

An Evaluation of the Connecticut Rapid Re-housing Program

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Acknowledgements

The Connecticut Coalition to End Homelessness (CCEH) initiated this evaluation of the CT Rapid Re-housing program (CT RRH) across the state of Connecticut to understand and improve state-wide RRH performance. CCEH provides technical assistance to Connecticut Rapid Re-housing providers on behalf of the Connecticut Department of Housing (CT DOH) with whom each Rapid Re-housing provider has a contract. CCEH runs trainings for providers pertaining to homelessness, housing stability, and program performance, as well as oversight and guidance for data entry requirements and quality. They also work with Nutmeg Consulting to ensure data collection systems are working smoothly and providers have the needed knowledge to use the Homeless Management Information System (HMIS) to track and report client outcomes. In evaluating the Rapid Re-housing program across the state of Connecticut, CCEH sought to understand and improve state-wide RRH performance.

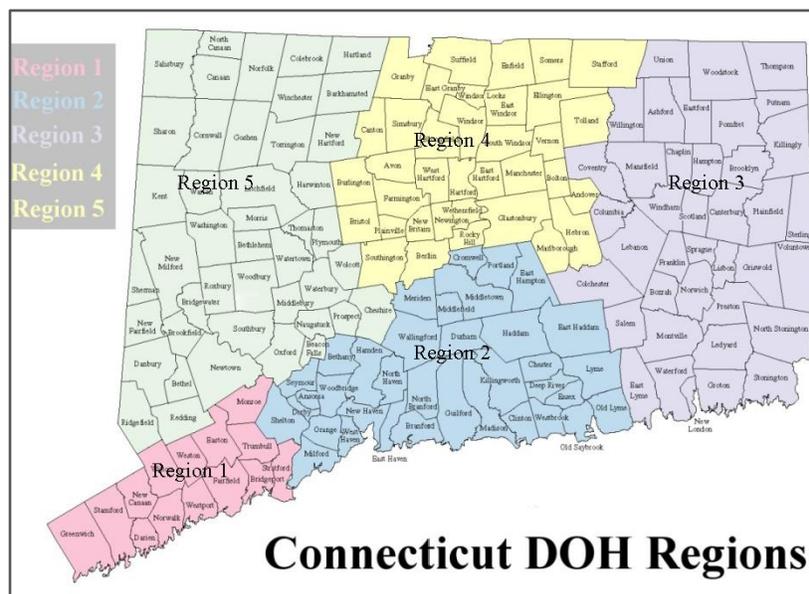
The UConn Health Disparities Institute (HDI) evaluation team (Aubri Drake, MSW, MLS; Emil Coman, PhD, Bhumika Parikh, MPH), under the direction of Dr. Judith Fifield, conducted the evaluation in collaboration with CCEH. Funding was provided from January 2014 to October 2016 and data collection occurred from September 2014 to April 2016.

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Terminology.

CT Rapid Re-housing Program data (CT RRH): throughout this report the *survey sample data* refers to data from CT RRH clients who were recruited into the evaluation study and completed one or both evaluation surveys. In contrast, the *CT RRH population sample* refers to all those CT RRH clients whose data is available in the Homeless Management Information System, or HMIS data set. The *survey sample* is a sub-set of the *CT RRH population sample*. The number of CT RRH population clients with relevant HMIS data varies across evaluation questions, but is meant to represent the total CT RRH population as compared to the smaller survey sample.

CT RRH regions: For the majority of the evaluation period, the CT RRH was divided into five regions corresponding to the CT DOH regions shown below; most CT RRH regions contained two or more nonprofit agencies administering Rapid Re-housing. While CT RRH regions and Coordinated Access Networks (CANs) overlap, many CT RRH regions and agencies worked with multiple CANs. At the time of this report, CT RRH is in the process of organizing the state by CANs rather than regions. This report will refer to regions and not CANs. See Appendix A for further information about the location of regions.



Executive Summary

Research suggests that placing families experiencing homelessness into Rapid Re-housing Programs may decrease the time families spend in homelessness, reduce shelter recidivism, and increase housing stability. It may also positively affect parental quality of life, and child wellbeing. Per the National Alliance to End Homelessness (NAEH), “rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness, return to housing in the community, and not become homeless again in the near term (2016b).” This evaluation was undertaken to assess whether this growing evidence could be confirmed in Connecticut, where 4,450 individuals were homeless in 2014 (National Alliance to End Homelessness, 2015b).

The evaluation specific aims were to examine the rapidity, stability and cost of housing associated with the Connecticut Rapid Re-housing Program (CT RRH) between September 2014 and April 2016, as well as to obtain client’s reports of changes in quality of life and their personal program experiences.

Both quantitative (surveys and HMIS administrative data) and qualitative (focus groups and case studies) data were collected to describe baseline status and changes over time. Due to the fact that clients in the survey sample remain in the CT RRH program on average for eleven months and the observational study design was over twelve months, all clients had left the program prior to the twelve-month follow-up survey and final case study interview. Therefore, in all cases, quality of life and client perspectives on the program reflect time in the CT RRH program plus time after exiting the program, which varied by individual (for an average of 5.7 months post program exit).

This evaluation reports on the experience of a small convenience sample of currently enrolled CT RRH clients recruited through CT RRH front-line staff. It also reports on program metrics for the total population of active CT RRH clients whose data are available in HMIS during the same timeframe as our evaluation study. The survey sample includes one hundred two (N=102) unique CT RRH clients who completed surveys. Of those completing surveys, seventy-six (N=76) attended a focus group. Thirteen (N=13) of those who attended a focus group also completed a case study. HMIS data on 1,175 households who were active in CT RRH between February 1st, 2013 and November 1st, 2015 were utilized to add important indicators of rapidity and stability to the survey data and to offer insights into the CT RRH program state-wide.

Results

Demographics

The ‘average’ survey participant was a forty-one year-old, heterosexual woman of color (Black, Hispanic, American Indian/Alaskan Native, Asian) with a child. The ‘average’ CT RRH population client was a single, thirty-six year-old woman of color without children. When comparing all CT RRH population clients with the survey sample that can be matched in HMIS (n=87) survey respondents are slightly older and CT RRH population clients have slightly larger households. In all other ways, they are comparable demographically.

CT RRH Outcomes

In 2016, the National Alliance to End Homelessness (NAEH), together with the U.S. Department of Veteran Affairs (VA), the U.S. Department of Housing and Urban Development (HUD), U.S. Interagency Council on Homelessness (USICH) and other partners developed a set of standards for rapid re-housing based on what is currently considered promising practice. This document provides

details on performance benchmarks that would qualify a program as effective. We review, below, the performance of CT RRH against these standards (NAEH, 2016b).

CT RRH rapidity: How long do clients wait to be placed in housing once in the program?

- This study found that on average, clients in the survey sample were housed in 1.6 months (SD 2.2) and CT RRH population clients were housed in a statistically comparable time frame of 1.4 months (SD 2.1). Fifty percent (50%) of the survey sample clients and 56% of the CT RRH population clients (statistically equivalent) were housed in thirty days or less, which **approaches meeting** NAEH's first performance benchmark of housing households in 30 days or less (NAEH, 2016b).

CT RRH stability: Once in housing:

- *What proportion exit the program into permanent housing?* This study found that at time of program exit, eighty-four percent (84%) of CT RRH population clients with valid HMIS data (N=669) exited to permanent housing with only five percent (5%) returning to literal homelessness. This **meets** NAEH's second performance benchmark of exiting at least 80% of households to permanent housing (NAEH, 2016b).
- *What proportion moved one time or less since being housed in RRH?* This study found that among the survey sample completing a baseline and follow-up survey, ninety-four percent (94%) had moved one time or less since being housed through RRH.
- *What proportion returned to shelter post-program exit?* Of those CT RRH population households with valid HMIS data, ninety-two percent (92%) did not return to shelter in the first twelve months, and at twenty-four months post-program exit, eighty-nine percent (89%) had not returned to shelter. This **meets** NAEH's third performance

benchmark of at least eighty-five percent (85%) of households exited to permanent housing should not reenter homelessness within a year.

- *How do CT RRH return to shelter metrics compare to other programming?* Those enrolled in CT RRH were significantly less likely to return to shelter by twelve and twenty-four months post-program than those who received services through emergency shelter (ES) and reported leaving to permanent housing: twelve months return (CT RRH 8% vs ES 11%); twenty-four months return (CT RRH 11% vs ES 16%).

Financial assistance: What is the average amount of financial assistance received by clients?

- Surveyed clients received significantly more financial assistance on average than CT RRH population clients in general: (surveyed clients received \$5,177 vs. CT RRH clients who received \$3,409, $p < .001$). This is in comparison to the Supportive Services for Veteran Families study where the Rapid Re-housing program cost \$3,028 per household (Department of Veterans Affairs, 2015) and the Family Options study where the average cost was \$6,578 (National Alliance to End Homelessness, 2015a). Additionally, in the Family Options study, average emergency shelter for each household cost \$16,829, subsidy cost \$18,821, and transitional housing cost \$32,557 (National Alliance to End Homelessness, 2015a).

Quality of Life: Did quantitative indicators of quality of life increase over time with the rapid placement into relatively stable housing?

- Quality of life for surveyed clients either remained stable or deteriorated somewhat over the study period. No change was reported on the number of days on which they were affected by their physical or emotional health, although at baseline a large proportion reported over the course of the last thirty days that they had some days when their

physical or emotional health was not good. Survey clients reported no change in their level of food insecurity over time although they reported high levels at baseline. Household chaos and environmental confusion increased significantly between baseline and twelve-month follow-up. Additionally, clients' reported a significant decline in emotional social support ('always have someone to have a good time with') between baseline and twelve months.

Client experiences: What can be learned from the perspective of surveyed RRH clients participating in focus groups and/or case studies?

- **Case Studies:** One-on-one conversations with one of the evaluators illustrated the ongoing social and emotional struggles reflected in the quality of life indicators reported in the survey. A full report of the case studies can be found in Appendix B.
 - People struggled to find and maintain employment that paid a living wage. Of thirteen people interviewed, only one case study participant had a full time job at any point during the twelve months.
 - Poor physical and/or mental health (either of head of household or a child) impacted twelve people's entering into homelessness as well as their ability to stay housed once out of CT RRH.
 - Many people experienced traumatic life events (e.g. death in family, community violence, assault, suicide attempt) during their time in CT RRH and these experiences often destabilized them, disrupting their progress and putting their housing at risk.
 - Most case study participants reported having few friends and family social

supports. Some had family support but often those connections were unhealthy and they were trying to avoid reentering into a relationship with them. Two case studies had to return to those unhealthy family dynamics in order to obtain housing after the CT RRH program ended and they reentered homelessness after losing housing.

- **Focus Groups:** Group discussions revealed benefits and challenges of the CT RRH program experience: Clients revealed the high value they placed on the notion of self-reliance promoted by many case managers, the benefits of the program, and the many ways that the program had met the most pressing needs of their families.
 - People with children reported seeing their children stabilize after being housed and either begin or continue to do well in school, socialize more with peers, and become happier overall. Forty-six percent (46%) of the case studies had a child enrolled in college or were preparing to begin college. Additionally, guardians perceived the presence of children in the household to be a motivator to continue to persist through hard times.
 - Many described being very resourceful, often receiving services (e.g. job readiness classes, therapy, healthcare) and goods (e.g. food, clothes, furniture) from over half a dozen different social service agencies at any given time.
 - About half reported that their case manager was invaluable, both in terms of connecting them to community resources, like those cited above, but also in providing encouragement and social-emotional support.
 - Many participants offered up heart-felt and sincere thanks for RRH providing them the opportunity to succeed.

Conclusions: Rapid Re-housing in Connecticut is largely successful in approaching or meeting NAEH benchmarks for moving homeless clients into housing quickly and for exiting clients to permanent housing and avoiding return to shelter at one and two years out of the program. It is a relatively low-cost intervention and compared to those who exited emergency shelter to permanent housing, initial indications suggest that those assisted through Rapid Re-housing are significantly less likely to return to shelter by twelve months and twenty-four months.

Clients interviewed through survey, Focus Groups and Case Studies provided an in-depth look at the experience of families who exited homelessness through CT RRH. From the perspective of survey participants, who are on average most representative of forty-plus year old women of color with a child, the picture that emerges of their life experience following CT RRH is one of improved quality of life for their children, but unchanged quality of life for adults, with days each month affected by physical or emotional health issues, stable and high levels of food insecurity, increasing levels of environmental chaos and decreasing levels of emotional support. Concerns that these households shared after rapid re-housing are broadly consistent with the challenges that face low-income, housing-cost burdened households in Connecticut, generally – whether or not those households experience homelessness. A picture also emerges of clients who are generally satisfied with their housing and their case management, and who are resourceful, who value self-reliance and who are thankful for the opportunity provided by the program to secure new stability for their children. Many clients agreed that the program could be even more beneficial with stronger community supports, provided through improved linkage to more responsive local social service organizations. We suggest generalizing with caution from our survey results, especially with regard to quality of life and program experience findings, to the experience of the CT RRH population

client as our survey participants were slightly older, had slightly smaller households, stayed in the program longer and received more financial support.

Introduction and Study Overview

In a January 2015 point-in-time count, 564,708 people in the US were experiencing homelessness (National Association to End Homelessness, 2016a). Homelessness is a complex issue with many influencing factors and numerous avenues for interventions with the potential to improve quality of life. Those who experience poor family functioning, poverty, victimization, or out of home care (e.g. foster care, juvenile detention) during childhood were more likely to experience homelessness in early adulthood (Brown, Goodman, Guzman, Tieu, Ponath, & Kushel, 2016; Shelton, Taylor, Bonner, & van den Bree, 2009). Additionally, adverse life events are independently associated with an increased risk of becoming homeless (Brown et al., 2016).

People experiencing homelessness are more likely to report mental illness and nicotine, alcohol, and drug abuse (Heffron, Skipper, & Lambert, 1997). They are more likely to have been jailed as adults, be less educated, have job experience primarily in manual and unskilled labor, and have problems with gambling (Heffron et al., 1997).

From 2007 to 2009, the national median household income decreased by \$2,200 and the percentage increase of households in poverty was the highest recorded since 1994 (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013). Research indicates most homeless families are single parents with multiple young children (Grant, et al., 2013; Levitt, et al., 2013). Based on standard fair market rental prices, a full-time worker earning federal minimum wage cannot afford a 1-bedroom apartment (Grant, et al., 2013). In 2012, a study of NYC residents by Bach and Waters found that poor and low-income families living without rent subsidy “typically spent 49% of their monthly income on rent, leaving \$4.40 per family member per day for food and everything else.”

Forty percent (40%) of homeless people report at least one chronic health problem (Plumb, 1997). Based on a systemic literature review, homeless young adults report a prevalence of psychiatric disorders ranging between 48-98% (Hodgson, Shelton, van den Bree, & Los, 2013). Premature mortality is a major issue for homeless individuals; the average age at death for homeless individuals is between 41-47 years of age (Plumb, 1997). In one study, sixty percent (60%) of newly homeless people reported a medical condition; seventeen percent (17%) had hypertension, seventeen percent (17%) had asthma, more than a third experienced major depression, and more than half experienced a substance use disorder (Schanzer, Dominguez, Shrout, & Caton, 2007). Additionally, nearly 80% had sought medical treatment in the year before their homeless episode, with a third going to the emergency department. At that time, more than 40% did not have insurance (Schanzer et al., 2007) and there was significant co-morbidity between physical medical issues and major depression as well as substance use disorders. Despite these issues, participants' perceptions of their health and functioning did not differ from their non-homeless peers. Eighteen months later, those who had obtained housing had significant decreases in visual, dental, and podiatric complaints, as well as reduced rates of high blood pressure (Schanzer et al., 2007).

In a study by Levitt, et al. (2013), a rapid re-housing program in NYC found a significant effect with intervention participants staying out of shelter longer than those in the standard care control group and decreased clients' total days spent in shelter. A Rapid Re-housing evaluation in Philadelphia found that 13.6% of those who received RRH returned to homelessness, compared with 39% of those who did not receive RRH (Taylor & Pratt-Roebuck, n.d). The Connecticut Coalition to End Homelessness (CCEH) found that of families who received rapid re-housing, 94% had not returned to a Connecticut shelter by two years post-program (2013).

In the Family Options Study (Gubits et al, 2015), Rapid Re-housing showed equivalent results when compared to usual care in terms of housing stability, family preservation, and adult and child well-being. Relative to usual care, RRP did not affect subsequent shelter stays or housing stability. Rapid Re-housing did lead to less school and childcare absences. In the study, Rapid Re-housing led to higher family income and reduction in food insecurity, compared to usual care. Of all services being studied, rapid re-housing was of the shortest duration and most cost-effective, allowing the program to serve more families. When comparing cost, Rapid Re-housing cost the least, with the average monthly cost per family being less than \$900, with other kinds of programs varying from \$1,200 to \$4,800. However, this study was examining the offer of a particular type of service, not the usage of those services; over half of those assigned to Rapid Re-housing did not participate in the program (Gubits, 2015; National Alliance to End Homelessness, 2015a).

In Supportive Services for Veteran Families, seventy-five percent (75%) of homeless veterans and eighty-two percent (82%) of families who received Rapid Re-housing exited to permanent housing (Department of Veterans Affairs, 2015). Families who received more than ninety days of services were at decreased risk for homelessness post-exit (Byrne, Treglia, Culhane, Kuhn, & Kane, 2016). Of the families that received Rapid Re-housing, nine percent (9%) and sixteen percent (16%) had experienced another episode of homelessness by one and two years post-exit, respectively (Byrne et al., 2016).

While evidence in support of rapid re-housing is limited, findings suggest that placing homeless individuals and families into rapid re-housing programs may reduce shelter recidivism and increase housing stability, client quality of life, and child wellness. This evaluation was undertaken to assess

whether this growing evidence could be confirmed in Connecticut, where 4,450 individuals were homeless in 2014 (National Alliance to End Homelessness, 2015b).

Methods

Sample: Based on available HMIS data during the timeframe of this evaluation, there are approximately three hundred fifty households receiving services in CT RRH each month. Households remain on average 5.9 months (households with valid entry and exit dates N=794). Therefore the number currently receiving services is fluctuating from month to month. Based on the monthly enrollment it was estimated that approximately three hundred fifty (N=350) households would be eligible for recruitment into this voluntary evaluation of the program.

Recruitment: The CT RRH case managers had direct contact with enrolled CT RRH clients and, at their discretion, offered clients an evaluator-developed survey packet which included options for participants to take the survey on paper, by phone, or online (see Figure 1 timeline below). Multiple trainings were provided for frontline staff, as well as weekly emails and monthly updates at their provider meetings. Data collection was revised due to a low response rate after the fall 2014 launch. Case managers continued to recruit clients who were then invited to participate in a Focus Group (FG) in the winter or spring of 2015 at which time the baseline survey was offered to them for completion by paper and pencil. Two FG were conducted in each region for a total of ten (N=10) FG. Evaluation staff who conducted the focus groups were also available to clarify survey questions for clients requiring assistance. All clients who completed a survey were contacted for 12-month follow-up. The duration of participation in the CT RRH program for each surveyed individuals was on average eleven months (SD=3.8); duration was calculated based on dates of received services which could include case management or financial assistance. Therefore, all follow-up interviews fell

- Did indicators of quality of life (social support, environmental chaos, health-related quality of life, and food security) increase over time with the rapid placement into relatively stable housing?

Financial assistance:

- What is the average amount of financial assistance received by clients?

Client experiences:

- What can be learned from the perspective of CT RRH clients participating in focus groups and case studies?

Measures & Data Collection

Client Focus Groups

Focus groups were conducted by experienced research faculty and staff. An interview guide with open-ended questions was utilized to explore participants' perceptions of Rapid Re-housing, benefits of the program, its effects on their health and children; and ways it could be improved (see Table 1 below). The discussion themes were gleaned from academic articles focused on the issue of homelessness, as well as question topics that CCEH wished us to explore (Grant, Gracy, Goldsmith, Shapiro, & Redlener, 2013; Mayberry, Shinn, Wise, & Benton, 2014; Patterson, Markey, & Somers, 2012; Tischler, Rademeyer, & Vostanis, 2007).

Client Surveys:

Surveys included questions about demographics (e.g. race and gender), current housing situation, attitudes and perceptions of case management, and how the Rapid Re-housing Program has worked for them (see Table 1 below). Housing questions included such as; "please check all the places you have stayed over the past week," and "how long were you in temporary housing before you moved

into housing/apartment provided by the program?” Case management questions included such as; “how many times per month are you meeting in person with your RRH case manager?” Items addressing the subjective experience of RRH included; 1) case management questions (e.g. how satisfied are you overall with the case manager you see for Rapid Re-housing?),

Table 1: Data sources

Measure	Source		
	Surveys & Focus groups	HMIS	Case studies
<i>Demographics</i>	Region, age, gender, race, sexual orientation, household size	Age, gender, race, household size, number of children	Household size, children’s ages, employment status
<i>Housing rapidity</i>	Client reported time from RRH enrollment to RRH placement	Time between Date Housed and date they entered RRH	Client reported time from RRH enrollment to RRH placement
<i>Housing stability</i>	Client reported number of moves from beginning of RRH	Financial assistance; Services received; Exit destination at end of RRH	Client reported number of moves from beginning of RRH
<i>Quality of life (client)</i>	CHAOS mMOS-SS Health-Related QoL Food insecurity		X
<i>Client self-report: Case management, housing, overall life changes</i>	X		X
<i>Quality of life [child(ren)]: Overall life changes</i>	X		X
<i>Qualitative experiences & feedback</i>	X		X

2) subjective housing questions (e.g. how satisfied are you with your housing's location?), and 3) subjective children's wellbeing questions (e.g. since you entered Rapid Re-housing, has child #1 experienced changes in their: health?).

Quality of Life The Confusion, Hubbub, and Order Scale (CHAOS) measures environmental confusion and parental behaviors (Matheny, Wachs, Ludwig, & Phillips, 1995). Scores can vary from six-to-twenty-four (6-24), with higher scores indicating greater chaos in the home. Environmental confusion is stressful, non-specific background factors such as noise, crowding, and situational "traffic patterns" (e.g. number of people coming and going in the home). Research indicates that environmental confusion is negatively related to developmental outcomes including school achievement, language, temperament, and health (Ivanova & Israel, 2006; Malatras, Luft, Sokolowski, Israel, 2012; Pike, Iervolino, Eley, Price, and Plomin, 2006). This measure indirectly examined CT RRH's effect on children through changes in the perceived environment.

The modified Medical Outcomes Study-Social Support tool (mMOS-SS) measures social support, both emotional and instrumental (Moser, Stuck, Silliman, Ganz, & Clough-Gorr, 2012). Scores range from eight to forty (8-40), with a higher score indicating higher social support. Studies have shown that those with adequate social support are less likely to have negative long-term effects (e.g., poor emotional health, pessimistic attitude, hospitalization, poor survival) of life stressors (Holt-Lunstad, Smith, & Layton, 2010; Moser, Stuck, Silliman, Ganz, & Clough-Gorr, 2012; Sherbourne & Stewart, 1991).

The health-related Quality of Life (HRQoL) tool measures people's perceived health, their physical and mental health in the past month, and the impact of poor physical and mental health on their day-to-day functioning (CDC, 2000). People's perceptions of their health are very important, as they serve as a proxy to measure perceived level of symptom burden for both acute and chronic health issues. Additionally, self-perception of health can predict future healthcare interactions, as people

generally seek healthcare only when they're feeling unwell (CDC, 2000). Some research has shown Housing First models improve subjective quality of life for individuals who were experiencing homelessness (Patterson et al., 2013).

HMIS Data

The Homeless Management Information System (HMIS) data included all homeless individuals and households who sought services at a homeless shelter in Connecticut, participated in CT RRH, and provided consent to have their data entered into HMIS during the evaluation period. This included data regarding single adults, unaccompanied minors, and families (head of household and their dependents). The Head of Household is considered the primary person receiving services who is typically responsible for rent and utilities. HMIS data analyses allow us to examine outcomes for all RRH clients in CT (e.g., the CT RRH population) as well as to comment on whether our survey sample is representative of the CT RRH population and whether our findings can be generalized to all RRH clients in CT. Throughout this report the HMIS data are used to contrast with our survey results as well as to supplement the data obtained by survey. Figure 2 below illustrates the full sample size for each data source, however, the size of the sample for each question varies depending on whether the question is directed at our survey sample or all of active CT RRH clients in the state, the availability of HMIS data for our survey sample, and occasional missing data due to client's discretion in responding. At times we report on only N=87 individuals, since fifteen survey participants of the one hundred and two unique individuals could not be matched within HMIS (e.g., the matched sample in Figure 2 and Table 2)

HMIS data included baseline and follow-up data for Rapid Re-housing clients, as entered by the

community agencies. HMIS contained data regarding demographics (e.g. race, ethnicity, gender), objective housing measures (e.g. exit destination, time waiting to be housed), services received (e.g. case management), and financial assistance (e.g. rent, security deposit) (see Table 1 above). HMIS data were received on 1,175 households who were active in CT RRH between February 1st, 2013 and November 1st, 2015. 1.5-year lookback period (Feb 2013-Sept 2014) in the HMIS data provided essential rapidity and stability indicators for clients who were nearing the end of their twelve-month program eligibility when this evaluation study began. HMIS data quality and integrity issues were corrected for this report such as: removal of numerous data duplicates at the family and client level, including general enrollment, financial assistance, and case management services. We combined individuals and families who received services under more than one individual or family ID number; discerning which ID number was the “true” ID number. This process often required manually comparing services received by both ID numbers and editing data fields by hand. In some cases, there was no way for us to determine if certain data were duplicates (e.g. participant received \$300 twice for rent on the same date). If these data could not be determined to be duplicates, they were retained. Over the course of data cleaning, judgements were made regarding the use of various categories in HMIS (e.g. assuming someone is housed if they are receiving services directly related to housing i.e. rental assistance; used the "date moved in" to back fill "date housed" if the latter was not completed). After extensive data cleaning and consulting with CCEH, Nutmeg, and AIDS CT, we have confidence the HMIS results we report are accurate.

Client Case Studies

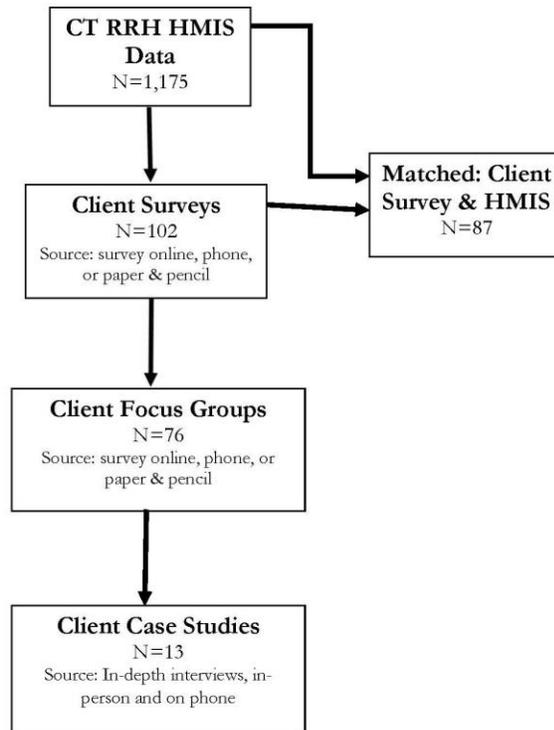
For case studies, an interview guide with open-ended questions was utilized to explore in greater detail the experience of CT RRH for clients, and how it has affected their employment situation,

their families, and their ability to maintain stable housing (see Table 1 above). The interview guide focused on themes gleaned from academic articles related to family routines, narrative interviews, and stability, as well as question topics which CCEH wished us to explore (Mayberry, Shinn, Wise, & Benton, 2014; Patterson, Markey, & Somers, 2012; Tischler, Rademeyer, & Vostanis, 2007). Additionally, the research assistant kept extensive field notes about each individual and followed up on life events during subsequent contact.

Results: Demographics

As Figure 2 (below) illustrates, the survey sample includes one hundred two (N=102) unique CT RRH clients who completed surveys, which represents approximately thirty-three percent (33%) of active households in CT RRH in any given month during the study timeframe. Of those completing surveys, seventy-six (N=76) attended a focus group. Thirteen (N=13) of those who attended a focus group also completed a case study. HMIS data on 1,175 households who were enrolled in CT RRH between February 1st, 2013 and November 1st, 2015 were utilized to add important indicators of rapidity and stability to the survey data and to offer a State-wide comparison group for the small survey sample. The one and one-half year lookback period (Feb 2013-Sept 2014) in the HMIS data provided essential rapidity and stability indicators for clients who were nearing the end of their twelve-month program eligibility when this evaluation study began.

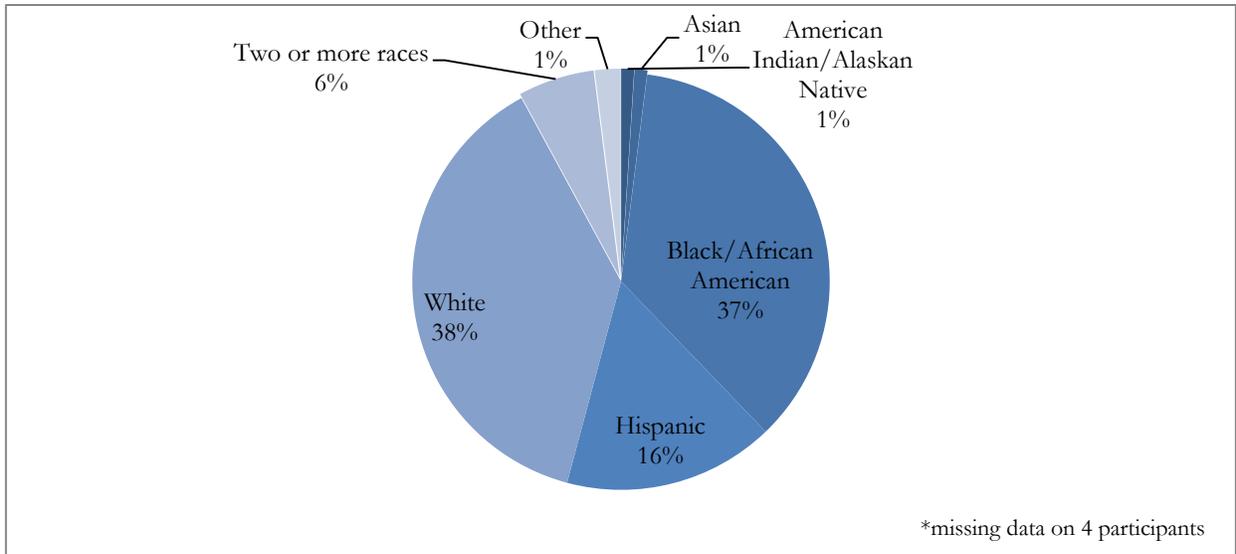
Figure 2: Data Sources



Survey sample

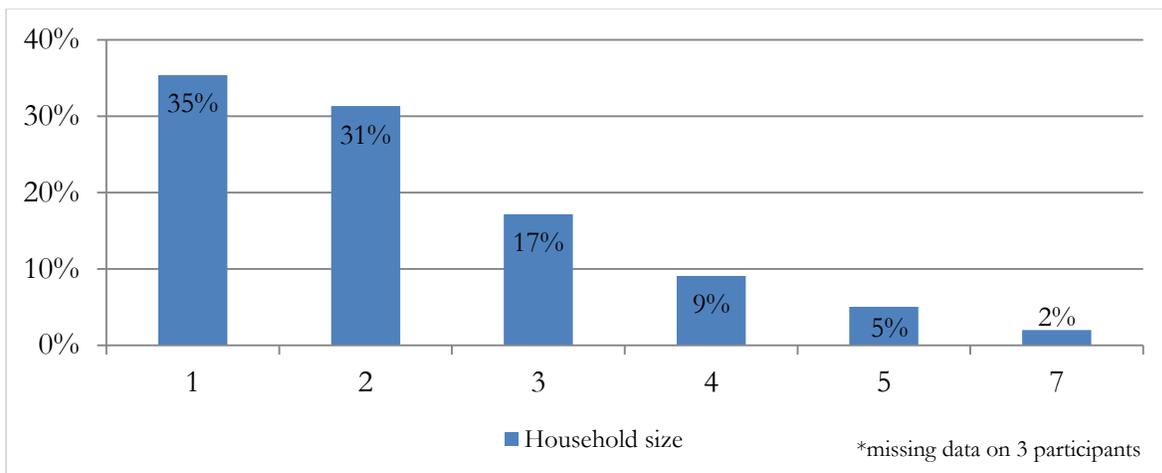
As Table 2 below shows, the average age of the survey participants was 41.0 years (SD=11.2 years). Most survey participants were women (72%). No one reported their gender as transgender or other. Almost all participants (95%) reported being heterosexual or straight, three percent (3%) were bisexual, one percent (1%) were gay or lesbian, and another one percent (1%) marked 'other.' Participants were White (38%) or Black/African American (37%); sixteen percent (16%) of participants were Hispanic (see Figure 3).

Figure 3: Survey Participants' Race & Ethnicity (survey)



The average size of the household was 2.28 members (SD 1.34, range 1-7) (see Figure 4). More than a third of those who responded (35%) came from a single-person household. Another thirty-one percent (31%) came from a two-person household. Two clients had a seven-person household at baseline. More than half of the participants (69%) had children.

Figure 4: Survey Household Size at Baseline (survey)

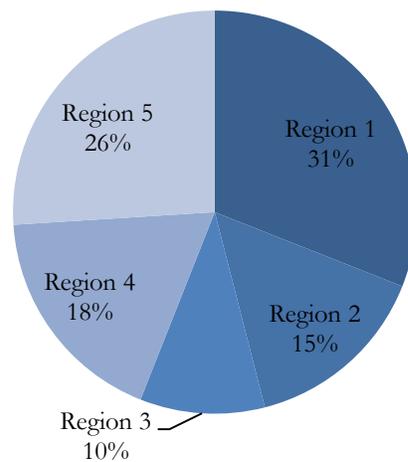


Most of the survey participants came from Region 1 (31% or 31 people), as seen in Figure 5 below. Of the thirty-one people, eleven people received services from Inspirica, nine received services from Operation Hope, eight from Supportive Housing Works, and three from Homes with Hope. The

next largest group of participants came from Region 5 (26% or 26 people).

Of the twenty-six people, ten people received services from Salvation Army of Waterbury, eight from New Opportunities, and eight from The Association of Religious Communities (ARC). Eighteen percent (eighteen percent or eighteen people) came from Region 4, all receiving services from Community Health Resources. Region 2 contributed fifteen percent (15%) of the respondents

Figure 5: Survey Participants' Region (survey)

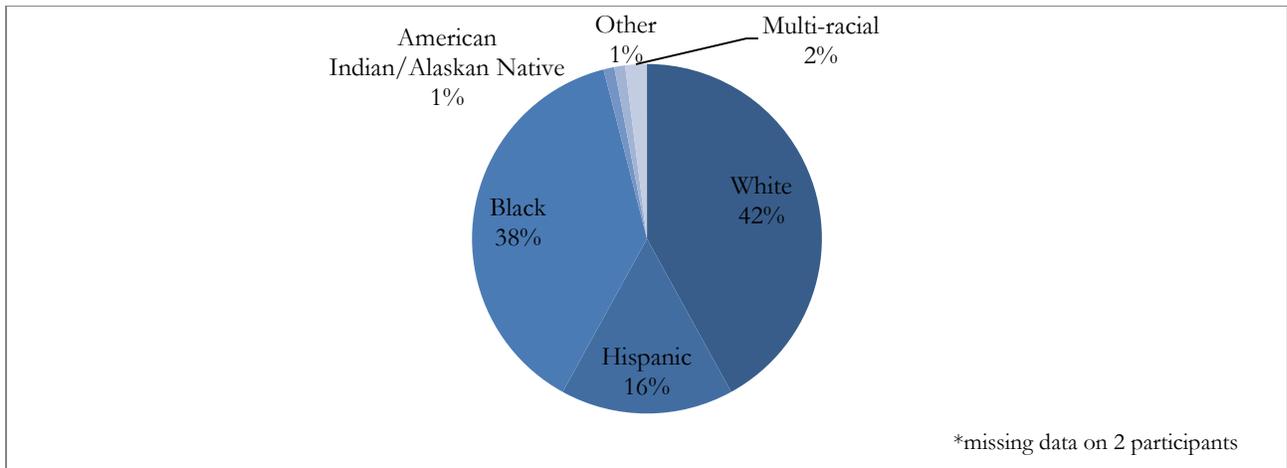


(fifteen people). Seven people received services from BH Care, five received services from New Reach/NHHR, and three from Columbus House. Ten percent (10% or ten people) of the respondents came from Region 3, six of which received services from Thames Valley Council of Community Action (TVCCA) and four from Thames River Community Services. Regional data was missing for 2 people (2%).

HMIS Data

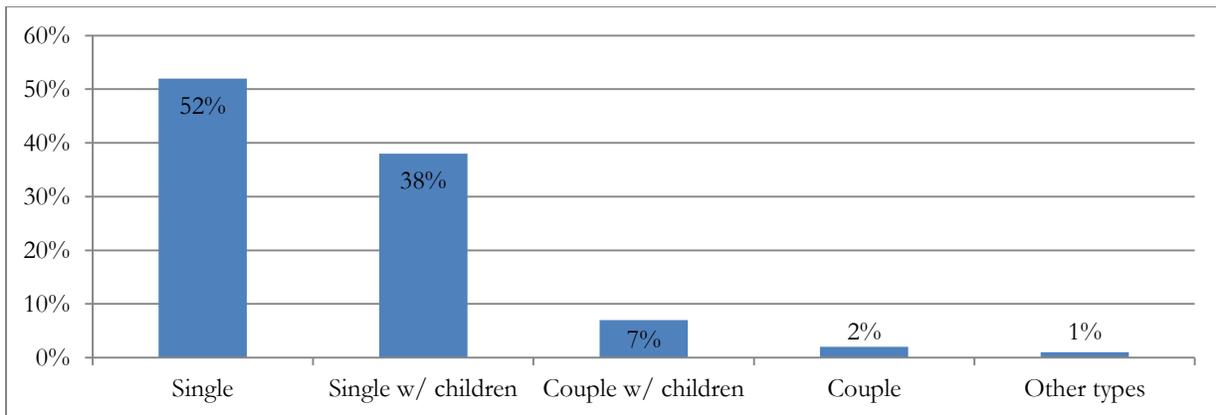
Our sample size within HMIS was 1,175 heads of households active in the CT RRH program between February 1, 2013 to November 1, 2015. Seventy-five percent (75%) were women (with 0.2% identifying as transgender women), and the remaining twenty-five percent (25%) were men. Most were white (42%) or Black (38%); sixteen percent (16%) were Hispanic (see Figure 6 below).

Figure 6: HMIS Race & Ethnicity



The mean age for head of household was 36.4 years of age (SD=12.5). Fifty-two percent (52%) were single, thirty-eight (38%) were single with children, seven percent (7%) were a couple with children, two percent (2%) were couples without children, and one percent (1%) were other types (e.g. with relatives) (see Figure 7). In HMIS, the average size of the household was two members (SD= 1.32). Veterans comprised three percent (3%) of the sample.

Figure 7: HMIS Household Types



Compared with state-level demographics, Black individuals are over-represented (4x) in both the survey and HMIS data (37-38% vs 10% state wide), while white individuals are under-represented (~40% less) in both the survey and HMIS data (38-42% vs 70% state wide). Black individuals

accounted for almost 40% of individuals in both HMIS and survey data, while they only account for 10% of the Connecticut population. White individuals only accounted for 40% of individuals, even though they account for 70% of the Connecticut population. This difference reflects the demographics of people experiencing homelessness in Connecticut. According to HMIS, the statewide demographics for those entering emergency shelter are: Black non-Hispanic (34%), white non-Hispanic (32%), Hispanic/Latino (30%), Asian /Pacific Islander (1.3%), 2 or more races (1.2%), and client doesn't know/refused/not entered (1.5%).

Client Case Studies

Thirteen (N=13) CT RRH case studies were completed representing all five regions. One participant withdrew seven months into the case study; the other twelve case studies completed the expected ten-to-twelve months of in-person and phone contact.

The mean participant was fifty years old (range of 37 to 63). Six case study participants were Black/African-American (46%), four were white (30%), one was Hispanic (8%), one was more than one race (8%), and one was American Indian (8%). Ten (10) participants were women (77%). Eleven (11) participants identified their sexual orientation as straight/heterosexual (84%), one as bisexual (8%), and one as other (8%).

Seven were individuals living alone (54%); of those seven, four had children who were no longer living with them. Six were individuals who had at least one child living with them during the case study (46%). The average size of the household was 1.6 (range 1-3).

Table 2: Client demographics

Characteristics	Surveys		Matched HMIS		HMIS		P <i>Comparing matched And unmatched HMIS</i>	Case studies	
	N	%	N	%	N	%		N	%
Age (yrs.) M(SD)	97 ^{PA}	41.04 (11.24)	87	40.54* (11.09)	1,146 ^{PA}	36.36 (12.54)	.001	13	49.77 (7.44)
Sexual Orientation (%)	97 ^{PA}							13	
Heterosexual		94.8							84
Gay/Lesbian		1.0							0
Bisexual		3.1							8
Other		1.0							8
Gender (%)	97 ^{PA}		87		1,170 ^{PA}		.324	13	
Men		27.8		31.0		24.5			23
Women		72.2		69.0		75.5			77
Race (%)	98 ^{PA}		87		1,171 ^{PA}		.620	13	
American Indian/ Alaskan Native		1.0		-		1			8
Asian		1.0		1.1		0			0
Black/African American		36.7		40.2		38			46
Hispanic		16.3		16.3		16			8
White		37.8		55.2		42			30
Two or more races		6.1		2.3		2			8
Other		1.0		1.1		1			0
Size of household M(SD)	99 ^{PA}	2.28 (1.34)	87	1.74 (1.00)	1,175	1.99* (1.32)	.020	13	1.69 (0.86)
Have Children (%)	97 ^{PA}		87		1,175		.368	13	
Yes		69		40		45			46
No		31		60		55			54

Notes: ^{PA} Some participants did not answer question (partial answers); ^{NA} Variable not available; * significantly higher (matched vs. not-matched).

Summary

The demographics of the three data sources, client surveys, client case studies, and HMIS data on the total CT RRH population, are comparable with some small but significant differences. As illustrated in Table 2 above when comparing all CT RRH population clients with the survey sample that can be matched in HMIS (n=87) survey respondents are slightly older and HMIS clients have slightly larger households. In all other ways, they are comparable demographically.

Results & Analyses

Overview: Client Surveys

One hundred and two (N=102) clients completed surveys at baseline and forty (N=40) completed a twelve-month follow-up survey (39% of the baseline N). The test for statistically significant change from baseline to twelve months only included those with twelve-month data. The Wilcoxon Signed Ranks Test was used to determine the change over time for categorical variables. A paired t-test was used to determine the significant change over time for continuous variables such as those regarding quality of life.

Housing Rapidity: HMIS and Survey Sample

This study found that on average, clients in the survey sample were housed in 1.6 months (SD 2.2) and clients in the total CT RRH program were housed in a statistically comparable time frame of 1.4 months (SD 2.1). Fifty percent of the survey sample clients and fifty-six percent (56%) of the total CT RRH sample (statistically equivalent) were housed in thirty days or less, which approaches meeting NAEH's first performance benchmark of housing households in thirty days or less (NAEH, 2016b).

The following comments from clients indicate their perceived satisfaction with being rapidly re-

housed.

Client Voices: Housing Rapidity

"It kinda gets you a new lease on life... it's almost culture shock [after a shelter]."

"[Rapid Re-housing] helped me get my confidence back."

"Before we got there, we didn't have anything. So anything they do for us is a plus."

"It's really nice... the apartment is pretty much brand new. There's all new carpet."

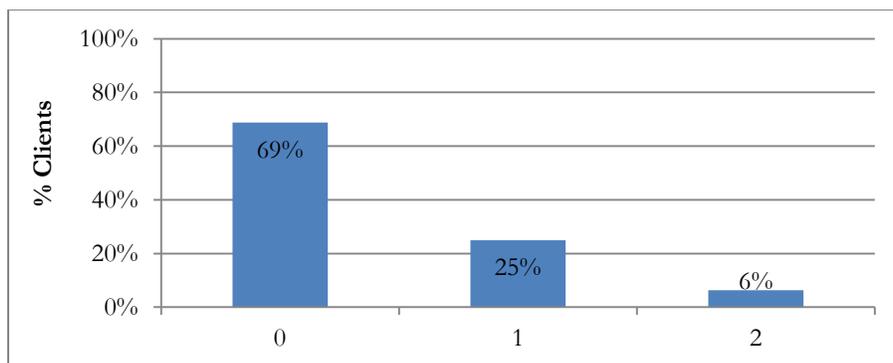
"I was able to have some medical issues addressed that I wouldn't have been able to take care of without a stable living situation, and made finding full-time employment more realistic."

"...I am happy and grateful to have what we're in because without the program, my daughter, her father, and I would be homeless. Life has been a bit easier, more healthy for my family."

Housing Stability: Client Surveys - # of Moves

At twelve months, only six percent of the survey sample (6%) reported moving more than once since they were housed through CT RRH (see Figure 8 below). Ninety-four percent (94%) had moved only once or not at all. Approximately thirty-two (32%) had moved once or more in the past year; this is compared to the national rate of 16.3% for moving once or more among those living below the Federal Poverty Line, according to the 2010-2014 ACS 5-year estimates from American Fact Finder (US Census Bureau, 2016).

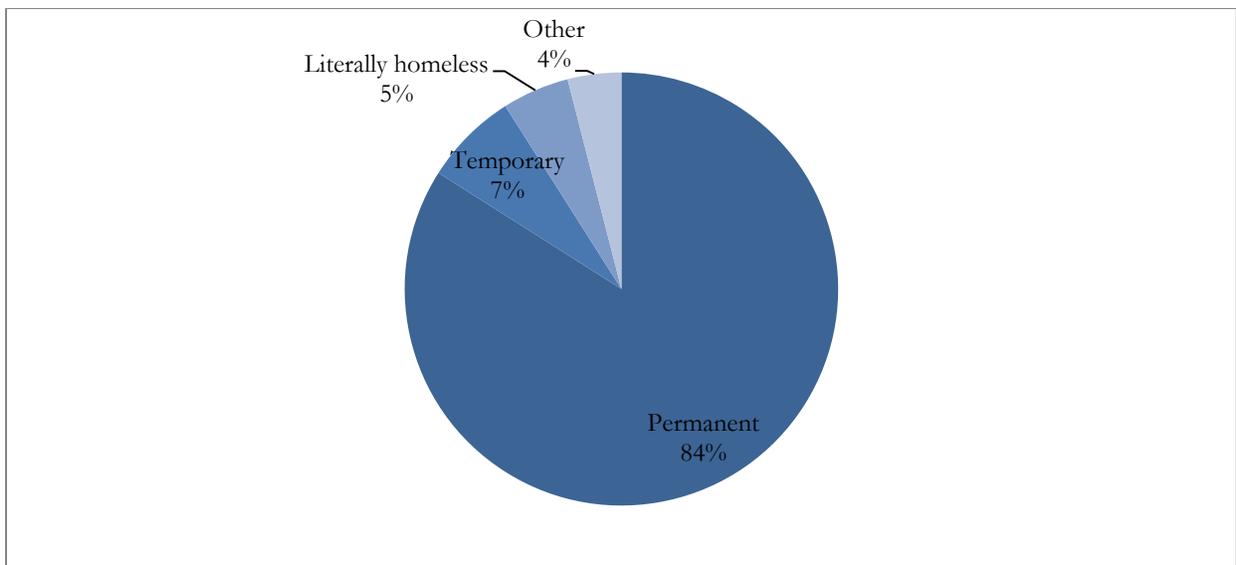
Figure 8: # of moves since RRH placement (survey)



Housing Stability: CT RRH population – Exit Destination & Return to Shelter

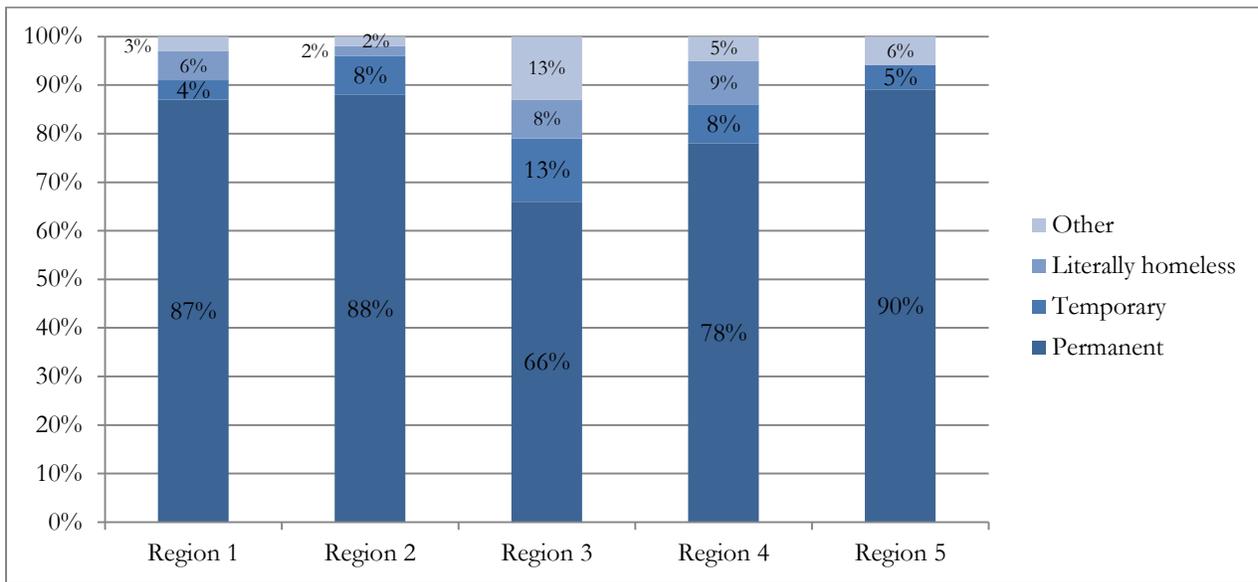
For those with valid exit destinations entered (made available to us at the summary level only and therefore only reportable at the level of the Total CT RRH population (N=669)), the majority exited CT RRH to permanent housing (84%) (Figure 9 below). Permanent housing included both subsidized and non-subsidized housing. Temporary housing included destinations such as staying with friends or family temporarily, substance abuse treatment facility, and motel paid for without emergency shelter voucher. ‘Other’ exit destination was a response option in HMIS with no further explanation provided. At program exit, only five percent (5%) had returned to literal homelessness – staying in a shelter, motel with emergency housing voucher, or a place not meant for habitation (e.g., car, outside, abandon building).

Figure 9: CT RRH Exit Destinations (HMIS)



Destination at time of program exit varied across region, with Region 5 having the highest rate (90%) of exit to permanent housing, with Region 3 having the lowest rate (66%) (Figure 10).

Figure 10: Exit destination by region (CT RRH)



At twelve months post-program exit, ninety-two percent (92%) of the CT RRH population clients had not returned to a Connecticut (CT) shelter. At twenty-four months post-program exit, eighty-nine percent (89%) had not returned to a CT shelter. For the eleven percent (11%) who returned to a CT shelter, most returned within the first year; a) 39% returned in first six months; b) 36% between seven to twelve months; c) 25% returned between thirteen and twenty-four months.

Comparing HMIS data for those who exited emergency shelter to permanent housing with those enrolled in CT RRH, the latter were significantly less likely to return to shelter by twelve months (8% vs 11% return) and twenty-four months (11% vs 16% return) (see Table 3).

Table 3: Rates of Return to Shelter

	<u>Emergency shelter</u> ¹	<u>Rapid Re-housing</u> ²
Total N	2654	1172
≤ 12 months	11% (309)	8% (96)*
Total return by 24 months	16% (418)	11% (127)*

¹ those with valid HMIS data who exited between 10/1/12 and 9/30/13

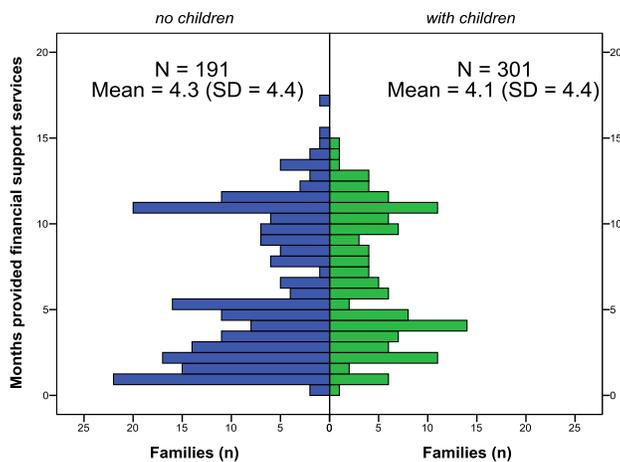
² those with valid HMIS data who were enrolled between 2/1/13 and 11/1/15

* Significant difference

Financial Assistance: CT RRH population with valid HMIS data (N=529)

On average, CT RRH population clients received financial assistance for 4.2 months. Families with and without children received similar months of support (Figure 11 below).

Figure 11: # of months of financial support (CT RRH) by family type



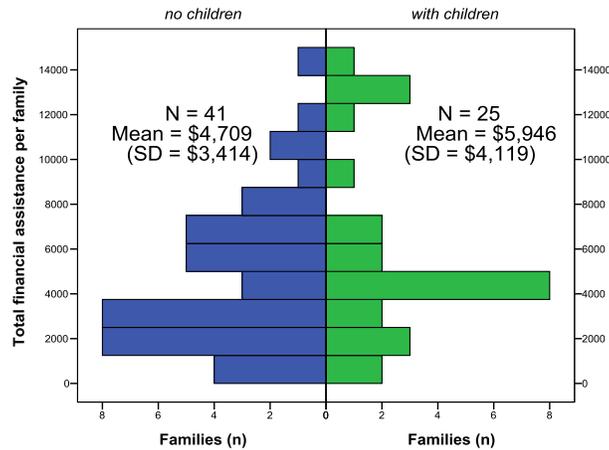
The average financial assistance received was \$3,409 (SD=\$3,152, n=529). Families with children received more (\$3,793) than those without families (\$3,157).

Financial Assistance: Survey sample with valid data (N=66)

The average financial assistance received by surveyed clients was \$5,177 (SD=\$3,715), which is significantly more than the amount of assistance received by CT RRH population clients not in the

survey but in the CT RRH program ($p < .001$). Couples with children in the survey received on average \$5,946, whereas couples without children received \$4,709 (see Figure 12).

Figure 12: Total Financial Assistance by Family Type Survey sample (N=66)



CT RRH population results compare favorably with the Supportive Services for Veteran Families study where the Rapid Re-housing program cost \$3,028 per household (Department of Veterans Affairs, 2015) and the Family Options study where the cost per household was \$6,578 (National Alliance to End Homelessness, 2015a). Additionally, in the Family Options study, emergency shelter for each household was \$16,829, subsidy was \$18,821, and transitional housing was \$32,557 (National Alliance to End Homelessness, 2015a).

Qualitative: Financial Support. A number of survey clients reported during focus groups and/or during case study interviews, that they struggled to stabilize while in CT RRH due to debt, particularly in relation to past utility bills. Some participants were placed in CT RRH housing when they owed utility companies over \$500; with this debt present from the beginning, they started out at a disadvantage. It made it extremely hard to keep electricity and/or gas connected. In these cases, community-based resources to assist clients in paying down outstanding bills would have been helpful in providing more financial stability.

Clients suggested the need for some kind of utility forgiveness, funds to help pay down their past utilities, and help negotiating with the utility companies. They also suggested the program wait a few months to increase their rent percentage if they have a lot of debt needing to be paid to keep the utilities connected.

Clients also talked about how they felt their percentage contribution towards rent rapidly increased, regardless of their employment status or income. Some found this increase to be too rapid, not providing them enough time to stabilize financially. An aspect of the program that clients found difficult was receiving a security deposit and part of the first month's rent, and then being discharged from the program after a few months of case management.

Qualitative: *Employment Support.* While employment coordination is not a core service provided through CT RRH, focus group and case study participants returned to this topic frequently, saying that more robust employment supports would be helpful. While clients were often provided referrals to employment services, like CTWorks or local non-profits, they did not feel they had received individual support or coordination through these services in their job search. They found available employment services scattered and complicated. Focus group and case study participants had to patch together employment support from many different locations, often from multiple non-profits agencies and state-supported initiatives. They had to navigate the system alone, some more successfully than others. Clients were very interested in having more localized access to job coaching and employment support services.

Participants had often entered homelessness because they became unemployed. Some of them were

not yet employed again, or were underemployed, when they left CT RRH. In the end, it meant some participants were unstably housed when the program ended because they did not have a steady form of income. The integration of effective, community-based employment support is critical for long-term housing stability.

Qualitative: *Housing Stability*

Of the thirteen case studies, four heads of household were evicted during the twelve-month period, one moved to avoid eviction, and four others were in the process of being evicted when the study ended. Of the four heads of household who were evicted, two moved down south to live with family. None of the thirteen households re-entered shelter. Of the thirteen households, only four (31%) had not been evicted or threatened with eviction when their case study ended. The following are client comments on housing stability.

Client Voices: Housing Stability

"[Rapid Re-housing is] a great concept. It was well intentioned and it's great for the time it lasts; the weakness is there's no transition."

"The bad thing about the program is it ends in a year and none of the programs have any transitional programming."

"My biggest fear right now, if I can't pay my rent, is I'll have to go back to a shelter."

Quality of Life: Client Surveys - *Health & Well-being*

There was no significant change in clients' perceived quality of life for either themselves or their children between baseline and twelve months (N=38, $p=0.401$; N=19, $p=0.655$).

When asked about their overall health, on average clients reported their health was good and there was no significant change in the clients' health between baseline and twelve months (N=39,

$p=0.362$). When asked specifically about their physical and mental health, analysis revealed no statistically significant change in their day-to-day health. When comparing average numbers of days clients were physically and mentally not well in the past thirty days, there were no significant changes. Around half of the participants reported some days where their physical health was not good in the past thirty days, both at baseline and twelve months. About two-thirds of the participants reported some days where their mental health was not good both at baseline and twelve months.

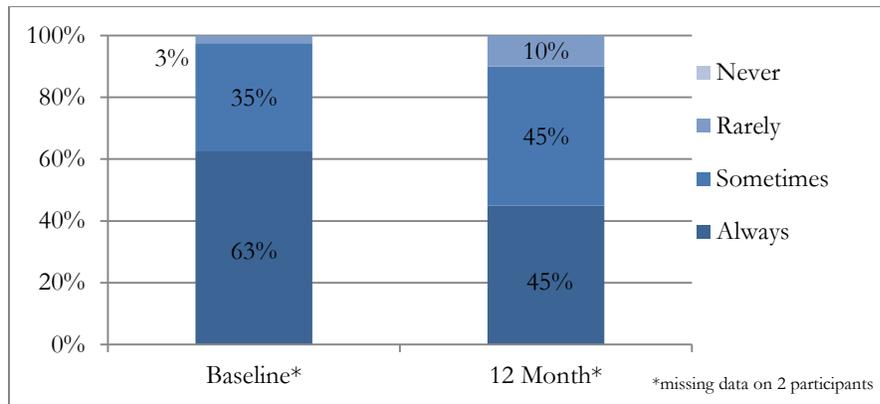
About half of the participants reported their physical and mental health kept them from their daily functioning in the past thirty days at baseline and about sixty percent (60%) at twelve months.

Quality of Life: Client Surveys – *Environmental chaos*

Clients were asked the six CHAOS questions regarding their daily life. These questions were: 1) if they were able to stay on top of things, 2) whether they were able to hear themselves think, 3) if it was a calm atmosphere, 4) if it was a real zoo where they lived, 5) whether the TV was always on, and 6) if they had a regular bed time routine. The average CHAOS score increased from the first survey (mean=11.85) to the survey a year later (mean=13.02), with an increase in score indicating an increase in chaos. A paired sample t-test revealed this change was a statistically significant increase of chaos within the home ($t=-2.064$, $df=39$, $p=0.046$).

Additionally, when the questions were analyzed individually, there was a statistically significant increase for one of the six questions (see Figure 13): ‘We are usually able to stay on top of things’ ($N=40$, $p=0.033$).

Figure 13: CHAOS: Stay on top of things (survey)



Despite the survey results indicating a more chaotic environment over time, clients reported the benefits of stable housing for their children below.

Client Voices: Quality of Children’s Lives

“[Now that we’re in stable housing] they are giving my daughter 3rd grade work because she is ahead and reads whole books.”

“[My son] suffers from ADD and I've been able to take him off his meds and he's doing wonderfully in school.”

“[My daughter] has been more active in everything and much happier due to the fact she has her own room and space.”

"The girls can go to school every day and feel confident. They have their own rooms. *They're going to have their own friends over. They have privacy.* They're back to living a normal life."

"[The best thing about Rapid Re-housing is] me and my girls have a place to live... we were at the shelter for 7 months."

“I'm less stressed because my son and I have a place of our own. My son is a lot happier I think because I'm a lot happier.”

Quality of Life: Client Surveys – Food Insecurity

While there was no significant change in food insecurity, a review of items indicated stable and relatively high levels of food insecurity at both time points. At baseline, a substantial fifty-nine percent (59%) of participants sometimes or often couldn't afford balanced meals and twelve months later, sixty-five percent (65%) sometimes or often worried about it ($N=39$, $p=0.963$). Over time, there was no significant change in whether clients were worried they would run out of food before they got money to buy more ($N=39$, $p=0.653$). There was also no significant change in the number of clients reporting they or other adults in the household cut the size of skipped meals because there wasn't enough money for food ($N=39$, $p=0.782$). At baseline, forty-six percent (46%) of clients reported they had cut the size or skipped a meal; twelve months later, this number remained constant at forty-five percent (45%) ($p= 1.000$). The number of clients who did not eat for a whole day increased slightly from thirty-one percent (31%) at baseline to thirty-three percent (33%) twelve months later ($N=39$, $p=1.000$). While this scale specifically avoids asking about the clients' children, it can be inferred that if adults in the household are struggling with food insecurity, their children will be struggling with food insecurity as well.

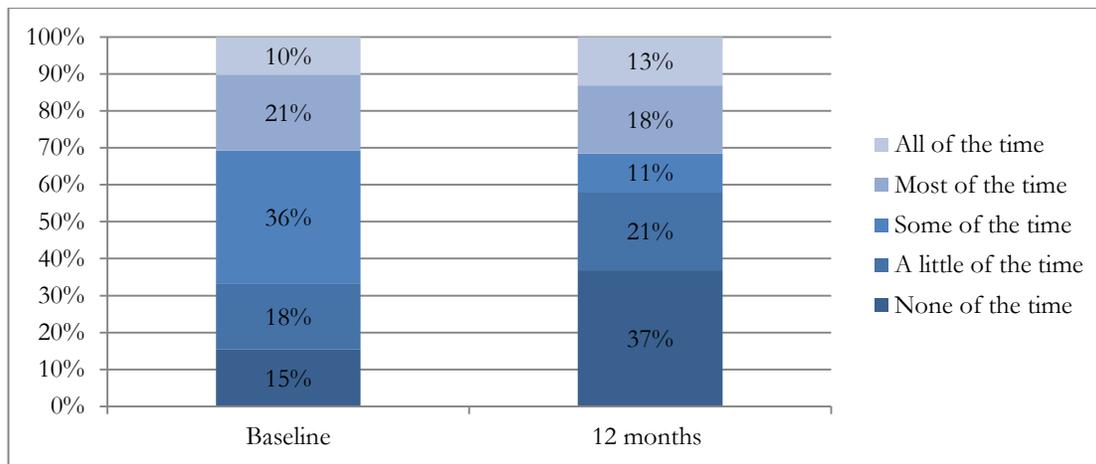
Quality of Life: Client Surveys – Social support

Surveyed clients were asked eight questions regarding their social support. These eight questions could further be divided into two subgroups, instrumental/tangible social support and emotional social support. The instrumental support subgroup consisted of four questions: having someone to take them to the doctor, prepare meals when ill, help with daily chores, and help getting around if they were to be confined to their bed. The emotional support subgroup consisted of four questions: having someone to have a good time with, turn to for suggestions for personal problems,

understand their problems, and make them feel loved or wanted. These questions were summed to create an overall score for each participant (potential range of 8-40). A higher score indicates higher social support.

The average scores for the overall social support questions decreased slightly over the twelve month time period from a low of twenty-one at baseline (M=21.21) to twenty at twelve months (M=19.63). However, analysis showed this was not a statistically significant decrease in social support (t=1.188, df=37, p=0.243). The eight questions were analyzed individually as well. There was a statistically significant decrease in reports of having ‘someone to have a good time with’ (N=37, p=0.040), an indication of emotional support (See Figure 14). At baseline, only about fifteen percent (15%) responded not always having someone to have a good time with, compared with thirty-seven (37%) of clients at twelve months.

Figure 14: mMOS-SS - Someone to have a good time with (survey)



It should be noted that while emotional aspects of the social support scale generally had more support, instrumental aspects were the most lacking. Around fifty percent (50%) of participants had no one to help with instrumental social support if they were sick both at baseline and twelve months

later.

Qualitative: *Social Support.* Clients frequently reported feeling like they were struggling through on their own, with no one to turn to besides their case manager and social service/mental health workers. Client suggestions were extensive on this topic. They felt it would be helpful for agencies to organize a peer support network; support peer mentorship; offer support groups run by peers; have events where CT RRH families can come together (e.g. picnic in the park); as well as invite former clients to be involved with the agency (e.g. board of directors).

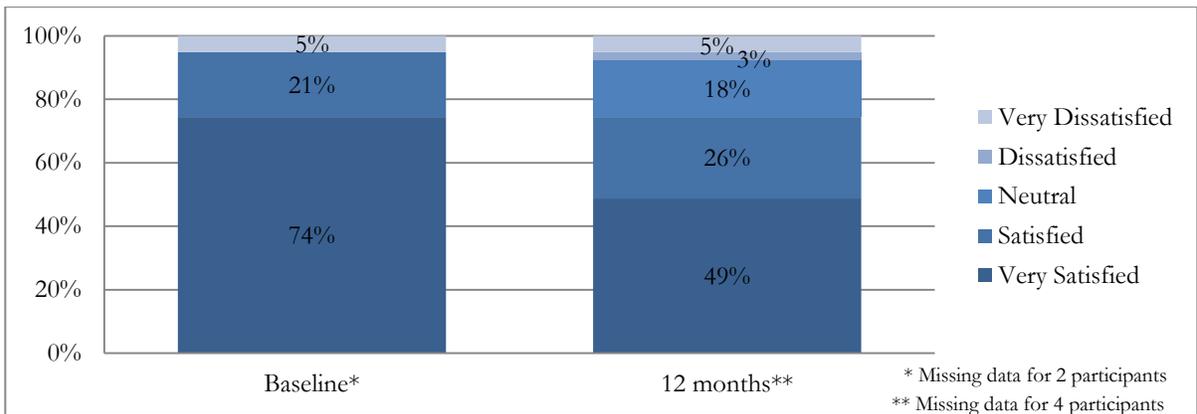
Interestingly, most case study participants spontaneously reported they found the monthly non-intervention contact with the evaluator to be very helpful and made them feel seen, heard, and remembered. During monthly phone calls, participants would be asked about how things had been progressing since the last point of contact. The evaluator kept extensive notes from each contact and followed up on them during the next contact to personalize the call. This included topics such as how an application to SSDI was progressing, if they'd scheduled an appointment for their child to see a neurologist, and how their job interview had gone. Case studies were especially grateful for the phone calls around holidays and during difficult times. One said the phone calls made her feel better, as they happened every month and weren't connected to her financial support. Another said the monthly phone calls made him feel safer, knowing someone with no "ulterior motives" would be checking in on him.

Housing & Case Management: Client Surveys

There was no statistically significant change in surveyed clients' satisfaction with their current housing over the twelve months, although satisfaction was on a downward trend (N=37, $p=0.098$). At baseline, eighty-two percent (82%) of clients were satisfied or very satisfied with their current

housing; twelve months later, only sixty-eight percent (68%) were satisfied or very satisfied. Clients' satisfaction with their case manager decreased significantly over the twelve month period (N =38, $p=0.010$) (see Figure 15 below). At baseline, ninety-five percent (95%) of clients were satisfied or very satisfied with their case manager; twelve months later, only seventy-five percent (75%) were satisfied or very satisfied.

Figure 15 Client satisfaction with case manager (survey)



During CT RRH, for those surveyed clients who saw their case manager at all (98%), sixty one percent (61%) saw their case manager in person once a month, twenty-seven (27%) saw them twice a month, and ten percent (10%) saw them three or more times. Of those reporting some phone or text contact with their case manager (96%), sixty-four percent (64%) had talk/text contact with their case manager 1-3 times a month, twenty-two percent (22%) had talk/text contact 4-7 times a month, and ten percent (10%) reported talk/text contact ten or more time a month. At twelve months, after everyone had exited the CT RRH program, twenty-five percent (25%) of surveyed clients still desired case manager-initiated contact at least once a week. Surveyed clients believed case management was important and that did not change over the course of their involvement in CT RRH. At baseline, ninety-two percent (92%) of the survey sample believed case management should be required and twelve months later, eighty percent (80%) believed it should be required; this

difference was not statistically significant.

Qualitative: *Case Management.* Case management was a much-discussed topic. Experiences varied widely. Some participants spoke highly of their case manager and had a very positive experience. The most common trait mentioned for positive case management experiences was availability – the participant could get in touch with their case manager fairly easily; the case manager would also take time to answer their questions and guide them to resources. The “available” case managers were said to be kind and compassionate; clients noticed when they went above and beyond what was strictly required.

On the other hand, some survey participants had negative experiences with their case manager. The most common trait mentioned for negative case management experiences was unavailability – the participant could not get in touch with their case manager and when they did, the case manager did not answer their questions or provide referrals. The “unavailable” case managers were said to be terse, angry, and “just there for the paycheck;” clients were sensitive to perceptions of being treated as a number rather than a person.

Regardless of client perceptions of their relationship with their case managers, most of survey respondents believed case management was a crucial part of the CT RRH program. Even for those who reported negative experiences, they believed a good case manager could make a large difference and advocated for change within the system to improve case management. The following client comments capture the varied perception of Case Managers.

Client Voices: Case Managers

“[Focus group participant directly addressing focus group facilitator] Thank you so much for helping us with the apartment. Everything you guys did was wonderful. You guys were very polite

and respectful. Thank you.”

“You’re not a statistic. There’s somebody there that you can say, hey, I’m havin’ this problem. Even if there’s something she can’t help with, just to be able to talk to ‘cause it’s not always financial.”

"[My case managers] opened up their hearts to me and it helped me open up too."

"[My case manager] is terrific. She helped connect me with computer classes and CTWorks."

"[My case manager] would schedule and wouldn't show up."

"It takes two people - the worker and the client."

“I take a half-a-day once a month to meet with the case manager, so I hafta take a half-a-day out of work to meet with them because their hours only go until 5:00. Well, so do mine.”

"[My case manager] has been really good, I've never had any problems."

"[Talking about feeling pushed into an apartment] It's not even like they care about you. They just want you out the door."

"[My case manager] worked with me and we've applied for senior housing."

“You need more case managers to be able to have one-on-one time... there’s only one [case manager] and that’s not fair. She’s running herself ragged. She’s busting her butt but she doesn’t have time to call me back.”

Qualitative: *Autonomy and Respect in the Housing Process.* Some people felt they had no choice about where they were housed; they felt they were expected to take whatever was offered without question. Some people reported being told if they refused to take the first apartment shown to them, they would be put back in shelter and not housed; these clients said they felt coerced into signing a lease. Others were only offered access to affordable housing away from their work, families, friends, or other support networks; this was especially difficult for those who relied on public transportation.

Client Voices: Autonomy and Respect

“While you’re going through the program and you’re looking for places and stuff like that, you get people that say, ‘well, I’m helping you. You take what I can give and if you don’t, well, you’re the one that’s homeless.’”

“It’s like everybody come through different circumstances and there was no type of empathy for anything. It’s just ‘get here and if you don’t come here by this date, you goin’ back to the shelter.’”

“You’re homeless. It just means you don’t have a home. That doesn’t mean you’re not human.”

“They don’t know anything about you but they just lump you into that and they treat you like you’re not a person.”

“I want help. I want respect. I don’t want you looking down [on me].”

“I do think that there’s a flagrant lack of respect from the staff in the Rapid Re-housing Program and through the shelter systems, where they feel that if you are in a financial difficulty and you’ve ended up at the shelter, you’re no longer capable of managing your life.”

"Try to be a bit kinder to people; we're in a bad situation, instead of yelling and being mean."

Qualitative: *Program Transparency.* Clients were often confused about program expectations and individual details about program length, amount of financial support, and case management expectations. Frequently expressed themes in focus groups and case studies were frustration about the substantial program changes that occurred when their case manager changed and dissatisfaction about the perceived secrecy of how funding was dispensed.

Client Voices: Program Transparency

"The only thing that worked was the deposit that they helped me with...I heard about the Rapid

Re-housing where they help you for a whole year... I don't understand why they didn't put me on that. I'd never lived on my own. I'd always relied on my family or the person I was with to take care of me."

"I wish [the people at the shelter] had explained my [housing program] options to me better. Maybe I wouldn't be in such a tight spot now if she had."

Summary: Client Surveys

The results showed most surveyed clients didn't move or only moved once in the studied twelve-month period. At follow-up, after program exit, clients reported a decrease in their satisfaction with their case manager. At the same time, most surveyed clients believed case management should be a requirement of CT RRH.

Clients' food insecurity did not significantly change between baseline and twelve months, though levels of food insecurity were persistently high. Perceived life improvement and health and that of their children did not significantly change between baseline and twelve months although there were consistently high reports of days with physical and/or emotional issues throughout. Overall, clients' instrumental and emotional social support, which was low at baseline, did not significantly change; however, there was a significant decrease in an indicator of emotional support, 'someone to have a good time with.' Overall levels of household chaos and confusion increased, as did the individual question "We are usually able to stay on top of things."

Summary: Survey and CT RRH population clients

On average, clients in the survey sample were housed in 1.6 months (SD 2.2) and clients in the full HMIS were housed in a statistically comparable time frame of 1.4 months (SD 2.1). Fifty percent

(50%) of the survey sample clients and fifty-six percent (56%) of the total CT RRH sample (statistically equivalent) were housed in thirty days or less, which **approaches meeting** NAEH's first performance benchmark of housing households in thirty days or less (NAEH, 2016b). At time of program exit, eighty-four percent (84%) of the total CT RRH sample with valid HMIS data (N=669) exited to permanent housing with only five percent (5%) returning to literal homelessness. This **meets** NAEH's second performance benchmark of exiting at least 80% of households to permanent housing (NAEH, 2016b).

Among those completing a baseline and follow-up survey, ninety-four percent (94%) had moved one time or less since being housed through CT RRH.

Of the CT RRH population with valid exit data in the HMIS dataset, ninety-two percent (92%) did not return to shelter in the first twelve months, and at twenty-four months post-program exit, eighty-nine percent (89%) had not returned to shelter. This **meets** NAEH's third performance benchmark of at least eighty-five percent (85%) of households exited to permanent housing should not reenter homelessness within a year. For the eleven percent (11%) who returned to a CT shelter by twenty-four months, most returned in the first year.

Those who were enrolled in Rapid Re-housing were significantly less likely to return to shelter by twelve and twenty-four months post-program than those who received services through emergency shelter and reported leaving to permanent housing.

Surveyed clients received significantly more financial assistance on average than other CT RRH

population clients in general. The average financial assistance received by surveyed clients was \$5,177 (SD=\$3,715, N=66), which is significantly more than the amount of assistance received by CT RRH clients not in the survey but in the HMIS data ($p<.001$). Couples with children in the survey sample received on average \$5,946, whereas couples without children received \$4,709.

The average amount of total financial assistance provided to each CT RRH household with valid HMIS data was \$3,409. This is compared to the Supportive Services for Veteran Families study at \$3,028 per household (Department of Veterans Affairs, 2015) and the Family Options study at \$6,578 per household (National Alliance to End Homelessness, 2015a).

Summary: Client Voices

Clients clearly articulated their perceptions of the benefits and struggles of the program – such as stability for their children, case manager interactions, program transparency, ways to improve the program, and the benefits of contact with evaluation staff. Additionally, they spoke to their varied experiences with community-based agencies beyond rapidity and stability of housing.

Conclusions

CT Rapid Re-housing is meant to address three aspects: 1) rapidly placing literally homeless individuals and families into housing; 2) exiting individuals and families from Rapid Re-housing to permanent housing situations; and 3) assisting these individuals and families in such a way that they do not return to homelessness 12 months later. This evaluation found strong evidence that CT RRH is approaching, meeting or exceeding national benchmarks for these outcomes. Clients in both the survey sample and the total CT RRH population are on average placed in housing in less than two

months and close to half (50% and 56%) of each group is in housing within one month. At the time of program exit, eighty-four percent (84%) of CT RRH population clients exited to permanent housing with only five percent (5%) returning to literal homelessness. Stability in housing appears to have both a current and a lasting effect. For our survey sample most (ninety-four percent (94%)) had either not moved or had moved only once since being placed in housing through CT RRH. For the CT RRH population, it was found that at twelve months post-program exit, ninety-two percent (92%) had not returned to CT shelter and at twenty-four months out, eighty-nine percent (89%) had still not returned to a CT shelter. CT RRH clients were significantly less likely to return to shelter at one and two years out than were those who left emergency shelter to self-reported permanent housing without the benefit of the CT RRH program. These strong outcomes are associated with relatively low rates of financial assistance that are comparable to the financial assistance provided in the Veteran Families Study (Byrne et al, 2016) and much lower than reported costs for other types of services such as emergency shelter, subsidy and transitional housing costs. (National Alliance to End Homelessness, 2015a).

Client feedback through surveys, focus groups, and case studies indicates client confusion about program entry and start dates, as well as frustration with a perceived lack of transparency. An increase in program transparency and consistency across the state and within programs may increase client-staff rapport and decrease client confusion

Community Supports. Rapid Re-housing is a program that helps individuals and families quickly obtain housing, providing a step out of homelessness. While they remained housed, once clients exited the program, they reported struggling with environmental chaos, obtaining adequate

emotional social support and food insecurity. Based on qualitative client feedback, more community support would be helpful in their efforts to make their housing sustainable for a year past their exit from CT RRH. Clients attested to the fact that a large part of remaining housed twelve months after the program ends is income. Providing stronger, direct community links to effective employment assistance for Rapid Re-housing clients is highly recommended. Clients also indicated a need for increased social support. Increased levels of interagency collaboration and communication could help provide better wrap-around services for some of the community's most vulnerable: homeless individuals and families.

Social support. A potential addition to the CT RRH program would be to have peer support or professional workers to call and provide phone-based check-ins, using techniques similar to Motivational Interviewing. Another option to address the same aspect would be a warm line, staffed by trained laypersons, perhaps volunteers who have experienced homelessness. Warm lines are phone numbers people can call when they're not in crisis but need someone to talk to and support them. Warm lines can reduce feelings of loneliness and provide peer support to those who are geographically isolated. If there are applicable, existing warm lines in the area, that information could be provided to CT RRH clients. We acknowledge that these options would likely depend on additional funding made available to offset costs of organizing, staffing, and managing even largely volunteer-based efforts.

Respect and autonomy in housing. When at all possible, clients need to be provided with multiple viable options. However, it is important to acknowledge that given Connecticut's high-cost housing market, there can be significant tensions between client desires with regards to housing and

availability of affordable housing options that meet those desires. Rapid Re-Housing case managers and housing locators must often work in a very narrow space with regard to the housing they can identify and offer. Respecting client autonomy in the housing process is paramount; supporting housing choices for clients through evenly applied policies and practices is critical. It would be helpful to client rapport to have a uniform client-centered policy across agencies regarding the housing process. Some people said they were told they could not look for housing but had to wait on the housing coordinator while others were told they must find their own housing; having a uniform policy that encourages maximum client self-advocacy, but offers the housing support needed, could reduce client confusion and reify trust.

Program transparency. More transparency in how funding is assigned and what elements are considered would be helpful in building client rapport. Clients suggested a written agreement be put in place at the beginning, with details included about what could change the agreement in the future so everyone understands the expectations. They would like it to include a list of “qualifying events” for being considered for an extension beyond the stated timeline or reevaluating the percentage of rent paid by the client. This written agreement would also help assure clients of continuity if their worker changes.

Limitations

While there is value in having multiple data sources when conducting an evaluation so that a fuller view of the program or implementation can be described, there is also the question of comparability across data sources. In this evaluation, the main comparison between the survey sample (all of whom are in the CT RRH program) and the total CT RRH program is limited by problems encountered in matching clients in both data sources such that the matched sample is small and may not fully represent the survey sample. Thus, we report baseline equivalency between the CT RRH

program and our matched survey sample on the basis of eighty-seven participants. There are few significant differences (survey client is on average four years older than the CT RRH client; the CT RRH client has a slightly larger household (1.99 vs. 1.74 members), survey client remains in the program for approximately five months longer and receives more financial assistance). We suggest generalizing with caution from our survey results, especially with regard to quality of life and program experience findings, to the experience of the CT RRH population client as there may be some systematic difference in clients who did and did not agree to participate in our survey or in clients that case managers approached to participate. Our survey findings are best used to describe the experience of the small family with at least one child, headed by a forty-plus year old woman of color who is in the program for eleven months, moves into permanent housing in less than 2 months, moves one or fewer times in the first year, receives on average of \$5,946 in assistance and exits to permanent housing where she remains for at least two years.

In addition, certain regions had more representation in the data; it could be CT RRH is operationalized significantly differently in those areas as clients reported differences in their experiences by region.

Due to problems in locating participants for follow-up data collection, our final sample was relatively small. Those who returned for twelve-month data collection, or engaged in the research at all, could have been more interested in the research because they had something pressing to share. This can skew results, both in positive and negative directions.

This study's follow-up data collection occurred after program end. As a result, some of our findings

may reflect post-program experience; for instance, we do not know when the increase in chaos began to occur, whether during or after CT RRH.

While people reported that certain aspects of their lives were more difficult outside of Rapid Re-housing, they also expressed intense gratitude and appreciation for the program, believing their success was due to the opportunity CT RRH offered them. The data provide us with information about the difficulties: food insecurity, chaos, lack of program transparency, and social support, without offering up reasons for reported changes or how these results would differ if the clients were not in the program but continuing in shelter or homelessness; further investigation into these aspects is warranted.

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Appendix A: Regions

Region 1 (Fairfield County):

Supportive Housing Works

Subcontractors:

Operation Hope

Homes with Hope

Inspirica

Region 2 (New Haven and Middlesex Counties):

New Reach (formerly NHHR)

Subcontractors:

Columbus House

BH Care

Region 3 (New London and Windham Counties):

TVCCA

Subcontractors:

Windham Regional Community Council

Thames River Community Services

Region 4 (Hartford/Tolland Counties): Community Health Resources

Subcontractors: NA

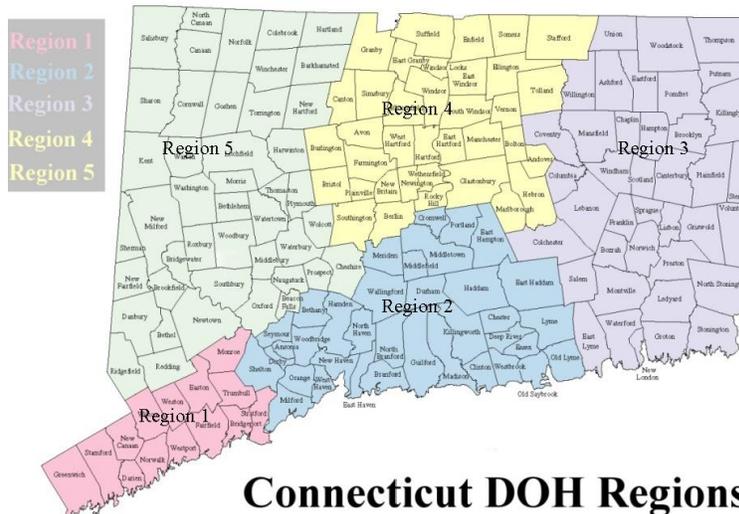
Region 5 (Litchfield County + Danbury & Waterbury):

New Opportunities

Subcontractors:

Salvation Army of Waterbury

The Association of Religious Communities



Connecticut DOH Regions

Appendix B: Family profiles

Rapid Re-housing Family Profile #1

Victoria¹ is a 36-year-old Hispanic woman. She has two children who live with her: Daniel (16) and Emily (13), as well as three other children who live with their father. She has experience working as a chef and as a beautician. **Daniel** is an artist and musically inclined. He was also diagnosed with a brain stem tumor when he was 10; he entered remission when he was 13 but continued to have life-threatening side effects. **Emily** is artistically inclined as well, playing the flute and writing poetry. Both Daniel and Emily began attending public schools upon their arrival to their new city.

The medical care available to Daniel in Florida was not enough, so Victoria, Daniel, and Emily moved from Florida to Connecticut in Fall 2014, seeking a comprehensive children's hospital with expertise in cancer treatment. They lived with a friend for a few months until the situation became untenable, and then moved into a shelter. Victoria found a suitable apartment and Rapid Re-housing paid for the deposit and first month's rent.

Soon after their arrival, Daniel was hospitalized three times, twice for surgery and once for psychiatric in-patient. Emily began struggling with anxiety, depression, and self-injury. Despite having a degenerative disc disorder which causes her significant back and nerve pain, Victoria began doing catering work in food service soon after their arrival and continued to search for full-time work.

One Year Later

All members of the family are seeing individual therapists. In addition, the family is being supported by numerous agencies; they've gone through the IICAPS program which provides in-home services for children at risk of psychiatric hospitalization. **Victoria** is working as a temp and caterer in various food services roles, often as a head chef for events at prestigious hotels, as well as attending community college for business administration. Despite her hard work, she has only been able to pay part of her rent for a number of months. Her landlord has begun the process of evicting her. She's hoping to hear back soon regarding a rental voucher or other supportive housing, so she can move prior to eviction.

¹ Names changed for privacy

Daniel and Emily spent their summer days at the Boys and Girls Club. **Daniel** applied and was accepted to a magnet art school in Fall 2015. He's an honors student and has excellent grades. His mental health is still a struggle but his physical health has stabilized. **Emily** is still attending public school but her grades have improved, including turning an F into a C-. She joined a local ballet program specifically for young people of color a few months ago and it has substantially increased her self-esteem; she recently performed in their first recital. She's no longer self-injuring and her school work has improved. She will be performing a flute solo in a school recital soon.

Suggested Solutions

- *Social support:* Victoria doesn't have any family within New England and her family cut all ties when she had children with a man who was not of her ethnicity. Victoria had one local friend but she also was a single mom, raising five children, so she had little time to spare. Victoria was very isolated; other than people she worked with and social services she received, she had no one in her life. She wished there was a support group or social gatherings for other families going through similar life struggles.
- *Employment support:* Victoria struggled to find work. She attempted the CT hairdressing license exam twice so she could continue the work she'd done in Florida but failed by a few questions each time. She took positions with multiple catering companies but the work was inconsistent. She found more consistent hours working in food service nights and weekends through a temp agency. Additionally, she worked at a clothing store during the day while her children were in school. She received SSDI funds as her son's primary caregiver but it wasn't enough to cover the family's expenses. When her SNAP card was stolen out of her mailbox three times, she didn't have money to buy food for her children for a few weeks. A small corner store let her take some milk, bread, peanut butter, and jelly with a promise to pay later. This held them over until she was able to pick up her SNAP card directly from DSS. She had no support in her job search and didn't know of any job readiness services available to her.
- *More wrap-around case management:* Victoria had to find her own apartment at the start of Rapid Re-housing; no one was available to help her find housing. She had no one to help her navigate the complicated maze of healthcare, therapy, employment, mental health crisis,

SNAP problems, summer activities and school supplies for her children, custody struggles, family exposure to gun violence, chronic pain, and eviction. Her Rapid Re-housing case manager was extremely difficult to get a hold of, often taking weeks to return her phone calls. Given her family's intense needs, Victoria would have benefited from a case manager through a local community agency and better access to resources.

- *Long term stability:* In Rapid Re-housing, Victoria was only provided with a security deposit and the first month's rent. This meant she was housed, but was barely paying all her bills when everything was going well. With her son's ongoing medical condition, finances were rarely going well. It left her with no buffer between her family and homelessness.

Rapid Re-housing Family Profile #2

Edith² is a 53-year-old Black woman living in Fairfield County. Before she entered Rapid Re-housing, she was living out of her car. She struggles with diabetes and controlling her blood sugar. Despite her protests, they housed her in a rooming house half an hour away from her job and her family; she felt very disconnected and alone. While housing was unstable, she received SNAP and food access wasn't an issue for her.

Shortly after she was housed through Rapid Re-housing, she was hospitalized for high blood sugar. After being threatened at work, she quit her job; finding work after that was a significant struggle. Once the rental assistance ended, she was unable to pay for her apartment and moved in with her sister and her sister's family. While she was grateful for a place to stay, her relatives were not kind to her. The children regularly harassed her and said cruel things. Her blood sugar skyrocketed during this transition; her doctor told her she needed to lower her blood sugar or she could lose her sight.

A few months after moving in with her sister, she started a position as a home health aide. This job helped add structure to her life so she was eating at regular intervals. She also started a new medication; with these two pieces, she found it easier to maintain lower blood sugar. To relieve some of the tension between her and her sister's family, she would spend some of her nights at her mother's house.

One year later:

With a healthy blood sugar level, she quit her job and moved down to Florida, seeking new opportunities, community, and warmer weather. She did not realize that moving out of state would terminate her state Medicaid; she was left without health insurance and no way to pay for her diabetes medications. The roommate situation she moved into ended abruptly and she couch-hopped with family throughout Florida.

Because she had nowhere to forward her mail, she did not receive the notification in time that a spot in permanent supportive housing had opened up for her in Connecticut. She received the information a few weeks after the cut-off date. She's considered moving back to Connecticut to further explore her options here. For now, she's living with relatives in Florida, applying for jobs, and hoping something changes soon.

² Name changed for privacy

Suggested Solutions

- *More wrap-around case management:* Edith found the case manager to be completely unresponsive to her needs; she would call and leave a message and the case manager would never call her back. She was left to navigate the system alone. She had no one to help her navigate the complicated maze of healthcare, therapy, employment, mental health struggles, SNAP, health problems, and eviction. Given her needs, Edith would have benefited from a case manager through a local community agency and better access to resources. She said that being out of Rapid Re-housing was much less stressful, despite the uncertainty.
- *Autonomy and respect in the housing process:* She was shown basement studios without two exits (which are not legal). She was given two housing choices; when she tried to push back, she was told they wouldn't look for housing for her if she didn't pick one of the two. Once she was housed, the case manager kept threatening to evict her if she didn't pay more each month. Being housed half an hour from her job and family made transportation a financial strain on her and cut her off from her support network.
- *Program consistency and transparency:* Edith reported the case manager wasn't upfront about the program or what their expectations were. She said it "felt like a game" to the program managers, that they didn't understand clients' situations.
- *Employment support:* Once she was unemployed, she struggled to find work. She needed help with job searching and didn't know of any local job readiness services.
- *Social support:* Edith felt entirely alone and isolated once she moved into her Rapid Re-housing placement. She didn't know anyone else who was going through the same experience. She recommended that support groups or mentorship programs should be put in place to support those in Rapid Re-housing so they can have peers who can relate to their experiences.

Rapid Re-housing Family Profile #3

Laura³ is a 62-year-old white woman. She is mother to three children and grandmother to 6 grandchildren with a great-grandchild on the way. Some of her family lives in Connecticut but most live in North Carolina.

When she entered the Rapid Re-housing program, she was living in her car. Rapid Re-housing placed her into an apartment in a small suburban town. Since she had her own car (paid for by one of her children), transportation was not an issue for her. Her car was running well and she had a part-time job as a Product Demonstrator to supplement her monthly SSI. She struggled with chronic back pain which was exacerbated by being on her feet all day at work. In the first few months of being housed, her brother died suddenly. Laura was very good at finding local resources to buoy her limited income – she knew all the local food pantries, furniture banks, and clothes closets. Because of her resourcefulness, she was able to obtain furniture for her apartment.

As Rapid Re-housing support was ending, Laura's car needed work done on the radiator; her work hours were reduced during the summer months, making it harder to pay her bills. Her food stamps were discontinued; she was grateful that work allowed her to bring home excess food from demonstrations. Her apartment building was purchased and her landlord changed. One of her building's tenants attempted to sexually assault her; she was afraid to go to the police due to the tenant's drug use, explicate threats, and past violent outbursts she had observed. She began a relationship and was initially happy about it but after a few months, the man's behavior turned abusive and she broke up with him.

One year later:

Her family had many medical emergencies over the past year. One of Laura's daughters needed surgery and asked her for money; she gave her daughter more money than she could afford. She was unable to pay her rent; her landlord took her to court and evicted her. As she was being evicted, her sister was given a terminal cancer diagnosis and less than a month to live; Laura wasn't able to afford a bus ticket to see her sister in Tennessee before she died. She stayed on a friend's couch for a few months, before moving down to North Carolina to live with one of her daughters. She

³ Name changed for privacy

unsuccessfully tried to get her job transferred down to North Carolina. She lost her health insurance since she moved out of Connecticut; she's applied for health insurance through the state. Her family is providing her room and board for now.

Laura says it's her fault she didn't remain housed; she spent more money than she had, ignoring her budget. She still needs to travel back to Connecticut to get the rest of her belongings from a friend that's storing them for her. She's in the process of applying for part-time jobs; she hopes North Carolina is only a temporary stop.

Suggested Solutions

- *More wrap-around case management:* Laura's needs were beyond the level of support her RRH case manager could provide; she would call and leave a message and the case manager would take weeks to call her back. Given the loss and attempted assault she experienced in addition to all the other stressors in her life, she would have benefited from more case management and mental health support through a local community-based agency.
- *Autonomy and respect in the housing process:* She reported being told she had to find her own apartment with a landlord who was willing to work with RRH clients; the housing placement worker refused to provide her with any assistance.
- *Program consistency and transparency:* Laura was told differing stories – the housing placement worker, manager, and case manager told her conflicting things regarding the program's timeline, degree of financial assistance, and frequency of case management.
- *Social support:* Other than her family, Laura didn't have any support system. She was very isolated and had no one to talk to who was going through similar struggles. She would have liked to be part of a peer support network.

Rapid Re-housing Family Profile #4

Michelle⁴ is a 52-year-old Black woman. She has two daughters who live with her, **Jessica** (17) and **Riley** (14). Before entering Rapid Re-housing, they were staying at a shelter. When they were placed into housing, Jessica was a junior in high school and Riley was in 8th grade. Riley has Fetal Alcohol Syndrome and receives special education at school. She's been receiving services since she was born; she participated in Birth to Three. Michelle was made aware by her case manager that she should be receiving SSDI for Riley; she began the application process soon after she was housed. Michelle was unemployed and seeking working; she had experience as a home health aide and CNA. She was struggling with high blood pressure, insomnia, and depression. The apartment the family was placed in had major issues with pests which the landlord wouldn't address; the health department was investigating the situation.

One Year Later

Michelle persisted in her job search, working with the CTWorks and Step Up programs, as well as career services through a local non-profit agency. During the holidays, she was hired for part-time work at TJ Maxx and Dollar Tree. They retained her after the holidays; she's scheduled for ~32 hours a week between the two jobs. However, her schedule intermittently shifts from mornings to evenings, making it difficult to attend therapy and spend time with her daughters. She continues to look for more stable work.

During the summer, just as the program was ending, Michelle's inability to fully pay the electric bill came to a head when the company turned off her power. She was without power for *almost 3 months*; it was difficult to feed the family without electricity. After exhausting other avenues, Michelle contacting DCF for assistance; they helped her get the electricity back on and arranged a payment plan. They're still providing support to the family, including offering financial support to move to a better apartment. They're also looking into connecting the family with permanent supportive housing.

The landlord took Michelle to court as she had been unable to fully pay her rent for many months; she was allowed to stay with a payment plan in place. The landlord still hasn't addressed many issues with the rental property; Michelle is still looking to move to a better location and DCF supports that plan.

⁴ Names changed for privacy

Thanks to persistence on Michelle's part, Jessica and Riley were able to remain in the same schools they were attending before they encountered homelessness, surrounded by the same peers and teachers. **Jessica** is about to graduate from high school; she's applied to a local community college's RN program. Her aunt is helping her apply for FAFSA. **Riley** has done well adjusting to her first year of high school; her SSDI was turned down and Michelle is looking into a lawyer for the appeal.

All three members of the family have been in therapy for over six months and Michelle reports it's been very helpful. A few months ago, Michelle's step-father died suddenly; the family was very close with him. He was a father-figure to Jessica and Riley; his death was very difficult for the whole family. They're still adjusting to life without him. Over the past year, Michelle has been receiving treatment for her insomnia and her overall health has significantly improved. She is hopeful she'll find a better job and apartment soon.

Suggested Solutions

- *Social support:* Michelle had very little social support; she had no friends locally and no one in her life who was experiencing similar life situations. She was isolated and had only her therapist to talk with about her joys and stresses.
- *Employment support:* While Michelle was persistent and resourceful, seeking out employment resources and training programs at numerous agencies, she was left to muddle through the maze on her own. Her housing wasn't stable because she didn't have consistent income. She had experience as a CNA but her certification had lapsed and she didn't have the funds to be recertified.
- *More wrap-around case management:* While Michelle was very happy with her case manager, she had many needs which were beyond the scope of the current case management arrangement. She needed support and guidance around landlord relations, tenant legal rights, child support, SSDI applications, employment services, mental health struggles, and food access. There was no transition services built into Rapid Re-housing so Michelle was left on her own at the end of the 12 month program, regardless of her continued need.

Rapid Re-housing Family Profile #5

Lisa⁵ is a 55-year-old white woman. She is divorced and has a 21-year-old daughter who doesn't live with her. Lisa had another daughter who died five years ago at age seven, passing away after a fight with brain cancer. She has an emotional support animal, Daisy, who was originally her daughter's companion animal.

Before being housed through Rapid Re-housing, she was living in a shelter. The apartment she was placed in was located in a very small suburban town with little public transportation. Lisa had a car but it was in disrepair and wasn't a reliable form of transportation. She received monthly SSI and was looking for work. Shortly after entering Rapid Re-housing, Lisa found volunteer work at a local clothing bank within walking distance. She volunteered multiple days a week throughout her time in the Rapid Re-housing program.

One year later:

Lisa never got her car working. She sold her car, as it would cost more to repair it than it was worth. She had issues with pipes from the floor above her leaking into her pantry, ruining much of her food. Daisy had a skin infection that required veterinary treatment. Lisa had heart trouble and needed a number of tests; she's on medication and doing better now. She and her landlord have been to court multiple times; she's withheld rent from him due to issues with the property. Her housing is unstable; she wants to move closer to a city with better transportation and affordable housing. She hasn't been able to find any paying work but continues to volunteer at the clothing bank.

Suggested Solutions

- *More wrap-around case management:* Lisa found her case manager to be unresponsive to her. The worker pressed her to do what the worker wanted; their work wasn't focused on what she wanted or needed. Her program requirements changed drastically when her worker changed

⁵ Names changed for privacy

partway through the program. Given her needs, Lisa would have benefited from a case manager through a local community agency and better access to resources.

- *Autonomy and respect in the housing process:* She was moved into the apartment with almost no furniture – she only had a blow-up bed, chair, and TV; and public transportation was almost nonexistent. She would have benefited from more connections to local non-profit agencies that could help with furniture, transportation, and food. She was told she had to take the apartment or they wouldn't house her through Rapid Re-housing. The apartment was in an area of town where she didn't feel safe; she saw people engaging in sex acts at the local park. When she expressed her frustration to the agency, she was told she had been discharged from the program when she was housed so they could do nothing more for her. She felt manipulated into taking on a 12-month lease with a difficult landlord in an undesirable location.
- *Program consistency and transparency:* She reported being told different things – the housing placement worker, manager, and case manager told her conflicting things regarding program length, amount of financial support, and how the housing process worked. Lisa suggested a class for all frontline providers to make it clear what's expected of them and what they should expect from the clients, so all providers are telling clients the same information. Expectations seemed to change staff member to staff member; she suggested the client be provided in writing with the current agreement's details and what might change the agreement in the future.
- *Social support:* Lisa had very little social support. She had some acquaintances through her volunteer work but no friends. Her daughter lives locally and calls and visits occasionally, as does her sister who lives in New Hampshire. She had no contact with other people experiencing similar things.
- *Employment support:* Lisa was referred to an employment support service but it was half an hour away via car and she didn't have transportation. She was unemployed at the beginning of the program and unable to find paying work by the end.

Rapid Re-housing Family Profile #6

Derreck⁶ is a 53-year-old Black man living in Fairfield County. He has experienced chronic homelessness, living on the street and in abandoned buildings off and on for many years. He was approached about Rapid Re-housing during one of his shelter stays. He left shelter and returned later to follow up on the offer of housing. He was unemployed when he entered Rapid Re-housing, after being laid off from the US Postal Service. He had his CNA license, and was seeking out a security guard certification.

Rapid Re-housing placed him in a boarding house, with a room to himself but shared bathroom and kitchen facilities. Derreck didn't own a car and used the bus for transportation. He would occasionally use soup kitchens and food pantries but he received SNAP and avoided using them when he could scrape by on his own. He didn't want to take food away from others who might need it more than him. Derreck attended church on Sundays for services and Tuesday nights for bible study.

One Year Later

Derreck moved boarding houses, to a nicer one in the same city. Derreck has friends and acquaintances nearby; he still attends church twice a week and has support from people there. He also has a girlfriend of two years, though it's difficult to see each other since she works three jobs. He still finds public transportation meets his travel needs. Derreck completed a job readiness program but was unable to find employment. He used all unemployment available to him and was left with no income part way through the year, though he was still receiving SNAP and HUSKY-D.

When Rapid Re-housing ended, he had no funds to pay his rent. However, when the case study ended, he was still tenuously housed at the boarding house. After Rapid Re-housing's support ended, people from church helped him pay his rent. They've also helped provide him with food and clothes. Derreck continues to search for work, as a CNA, security guard, or package handler. He's resourcefully hanging on to his housing for now but he's not stably housed.

⁶ Name changed for privacy

Suggested Solutions

- *Employment support:* Derreck struggled to find work the entire time he was in Rapid Re-housing. While having numerous skill sets for a wide variety of work opportunities, he couldn't find any positions. He had a number of interviews but none of them resulted in being hired. Derreck would have benefited from more employment support and coaching in his job search beyond what the Department of Labor provided.
- *More wrap-around case management:* Without a job, Derreck didn't have many things to do. He went to the library, searched for work, and spent time on the street with his friends. On the street, he had no one dictating rules to him; he was used to complete and total autonomy. He chafed under Rapid Re-housing's guidelines. As someone coming from a background of chronic homelessness, with a trauma history and disenfranchisement with "the system" and anyone affiliated with it, Derreck would have benefitted from a longer, more rapport-based intervention.

Rapid Re-housing Family Profile #7

Thomas⁷ is a 50-year-old white man. Eight years ago, he was in a serious workplace accident. He was in a coma for two years following the accident. His most long-lasting effects from the accident are a patched hole in his heart and a significant Traumatic Brain Injury (TBI), which seriously affects his executive functions (e.g. attention, memory, judgement, impulse control). While he was awarded a large sum of money in the workplace lawsuit that followed, he quickly lost all of his money as a result of poor money management and judgement because of his TBI. When he entered Rapid Re-housing, he was living in his car with his cat, Angel. Because no shelter would take him and the cat, he refused shelter until they housed him.

One year later:

Thomas had a number of issues with back taxes over the year. He owed one Connecticut town over \$500; at one point, he was brought in by the police because he hadn't paid a \$17 fine and it had accumulated to over \$250. With those fines, it became difficult to buy food and pay rent. Part way through the year, his housing became unstable; his lease had expired, he was renting month-to-month, and had an altercation with his landlord's friend. His landlord decided he wanted a quiet tenant who would pay in full each month. Around the same time, a shift in insurance coverage meant Thomas's medications were no longer covered. He couldn't afford to pay for them out of pocket so he stopped taking them, including two heart medications he needed because of his heart's damage. Thomas became homeless again, living in his car.

After a few months, an acquaintance helped find him an apartment and pulled together money to loan him for the security deposit. His doctor found out insurance wasn't covering his medication and called to advocate for him. He was finally able to obtain his medications. After settling into his new apartment, Thomas received a call informing him he'd finally reached the top of the Section 8 waiting list; he'll receive his voucher in a few weeks' time.

Suggested Solutions

- *Social support:* Thomas was raised in foster care; he doesn't have any close family relationships. He was married prior to his accident but was divorced in the years following.

⁷ Name changed for privacy

His Rapid Re-housing case manager was his only social support. Thomas was very resourceful and managed to make connections with people, though his judgement was often compromised. He would have benefitted from more social support in a structured environment, like peer-support groups or gatherings.

- *Employment support:* Thomas received some assistance from a local non-profit focused on those with disabilities but the interactions were entirely driven by whether Thomas could schedule and show up for appointments; given his intense emotional fluctuations, if he became upset by something, he wouldn't go for months. At the same time, he didn't have enough income to cover all of his expenses and financially needed a part-time job. He needed more support than what was offered to him by the one non-profit.
- *More wrap-around case management:* Thomas needed an all-around case manager badly; because of his TBI, he was very bad with money and finances. He was aware of this and sought out people to help hold his money. When more reliable sources were unable or unwilling to do that, he would turn to acquaintances with mixed results. He also struggled with emotional regulation and suicidality; he needed more constant contact and support. He was a prime candidate for permanent supportive housing.
- *Long term stability:* Thomas had no savings whatsoever when he was housed and since Rapid Re-housing quickly increased his percentage of the rent, at the end of Rapid Re-housing he didn't have enough money to afford the security deposit of a new apartment. He needed more time to save and stabilize before fully paying the rent.

Rapid Re-housing Family Profile #8

Lynn⁸ is a 49-year-old American Indian woman. She has two daughters living with her: **Makayla** (15) and **Kiara** (17). Both daughters attend the same high school; Makayla is more involved with school while Kiara spends most of her time with her boyfriend. Makayla takes medication for mental health struggles and Kiara takes medication for Tourette's syndrome. When Lynn entered Rapid Re-housing, she was living in a shelter. She'd spent time at a Domestic Violence shelter after leaving her boyfriend and then moved to a regular shelter. She was initially placed into a one-bedroom apartment but shortly after, she was granted full custody of her children so she was moved into a three-bedroom apartment. Lynn was working at a casino part-time, around 32 hours a week. She and her daughters received SNAP and child support, as well as HUSKY-A.

One Year Later

Lynn is still working at the casino; occasionally, she'll pick up shifts with a temp agency. She took driving classes, looking to get her license back. She took the classes but has not yet applied for her permit. She sought out services at the American Job Center's Step Up program; she applied to other jobs but was not hired. She was recently diagnosed with Type 2 Diabetes; she's measuring her sugar twice a day and trying to eat better but she refuses to take the medication. Over most of the year, Lynn struggled to pay all of her bills; if she paid all of her utilities, rent wouldn't be fully paid. At the end of the year, Lynn was behind on rent by \$225 and hadn't paid the electricity in full; the utilities company is threatening to turn off her electricity. She's still receiving SNAP and child support, though food is a constant struggle. She's in the process of paying back \$15,000 of state aid provided to her children while they were in their father's care; she's working with a local agency to see about reducing her payments.

Makayla is a sophomore and very interested in attending college; she did a tour of Historically Black Colleges and Universities this spring. She was on the JV cheerleading team in the fall and is on the Track and Field team this spring. **Kiara** has brought her grades up, is at home more, and started working part-time at the casino as an usher for events.

⁸ Names changed for privacy

Suggested Solutions

- *Social support:* Lynn has no family and few friends; she felt lonely and isolated. She would reach out to her case manager sometimes but didn't want to bother her too frequently. Lynn would have liked a peer-support group or gathering.
- *More wrap-around case management:* Lynn loved her case manager and had a positive experience with her. However, the case manager was busy with a large caseload. It would take her weeks to respond to Lynn's phone calls. Given her level of need, Lynn would have benefited from a case manager through a local community agency and better access to local resources. She could have used more support as she struggled with landlord conflict, negotiation with utility companies, struggles with her children, custody fights, and food insecurity.
- *Long term stability:* While Lynn was housed at the end of the case study, it was an unstable position. Her income wasn't paying all of her bills. She had no savings or fiscal resources to speak of; she will be unable to afford a security deposit in the future.

Rapid Re-housing Family Profile #9

Dennis⁹ is a 63-year-old white man. He's divorced and has two adult children; his son and daughter lives in Vermont. His daughter has a child; Dennis is very invested in being a good grandfather. Before entering Rapid Re-housing, he was living in his car. After a messy divorce, he struggled with addictions, which led to chronic homelessness. His health is a challenge; he has degenerative disk disease, colitis, fibromyalgia, PTSD, and depression. Soon after entering Rapid Re-housing, Dennis applied for SSDI.

Shortly after he entered RRH, his apartment was burglarized. Dennis's depression got worse and he attempted to end his life on Father's Day. He survived and needed medical treatment to repair the physical damage. Shortly after, he lost his apartment. He was moved into shared, supportive housing for men in crisis. He resided there for a few months, until he was notified there was an apartment available for him in HUD-supported senior housing. Dennis was able to move into an apartment there, paying only 30% of his monthly income towards rent. Shortly after moving, his cousin passed away and he had to help plan the funeral. He was also in a car accident and had to go to court to settle it.

A year later

Throughout the year, **Dennis** has continued to send his grandchild a book each month. He's been taking online college classes, though the cost of tuition and fees have often been a source of stress for him.

After Dennis moved into senior housing, he accepted his SSI; unfortunately, this placed his income over the threshold for Medicaid and he lost his insurance. He had to select and pay for a

⁹ Name changed for privacy

new plan from the healthcare exchange; the new company refused to cover his existing medications. Dennis is still struggling to get his medication regiment back to what was working before his insurance changed.

Dennis was denied SSDI; his appeal was still pending at the end of the case study. Thanks to senior housing, Dennis has been able to save some money and began paying off his debts. His credit improved enough he was able to buy a nice used car when his 25-year-old car broke down. He's been seeing his daughter and grandchild more lately, as well as slowly building a better relationship with his son.

Suggested Solutions

- *More social support:* Aside from his RRH case manager, his daughter, and a few coworkers, Dennis didn't have much in the way of social interaction. He rarely had people to talk to about his troubles. Dennis would have benefited from more social support
- *More wrap-around case management:* While Dennis was happy with his case manager, he had many needs which were beyond the scope of the RRH case management arrangement. He needed support and guidance around his mental health struggles, SSDI/SSI income, health insurance, employment support, and food access. There was no transition services built into Rapid Re-housing, so Dennis was left on his own at the end of the 12 month program, regardless of his need.

Rapid Re-housing Family Profile #10

Monique¹⁰ is a 41-year-old Black woman living in Fairfield County. She has a daughter, **Kala** (5), who lives with her. She also has a 22-year-old **son** who lives on his own. Before she entered Rapid Re-housing, she was living in a shelter for survivors of domestic violence as a result of family abuse. Her **husband** was incarcerated two years ago and was unable to help her. She was struggling with PTSD, anxiety, and depression; she applied for SSDI while in shelter. She had not been attending church like she had in the past.

One year later

Her SSDI was approved early on in the RRH program. This provided a steady income for Monique and Kala, which kept them stably housed. With the help of her case manager, she was able to set up a monthly payment plan with her utility companies, for a set amount each month.

However, Monique's health was in fluctuation for most of the year. Early in the year, she went to the hospital for some tests and was kept for two days due to pericardial effusion (fluid build-up around the heart) and congestive heart failure. Her anemia and B-12 deficiency also caused her medical issues to the point that blood infusions were recommended. Monique's PTSD, depression, and anxiety often manifested in agoraphobia, making it difficult for her to leave the apartment. She was able to locate an excellent Primary Care Physician; he has provided her with medical support and direction. A few months before Monique was hospitalized, her father died unexpectedly. It was a very difficult time for Monique, Kala, and her son. Additionally, during the year, her car and apartment were burglarized.

¹⁰ Name changed for privacy

Her **husband** was released in the fall to a halfway house; he was able to return home three months later, in February. He's now living with her; he did temp work until he was recently hired by a recycling company. **Kala** is doing well; she's enjoying the local kindergarten and starts 1st grade in the fall. She's doing better now that she has consistency, stability, and a room of her own. Her **son** has been taking community college classes and lives with his girlfriend of 4 years. Monique, her husband, and Kala have returned to attending church.

Suggested Solutions

- *More social support:* Monique had little social support; she ended up in shelter because her family members were abusive towards her. Her case manager was her only source of social support. Her lack of social support exacerbated her mental health struggles. She didn't have anyone to reach out to for emotional and instrumental social support. Monique would have greatly benefited from a wider support network.
- *More wrap-around case management:* Monique loved her case manager. She had a very positive experience. But the role of the program was to provide minimal case management. As she struggled with her physical health, mental health crisis, loss, robbery, and major life transitions, she had no one to help guide her through the system. More wrap-around services would have been helpful to Monique.

Rapid Re-housing Family Profile #11

Amanda¹¹ is a 43-year-old Black woman living in Fairfield County. She has a 10-year-old son that went to live with her ex-husband in a different county after she lost her apartment because of a job layoff. Before she and her ex-husband were divorced, they owned a 3-family home and acted as landlords. Before she entered Rapid Re-housing, she was living in a shelter.

Prior to the divorce, she'd taken all classes required for her RN. While in shelter, she applied for many jobs; she was hired at an insurance company, initially part-time but quickly promoted to full-time, right before being housed. Unfortunately, the full-time position did not pay enough to cover her rent, utilities, and bills. Amanda was discharged from Rapid Re-housing three months before the case study began.

While working full-time, **Amanda** applied and interviewed for other part- and full-time jobs. She did temp work in the evenings, such as facilitating market research interviews. She was not eligible for SNAP or any other government benefits due to her income. Her access to food was relatively secure, though things were tight when her son would come to stay with her on the weekends. She had medical insurance available to her through her full-time job (though no vision or dental) but did not initially sign up due to cost. She needed dental care but could not afford it.

She was working to improve her financial situation; she restarted paying her student loans each month and had a credit card to rebuild her credit. She was working with the courts to remove her from her ex-husband's mortgage, which would improve her credit as well. Her son was coming to stay with her every weekend and she would sometimes takes the train to see him on weeknights; she was looking forward to the summer because he could stay with her for longer periods of time. She would like her son to live with her full time by next school year, provided she's financially stable.

¹¹ Name changed for privacy

She was hired part-time at a small private theater for three evenings a week, after she left work for the day. When she withdrew from the study at six months, she had recently attended a second interview with a local hospital for an administration job; she expected to hear back shortly with a job offer.

Suggested Solutions

- *Autonomy and respect in the housing process:* The housing coordinator initially tried to press Amanda into a roommate situation, rooming with another single woman. Amanda refused because she wanted a one-bedroom where she could comfortably have time with her son on the weekends and didn't want to share space with a stranger. The coordinator then refused to house her, saying she'd have to find her own housing. Amanda successfully found an apartment on her own.
- *Social support:* Amanda was passionate about getting on her feet so she could have her son living with her again. This was her driving force but in the housing process, she reported it was ignored. In her pursuit of funds to keep her housing and pay her bills, she had no social supports available to her.

Rapid Re-housing Family Profile #12

Sonya¹² is a 47-year-old Black woman. She has two children who don't live with her: a 22-year-old son, who is attending Nichols College on a full football scholarship, and a 26-year-old son, who works for a bank in Delaware. She is native to Boston; her mother lives and works there. Before she entered Rapid Re-housing, she was staying at a domestic violence shelter. She came to Connecticut due to intimate partner violence; she wanted to start fresh, away from her abuser. Sonya was discharged from Rapid Re-housing a month before the case study began.

Rapid Re-housing helped with the security deposit and the first 3 months of rent; she was discharged shortly after they stopped providing rental assistance. She received SSDI each month and had Medicare but did not qualify for state insurance. Her mother had a car she could have but she needed a permit to get her license, and glasses to get her permit.

Every three months, Sonya traveled up to Boston to see her therapist and physician; she received a 90-day-supply of her medications. She receives the services there at reduced cost; she cannot afford the medications if it's dispensed in Connecticut.

One year later:

Part way through the year, Sonya was visited by her abuser. They got into a fight at her apartment; the police were called. When the police arrived, they saw her shove him. They arrested her and allowed him to remain in the apartment. She was not allowed to bring her pocketbook; neither the police nor the lawyer would retrieve it. It took a week before she was released; she was held for outstanding fines she owed in Boston. Once she was released, she canceled her SSDI card; however, by that point, her abuser and his brother had spent a month's worth of her support. She was still contesting the charges and attempting to get reparations when the case study ended. She was required to attend 12 anger management sessions and then the court expunged the arrest from her record.

At the end of her lease, her landlord took her to court to evict her and recover back rent. Due to the financial cost of handling her arrest and her money being stolen, she had gotten behind on her rent payments. She was able to find a new apartment in a nearby city and move out prior to

¹² Name changed for privacy

being formally evicted. She's much happier in the city; she regularly goes to the gym and the library, socializing with people there and in her apartment building. Transportation is much better; the bus near her apartment stops throughout the day. There's a grocery store within walking distance.

Her older son lost his job in Delaware, experienced homelessness, and then moved back to Boston and found a job there working at a bank. Her younger son is set to graduate a few weeks after the last case study interview with his Bachelors in Sports Management. Sonya is in the process of applying for computer networking classes at Porter and Chester Institute. She hopes to get her glasses in Boston soon.

Suggested Solutions

- *Autonomy and respect in the housing process:* Sonya took an apartment she did not want because she was desperate to leave the shelter. She was provided with only a mattress; she furnished her apartment through Rent-A-Center and second-hand items from her family. Her case manager tried to convince her to go to court to designate someone at the agency as her financial conservator, saying her family members were not an option since they would be partial to her. She refused, saying she had good credit with no history of evictions.
- *Employment/social support:* Sonya was placed in a rural apartment where there was a bus stop across the street; however, a bus only stopped there twice a day on weekdays (once early morning going towards town, and once early afternoon returning). It was not a feasible form of transportation for Sonya. Since she had no car, this made locating employment impossible and social support extremely difficult.
- *More wrap-around case management:* Sonya was unsatisfied with her case management; she said it felt perfunctory and was very short (~5 minutes). She reported they did nothing to help her access affordable medical care in the area, nor connect her with resources to help her manage her bipolar disorder, PTSD, or intimate partner violence. Sonya needed support and guidance when she was involved with the court system and was unable to locate any. She could have benefited from case management and support through a local non-profit agency.

Rapid Re-housing Family Profile #13

Sarah¹³ is a 53-year-old Black woman. She has four children: **Carl** (32), **Shawna** (26), **Jason** (20), and **Darrell** (12). Sarah left Section 8 housing in South Carolina to come take care of her elderly mother. At the time of her entry into the Rapid Re-housing Program (RRH), Sarah was looking for housing for her and Carl. While she was waiting for housing, they lived with her mother.

Sarah was the first person in her family to graduate high school. She was accepted to UCLA but needed to stay home to take care of her family. Before Darrell was born, she was taking classes at community college and a local university. Sarah has had her share of struggles; a few years ago, she received a breast cancer diagnosis that required surgery. She had been in remission for a year before entering RRH. She was unable to work and in the process of applying for SSDI. **Carl** is father to a vibrant 3-year-old daughter. He also has sickle-cell anemia and needs frequent medical treatment which makes living on his own difficult. **Shawna** has a Bachelor's degree and an MPH from prestigious universities; she works for NIH. **Jason** attends college, studying business administration. **Darrell** is a middle school student doing well in school. He lives with Shawna during the school year and with Sarah during the summer.

One Year Later

Sarah is still cancer-free, despite a scare this summer, and living in subsidized housing with her mother; she was not housed through Rapid Re-housing. Her health has been good, though she needed physical therapy for muscle spasms in her arm and chest, side effects from surgery. She began working as a home health aide. She's considering moving further south to be closer to Shawna, Jason, and Darrell. **Carl** moved out, getting an apartment with a friend, though he's been in

¹³ Names changed for privacy

and out of the hospital as he struggles with his illness. When he can, he spends time with his 4-year-old daughter. **Shawna** continues to work for NIH; she is returning to school to pursue her PhD and NIH is supporting her in that endeavor. **Jason** recently graduated with his Associate's degree and was frequently on the Dean's List for his good grades. He continues coursework to earn his Bachelor's degree. He is considering transferring to a larger, more prestigious university closer to Shawna and Darrell. **Darrell** attended a summer tech institute on a full scholarship, and also received a scholarship to attend a college prep middle school next to a university for his 2015-2016 school year. His grades dipped during the first semester at the new school but he quickly adjusted, bringing his grades back to A's and B's. He enjoys playing both saxophone and cello and has done some child modeling to raise funds for college.