COST OF RURAL HOMELESSNESS

Rural Permanent Supportive Housing
Cost Analysis

State of Maine

May 2009

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Table of Contents

Page

Acknowledgements.. **1**

Executive Summary.. **2**
Permanent supportive housing reduces the cost of care and improves the quality of life for formerly homeless tenants.

Cost Benefit Analysis Results.. **3**

A. All Services.. **6**
B. Emergency Shelter... **7**
- *Costs decreased 99%*

C. Emergency and Public Services......................... **8**
- *Ambulance transports decreased 45%*
- *Emergency room visits decreased 21%*
- *Jail nights decreased 95%*

D. Physical Health Care.. **10**
E. Behavioral Health Care.......... **11**
- *Mental health care costs decreased 57%*

F. Income Levels.. **13**

Quality of Life Indicators.. **14**

Summary.. **17**

Research Design.. **20**

A. Participants
B. Permanent Supportive Housing Programs
C. Timeframe
D. Data Sources
E. Limitations
F. Next Steps

Appendix

A. Demographics.. **24**

B. Prior Living Situation …………………………………….. **25**
C. Data Sources ……………………………..…………… **26**
D. Service Categories.………………………………….… **28**

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The breadth of the study required us to obtain data from one hundred and two different organizations. For some providers this turned out to be a complicated and expensive process; we are indebted to their willingness to surmount considerable technical obstacles.

MaineHousing provided the impetus for this study; applied for the funding to pay for it; and convened an advisory committee to oversee the process.

The Advisory Committee and Statewide Homeless Council provided crucial feedback, support and encouragement for this project.

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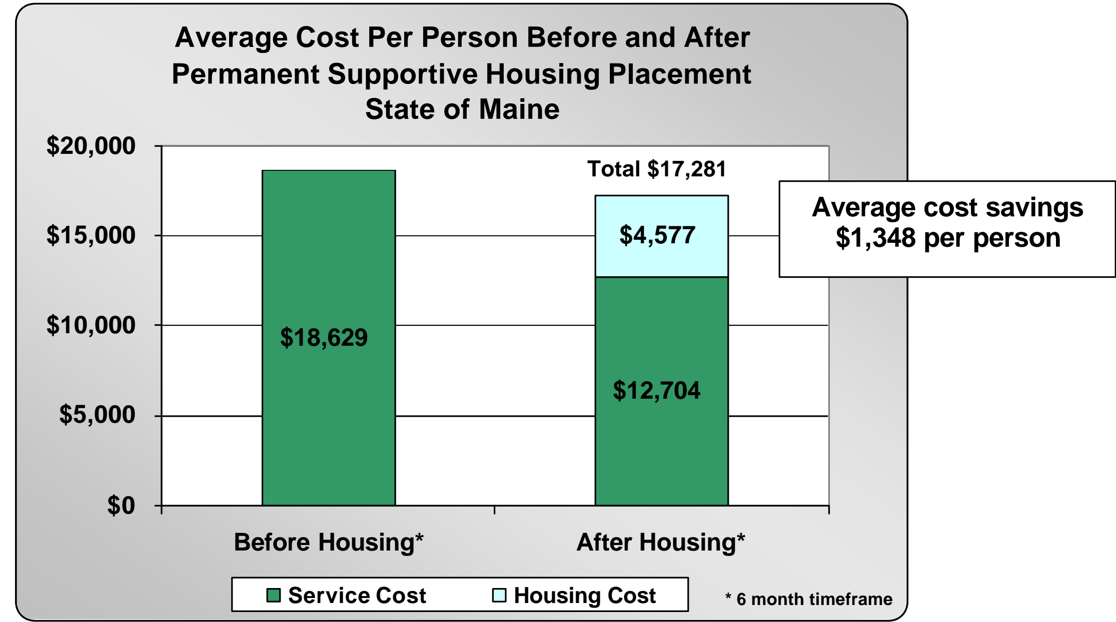
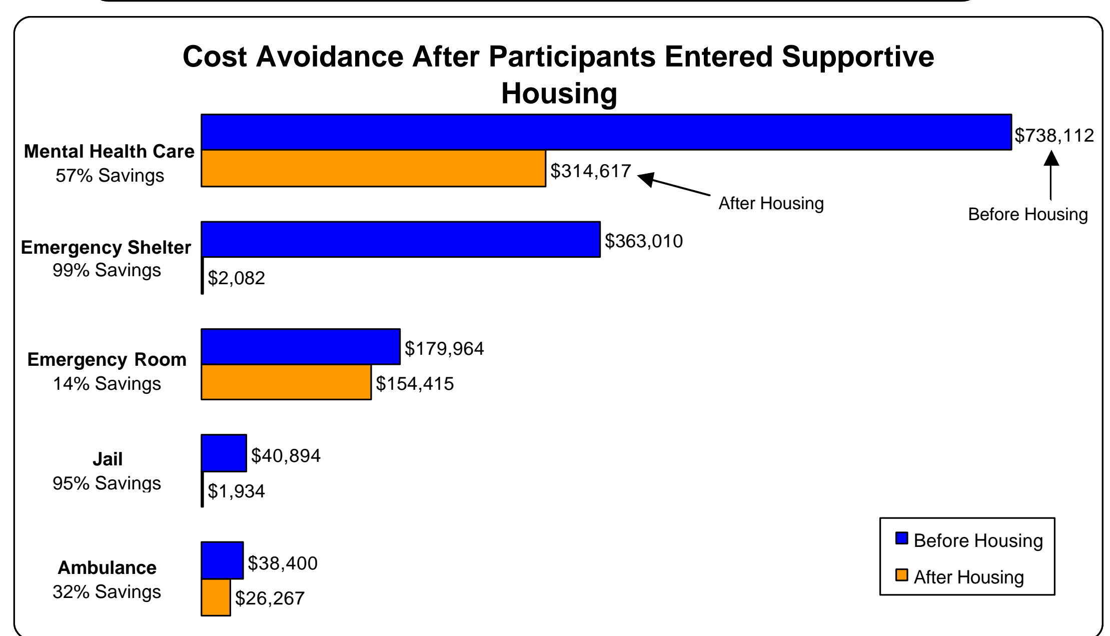
COST OF RURAL HOMELESSNESS
EXECUTIVE SUMMARY

Permanent supportive housing allows people with disabilities who were homeless significantly more efficient and appropriate housing and service delivery with tangible cost savings. Not surprisingly, permanent supportive housing also improves quality of life for all involved.

- **32% reduction in service cost** by providing permanent supportive housing to people with disabilities experiencing homelessness in rural areas
- **57% reduction on expenditures for Mental Health Services**, illustrating a shift away from expensive psychiatric inpatient care to less expensive outpatient community-based services
- Permanent supportive housing placements reduced service costs: **shelter by 99%, emergency room by 14%, incarceration by 95%, and ambulance transportation by 32%**
- $1,348 per person cost avoidance
- $219,791 six month cost avoidance total for all 163 tenants





INTRODUCTION

This study is the first statewide cost of homelessness data collection effort in the nation to be conducted in a rural setting. This report contains information pertaining to the cost and frequency of services used by people with disabilities who were homeless before entering a permanent housing program. This study reinforces Maine's positive work while offering data to support Maine in continued leadership to develop strategies to end homelessness. Our goal is to provide crucial information to those creating policy in Maine and other States about the real cost of rural homelessness for people with disabilities. We seek to help individual communities better understand the financial impact of homelessness on their resources and to assist our public officials by providing data to be used in the difficult task of how to allocate limited resources.

The crisis of homelessness in Maine has lasted thirty years and resulted in millions of dollars being spent on shelters, emergency services, and corrections for individuals and families experiencing homelessness. Based on self-report 28%[1] of people who are homeless also struggle with mental illness, substance abuse, or co-occurring disorders, a fact that makes finding stable housing and needed community supports especially challenging in difficult economic times. Most shelter providers report a higher percentage of persons experiencing mental illness living in shelters based on their observation and professional assessment throughout the years.

There has been a significant State commitment to work toward ending homelessness. Efforts are underway to direct resources towards strategies aimed at developing affordable housing built on evidence-based practices demonstrated to assist individuals and families in finding and maintaining stable housing. Studies around the country have consistently found that permanent supportive housing is effective in helping people with disabilities remain stably housed once they move out of homeless situations. Studies comparing the cost of homelessness and the cost of permanent supportive housing conducted in urban areas around the country have consistently found that permanent supportive housing also costs less than leaving people homeless. These studies have had varied results depending on the population and methodology used, ranging from enormous savings to a general shifting of costs within communities. However, it is clear that permanent supportive housing can be cost-effective and, more importantly, works as an effective strategy in the effort to end the blight of homelessness for people with disabilities.

The impact on a person with a disability who is experiencing rural homelessness is no less severe than a person experiencing urban homelessness but it is often a hidden problem. A complex system of barriers in rural areas makes access to limited resources difficult. Valuable insight into the nature and cost of rural homelessness emerged from the study.

- Rural homelessness is often hidden because people live in doubled-up situations, garages, barns and abandoned buildings instead of on the street or in a shelter.

- Rurally homeless people with disabilities tend to rely on their support network of family and friends to find temporary housing instead of relocating to shelters. Due to the existence of this temporary network of resources individuals and families may not qualify for housing assistance.

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[1] Maine Point in Time Survey, January 28, 2009

- Strict homeless definitions which govern the housing programs often lead to rurally homeless people not qualifying for permanent supportive housing programs.

- Emergency shelter stays in rural areas are typically shorter than urban areas.

- Rural emergency shelters often lack bed capacity and may be located far from a person's home community.

- Centralized service and referral centers are not common in rural Maine. Often people with disabilities must interact with many different providers to access the few available resources.

- Distance to service providers prohibits their utilization in some communities.

- Transportation is not usually available unless there is a documented medical need.

- The number of outreach workers has been decreased throughout Maine. This has left rurally homeless people with disabilities without a navigator for the complex service network.

- Gaps in needed resources leave homeless people with disabilities with no place to go.

Access to information and resources in Maine's large geographic area continues to be a challenge. Although many groups are beginning to recognize and discuss this problem, the lack of funding and staff impedes their ability to implement comprehensive solutions. Maine recently invested in the *2-1-1 Maine* information and referral system which provides a phone health and human services referral system for all counties in Maine. Since July 2006 this toll-free number has helped rural areas centralize available assistance resources. Unfortunately, this centralized referral source provides little tangible help if the resources themselves are not available in rural areas. Another program available in Maine to help link people with disabilities who are homeless to resources is the Projects for Assistance in Transition from Homelessness program (PATH). Although these PATH funds are available to fund outreach workers for adult services this program has been flat-funded for 15 years resulting in fewer available services to people with disabilities in vulnerable homeless situations. Both of these programs are good examples of existing programmatic structure which could be further utilized in helping Maine succeed in end homelessness.

This study provides rural information about the cost-effectiveness of providing permanent supportive housing to people who are homeless and have a disability. To determine this, the study focused on following questions:

- How did permanent supportive housing effect the use of emergency services such as police, hospital emergency rooms, ambulances, and shelters?

- How did permanent supportive housing impact the use of health and behavioral health resources including primary and hospital care, community support, and substance abuse services?

- How did costs shift as a result of moving people from homelessness to permanent supportive housing?

- How did living in permanent supportive housing effect the quality of life of people who have histories of homelessness and disability?

METHOD

In addition to adding to the current understanding about rural homelessness for people with disabilities, we exposed the challenges in developing methodological data gathering techniques. The "Cost of Rural Homelessness" study compares participants' cost of care prior to and following their move into permanent supportive housing. It was conducted in two phases; first the Greater Portland area and second the balance of the State of Maine. This report contains data collected in Phase Two of the Project.

This study is the first to use data collected on: individual service contacts and cost while homeless and subsequent cost and contacts while in permanent supportive housing. Unlike previous studies which were limited to estimated costs of key services, this study used specific billing and contact records creating an accurate picture of expenditures and sources of funds used to serve homeless and housed individuals with disabilities. Additionally, the study participants were drawn from the entire population of previously homeless persons with a disability living in permanent supportive housing. Unlike most previous studies, this study was not limited to individuals who were chronically homelessness or high users of hospital services. Therefore a complete and accurate indicator of cost to communities and the State in serving people with a disability was achieved.

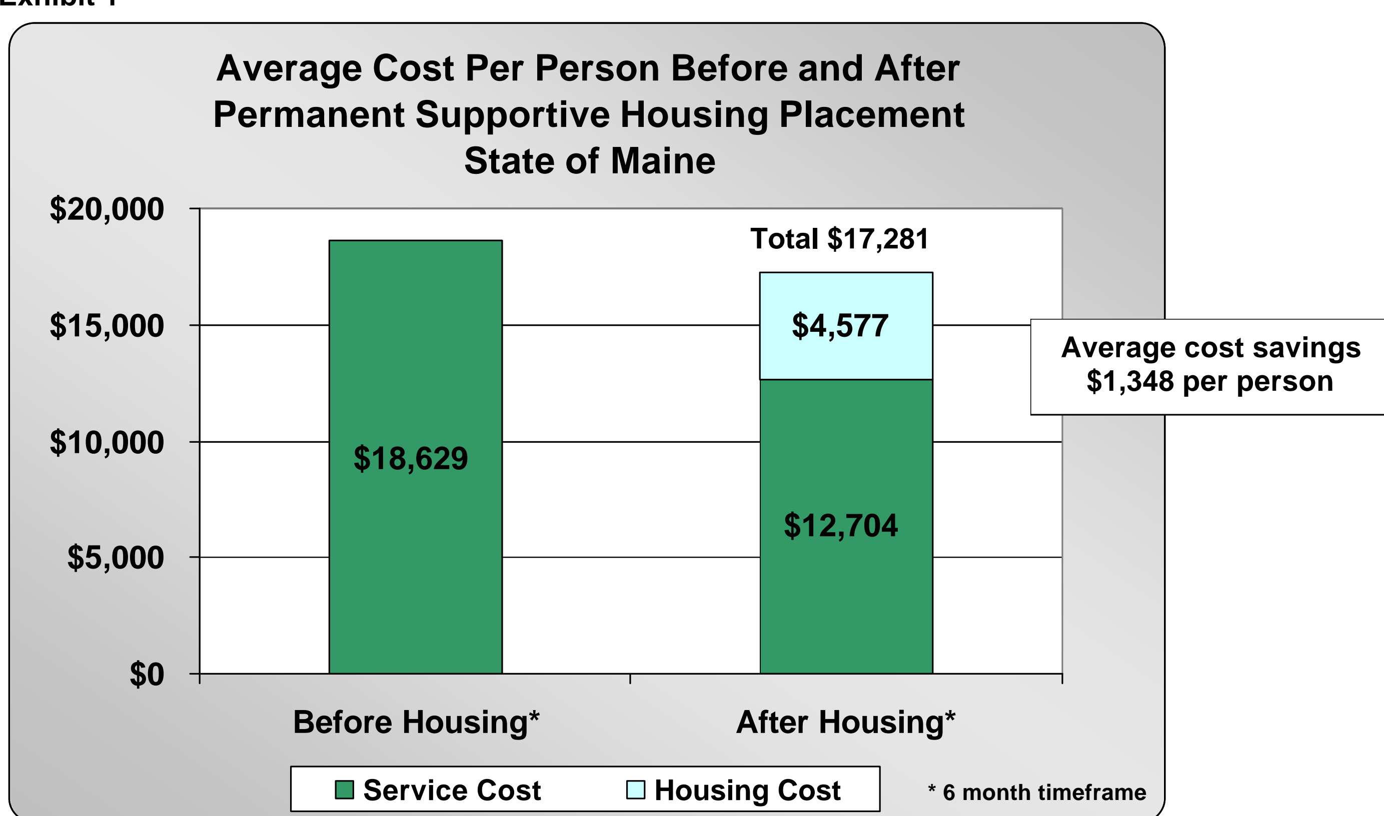
	Maine Study	**Previous Studies**
Population Sampled	Chronically homeless individuals Homeless individuals with disabilities Homeless families with disabilities	Chronically homeless individuals High users of emergency services
Cost Calculation	Cost records from providers	Estimates based on sampling
Service Contacts	Individual service records	Estimates based on sampling

A. ALL SERVICES – RURAL MAINE

Across all housing types, study participants, and service components, the average annual cost of care savings produced by living in rural permanent supportive housing was **$1,348 per person** when comparing the six months prior to housing placement with the second six months of living in permanent supportive housing. The six month cost avoidance to the system of care totaled $219,791.

As can be seen in Exhibit 1, housing costs increased while service costs decreased enough to more than offset the additional cost of housing. This summary includes permanent housing programs serving formerly homeless people with disabilities from eleven of Maine's sixteen counties.

Exhibit 1



Housing costs include ongoing rent subsidy, staffing for residential programs, operations expenses for buildings used for permanent supportive housing, and administrative costs.

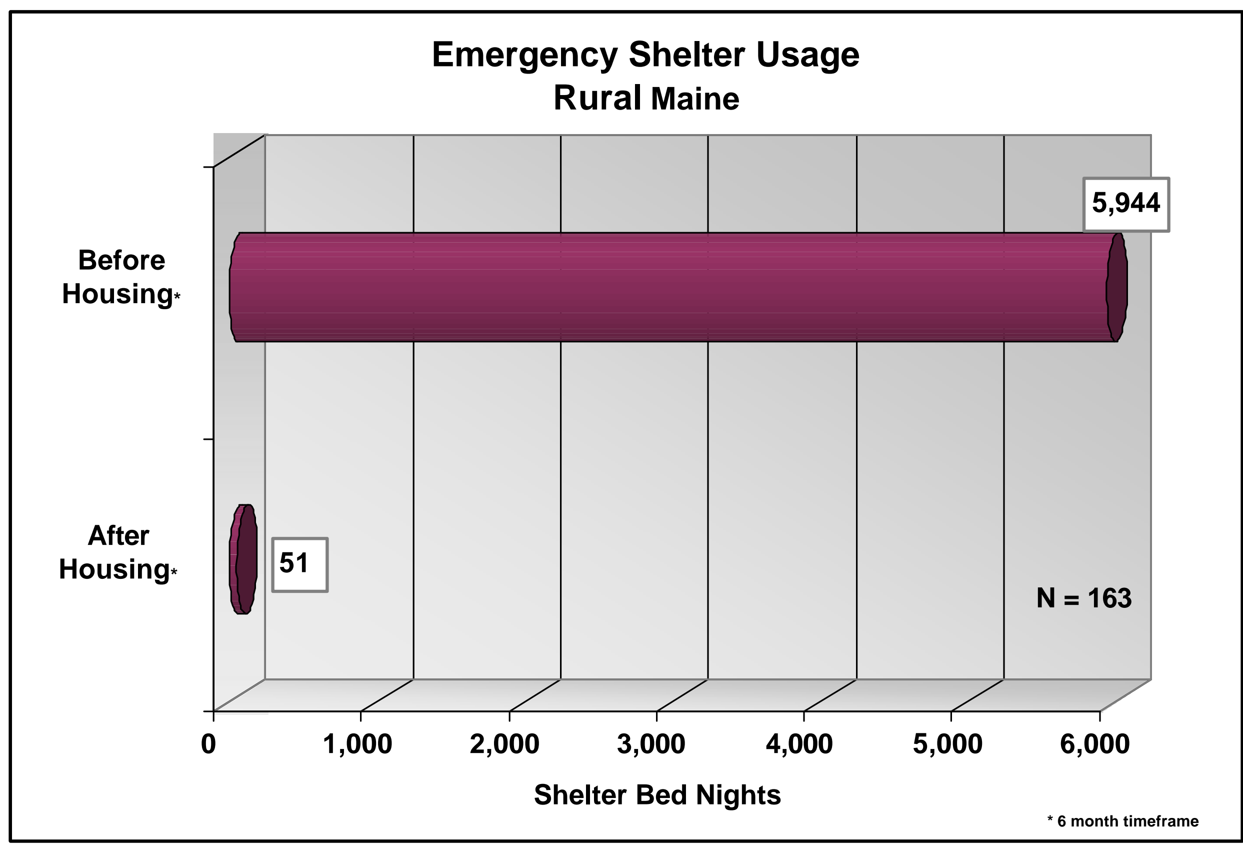
The total housing expenses for the 163 tenants six months housing placement was $746,125. Shelter Plus Care, a federal rental subsidy, costs accounted for $402,583 or 54% of the housing costs, showing a significant shifting of cost from state to federal resources.

B. EMERGENCY SHELTER USAGE – RURAL MAINE

One of the most dramatic decreases was in use of emergency shelters. Across all housing types, permanent supportive housing was highly successful in helping homeless individuals and families with a disability stay out of shelters and remain stably housed

Study participants' shelter usage plummeted more than 99%, when the six months prior to permanent supportive housing are compared to the second six months in housing. Bed nights in emergency shelters fell from 5,944 to 51. Correspondingly, the cost of emergency shelter provision decreased from $363,010 in the six months prior to housing entry to $2,082 in the second six months in permanent supportive housing for a savings of $360,928.

Exhibit 2



C. EMERGENCY and PUBLIC SERVICES – RURAL MAINE

People with disabilities living in shelters, on the streets or in other homeless situations experience great difficulty in managing their physical health, mental health, and substance abuse. Homeless studies in urban areas have shown that long term instability can lead to crises that require frequent use of police, ambulance, and 911 emergency services. Once people are stably housed it is easier to engage in, and benefit from, the needed treatments. Findings generally provided strong support for cost savings in emergency and public services, although the degree of savings varies between the type of emergency service and the region of the state.

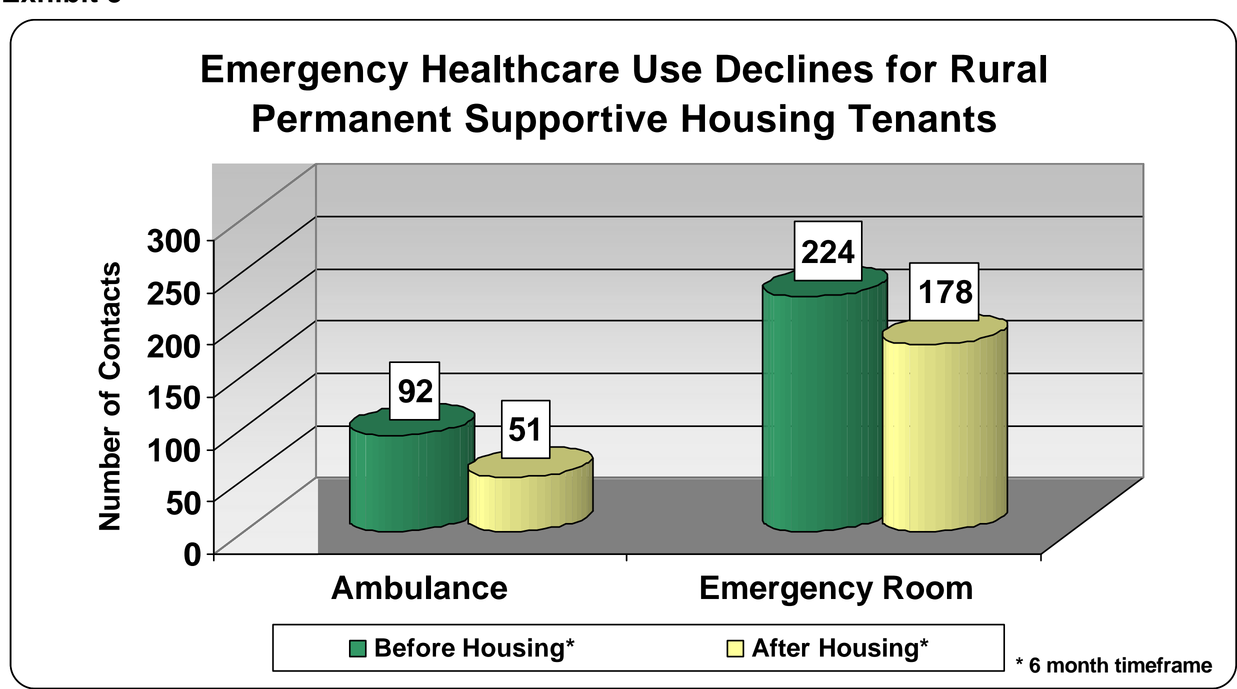
Statewide, the six months before entering permanent supportive housing is more expensive than the second six months in stable permanent supported housing when combining ambulance and emergency room visits. The cost to communities of these services decreased from $218,364 to $180,682 or 17%.

Specific findings include:

- **Ambulance transports decreased by 45% (41 fewer transports)**
- **Ambulance costs decreased 32% for a savings of $12,134**

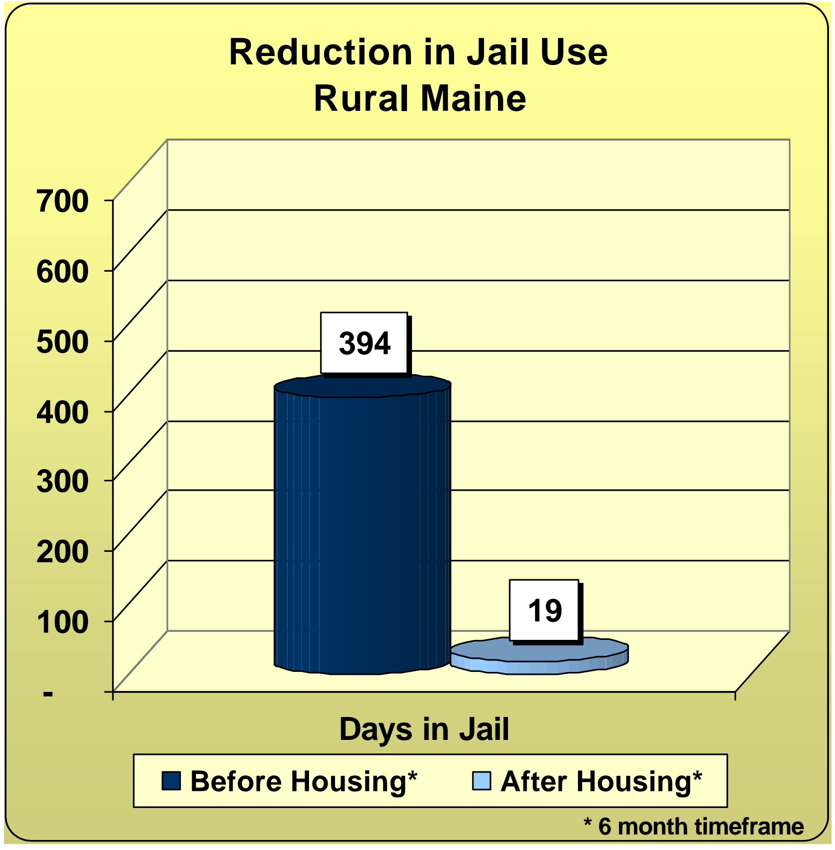
- **Emergency room visits decreased by 21% (46 fewer visits)**
- **Emergency room costs decreased by 14% for a savings of $25,550**

Exhibit 3



JAIL

Exhibit 4



Study participants spent significantly fewer days in jail following their entry into permanent supportive housing, from 394 days before to 19 following a housing opportunity, a reduction of 95%. This was accompanied by a 95% drop in the cost of incarceration, from $40,894 to $1,934.

Only 18 people of the 163 tenants (11%) had one or more jail nights before housing.

POLICE

Data on police contacts was particularly difficult to obtain in this rural state with numerous jurisdictions. Complete data from police departments in several geographic area areas of Maine was not available and in many situations data on contacts during the six months before entering housing was unobtainable. Therefore the data in this area needs more investigation and is not included in this report.

D. PHYSICAL HEALTH CARE – RURAL MAINE

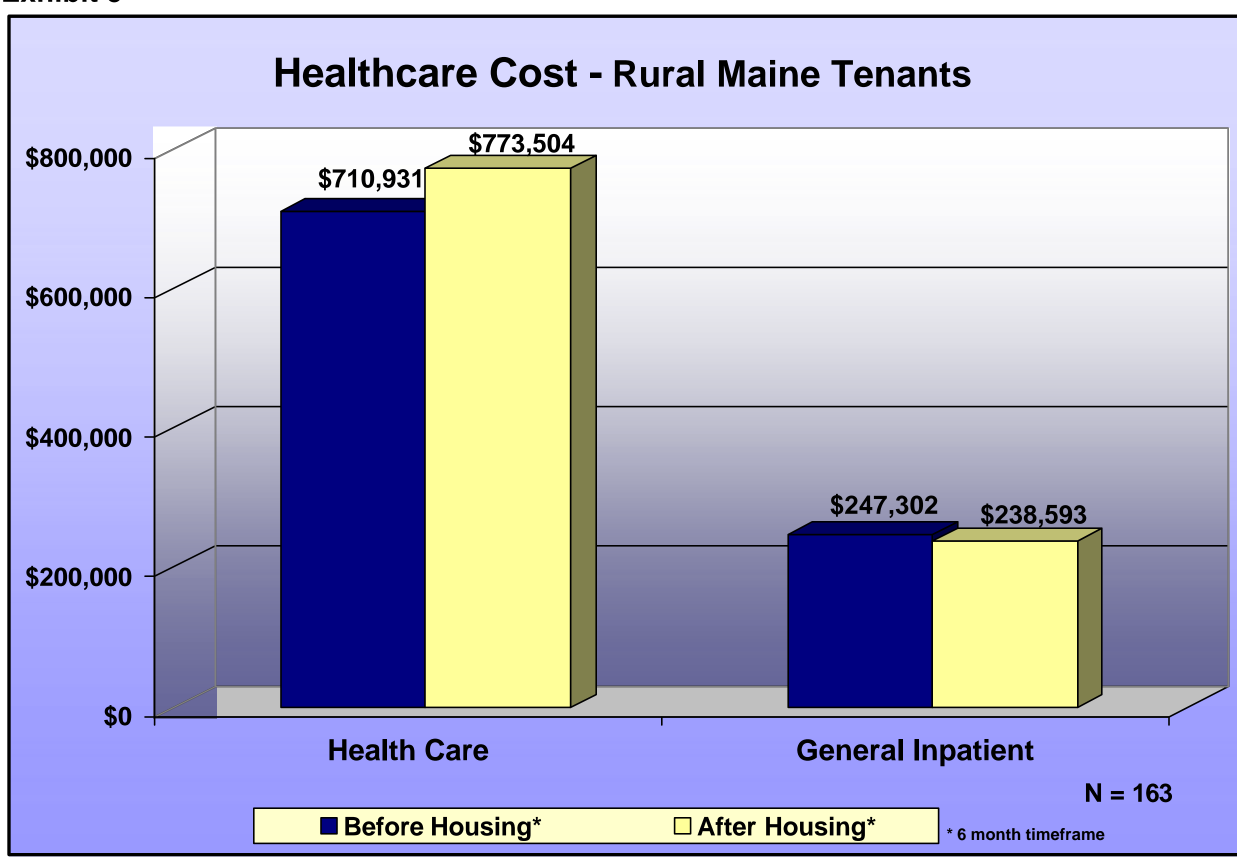
This section examines the cost of providing physical health care to people experiencing homelessness. We have already noted the difficulty of managing physical health and mental health while living in homeless situations. Stressful living conditions exacerbate symptoms, and make it difficult for people with disabilities who are experiencing homelessness to follow through with treatment and receive preventive care.

Participants experienced fewer physical health and mental health crises that required emergency room visits and hospitalizations. Included in physical health costs are general inpatient hospitalization, general outpatient services, physician contacts and other community healthcare.

Results show:

- **Overall health costs increased by 9% or $62,573**
- **General inpatient hospitalizations decreased by 20% (6 fewer visits)**
- **General inpatient hospitalization costs decreased by 4% for a savings of $8,709**

Exhibit 5



E. BEHAVIORAL HEALTH CARE – RURAL MAINE

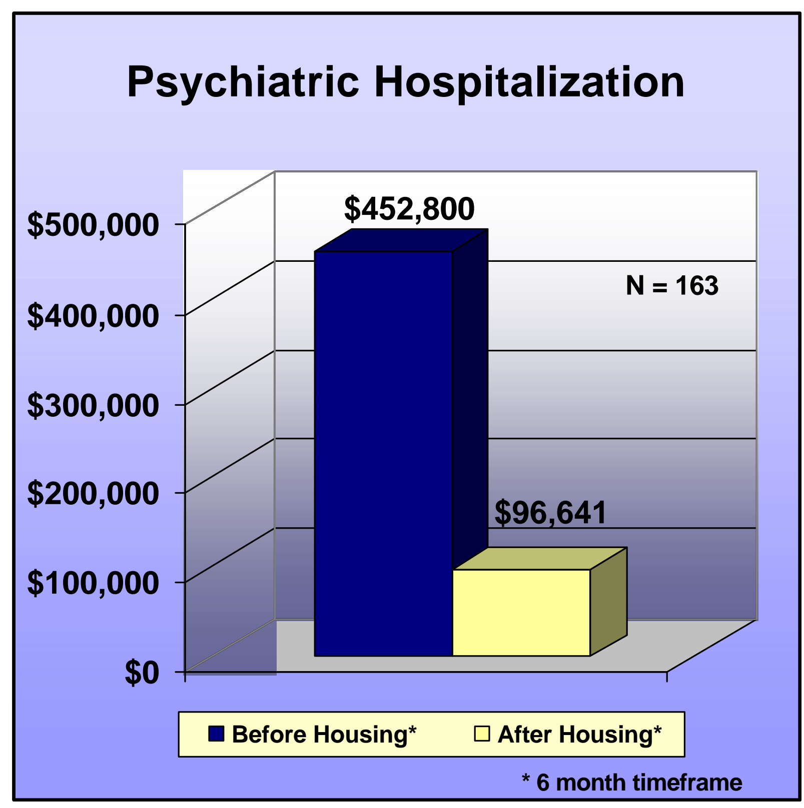
Similar studies in other cities have demonstrated that providing people with a disability who are homeless with affordable housing, and a flexible menu of supportive services, is highly effective at helping them remain stably housed. In fact, stable housing is fundamental to people engaging in treatment that improves their physical health and mental health.

In this study of a rural state, there are clearly indications that stable housing changes the ways in which community mental health services are utilized and, while regions of the State showed variation in service usage and cost shifting, **behavioral health costs decreased dramatically.** Behavioral health costs include the following:

- Mental Health Treatment
  - Psychiatric Hospitalization
  - Outpatient Mental Health Treatment
- Community Support Services including Intensive Case Management, Assertive Community Treatment, and Community Integration Services
- Substance Abuse Treatment including outpatient, residential, and detoxification

Savings in mental health costs were substantial, with costs declining by 57% ($423,495 less).

Exhibit 6



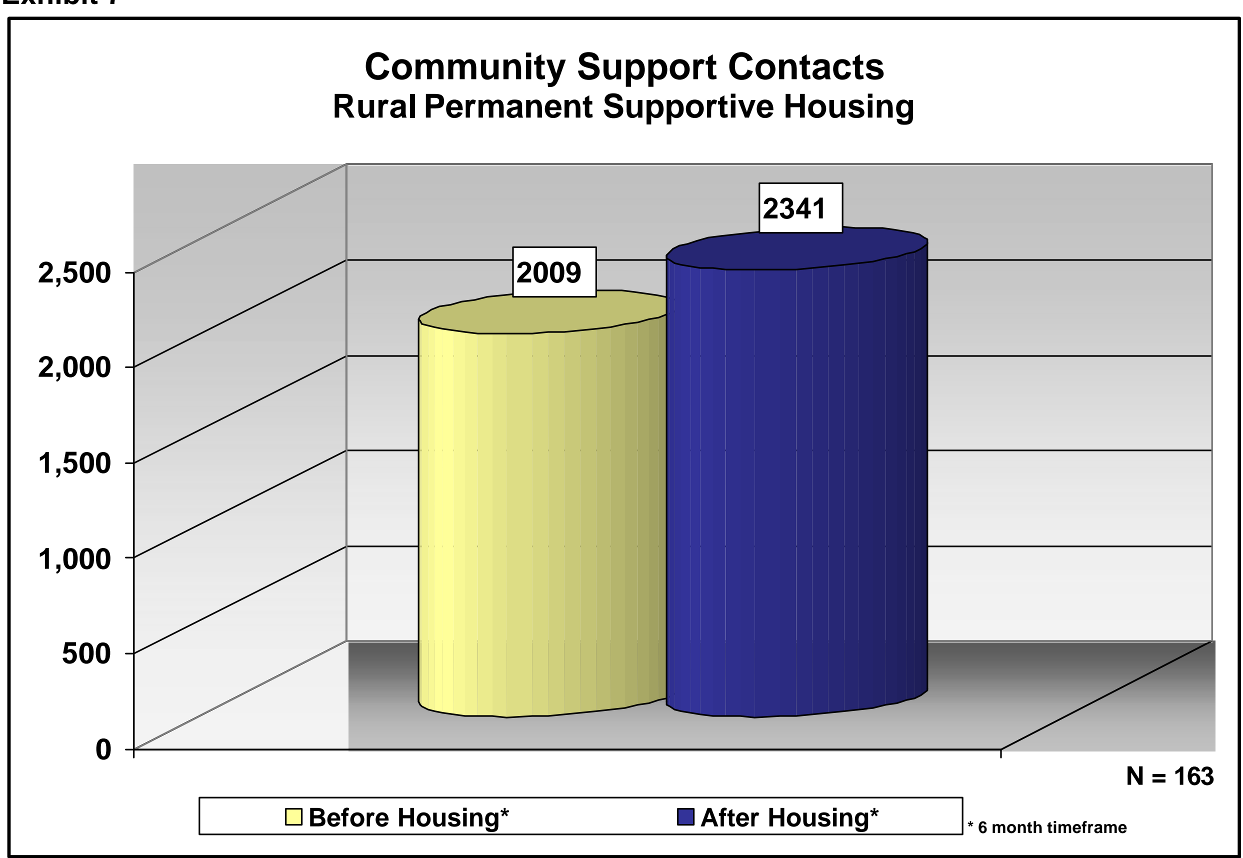
The reduction in psychiatric hospitalization cost accounts for a substantial part of the cost shifting, a fact that substantiates the critical relationship between stable housing and mental health stability for persons who are challenged with by mental health issues.

Psychiatric hospitalizations admissions decreased by 58% which resulted in a 79% savings of $356,159.

Increased community support services and costs reflect the movement from instability, crisis, and lack of case management support to more consistent development of ongoing community connections within the mental health system. The increased cost of these services is expected as people begin to utilize the community supports that are offered through the community mental health programs. These critical services are more than offset by the decreasing costs of overall treatment service, a fact that further indicates the potential of permanent supportive housing to move resources in efficient and effective directions.

- **Community Support Service costs increased by 24% ($84,852)**
- **Community Support Contacts increased 17% (332 contacts)**

Exhibit 7



Substance Abuse Treatment costs reflects a broad range of services including detoxification, intensive outpatient treatment, and outpatient counseling. It is important to note that substance abuse services are not available throughout the state and even though we saw a decrease in services in this data sample, it could be due to geographical location of programs instead of lack of need for the service.

F. INCOME – RURAL MAINE

'When I was in the shelter, I had no income. I am back on my feet and get along well with my finances. I save money, go to the food pantry, and use coupons." (Tenant quote from Quality of Life Survey)

All participants in this study received rental assistance. This assistance took the form of either a tenant-based voucher, a project-based voucher or a subsidized building placement. Even with subsidy to assist with housing costs all programs feel it is important for tenants to increase their income base while they work toward independence and self-sufficiency.

Of 163 study participants, 135 or 83% had secured an income source after entry into housing. Prior to living in permanent supportive housing only 96 or 59% of tenants reported having an income source. Support service staff help people with disabilities navigate the complex eligibility rules surrounding benefit programs. Staff help tenants meet requirements to provide social security cards and other identity documentation to qualify for entitlement benefits and job training programs. Many people with a long history of homelessness and disability have difficulty complying with these requirements without assistance from service providers. Permanent supportive housing placements provided tenants with staff assistance to engage mainstream income resources.

Exhibit 8

	Before Housing	After Housing
No Income	41% (67 tenants)	17% (28 tenants)
Some Income	59% (96 tenants)	83%(135 tenants)

Exhibit 9

	Mean Admission Income	Mean Income at Interview	% Increase
All Study Participants	$362	$641	77%

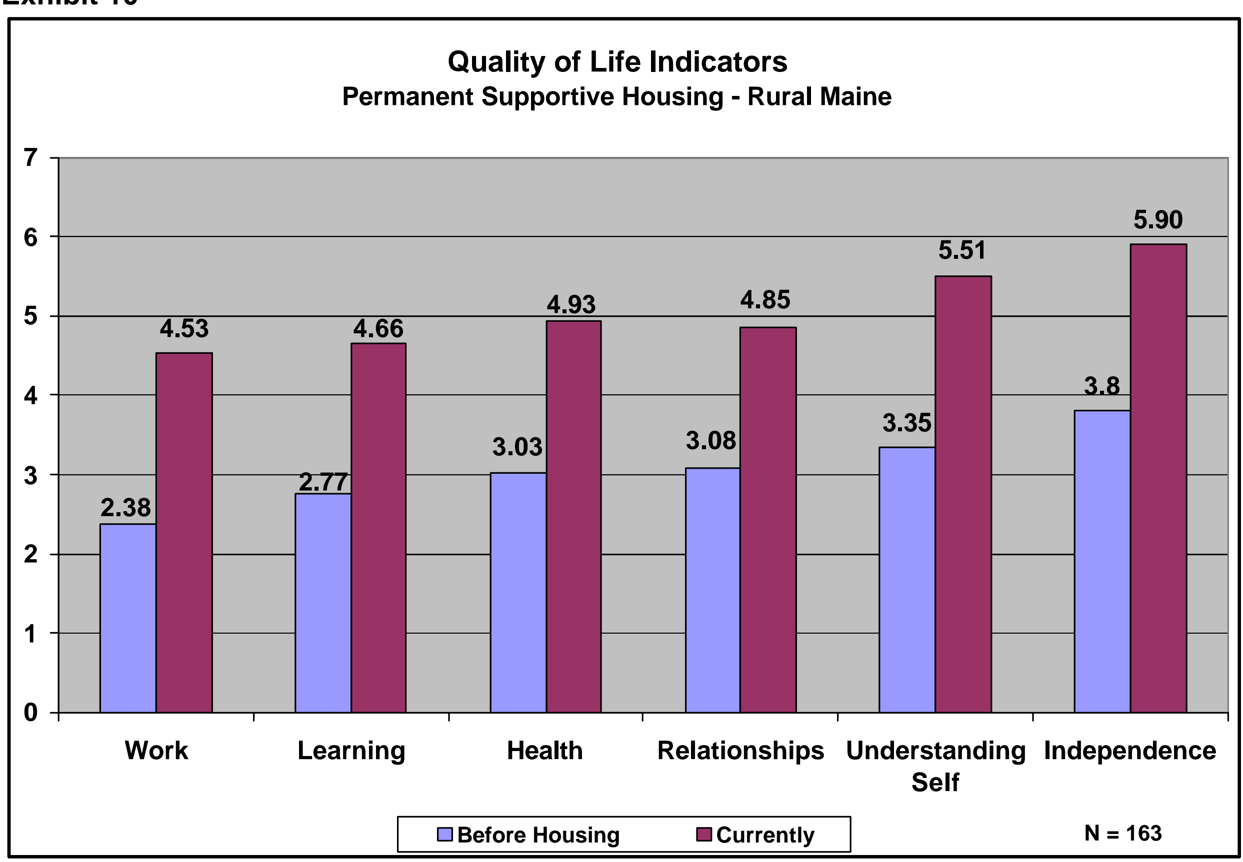
Increased financial responsibility was an important theme in the narrative responses where some tenants wished to continue improving their ability to manage their finances. For some this responsibility was framed as a positive, while others acknowledged that taking care of essential bills first (such as rent) meant having less discretionary income for recreation.

QUALITY OF LIFE

The tenant interview included a one-page 16 question survey about each tenant's quality of life before and after moving into permanent supportive housing. The exhibit below shows responses to questions regarding work, learning, health, relationships, understanding oneself, and independence. The seven point scale for all 16 questions ranged from Terrible (1) to Mostly Delighted (7).

The six question responses in Exhibit 10 all show improvement of more than 1.5 points on the scale and increases of 149% or more after moving into permanent supportive housing. Each question represents a key life area which demonstrates the importance of permanent supportive housing in meeting shared societal values and improving individual self worth. In addition, positive changes in life areas can ultimately impact the public cost of housing these individuals.

Exhibit 10



The results of the Quality of Life Survey are generally consistent across gender, length of homelessness, and region of the State. Satisfaction substantially increases after housing on all questions for all groups. Although each question is scaled separately, when viewed in groups, there is an even more powerful indication of the importance of housing in improving lives and of creating potential for individuals and families.

Finally, growth in satisfaction with understanding one's self, knowing your assets and limitations as well as satisfaction with self-expression may be critical contributors to gaining control over emotional health, developing personal goals and creating a fulfilling life.

HEALTH AND ACCESS TO HEALTH CARE

> *'My health care is 100% better. I am now treated like a human being as opposed to just a junkie." (Tenant quote from Quality of Life Survey)*

Increased access: At times tenants spoke about access being a result of having insurance. Other access comments referred to being able to access care due to transportation or proximity of clinic to current living situation.

- I have MaineCare now, before had nothing and no providers
- I got MaineCare and then Medicare. Co-pays were expensive. Then MaineCare started taking care of the co-pays.
- Closer to providers, easy to get to

Positive impact: Comments suggested an improvement in one's health due to having a place to live. Themes within this category included how having housing improved one's health as it allowed people to have more time, be more comfortable, and feel less worried or feel better overall.

- Today being stable I've made sure our family has all got primary care providers, dentists, counselors, etc. Homelessness hindered our ability to do those necessary things.
- I was able to concentrate on a DBT group (therapy) because I wasn't worried about where I was going to place my children and I on a daily basis.
- Less worry so easier to keep track of appt and other needs
- More time to go to see the doctor
- When in the shelter I couldn't give health care places an address…if I didn't have housing I wouldn't be able to take my shots and pills each day

INDEPENDENCE

> "I have regained my self-assurance which was absolutely taken from me during 11 months of homelessness." *(Tenant quote from Quality of Life Survey)*

The majority of respondents experienced improvements in their capacity for self care following their entry into permanent supportive housing. Respondents often cited an increased feeling of independence (n=85) and a sense of feeling better (n=18).

Individuals in the survey expressed a substantial improvement in satisfaction with independence and doing for oneself, showing permanent supportive housing assisted tenants in becoming more self reliant. Improvements in satisfaction in work and learning, including attending school, support the possibility that stability leads to individuals making gains in vocational areas that can lead to increased independence.

RELATIONSHIPS

> "My parents and I get along very well. Since I have had my apartment, it has made it easier to get into treatment, which strengthens my relationships" *(Tenant quote from Quality of Life Survey)*

A key measure of quality of life concerns satisfaction with socializing, meeting other people, with making friends, and maintaining relationships with friends, family and significant persons.

There were 89 responses indicating a positive change in relationships, including increased frequency or contact and/or improved communication with family members. Many of the responses indicated that these improvements are a result of being less stressed and/or how their families are now less worried given they have a place to live and/or are leading a healthier life. Some of the reported improvements were characterized as small steps towards improvement, while others discussed more considerable changes.

The dramatic changes in social and relationship satisfaction may indicate both the likelihood of future stability and meaningful improvement in the quality of life of partners, family, and friends of formerly homeless individuals.

EATING

> "Before we ate poorly, especially myself as I would give most of the food to my children. I usually ate once a day. Now we eat a relatively good diet and we all have enough to eat 3 meals a day plus." *(Tenant quote from Quality of Life Survey)*

Permanent supportive housing participants report benefits of having a kitchen (n=31) to prepare and store food. Preparation benefits included having greater choice and control over food. Several tenants (n=28) reported increased quantities of food available as well as how the food eaten is now healthier (n=22). Several respondents indicated that prior to current living situation they would eat less in order to provide more to their children.

THE COST OF RURAL PERMANENT SUPPORTIVE HOUSING

This study demonstrates that permanent supportive housing provides homeless individuals and families with disabilities stability, support and greatly improved quality of life for less money.

Are there cost savings and/or avoidance in a rural state?

The key finding of Maine's rural cost study is that there are savings when individuals and families with disabilities are helped out of the homeless system and offered housing in permanent supportive programs.

Although there was great variation in specific costs, the difference in utilization of state and local resources when people are stably housed and provided support services is clear. Service costs decreased in all of Maine's seven regions with decreases in emergency shelter nights and behavioral health costs representing the greatest savings.

In addition to the decreased costs, there are other important findings to help us understand the impact of providing stable housing. First is the importance of shifting contact away from emergency services which greatly impact local community budgets and draw needed resources away from other community priorities. Each time a person experiencing homelessness uses the emergency room for primary care, it adds to crowding and waiting time for all seeking emergency care. Each day a person with mental illness who is experiencing homelessness spends in jail, sleeps on the street or uses an emergency shelter to sleep, a community is effected.

Second, as individuals are housed and appropriate services are put in place, not only does the actual cost decrease, but the funding burden shifts from local and state budgets to leveraged federal funding due to the utilization of federal housing programs and MaineCare reimbursable treatment. For example, Shelter + Care housing vouchers, which account for 82% of the housing placements, are almost 100% funded by the Department of Housing and Urban Development.

Finally, the importance of increased quality of life for individuals with disabilities cannot be overstated. Beyond the fact that Maine cares about each individual and family experience, the benefits of increased independence, self awareness, and interest in vocational growth all suggest the possibility of decreased dependence on public resources and increased contribution to community.

What were the challenges of a cost study in a rural state?

Scope of work, data availability and data quality were the biggest challenges. Obtaining and interpreting data and issues related to the accuracy and availability of the data were particularly challenging. Contacts were made with over 100 hospitals, housing providers, police and sheriff departments, and mental health agencies in Maine. Each potential data resource was educated about the study and most agreed to assist the researchers. Several local hospitals initially thought they did not serve many people who were homeless and were surprised at the number of contacts that emerged once the data was processed.

As data was gathered, it became clear that understanding the data presented complicated challenges such as:

- Many smaller shelters previously had time limits that meant individuals may have been asked to leave before finding housing and, in some situations, people may have left and returned based on occupancy rules rather than housing placement. This impacted data on both costs and days in shelters.
- The homeless definition used by this study impacted the participation of individuals who might have been included if a broader definition was utilized.
- For people who have dual insurance coverage, such as both Medicaid and Medicare benefits, the difficulty of discovering sources of payment and varying rates created a challenge to get to real cost for services.
- Limited documentation and antiquated systems of data collection and storage added to the staff burden of retrieving records.
- 103 service categories which ultimately were blended into 14 categories were created to accurately obtain cost data. This number and the related volume of data made development of a strategy for analysis for this unique data set challenging

Recommendations for Cost Studies?

Based on the experience of all phases of the Maine study, these recommendations may be helpful to others interested in pursuing a similar study:

- Researchers must gain the support of the highest level staff in the state or local authorities who control the necessary data. Access to Medicaid data and data from institutions often requires clear mandates from those with decision-making authority.
- Define populations and services carefully and consistently. It is easy to find varying definitions and expectations from project funding sources and partners. Homeless and service definitions vary as well between specialized service providers.
- Recognize the different costs that emerge between individual and families. In this study the family data was collected from only the adult disabled head of household. Family members were not included so there were possible family costs not included in this data set. In future studies exclusion of families might be considered unless there is a viable plan to collect a more complete data set specifically created for the family related costs.
- Stick with the study design once it has been created. Pressure to re-think and re-define issues that have policy and financial repercussions is inevitable. For example, this study only included permanent supportive housing and did not include data from transitional housing programs although these programs were of interest to many providers.

Next Steps?

A major limitation of cost studies has been the inability to track changing costs over time. The Maine Cost study will be tracking the formerly homeless individuals who remain in stable housing during their second year of stable living in order to see if there are additional changes in service and housing costs.

In the second year, questions related to employment will be included in the study. A primary area of interest in current homeless services and an emerging best practice is "employment first", a recognition of the importance of work to individuals with disabilities whether homeless or housed, and the use of work as a means of helping homeless individuals gain the desire to succeed in housing. The fact that many formerly homeless people in the Maine study viewed improvement in the quality of their lives related to work, education, and independence reinforces the possible importance of employment to participants.

RESEARCH DESIGN

PARTICIPANTS

Tenants were asked to participate in this study if they met all of the following criteria:

1. They had been living in permanent supportive housing for a minimum of one year; and
2. They had a current diagnosis of a long-term disability, such as a mental illness, substance abuse, physical disability, or co-occurring disorders and
3. Prior to entry into permanent supportive housing they lived in a homeless situation as defined by the Department of Housing and Urban Development (HUD).

It is important to note that the HUD definition of homelessness includes individuals and families who lacks a fixed, regular, and adequate nighttime residence. This can include people staying in a shelter, temporarily institutionalized for less than 30 days; or a sleeping accommodation that is not designed for human beings (outside, a car, a pubic place). This definition does not include staying with friends or family, overcrowded housing, moving from home to home, or couch surfing. It does include imminent eviction from a dwelling that is rented or shared.

Participants are included from throughout Maine with the exception of the Greater Portland area, which was excluded from this portion of the research because a full report was published relating to Greater Portland in 2007. A total of 341 formerly homeless tenants in rural Maine met the study criteria; they were interviewed and asked to participate in the Rural Maine Cost of Homelessness study. One hundred sixty-three (163) tenants agreed to fully participate and 178 did not respond or declined. Those who agreed to fully participate in the project signed releases of information authorizing sharing of their data from the list of service providers.

Eleven of the sixteen counties in Maine were represented by the 163 participants. Previously homeless families with a disabled head of household accounted for 21% (34) of the sample and the remaining 79% (129) were individuals with disabilities. Aggregate demographic data for the 163 tenants who agreed to fully participate in Phase Two of the study can be found in Appendix A, attached at the end of this report. A summary graph of the living situations prior to permanent supportive housing is available in Appendix B.

HOUSING PROGRAMS

Permanent supportive housing provides affordable housing and supportive services for people in a homeless situation who have a disability. There is no limit on the length of stay. The intent of this type of supportive housing is to offer independent living options in a community setting with the tenants' needs determining the type and intensity of services provided.

Participants were drawn from sixteen permanent supportive housing programs throughout the State with the majority coming from the Department of Health and Human Services and City of Bangor's Shelter Plus Care programs. Shelter Plus Care is a rental subsidy program funded through Maine's Housing and Urban Development Continuum of Care funding allocation. This program provides rental subsidy funding to study participants which is matched by money spent on service provision to tenants. The vouchers are mainly used to rent apartments from private landlords in the community.

Other participants lived in supported apartment buildings with varied levels of on-site staffing. These programs are listed below by county and agency.

Kennebec County
Bread of Life Ministries – State Street SRO
Community Housing of Maine – Veteran's Waterville Project
Tedford Housing – Pleasant Street Augusta

Penobscot County
Bangor Area Homeless Shelter – Cedarview Apartments
Community Health and Counseling – Riverview II
OHI – Chalila House
Community Housing of Maine – Lewey House

Sagadahoc County
Tedford Housing – Gilbert Place

Somerset County
Kennebec Behavioral Health – Wilson Place

York County
York County Shelters Programs -
11 Lebanon, 17 Thornton, 57 Lebanon, Bates and Bowdoin, and Janis Apartments

TIME FRAME

In gathering data for the second phase of the study in rural Maine, it became clear that most homeless individuals and families were not chronically homeless and that costs associated with homelessness were primarily evident in the months leading up to provision of permanent supportive housing. Therefore a six month framework was adopted for this part of the cost study. There may be costs associated with long term rural homelessness that cannot be captured for individuals or families who are precariously housed and are couch surfing prior to meeting the homeless definition.

It also became apparent that the initial six months in housing often resulted in a spike in service need and cost that appears to represent the continuing challenges of situational crises and the beginning treatment of many long unmet needs. In the second six month period, from six months to one year in tenancy, service needs lessen as the benefits of stable housing become clear and initial crises resolved. Therefore, to best understand the relative impact of permanent supportive housing compared to homelessness, this report will focus on the six months prior to housing in comparison to the housing period from six months to one year in permanent supportive housing.

DATA SOURCE

Data was collected from local and regional sources throughout Maine including the following:

- Fire Departments
- Health Clinics
- Hospitals

- Jails
- Mental Health Centers
- Police Departments
- Shelters
- Sheriff Departments

A complete list of sources can be found in **Appendix C .**

ANALYSIS

For analysis and reporting purposes data from all sources were assigned to high-level groupings based on service categories. These are:

- Health
    - General hospitalization
    - Outpatient treatment
    - Emergency room visits

- Behavioral Health
    - Mental Health Care
        - Psychiatric hospitalization
        - Mental health treatment
    - Community Support
    - Substance Abuse

- Emergency Shelter

- Emergency and Public Services
    - Police Contacts
    - Jail Nights
    - Ambulance
    - Emergency Room

- Housing specific costs and services

Appendix D contains a detailed list of the data sources that formed these groupings.

LIMITATIONS

This study was modeled after the Maine phase one, Greater Portland Cost Study, and similar studies completed in Denver, New York, and other major cities. The study design tracked service utilization by a set of individuals for defined periods before and after their entry into permanent supportive housing. It does not compare the cost-effectiveness of permanent supportive housing with other forms of housing. Due to confidentiality requirements this study relied on the voluntary participation of tenants. Therefore it is possible there was some skewing of results due to self-selection; those who agreed to participate might have differed in service utilization from those who refused to allow their data to be used.

It was only possible to obtain supportive service data for those participants who were receiving MaineCare benefits; therefore, results may undercount utilization of services by those who were not enrolled in MaineCare for the full duration of the study period. As such the results should be

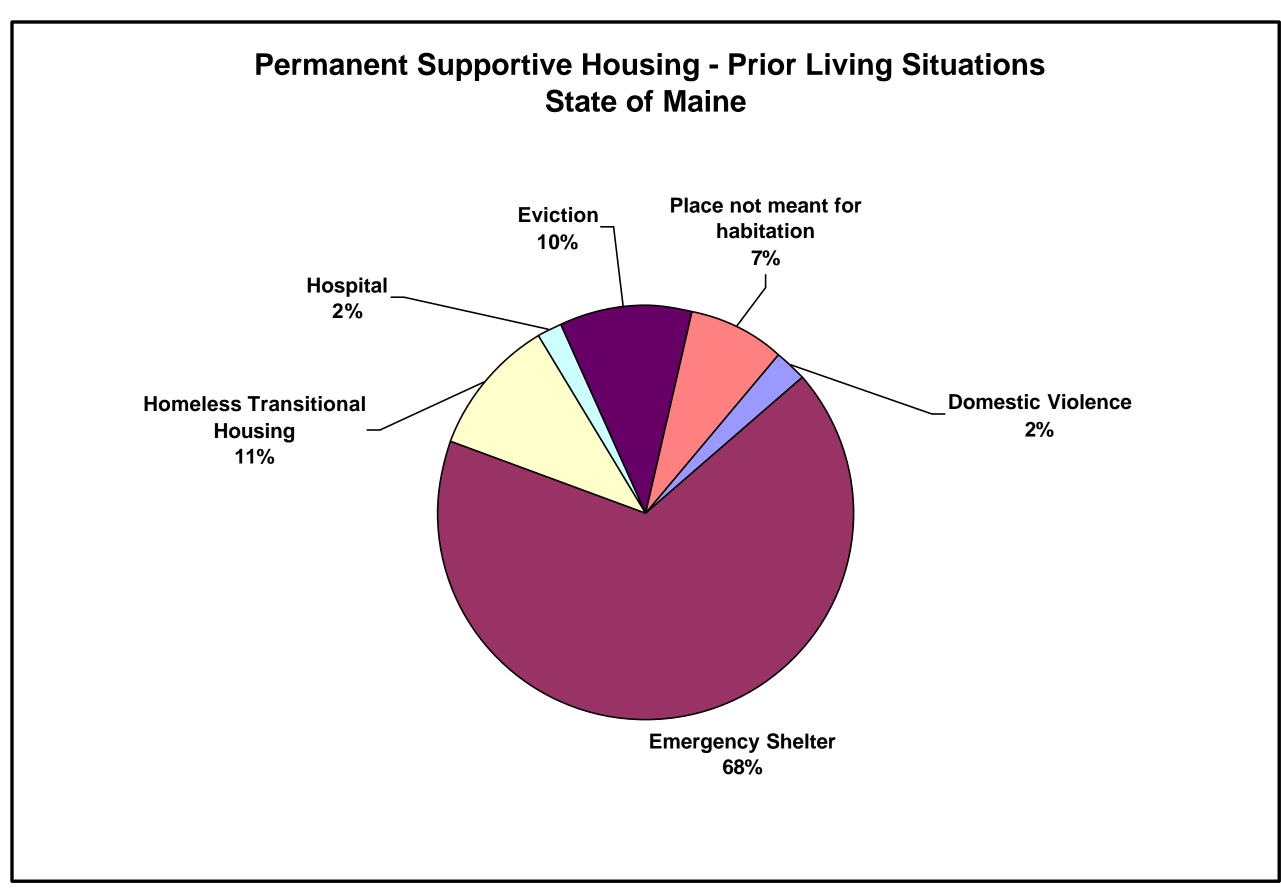
viewed as conservative projections of true costs. Additionally, for those tenants who were part of a family only the head of household service information was available.

APPENDIX A
Demographics

Median Age	Median Age Female	Median Age Male	Single	Family	Caucasian	Black/ African American	American Indian Alaska Native	Other Race	Unknown
43	42	44	129	34	139	3	15	5	1
			79.1%	20.9%	85.3%	1.8%	9.2%	3.1%	0.6%

GENDER			DISABILITIES				
Male	Female	Veteran	Severe Mental Illness	Chronic Alcohol Abuse	Chronic Drug Abuse	Physical Disability	Other Disability
77	86	18	158	30	26	3	1
47.2%	52.8%	11.0%	96.9%	18.4%	16.0%	1.8%	0.6%

APPENDIX B
Prior Living Situations



APPENDIX C
Data Sources

Data Provider		Data Provider
Acadia Hospital		Hancock County Jail
Alfred Rescue		Hancock County Sheriff
Androscoggin Sheriff and Jail		Health Care for the Homeless Clinic
Aroostook County Jail		Hope Haven
Aroostook Shelter Services		Hope House
Auburn Police Department		Hospitality House
Augusta Fire Department		Kennebec Behavioral Health
Augusta Police		Kennebec Sheriff and Jail
Bangor Area Homeless Shelter		Kittery Police
Bangor Fire Department		Knox County Jail
Bangor Police Department		Knox County Sheriff
Bar Harbor Police Department		Lewey House
Bath Police Department		Lincoln Police
Biddeford Fire Department		Maine Coast Memorial Hospital
Biddeford Police Department		Maine Department of Health and Human Services
Blue Hill Memorial Hospital		Maine Medical Center
Bread of Life Ministries		MaineCare
Brewer Police Department		MaineGeneral Hospital
Brunswick Fire Department		Mercy Hospital
Brunswick Police Department		Meridian Mobile
Caribou Fire and Ambulance		Midcoast Hospital
Caribou Police		MidMaine Homeless Shelter
Chalila House		Milestone Foundation
Central Maine Medical Center		Mount Desert Island Hospital
City of Bangor – Shelter Plus Care		Newport Police Department
Community Health and Counseling		Northern Maine Medical Center
Community Housing of Maine		Old Town Police
County Ambulance		Orono Police Department
Cumberland County Jail		Oxford Street Shelter
Delta Ambulance		Parkview Hospital
Dorthea Dix State Hospital		Penobscot Bay Hospital
Ellsworth Police Department		Penobscot Community Health
Emmaus Shelter		Penobscot Jail and Sheriff
Eastern Maine Medical Center		Portland Fire Department
Fairfield Police Department		Portland Police Department
Gardiner Fire Department		Preble Street
Gardiner Police Department		Presque Isle Police
Goodall Hospital		Redington-Fairview General Hospital
Hallowell Police Department		Riverview State Hospital

Data Provider (cont)
Rockland Fire Department
Rockland Police
Saco Police Department
Sagadahoc Sheriff
Sanford Fire Department
Shalom House
Skowhegan Police
Southern Maine Medical Center
Spring Harbor Hospital
St.Joseph's Hospital
St.Martin de Porres
St.Mary's Hospital
Tedford Housing
Veteran's Administration
Two Bridges Jail
Topsham Police Department
Two Bridges Jail
United Ambulance
Veazie Police Department
Waterville Police Department
Winslow Police Department
Winthrop Police Department
York County Shelters Programs
York County Sheriff and Jail

APPENDIX D
Service Categories

GROUPINGS	Sub-categories
Ambulance	Ambulance
Case Management	Case Management Community Support Day Shelter Adult Protective Services
Dental	Dental Denturist
Emergency room	Emergency
	Healthy Families Adult PDN Service Ambulatory Care Clinic Service Ambulatory Surgical Center Attendant Services Certified Rural Health Clinic Chiropractic Services Family and Pediatric Nurse Practitioner Family Planning Clinic Federally Qualified Health Center General Inpatient General Outpatient Health Clinic Home Health Services Independent Lab Indian Health Services Medical Imaging Services Medical Supplies/DMI Supplies Medicare B – X-over Medicare Part A – X-over Nursing Facility Occupational Therapy Optical Services Optometric Services Physical Therapy Physician Podiatrist Prosthetic Devices Rehabilitation Services (Head Injury) V.D. Screening

SERVICE CATEGORIES (cont)

Category	Services
Housing	11 Lebanon Street 17 Thornton Avenue 57 Lebanon Bates and Bowdoin Chalila House Croquet Lane Gilbert Place Janis Apartments Lewey Logan Place Personal Care Services Pleasant Street Augusta Private Non-Medical Institutions Riverview II Shelter Plus Care Janis Apartments Lewey Logan Place Personal Care Services Pleasant Street Augusta Private Non-Medical Institutions Riverview II Shelter Plus Care Spring Street State Street SRO Stevens Avenue Veteran’s Project Wilson Place
Jail night	Jail Night
Police contact	Police Contact
Mental Health Care	Mental Health Services - counseling, psychiatry Mental Inpatient - State Hospital and Private psychiatric beds Outpatient Mental Health Psychological Services
Prescribed drugs	Prescribed drugs
Transportation	Transportation
Shelter night	Shelter Night
Substance Abuse Treatment	Detoxification Bed Health Clinic Substance Abuse Services Substance Abuse Case Management Substance Abuse Treatment - Inpatient and Outpatient