Ann Denton

If you have a flood of people with serious mental illnesses approaching you for services and housing because they've heard about the housing, that's a good thing.

Sam Tsemberis

That's not the problem. The problem is you don't have enough apartments and it's hard to keep a waiting list in programs like this. You soon become like Section 8 because the need is so high. The way we do it is whenever there's an open unit we contact the outreach team or the drop-in center where we work and say, "Do you have somebody that's been difficult to place and has been homeless for a long time? We have an opening." We go around town on our list that way and take the next neediest person.

If we don't have a unit available we say we're filled. We tried a couple of years ago keeping a list, but then we had quickly 1,000 people on the list. It was like Section 8. It didn't make any sense and it's very hard to recontact people. Now, we contact the outreach teams when we have an opening.

Q. One more question, Sam. How do you handle people who just refuse to pay their rent? How much time would you allot them to decide to do so?

Sam Tsemberis

Well, it depends on their reason. Is it because the person doesn't have SSI yet and is waiting for that?

Q. No, they have their SSI but they need clothes.

Sam Tsemberis

There is an agreement up front that 30 percent of the SSI goes to paying the rent. Usually that's done through a payeeship. Even if we don't have the payeeship, that's the deal. If the person somehow just isn't doing it, we're not the landlord. We rent the apartment. The landlord notices will start to come because the rent is going to be short since we only pay 70 percent of the rent. The person is going to be facing a choice there. Either they pay the 30 percent or the landlord is going to take them to court.

Q. How often are you using the payeeship?

Sam Tsemberis

We're using the payeeship quite a lot, about 70 percent or 80 percent of the time. There's no practical way to collect rent from a scattered-site program like this without the payeeship. The payeeship comes to a client account, direct deposit, 30 percent gets taken out, and then checks are issued for the remainder to the clients right there. There are logistical and practical problems. In addition to things like refusal, that's not so frequent, the more compelling reason to me is the administrative burden. We can't collect that many rents from scattered-site apartments in time to pay the rent on time.
Sheryl Silver

This is also another good example of where relationships are very helpful. We have on my team now, for example, one woman who keeps appealing our decision to be her payee. We've gone back and forth with her a few times. Now we've gotten to a supervisor at the local Social Security office who suggested we write a letter because this woman is at risk of eviction. They're going to allow the payeeship, and they're not going to follow through with an appeal because it could go on forever this way. We haven't been able to collect rent from her. So that's another way to go about it, just developing these relationships with people and trying to listen to what they know about how we can make things happen.

Q. My question has two parts. One, how do you bridge the gap for a person who is on the street and in need of housing when you don't have housing stock available? Second, if you require a payeeship, you're going to screen out a number of people who aren't willing to consent. We run a scattered-site Shelter Plus Care program and what we do is get the person involved in the program. Then, if they have trouble paying their portion of the rent or they are not willing or able to take care of their own finances, we apply for payeeship. The Social Security Administration will typically mandate it.

Sam Tsemberis

Well, it's a different way of doing it, and I think that's great. What we do for the gap part is not offer someone housing unless we have a unit available or the funding for a unit available. Let's say we have no unit but the funding available. Once the person agrees to participate in the program, we would take them right off the street and then put them in an interim place, either a nearby hotel or a YMCA or something like that. It usually takes 2 weeks to find an apartment, so we would pay for that emergency placement.

Q. I see. Do you use Safe Havens at all?

Sam Tsemberis

No, we don't do any transitional housing. Paying a couple of weeks of rent in a YMCA is the closest we come; most of the time we typically have an apartment in stock

Sheryl Silver

You said we must be screening out a lot of people out because of the payee issue, and that's actually not true. I've been with Pathways for 3 years and we haven't screened anyone out in the time that I've been here because they said that they didn't want us to be their payee. As I said, we really try to be creative and not let anything be a deal breaker. It really isn't that many people who say, "No, absolutely not."

Sam Tsemberis

You have to consider that most people we deal with on the street have had many offers. This is the typical offer they get: "If you come with me (this is offer A), we'll get some coffee, we'll talk, you'll see the psychiatrist, and we'll get you a sandwich. You'll take a little medication, stay in our drop-in for a while, get sobered up, get cleaned up, and we'll think about housing. In a year or two, no problem." Then they say, "Okay, I'll think about it."

Or, at the housing end, you have finally made it a year later; you're at your housing interview. "Are you on medication? How long have you been clean and sober? These are the curfews. This is your little room here. No overnight guests. No pets. No dates. No this, no that. Participate in this. Sign here." The person says, "I'll try," if they even get that far.

Option B is this: "You're on the street. I'll tell you what, I'll give you a furnished apartment of your own with people to support you, to help you get it all organized and get your life back together. You have to just sign this payeeship here. That's the deal." People are smart shoppers. Even though we recognize that's an enormous trusting thing for them to do, to sign over control of their money, what they're getting in return is not insignificant to them.

Q. I think your model is excellent. We've experienced the same thing. Being able to offer somebody an apartment with no strings attached or minimal strings really works. It's helped us engage some of the most difficult people, some of the people who are absolutely unwilling to participate in any other services, but we've put a roof over their head and we're able to monitor them.

Q. I've managed a number of Shelter Plus Care grants here in Raleigh, North Carolina. I'm assuming that since you're using the Shelter Plus Care subsidies the lease is between the tenant and the landlord, not between the agency and the landlord. Is that correct?

Sam Tsemberis

We have a lot of different types of arrangements. Sometimes the vouchers are between the tenant and the landlord because it's a voucher. Sometimes the tenant holds their own lease. Other times we hold the lease and we sublease to the tenant. Sometimes we sign as the guarantor. It depends on the comfort level of the tenant, us, and the landlord.

Q. In our program, our agency will not lease units. It has to be between the tenant and the landlord. In situations like that, do you have a pool of landlords, and do they screen your applicants?

Sam Tsemberis

Yes, we do have a pool of landlords, but they don't screen our tenants. We've been doing this a while. We have 115 landlords for these 450 apartments. It's the burden and the blessing of

scattered-site; you get to know a lot of people. I think it's hard to do this if your agency isn't willing to step out and take a risk.

Remember, this is not a clinic program. This is not a supportive housing program where you have a guard at the door. This is a program for which everybody has to be willing to step out and take a risk and say, "I believe in people and I'm going to take a chance on them."

That doesn't have to be your outreach worker or your case manager who has the least authority. That has to be your board of directors and your CEO, and everybody down the line has to understand that we're doing something different. You can't take a risk without relinquishing some control, and therefore increasing your liability. You have to do that. I'm telling you it works well, but each agency and each program has to come to that on their own. If you're not willing to sign a lease for people and back them either as a guarantor or sign a lease directly, that's actually a hindrance to you.

Q. Do your landlords sometimes lease these apartments without ever seeing the person who will reside in them?

Sam Tsemberis

Yes, but not always. It depends on how far away the landlord is. Sometimes their broker does it. People understand that we're an agency that helps people get housing. That's about all they understand about us, although if the landlord is nearby, they know that the person maybe has special needs. The 24/7 number that we give tenants is also given to the super or the landlord, whomever is nearby. You want people supporting your efforts. You don't want to sneak people in. That's the other thing about being on the lease. Your agency is also responsible for that apartment. You are paying the majority of the rent. So even though you may not want to sign the lease as the rent payer, you are implicitly responsible because you're paying the bulk of the rent. When you sign the lease, the landlord becomes your ally and helps you when there's an issue in the apartment. The team isn't there all the time, but the super can call you when there's a problem.

Q. I totally agree. I have two more quick questions. My experience with our Shelter Plus Care program has been that most people take care of the apartments and themselves. We do have a few individuals, though, who are so ill their hygiene is very, very problematic and has even precluded hotels from being willing to take them in. Have you successfully used the Housing First model with individuals of that nature? Does the landlord do inspections?

Sam Tsemberis

Yes, we have been successful with these individuals. Here's the sneakier part of the business: When we have to move the woman in from Broadway who's staying on the street, and the only way she's going to move is if she brings her tent into the apartment and sets it up in the living

room, we won't take her to a building that has a landlord on site. We'll take her to a building with an absentee landlord.

Even within your own system of renting apartments, you'll have landlords who are more tolerant. Do you know what happened to that woman, by the way? In a very short time she got rid of the tent and she thought it was a terrible apartment, why did we move her in there? She moved to a much nicer place.

Q. Is there a way to use Emergency Shelter Grant funds to create a Housing First program?

Ann Denton

I don't think so. Based on the allowable activities, you could use ESG to do homelessness prevention, which will allow you to do some creative things under that category.

Sam Tsemberis

Right, like putting people in apartments.

Q. I know that homelessness prevention can only be 30 percent of your funds, right? But it does allow you to pay operating costs for transitional housing.

Sam Tsemberis

Everybody is in transitional housing until they get their Section 8 voucher. It might take 10 years.

Q. Do you think it would work to use ESG funds for this purpose?

Ann Denton

I think it's worth a try. It's a little outside what they intend, but you might be able to be creative, as Sam said.

Q. We are a PATH provider in Nevada. When moving from a traditional outreach activity to a Housing First policy, how does it impact caseloads and workloads of the outreach workers?

Sam Tsemberis

That's a very good question. The caseload of the Assertive Community Treatment team is typically one caseworker to 10 clients; they recommend one to 10 or maybe one to 12 because of all the travel and the intensity of the work of getting people hooked up with all these services after they're housed. The work of outreach is just a few weeks and then the person is housed. That same worker starts doing all the recovery-focused work. Caseloads in outreach are infinite,

right? It's like you "outreach" everybody in the community because sometimes they show and sometimes they don't.

The difference is that once they're in the Housing First ACT team, the relationship is permanent. You work with these people all the time. The team works together. In Sheryl's case there are about seven to eight people on the team, including the administrative assistant, and they serve about 70 people. That's a one to 10 caseload. I would say the minimum number of people you want is 50, but you can go anywhere between 50 and 100 and scale up your staffing to represent a one to 10 ratio. One to 10 would be your rule of thumb.

Q. Have you had difficulty finding apartments for individuals with histories of arson or sex offenses? How do you handle folks who property owners do not wish to lease to?

Sam Tsemberis

Let's say you look at the arson history and the kid was 13 when he set the garbage on fire, and it follows him in his clinical record forever. I wouldn't worry about that. If the person is a real fire setter, time after time, and it's not related to interpersonal issues, look at what it really means and make the judgment from there.

Q. I'm curious about the President's budget for Section 8 vouchers in 2005. I understand that some cuts are proposed and there are efforts nationally to try to advocate a course for reinstating vouchers across the country. Does anyone have any additional information about that or other actions that we may want to take relative to Section 8?

Ann Denton

I think you have the most up-to-date information on that. I think it's going to take a determined effort, I have a lot of faith in the people in Washington who are carrying that fight for us. If anybody can do it, I think they can. It sounds ominous, but we've seen a lot of fights over Section 8 over the years. The historical pattern is that over time our Section 8 has gradually increased.

Q. Within your ACT team, how much psychiatry time do you allocate to your participants in the program? Do you have it figured on a ratio?

Sam Tsemberis

It is a ratio. It's one FTE for every 100 clients. If you're serving 50, it would be a half-time person. If anyone would like more information on this or any of the topics we've discussed, they can send an email to me at tsemberis@pathwaystohousing.org. Our website is www.pathwaystohousing.org.

Closing Remarks

Tom Lorello

Thank you very much, Sam. Special thanks to Margaret Lassiter and our colleagues at Policy Research Associates and also to Dr. Michael Hutner at the Center for Mental Health Services. Thank you so much, Sam, Sheryl, and Ann, for your presentations. This concludes today's national presentation. Thank you all for participating.