

Here's a piece on homelessness and Boston's fledgling Housing First initiative to try to end it, that I wrote in the autumn of '06, that never found a home. I wanted to at least post it here, as a small way to pay tribute to all those involved in the Housing First project who helped me with the piece.

If you find it interesting, feel free to clue your friends and colleagues in and link to it. The topic is timely, and these folks deserve all the support we can give them.

The names of all of BHCHP's Housing First clients have been changed to protect their identities.

*Mike Mennonno
mmennonno@yahoo.com*

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Joe Finn is a fighter. The director of the Massachusetts Housing and Shelter Alliance (MHSA) is a former Franciscan who's been in the trenches fighting homelessness in Boston for fifteen years. Finn advocates for over 80 agencies statewide serving the Commonwealth's growing homeless population. Boston's 2005 Homeless Census identified 6,365 homeless men, women and children, an increase of almost 10% over the previous year. MHSA's mission, simply stated, is to end homelessness for single adults in Massachusetts. Finn believes it can be done, and that Housing First is the way. And when he says "believe," you'd better believe.

The data on the health of the homeless is shocking. Mortality rates are 3.5 – 4 times higher than the general population. The homeless are also hospitalized five times as often. The leading cause of death is homicide, followed by AIDS, heart disease, and cancer. It's a crisis the health care community has been more or less helpless to address, as Dr. Jessie Gaeta of MHSA and Boston Health Care for the Homeless Program (BHCHP) points out, because the lack of housing makes effective health care impossible.

Over a five-year period, a BHCHP team followed 119 of Boston's chronically homeless "rough sleepers"—those who "diligently avoid shelters," preferring to stay outside instead. The medical and human costs were astronomical. The cohort accounted for 18,383 emergency room visits, and 871 medical hospitalizations. The total cost of health care for the group was \$12.7 million. Still, 30 percent of the cohort died on the streets. As Dr. Gaeta states, emergency shelter is obviously "not an effective policy strategy." Something clearly had to change.

The sticky spring day I visited MHSA, Joe Finn was fielding phone calls left and right about the budget negotiations going on at the State House, fighting hard for funding for Housing First initiatives. The outcome was good. He was able to win \$600,000 for housing pilots, with which MHSA hopes to provide 130 units

statewide to house the chronically homeless.

It's not hard to see why Finn is the one lobbying the legislature on the issue. He is immediately likeable, with a self-deprecating sense of humor, but when it comes to discussing the issues near and dear to his heart, there is an unavoidable moral gravity to him. In contrast to the often clinical language of social services, Finn lets fly with phrases like "institutional evil" and "moral surd." He told me that his aggressive advocacy of the Housing First solution is a matter of "intellectual honesty" for him. "I don't want to participate in another cliché like 'continuum of care,'" he says. "This is the real deal."

Housing First turns the old way of dealing with homelessness on its head by placing clients into leased, independent apartments in integrated communities as the first step in the rehabilitation process. From a stable setting they can then access healthcare and social service providers. That means fewer, if any, emergency room visits or extended hospital stays. It means consistent and effective substance abuse treatment. It means the eventual possibility of vocational training, and at least the hope, however far off, of a degree of self-sufficiency, and the self-respect that accompanies it.

And Joe Finn and his colleagues at MHSA are by no means the only ones who think this model could prove the beginning of the end of homelessness as we know it. In fact, Housing First is a bona fide mainstream movement. With support from the Bush Administration, over 200 cities have launched 10-year plans aimed at ending chronic homelessness. In more than 20 cities, from New York to San Francisco, a Housing First model is being tested. Initial results have been impressive. New York's homeless population reportedly fell 13 percent in 2005. In San Francisco implementation of the Housing First model was a major factor in a reported 28 percent drop in the homeless population.

But as logical as it seems to get those most at risk off the streets and in a stable environment where mental health and substance abuse issues can be dealt with, a paradigm shift has been a long time coming, and may still be a long way off. Finn describes the current system as "compliance-based." A client must deal with his substance abuse before securing housing, and housing can be revoked if he relapses. The first hurdle is often impossible to clear. For many of the chronically homeless, this means a vicious cycle with no end in sight, which often leads to a spiral of despair exacerbating their mental health and substance abuse problems. As Finn puts it: "The crisis of homelessness does not allow anyone the leisure to think about giving up their addiction." For healthcare professionals and social workers the status quo has been no less frustrating. Unable to stabilize their homeless clients' conditions for any length of time, they're often relegated to offering emergency services with little hope of promoting preventative care.

One of the biggest surprises of the Housing First movement is the political momentum it has gained. Providing long-term housing at no cost to clients

seems an especially bitter pill for conservatives, however compassionate, to swallow. Former head of MHSA, Philip Mangano, now director of the US Interagency Council on Homelessness, which is spearheading the administration's effort to end homelessness, deserves credit for convincing conservatives by embracing a faith-based rhetoric that has likened the struggle to end homelessness with the Abolition movement, whose proponents he compares to modern-day Evangelicals, with their "biblical notions of the dignity of every person."

But what helped Mangano's case immeasurably, making a new housing paradigm politically palatable, was the research of Dennis Culhane, a Boston College grad and University of Pennsylvania professor, and the author of a groundbreaking study that tracked 4,679 homeless people with Severe Mental Illness for seven years. His study was vast, thorough, and his findings incontrovertible. Housing the chronically homeless and providing them with support and preventative care was actually cheaper than leaving them to fend for themselves. The paper had an immediate impact on policymakers nationwide who saw that most rare of things: a politically palatable solution to an intractable social ill. This was a win-win. The Administration's ten-year plan to end homelessness would serve as the cornerstone of compassionate conservatism, a monumental legacy of the Bush domestic policy, if they could pull it off.

Initially there was considerable skepticism among those who had been battling homelessness in the trenches for years, not that Culhane's research was accurate, but that it was applicable. Tom Lorello, of Cambridge's Shelter, Inc., an organization headed by Joe Finn before him, was doubtful at first that Boston and the tri-city area could benefit from a Housing First model. "I visited a couple places that were doing it," he told me. "And I was skeptical. I thought, this doesn't make sense. And I was also very aware that sometimes there's a big difference between research results and what really happens on the ground. I just had this suspicion that there was something about the research study that was done in New York that was somehow different from what we would all see." But the closer he looked, the more convinced he became that a Housing First model could succeed. Shelter, Inc. now has sixty clients in its Housing First program.

He admits that it's still difficult for many people to accept aspects of the model. "One of the major debates is, are you really helping anybody by doing this for them? First of all, what's the message, responsibility-wise, that somebody just gets given something that most people have to work for? And it's not just in the community, it's in us. But I loved the idea, and what I loved about it was that it was working."

Joe Finn couldn't agree more. "What makes this so exciting now is that I've been around homelessness in Massachusetts for fifteen years, and this is the first time I can remember where people are really looking seriously at having some kind of real outcome. That in itself is a significant accomplishment."

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If Joe Finn and Tom Lorello are warriors, Dr. Jim O'Connell, President of the Boston Health Care for the Homeless Program (BHCHP), is a saint. O'Connell, a tall, soft-spoken man, who exudes an infinite patience and fortitude, is at the forefront and on the frontline of health care for the homeless in Boston. I visited him recently as he was wrapping up his walk-in street clinic, which he runs out of Mass General every Thursday with Dr. Pat Perri.

While the government bureaucracy seems to just be finding out, O'Connell has known the importance of preventative healthcare for the homeless all along. His mantra is "housing first based on health care." His partner, Dr. Perri, says the switch from an urgent care to a primary care model, while an enormous undertaking, is the only way to improve outcomes. "Previously the homeless were using the health care system for survival," he says. Now the task is to build a relationship with the patient, "to move from old-school case management to a more intimate partnership."

Outreach is a vital part of the program. "psychologically, for us to go to them enables them," O'Connell says. A couple days a week, he and Perri meet up with case workers and physician's assistants, sometimes psychiatrists and advocates, too, visiting clients in the Housing First program at home, and homeless people on the streets and in public parks along the way.

Because the program is currently "scattered-site," housing clients in individual apartments in Back Bay, Quincy, Jamaica Plain, and elsewhere, with vouchers, O'Connell and his crew spend a good deal of time in transit, which he readily admits is not the best use of scarce resources. Money is a major issue.

"We know the cost of the housing," O'Connell says, "but no one yet really understands the cost of the services. The time involved is really remarkable, because these are people with varying skills—many have no living skills whatsoever...leaving the gas on on the stove. It's taken a huge amount of work, the housing stabilization issues, and then there's all the clinical issues, what's going on with their substance abuse and medical problems."

O'Connell's frustration with the scattered-site mandate is just another of these daily hurdles. "[BHCHP] got asked to look at a particular group of people—can you house them with a particular model of housing, which is vouchers, go out and find a landlord somewhere. That was not what we created. It's what we got asked to do. But one type of housing doesn't fit." He pauses. "Of course, having any options in housing is a luxury."

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I join Dr. Perri and Physician's Assistant Jill Roncarati on a rainy Friday morning in May. We meet up with Jesse Auth, a Housing First case worker from

HomeStart, an organization dedicated in part to finding permanent housing for the homeless, who joins Roncarati regularly for client visits. They are all dressed for extreme weather, like seasoned hikers on an expedition.

We make our way from Chinatown, across the Common, and through the Boston Public Garden, where Perri spots a woman he recognizes dragging two enormous suitcases behind her in the downpour. They greet each other like old friends. After a few routine questions about her health and medications, Perri digs into his backpack and pulls out a bundle of Dunkin Donuts gift cards, handing her one so that she can get out of the rain and have a hot cup of coffee.

On Commonwealth Ave., Perri encounters another of his regulars pushing a shopping cart filled with neat bundles wrapped in bright-colored plastic bags. He has been looking for her lately, and bounds across Arlington Street to catch up to her. A psychiatrist who has come along runs after him.

Roncarati, Auth, and I walk on to Marlboro Street, where one of the Housing First units is. We are supposed to visit the latest client to be housed through Boston's Housing First program. But he has been aloof since being assigned his studio apartment, and has not returned Auth's phone calls for a couple of days. He is not at home when we drop in, and Auth leaves a note, and says he will look for him again come Monday.

The challenges of BHCHP's mandate are daunting. Some potential candidates for housing have mental conditions that make them reluctant to accept BHCHP's offer. Others, when they are housed, have no social network in their new neighborhoods, and return to their old stomping grounds, where bad habits persist. "The one thing that's missing for them," O'Connell says, "is if they could build some kind of community outside of the home—if they had friends in the community that weren't homeless, that also were sober, or didn't have substance abuse issues, so that they could be active participants in society."

O'Connell sees loneliness as a serious issue that Housing First can't always address. "They get their own place, they're thrilled to have that room and the bed, although they often sleep on the couch, and that lasts about a week or so, and then they get profoundly lonely, and, 'what am I living for?' Because they have no community and no job, so I think the challenge ahead of us is how do you get people to feel a vibrant part of something?"

Work is seldom an option, either. In fact, many can't work because of their medical conditions, and those who might be able to risk losing their housing status if they do.

When I asked Joe Finn about this, he acknowledged both the difficulties of disabilities for clients, and the PR problem Housing First programs might have on account of them. "It's critical in our culture today to talk about people improving,

reaching self-sufficiency and independence. Those are all key, critical things. Believe me, I think those are ideals to strive for as well. But I think the other thing that we have to be honest about is that we have to recognize that a significant segment of the population will never really fully obtain that level of economic independence. One, because of severe mental health issues. Two, because of organic or physical damage, that's either the cause or the product of their homelessness. So, we have to ask ourselves: what's the best way of dealing with this segment of our culture? Is it to confine them to the streets and shelters for eternity?"

Roncarati knows firsthand what an uphill battle self-sufficiency is. She, like her colleagues, remains focused on creating and maintaining relationships. "You can't just plunk somebody down in independent living. You need to have time to show them how to cope with whatever comes along, or just to do the day-to-day things they haven't been doing for thirty years."

And that's where Auth and HomeStart come in. Not only do they locate housing for their clients, accompanying them to interviews with potential landlords, but once they are in housing, Auth and his fellow case managers troubleshoot everything from where to wrangle up furniture to where to (and more importantly not to) plug in the coffeemaker, how to use a phone other than a pay phone, and how to shop for day-to-day staples other than cigarettes. The list of life skills can be very long, indeed, and often includes basic things those of us who haven't been on the street for decades take for granted.

Auth says housing itself can sometimes prove frighteningly overwhelming for clients. He says he often has a tough time convincing them that being in housing is not only about challenges but also about new possibilities. He tries to show them, "here, this is what you can do. It's not as limited as being in a shelter or on the street."

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Currently there are ten clients, a tiny portion of Boston's chronically homeless population, being served by the BHCHP housing first pilot. BHCHP's clients are the hardest of the hard-luck cases, high utilizers of the emergency rooms, some averaging, by O'Connell's count, over fifty trips to the emergency room per year, at a cost to taxpayers of between \$3,000 and \$10,000 a visit. The challenges faced by O'Connell and his staff are unique.

"Most Housing First programs have looked at mental health primarily," he says. "But we're now looking at heavy duty medical problems complicated by substance abuse and mental health, and those are uncharted waters."

The program is still in its infancy--the first of BHCHP's clients were housed in the summer of 2005--but already O'Connell has learned a lot. "I'm really surprised that after nine months all ten are still in housing. I've been also stunned about

how poor we were at predicting who was going to do well, and who wasn't going to do well. You have to toss out your usual prejudices completely."

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When I next meet up with Roncarati, it's sunny and in the seventies. Her rounds today take her to North Quincy, and she's joined by another case worker from HomeStart, Katie Aliberti.

Before visiting their clients, three of whom are housed in separate apartments in the same building, Aliberti asks Roncarati to drop by the supermarket so that she can pick up some provisions for one of the clients we're about to see. Once there Roncarati heads to the pharmacy to get a prescription for smoking patches filled. They discuss whether the client the patches are for has been adequately briefed on the dangers of wearing the patch while smoking. They both agree it would be a good idea to mention it as often as possible, whenever they see him. This seems to be a constant theme among case workers dealing with clients with chronic medical conditions in independent living. They must be reminded regularly not only to take their medications, but to refrain from taking anything else that might interfere with them.

I accompany Aliberti on a blitz through the aisles of the supermarket.

"We're looking for Chef Boyardee" she tells me as we set off. Soon the shopping cart is loaded up with canned soups, microwaveable breakfast sandwiches, and frozen dinners. Although Sonny* doesn't eat out, she says, "I don't know how often he eats what I bring him."

We finish filling up the shopping cart—it's a good haul—and find Roncarati still waiting for her prescription. They seem to be out of the patches.

Aliberti tells her Sonny has been called as a witness in a court case.

Roncarati looks dismayed. "Oh, no," she says.

Aliberti says Sonny's worried, too. She's told him, "Sonny, all you've got to do is tell the truth."

The trouble is, Sonny doesn't exactly remember what happened.

Roncarati turns and explains to me: "There was an altercation."

Apparently involving Sonny, Sonny's girlfriend, some flying fists and a frying pan.

We wait a little longer, while Roncarati tries to straighten out her order with the pharmacist. Aliberti surveys the frozen meals she's picked out for Sonny, looking skeptical of the Salisbury steak dinner.

“I’m a vegetarian,” she tells me.

In fact, she grows her own vegetables in her garden in a community plot, about which she seems philosophical.

“I don’t care if I can harvest them,” she says. “I just like to see them grow.”

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The red brick building in North Quincy is situated back from the street. It’s not far from the T, in a quiet, clean, rather nondescript working class neighborhood. There’s a basketball court nearby and kids can be heard playing in the distance. Three of BHCHP’s clients have studios there. Roncarati admits there are at least as many cons as there are pros to housing the men so close together, without supervision.

When we arrive the three are gathered in Sonny’s first floor studio. Lionel is the first to introduce himself to me. He is handsome, gregarious, with bright eyes and a mischievous smile. He greets the three of us with exaggerated deference, looking a little like the cat that ate the canary. Sonny rushes up and shakes my hand. Behind him, Pete is nearly passed out on a mattress on the floor. There’s a game on TV. Although all the men are middle aged, the scene recalls nothing so much as a dorm room bust by the Resident Assistant.

While Roncarati attends to Pete, and Aliberti wearily asks Lionel how much he paid to have his hair newly corn-rowed, I chat with Sonny in the kitchenette. It’s easy to see where Aliberti gets her doubts about whether or not Sonny eats anything she brings him. Small and compact, with a wiry build, he looks like he could survive for a long time on nothing but air, if necessary, and probably has. When he smiles I see he’s nearly toothless. Sonny’s age is impossible to tell—though slightly stooped with a bushy beard and wrinkled face, he is spry, impish even, a wizened little man from a Children’s fairytale. He speaks in a high-pitched staccato, a tone of urgent compliance to everything he says, and he moves about staccato-style, as well. He seems built for tight spots and quick escapes. His eyes dart here and there. I get the feeling he knows where all the exits are at all times. He says he spent twenty years on the street, and I have no trouble believing him.

He’s obviously used to traveling light. His studio apartment is sparsely furnished: a mattress, a lamp, a TV at one end. At the other, a small table with a microwave on it (the gas has been turned off), two chairs, and a bare-bones kitchenette. There’s nothing on the walls, no curtains on the windows. Sonny has been living here for eight months.

Aliberti sets to, loading up the fridge. I ask Sonny if he eats at home.

“I eat every day!” He assures me. “I cook! I wake up every morning and have bacon and eggs, or sausage and eggs. For lunch time I have a can of soup. For supper I go to my freezer and pull out a piece of meat.”

Sonny’s urgent tone suggests that after years in a compliance-based shelter system he isn’t about to risk giving me the “wrong answer” to any question I might come up with. After nearly a year in housing, he still seems a bit suspicious, like any moment he might be asked to leave.

“I love this place!” he assures me eagerly. “It’s a nice little apartment! I get along with everybody in the building!” He’s not sure what he’s doing in Quincy, being from South Boston, but says “I get back to Southie at least three times a week.” His girlfriend lives there. She’s the one with whom he had the now famous altercation he claims he has no memory of. His face still bears the cuts and bruises.

“I see her about twice a week,” he tells me. “We both help each other. She lives in Dorchester. We’ve been together fifteen years. She loves this place. She comes over here, I go over to her house. We both got nice places.”

Roncarati’s across the room, warning Pete about the dangers of mixing alcohol with his meds: “You hear me? You shouldn’t take that if you’re drinking!”

Aliberti is asking Lionel if he’s got his T pass. When he can’t find it, she asks the others if they’ve got theirs. Sonny’s not sure he’s got his. Pete doesn’t have his either, and accuses Sonny of stealing it. Sonny looks abashed. “But I gave it to you, didn’t I?”

Roncarati zeroes in on Sonny now. “Hey, what’s going on with your eye?” she asks him, striding over to take a look. “It’s all red—is it itchy?”

“What? This one?” Sonny says, scratching it. “Yeah.”

“Is it infected?”

“Yeah!” he says, sure that that’s the right answer. “I’ve been rubbing it a lot.”

“Oh, no!” Roncarati pleads, “Sonny, don’t do that, all right?”

“Oh, OK!” Sonny says, cheerily.

While Roncarati takes a closer look, I chat with Lionel. In 2005 he had the most emergency room visits of anyone in the program. Since getting housing he has had only one. He was on the street for twenty-one years, he tells me. And while I could see it with Sonny, I find it hard to believe in his case. One of the reasons is that Lionel seems more aware of his condition, though no less self-conscious. He

notes my surprise. He says in the eight months since he's been in the program his life has changed "quite a bit."

"Normally, right about now I'd be passed out in the middle of the street."

He would find anywhere he could to sleep, including public garages, and "under the Red Line, scrunched in the corner, you know, so when the train comes I wouldn't get hit."

Now that he's got a place of his own he can focus on some projects. He says he's a huge "puzzle freak," and loves putting jigsaw puzzles together. He's currently working on a couple of big ones. He's enthusiastic and articulate, but there is also something frighteningly intense about him at close range.

I ask him about employment.

"I'm bipolar," he tells me matter-of-factly. "My mind's not right. I'm not going to be able to work. My mood swings are too much. The type of work I'm able to do, I know I'd end up snapping."

He also says he's got a substance abuse problem he's trying to deal with. "I can't sleep," he says, "so I end up turning to alcohol, so I can sleep."

He's hopeful that the doctors now on his case will get him medication that "will take all the craving away. That's what I need."

Aliberti tells him, "hopefully down the line there'll be a shot you can take once a month, then you don't have to worry about remembering."

He smiles at her, turns to me, and says, "she's gotten me to realize that I'm bigger than who I am. You know, that I'm a bigger person, a better person. They're dynamite people. They're the best."

Roncarati and Aliberti are struggling with Pete now. Sonny's helping them. Pete is a gruff bear of a man, and he's in a grumpy mood. But if the scene is a little burlesque, there is an air of genuine goodwill in the room. I feel I'm witnessing a good-natured, even comical struggle between those who are acknowledged to be trying to help and those who would like to let them, if only the better angels of their nature weren't being throttled by their inner demons.

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Though only there a half an hour, a quick visit, by Roncarati and Aliberti's standards, I'm exhausted when we leave. Roncarati informs me we've got one more stop, a few blocks away, but promises it won't be quite as hectic.

Wade lives on a tree-lined street in one half of a duplex with a small, neatly kept

lawn. A Vietnam Vet, Wade has only lived there for six months, but the place looks like a home. It is modestly furnished but comfortable. There are pictures on the walls—one a homemade painting of Fenway Stadium--and perhaps more importantly, there are curtains on the windows. Curtains, Roncarati and Aliberti both confirm, are a good indicator of stability and success in housing.

When we arrive Wade is entertaining his friend Charles, who sits on the sofa doing a crossword. They're both sipping tea. The room is suffused with afternoon sunlight. There's no other word for it but "homey."

After brief introductions Wade, who bears an uncanny resemblance to Jackie Gleason, takes control of the proceedings, turning to Roncarati and saying: "the reason I wanted to see you, and the only reason I wanted to see you, is I'm wondering what happened with that heart thing."

Roncarati apprises him of various test results. There are some minor difficulties with prescriptions and a bill, which Roncarati promises to take care of.

Wade, like most of the chronically homeless who were also high utilizers of emergency medical care before obtaining housing, has a seemingly inexhaustible inventory of physical complaints, from the heart, to the hips and the knees, to insomnia, and general pain, for which medications are adjusted and recalibrated constantly.

"If the Ambien's not working, we could move you to Sonata," Roncarati offers.

Wade is so on top of it that it's hard to believe he, too, was a high utilizer of the emergency rooms, like Sonny, Pete, and Lionel. Wade was in and out of housing for decades, and has battled alcoholism all his adult life. Aliberti tells me he has had a couple of relapses since he got the apartment, but he has always sought help, and because he wasn't in danger of losing his housing, he was able to get back on the wagon instead of being forced back into the shelters and onto the streets, with little hope of managing his illness.

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It's early Autumn when I meet Roncarati again. She is just back from two week's off, and looks more relaxed and refreshed than the last couple of times I saw her. I ask her about Sonny, Lionel and Pete. She tells me that, sadly, Sonny has died. Lionel has been having a hard time of it, and was recently sent to Bridgewater, a correctional facility, for a short stint. But Pete has improved and is doing surprisingly well.

Wade is attending AA, and still has a take-charge attitude about his health care. He picks up his own medications at the pharmacy, and he's managing his daily doses on his own, as well. He has also begun to venture out into his neighborhood in Quincy. Wade, in particular, seems to be the kind of Housing

First client who could eventually gain a degree of independence and become a part of the community in which he lives.

Roncarati likes to look on the bright side. No one dealing with the chronically homeless has any illusions about a painless transition into housing. But even with the often seemingly insurmountable challenges, she says she has no doubt Housing First is worth it all around. "I think it's been incredibly wonderful to watch some of our folks really flourish, and to watch them grow healthier, and to think they can participate again in society. And for those still dealing with mental health issues and substance abuse issues I feel comforted that we can get to them a little more easily, and get them the care they need."

Joe Finn is used to hearing the doubting Thomases ask him if it'll really be worth it in the end. "Is it less costly or is it going to wind up a wash? For me it's more a question of what's more effective utilization of resources. If we've got this whole institution built around keeping people caught up in shelter, and a lot of people aren't even accessing that resource, and they're out on the street, costing millions in healthcare costs, there's got to be a better way to do it."

"Supposing it is a wash?" he asks. "In the one case, you're still funding an emergency system, in this case the wash is making sure somebody's permanently housed."

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