

# Housing First Charlotte-Mecklenburg Research & Evaluation Project Executive Summary

November 2020/Executive Summary

Funded by Mecklenburg County, Roof Above, UNC Charlotte College of Health & Human Services, School of Social Work, and the UNC Charlotte Urban Institute

In memory of Nancy Crown and John Yaeger.  
In honor of HFCM research participants.



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# Housing First Charlotte-Mecklenburg

## Timeline

2014

### AD HOC CONVENING

Charlotte Center City Partners convenes homeless services providers and Charlotte-Mecklenburg police officers to address street homelessness

### OBSERVER ARTICLE

Article reporting proposal to remove Uptown benches to address street homelessness

### DAWN WALKS

Center City Partners and Urban Ministry Center host dawn walks with community leaders to discuss rise in street homelessness

### HFCM FORMALIZES

Ad hoc group becomes Housing First Charlotte-Mecklenburg Working Committee and Steering Committee is recruited

### ANNOUNCEMENT

Broad HFCM Coalition holds media event announcing public goal to end chronic homelessness by the end of 2016

### BY-NAME REGISTRY

Over 250 volunteers assist in extended Point-In-Time count to create By-Name List of 516 individuals experiencing chronic homelessness

2015

### OUTREACH GROWS

Outreach team expands from 3 to 12 staff and PATH team members are added to the Urban Ministry Center outreach staff

### PATHWAYS

Dr. Sam Tsemberis and Pathways Housing First begin technical assistance for the community, aimed toward direct service providers

### 200+ HOUSED

HFCM houses 214 by end of 2015

### EVALUATION

Contracts completed between UNC Charlotte and Mecklenburg County for the Outcomes & Utilization Evaluation, & with Urban Ministry Center for Process Evaluation

2016

### EXPANSION

Moore Place Expansion opens, providing 35 efficiency apartments for veterans experiencing chronic homelessness

### TRANSFERS

Service providers establish practices that allow housed individuals to transfer between programs

### SITE STALLS

New single site facility tabled when neighborhood resists its planned placement.

### MANAGEMENT

Urban Ministry Center names new project manager

### 440+ HOUSED

HFCM houses 445 by end of 2016. Effort extended to meet goal

### GROUPS MERGE

Data and 250 PSH committees combine to better address inflow and need for additional units

2017

### CONSORTIUM

Housing CLT Landlord Consortium established

### MANAGEMENT

Project manager leaves and is not replaced

### 600+ HOUSED

HFCM houses 617 by end of 2017

### CONSOLIDATION

Operational effort to end chronic homelessness becomes a committee of the Continuum of Care

### AWARD

Charlotte Center City Partners presents HFCM with a 2018 Vision Award

2018

### 800+ HOUSED

HFCM houses 814 by end of 2018

### 1000+ HOUSED

HFCM houses 1011 by January 2020

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# HFCM Research & Evaluation Project Executive Summary

## Introduction

Housing First Charlotte-Mecklenburg (HFCM) is a multisector collaboration to end chronic homelessness by scaling housing first, and particularly the housing first permanent supportive housing model. Housing first programs prioritize housing as an early step in service delivery, have low barrier admissions policies with minimal eligibility criteria, maximize client choice in housing and services, use a harm reduction approach to substance use and other personal challenges, and do not require service compliance or success in order for a tenant to maintain housing. The Housing First Charlotte-Mecklenburg Research & Evaluation Project examined the implementation and outcomes of the effort between 2015-2018.

This executive summary describes findings from the final Process Evaluation Report and the Outcomes Evaluation and Service Utilization Study Report, both available on the Charlotte-Mecklenburg Housing and Homelessness Dashboard. The study suggests evidence of positive impact and opportunities for improvement at program and community levels.

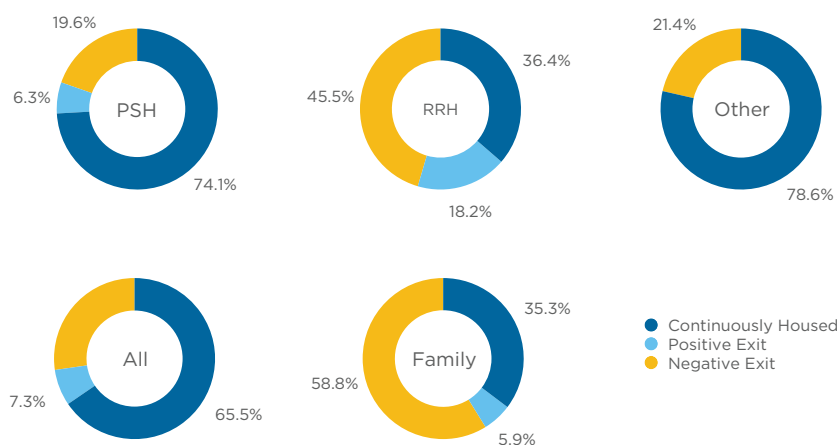
# Key Findings

## OVER 1000 HOUSED: Numeric Goal Exceeded

HFCM led to housing placements for over 1000 individuals experiencing chronic homelessness as of January 2020, nearly twice the initial goal of 516. Based on a sample of 330 individuals from the chronic homelessness by-name list, about 70% of individuals remain in housing after a year.

The majority of individuals housed moved into housing first permanent supportive housing and over 80% of those individuals remain in housing. Evidence suggests that they will remain stably housed over the long-term.<sup>1</sup>

Figure 1: Housing retention rates of participants housed 12 or more months (n=165)



Despite numbers housed, the effort did not meet its original goal of ending chronic homelessness by the end of 2016 or 2017, primarily because of a lack of available and affordable housing for extremely low-income individuals. Lack of affordable housing pushes more people into chronic homelessness, since the longer people remain homeless, the more likely they are to “weather” on the streets and develop disabling conditions.<sup>2</sup> In addition, it prevents people from leaving chronic homelessness because despite best efforts, direct service providers must compete with each other to secure the few available rental units. With the shortage of affordable housing estimated at 23,060 for households that earn under \$26,200 for a family of four or \$17,550 for a single individual (less than 30% of the Area Median Income or AMI), there are not enough units of available and affordable housing and/or rental subsidies to end chronic homelessness in Charlotte-Mecklenburg.

<sup>1</sup> e.g., Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. *Journal Epidemiological Community Health*, 73(5), 379-387.

<sup>2</sup> e.g., Brown, R. T., Kiely, D. K., Bharel, M., & Mitchell, S. L. (2012). Geriatric syndromes in older homeless adults. *Journal of General Internal Medicine*, 27(1), 16-22; Geronimus, A. T., Hicken, M., Keene, D., & Bound, J. (2006). “Weathering” and age patterns of allostatic load scores among blacks and whites in the United States. *American Journal of Public Health*, 96(5), 826-833.



## THE IMPACT OF HOUSING IS MEASURABLE:

# On People and the Community

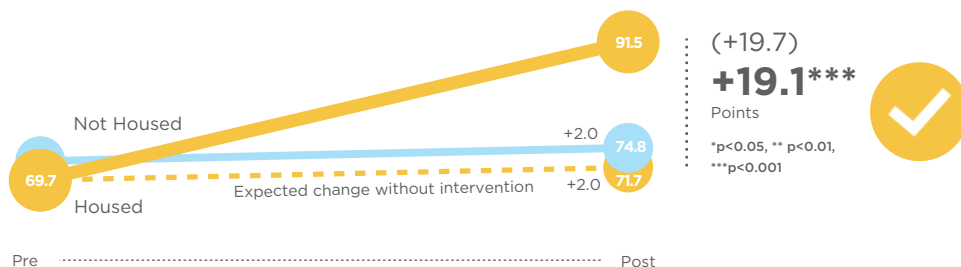
### People Do Better in Housing

When compared to study participants in the sample who weren't housed, people who were housed fared better on a number of standardized measures.

### Quality of Life Improves

Quality of life scores improved 30% after housing. Housed participants scored nearly 20 points higher on a 120-point standardized scale (20-140) than did unhoused participants. This is a large and substantial improvement and it aligns with existing research demonstrating the positive impact of housing first permanent supportive housing on quality of life among formerly chronically homeless individuals.<sup>3</sup> As one housed study participant noted, "Everything has changed. I just feel like a big boulder has fallen off my shoulders. I have a sense of belonging, I actually have keys, it is just awesome."<sup>4</sup>

Figure 2: Adjusted change in quality of life scores after housing, Housed (n=111) v. Not Housed (n=64) Scale 20-140



<sup>3</sup> e.g., Henwood, B. F., Matejkowski, J., Stefancic, A., & Lukens, J. M. (2014). Quality of life after housing first for adults with serious mental illness who have experienced chronic homelessness. *Psychiatry Research*, 220(1-2), 549-555.

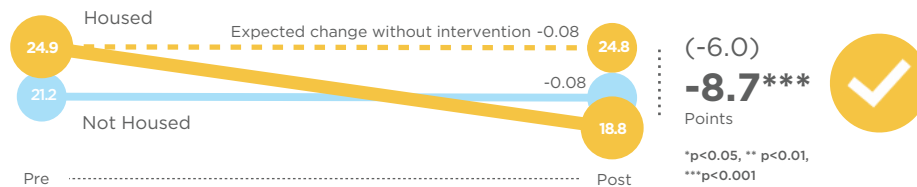
<sup>4</sup> E-648:2



### Their Overall Mental Health Improves

Mental illness symptom scores decreased 35% after housing. Housed participants scored 9 points lower on a standardized 56-point scale (0-56) of mental illness-related symptoms than did unhoused participants. In addition, perceptions about their general mental health improved, although they remained lower than the general population. A number of study participants described how housing had positively impacted their mental health. One housed participant noted, “Mentally, I think I’m a lot better.”<sup>5</sup> The HFCM study suggests that housing is effective in addressing the poor perceived mental health of participants as well as mental health symptoms.

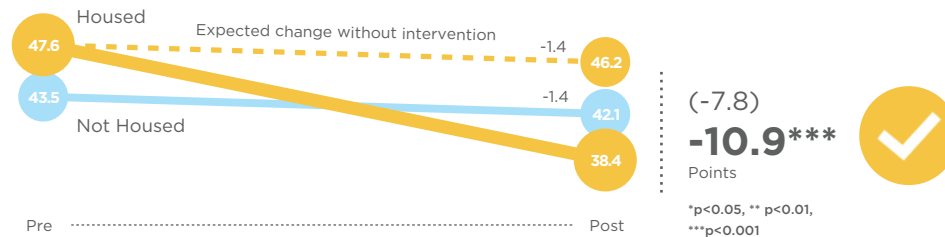
Figure 3: Adjusted change in perceived mental health symptom scores after housing  
Housed (n=111) v. Not Housed (n=64)  
Scale 0-56



### Specifically, They Have Fewer Symptoms of Traumatic Stress

Traumatic stress and the symptoms that arise from it are common among those experiencing homelessness and lifetime rates of trauma exposure were high among study participants. After housing, trauma-related symptoms decreased 26%. Housed participants, who had high lifetime rates of traumatic stress, scored 11 points lower on a standardized 68-point scale (17-85) of trauma-related symptoms than did unhoused participants who only scored 1 point lower after baseline. The Veterans Administration National Center for PTSD considers a 5-10 point reduction a reliable indicator that a person is responding to an intervention and 10-20 improvements suggest a clinically meaningful change has occurred.<sup>6</sup>

Figure 4: Adjusted change in Trauma-Related Symptom score after housing  
Housed (n=111) v. Not Housed (n=64)  
Scale 17-85



5 E-649:4

6 Monson, C. M., Gradus, J. L., Young-Xu, Y., Schnurr, P. P., Price, J. L., & Schumm, J. A. (2008). Change in posttraumatic stress disorder symptoms: do clinicians and patients agree?. *Psychological Assessment*, 20(2), 131.

### And, Housing Reduces or Moderates Use of Substances

Housing first does not require sobriety or abstinence. Nevertheless, after housing the percent of participants that used any drug fell 37% and the average number of days in the last 30 days that housed participants used alcohol to intoxication fell an average of 3 days more than it did for unhoused participants. Other substance use measures didn't change after housing, a reminder that harm reduction doesn't necessarily result in increased use of alcohol or drugs. Despite no change in alcohol use in the larger housed group, individuals in Housing first permanent supportive housing used alcohol 3.2 fewer days than did the individuals in non-PSH housing, suggesting that the harm reduction practices of housing first permanent supportive housing and meeting people where they are may be effective in reducing the use of alcohol. As one housed participant stated in the language of harm-reduction, "I'm practicing how to deal with life without the use of drugs and alcohol."<sup>7</sup>

Figure 5: Adjusted change in percent who use any drug in last 30 days after housing Housed (n=111) v. Not Housed (n=64) Scale 0-100

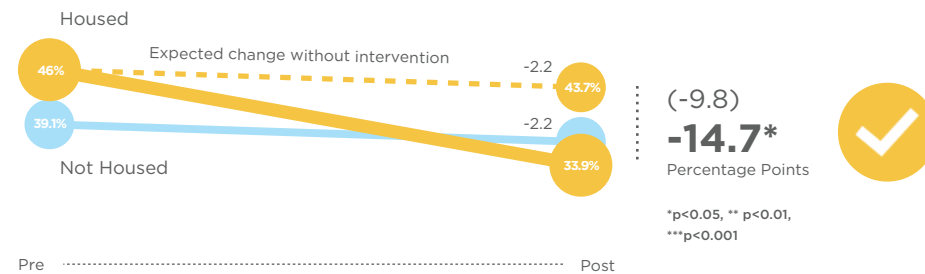
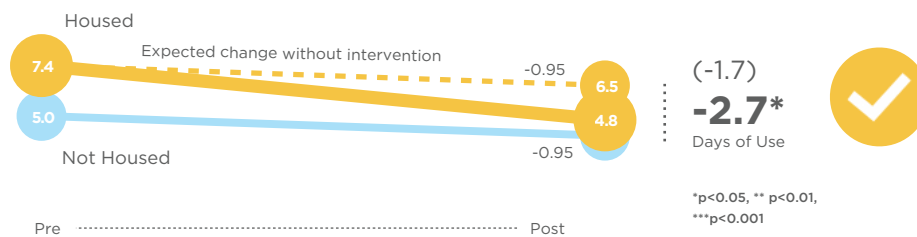


Figure 6: Adjusted change in days of alcohol use to intoxication after housing Housed (n=111) v. Not Housed (n=64) Scale 0-30

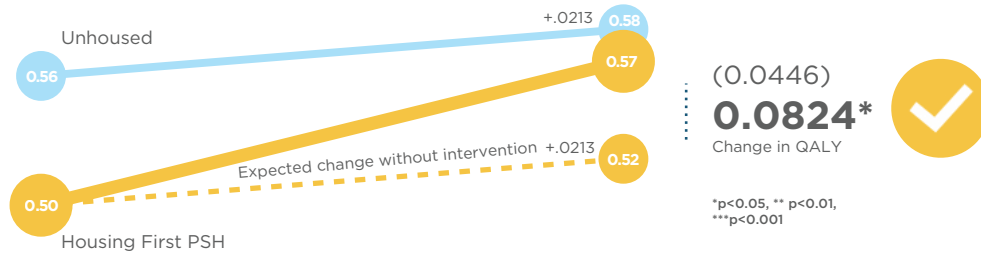


<sup>7</sup> E-870:1

### Quality of Life Improvements Have Value

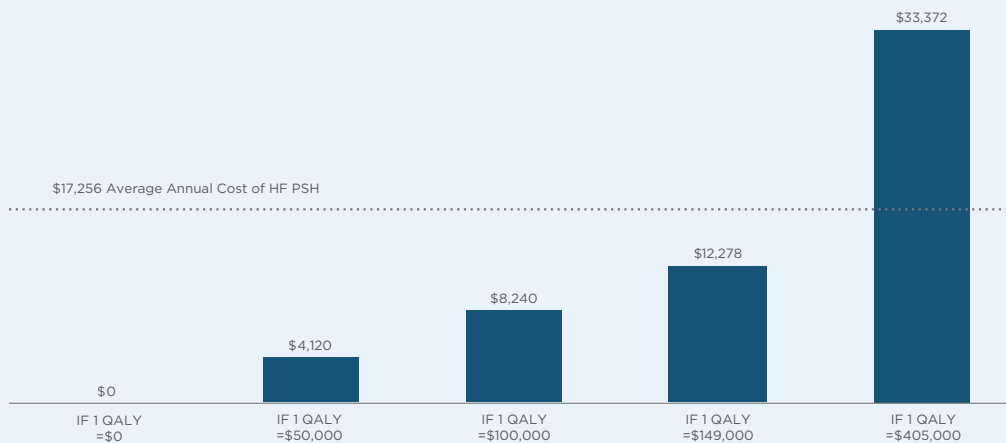
Quality of life changes can be mapped to a scale that measures changes in a person's health state, called a quality adjusted life year (QALY).<sup>8</sup> QALYs range from 0 to 1, with one representing a year of full and perfect health. On average, QALYs improved approximately 8% for individuals housed in housing first permanent supportive housing, a meaningful improvement.

Figure 7: Adjusted Change in Quality Adjusted Life Year  
HF PSH (n=70) v. Unhoused (n=47)  
Scale, 0 to 1



When examined through the lens of a QALY, improvements in health related quality of life due to housing first permanent supportive housing can be valued annually from \$4,120 to \$33,372 depending on the value assigned to a year of full and perfect health. This monetary estimation of health benefits is another way of understanding the benefits of housing first and specifically, housing first permanent supportive housing.

Figure 8: Monetary Benefit in Quality of Life Improvements



<sup>8</sup> Franks, P., Lubetkin, E. I., Gold, M. R., & Tancredi, D. J. (2003). Mapping the SF-12 to preference-based instruments: convergent validity in a low-income, minority population. *Medical Care*, 1277-1283.



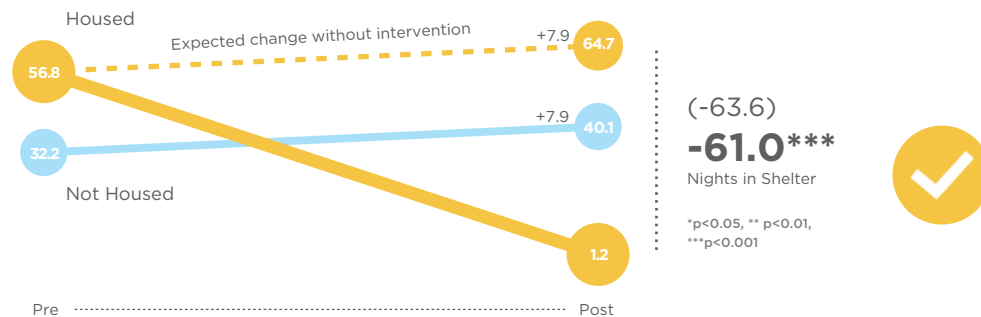
### The Impact Extends to the Community

The impact of housing could also be measured in how it impacted use of community services.

#### Fewer Nights in Emergency Shelter

The average number of nights in emergency shelter dropped 94% for housed participants. Housing nearly ended the use of emergency shelter. The findings echo other studies documenting the effectiveness of housing first permanent supportive housing in ending shelter use specifically and homelessness in general.<sup>9</sup> While the reduction of emergency shelter use is an important indicator of success in addressing chronic homelessness, it is also an important community indicator of system effectiveness and efficiency. It suggests that the freed shelter space can be otherwise used to address the needs of non-chronic homeless populations, most of which will not return to homelessness after receiving brief emergency services.<sup>10</sup> Successfully addressing chronic homelessness frees up resources to address short-term crises and allow for a more effective and efficient coordinated response system.<sup>11</sup>

Figure 9: Adjusted change in average number of nights in emergency shelter after housing, Housed (n=165) v. Not Housed (n=129)



<sup>9</sup> e.g., Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651-656.

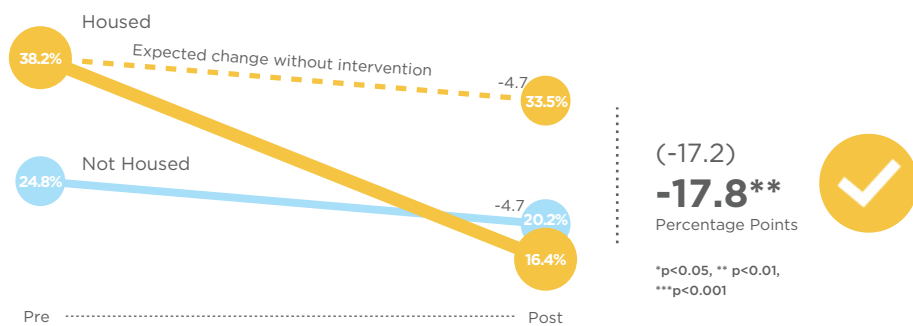
<sup>10</sup> e.g., Kuhn, R., & Culhane, D. P. (1998). Applying cluster analysis to test a typology of homelessness by pattern of shelter utilization: Results from the analysis of administrative data. *American Journal of Community Psychology, 26*(2), 207-232.

<sup>11</sup> e.g., Padgett, D., Henwood, B. F., & Tsemberis, S. J. (2016). *Housing First: Ending homelessness, transforming systems, and changing lives.* Oxford University Press, USA.

### Fewer People Arrested and Incarcerated

The percent of housed individuals arrested fell 58% and percent of housed individuals incarcerated fell 59%. The decline in the percentage of participants arrested is approximately 5 times what would have been expected without housing and decline in percentage of participants incarcerated is 11.5 times what would have been expected without housing. Study participants suggested that this was one of the most difficult parts of being homeless. As one man said, "It's tough...it's hard to use the restroom on the street or you'll be charged, I have a lot of public urination charges."<sup>12</sup> This indicates that housing may be particularly effective and protective for Black, Indigenous People, and other Persons of Color - 52% fewer housed Black or Non-White individuals were arrested than unhoused Black or Non-White individuals.

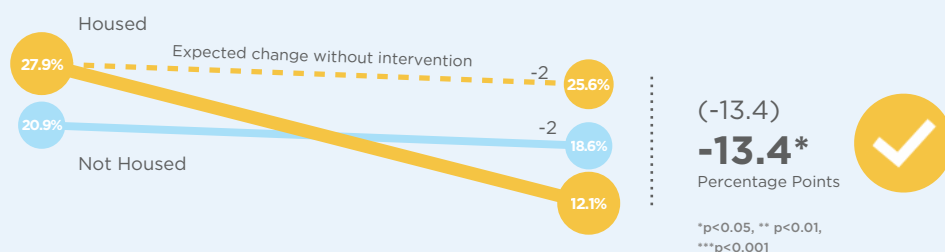
Figure 10: Adjusted change in percent arrested after housing  
Housed (n=165) v. Not Housed (n=129)  
Scale 0-100



### Fewer Health Department Visits

The percent of housed individuals using the Mecklenburg County Health Department fell 56% and the average number of visits fell 71%. The decline in average number of visits is nearly 7 times what would have been expected without housing. As people are housed, particular risks like tuberculosis or sexually-transmitted diseases and the fear or likelihood of becoming infected may decrease. In addition, some reduction may be due to service availability in housing programs or more regular access to outpatient care. Homeless service utilization studies do not typically include the examination of public health departments and their clinic services, instead focusing on emergency department and inpatient utilization. The findings and further research provide an opportunity to better understand how and why housing impacts the utilization of public, free, and low-cost clinics.

Figure 11: Adjusted change in percent of participants using the health department after housing  
Housed (n=165) v. Not Housed (n=129)  
Scale 0-100



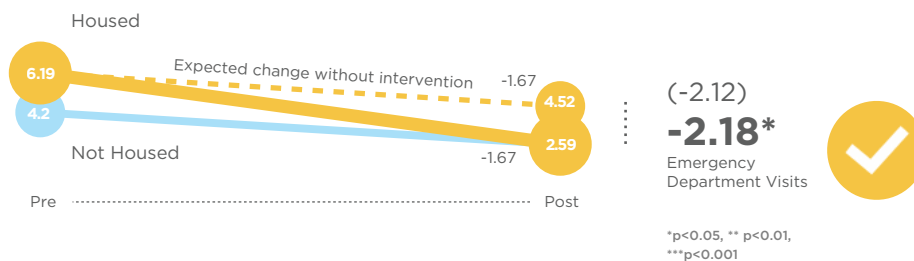
<sup>12</sup> E-168:10



### Fewer Emergency Department Visits

The percentage of housed participants using the ED didn't change after housing, but the average number of ED visits fell 59%. On average, housed participants had 2 fewer visits to the ED than unhoused participants in the year after housing. Similar to existing estimates,<sup>13</sup> the majority of study participants (83.3%) visited one of the major hospital systems during the study. Diagnoses indicate the participants used the emergency department mostly for conditions related to mental health and co-morbid alcohol or drug use disorders, chronic physical pain, or injury. The study suggests a positive impact on the use of emergency resources.<sup>14</sup>

Figure 12: Adjusted change in average number of emergency department visits after housing, Housed (n=165) v. Not Housed (n=129)



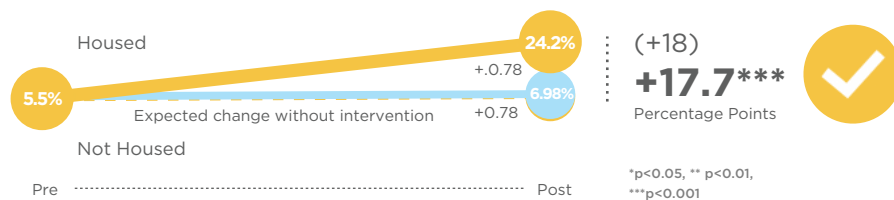
<sup>13</sup> Ku, B. S., Scott, K. C., Kertesz, S. G., & Pitts, S. R. (2010). Factors associated with use of urban emergency departments by the US homeless population. *Public Health Reports*, 125(3), 398-405.

<sup>14</sup> Sun, R., Karaca, Z., & Wong, H. S. (2017). Characteristics of homeless individuals using emergency department services in 2014. *Agency Health Research Quarterly*, 1-13.

### More Use of Crisis Assistance Ministry

About 66% of housed participants used financial assistance services and 45% used furniture assistance services in the 1 month period immediately before or following their housing date. About 42% (n=69) received financial assistance in the one month prior to and following their housing. These seemed to be one time costs associated with moving into housing including the money for security deposits and furniture for apartments. More housed participants used Crisis Assistance Ministry, however, even after the housing period was over. Only 5% of housed participants used financial assistance before housing, but 24% used it after the immediate housing period and only 2% used furniture services before housing, but 12% used the services after the housing period. Very few unhoused participants used either service. While Crisis Assistance Ministry primarily serves households that are in financial crisis and are housing insecure in order to prevent homelessness, these findings suggest that they are also a part of the continuum of housing services that help households exit chronic homelessness and remain housed. Some added service use may be expected to help formerly homeless individuals remain housed.

Figure 13: Adjusted change in percentage using financial assistance services after housing Housed (n=165) v. Not Housed (n=129) Scale 0-100







**\$17,256** Average Annual Cost of PSH

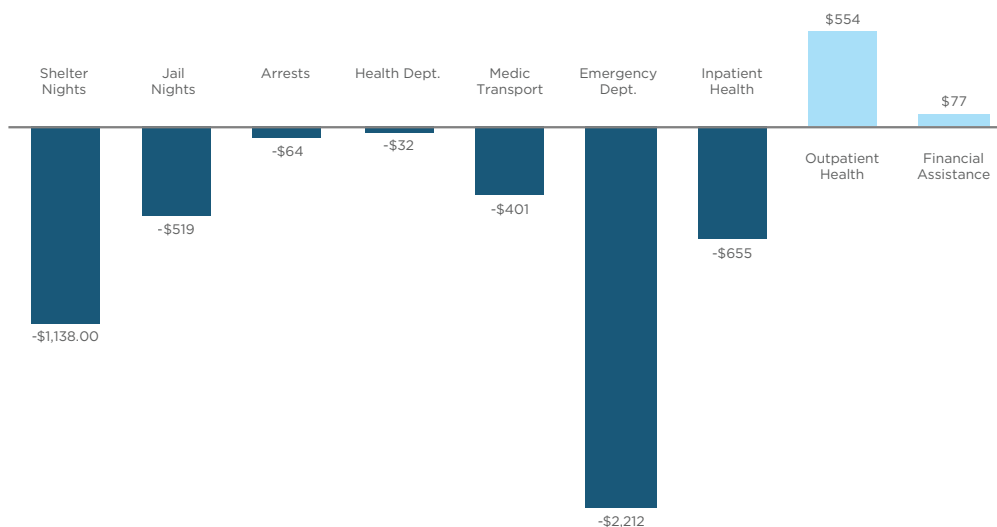
**-\$4,390** Reduction in Cost of Community Services

**\$12,866** Average Annual Cost of HF PSH with Cost Offsets in Other Community Services

### Housing Costs are Partially Offset in Other Community Services

As expected from the service use changes discussed above, housing resulted in savings in other community services, even if more modest than earlier local and national studies of housing first permanent supportive housing (HF PSH) suggest.<sup>15</sup> For every \$10 invested in HF PSH, there is a \$2.54 cost reduction in other community services. These savings reduce the average annual cost of HF PSH from \$17,256 to \$12,866. As discussed in the full report, study participants were not exclusively individuals who regularly and frequently used emergency services before housing but rather, represented a cross section of individuals with a range of service use histories, including little or no use of emergency services. HF PSH does not necessarily “pay for itself” - an expectation other health and social interventions are not expected to meet - but it remains the most effective intervention to end chronic homelessness to date, with housing retention rates that often double that of non-housing first services.<sup>16</sup> As an effective intervention, it is relatively low cost and given partial cost offsets and the potential economic, social, and personal value of benefits, it has become the best evidence-based practice to address and end chronic homelessness.<sup>17</sup>

Figure 14: Annualized Adjusted Average Change in Cost of Community Services Per Person after HF PSH



<sup>15</sup> e.g., Thomas, M. L., Priester, M. A., Shears, J. K., & Pate, M. C. (2015). Moore Place Permanent Supportive Housing Evaluation: Final Report. Charlotte, NC.

<sup>16</sup> e.g., National Academies of Sciences, Engineering, & Medicine. (2018). Permanent supportive housing: Evaluating the evidence for improving health outcomes among people experiencing chronic homelessness. Washington, DC: The National Academies Press. <https://doi.org/10.17226/25133>.

<sup>17</sup> Kertesz, S. G., T. P. Baggett, J. J. O'Connell, D. S. Buck, and M. B. Kushel. 2016. Permanent supportive housing for homeless people—reframing the debate. *New England Journal of Medicine*, 375:2115-2117



**WHY THESE IMPACTS WERE POSSIBLE:**

## The Community Invested in What Works

### **Multi-Sector Collaboration**

HFCM brought together diverse community partners for a new collective purpose. The multi-sector collaboration allowed the services sector to extend its reach beyond typical and often fragmented resources and accelerate the rate at which individuals were housed. Convened by Charlotte Center City Partners, collaborating organizations included service providers, local government, businesses, the university, congregations, and neighborhood organizations. Reflecting on what made HFCM successful, one service provider noted, “I’m a very strong believer in collaboration, and I think whenever people in a community get together around a common goal that it matters. It changes things.”<sup>18</sup>

[See HFCM stakeholders on page 18](#)

### **Orientation Toward Permanent Solutions**

HFCM put substantial resources behind housing first permanent supportive housing, an evidence-based practice with a documented track record of success locally, nationally, and internationally.<sup>19</sup> In doing so, the effort help facilitate a reorientation of chronic homeless services and broader public perceptions of chronic homeless services from crisis management to permanent housing solutions. As one effort leader stated, “I think there was generally this accepted, assumed rather reality that homelessness was this huge, monolithic social problem for which there was no answer. And I think we have changed the conversation to, ‘Yes, there is an answer.’”<sup>20</sup>

### **A Project Infrastructure to Support the Effort**

HFCM developed a project infrastructure to support the effort that did not rely solely on already over-extended resources and services. Collaborators brought over \$1 million to the effort stimulating additional financial and in-kind investments from Charlotte Housing Authority (now Inlivan), Crisis Assistance Ministry, and UNC Charlotte. Funding was used to develop a project management infrastructure that propelled early housing success including regular data monitoring, creative problem solving as the cost of available housing rapidly increased, effective communication, and training for direct service providers.

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## **LESSONS LEARNED:**

### **Evaluations are Teaching Tools**

#### **Examine the Racial Equity Implications of the Prioritization Tool**

Analysis of scoring on the Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT), the instrument used to prioritize housing for those on the By-Name List, suggests that on average, the prioritization tool scores White individuals higher than Black individuals. In addition, a greater percentage of White individuals were housed in permanent supportive housing than were Black individuals, an outcome likely related to the VI-SPDAT. These findings are similar to a study of three Pacific Northwest Continuum of Care (CoC) communities that found that the instrument better predicted White vulnerability than Black vulnerability and thus prioritized more extensive housing supports for White people.<sup>21</sup> The CoC should examine and review use of the tool and develop a prioritization process that is more sensitive to vulnerabilities that may vary by race and ethnicity.

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<sup>19</sup> e.g., Thomas, M. L., Priester, M. A., Shears, J. K., & Pate, M. C. (2015). Moore Place Permanent Supportive Housing Evaluation: Final Report. Charlotte, NC; Padgett et al., 2016; Busch-Geertsema, V. (2014). Housing first Europe—results of a European social experimentation project. *European Journal of Homelessness*, 8(1).

<sup>20</sup> A-17:19

<sup>21</sup> Wilkey, C., Donegan, R., Yampolskaya, S., & Cannon, R. (2019). Coordinated entry systems: Racial equity analysis of assessment data. Needham, MA: C4Innovations

## Address Project Infrastructure Improvements

Despite successes, study participants in the process evaluation identified several aspects of the project infrastructure that could improve, particularly as the effort faced challenges in 2016.

- › First, engage stakeholders in strategic and operational decision-making. Steering committee members noted that they could have helped address initiative challenges had they been aware of them earlier.
- › Second, sustain project management throughout the initiative and ensure its capacity. During key transition periods - August 2016 through February 2017 and after October 2017 - the initiative lost half of its project management capacity.
- › Third, sustain communication especially in the case of initiative setbacks. Study participants noted the difference between the effectiveness of early communication and the lack of information when the effort struggled.
- › While process evaluation study participants celebrated the diversity of collaborators, they also noted missing sectors, missing voices, and the resulting missed opportunities.

## Improve the Housing First Response

**Housing Retention:** Housing retention rates were lower for those placed in Rapid Re-Housing or in permanent placements with family or friends. Only 55% of those placed in RRH remained housed and only 41% of those placed with family or friends remained housed. Further study of these models are warranted as is testing innovations that may increase the effectiveness of these housing interventions.

**Food Insecurity:** Rates of low and very low food security remained high - 83% - for housed participants after housing and increased 26.8 percentage points more for PSH participants than it did for non-PSH participants, a 32% increase in the rate of low and very low food security. The percentage of households that experience food insecurity is higher in Mecklenburg County (14.9%) than it is in North Carolina (13.9%) and the U.S. (11.1%) suggesting elevated risk for low-income individuals,<sup>22</sup> particularly those with multiple disabilities and limited access to transportation. Housing first permanent supportive housing services should consider ensuring food security a regular part of the service array.<sup>23</sup>

**Physical Health:** Even though it improved slightly, housing did not statistically change housed participants perceptions of their own physical health. Scores on a standardized health assessment started and remained below those of the general U.S. population. Given that the majority of study participants have 2 or more disabilities, this isn't surprising and suggests opportunities to improve and better integrate health services.<sup>24</sup>

Housed participants continued to use inpatient and outpatient services at rates statistically similar to their use before they were housed. While there are opportunities to improve health-related services within housing programs, the findings serve also as a caution to those

<sup>22</sup> Harris, V.G., & Boger, M. (2020, January 20). Food deserts: Food access update. Presentation to the Mecklenburg County Board of County Commissioners.

<sup>23</sup> Henwood, B. F., Cabassa, L. J., Craig, C. M., & Padgett, D. K. (2013). Permanent supportive housing: addressing homelessness and health disparities?. *American Journal of Public Health*, 103(S2), S188-S192.

<sup>24</sup> Weinstein, L. C., Henwood, B. F., Matejkowski, J., & Santana, A. J. (2011b). Moving from street to home: Health status of entrants to a housing first program. *Journal of Primary Care & Community Health*, 2(1), 11-15.

expecting drastic reduction in utilization and related costs.<sup>25</sup> The impact of years without housing and access to preventative care may require some ongoing investment from the community to effectively address.

### Support the Philosophical Shift

Housing first is a significant departure from traditional homeless service delivery and shifting perspectives from the front-line to the board room can be challenging. In the housing first model housing is a foundation not a reward, people are born housing-ready, and services begin with the person instead of a meeting a high threshold of eligibility criteria. These are fundamental reorientations of many programs and organizations. Study participants suggested that multiple layers of support are needed to facilitate and sustain a lasting change in philosophy even among organizations that are housing first proponents.<sup>26</sup>

### Connect to the System Context

Study findings suggest the importance of connecting chronic homelessness to larger community issues like the overall homeless problem, access to housing, limited economic mobility, and the patterns of racial exclusion that undergird all three.

- › The broader homelessness problem, particularly among single adults, impacted the flow of people into and out of chronic homelessness. where on average the cost of housing exceeds 22% of income<sup>27</sup> and in Charlotte-Mecklenburg, the average cost of housing is 24.3% of income.<sup>28</sup>
- › The cost of housing impacted the flow of people into and out of chronic homelessness and the outflow of people into permanent, safe housing. Homelessness increases in communities
- › Chronic homelessness is a life course outcome of the same system dynamics that create barriers to economic mobility, particularly structural racism and segregation.<sup>29</sup>

For longevity and effectiveness, defining and understanding how a problem connects to the systems and issues around it should be an early and ongoing part of any change initiative even if solutions are focused more narrowly.

It is important to note that some participants expressed frustration that they had tried to connect the problem of chronic homelessness more purposefully to larger system issues like affordable housing and economic mobility but did not always find other sectors receptive. Homeless service providers must define their work in terms of other sectors such as housing, mental health, criminal justice, and employment, however, the reverse is not true. Homelessness is often considered a problem apart from these other issues instead of a direct reflection of them.<sup>30</sup> Had HFCM proponents waited until other initiative advocates were on board, the effort may have never happened.

<sup>25</sup> Ly, A., & Latimer, E. (2015). Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature. *Canadian Journal of Psychiatry, Revue Canadienne de Psychiatrie*, 60(11), 475-487.

<sup>26</sup> Padgett et al., 2016.

<sup>27</sup> Glynn, C., Byrne, T. H., & Culhane, D. P. (2018). Inflection points in community-level homeless rates. Retrieved from [https://wp.zillowstatic.com/3/Inflection\\_Points\\_20181213-ee1463.pdf](https://wp.zillowstatic.com/3/Inflection_Points_20181213-ee1463.pdf).

<sup>28</sup> Glynn, C. & Casey, A. (December 2018). Homelessness Rises Faster Where Rent Exceeds a Third of Income. Retrieved from <https://www.zillow.com/research/homelessness-rent-affordability-22247/>.

<sup>29</sup> Charlotte-Mecklenburg Opportunity Task Force. (2017). The Charlotte-Mecklenburg Opportunity Task Force Report. Retrieved from [https://s3.amazonaws.com/static.leadingonopportunity.org/downloads/LeadingOnOpportunity\\_Report-Compressed.pdf](https://s3.amazonaws.com/static.leadingonopportunity.org/downloads/LeadingOnOpportunity_Report-Compressed.pdf)

<sup>30</sup> Culhane, D. P., & Metraux, S. (2008). Rearranging the deck chairs or reallocating the lifeboats? Homelessness assistance and its alternatives. *Journal of the American Planning Association*, 74(1), 111-121.



## WHAT'S NEXT:

# HFCM Continues

### **The CoC Continues the Work**

In 2018, with guidance and technical assistance from Built for Zero, HFCM working committee and sub-committee members established the chronic homeless workgroup under the Charlotte-Mecklenburg Continuum of Care (CoC) to continue the effort to end chronic homelessness. In 2019, Mecklenburg County became the lead agency for the Charlotte-Mecklenburg CoC. The chronic homeless workgroup has since reviewed and revised prioritization processes, continued case conferencing and training, and revised the methodology for creating the by-name list of chronic homelessness. The change in the by-name list has resulted in a more comprehensive measure, but a higher number of individuals on the list. For the first time since HFCM began, the list exceeded 500 in January 2020, suggesting the importance of redoubling efforts on housing people from the by-name list and addressing the immediate inflow into chronic homelessness.

### **The Collaboration Extends Upstream**

In January 2020, Charlotte Center City Partners reconvened the HFCM steering committee to revisit the problem of both chronic homelessness and street homelessness. With a brief delay because of the pandemic, plans are currently underway to recommission a steering committee of Charlotte leaders to examine the problem from a systems perspective. CCCP has stated that addressing the problem of inflow is central to the recommissioned HFCM effort.

### **The Research Continues**

The research team continues to examine HFCM data. Graduate student members of the research team have also started a deeper dive in the data to understand the VI-SPDAT and the dynamics of community integration. In addition, the research team will work with service providers and Mecklenburg County Support Services to translate learnings into actionable information for programs. In this way, HFCM becomes an ongoing part of the local and national story on ending chronic homelessness. The HFCM reports and all future findings will be reported on the Charlotte-Mecklenburg Housing & Homelessness Dashboard and the [UNC Charlotte Urban Institute](#) website.

## Initial HFCM Stakeholders

### Corporate:

Bank of America  
U.S. Bank  
Wells Fargo

### Government:

City of Charlotte  
Mecklenburg County  
Inlivan  
U.S. Veterans Affairs  
UNC Charlotte

### Networks & Coalitions:

Housing Advisory Board of  
Charlotte-Mecklenburg  
Homeless Services Network

### Individual Donors:

Gwen & Robert Dalton  
Lynne & Nevan Little  
Deborah & Jimmy Profitt  
Keith & Lucy Trent

### Non-Profit Organizations:

Atrium Health  
Cardinal Innovations Healthcare  
Carolina Cares Partnership  
Chapelwatch Homeowners  
Association  
Charlotte Center City Partners  
Charlotte Chamber of Commerce  
Charlotte-Mecklenburg Library  
Charlotte-Mecklenburg  
Police Department  
Charlotte Regional Visitors Authority

Community Link  
Crisis Assistance Ministry  
Donna Lee Jones Foundation  
Elevation Church  
Friends of Fourth Ward  
Foundation for the Carolinas  
Haven Foundation  
Novant Health  
Providence United Methodist Church  
Roof Above - Men's  
Shelter of Charlotte  
Roof Above - Urban Ministry Center  
Saint Martin's Episcopal Church  
Salvation Army Center of Hope  
Supportive Housing Communities  
United Way Central Carolinas

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