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HEALTH AND THE HOMELESS POPULATION OF MISSOULA: “HOUSING FIRST” AS A  
SOLUTION

By

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Undergraduate Thesis

Presented in partial fulfillment of the requirements  
for the University Scholar distinction

Davidson Honors College

University of Montana

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Health and the Homeless Population of Missoula: “Housing First” as a Solution

Faculty Mentor: Laurie A. Minns

Missoula, Montana has an extremely high rate of homelessness at .75% of the population (compared to other large cities, Seattle, Washington at .23% and Los Angeles, California at .32%). This is due to there not being much done to help chronically inebriated homeless individuals. All are turned away from Missoula's overnight shelters if they are not sober. For an inebriated homeless person, the jail and the hospital are the only two places where they can stay the night. Through comparison to other cities, such as Seattle, Washington, I have identified that Missoula needs a wet housing program. Wet housing provides permanent housing where residents are allowed to drink. It is a form of permanent supportive housing targeting those high-risk individuals who need treatment.

Through interviewing professionals who work with this population daily, themes emerged from these interviews and were identified and evaluated in the context of the peer-reviewed literature. Chronic alcoholism is preventing people from getting the care they need, as well as co-occurring conditions are preventing people from staying healthy so they can get to resources. There is also a lack of services for those who need it most and many people do not support this plan and by further understanding how to combat these obstacles. Missoula is not only in need of a permanent supportive housing solution for these high-risk individuals, it would be a good candidate through the further understanding of this project and the current resources available. The creation of a wet house/wet shelter, although part of the 10-year Plan to End Homelessness, has never been implemented in Missoula before, and it will be a huge step forward in caring for Missoula's homeless population.

## Heath and the Homeless Population of Missoula: “Housing First” as a Solution

### **Background**

Homelessness is an increasingly growing problem in Missoula, Montana. The Missoula homeless rate represents 0.75% of the entire Missoula County population (Google, 2016c; T. O. E. N. D. Homelessness, 2012). This statistic is higher than other well-known homeless stricken areas in the United States such as Los Angeles (.32% of the LA population) (Gale Holland, 2015; Google, 2016b). Cities large and small have difficulty addressing the multitude of problems surrounding the homeless population, but Montana seems to be losing the battle. Between 2009 and 2011, national homelessness decreased by 1% while Montana’s increased by 48% (T. O. E. N. D. Homelessness, 2012). Of the increased homeless population in Missoula, many non-sheltered residents suffer from alcohol and drug addiction making access to housing resources difficult. It is estimated, nationwide, that 38% of homeless individuals are addicted to alcohol while 26% abused other drugs (Vangeest & Johnson, 2009).

Multiple studies document the incidence of alcoholism in the homeless population, demonstrating time and time again that many individuals living on the streets have an addiction to alcohol. It is a frequent root cause of homelessness, and both homelessness and alcohol use influence the quality and quantity of interactions with health care providers and social workers (Gordon et al., 2006). Once individuals have been placed into permanent supportive housing, alcohol consumption is reduced by 33% (T. O. E. N. D. Homelessness, 2012). Without housing, it is more difficult for these people to find jobs or to find a stable living condition, as shelters in Missoula, such as the Poverello Center, do not allow drunken residents. The issue of alcoholism is much more complicated than it first meets the eye, and stems deeper than just alcohol consumption or chemical dependency.

What constitutes chemical dependency? It describes the abuse of drugs or alcohol that continues even after significant problems have developed from it. It is characterized by tolerance and withdrawal as well as continued use, even though one may know the detrimental effects it has on them (Medicine, 2016). Alcohol, prescription medications and methamphetamines are some of the most commonly abused substances (Medicine, 2016). Any lack of abstinence will prevent one from sleeping in many overnight shelters, especially in Missoula.

Alcohol induced disorders include enlarged livers, esophageal varices and induced dementia (Appendix B). If these go unchecked, they could lead to death. Some people may even develop depression, anxiety or sleep problems. Many of the aforementioned issues of homelessness are similar to chemical dependencies. By doubling the problem, one is increasing their risk of death (Appendix D). Crime rates may also increase by obtaining the chemicals illegally, whether that means they cannot afford it or the purchased drug is prohibited (Hwang, 2002).

Risky sexual behavior is not only common amongst homeless populations, but among chemical dependents as well. Without proper protection and with increased availability of many sexual partners, it is not difficult to pass on multiple sexually transmitted diseases (STDs). STDs are prevalent in over 70% of homeless individuals in a population (Vázquez & Muñoz, 2001). Some diseases are benign, but many cause other health complications in different organ systems, such as hepatitis, as well as some being cancerous and malignant, such as human papilloma virus (Stein, Andersen, Robertson, & Gelberg, 2012).

Hypothermia also poses a large issue, especially in Montana. With average temperatures in January being a low of 18° F and a high of 33° F and snow not being uncommon, unsheltered individuals may have difficulty keeping warm (Data, n.d.). More people need to find shelter in these circumstances. Last winter, the Poverello Center in Missoula slept over 170 individuals on overflow mats when they typically have room for 120 (Appendix D). Hypothermia and frostbite are common ailments seen in those who sleep outdoors. Hypothermia happens in three stages: mild, moderate, and severe. Mild hypothermia shows symptoms such as shivering, slight confusion, trouble talking, dizziness, hunger, nausea, and difficulty with complex motor skills. Moderate hypothermia causes violent shivering, sluggishness, progressive loss of consciousness, weak pulse, and trouble with fine motor skills. Severe hypothermia is shown by no shivering, rigid muscles, a dazed stare, erratic heartbeat, blue-tinted skin, sleepiness, and eventually unconsciousness (Roddenbery SA, 1967). Cold causes extremities to be a secondary priority for heating after the vital organs, causing the numbing and tingling in the extremities. This has the potential to lead to frostbite. Depending on the severity of the condition, amputation may be a necessary treatment. This treatment, of course, is reliant on whether an individual is well enough to find their way to get medical help.

Mental health poses one of the greatest threats of all toward unstably housed individuals. For some, this may be a reason why they lost a home. For others, a disorder may be chemically induced through years of abuse. There is much lacking in support for treatment of these issues. It is well understood by all interviewees of this project that one of the first steps in treating chemical dependency is targeting mental health. If left untreated, many people in this population are likely to self-medicate because these resources may be cheaper and more accessible to them (Appendix D).

Temporary housing can address the housing needs of some of the homeless Missoulians. Missoula has many 'dry' shelters for sober clients such as the Poverello Center, the Valor House, and the YMCA, but a housing solution for homeless alcohol and drug addicted Missoulians does not currently exist. Since this sector of the homeless population also has a wide variety of medical needs, the basic needs of housing and appropriate medical interventions in this high-risk group is un-met in Missoula. Studies of other cities' approaches to dealing with the multitude of issues facing alcohol and drug addicted homeless may offer a viable solution for Missoulians.

## **Methods**

Social service workers and health care providers in Seattle and Missoula were interviewed with a standard set of questions. These questions inquired about the types of care or service the agency provided and what the most common health risks seen in this population were. Other questions targeted the services and what was lacking in their current system. The goal was to gain themes and come to a conclusion on a better solution for housing this subset of the unsheltered population. Themes emerged from these interviews and were identified and evaluated in the context of the peer reviewed literature.

Those interviewed were asked for consent to record the conversations to include as transcripts as a part of this paper. If emailed, this was discussed with responding emails. All conversations are included as transcripts in the appendices. Experts in Missoula, Montana that were interviewed included Laura Folkwein of the Poverello Center and Netta Linder of Partnership Health Care. Netta Linder's office works closely with the Poverello Center and she is there four days a week. Two individuals with the Multi-Service Center in Federal Way, Washington that were interviewed include Manuela Ginnett and Tammy Money. The Multi-

Service Center is a social service agency that provides assistance to low-income and homeless individuals, but it is located about 30 miles south of Seattle. Finally, Noah Fay of the Downtown Emergency Service Center (DESC) of Seattle, Washington was also interviewed. Noah Fay used to be the project manager for 1811 Eastlake which is a “Housing First” solution located in downtown Seattle.

## **Themes**

**Chronic alcoholism is preventing people from getting the care they need.** In Missoula, most programs helping homeless and low income individuals target recovering addicts and the previously sobered. It is rare for chemical dependents to get help because of stigmatization against programs and the inability to keep them on stable or successful plans. A community may support these ideas in theory as these plans aim to keep what is perceived as dangerous individuals off the streets. When they are told it will be near them, they begin to reject the idea because they believe it is putting them or a loved one in a risky situation. Without a roof over someone’s head, it is difficult to carry out a successful treatment plan, whether that be for chemical abuse or mental health. Without this help, these individuals stigmatized as dangerous will continue to stay on the streets and have a higher chance of harming themselves or others. This is a clear issue that needs to be worked against according to all of the interviewees.

The two most well-known services for homeless in Missoula are the Poverello Center and Partnership Health Care. These programs are closely tied as Partnership has a medical respite program set within the Poverello Center itself. The respite program is for those who have recently been discharged from a hospital and may not have a place to return to for recovery. Unfortunately, they do not provide nursing care, but there are ten beds available. When people are discharged from a hospital and are still recovering, they are still susceptible to other common illnesses. Without the help of the Poverello Center’s respite program, a common cold may take a turn for the worse, especially during cold winter months throughout cold and flu season (Appendix D). Partnership’s office is open four days a week, ten hours a day at the Poverello Center. This is convenient for those who may struggle to get across town because of a disability, current weather or illness. Partnership itself offers medical services that are in high demand to

homeless individuals. Around 700 individuals are run through this program every year (Appendix A).

**Co-occurring conditions are preventing people from staying healthy.** Many individuals that are homeless are there due to a previous condition that is preventing them from getting or keeping a job. This could resonate as a physical, chemical or mental health issue. When people go out on to the streets to live, they become vulnerable to worsening the issue by developing a new physical, chemical or mental health issue. Co-occurring conditions are highly prevalent in this population and are often a cause of death of an individual. Without access to care, small issues can become large. The availability of medical respite rooms (such as those in the Poverello Center) provide people recently discharged from the ED to have more time to recover. Even any individual coming home from the hospital will have a safe, clean and restful environment to recover successfully in. This is the goal for ending homelessness through keeping someone alive and healthy.

The major health risks in Missoula range from minor injuries to severe lifelong diseases. Foot and leg injuries are common, likely due to poor footwear and continual walking around town. If left untreated, minor foot and leg injuries may become infected to where an individual may become septic and die. Also, many individuals present with hypertension and diabetes (Appendix D). Many unsheltered individuals encounter lack of adequate food, which can cause dietary deficiencies, which may lead to type 2 diabetes (Tsai & Rosenheck, 2013). All of these are manageable for an individual when housed. If diabetes goes untreated, issues such diabetic neuropathy could develop, causing increasing pain, making it even harder to commute to a medical office (Appendix D).

**Missoula is in need of a “Housing First” solution.** Most of Missoula’s services to the homeless include overnight stay shelters with a limitation on length of stay. For example, the Poverello Center has a maximum stay of 45 days with the possibility of a 20 day extension (Poverello Center, 2016). Those who need to recover from drugs and alcohol are in need of a permanent housing solution. Without a stable roof over someone’s head, successful treatment is unlikely. It is believed that helping this population will enable them to stay unsheltered when this is untrue. Providing shelter, food, rehabilitation, and services to help them learn skills to get them



back on their feet are essential to treating the whole person (Mission, n.d.). The more permanent this support is and with increased access to these resources increase someone's chances of getting off the streets.

“Housing First” is an approach to ending homelessness. It aims to provide permanent supportive housing primarily and then providing services as needed (NAEH, 2016). This can be compared to the treatment first approach where sobriety must be attained before housing is provided. The threat of death can be greater when the person is homeless and lower when the person is housed, as homelessness has direct adverse effects on health. Homelessness can result in a multitude of illnesses that may build on each other, eventually causing death if gone unchecked. It has always been questioned whether sick people become homeless or whether homeless people become sick. When individuals find themselves in a ‘period of heightened risk’ while unsheltered, it is seen that they live in unsafe areas, exposing themselves to higher rates of homicide and suicide (Hwang, 2002).

Medically, it is extremely difficult to come up with a treatment plan for homeless persons with chemical dependency issues. Difficulty with transportation in larger cities holds back the ability of one to get to treatment. For instance, a veteran living in south king county may have to take three or more busses to get to an appointment at the VA hospital in Seattle, which could take hours. Not only may a person not be well enough to travel on their own at such a long distance, but they may miss their appointment and be put on a large waitlist. The Mountain Line in Missoula, has become a huge asset to transportation. The free-fare services have allowed easier mobility for those without alternative transportation to travel freely and quickly to necessary appointments. This proves that Missoula would be a solid candidate for a “Housing First” program that will be successful. Compared to larger cities, this is one obstacle that Missoula does not have to deal with.

Other cities, such as Seattle, have “Housing First” solutions in place that are helping decrease the homeless population. According to King County's annual One Night Count in January 2016, 4,505 out of 2.044 million were unsheltered; this means, per capita, the population is only .23% (you now need to fix the percentage) (Google, 2016a; S. C. C. on Homelessness, 2016). Located in downtown Seattle, which is part of the Downtown Emergency Service Center

(DESC), is 1811 Eastlake. It provides “housing and on-site services without requirements of abstinence or treatment”, commonly known as a ‘wet house’ (DESC, 2009). These types of services target the highest risk individuals, those who are constantly in the emergency department or jail due to substance abuse and help provide a permanent housing solution.

The Multi-Service Center in Federal Way, Washington provides a plethora of services to low income and homeless individuals. Their housing department provides shelters and transitional housing for those in recovery from drugs or alcohol. Case managers are assigned to provide assistance to get them to their next step in recovery. They also provide permanent supportive housing for families with children. This program may or may not be indefinite, depending on the choices of the family and whether they wish to rely on this solution forever. This is still a chemical-free program, but it is the type of housing that many need to recover. This type of housing ensures that people can get access to mental health assistance, increase their education level, take care of their children and even work on past legal issues. The aforementioned issues likely hinder someone from obtaining housing, but once someone can remove these issues and get housing, they can likely move on and improve their quality of life (M. Ginnett, personal communication, February 28, 2016).

At 1811 Eastlake in Seattle, Washington is a working “Housing First” model and the first of its kind in Western Washington. They provide supportive housing to 75 homeless men and women who are chronically addicted to alcohol. It was created to address the needs of chronically inebriated homeless people who are the heaviest users of the jails, emergency departments and other publicly-funded crisis services. DESC decided to implement a “Housing First” solution in Seattle and published positive outcomes in the Journal of the American Medical Association (DESC, 2009). This study stated that “Housing First” shows that providing housing and on-site services without requirements of abstinence or treatment is significantly more cost-effective than allowing them to remain homeless” (JAMA, 2009). The population of Seattle is large along with the homeless population, therefore a small program like this is not likely to eradicate the issue immediately, but this housing is set up in a way to improve the lives of those who are at the highest risk in the community. All of their clients have a severe mental health disorder or a persisting chemical dependency issue. That stability they are afforded by being housed allows people to make major inroads in addressing major mental health medical concerns.

With the “Housing First” model, people behind it believe that housing is a basic human right that should be available to all.

**There is a lack of services for those who need it most and many people do not support this plan.** These barriers make it much more difficult to complete this project. It is not uncommon for many to support an idea, but when they realize where it will be placed, an uproar occurs. This can happen if it is too close to a certain neighborhood, or a local school. Often referred to as N.I.M.B.Y. (not in my backyard), many who may have previously been in support of a general idea because it will lower their taxes, help humanity, etcetera, dislike it if they feel it would harm their daily lives. It is not uncommon to see this lack of support in smaller communities if a mental health rehabilitation center has the intention to be built near an elementary school. In Des Moines, Washington, this is apparent with signs stating “No Woodmont Rehab, kids before addicts”.

Depending on the place one lives and the demand for services, such as mental health treatment or rehabilitation programs, the waitlists can be terribly long. Caseloads can also be too large for case managers to handle. This is extremely detrimental to those who seek immediate treatment. If someone with depression is seeking therapy but the waitlist for the service places them back a few months, this person may be at risk for harming themselves or others. The dislike for services near local neighborhoods also sets this back. Communities are voting against rehabilitation centers for chemical dependents. The goal is to treat these people who may be violent and prevent them from being this way in the future, but the lack of support is pushing this in the wrong direction.

Missoulians address their concern for this project in a variety of ways. Through contact with Missoula’s neighborhood councils, there was a resounding liking for a “Housing First” solution and would like to see it implemented just like in Seattle. Many concerns include funding sources and costs of staffing such a project. An editorial published in the Missoulian referencing this topic addresses the concern of someone only wanting to provide support for this project if it were in a place far away from them, preferably one they disliked. Their comment is as follows: “The only way that I would support a "Wet Shelter" is if it was planned in the South Hills. I think that the drunk and the destitute should be able to enjoy the [same] view of Missoula as the people

who are pushing this idea” (Friedl, 2016) . Hearing the comments from local individuals can educate others on the lack of support and figure out what can be done to combat it.

In correspondence with some of the neighborhood councils of the city of Missoula in which the plans for a ‘wet house’ were shared, concern and excitement were expressed. Many were in favor of implementing this service such as those already in place in Seattle, Denver and Portland. The major concern is funding availability. It is costly to fund 24/7 staff and councils are concerned as to where this funding will come from (Appendix G). Michael Moore, the Reaching Home Coordinator of United Way is currently searching for funding sources. He works closely with Missoula’s 10-year Plan to End Homelessness, otherwise named “Reaching Home” (T. O. E. N. D. Homelessness, 2012). His work addresses these concerns and aims to get all the necessary funding and owners in the near future.

Certain types of services also are rare, such as medical and dental provisions for low income and unsheltered people. Mobile clinics are available to some, but not all. They do not travel everywhere and it still may be difficult to travel to certain locations, or to even know when the services are provided (Appendix E). Technological advances may benefit the majority of the population, but when one does not have regular access to computers, phones, chargers or the internet, it may be difficult to relay information to those who are at its highest need.

## **Conclusion**

By focusing on health aspects of homelessness, the proposal of a “Housing First” treatment is aimed toward the betterment of quality of life. Everyone interviewed agrees that “Housing First” is a great model and that it is in high demand from all providers. Since all of Missoula’s options all have a requirement for sobriety and the main reason people are turned away are for that very issue; it is apparent that people need shelter before they can start the process of achieving abstinence from drug use. When interviewing Noah Fay as well as doing other research on successful “Housing First” models, it has become evident that it works. Individuals are motivated to get sober through team efforts as well as appreciating that someone has given them a place to live, even a second chance. This issue is broader than helping to find someone a place to sleep at night. Through “Housing First” the goal is to treat the whole person through providing health care, resources for success and a stable roof over someone’s head.

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## Appendix A

### Interview with Netta Linder of Partnership Health Care/Poverello Center 14:22

8:00 am, 3/18/16, verbal consent

**Marissa:** Do I have your consent to record this conversation as well?

**Netta:** Yes.

**Marissa:** Okay, great. So, I think I'm going to start off by reminding you a little bit about what I'm doing with my project. So, I'm a senior at the university and I'm working with a group of students, pretty closely with United Way and I'm kind of just working on a public relations campaign to kind of improve the idea of what housing in Missoula and my specific research with these interviews focuses around the health aspects of homeless individuals and the services provided and what's kind of lacking in the current system and what is being done to kind of improve in the community.

So, I guess I could start off by asking you what your specific position or kind of what around you-- What kind of care and services do you, as part of partnership working with the Pov provide to the individuals that you see coming in?

**Netta:** My role, basically-- I'm a medical social worker and I'm embedded four days in a week in the clinic. And generally, what I provide, I do brief assessments coming in and usually the reason being is because the primary purpose of someone coming in is usually going to be an urgent medical issue. We're not urgent care. We are primary care so we treat a number of chronic conditions as well.

But one of the things that I do take a look at and screen for is their housing status. And in the '70s it was considered a radical thing to say that housing is healthcare. But I can tell you firsthand the impact that having some form of a shelter can have on someone's ability to manage their health conditions.

So, I do a lot of community referrals. It's kind of the model. And I do a lot of interventions and community referrals because we do have, you know, [unintelligible 00:02:37] sleeps about 120-

40 a night. And we don't see every patient that uses the Pov and not every patient that we see uses the Pov. But we tend to run around 700 people through our program per year. So, we have high need and I offer-- they don't have to accept, I offer some basic non-intensive case management services to them.

**Marissa:** Okay. And so, with that, what would you say are the biggest health risks that you commonly see like walking through the door? Like, say, if you could pick the top three, for instance.

**Netta:** Giving conditions or risks space?

**Marissa:** Yes, just anything that you can think of that kind of stands out to you.

**Netta:** It's really tough to say as far as pinning down the top three. I mean, there are so many complex conditions and chronic conditions that can definitely make someone at high risk and it really varies by the individual. Usually, we do have folks that are co-occurring and that can definitely be a challenge if someone's unable to manage self-infused issues and their mental health issues. It can definitely put them at risk just on the individual basis not quite as far as public health risk.

We do see a lot of-- not loads, but we do see a lot of communicable disease. Sometimes there're days spent to [unintelligible 00:04:44] viral illnesses, too. We definitely do see some people. We do refer for intensive in patient treatment.

**Marissa:** Right, okay.

**Netta:** That's not common-- But it's not every patient that walks through the door. I'm trying to think of what the top three would be. I suppose it depends on which level of illness we're talking about because the more common, diabetes, hypertension. Those are two huge things that definitely can be difficult to manage for someone with an unstable housing status.

**Marissa:** The last thing I have to ask you is kind of combined of my last two questions. What are the biggest problems that your program faces and what is currently being done to fix those problems?



**Netta:** You mean social problems, or--?

**Marissa:** Just kind of in general. I'm just trying to figure out what the gaps are and what the needs are.

**Netta:** Okay, so, I mean, transportation use to be a huge issue prior to Mountain Lion, during the free [unintelligible 00:06:36]. I'm trying to identify the history because I definitely come up with a lot of unique issues to the place where we are. It's difficult for someone to adhere to a treatment plan or to be ready to address the treatment plan if they're not adequately sheltered. It helps. And they can give you a somewhat specific example. I have someone who is co-occurring, lost their housing and have had multiple ER visits since they've lost their housing. While they were housed-- and largely for hyperthermia because it's a combination of [unintelligible 00:07:37]. While they were housed there's never been an issue and they've been working with them for several years while they were housed. They have a few people who have unfortunately been unable to maintain housing. Some of them do kind of revolve. It may sound like common sense saying that bring us healthcare. In the '70s that was a radical thing to say. I wasn't alive then but according to my supervisors, it's definitely gotten sideways [unintelligible 00:08:17] that healthcare. But I know that's usually the biggest thing and I work with people at risk or currently literally homeless.

And it doesn't matter if it's co-occurring, if it's diabetes, if it's hypertension. If you are living on the street especially if you're drinking and you can't utilize services at the Pov. If you can't abstain-- because I do have people who are at a level that they can't abstain. They do have to meet a shrink otherwise they're going to get sick and they're putting themselves at risk of death. But they're not ready to try to achieve sobriety because they aren't adequately sheltered. And they're not ready to address it. I do have some people that would definitely benefit from more stable housing. But it's -- I'm sorry I feel like I'm starting to sound very redundant. It's very difficult to address this issue if you're not sheltered or at least minimally housed, especially if you have to take medication several times a day, if you need adequate light, if you have to keep insulin at a certain temperature. Or if you have to have some device. Not everyone has phones or access to electricity, especially [unintelligible 00:10:00]. To know what time it is in order to take your medication.

**Marissa:** Right, right.

**Netta:** And we do try to find a way around that, like the providers are pretty good about [unintelligible 00:10:11] we need to make this as simple as possible. But even trying to take one pill, one time a day, or two pills at the same time once a day can get to be a lot when you're struggling with basic needs.

I don't know, it's not quite bullet pointed. I feel like it's all really the same issue.

**Marissa:** No, great, I mean that's very helpful. Basically I've heard pretty consistent things with the people that I've interviewed and I've heard smatterings of different things all over the place and that's good to hear. I've got a lot of information that I can use. So thank you very much for [laughs] working with me last minute and doing this sudden interview. So if there's anything else that you'd like to add, I mean, that's pretty much all I have for you.

**Netta:** Trying to think. I kind of have a question for you.

**Marissa:** Of course.

**Netta:** Since I know you're working fairly closely with Mike at [unintelligible 00:11:25]. Have you guys noticed an uptick in resistance to [unintelligible 00:11:32] housing or do you feel like there's maybe a little bit more of a reception to it?

**Marissa:** Well, so far it's very well received by kind of the University population, where we've set up a Facebook page, we're getting a lot of likes on our Facebook page and the people who we've been discussing it with seem to be pretty well received. But kind of our next step is we're going to meet with some of the neighborhood councils around town and see how that's currently being received by the general population. So I'm not really a 100% sure on that yet.

**Netta:** Okay, sorry you guys taking-- it seems like it's kind of shifted taking the consent versus consensus approach.

**Marissa:** Yes, exactly.

**Netta:** Well, I'm very glad that I remember you from Project Homeless Connect. And I'm very glad that you've been working so diligently on [unintelligible 00:12:50]. Because trust me, if we can find a solution or flexibles, small solutions, this will definitely have major positive effects for a lot of my clients.

**Marissa:** Yes, we're hoping so. And of course the downside is that most of us are graduating in May, and we're hoping that what we get started we can pass on to Michael and he can hopefully use it to keep the ball rolling with the project, because he's obviously very dedicated, so. Yes.

**Netta:** All I can say is just keep good notes. Write out procedures, because if he has a fresh batch of students coming in it's usually beneficial, because they know. When I've contributed to projects that were taken over from someone else, if there wasn't documentation on what they'd actually done, I was kind of left in the dark and starting from the scratch.

**Marissa:** Right, and we are actually going to be presenting a bunch of this information at the Undergraduate Research Conference on campus, so that shouldn't be an issue [laughs].

**Netta:** All right. I wish you-- I'd like to thank you for working on this.

**Marissa:** Thank you very much for taking time out of your day to help me out.

**Netta:** No problem, thanks Marissa.

**Marissa:** Right, bye.

[END]

## **Appendix B**

### **Transcript from interview with Noah Fay of DESC, Seattle**

**2:15 pm, 3/10/16, verbal consent**

**Marissa:** Just want to get a verbal confirmation that it's okay that I record this conversation, first of all.

**Noah:** Sure.

**Marissa:** Okay, great. Let me just tell you a little bit about myself. I don't know how much you got from forwarded emails, but I'm a senior at the University of Montana and I'm originally from Seattle and we're working on a project here. We're kind of working closely with United Way to, hopefully, in the near future, get the ball rolling on setting up some kind of wet house or wet shelter here in Missoula, Montana. My project is kind of focused on the health aspect of homelessness and I'm kind of hoping to direct that, in turn, to write a thesis paper about, I guess, kind of the flaws in the system and direct it towards housing for a solution. Does that make sense?

**Noah:** Yes.

**Marissa:** Okay, so I just have like four simple questions that kind of ask you about general health questions of homeless population over in Seattle and other things along the lines of that.

**Noah:** Okay, no problem.

**Marissa:** All right. I guess my first question, I'll start off by asking about the kind of services that you, DESC, 1811, East Lake, provide for incoming individuals.

**Noah:** The DESC provides a very wide range of services all geared towards providing services to highly vulnerable, high service needs, homeless men and women. Those services are running from clinical services that are based in mental health and chemical dependency, sort of, outreach programs. I guess I should say first that we have a fairly traditional community mental health programs that are available to people that qualify for Medicaid service and then, we have a little bit more unorthodox mental health and chemical dependency programs that are outreach based

that can target specific populations that may be high utilizers of psychiatric hospitals or may regulate being in and out of jails or people that are so severely disabled by their mental health condition that they're unable to access services on it might be due to the lack of insight into the need for services.

Those critical services are pretty far ranging. I cannot, off the top of my head, determine how many people are enrolled in them, but it's in the thousands that likely are enrolled in those services. The housing program that we provide is known as a permanent supportive housing. We had it modeled in two separate ways. We've got a psych based permanent supportive housing model and then a scattered site permanent supportive housing model. The scattered site model is one where we lease from units either from landlords in the community and then sublet out to our tenants or our tenants have a voucher that directly follows them that they're able to use to pay rent.

Then, we provide the additional supported services for people living in those housing, meaning we have case management services that go and visit people in their house or in their apartment, that do home visits and help connect people to whatever services they need to keep stabilized and maintain their housing or get connected with any other appropriate services to help people attain their goals and their highest level of self-sufficiency.

It's very similar in the site based model, except those are housing projects that we essentially build or operate ourselves. There are buildings that are entirely owned and operated by DESC where we staff the buildings 24 hours a day with residential counselors and in-site housing community managers that provide those same sort of services to people to help them maintain their housing or get connected to whatever services of the community that they may qualify for.

We basically consider supportive housing essentially in a combination for people with severe behavioral health disorders, so people who'd be really severe with persistent mental health disorders or consistent chemical tendency issues can struggle to maintain their housing and to maintain their stability in non-supportive housings. We believe by bringing support on site, mainly we can [unintelligible 00:04:49] staff that we bring on board so the staff provides programs like meals, medication management and other services in-house that help people retain their housing.

All of that is done using a “Housing First” and [unintelligible 00:05:02] approach. “Housing First” being the notion that the solution to homelessness is the home and we believe it’s a basic human right that people have access to a place to live and that there’s no requirement whatsoever that people need to be clean and sober or agree to treatment or engage with a case manager or make a pledge to be medication compliant in order to enroll in housing. People need housing by virtue of not having it and it’s that simple. That’s how we offer people housing, there are no conditions whatsoever that people have to participate in treatment in order to get into our housing programs.

Then, with the in-housing programs, then we provide sort of outreach services to people. People do not have to talk to the case manager that we have in house that they may be assigned. We, the case management staff that is, will certainly outreach clients and tenants in our housing projects because we want to engage people in services and we want to help connect them to whatever service they may qualify for or they want, but participation in those services is not contingent – or the contingency is not contingent on ongoing participation in services. That’s kind of it, in a nutshell.

**Marissa:** Okay, great. Then, with that, I don’t know how closely you specifically work with individuals, but would you potentially be able to tell me the biggest health risks that you commonly see, based off on frequency or possibly difficulty to deal with?

**Noah:** Sure. Do you want specifically 1811 or DESC as a whole?

**Marissa:** Both would be great actually.

**Noah:** I used to be the project manager for [unintelligible 00:06:43], one of our housing program managers who still oversees the building. 1811 is a bit unique in that it’s all the same things I just described except instead of targeting simple the most vulnerable of the homeless population, we’re targeting the men and women who are the highest service utilizers of publicly funded emergency services as it relates to their alcohol use. People who are cycling in and out of jails, local emergency rooms, our sobering center, those folks all have a severe persistent alcohol related issue.

With the rest of DESC, certain clients, they also have alcohol related issues, but likely have almost 100% of our clients in the rest of our housing have a severe persistent mental health disorder and/or an existing chemical dependency issue. But 1811 is specifically alcohol. People may have mental

health related issues here as well, but everybody in 1811 has an alcohol disorder. What that means is people have pretty severe health problems that often have gone untreated for years living on the streets.

The people here have disorders of liver. It's not uncommon. Esophageal [unintelligible 00:07:53] issues at any time and the esophagus where it's just swollen and inflamed blood vessels that can burst which is life threatening [unintelligible 00:08:09] for people. We have a lot of alcohol related dementia [unintelligible 00:08:12] is a well-known alcohol related dementia type issue, essentially, alcoholic Alzheimer's is another way of thinking about it.

Traumatic brain injuries, they're very common due to falls for this population. And then, chronic and persistent risk of withdrawal related complications for people whose alcoholism is so severe, it's [unintelligible 00:08:35] tenant that people go through delirium tremens and pass away or alcohol related withdrawal related seizures are common here.

**Marissa:** Okay, great. I appreciate you being so specific. That's great.

**Noah:** DESC as a whole is far ranging, but it's often untreated chronic conditions that people have not treated due to the chaos of experiencing homelessness combined with acute or chronic mental health related issues or alcohol related issues that we try to engage people over and often, we see people make major strides when they get housed. That stability they're afforded by being housed allows people to make major inroads in addressing major mental health medical concerns.

**Marissa:** Okay. I guess my last question for you would be – I kind of been focusing these questions for people that I've been asking that don't necessarily have a place like 1811 East Lake in a local community such as south of Seattle and here in Missoula, but are there still any large problems or gaps that you're seeing, that you're working to fix with this whole setup in housing for a solution?

**Noah:** We can use more. The need certainly dwarfs the available resource. I think that is certainly an area that we want to see expand. We can use a lot more permanent support housing in our city. Not everybody is willing to house people. Purely using a "Housing First" approach, some of our local partners can be hesitant to serve people who have untreated mental health and alcohol issues, concerned for behavioral issues that may arise. People are concerned to take on the risk of housing people with a criminal background, or poor rental history, or poor credit scores, all things that DFC

does not consider to be something that is the barrier for housing and in large part, intentionally, people with those kinds of issues would be those issues making people inherently more vulnerable.

I think that's the gap, the need dwarfs the resources and that's because one, we still don't have enough housing, and even housing we do have, not everybody is on board with, targeting the most at risk people.

**Marissa:** Okay. All right, is there anything else that you'd like to add that you'd think would be helpful for me?

**Noah:** I could talk for hours, but I think that's a pretty good snapshot.

**Marissa:** Yes.

**Noah:** Good luck with your paper.

**Marissa:** Great, thank you.

**Noah:** Here's one thing I would say. I'm always using the term wet house or wet shelter, we definitely shy away from that term

**Marissa:** Okay

**Noah:** It's housing that's set apart. I know I can drink in my house so people can drink in their house too

**Marissa:** Okay

**Noah:** That would be my advice

**Marissa:** Okay, great, thank you. I appreciate it

**Noah:** No problem, of course

**Marissa:** Thank you very much

**Noah:** Good luck



## Appendix C

### Transcript from interview with Tammy Money

Email, March 2016

Tammy Money <tammym@mschelps.org>

Mar 3 to me

People think homeless and they think drunk in the alley. They don't know about the single parent who was making it but just barely and suddenly lost his/her job, or the person fleeing from domestic violence, or the dad who was a mechanic and a good provider until a car fell on top of him causing a head injury permanently disabling him for working, etc. People who don't work with this population have a very narrow view of who the homeless are. It is like the kid who never sees anyone in his/her family go to college. He/she feels like college is not possible because of under exposure. So college, like the homeless, becomes this big scary, impossible, overwhelming thing.

I have attached something that might be helpful.

From: Marissa Ginnett [mailto:marissaginnett@gmail.com]

Sent: Thursday, March 03, 2016 2:49 PM

To: Tammy Money

Subject: Re: Senior Project Interview

Would you be able to expand on question 3 and the myths about who homeless people are?

Thank you,

Marissa

On Wed, Mar 2, 2016 at 6:22 PM, Tammy Money <tammym@mschelps.org> wrote:

So these are answers just off the top of my head. If you want me to expand more or don't understand things (because I do tend to ramble) let me know.

From: Marissa Ginnett [mailto:marissaginnett@gmail.com]

Sent: Wednesday, March 02, 2016 3:41 PM

To: Tammy Money

Subject: Re: Senior Project Interview

Tammy,

The way this week is going, I think a response via email would be best for me. I'll send the questions again here and expand on them. I apologize for taking so long to get back to you.

1. What are the biggest health risks (mental or physical) you commonly see with this population (potentially name them by frequency or difficulty to deal with and be as descriptive as possible)?

Lots of untreated mental health. In part untreated because of the disease itself (don't believe he/she is mentally ill, the paranoia, etc) and partly because of lack of mental health care that is affordable and accessible.

Drug addiction –hard to escape when you are homeless. Post Traumatic Stress and Depression are triggered by homelessness. You want to be comforted in any way possible. Then by the time they are housed the addiction has taken over.

2. What kind of care (services) do you provide to help this population?

We provide temporary housing and case management. We partner with other agencies for physical and mental health needs.

3. What are the biggest problems the program faces in helping this population? (for example, I have heard that the local population was quite large after this years one night count, do you have an inkling on what may be causing this?)

Not enough affordable housing

Not enough shelters, transitional

Not enough political and community will to change things .

Many myths about who homeless people are.

4. What is currently being done to fix these problems (in either your agency or nearby)? For example, if you cannot provide service to someone for any particular reason, what else can you do for them?

In King County we have a coordinated entry system for families(soon to be all populations). So we refer them to that system and 2-1-1. We also make referrals to food banks, emergency meals, clothing banks, DSHS, etc.....

There is no rush on this, just get it back to me when you can. I am hoping to have all my interviews done in the next 2 weeks. I will eventually be including these email responses in an appendix at the end of my thesis paper.

Thank you,

Marissa

On Mon, Feb 29, 2016 at 10:10 AM, Tammy Money <tammym@mschelps.org> wrote:

I would be happy to do this . We can set a time or we can email whichever is easier for you .

From: Marissa Ginnett [mailto:marissaginnett@gmail.com]

Sent: Sunday, February 28, 2016 1:19 PM

To: tammym@mschelps.org

Subject: Senior Project Interview

Hi Tammy!

I hope all is well. I interviewed my mom recently for my senior project and she suggested you as someone who would also be a great person to get some information from. My group project is on “Housing First” solutions, specifically wet housing. The overall goal of our project is to get the

ball rolling (by working closely with United Way of Missoula) on setting one up here since the homeless population here is so severe. As a pre-health professions major, I am more interested in focusing on the health risks associated with homelessness, as I hope to eventually write a thesis proposing “Housing First” as a solution. I'd love to set up a time to interview you on this topic and what your department at MSC does. If you are busy, I am also more than happy to correspond via email. My main questions are:

1. What are the biggest health risks you commonly see with this population? (Potentially name by frequency or difficulty to deal with)
2. What kind of care (services) do you provide to help this population?
3. What are the biggest problems the program faces in helping this population?
4. What is currently being done to fix these problems (in either your agency or nearby)?

The main goal of talking to MSC is to gather information to compare the communities. I am also hoping to speak with 1811 Eastlake in the near future about their program specifics.

If we need to correspond over email, I would be more than happy to clarify things for you before you officially answer these questions.

Thank you, and I hope to hear from you soon,

Marissa

## **Appendix D**

### **Transcript for Interview with Laura Folkwein, Development Associate at the Poverello Center, Missoula**

**1 pm, 2/24/16, Duration: 8:27, written consent via e-mail**

**Marissa:** I just want to give you a little bit more of an overview of why I'm here. So, again I'm a senior at the university, I'm a human biology major. I'm hoping to go into physical therapy. I am kind of doing a joint project through a couple different things on campus through the global leadership initiative, and the honor's college, etcetera. And I'm more interested in the health aspects of the homeless population and my whole group in the global leadership initiative is, were now trying to work closely with United way and were going to help them canvas to find a place for a wet house, or something along the lines of that, so, yeah some sort of "Housing First" solution, we might help them set up a Facebook page to kind of get the ball rolling because it is very, very premature right now. I'm sure you know a decent amount about it.

**Laura:** A little bit; I've been involved in those conversations

**Marissa:** Yes, of course. Okay, so I've got like four questions for you basically that are kind of part of my research for my writing sample that I'm going to be doing for the project. So what are the biggest health risks that you see in this population that you mostly see coming through. What are the top three that you would choose?

**Laura:** Well, you've come at a great time because I've been doing a little bit of research, myself.

**Marissa:** Ok, great.

**Laura:** For some of our projects here, and I just read that simply by being homeless, a person, I think, a persons mortality rate goes up by 3-4 times than a health person.

**Marissa:** Right, yes.

**Laura:** So, simply mortality. I think that folks are simply at more of a risk for violence, if they are living on the street, even if they are couch surfing, especially a lot of women.

**Marissa:** Right.

**Laura:** Sometimes people are doing sex acts in exchange, so they are STD risks, violence, certainly cold risks. Some People who are homeless are certainly dealing with mental illness. And yea, just risk of violence certainly from other homeless folks. But even other people unfortunately, they might encounter somebody camping and want to do them harm. And also, foot and leg kind of injuries. Just from people having to be on the move all day long, not having a place to sit and be. Yeah, I think those extremities and also just side effects of substance abuse are pretty big in the homeless population, so kind of anything and everything.

We actually have, you probably know, Marissa, that we have a fairly new medical respite program here at the Pov for homeless folks who are, have been recently discharged from the hospital or another medical provider who don't have a home to stay in. Otherwise they would have been discharged home. So we have about 10 beds here. With a medical referral so we can help people. We don't offer any nursing care, but it's a place to stay. Even something as simple as a common cold, or pneumonia or other respiratory stuff can drag on and turn into something worse. If somebody doesn't get in, out of the cold, off their feet, good rest, good food, I think that hunger and nutrition also certainly affects people, health-wise. Just staying healthy, affects people's immune systems. You're not getting enough to eat and not getting a chance to sit down. Or if you are sitting, you know, vice versa, you need to get up and move around.

**Marissa:** Of course.

**Laura:** And get off our feet. That's a long answer I think.

**Marissa:** No, that actually answers my second question as well about the kind of care that you specifically provide to people

**Laura:** Actually let me expand on that a touch, because we have the medical respite rooms, which are new here in the new Pov. And folks in those rooms get a little more case management support, connection to other resources, like housing, health care and benefits they haven't applied for disability and maybe they are very eligible. They might be newly disabled so we can connect them to those resources. We also have, um partnership healthcare office right here. So they are here four days a week, 10 hours a day. We call partnership, their main office, to get an

appointment then they can see them right here, which is amazing. And you can imagine even with the free bus systems, if you're not feeling well, it's hard to get across town to that appointment. So people can see a doctor right here.

**Marissa:** That's good to know. I am actually hoping to set up an appointment with someone at partnership and also kind of talk about this kind of stuff as well. Might be some crossover.

**Laura:** And they'll know more about specific health related things.

**Marissa:** I'd like to see if on both ends. My next question is what are the biggest problems that the program faces in helping the population, do you feel like there are any holes or gaps that you are trying to fix, what are those and how are you trying to improve that?]

**Laura:** Well, I think that wet shelter is a huge one, if people are under the influence, and are staying outside because they can't stay here, we don't serve anybody that is intoxicated, and they're going to have some pretty serious health repercussions. You know, in the summer, the limited summer months here are one thing, but you can still get a spider bite or something and if that goes untreated, or gets worse or gets dirty, so I think wet shelter is a huge need and a huge gap in the system.

We are also continuing to refine our medical respite program and we could use more staff to staff it to provide that case management to work closely with discharge planning from a hospital and then discharge planning and good, you know move into more stable circumstances from here or even from you know we call it harm reduction, if they're going to go out and camp again how do we work with them to prevent another health episode that got them in here, right?. And I think that behavioral health services, mental health and substance abuse recovery are huge, huge, huge needs in this community, and there's just not enough. There's a long waitlist and sometimes care is, eh, not the best. Not the best, not to bad mouth any other partner, but they are so stretched. Case managers and providers have caseloads that are way too big, and they don't have enough resources to work with. So I would actually say substance abuse and providing care

**Marissa:** Okay, great. Yeah, and some of the things we're talking about when we met with Michael Moore from United Way last week, and he says that hopefully there hopefully trying to potentially set up a mental health facility first and then kind of expand to maybe do wet shelter,

wet housing later, in the future. But they're not 100% sure I mean, obviously we don't know what's going to happen or is going to go down, but, yeah.

**Laura:** Interesting, it's really exciting that a city the size of Missoula, which is not big, is pursuing this kind of stuff. That we're even blinking at wet housing, is pretty incredible.

**Marissa:** Yeah, it's great. Well, is there anything else you would like to add, that was basically as far as what I have for you today, so, it's pretty short.

**Laura:** I just think health care, housing and homelessness are so closely related and I just learned, too, that Healthcare costs in Montana, per capita are increasing, increasing like were, there are only nine other states whose healthcare costs are increasing per capita bigger than ours.

**Marissa:** Oh, wow.

**Laura:** And that's probably because of rural care, healthcare resources all together. I thought that was really interesting. And I could probably figure out the source on that if you wanted.

**Marissa:** Yeah, that would be great. If you find it, just shoot me an email.

**Laura:** Okay, great. Thank you very much!

**Marissa:** You're welcome.

**Laura:** Thank you for your interest.

CONSENT: VIA E-MAIL

Recording is fine.

See you on Thursday,

Laura

> 1 pm on the 25th should be great. Do you mind if I record our meeting?

> I will let you know if anything changes.

> Thanks,

> Marissa Ginnett



## Appendix E

### Interview with Manuela Ginnett of the Multi-Service Center, Federal Way, 25:42

12:00 pm, 2/28/16, verbal consent

**Marissa:** Alright, do I have your consent to record this conversation?

**Manuela:** Yes.

**Marissa:** Okay. So, Obviously you and I have had discussions about my project and “Housing First” solutions, but I think some of the things I have left out for you, we met with Michael Moore from United Way last week, my GLI group did, and kind of the direction that project is going is that he was obviously a few steps ahead of us because he gets paid to do what we were trying to research, so we are mostly going to be talking to neighborhood ambassadors about the potential project and just kind of see if we can speak to the public about it, write letters to the editor, and potentially set up a Facebook page to get the word out that this is something that is on Missoula’s radar and hopefully improve the public image of the idea of a wet house.

Specifically this interview is focused on the health aspects of the homeless population, and the goal is to compare similar communities to Missoula to help enhance the idea of “Housing First” solutions to work here in the future. Does that make sense?

**Manuela:** Yes.

**Marissa:** Okay. So at the Multi-Service Center, I know you guys don’t have a whole medical respite program like the Poverello center specifically does, but let’s start with you giving me an overview of your housing program and the services that you provide.

**Manuela:** Ok so for our homeless program, we have shelter for families with children, transitional housing for families with children, transitional housing for single men and single women with non-custodial children, who are in recovery from drugs or alcohol. And in those programs, once they are in there, they have a family development specialist assigned to them, which is basically a case manager to help guide them to the next step. So, the case manager doesn’t have all the answers, the case manager is really a tool, to help the individual figure things

out. So each household, whether it's a family or an individual, gets a housing plan developed, and it's not us telling them what the plan needs to be, it's what their plan is and what they and what they want to do, because if we tell them what to do, that's not a good goal plan. They're not going to buy into it, however, there is limited time they can stay with us, so they can't just do whatever they want. So, within that housing plan, it could be everything as simple as getting on low cost housing waitlist can take months, years to get in to, so figuring out how to increase income, if someone comes in with zero income, do they qualify for social security, or TANF. Do you know what TANF is?

**Marissa:** No.

**Manuela:** TANF is basically welfare for family with children, it stands for temporary assistance for needy families. In most cases if people are capable, they probably do need to find employment because they need to be able to get more income to afford housing. And if they're on a fixed income, like TANF or social security, they really can't afford most things on their own without some sort of subsidy, and subsidies are hard to come by. Or, if their own apartments aren't affordable to their very low income, extremely low income, those are going to have very, very long waitlists. So even apartments that we own, our services are all low income apartments, but even the lowest units aren't affordable to every income level, but the lowest rent level has the longest waitlist. So they're much harder to get in to.

One piece of housing that I didn't mention that is also homeless housing is permanent supportive housing, so that kind of an indefinite length of time, right now I only have funds for households with children, but it's the same thing, there's a case manager or a family development specialist assigned to them to help move them forward because ultimately they don't want to, even though its permanent supportive, at some point things will go away or they don't want to rely on the housing forever. And we have very few people on that anyway. Basically they are in their own apartment and we subsidize their rent and work with them.

So part of the housing stability plan is also with a need to increase their education, do they need to get mental health assistance, physical health assistance, assistance for their children, you know? It could just be everything. Do they have past legal issues that need to get worked on because if you have felonies and evictions on your record, it makes it very hard to lease a place

Because you could be doing a bang-up job in our program, but if you have a history, it still makes it very difficult because that's what landlords are going to look at. You know, we connect them with any kind of money saving stuff if they if they haven't already been doing it, like going to the food bank, utilizing food and clothing bank, going to community suppers and community lunches, because wherever they can save money, not spending it on food is money that can go toward paying rent or program fees, paying utility bills if they need that, paying for medications that might not be covered by insurance, etcetera, etcetera, etcetera.

**Marissa:** Okay. Alright, so I guess the amount of people that you see day to day or you know that your department sees day to day, what are the biggest health risks that you commonly see? Like, for instance if you could list the top three that you see most frequently or are the most troublesome.

**Manuela:** So, the two most troublesome are what I would say, mental health and chemical dependency, not necessarily physical health. So, I would say mental health and chemical dependency issues are the two biggest, and a lot of time they'll go hand-in-hand, because a lot of time people are self-medicating for a mental health issue, and so then they get addicted to drugs to try to deal with whatever's going on, and so, it's a vicious cycle. Those are two of the biggest pieces, now of course, when two of our programs the single men's and the single women's programs are geared toward people in recovery, of course we're going to see that a lot. But even not in that program, we see a lot of issues with chemical dependency, no question about it. And then when it comes to physical ailments, you know, that can just...there is just an array. I couldn't pinpoint one over another.

**Marissa:** Would you be able to list a couple from the top of your head, that maybe you have seen recently?

**Manuela:** I might need to defer you to Tammy\* to answer that one, she can answer that one a little better than I can because I am more removed from the direct service. That might be an easier thing that she can answer.

**Marissa:** You kind of already answered my question of what kind of care do you provide, obviously you are not a healthcare provider, but you talked about the kind of services you

provide to potentially help them pay medical bills, etcetera, I mean, if you have anything else to add to that go ahead and do that now, but otherwise, I think I have a decent amount.

**Manuela:** Yeah, so what we do have, in some of our programs we are connected with what we call in King County the Healthcare for the Homeless Network, and we as an agency don't pay for it, but chemical dependency councilor and mental health councilor can come to our program and work with people and kind of connect them to longer term services, whether they have insurance or not. When it comes to the medical stuff, people are hopefully hooked up with Medicare/Medicaid of some sort or with now all the changes that have come into play in the Affordable Care Act, then getting insurance that way if they didn't have something. There is also things like a mobile medical van that goes to different places throughout the county that basically is like a big, huge RV or like an old bus converted and they have actual medical folks on there that help homeless with stuff. More so people who aren't in our program utilize this like, more in the community, I should say. But we direct people to it, even in our programs, and so they can get immunizations, they can get some light medical stuff, and needs, some tests, and as well as the dental van that goes around, cause dental is...AH, that's a big medical thing that a lot of people are in need of! Dental Services.

**Marissa:** Dental Services, okay.

**Manuela:** That's a harder one to come by because even if people have state insurance, fewer and fewer dentists will accept it or they will put you on a waitlist, so they only end up taking the people who go in for an emergency, like a tooth abscess or something like that. So, yeah, I would say dental going back to not having a third issue. Dental is a big problem.

**Marissa:** That is definitely not something I have heard of or come across yet, so, that's good to hear. So leading into my next couple questions, so, you are far enough away from Seattle that it is probably difficult to deal with anything from 1811 Eastlake, right?

**Manuela:** Correct. And the folks that qualify for 1811 and any of the DESC programs, which is who runs 1811, they really work with the most severe of the most severe, highest barriers, highest needs folks, it's not quite the population, although our population is getting tougher and tougher and tougher because of more mental health and severe chemical dependency issues. I

mean, we are definitely seeing, in the 18 years I've been here, even over the last 5 years, much more significant the issues have become, mental health issues have become very noticeable.

**Marissa:** So, with that, what are the biggest problems that your program faces in helping the population and what are you guys currently doing to potentially fix these problems, in your area?

**Manuela:** It's really tough because all services are limited, so even though we as a county are much bigger than Missoula, there are more services, but of course there are more people in need of those services. So just even trying to, Like one of my case managers, who is really, really attempting to get one of his men in the program who is ready to go in with the inpatient treatment for chemical dependency and mental health issues, he hand walked him in to get an assessment, because you have to have an assessment to get into a facility, right? And it took him a long time, well it feels like an eternity when the guy is ready to go, right? Gets him the assessment and then it's a waiting game for an open bed. And in the meantime, this guy might be suicidal and hurting and depressed, and everything. So we as an agency, what are we doing? We take each person we are working with, one person at a time, figuring out what their needs are, and then we look for all the best solutions out there for them. So when it comes to health issues, physical is a little easier, we can usually get them something, but mental health can be a waiting game. Depending on what kind of insurance they have, then it's on a sliding 'C' scale, and, but even then, that might not be affordable to them.

The other issue sometimes that can be a big issue is transportation. The service we can find for them is not necessarily nearby. Especially in Seattle, because there is only limited 'whatever'. So let's say we were working with a veteran and they need to go to the VA hospital, well that's up in Seattle. So then they're going to be able to best utilize the type of insurance they have, but then there is the transportation to get up there. If they have a car that is rickety, it might break down, it's a lot of gas to go up there, and then pay for parking. Or to take a bus, is not that easy from South King County into Seattle. Even if the service is in South King County, anywhere you need to go in South King County, to another spot, there may even be three busses you need to take, with changes and even waiting for the next bus. I'll give you an example, one of our apartments in Kent, we used to have a resident manager there, well I was looking to hire someone who didn't have a car because they'll say "I ride the bus" and then they have to bring the rent into our office,

right? So I looked, how do you get to our office in Federal Way by bus? Because it's 10 miles away when I drive it, so it was 3 busses to get to the office, and it was an hour on the three busses. So, when people are dealing with issues that becomes a barrier, right? You've got mental health issues then all of a sudden you don't want to be on a crowded bus. And then change busses, and the change again. So transportation is a huge barrier in getting people to services they need. Along with simply not enough services. Doesn't mean they might not get that service eventually, but if they need it now, right?

**Marissa:** Right.

**Manuela:** Because our housing is not wet housing like 1811. Doesn't mean people don't relapse and we don't continue to work with them, but at some point, we do have to ask them to leave if it continues to be an issue because it's shared living in the single men and single women's program. There's some shared living aspect and if their using and putting their other housemates in jeopardy, that's a problem. So we might have someone who is willing to go into inpatient treatment for chemical dependency and we'll hold their spot for them for a while, while they are doing that, but if it takes too long to get into that treatment, and then they blow out of the house and then they are back out on the streets. So those are some limitations and difficulties that we fight.

**Marissa:** I am glad you mentioned the transportation thing, it's still an issue here in Missoula because it can be a little frustrating, but the fact that every single bus is free to public, free and open to the public, and it's a smaller city, I mean yes it is still an issue and there can still be some barriers, but its significantly easier and depending on where these services get placed, where they hopefully will get placed, you don't want them too far from a bus line, but you don't want them too close to bus line either.

**Manuela:** Why don't you want them too close to a bus line?

**Marissa:** Well, just because people are going to be upset if it's too close to a bus line.

**Manuela:** Well unfortunately you're always going to deal with that. Are you familiar with N.I.M.B.Y?

**Marissa:** Yes.

**Manuela:** So, I don't know if you were home if you saw the signs by Woodmont\*\* school, "children before addicts, no rehab in this area"

**Marissa:** No.

**Manuela:** So, it would be up on Pacific Highway, they are building this campus with all sorts of mental health services and eventually also an actual methadone clinic, treatment for heroine. Some people don't believe in methadone because it's basically also heroine...it's the harm reduction version of heroine. So eventually people can wean themselves off of heroine, but might be on methadone forever. So people are really up in arms about that, of course. You do need things close to a bus line, and the problem is here in South King County, you can be close to a bus line, but it doesn't mean it's still easy to get to. SO picture where Villa Capri is, that's on a bus line but you still have to change the bus out to Pac highway and then you have to change again. You know what I mean? And then if you are dealing with a family, a single mom with three kids, and a stroller, the little ones are walking, it's hard.

**Marissa:** Alright, that is it for the questions that I have to ask you, do you have anything else that you would like to add that you think would be helpful to my research?

**Manuela:** Again, you're trying to focus it around health, right?

**Marissa:** Yes.

**Manuela:** I would look at Health Care for the Homeless Network. There is counseling and nurses provided there. You might be able to get more information there.

**Marissa:** Alright, thank you.

**Manuela:** Good luck.

\*Referring to my interview I conducted later with Tammy Money

\*\*Local elementary school near my hometown (Des Moines, WA)

## **Appendix F**

Editorial Published in the “Missoulian”

Homelessness

Homelessness: 'Wet' shelter would be beneficial

Mar 28, 2016

The homelessness problem is well documented here in Missoula. In Mayor John Engen’s 10-year plan to end homelessness, he notes the need for a wet house/wet shelter project to provide aid to our most vulnerable citizens. This project would not only improve the lives of our unsheltered population, it would also improve the lives of the general population.

Every year, Missoula’s hospitals must spend hundreds of thousands if not millions of dollars on caring for the unsheltered. There is a law in Missoula that states that if police/fire/emergency respond to a down person, that person must be taken somewhere (in other words, they can’t just leave them there). If this person does not have a home to return to, they either spend the night in jail or in the hospital. This policy, although well-intentioned, is costing the taxpayers large sums of money and needs a middle ground.

That middle ground could and should be a wet shelter/wet housing project. This would allow intoxicated individuals to have a place to stay, since the Poverello Center is a dry shelter. This project would have an immense positive impact on the community at large, but many neighborhoods are unwilling to support it because they don’t want unsheltered people in their backyard.

I am urging the general public to have a more nuanced view of the situation and take more factors into account, rather than just the negative stereotypes that we have about homeless individuals. The United Way has been working very hard to make this project a reality and they only need a few more pieces of the puzzle before this project can come to fruition. One of those pieces is public support. I am urging citizens of Missoula to do their research and look critically at this issue.



For more information, find us on Facebook at “Support Reaching Home.”

Sophie Friedl,

Missoula

(5) comments

wowureallyR Mar 28, 2016 12:34pm

The only way that I would support a "Wet Shelter" is if it was planned in the South Hills. I think that the drunk and the destitute should be able to enjoy the save view of Missoula as the people who are pushing this idea.

DaveQ Mar 28, 2016 12:12pm

I am a logical person so I tend to consider a holistic view of these types of things. Missoula also has a homeless deer problem. They ruin property, beg for food and die in town all the time. Isn't it completely illegal to feed deer and encourage them to hang around the city? Why is it illegal to feed deer and keep them as pets in the city? Why doesn't the same logic apply to homeless people? Why do liberals have these kinds of double standards and lack of logic?

swanee Mar 28, 2016 10:19am

How about a one way bus ticket to California. Another soft headed/soft landing person no doubt. If we were less friendly to the professional panhandlers in Missoula and encouraged them to move on the problem would quickly diminish. Maybe the first stop should be a bed and breakfast at Ms Marler and the Mayor's house.

farly Mar 28, 2016 9:17am

Why don't we just go ahead and provide them with free booze while we're at it...

## Appendix G

### Response from Neighborhood Councils of Missoula

My opinions are that Missoula should look toward a "Housing First" model like Seattle, Denver and Portland. I am all for a wet shelter, but it will be extremely costly to staff as there will need to be 24 hour medical staff because of the medical fragility of many of the folks on our streets. Studies show nationwide that providing transitional housing in a communal situation with some supervision and assistance is much more effective than homeless shelters that can only provide a limited amount of time off the streets wet or dry. I say all of this having worked on this issue for many years in Missoula and in Seattle (for homeless youth). I am certainly willing to be more a part of the conversation, and I think this is on the right track. I know someone has done this research via the 10 year homelessness plan having looked at what other cities are doing (but it might need to be updated). I think this population needs something more like the Valor house with transitional housing assistance and medical/mental health/substance treatment on site. Of course, it is easy to say this, but hard to fund. Block grants would likely help, and touring the ones in Seattle that have worked in certain neighborhoods would also help to determine feasibility for a city our size. The United Way and your group could touch base with Sheriff McDermott, as he has worked on getting mental health shelter separate from the jail for those that are in the quandary you mention in your letter (i.e., the hospital can't keep the person, yet, they have committed a petty crime and go to jail unnecessarily--the revolving door situation). If the city/county, United Way, the Pov folks, and mental health providers could band together to come up with a longer term viable "wet living situation" it would be ideal. Not an easy feat, but we are so much further as a community on this issue than we were 5-10 years ago. I know it can be done with so many committed and caring people like yourself.