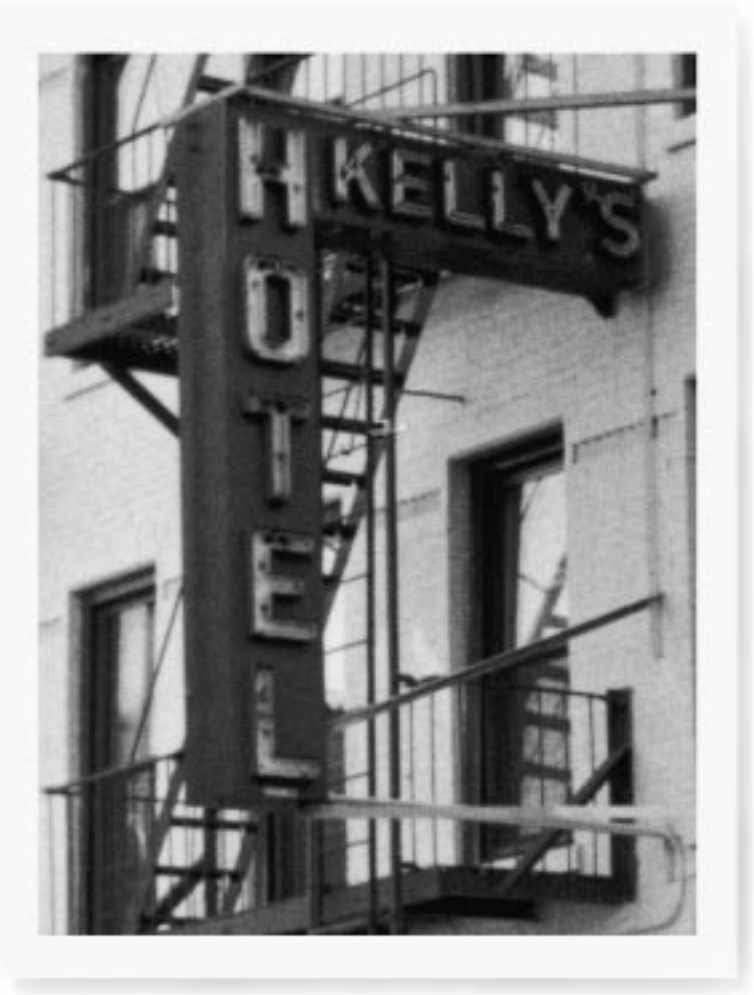
Closer to Home



Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel

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Commissioned by: Corporation for Supportive Housing

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Dear Colleague,

I am pleased to present *Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel* by Susan Barrow and Gloria Soto Rodriguez of the New York State Psychiatric Institute. This report is the second in our on-going *Closer to Home* series, funded by the Conrad N. Hilton Foundation, to document and evaluate programs targeted to the hardest-to-serve of the homeless population, those individuals who have experienced chronic homelessness over significant periods of time.

The first report on this topic was the 1996 *Closer to Home: An Evaluation of Interim Housing for Homeless Adults* by Barrow and Soto Rodriguez, a study of interim housing programs for homeless adults living on the streets. This second study is based on a specific evaluation of the Kelly Hotel, opened in 1997 by the Center for Urban Community Services (CUCS) for mentally ill, long-term stayers of the New York City shelter system and mentally ill, homeless individuals who have lived on the streets. The third study of the series will focus on the *Closer to Home Initiative,* a five-year program to develop and expand programs to house and stabilize mentally ill homeless in six sites across the country.

The goal of the Kelly Hotel interim housing program is to prepare its residents for permanent housing. With generous funding from the Conrad N. Hilton Foundation, CSH provided first-year financial support for the long-term shelter stayers program and commissioned this study, which describes the program model and its implementation, as well as tracing the histories and outcomes of the first group of long-term shelter stayers. Following are some of the study's key conclusions and recommendations:

- "Recruitment of clients in complex organizational environments like New York City's municipal shelter system requires combining one-on-one outreach and inter-organizational approaches.
- Cautious selection policies in the early stages of program development may be necessary to establish a program atmosphere that eventually can withstand riskier recruitment choices.
- Working with long-term shelter residents is a resource-intensive undertaking requiring clinically sophisticated staff and the organizational and supervisory support to sustain their effort.

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- Low vacancy rates severely limit options for long-term shelter residents, and unless the supply of supportive housing is expanded, they will continue to face prolonged homelessness.
- Fresh approaches to permanent housing are needed to end long-term homelessness among non-abstinent, dually diagnosed individuals."

Despite operational complexities, the Kelly Hotel has been successful in achieving its intended goal by placing 42 percent of the first shelter group in long-term housing situations within thirteen months; 70 percent of those housed were in supportive settings.

We, at the Corporation for Supportive Housing, firmly believe that interim housing programs such as the Kelly Hotel are a necessary housing intervention for those long-term homeless individuals who are not ready to attain a permanent home of their own. As the title suggests, programs such as the Kelly Hotel are indeed *Closer to Home*, as they represent a critical link between homelessness and permanent housing. It is a link that helps individuals gain valuable skills and reclaim the self-confidence that will enable them to successfully live in an independent setting.

It is our hope that these three *Closer to Home* studies, read in concert, will represent a significant contribution to the existing body of research on program models to serve the hardest-to-serve of the homeless population, leading to policies which provide the necessary resources and support.

Sincerely,

James A. (Jack) Krauskopf
President

Acknowledgments

This final report on our evaluation of The Center for Urban Community Services' Kelly Hotel Transitional Living Community for long-term shelter residents is based on more than a year of close observation, interviewing, and documentation of the program. Despite efforts to be unobtrusive, a research project always imposes a burden on those who are its subjects. For a program that is in its formative stages to offer itself for scrutiny by researchers is an exceedingly generous act and we are extremely grateful to CUCS for allowing us closely to observe the process of program development and implementation. Tony Hannigan, Joe DeGenova, Lolita Jefferson, and the entire staff of the West Harlem Transitional Services Program have given time and assistance in providing the access and information needed for this study. We benefited as well from the interest and support provided by Assistant Commissioner Laura Mascuch of the Department of Homeless Services. Constance Tempel and Heidie Joo at the Corporation for Supportive Housing, which commissioned the study, have been helpful throughout. We especially thank the residents of the Kelly TLC, who have graciously tolerated the presence of researchers in their home and were willing to spend hours of their time sharing their experiences and perspectives with us.

We take full responsibility for any errors of fact or interpretation.

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Executive Summary

I. INTRODUCTION. Recent evidence that a subgroup of homeless individuals have become long-term residents of New York City shelters has spurred a search for new approaches to engaging them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community (TLC), developed by the Center for Urban Community Services (CUCS) with first year funding from the Corporation for Supportive Housing (CSH), is one pioneering effort to help mentally ill long-term shelter residents obtain housing. This report presents results of an evaluation describing the TLC model, its implementation by CUCS, and outcomes achieved by its initial group of residents.

II. THE PROGRAM MODEL. The free-standing TLC, unconnected to particular shelter or housing sites, serves as a conduit into supportive housing. The program uses a low demand/high reward program structure and flexible admission criteria to help clients engage in services, make a plan and access housing. Services focus on developing motivation for change, and over time, demands and expectations increase as part of the process of promoting housing readiness. The TLC community, which includes individuals at different stages of recovery from substance dependency and housing readiness, fosters a "culture of change," with those closest to program goals serving as role models to new entrants.

III. PROGRAM IMPLEMENTATION. Recruiting residents from municipal shelters required a combination of one-on-one and interorganizational approaches. Outreach was facilitated by the attractiveness of a newly renovated building and the TLC's low demand, low threshold admission policies, as well as by cooperation of shelter system administrators and

staff. Four months after the Kelly first opened its doors, 21 long-term shelter residents had moved in and the TLC beds for this group were full; by mid-June, 1998, the program had admitted 24 long-term shelter residents.

In the Kelly's first shelter cohort, 79% identified as African-American or West Indian; 17% as Latino; 4% as white. Residents' mean age was 48.25 years; on average, they had stayed in shelters 2.75 years of the last four. Pressure to fill the TLC beds quickly favored a low admission threshold: 50% of women and 33% of men had florid psychotic symptoms and 50% of women and 25% of men were actively abusing substances at move-in; while at the TLC, 75% of women and 42% of men relapsed into substance abuse. The first cohort influenced the program's emerging "culture" and posed significant placement challenges.

CUCS incorporated the shelter residents into its existing West Harlem Drop-in Center program for the "street" homeless population. Before shelter recruitment began, 19 drop-in clients were moved to the TLC from a nearby Single-room occupancy (SRO) building where the agency leased rooms. Adding the shelter group increased the numbers at the Drop-in center, where most services were provided, and required adjusting both drop-in and TLC policies and procedures. Of greater concern, however, was the influx of active substance abusers before a change-focused culture had a chance to jell in the TLC. To better nurture a culture of recovery, CUCS enacted changes to enhance staffing, clinical services, and supervision.

Program services were organized around a focus on housing. Substance abuse and psychiatric services were brought to bear on housing readiness; the housing specialist ran a weekly housing group and conducted group tours of supportive residences; and case managers counseled TLC residents about housing options and helped them develop and pursue a housing plan. Successful placement depended on workers' abilities to broker the gap between clients' expectations, capabilities, and preferences for particular types of housing and the actual costs, vacancies, and preferences housing providers have for particular types of residents. To focus and support case managers' efforts, staff held weekly meetings to assess client progress toward housing and set objectives and timetables to structure the process.

IV. PROGRAM AND RESIDENT OUTCOMES. Thirteen months after filling the beds, the program had housed 42% of the first shelter cohort — 70% in supportive settings — despite such challenges as co-occurring mental illness and substance abuse, physical illnesses, methadone maintenance, and checkered histories of abstinence and relapse. Another 17%

remained at the TLC (one was about to move to a Community Residence), which speaks to both the program's success in engaging them and the tenacity of the housing obstacles with which they struggled. The remaining 42% had left or were discharged from the TLC without housing. One was referred to a MICA* TLC; the others either were discharged for repeated rule infractions (usually substance-related) or chose to leave the program rather than accept MICA housing. At follow-up, 6 were in shelters or other TLCs; the others were located in a MICA residence, adult foster care, or with relatives; whereabouts of one were unknown. Those successfully housed included equal numbers of men and women and spanned various ages and ethnic backgrounds; most had psychiatric diagnoses of major depression; and most were *not* abusing substances at TLC admission. In contrast, those who left or were discharged without placement tended to be women, were in their forties, had the most severe psychiatric diagnoses, and were actively abusing substances when admitted to the Kelly. Thus, the program successfully placed a diverse group of long-term shelter residents. Those who did not become housed constituted an identifiable subgroup that faced persistent barriers to permanent housing.

V. CONCLUSIONS AND RECOMMENDATIONS. Several conclusions and recommendations follow from the study findings:

- Recruitment of clients in complex organizational environments like NYC's municipal shelter system requires combining one-on-one outreach and interorganizational approaches.
- Cautious selection policies in the early stages of program development may be necessary to establish a program atmosphere that eventually can withstand riskier recruitment choices.
- Working with long-term shelter residents is a resource-intensive undertaking requiring clinically sophisticated staff and the organizational and supervisory support to sustain their effort.
- Low vacancy rates severely limit options for long-term shelter residents, and unless the supply of supportive housing is expanded, they will continue to face prolonged homelessness.
- Fresh approaches to permanent housing are needed to end long-term homelessness among non-abstinent dually-diagnosed individuals.
- Research is needed to better describe the long-stay shelter population, document other new models for housing its various subgroups, and assess outcomes over longer time periods.

* MICA is the acronym for "mentally ill chemical abuser," a term used to describe persons diagnosed with both mental and sudstance use disorders.

Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel

I. Introduction

Long-term or "chronic" homelessness has only recently become a focus of public policy, although researchers have repeatedly noted the phenomenon in descriptions and typologies of the homeless population (Arce et al., 1983; Hopper et al., 1997; Penney et al., 1996), and in discussions and critiques of the concept of "shelterization" (Gounis, 1992). Recent studies in New York City and Philadelphia have identified significant subgroups of homeless individuals who have resided in shelters for years (Culhane & Kuhn, 1998), using a disproportionate amount of shelter resources. The supportive housing models that have been demonstrated to be effective responses to the housing and service needs of many homeless individuals (Lipton et al., forthcoming; Rog & Holupka, 1998; Shern et al., 1997; Tsemberis, 1999), are either not available to, not accepted by, or not working for this group. New models and approaches for engaging them and linking them to housing seem to be required.

Since the mid-1990s, New York City's Department of Homeless Services (DHS) along with the Corporation for Supportive Housing (CSH) and several non-profit agencies have concentrated attention on long-term homelessness, seeking innovative solutions to the apparent intractability of the problem for those New Yorkers who have become quasi-permanent residents of the city shelters. The Kelly Hotel Transitional Living Community (TLC) constitutes one vanguard effort to target services to long-term shelter residents. It was developed by the Center for Urban

Community Services (CUCS) as part of its West Harlem Transitional Services Program, with first year funding provided by CSH, which also sponsored an evaluation to examine the project's development, implementation, and early outcomes. This report presents the results of that evaluation.

The TLC model of a free-standing housing readiness program located neither in a shelter nor in a particular permanent housing site is one of several possible approaches to helping long-term shelter residents transfer from shelter to housing. Alternative models currently under development[1] are still in the early phases of implementation, making attempts at comparisons premature. In documenting this pioneering effort to house those left behind by other programmatic responses to homelessness, this evaluation of the Kelly program offers a first look at issues that arise in the process of confronting long-term homelessness. It aims to describe how the TLC model approaches these issues; what the process of implementing the model entailed; and how the initial group of TLC residents fared.

The report[2] has five parts: (1) An introductory section describes the background for both the program and evaluation efforts by summarizing program start-up activities and briefly describing evaluation aims and methods. (2) Section two presents the model CUCS developed for serving the long-term shelter population. (3) Section three focuses on program implementation. After reviewing the recruitment process for the Kelly, the report summarizes characteristics of the TLC's first 24 long-term shelter residents; compares them to Drop-in Center clients admitted to the TLC's "general beds" during the same period; identifies issues that emerged in the process of incorporating the shelter group into the program; and describes implementation of housing readiness and housing placement services. (4) Section four presents placement outcomes achieved by the first Kelly cohort. (5) Section five, the final section, summarizes study findings, offers recommendations for serving the long-term shelter population, and identifies issues requiring further research.

Background and Context

Administrative data on shelter use in NYC show that approximately 20% of those who use city shelters for single adults in the course of a year have accumulated extended periods of shelter residence, either as quasi-permanent tenants or in repeated departures and returns (Kuhn & Culhane, 1996). While mentally-ill and substance abusing adults appear to be overrepresented in these long-stay groups (Culhane & Kuhn, 1998), not much else is known about the characteristics of the long-term homeless,

why they have remained in the shelters so long, or what might be done to house them. However, the new focus on individuals with chronic histories of homelessness has triggered a search for models addressing the barriers that prevent their exit from homelessness.

CUCS's 21-bed transitional housing program for long-term shelter residents is one such model. In developing the program, CUCS drew on its experience in operating two other transitional programs — the 350 Lafayette Street TLC for homeless mentally-ill women in city shelters; and the service program at the 126th Street Drop-in Center, which offered clients transitional housing at the Old Broadway SRO across the street. As previously reported (Barrow & Soto, 1998), after initially exploring the possibility of renting more space at the Old Broadway in order to mount a program for long-term shelter residents, CUCS undertook a long-term lease on an entire SRO building located a few blocks away from the Drop-in Center. The Kelly Hotel, as the building was known, was being renovated by the landlord, who agreed to modify the planned renovations to create a 40-unit building with single, double and triple rooms, as well as office, lounge and dining space for program activities.

When renovations were complete, CUCS moved the 19 drop-in center clients staying at the Old Broadway into the Kelly and began outreach in the shelters to recruit 21 mentally-ill individuals[3] who met the "long-term shelter resident" criterion — i.e. had stayed in city shelters for at least 730 days (two years) in the prior four years.

Evaluation Issues and Methods

Three aims have guided this study: to describe the program model CUCS developed to transfer mentally-ill men and women from shelters to housing; to describe program implementation; and to describe client outcomes and assess the program's role in reducing long-term homelessness for its initial group of residents. The research is intended to contribute to building a knowledge base that can inform the development of strategies for reducing long-term homelessness.

As the program has taken shape, the evaluation team has documented its development and implementation. Designed as an embedded case study (Yin, 1994), the evaluation has focused on several units and levels of analysis — the program as a whole; its outreach, drop-in, and TLC components; the phases of program implementation (filling the beds, incorporating the shelter population, developing housing readiness services, and moving people on); and the individual TLC residents

themselves. This descriptive approach is particularly appropriate for studying interventions in their formative stages, as it can document how the elements of a program model are translated into practice and how practices are transformed when implemented in new contexts (Barrow et al., 1991; Brekke, 1988; Mowbray et al., 1991). By identifying and documenting adjustments in the program model, changes in the target population, or obstacles in the larger service and resource context, descriptive implementation studies can also inform interpretations of findings on outcomes (Mowbray, Cohen & Bybee, 1993). While early findings on resident outcomes are necessarily provisional, the study results nonetheless indicate key issues those developing similar programs may confront, some guidelines for addressing them, and the kinds of effects that might be expected as the program continues to mature.

At each level of observation and analysis, the evaluation has used a combination of qualitative and quantitative methods to collect and analyze the data.

Program-level data as well as descriptions of program components and stages of development and implementation were obtained by interviewing administrators and staff, collecting documents describing program policy and practices, and observing program activities including presentations and outreach in the shelters, program development and management meetings, meetings focused on housing placement, community meetings at the Drop-in Center and the TLC, resident groups addressing housing issues, resident tours to several supportive housing programs, and other regular and special activities. The primarily qualitative program-level data were recorded in fieldnotes, indexed, and reviewed to identify themes and to develop summary observations. Data from multiple sources were triangulated and inconsistencies further explored with additional information from staff members or program documents.

Client-level data also came from multiple sources. During the initial outreach phase, individual-level data on shelter histories were derived from the Shelter Care Information Management System (SCIMS) database maintained by DHS, which tracks client movement through the shelter system; from observation and workers' records of outreach contacts, client tours of the TLC, and screening interviews; and from observation of intake review committee meetings.

Data on TLC residents came from observations at the Drop-in Center and TLC; and from program reports on client status. In addition, TLC residents were interviewed approximately four months after moving in. The TLC sample consisted of 48 individuals who entered the Kelly during or after

12/97. These included all 24 long-term shelter residents[4] who had entered the program by 6/98; and 24 street outreach/drop-in center clients recruited for the TLC's nineteen "general beds" between 12/97 and 12/98. Baseline information was collected on both subgroups of TLC residents. The shelter group was followed up through interviews conducted approximately 10 months after their entry to the TLC and through status updates provided by case managers and program administrators. Follow-up data were not collected on the outreach/drop-in group. While follow-up data are presented to describe the outcomes achieved by the long-term shelter group, the small size of the sample precludes analyzing predictors of outcome.

It is important to emphasize the provisional nature of the early findings on resident outcomes. While they provide an accurate *description* of the results of early program efforts, their predictive implications are unclear. In addition to the limitations of small samples and limited time depth that typically characterize formative assessments of new programs, the residents initially recruited often differ from those who enter a program in its more mature phases. And, subsequent outcomes may be affected by adaptations and alterations of the original program concept and practices that are especially likely to occur when a program is first implemented. Yet, in closely documenting both the early phases of program evolution and their results, formative studies can do muc to clarify the processes that link practices and outcomes.

II. The Program Model

In proposing to operate a TLC for long-term shelter residents, CUCS drew on its experience with transitional housing at both the West Harlem Outreach/Drop-in Program and the 350 Lafayette Street TLC where, for the last decade, CUCS has provided housing-focused services for mentally-ill women referred from throughout the shelter system (Hannigan and White, 1990). The Kelly TLC was envisioned as combining the philosophy and techniques of these existing programs, but adapted to address the special service issues posed by long-term homelessness.

The approach CUCS proposed for serving men and women with long shelter histories was premised on an analysis of factors preventing this group from leaving the shelters. These included "shelterization" (conceptualized as a learned resignation, dependence and hopelessness fostered by large, minimally structured, impersonal shelter environments), lack of knowledge of housing options, a mismatch between service offerings and needs, incapacitating symptoms of mental illness that interfere with accessing services, unmet medical needs, drug and alcohol abuse, victimization and trauma, age, extreme isolation, and lack of community living skills. These barriers were seen as leading to an inability to plan effectively and carry out the many changes involved in moving from homelessness to housing (CUCS, 1997:2).

A central tenet of the model developed for the new program is the importance of developing motivation for change. Techniques for doing this come from CUCS's experience as well as work on addictions by Prochaska, DiClemente and Norcross (1992), who elaborate the "stages of change" involved in achieving abstinence from substance abuse, and by Miller and Rollnick (1991), whose "transtheoretical model" of motivational interviewing attempts to match interventions to an individual's readiness to change. CUCS proposed to "tailor these techniques specifically for use with long-term shelter users…effectively applying and integrating them into the overall program" (CUCS, 1997:5).

CUCS proposed that the new Kelly TLC would have an array of services, including outreach, meals, laundry facilities, psychiatric treatment, case management, access to medical care, group activities, a transitional employment program, housing placement, and post-placement follow-up. All aspects of the program would "focus on helping clients engage in services, make a plan and access housing within a six to nine month time period" (CUCS, 1997:4).

The model entailed using motivational interviewing as part of the shelter outreach process, with CUCS outreach workers gearing their interactions with shelter residents to the individual's readiness to take on the "change" issues involved in exiting from homelessness. The outreach work would be supported by a low demand/high reward program structure, with the program's standard service contract modified to make initial demands more "modest and doable for service resistant clients" (CUCS, 1997:5-6). This entailed flexible admission criteria for the Kelly. For example, rather than requiring an extensive period of "clean and sober" time as an admission requirement, CUCS planned to use the Kelly as an incentive for abstinence, rewarding two weeks of clean time with admission. Over time, demands and expectations would increase as part of the process of moving people to housing readiness (CUCS, 1997:6).

Since people enter the program at different levels of "readiness," and change occurs at varied rates, at any point in time, the program would include both individuals who are well along the path to exiting from homelessness and achieving "recovery" from addictions and mental illness; *and* those with less firm commitment to recovery or housing. This mix of levels of motivation and readiness is seen as essential to developing a culture of change within the program, in which those who have moved closer to program goals serve as role models to new entrants and others in the early stages of change (CUCS, 1997:6).

Like CUCS's other transitional programs, the Kelly TLC is conceptualized as a conduit into supportive housing. As the service provider in several supportive SROs, and as the operator of a citywide clearinghouse for information on vacancies in supportive housing, CUCS has considerable specialized knowledge of placement approaches and options available to individuals with different patterns of preferences, abilities, disabilities and needs. The Kelly's program structure is geared toward moving individuals through this process to the desired endpoint, permanent supportive housing, (CUCS, 1997:8).

III. Program Implementation

By implementing transitional services for long-term shelter residents in the context of a pre-existing outreach/drop-in program for the street homeless population, CUCS has built on particular experiences and resources that are not inherent parts of the TLC model. However, *models* are abstract concepts that only become *programs* when they are implemented in particular settings. They are also invariably modified as they encounter the real-world imperatives and constraints of their immediate and broader environments. In providing detailed documentation of program implementation, this report considers both context-specific and more generic issues that have played a role in program development and outcomes. The sections that follow cover the start-up and recruitment period, characteristics of the first cohort of long-term shelter residents, the process of incorporating this group into the existing transitional services program, and the development of housing readiness and housing placement services.

Start-up and Recruitment[5]

Between December, 1996, and September, 1997, CUCS identified the Kelly Hotel as the site for a new 40-bed TLC, put together a funding package and negotiated a long-term lease with the Kelly's owner, that included specific renovations needed to operate the TLC. The lease was signed on September 12, 1997. While renovations on the building were proceeding, CUCS staff focused on planning the new program and its integration with the existing services at the Drop-in Center. Additional staff were recruited, and plans were made for moving the Old Broadway tenants to the new building and for relocating some staff offices from the Drop-in Center to the Kelly. The renovations were completed by December 1, 1997, and two days later, the 19 drop-in center clients housed at the Old Broadway moved into the building.

Outreach Process: Filling the Beds. Recruitment of long-term shelter residents for the TLC formally began on October 29, 1997, when CUCS hosted a breakfast meeting to introduce the new program to directors of nine shelters with large concentrations of long-stayers and encourage their support. This launched an outreach effort involving visits and

presentations to more than half a dozen shelters, but outreach activities were concentrated at four sites — Park Slope and Park Avenue Women's Shelters; and two large men's shelters, one in the old Bellevue Hospital building on 30th Street in Manhattan, the other in the Charles Gay shelter on Wards Island. Repeated visits to these shelters and tours of the Kelly by shelter residents continued through March, 1998.

Outreach workers described street outreach in terms of engaging potential clients in a relationship. In the shelter context, outreach contacts with clients are mediated through a complex service bureaucracy that includes both not-for-profit agencies that operate whole shelters or service programs within shelters and city agencies that manage the system as well as operate particular shelter facilities. The cooperation of shelter administrators and staff was essential for CUCS outreach workers to gain entry into the shelters, identify eligible residents, locate them within the facility, and verify their duration of shelter use and psychiatric status. DHS's decision to count placements in the Kelly toward the performance incentives that shelter programs earn for meeting housing placement goals was an important factor promoting cooperation from shelter workers.

But CUCS outreach workers[6] also needed to develop relationships with shelter staff who could encourage clients to consider the program and assist in verifying eligibility. This required some trial and error as well as troubleshooting by CUCS administrators. In some shelters — especially the smaller ones in the women's system — the process went fairly smoothly; it was more complex in the larger men's shelters where outreach workers had to contend with several co-located programs, agencies, and organizational styles. The result was a somewhat bifurcated outreach process, with repeated visits and contact between outreach workers and individual clients in the two women's shelters where most activity occurred[7], and a greater reliance on pre-screening and referral by shelter staff in the larger men's shelters [8]

Reasons for Moving: Staff and Resident Perspectives. Based on questions raised when they visited the shelters, outreach workers reported that shelter residents considered different issues in deciding whether to move to the TLC than those that were most salient for people recruited through street outreach. For example, the offer of a bed, meals, showers, or a warm place to stay provided less of an incentive to move to transitional housing than it had for people on the streets. The program's location also had different implications: For persons living on the streets in West Harlem, the neighborhood was simply a given, while for those residing in shelters in Brooklyn, Wards Island, or Manhattan's East Side, the neighborhood was an issue. Concerns about drug trafficking and other crime deterred

some from even coming to tour the program, and others knew the area only too well as a neighborhood where they had previously purchased drugs. While a few with relatives or friends in the vicinity had positive reasons to consider moving to the Kelly, other shelter residents had their fears alleviated after visiting the site or decided that moving to a newly renovated building compensated for any disadvantages of the location.

Other issues that shelter residents raised when outreach workers visited the shelters included cost and the amount of "clean time" needed for admission. Outreach workers described the fact that the Kelly program did not charge rent or require prior clean time as major "selling points." By eliminating these factors as obstacles to housing, CUCS was able to elicit interest from some individuals who had been repeatedly rejected by housing programs with steep admission thresholds. Overall, approximately 70% of those who toured the TLC or were interviewed for admission were accepted and moved in to the Kelly.[9]

Open-ended interviews with the Kelly's first cohort of shelter residents provide some additional insights into factors that influenced recruitment. Residents were asked what they had thought of the TLC and Drop-in Center when they first visited, what concerns they had about moving there, and what made them decide to move. Impressions of the TLC building and rooms were overwhelmingly positive. Almost all long-term shelter residents said they were impressed that the building looked new and clean ("beautiful," "decent," "nice," "modern," and "neat"). Other attractions included privacy, having a room alone or with one or two others, and having one's own key. Two people expressed disappointment that it was not an apartment building and not permanent housing, and one had felt the rooms were too small; but overall, the Kelly made a good first impression on those who ultimately moved there.

The staff also generally got high ratings on first impressions, earning descriptions such as "nice", "caring", "helpful", "pleasant", "seemed proud of the facility", or "they looked professional." Complaints were mild ("too relaxed", "they meant well", "they seemed aloof but are more warm as you get to know them"). This was less true of the neighborhood, which was seen by most as rundown ("burned out", "dilapidated") and drug infested ("drug city", "crack dealers at the corner"), although some were neutral ("it didn't faze me", "not so bad") and one liked the fact that "everything is close by." The Drop-in Center also failed to impress prospective residents. While some said it was "okay" or "better than where I was", and two saw it as a program that would offer needed help, a majority of the group viewed it negatively. Some described the center as "humdrum" or "a dump," but most focused on their impressions of the

drop-in center clients — describing “strange people”, or “bad odors” or “junkies” or “uncombed hair.” One resident said, “I looked around and thought, ‘I’m better than this.’” About half of those who indicated they had concerns about coming to the Kelly specifically mentioned exposure to active addicts either within the program or in the neighborhood more generally. Other concerns had to do with rules and roommates.

In general, then, residents reported some ambivalence about their initial visit to the program. What tipped the balance in favor of moving to the Kelly? A variety of reasons were given: 30% cited features of the Kelly (mainly cleanliness and privacy), making either explicit or implicit comparison to the shelters; 26% felt that the program at the Kelly would help them get permanent housing; 17% talked about wanting to leave a particular shelter or the shelter system, while another 9% referred more vaguely to wanting a change; and 17% said they were told by the shelter they had no choice; their time was up.

In response to the same questions, drop-in center clients admitted to the “general beds” at the TLC[10] during the same period also recalled favorable first impressions of the Kelly (“It looked like a nice place to live”, “liked it, the rooms, the building,” “it was clean”, “it looked secure, freshly painted”, “incomparable”, “beautiful”, “comfortable” or "I was overwhelmed”). The staff was “pleasant”, “great”, “nice”, “welcoming”, or “pretty adequate.” Unlike the shelter group, however, the majority of drop-in center clients with concerns about the TLC were worried about privacy and autonomy — having to share a room, having to undergo urine tests, whether they would be able to come and go as they pleased. Like the shelter residents, the drop-in center clients were critical of the immediate neighborhood, describing it as “a bit rough,” or “messed up,” though some saw it as “a little better than before” and one said that “when you live on the street, you don’t pick and choose. It's superior to the streets, parks or subways.” The sharpest contrast with the long-term shelter residents, however, was in the reaction to the Drop-in Center. Three drop-in clients had clearly negative reactions, describing it as “poor”, “depressing”, or “weird”; two were non-committal (“you need to get to know it”; “it’s nothing special”). But more than half had positive or enthusiastic responses, describing it as “busy”, “great, a nice place to get off the street”, “nice, everyone could smoke,” or even “I loved it, the staff was kind and generous” and “it was like heaven; you could relax and eat, there were activities, trips, even a doctor.” Their ultimate reasons for moving into the Kelly were similar to those cited by long-term shelter residents, but in different proportions: More than half (54%) referred to features of the building or rooms or program atmosphere — the room, privacy, cleanliness, its small size and its homeyness; 15% decided

on the Kelly in order to get out of the hospital or off the streets and away from street "associates"; 31% said they had no other options — they had to leave where they were staying and no other place but a shelter would take them. No one mentioned that the TLC would help them get permanent housing.

The contrasts between the reactions of the long-term shelter residents and those of other Kelly residents are consistent with reports from the outreach workers about the different role of the Drop-in Center and the concrete services it provides in street versus shelter outreach. Views of the neighborhood were more similar in the two groups than the outreach workers' comments would suggest, although shelter residents were somewhat more likely to talk critically about Harlem in general, while the other Kelly residents emphasized problems in the specific block where the TLC is located. The clean, newly renovated building was a powerful attraction for both groups, but their contrasting perceptions of whether sharing a room with one or two others constituted a loss or a gain in privacy appears to reflect different frames of reference based in differing recent experiences. Finally, for a surprising proportion of both groups, limited or absent alternatives had more influence on the "decision" to move to the Kelly than the specific attractions of the new program.

Recruitment Timing and Timetable. The recruitment process was influenced by the timing of the Kelly's start up and the time frame for filling the beds. Initial outreach efforts began just before the holiday season, when the onset of cold weather and a high number of non-routine activities tend to place extra pressures on shelter staff. Thus seasonal factors, along with the need to develop and adapt outreach strategies, may have contributed to a fairly slow start. The first screening interview for the long-term shelter stayer program was conducted in early December, 1997; and one month after that, on January 12, 1998, the first of the shelter clients moved into the Kelly Hotel. CUCS had set the beginning of April, 1998, as the target date for full occupancy of the long-term shelter beds at the Kelly, making it necessary to recruit an additional 20 clients during the subsequent ten-week period in order to meet the goal.

Although after the holidays there were more tours and visits by prospective residents and more sustained outreach efforts by CUCS, by then the pressure of an impending April deadline for "filling the beds" was at odds with the slow process of relationship building with individual shelter residents, and in some instances persons who were judged to require an extensive investment of time were skipped over while the team searched for those who could be recruited more easily. This did not, however, mean that the program sought out only the most motivated or housing-ready clients. In

fact, pressure to "fill the beds" also favored an extremely low threshold for admission. While this had the effect of providing options for people who were unlikely to be accepted into other housing or housing-readiness programs, it also produced a first cohort of long-term shelter stayers at the Kelly who posed many challenges to the program's placement efforts.

Four months after the Kelly first opened its doors, the program achieved its recruitment goal: On April 2, 1998, the twenty-first shelter client moved in and the TLC beds for long-term shelter residents were full. A few days later, a twenty-second shelter client moved to the Kelly, utilizing a vacant "general" bed, and by mid-June, 24 long-term shelter residents had been admitted to the Kelly.

The First Long-term Shelter Resident Cohort

Characteristics of the first 24 long-term shelter residents who entered the TLC are presented in ***Table 1***.[11] The long-term shelter group at the Kelly resembled the general shelter population in ethnicity — minorities comprise 96% of the Kelly population, with a large majority identifying themselves as African-American or West Indian (79%) and 17% identifying as Latino. However in gender and age, the long-stay population was distinctive. The Kelly residents were evenly split between men and women, in contrast with the preponderance of men (approximately 85%) in both the wider pool of longer-term shelter residents (Culhane & Kuhn, 1998) and the general shelter population (Struening & Pittman, 1987). The gender balance achieved at the Kelly in fact reflects an outreach strategy that actively sought to make the Kelly a comfortable place for women. The average age of the Kelly group was 48.25 years, almost 13 years older than the general shelter population mean (Struening and Pittman, 1987); 92% of the women and 83% of the men were age 40 or over.

Clinical assessment of the shelter clients by the CUCS psychiatrist identified a variety of severe psychiatric disorders. The majority (58%) were judged by their case manager or the program director to be psychiatrically stable[12] at admission and close to two-thirds (63%) were not actively using substances at that time, although at least 58% relapsed to substance abuse at some point during their stay at the Kelly. However, the clinical profiles of men and women diverge. Three-quarters of the men had diagnoses of depression, other less serious disorders, or no Axis I disorder; only 17% of the women were classified in these categories while 83% were diagnosed with schizophrenia, schizoaffective, other psychotic, or bipolar disorders. Moreover, at admission, half of the women but only a third of the men

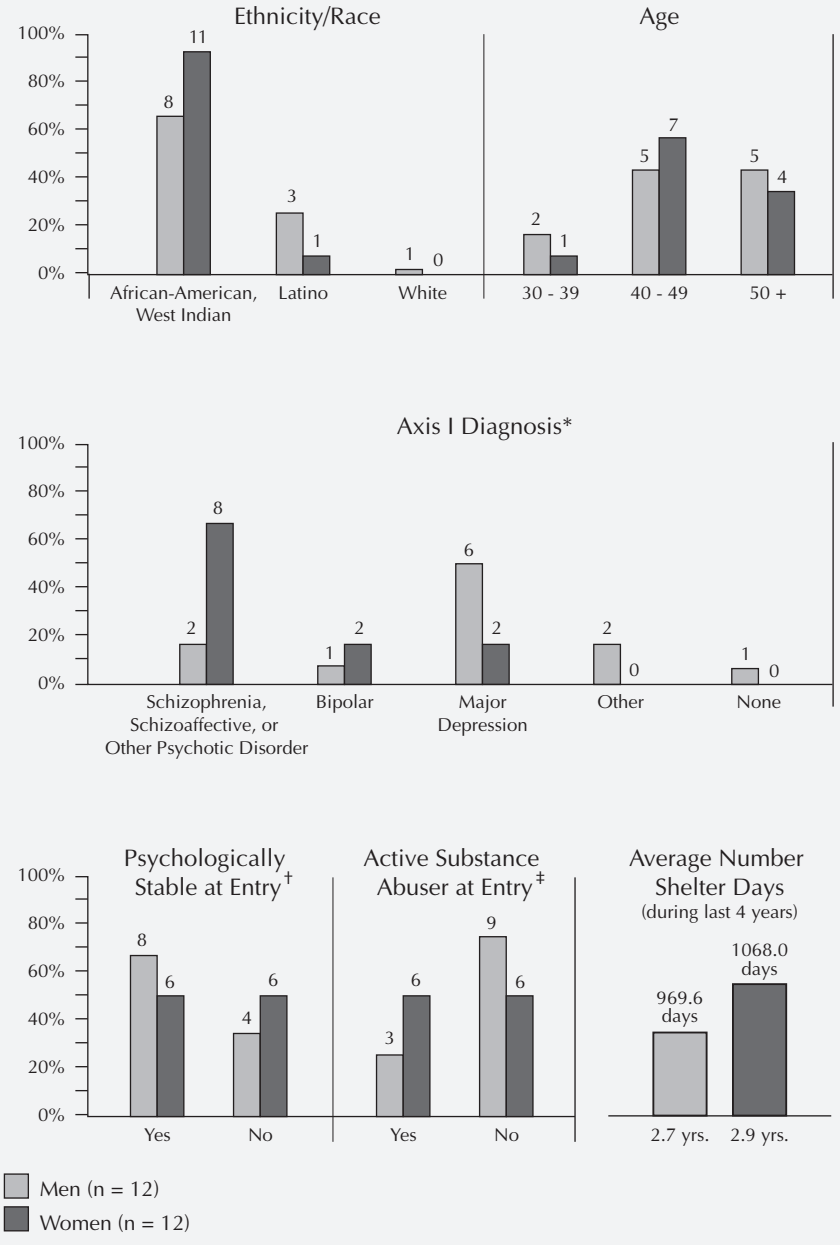
were assessed as psychiatrically unstable; half the women compared to one-quarter of the men were actively abusing substances; and 75% of women but only 42% of men relapsed to substance abuse while at the Kelly. Thus within a group characterized by multiple problems, the severity of psychiatric and substance abuse problems among the women who came to the Kelly after lengthy shelter stays was especially noteworthy and challenging.[13]

For both men and women, the time spent in shelters substantially exceeded the 730 day criterion. Men averaged 2.7 years (969.6 days) in shelters during the last four and 2.9 years (1068.0 days) in the last ten. Women had accumulated even more shelter time, averaging 2.9 years (1034.3 days) during the last four and 3.8 years (1375.7 days) over the past decade.

Table 2 compares characteristics of the TLC's long-term shelter group to 24 individuals who came to the Kelly via street outreach and the Drop-in Center. The latter group was almost two-thirds male, included a much larger proportion of Latinos (42%), and was somewhat younger (30% were under age 40) than the shelter cohort. While the psychiatric profiles of the drop-in group indicate severe mental disorders, they were more stable psychiatrically when admitted to the TLC and less likely to be abusing substances than either the men or the women in the shelter cohort; only a quarter abused substances while at the Kelly. Thus while both groups struggled with severe psychiatric and substance abuse problems, the drop-in clients overall had achieved greater stability at the point they entered the TLC; moreover, they tended to remain stable during their stay at the Kelly.

With the addition of the new program for long-term shelter residents, CUCS's West Harlem site not only had to serve a larger number of individuals than before; it also had recruited an initial cohort whose needs, concerns, and connection to the program differed from the drop-in clients. Initially, many staff viewed the change primarily as a process of extending services to a new and difficult group of clients; as the shelter residents were incorporated, however, the program itself was altered. The next sections describe the program development as it unfolded over the course of the first year.

Table 1: Selected Characteristics of Long-term Shelter Residents at the Kelly TLC

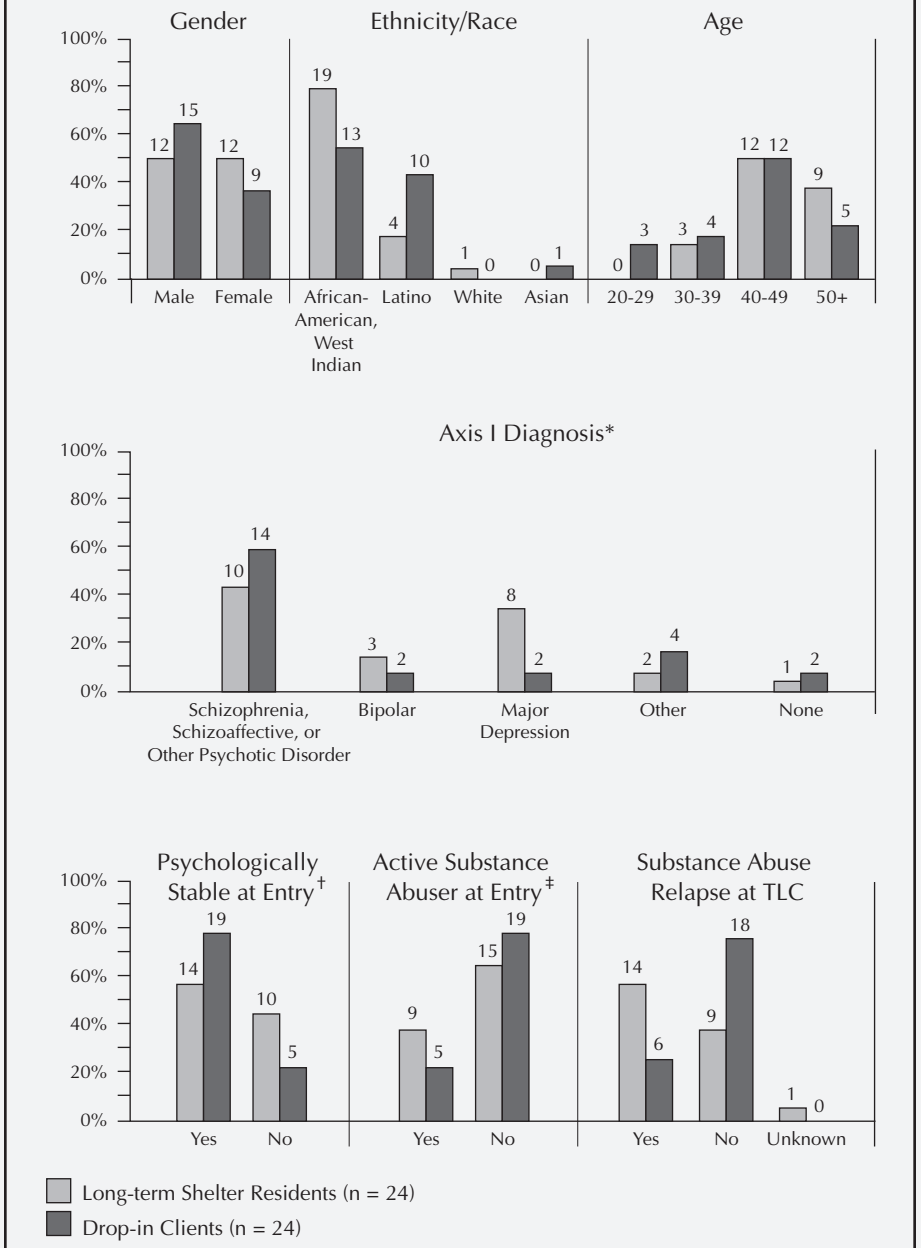


* Based on diagnosis made by CUCS psychiatrist at or soon after admission.

† Assessed by case manager or program director; mainly refers to absence of florid psychotic symptoms.

‡ Based on case manager's assessment. See Goldfinger et al. (1996) and Drake et al. (1996) on the validity of case manager reports of substance abuse in dually-diagnosed populations.

Table 2: Comparison of Shelter versus Drop-in Clients at Kelly TLC



* Based on diagnosis made by CUCS psychiatrist at or soon after admission.
† Assessed by case manager or program director; mainly refers to absence of florid psychotic s ymptoms.
‡ Based on assessment by case manager.

Integration of Long-term Shelter Residents into the Drop-in and TLC Program

Development of the program model, policies and procedures can be seen as occurring in three overlapping phases. In the first period, the emphasis was on "filling the beds," which involved adapting outreach strategies for the shelter context, as described above. The second phase, described in this section, focused on incorporating the long-term shelter residents into the drop-in program while modifying it to accommodate both the larger numbers of clients and the distinctive experiences of the street and shelter groups. A third phase, described in the subsequent section, focused on housing services and meeting the program's housing placement targets.

The Press of Numbers. Integrating the shelter residents into the program involved adjustments in operating policies and procedures at the Drop-in Center and TLC. Since many of the new shelter clients were not known to the program before moving to the Kelly, it was necessary to develop more formal admission procedures than had been used for admitting outreach/drop-in clients to the TLC. A Screening and Intake Committee, consisting of key supervisory and case management staff, was given responsibility for interviewing potential TLC residents and making decisions about admission. Day-to-day procedures at the Drop-in Center, where most of the program's service activity took place, were also restructured. Previously the drop-in space had been managed informally by case managers "keeping an eye on things" as they moved between the offices in the back and the activity area in front during the course of the day. With more people in the Drop-in Center, and the sometimes unscheduled arrival of individuals or groups to visit or tour the program, a more formal system was implemented, with staff assigned to "cover" the drop-in space throughout the day. A new sign-in procedure was also instituted.

With outreach workers spending significant portions of their time at the shelters just as the numbers and activity levels at the Drop-in Center were increasing, the program also had to reconcile a growing gap between level of services offered and resources available. The prior policy of attempting to identify and respond to the needs of all potentially eligible individuals who came to the Center was tightened up as the program began more rigorously enforcing the Drop-in Center's eligibility criteria (i.e., mental illness). "Walk ins" and people referred by other agencies who did not qualify for eligibility would be offered limited services and referrals elsewhere, and priority would be given to TLC residents and

drop-in center clients who were engaged in services. These changes de-emphasized work with unengaged drop-in clients in favor of engagement, case management and housing readiness work with those residing in the TLC. Thus, the Drop-in Center began to function less as an entryway into the program and more as the day program component of the TLC.

Integrating Two Populations. By design, the Kelly TLC program integrated the new target group of long-term shelter residents into an existing program of transitional housing and services for drop-in center clients recruited mainly through outreach in the neighborhood. Although no distinction was made between drop-in and shelter clients in service offerings at the Drop-in Center or in room assignments at the TLC, both staff and residents described the program as comprised of two groups. However, demographic differences were not large, although there were more women among the shelter clients, and more younger people and more Latino men in the drop-in group. Their homelessness histories differed in the amount of time spent in shelters in recent years, but many of the drop-in clients also spent fairly long amounts of time in shelters; and several of the shelter clients had sometimes stayed in the streets, parks or other public places.

When staff talked about the differences, they emphasized contrasts in the levels of engagement, the extent of active substance abuse among the shelter group, and mostly, the unprecedented service delivery issues they posed. Some of these differences were artifacts of program policies. Thus, drop-in center clients were only offered rooms in the TLC after engaging with the program and beginning to address issues of mental health, sobriety, and other problems. Shelter clients, in contrast, came in to the TLC with perhaps a vague commitment to address these issues but no demonstrated record of doing so[14]. Not only did that introduce more active substance use into the Kelly community; it also challenged existing strategies for defining program limits, leveraging cooperation, and working on goals. When the less engaged shelter clients were given greater latitude than their peers from the drop-in center program with respect to substance abuse, clients and some staff complained that a "double standard" was applied. However, this approach was in fact in keeping with a service philosophy that prescribes few demands during engagement but raises expectations as clients commit to working with the program. Staff reported that practices such as overnight suspensions also had different meanings and were applied somewhat differently to the two groups: For shelter residents, suspension offered a chance to visit friends in the shelter and perhaps slip into substance abuse; for street clients, suspension was a more powerful reminder of what they were risking by rule infractions.[15]

Substance abuse and the resulting clinical complexities were at the heart of many service delivery issues that emerged in the months after the beds for long-term shelter residents were filled. The Drop-in Center had served dually-diagnosed clients before the program for shelter residents began, but the new program, in a short space of time, brought a large number of individuals into the TLC who were actively using and abusing drugs and alcohol at the time of admission. Of particular concern to CUCS administrators and staff was the impact of this group of active substance abusers on the emergence of a "culture of recovery" at the TLC. Both the timing of the influx — before a change-focused program culture had had a chance to jell — and the number of individuals using drugs and alcohol threatened to undermine the sobriety of those struggling with abstinence. In addition, the resulting behavior management problems, evidenced by substance abuse incidents noted in the TLC log and frequent overnight suspensions from the TLC, engendered considerable frustration for many staff members, who for the most part had not had extensive training or experience with substance abuse and dual diagnosis.

The program responded to these challenges by enhancing clinical services and supervision. Two critical shifts involved increasing the on-site presence of the agency's Associate Director of Transitional Services to three and a half days a week; and expanding the role of psychiatrists. By recruiting two psychiatrists to replace one who departed, the program increased the availability of clinical services to clients.[16] But more important, one of the new psychiatrists took a significant role in staff training and program development, eventually becoming the agency's Medical Director. With turnover in two senior positions (TLC Supervisor, Outreach Specialist) other staff roles were redefined as well. Taken together, these changes have both augmented the clinical supervision provided to staff and increased the availability of clinical services for clients.

The impact of the long-term shelter residents on the program was first apparent in the program's concerns about managing behavior associated with active substance use and its impact on the TLC community. However, as the program began to focus on housing for the shelter clients, it had to address other implications: the limited housing options for people who had not achieved six months of abstinence or whose substance use history created particular placement issues[17]; a general disinclination by most TLC residents to consider placement in MICA programs; and — to compound these problems — a new unwillingness by the shelter system to accept back people who had been discharged for rule breaking.

Implementing "Housing Readiness" and Housing Placement Services

The Focus on Housing. Although housing placement had always been one of the program's major goals, the new program for long-term shelter residents sought to make housing a central focus that permeated all aspects of service practices. In developing services geared to housing readiness and housing placement, CUCS not only built on practices already in place at the West Harlem site but also drew on the extensive transitional housing expertise developed at the 350 Lafayette Street TLC.[18] While the evolution toward a placement-focused "housing readiness" program did not entail a sharp break with prior practice, the growing emphasis on housing was an important aspect of the TLC's development during its first year.[19]

To address housing readiness, several services were developed or enhanced, and new policies and procedures as well as some changes in program organization were put in place. A weekly housing group at the Drop-in Center, led by the Housing Specialist, was a major forum for the program to provide information and respond to residents' questions about types of supportive housing available, admission requirements for different categories of housing, as well as their amenities, services, rules, and costs. The Housing Specialist also organized and led group tours of various SRO and Community Residence (CR) programs, giving TLC residents a chance to see several supportive housing sites for themselves.

The program also focused on two other areas that were deemed central to housing readiness: substance abuse and psychiatric services. While abstinence and psychiatric stability were program goals in their own right, the link between working on these issues and expanding one's housing options was made in a variety of ways. The substance abuse specialist ran regular groups at the Drop-in Center that were based on a 12-step model and were attended by a large proportion of TLC residents. In addition, he met individually with those who had substance abuse problems. Abstinence was monitored by urine testing, and positive toxicology reports were followed up with counseling, suspensions, referrals for detoxification and, in some instances, rehabilitation.[20] Psychiatric services provided by the program psychiatrists involved assessments, medication, and individual sessions as well as groups focused on medication issues, coordinating treatment with outside psychiatric or medical providers, and writing psychiatric evaluations required for the New York/New York[21] housing application.

Case managers were responsible for much of the work on housing readiness. They assisted clients in such diverse activities as self care, applications for financial benefits, budgeting, handling interpersonal relationships, shopping, keeping medical appointments, and resolving legal issues. The case managers also counseled clients about their housing options and helped them develop and pursue a housing plan. To focus and support case managers' housing placement efforts, the program instituted a series of regular meetings during which staff assessed client progress toward housing and set objectives and timetables to structure the process.

Negotiating Housing Options. While CUCS thus put in place a number of organizational and service practices intended to provide staff with the tools to help clients obtain housing, their success depended on their ability to broker the gap — in some cases a chasm — between the expectations, capabilities, preferences and desires for particular types and qualities of housing that clients brought with them into the program and the real world costs, vacancy rates, and preferences and desires housing providers have for particular types of tenants or residents.

Some individuals in the long-term shelter group had devoted considerable effort to seeking housing prior to coming to the Kelly. A few had looked for apartments on their own, going to real estate agencies, filling out applications for public housing, or applying for Section 8 certificates. Others had caseworkers at the shelter or in other programs they attended who had submitted the paperwork to establish their eligibility for New York/New York housing and, in some instances, had applied to specific NY/NY programs. But most talked in a general way about planning to "get a Section 8" or waiting for the shelter "to find some place for me to go," without initiating action. The nearly universal hope was for "a one-bedroom kitchenette" that offered the prospect of privacy, cooking for oneself, and having control over decisions about what to watch on TV and who could enter the premises. Even those who had encountered the realities of New York's housing market in the course of looking for housing continued to express the desire for their own apartment.

When CUCS outreach workers went to the shelters to recruit long-term residents, they emphasized that the program would help with — in fact would guarantee — housing to anyone who was willing to work with the program. Skeptical shelter residents who asked about "Section 8"[22] apartments were told, "we can talk about that;" but outreach workers generally reassured those inquiring about independent housing that CUCS could help them. For the CUCS staff, this was usually the opening move in a complex negotiation process through which workers attempted

to use the interest in getting an apartment as a means of encouraging clients to address the issues that the program identified as major obstacles to housing — in particular, substance abuse problems and the need for psychiatric treatment — and to steer them toward supportive housing options.

CUCS staff assumed that few if any of the program's clients were candidates for fully independent housing; most would require some form of ongoing support in order to stay housed. However, supportive housing programs in New York City differ significantly in the degree of independence they offer. Ambiguity about whether "independent housing" referred to the relatively independent, supportive SRO and supported housing models, also called "Level 1,"[23] or ordinary unserviced apartments in the private rental market, facilitated CUCS's efforts to recruit people who said they wanted nothing to do with a program. The process of promoting "housing readiness" then entailed providing information on the high cost and low quality of "affordable" housing in the local rental market, while educating clients about admission criteria, costs, amenities, requirements, and services provided in the available Level 1 and Level 2 options. Staff hoped that with this additional knowledge, clients would be able to make more realistic housing choices.

The Housing Specialist used the weekly housing group to convey more specific information about the kind of housing CUCS could help TLC residents obtain. Sessions included discussions of the differences between Level 1 and Level 2 housing, and the advantages and disadvantages of each. TLC residents raised questions about application procedures, whether various aspects of their histories would disqualify them, whether particular sites required residents to participate in services, and whether particular programs had rules regarding curfews and overnight guests. Those who had attended recent housing tours reported back to those who had not gone, and with some input from the Housing Specialist, answered questions about sites they visited. When discussion of a particular type of program seemed to generate a negative consensus — which tended to happen with the more structured, restrictive housing programs — both clients and the group leader were likely to remind the group that some individuals would find such a site helpful. Those who denounced all programs and maintained that they would wait until their "Section 8 comes through" were sometimes told by other clients that supportive settings were more desirable than the kinds of independent settings they would be able to afford, even with a Section 8 certificate.

While several staff members had extensive knowledge of supportive housing options, there was less clarity, at least initially, about program

policy on Section 8 applications and how to handle requests for help obtaining Section 8 certificates. Scarcity of these subsidies made it unlikely clients would be able to obtain them. However staff discouraged efforts to pursue fully independent housing primarily because they felt that without supportive services on site, most TLC residents would have difficulty — as their histories suggest they did in the past — remaining abstinent, in treatment, and housed.

In April, 1998, when the effort to fill the beds had been successfully completed, the case management and supervisory staff began to hold bi-weekly "target placement" meetings, in which residents' progress toward housing was reviewed and next steps identified. On alternate weeks the meetings focused on "housing obstacles," and the group collectively brainstormed in an effort to resolve housing issues that had come up for individual clients. These approaches to housing placement had been developed at the 350 Lafayette TLC and were introduced to the West Harlem program in response to the larger numbers and thornier placement issues that came with the program's expansion.

Decisions about which housing types and programs to pursue were made by TLC residents and their case managers. In interviews the research team conducted with residents a few months after they moved in, over two-thirds (68%) indicated that they hoped to obtain their own apartment — variously described as "my own place," a "kitchenette," a "1-bedroom apartment," "a studio," or "a Section 8"; another 21% specified "an SRO" or "Level 1" housing, while 11% indicated they wanted more support — for example, "a place that has support and a focus on recovery." Profiles completed by the staff, in contrast, identified MICA residences (which are among the most structured and least independent of the supportive options) as the optimal placement for more than half (58%) of the TLC residents; 21% were assessed as needing intensive or moderate support (e.g. "a community residence," "Level 2" or a "CR/SRO"), while Level 1 supportive SROs were recommended for 21%. In the large majority of cases, there was a mismatch between workers' assessments and client preferences, with clients consistently saying they hoped to obtain a more independent living arrangement than their case manager felt was needed.

The residents identified a variety of obstacles to achieving the housing they desired: the need for documents (birth certificate; immigration documents); illnesses that precluded actively looking for housing or that limited their options; their own failings ("I'm not organized," "I'm a procrastinator," "I'm too emotional and need to develop coping skills,") but also their strengths ("I was rejected because they want people with

more mental illness than I have," or "I was told I'm too high functioning for Level 2 programs"); or the need to accept the label of mentally-ill to qualify for supportive housing.

The two most often-cited obstacles, however, were cost ("income," "financial," "the money," "the rent is too high,") and substance abuse ("I keep relapsing," "methadone," "staying sober," "clean urines,"). In identifying these two issues, many of the TLC residents were in agreement with the program staff, who used a variety of means (newspaper ads, visits) to convey the high cost of unsubsidized housing, while also alerting clients to the fact that most subsidized supportive housing programs would not consider applicants who did not have six months or more of continuous sobriety. Pointing out such discrepancies between individual goals and the likelihood of achieving them was part of the "reality testing" process workers employed to motivate clients to change behavior that stood in the way of housing. While behavior changes could do little to affect the high cost of unsubsidized housing, workers hoped to persuade clients to adjust their expectations and seek the more affordable supportive programs. Those willing to consider such programs could then, it was hoped, decide to address substance abuse and other problems that limited their supportive options.

Although residents participated in the housing group and were encouraged to attend housing tours early in their stay at the TLC, case managers did not usually initiate one-on-one discussion of specific options until a resident was considered close to "housing readiness." For people with substance abuse problems, this required a substantial period — usually six months — of abstinence, documented through "clean urines." Once that was achieved, however, it opened what might be considered a narrow window for successful application and acceptance by a housing program. If relapse were to occur, the counting of "clean time" would start over. When TLC residents and their case managers reached agreement on which options to pursue, applications were submitted to specific agencies — usually several. Interviews and visits followed, and those who did not present major placement issues (e.g. a history of violence or arson, or being on high-dose methadone maintenance) might be able to choose among programs where they gained acceptance. Others emerged from the application process with limited, if any, choices.

In creating a transitional program for long-term shelter residents, CUCS was confronted with three sets of tasks. The first involved developing an outreach strategy to draw potential clients from the shelters to the new TLC. This was successfully completed once a full house was achieved. The focus then shifted to integrating the shelter clients into the existing

service program while enhancing group activities and individual case management efforts to help residents achieve housing readiness. The third set of tasks revolved around placement — negotiating realistic housing options, submitting applications, and ultimately moving TLC residents into long-term or permanent housing. The outcomes of these placement efforts are described below.

IV. Program and Resident Outcomes

Program-level Housing Outcomes

The TLC model uses six to nine months as the time frame for housing placement. In its original program proposal, CUCS anticipated that 15 of the long-term shelter residents at the TLC would move on to permanent or long-term housing during the first year (CUCS, 1997:8). By February 1, 1999, when data collection for this evaluation ended, five long-term shelter residents had moved on to housing and thus this target had not been met; but over the next three months, seven more shelter residents[24] became housed, and one was accepted for placement and was about to move in. By mid-May, the program had completed 13 placements, thus approximating the original target, albeit within an expanded time frame.[25]

Individual-level Housing Outcomes for the Kelly's First Shelter Cohort[26]

Table 3 describes the placement status of the first group of Kelly residents. Five of the Kelly's first 24 long-term shelter residents (21%) had been officially declared successful placements by February 1, 1999, including three who moved into supportive housing after an average stay at the Kelly of 7.4 months, one who returned to family after 5.8 months, and one who moved to her own apartment after 3.0 months. The average length of time they spent in the TLC before placement was 6.6 months. By May, an additional five placements brought the proportion of the first cohort that were housed to 42%. This second group spent an average of 11.6 months in the TLC. Among the ten who were placed in total, seven had gone to supportive settings, two were placed with family, and one was on her own. On average, the ten clients who obtained housing did so in 9.1 months, a close approximation of the expected length of stay.

At the time of the February 1 follow-up, nine individuals (38% of the first cohort) had left the program without being placed in housing. They had resided there an average of 5.9 months. One of these nine was referred to a MICA TLC and remained there at follow-up. The other eight had either been discharged for repeated rule infractions (usually involving substance

abuse) or had chosen to leave the program — most often after reaching an impasse around the issue of pursuing MICA housing. These eight individuals had moved around and were in a variety of places at follow-up — shelters (four), MICA residence after being referred by a shelter (one), adult foster care (one), relatives (one), or unknown (one). Although almost all discharges or self-initiated departures involved substance abuse in some way, specific reasons and circumstances varied. By May 1, one more person had left the program and returned to a shelter, bringing the total who left without housing to ten (42%).

Ten (42%) of the original cohort were still living at the Kelly on February 1, 1999. They had been there for 10.4 months on average, and most were described by staff as progressing toward the goal of permanent housing. Workers classified seven as "engaged and going on housing interviews or preparing for the housing process"; two as "not housing ready but workable"; and one as "resistant, may require other options." By May 1, 1999, six of the ten were no longer at the TLC: One returned to a shelter after refusing placement in a MICA residence; one rejoined family out of state; and four were in supportive housing programs — one each in a supportive SRO and a CR/SRO, and two in MICA Community Residences. Four of the original group remained at the TLC, but one was scheduled to move in to a CR within a few days. The three others were actively working to address their remaining obstacles to housing (documentation of immigration status, substance abuse relapse, maintaining psychiatric stability).

We compared baseline descriptors of those successfully placed in housing with those remaining at the TLC and those who left or were discharged without obtaining housing. As ***Table 4*** shows, equal numbers of men and women became housed. They spanned various ages and ethnic backgrounds. Most had psychiatric diagnoses of major depression (only two were diagnosed as bipolar or psychotic) and most had not been abusing substances at the time of admission to the TLC. In contrast, those who left the program or were discharged without placement tended to be women, were in their forties, had the most severe psychiatric diagnoses, and had been actively abusing substances when admitted to the Kelly. Thus, the program successfully placed a diverse group of long-term shelter residents. Those who did not become housed constituted an identifiable subgroup that faced persistent barriers to permanent housing. Although the study sample is small, the distinctive profile of those whose stay at the Kelly did not lead to housing placement is notable and consistent with anecdotal reports by service providers and other observers have identified women with similar combinations of problems as a group that faces special difficulties in exiting from homelessness.

Follow-up interviews were conducted with 15 of the first group of long-term shelter stayers in January, 1999. Eight of these were still in the TLC, three were in the housing where they had been placed, and four were in other settings (three in shelters or other TLCs, one in a MICA residence she had been referred to by the shelter). When asked where they thought they would be living if they had not come to the TLC, seven (47%) referred to homeless situations (four thought they would be in shelters; two said the streets or other homeless situations, and one (7%) thought he'd be in jail or dead), three (20%) thought they would be in another program somewhere, three (20%) thought they would be in housing, and two (13%) had no idea. Interestingly, two remaining in the TLC thought they would have been housed by now, but one felt it would be in a place she didn't want to be, because the shelter she had come from "sends you to housing without your input"; and the other felt he would have an apartment but would have missed the chance the TLC gave him to "correct my mistakes."

Among those who were housed before or shortly after the interview, most expressed appreciation for what the program had done: "It got me out of a difficult shelter situation;" "The TLC served me well;" "I learned patience here; it will be hard to leave;" "I appreciate the place;" "The people here really helped me; They care." Specific aspects of their lives affected by the TLC included finances (several mentioned saving money while at the TLC; one related saving to abstinence from drugs; another valued his case manager's help with budgeting) and substance abuse services (one resident claimed exposure to active drug users motivated him to attend 12-step meetings daily; another felt referrals to detox and rehab had been helpful). Perspectives on the help they received with housing ranged from favorable comparisons to help provided by the shelters and gratitude for obtaining housing that exceeded their expectations to frustration with the limited options offered, the program's unwillingness to help with fully independent housing, and the slow pace of the housing process. Although most went to supportive housing with some on-site staff, several continued to hope for an independent "kitchenette" or one bedroom apartment without shared facilities and with no staff on site.

The individuals remaining at the Kelly also had diverse views on the program. They praised it for getting them out of the shelters, or for giving "a portion of my life back;" but expressed concerns about possibly having to return to a shelter or being sent to a MICA program if they were unable to get housing; and voiced impatience with the slow pace of the placement process and limited options offered. Obstacles to housing for these individuals included documentation of immigration status and sustaining sobriety.

Those who had left the TLC without obtaining housing also expressed varied views on the program. Some in MICA shelters or residences wished they were back at the Kelly. In contrast, those in general shelters felt they might now get the independent housing they had been unable to obtain through the TLC. All in this group had left or been discharged from the program because of issues in one way or another related to substance abuse. Except for one who was transferred to a specialized TLC for MICA clients, all left or were discharged after refusing rehab or MICA placements. All still hoped for independent apartments and shared negative views of MICA programs. Several felt CUCS had reneged on promises of independent housing. As one resident put it, "They sell you a dream, at the end they tell you you fail and send you to a MICA." Yet, despite expressions of feeling let down, almost everyone cited some positive aspects of their experience at the Kelly. One had found the "double trouble" group particularly helpful. Others said the TLC "was good and bad; I have some friends, I know myself better and they opened a door for me, let me correct my mistakes, stop drinking;" "It wasn't so bad…I was drinking, getting high, very upset. [Sending me to] detox helped;" or the Kelly was "a good experience, having privacy and having my check increased. I learned how to deal with my mental health, how to speak to people…People there are nice."

Despite residents' varied success in obtaining housing, some common themes also emerged from the interviews that transcended specific outcomes: an appreciation for the privacy the TLC offered, particularly when compared to shelter or MICA settings; the ongoing tension between the desire for "normal" unstaffed, independent apartments and the restricted options that limited incomes and struggles with substance abuse impose; and a general distaste for MICA housing, described by one resident as a place where you have "no money, no privacy, no passes, and they treat you like a child."

The data on individual outcomes and on residents' perceptions of their experiences show that the program ultimately approximated its placement targets within a slightly revised time frame. While the longer time needed for the long-term shelter residents to obtain housing may be related to the program's newness and the turbulence that typically characterizes programs during start-up, it is also likely that the placement obstacles faced by mentally-ill persons with years of homelessness and, often, substance abuse as well, necessitate a more flexible time frame for meeting placement goals. Moreover, the program began operating during a period when low vacancy rates in supportive housing throughout New York City[27] severely restricted housing options for all homeless people with mental illnesses. This has permitted providers to exercise considerable

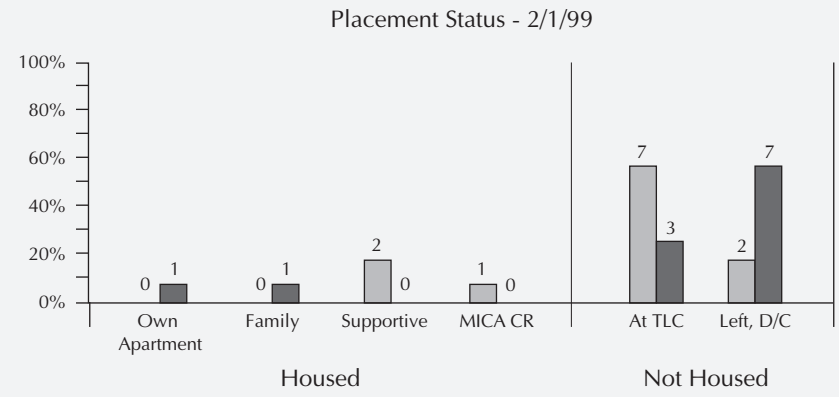
selectivity, further compounding the placement difficulties faced by the Kelly's residents.

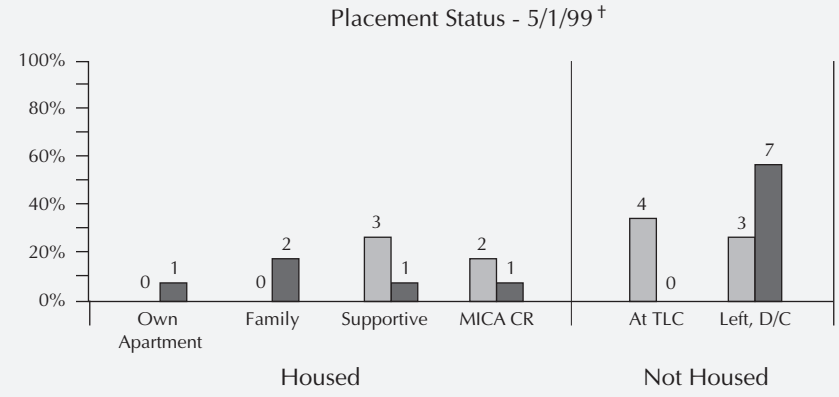
Among the ten individuals from the first cohort who had moved on to long-term housing by May, a large majority (70%) went to supportive settings. This group had overcome a variety of challenging housing issues — including not only combinations of mental illness and substance abuse, but also physical illnesses, methadone maintenance, and checkered histories of abstinence and relapse. For these individuals, the TLC interrupted the extended homelessness apparent in their residence histories: Collectively, they had spent 9503 days in shelters over the prior four years. It is beyond the scope of this study to determine the longevity of these housing placements, although longer term data on New York/ New York housing placements suggest fairly high retention rates over the three years after placement (Lipton et al., forthcoming).

Of the four residents remaining at the TLC, two were also close to placement. The fact that a group remained at the TLC more than a year after entering speaks to both the program's success in engaging them and the tenacity of the housing obstacles with which they have struggled.

Finally, the 42% of clients who left or were discharged without placement point to categories of shelter residents and types of housing obstacles that may require alternative approaches. It is notable that the issue leading to most of these clients' departures concerned CUCS's efforts to place them in a MICA program. Although from the program's perspective, repeated relapse precluded other alternatives, these individuals found that option unacceptable. While CUCS staff viewed rejections of MICA referrals as reflecting continued denial of substance abuse problems, evidence for the effectiveness of many MICA programs is limited. Longitudinal data on NY/NY outcomes (Lipton et al., forthcoming) suggest that substance abusers placed in MICA housing often do not remain housed as long as those going to non-MICA settings (although non-MICA programs rarely accept individuals with known substance abuse histories without the requisite clean and sober time). Other research questions whether the 12-step approaches used in many MICA settings are effective for persons with severe mental illnesses (Carey, 1996; Drake et al., 1996; Jerrell and Ridgely, 1995; Mueser, et al., 1997; Noordsy et al., 1996) or for women (Alexander, 1996; Zweben, 1996; Grella, 1996). In fact, the majority of those who left the TLC over issues of MICA placement were women with psychiatric diagnoses of severe disorders — those who may be least likely to be helped by the available programming. For these individuals, the absence of housing alternatives to traditional MICA residences may preclude their sustained exit from the shelters.

Table 3: Placement Status* of Kelly TLC's First Cohort of Long-term Shelter Residents





Men (n = 12)
Women (n = 12)

* "Placement status" refers to an individual's discharge status at the TLC. Follow-up information on location as of February 1, 1999, was also available for most individuals who left the TLC before that date and is described in the text of this report; further information on those individuals as of May 1, 1999, was generally not available.

† Based on an update from CUCS on status of residents who had still been in TLC on 2/1/99. Updates were not obtained on those who had left the TLC or been placed before February 1.

Table 4: Resident Characteristics and Housing Outcomes

	Discharged, Left w/o Placement (N=10)	Remained at TLC at Follow-up (N=4)	Placed in Housing (N=10)
Gender			
Male	3 (30%)	4 (100%)	5 (50%)
Female	7 (70%)	0	5 (50%)
Ethnicity/Race			
African-American, West Indian	10 (100%)	3 (75%)	6 (60%)
Latino	0	1 (25%)	3 (30%)
White	0	0	1 (19%)
Age			
30-39 years	1 (10%)	1 (25%)	1 (10%)
40-49 years	8 (80%)	0	4 (40%)
50-59 years	1 (10%)	3 (75%)	5 (50%)
Axis I Diagnosis*			
Schizophrenia, Schizoaffaffective, or Other Psychotic Disorder, Bipolar	9 (90%)	1 (25%)	2 (20%)
Major Depression	0	2 (50%)	6 (60%)
Other	0	1 (25%)	1 (10%)
None	1 (10%)	0	1 (10%)
Psychologically Stable† at Entry			
Yes	7 (70%)	2 (50%)	5 (50%)
No	3 (30%)	2 (50%)	5 (50%)
Active Substance Abuse‡ at Entry			
Yes	7 (70%)	1 (25%)	1 (10%)
No	3 (30%)	3 (75%)	9 (90%)
TOTALS	**10**	**4**	**10**

* Based on diagnosis made by CUCS psychiatrist at or soon after admission.
† Assessed by Case Manager or Program Director; mainly refers to absence of florid psychotic symptoms.
‡ Based on assessment by Case Manager.

V. Lessons Learned: Conclusions and Recommendations

In the year and a half after the Kelly Hotel TLC opened, CUCS succeeded in filling the 21 beds for long-term shelter residents, incorporating the shelter group into the ongoing program at the West Harlem site, and augmenting the components of the program designed to foster housing readiness. The program was also able to place a substantial proportion (42%) of its first cohort of residents in long-term housing situations, a majority of these in settings offering supportive services. During the same period, an equal number of the TLC's residents left or were discharged from the program without being placed. In documenting the development and implementation of the program, the evaluation has also sought to identify program practices and characteristics of residents that were associated with these contrasting outcomes; to present, where possible, resident and staff perspectives on the program and the housing options it offered; and to consider what general lessons the Kelly experience suggests about housing long-term shelter residents. While the study provides only an early snapshot of a program that remains a work-in-progress, it is hoped that the issues and findings documented will inform future policy and program discussion among those committed to developing alternatives to long-term residence in emergency homeless shelters.

Findings and Issues

The Transitional Living Community constitutes one of several possible models for housing long-term shelter residents. Unlike the major alternatives, the "freestanding" TLC model, which is lodged in neither a shelter nor in a housing program, must help clients accomplish two transitions: from the shelter into the program; and from the program into supportive housing. The first of these transitions is largely addressed during the outreach and referral process, when shelter residents are persuaded to leave a familiar setting for a program that promises to address their housing needs. Reports by both outreach workers and the long-term shelter residents they recruited indicate that this process was facilitated by the attractiveness of a new building and the low demand, low threshold admission policies, as well as a "push" from shelter staff,

who encouraged the referral or, in some instances, led potential clients to believe they had no alternative.

To accomplish the second transition, from the program into housing, the TLC approach entails an ongoing negotiation between residents and their case managers to establish congruence between the kind of housing an individual is willing to accept and the kind of housing that, in the case manager's assessment, the individual needs, as modified by constraints of income, availability, and admission criteria. The program uses educational and skill-building groups plus individual counseling to nudge preferences into closer alignment with assessed needs. Increases in expectations and demands on residents — to participate in services, achieve sobriety, comply with psychiatric treatment — are also used to enhance the possibilities for individuals to meet the relatively high threshold admission criteria of most supportive housing programs.

While the model as it was implemented conforms fairly closely to the version originally proposed, some modifications occurred during each phase of program development. During the period of start-up and recruitment, the realities of the shelter environment dictated a modification of the one-on-one outreach practiced in the street context, leading to a more prominent role of referrals by shelter staff and deferring the process of service engagement for some portion of the group recruited until after they had moved into the TLC. Thus motivational interviewing techniques did not play their anticipated role in the recruitment effort.[28] Moreover, with the pressure of a deadline for "filling the beds," what was intended as a flexibly low admission threshold was pushed even lower, so that some residents came to the TLC not only as active substance abusers, but without agreeing to work toward abstinence.

The inclusion in the program of people at different levels of housing readiness was specified as an intended part of the TLC model, but partly as a consequence of the lowered admission threshold, the first cohort from the shelters included a high proportion of people who had minimal engagement with the program as well as active substance abuse. Thus, the low demand admission strategy resulted in a first cohort that placed high demands on staff and the Kelly community as a whole. The effort to incorporate such individuals into the program over a short period of time[29] strained staff capacities and threatened to destabilize the emerging culture of recovery. In response, the program introduced a number of changes designed to provide staff with greater support and clinical supervision.

The population also presented a number of extremely difficult placement issues, due to the complexity of their situations and problems — e.g., in

addition to struggling with severe mental illness and substance abuse, several also had severe health problems, a number were on methadone maintenance, and one lacked immigration documents. In general, the process of placement proceeded as prescribed by the model, and over the course of the study period, a number of TLC residents were successful in moving on to supportive housing despite the limited options for residents with multiple problems or special placement issues.

One group emerges from the Kelly data as particularly complex in service needs: women in their 40s and 50s with severe psychiatric disabilities, active substance abuse over many years, often serious health problems as well, and strongly opposed to MICA housing. While some were persuaded to go to MICA residences, their success in such settings is by no means guaranteed. Moreover, a growing literature indicates that two groups of substance abusers — women and people who are mentally ill — often do poorly in services emphasizing traditional 12-step approaches which remain central to most MICA programs (Zweben, 1997; Grella, 1996; Drake et al., 1996; Mueser et al., 1996; Alexander, 1996). Even non-confrontational approaches to substance abuse based on "stages of change" theories (Prochaska, DiClemente and Norcross, 1992) or motivational interviewing (Miller and Rollnick, 1991) have been difficult to apply with people who have severe psychotic disorders.[30] While the TLC was able to place some of the women with this profile in MICA programs, generally these clients rejected MICA residences, leaving a return to the shelter as their only available option. Other providers have described similar experiences with dually-diagnosed women with long histories of homelessness. Although there is little research specifically focused on the housing needs of this group, several related studies (e.g., Alexander, 1996; Barrow et al., 1996; Watkins et al., 1999; Orwin et al., 1999) along with those cited above bolster the inference that permanent housing approaches tailored to their complex needs have yet to be developed.

Finally, it is important to emphasize that the Kelly program succeeded in moving a significant proportion of its first TLC cohort from the shelters into long-term housing despite the years of shelter time they had accrued. They did so, moreover, at a time when new resources for housing mentally-ill homeless adults had essentially disappeared and vacancies in the best of the existing programs are extremely low. While no placement benchmarks exist for the population targeted by the Kelly program, when measured against their own histories of long-term homelessness, extended shelter stays, and cycling between shelters, hospitals, and temporary or makeshift arrangements, the program's success in housing 42% is an accomplishment of no small magnitude.

Conclusions and Recommendations

Several implications about providing services to facilitate a transition for long-term residents of the city shelters to more appropriate, permanent housing follow from the results of this study.

Organizational and individual approaches to outreach

- Successful outreach in complex organizational environments like New York's municipal shelter system requires a combination of one-on-one and interorganizational approaches. Because there are multiple opportunities for agencies to work at cross-purposes, *active support from all levels of the shelter bureaucracy and the programs ongoing attention by the program to building interorganizational relationships are essential to ensure that the focus remains on identifying and recruiting clients who can benefit from the program.*
- The long-term shelter residents who came to the Kelly weighed a variety of factors in deciding to enter the transitional program: the site's attractions (clean, new, private) and detractions (neighborhood and Drop-in Center); the hurdles they would need to jump (clean and sober time, urine testing, medication compliance); cost — in terms of impact on disposable income; and whether the program would lead to independent housing. *A match between program offerings and the factors of most concern to the specific group(s) targeted for transitional services is critical for the success of outreach.*

Building community and a culture of change

- Fostering a culture consistent with a program's service goals — for change, recovery, stability, etc. — is an important part of program development. The effort to incorporate active substance abusers into the Kelly before a pro-recovery culture had become established there threatened to destabilize the program. *Flexible start-up time frames and cautious selection policies in the early stages of program development may be necessary to establish a program atmosphere that eventually can withstand some riskier recruitment choices.*

Program staffing and management

- Working with long-term shelter residents is a *resource-intensive undertaking that requires adequate numbers of clinically sophisticated staff and the organizational and supervisory support to sustain their effort.*

Focusing on permanent housing

- "Housing readiness" is a relative concept, contingent on local housing markets and the requirements of providers. However, *within the present context of supportive housing in NYC, most programs working with long-term shelter residents will need to address certain givens — health care issues; a significant required period of abstinence for substance abusers; psychiatric stability; and documented immigration status.*
- Long-term shelter residents with tough combinations of problems (severe mental illness and methadone maintenance; serious physical/medical problems plus dual diagnosis) have limited housing options that are reduced even further in the context of low vacancy rates. *Without an expansion of the total supply of supportive housing, this population will continue to face prolonged homelessness.*
- To provide permanent housing for a number of the Kelly residents who left the program without being placed — typically dually-diagnosed women in their forties who rejected the MICA option — as well as for others who are mismatched to available housing resources, *fresh approaches to providing permanent housing with support may be needed to end long-term homelessness among non-abstinent dually-diagnosed individuals.*[31]

Issues for further research

- Many of the women who were not successfully housed do not fit profiles developed to describe the long-term shelter population. They are mostly in their 40s and are severely mentally ill, but present many of the issues often described for younger, substance abusing women in the shelters. *To assess the impact on long-term shelter residents of the Kelly program or any of the other approaches currently being developed, we need more information than administrative databases provide about the population that is currently the focus of these efforts.*
- The Kelly program's success in housing many of those it recruited from the shelters provides an initial set of benchmarks where none existed. *Assessment of outcomes over a longer period of time is a critical next step.*
- In housing long-term shelter residents, one size does not fit all. As other models are developed, *it will be important to document whom they are serving, their service approaches and practices, as well as their outcomes in order to build a cumulative understanding of the most viable pathways out of homelessness.*

References

1 Other approaches are currently being developed through CSH's "Closer to Home" Initiative. These include: shelter-based services to engage long-term residents and identify and address factors that prevent moving on; transitional housing "co-located" with permanent supportive housing and other social services; and direct recruitment of long-stayers into permanent housing enriched with services specifically targeted to this group.

2 Several of the issues covered here were initially discussed in an interim report on the evaluation (Barrow & Soto, 1998). The interim report describes in greater detail outreach, screening, and intake procedures; the characteristics of those recruited through these procedures; and the organizational issues that emerged in the early phases of program implementation.

3 The criterion for mental illness is a DSM-IV Axis I psychiatric diagnosis of major mental illness. Those dually diagnosed with mental illness and substance abuse were also eligible for the Kelly program.

4 Baseline interviews were conducted with four additional long-term shelter residents who were not included in most of the analyses presented here because they entered the program too late to have adequate time for follow-up.

5 See Appendix for a timetable of program start-up activities and a description of the TLC and Drop-in Center.

6 Most of the outreach activities in the shelters were carried out by four staff members — the Outreach Specialist, the Senior Case Manager, the Peer Support Aide, and the Housing Specialist. The Program Director also participated in some of the presentations.

7 A total of 124 women who met the criteria for long-term shelter residence were identified during outreach visits to these shelters, and 51 of these were directly contacted by outreach workers. Fifteen women from these two shelters came to tour the Kelly, 12 were interviewed, and 11 were accepted and moved into the TLC. In addition, eight women from two other shelters toured the Kelly, four were interviewed, and one was accepted and moved in.

8 Data on the number of eligible men contacted during the initial period of shelter outreach were not available. However, 16 men came for tours, 16 were interviewed, and 12 were accepted and moved in.

9 Of those who did not become part of the Kelly' s program for long-term shelter residents, one was accepted but refused to move in; one walked out of the interview and was hospitalized shortly after; two were found not to qualify for the program; three were rejected for reasons such as violence or lack of access to benefits. One was deferred but subsequently admitted to the TLC; and two had unknown dispositions.

10 The 19 "general beds" at the Kelly were designated for homeless, mentally-ill individuals recruited through street outreach, community referrals, walk-ins to the Drop-in Center, or referrals from hospitals. How this group resembled and differed from the shelter cohort is discussed in subsequent sections of this report.

11 The profile of residents presented in the interim report was based on the first 22 individuals to enter the Kelly. The present report includes two additional individuals who had entered the program early enough for follow-up data to be available. As a result, the distributions reported here may differ slightly from those presented in the interim report.

12 When program staff assessed psychiatric stability, they usually referred to the presence or absence of florid psychotic symptoms. Thus, individuals might be judged psychiatrically stable but remain severely depressed, anxious, or otherwise symptomatic.

13 Since comparable data on diagnosis and clinical status do not exist for the larger pool of long-term shelter residents, it is unclear whether these gender differences are particular to the group that entered the Kelly or typify the long-term shelter populations more generally.

14 Although the program initially proposed that shelter residents would be admitted if they achieved two weeks of clean time, this was not implemented as a requirement during the period of recruitment, when the pressure to fill the beds was at odds with practices that might discourage potential residents from coming to the TLC. More often, shelter residents were told at admission that they would be referred for detox if they relapsed. However, this was not always feasible because of delays in obtaining the urine toxicology results and the inability to get some residents admitted to detox programs.

15 It was program policy to give residents who were suspended from the TLC a referral to a shelter during the period of the suspension.

16 In addition to using its own resources to contract for on-site psychiatric services, CUCS, like other programs serving homeless mentally-ill individuals, has drawn on the resources of the Project for Psychiatric Outreach to the Homeless (PPOH), which makes volunteer psychiatrists available to programs needing clinical expertise. One of the new psychiatrists recruited from Columbia University's Public Psychiatry Fellowship program during the study period was supported through PPOH as well.

17 Almost 20% of the shelter cohort were on methadone maintenance, and this group, even if they had years of abstinence from other drugs, faced particularly restricted housing options.

18 The "350" TLC has served as a general program model and a source of service strategies for housing placement. It has also been a direct source of staff and administrators experienced in developing and providing housing-focused services: the Director of "350,"also the agency's Associate Director of Transitional Services, is based at the Kelly several days a week; and two critical positions in the West Harlem program — the Drop-in Center Supervisor and the Housing Specialist — were initially filled with individuals who had previously worked at "350." In addition, the program has considered implementing the "team" structure used at the 350 Lafayette TLC, where different phases of the transition to housing are handled by different staff teams — i.e., clients initially work with outreach and case management staff, but as they approach housing readiness, the case management responsibility is transferred to a housing team, which carries out the placement process. However, this change had not been put in place at the point the research team concluded its observations of the program.

19 While the difference in emphasis on housing goals is not huge, it was apparent in interviews conducted with staff during the first months after the TLC opened: when asked about program goals, those who had worked at the drop-in program prior to the development of the Kelly TLC described a broad range of program goals that included but did not give privileged status to housing. In contrast, staff recruited from "350" or those newly hired when the Kelly was opening described the program as a housing readiness/housing placement program,

albeit one that addressed the multiple issues that affect clients' ability to obtain and sustain housing.

20 Residents who were referred to seven-day detoxification or 28-day rehabilitation programs were expected to return to the Kelly, and their rooms were held for them.

21 "New York/New York" refers to a 1990 agreement between New York City and New York State to provide housing for 5,225 homeless mentally-ill adults in a variety of supportive housing programs. Over 3,300 new housing units were created under the terms of the agreement; the remaining slots consisted of placements into existing supportive housing. To access NY/NY housing, an individual must be referred by an agency or hospital, which submits a packet consisting of the application form (the HRA 1995), a psychiatric diagnosis and assessment, medical clearance, and a psychosocial evaluation. The Office of Health and Mental Health Services in NYC's Human Resources Administration reviews all applications to determine whether eligibility criteria (homelessness, Axis I psychiatric diagnosis) have been met. Once approved as NY/NY eligible, an individual's worker at the referring agency can then send the packet plus any other required materials to individual housing programs.

22 Federal Section 8 subsidies provide one of the few ways poor New Yorkers, including those who depend on SSI benefits, can afford apartments in the private rental market.

23 Level 1 designates the SSI reimbursement rate for programs that do not provide 24-hour staffing and intensive services; Level 2 housing provides more intensive services and is reimbursed at a higher rate. Applications for all NY/NY and other supportive housing must be submitted by an agency or program, and the application packet includes medical and psychiatric assessments, as well as a psychosocial assessment. Eligibility, which depends on psychiatric review and documentation of homelessness, can be general or, for those deemed to need more support, restricted to Level 2. Thus for an individual to gain access to supportive housing, it is necessary that the referring agency assembles the packet in a way that conveys the appropriateness of a particular housing choice.

24 Two of these were individuals who entered the TLC in the Fall of 1998 and were not part of the "first cohort" whose progress was tracked in this study and reported on here.

25 During this same period, CUCS reports that it also placed 13 of the drop-in center clients who had entered the Kelly.

26 The discussion of individual-level outcomes is based on follow-up data on the first shelter cohort (the 24 individuals who entered the TLC by June of 1998). We draw primarily on data collected up to February 1, when the data collection phase of the evaluation project ended. Additional information on the placement status of TLC residents as of early May, 1999, is based on a brief update provided by the program directors.

27 The low vacancy rate reflects the dearth of new supportive housing caused by extensive delays in the negotiation of a second "New York/New York" agreement to develop supportive housing for mentally-ill homeless individuals.

28 The process of negotiating housing options, however, uses many techniques that resemble those of motivational interviewing.

29 While the same residents that proved difficult to accommodate in an emerging program might have had a less destabilizing impact on a more established community or in smaller numbers, it is notable that the next four long-term shelter residents admitted to the program appeared to replicate the initial pattern: All were women with severe psychiatric and substance abuse problems who arrived at the TLC actively using drugs and/or alcohol and with minimal commitment to address these issues. Two were subsequently placed in MICA Community Residences; the other two left or were discharged without placement.

30 Current efforts to adapt staged models of substance abuse treatment for people with severe psychotic disorders, using skills training approaches developed in psychosocial rehabilitation (Bellack and DiClemente, 1999), are still under development. (See also Carey et al., 1999.)

31 Possible models include "damp" housing approaches based on harm reduction principles (Wittman, 1993) or supported housing that de-couples access to housing from clinical or substance abuse compliance (Tsemberis, 1999). These approaches have never been specifically targeted to long-term shelter users.

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Kelly Hotel for Long-Term Shelter Residents

Appendix: Background and Start-Up

1. Program Start-up: Timeline of Critical Events

2. Program Building Blocks: Physical and Organizational Structures

1. Program Start-up: Timeline of Critical Events

1983: CUCS begins operating outreach services and Drop-in Center for mentally-ill people from brownstone on West 115th Street.

1994: CUCS relocates services to St. Mary's Episcopal Church in West Harlem.

2/96: CUCS receives HUD grant to enrich outreach and drop-in center services and to expand the program to include a 19-bed transitional residence for mentally-ill homeless people from the streets who have been residing in public spaces. The transitional residence is located in one 16-room wing of the Old Broadway Hotel, a commercial SRO hotel across West 126th Street from St. Mary's Church.

10/31/96: At DHS Shelter Directors' Meeting, DHS informs directors that City anticipates need for 1000 additional beds over the coming two years. CUCS raises the possibility of adding 21 beds to their 19-bed TLC located at the Old Broadway Hotel and receives encouragement to explore that possibility.

11/96: CUCS begins discussion with the Old Broadway Hotel landlord about the possibility of leasing another 16-room wing of the hotel. DHS Informs CUCS about the Kelly Hotel, a privately-owned SRO on West 127th Street that is in the process of being renovated. Raises possibility of the Kelly as a site for the proposed new beds.

12/9/96: CSH and DHS present the newly identified issue of "long term shelter users" to CUCS and ask CUCS to consider developing beds specifically for this group.

12/20/96: CSH, DHS and CUCS tour the Drop-in Center and the TLC at the Old Broadway and continue discussing the possibility of developing a transitional program for mentally-ill, long term shelter users. CUCS offers to develop a proposal describing the needs of the mentally-ill long-term shelter users and a program for addressing them.

12/96: CUCS concludes discussions with Old Broadway landlord who says that CUCS can have an additional 16 rooms, but that the rent will be 17% higher than the original 16 rooms, and that rooms will not be grouped in one wing of the building but spread throughout three wings. CUCS decides that this arrangement is not programmatically or fiscally feasible and chooses not to pursue.

1/2/97: CSH, DHS and CUCS meet to continue discussing the possibility of developing a transitional program specifically for the mentally-ill, long-term shelter users.

1/24/97: CUCS tours the Kelly Hotel.

1/31/97: CUCS completes Year One of HUD contract with 15 housing placements made from its 19 transitional beds, meeting its contracted housing placement goal.

2/13/97: CUCS tours the Kelly Hotel with an individual representing the building's owner.

3/20/97: CUCS tours the Kelly Hotel with Praxis Housing Initiatives, a nonprofit housing developer who has begun representing the building's owner. Joe Farrow, DHS's Deputy Commissioner for Facility Maintenance, accompanies CUCS on the tour to assess building's feasibility as a transitional residence. Praxis proposes operating the entire building and subleasing the western half to CUCS for new 21-bed transitional program. CUCS begins evaluating the building's suitability for such a program.

4/97: CUCS delivers proposal to CSH.

4/97: After a number of meetings with Praxis, CUCS decides that subleasing half the building from Praxis is not financially viable. CUCS decides to attempt to lease the entire building directly from the building's owner and locate all 40 transitional beds there.

5/6/97: CUCS holds first meeting with building's owner.

6/97, 7/97, 8/97: CUCS carries on negotiations with the building's owner and continues program development meetings with DHS and CSH.

8/4/97: CUCS applies for second HUD grant to replace CSH funding at end of one-year demonstration grant.

8/29/97: CUCS signs agreement with CSH for one-year demonstration grant to fund the 21 beds for long-term shelter stayers and the associated services.

9/12/97: CUCS signs lease for the Kelly Hotel.

10/97: CUCS begins hiring new supervisory staff member to assist with program development.

10/29/97: CUCS, DHS and CSH host breakfast to introduce program to shelter directors and the New York City Department of Mental Health.

11/97: CUCS begins hiring and training new direct care program staff.

11/4/97: CUCS outreach into the shelters begins. CUCS makes first outreach presentation at Brooklyn Women's Shelter.

12/3/97: Renovations are substantially completed and 19 residents of the Old Broadway TLC beds are moved to the Kelly.

12/11/97: CUCS conducts first screening interview for long-term shelter users.

1/12/98: First long-term shelter user moves into the Kelly.

1/13/98: First group tour of the Kelly by long-term shelter users.

1/31/98: CUCS completes Year Two of its HUD contract with 22 housing placements made from its original 19 transitional beds, a 47% increase over the previous year and 10% above its contracted housing placement goal.

3/23/98: HUD awards CUCS a second contract for the continued funding of the 21 beds for the long-term shelter stayers and the associated services.

4/2/98: CUCS admits the 21st long-term shelter user to the Kelly, filling all of its long-term shelter user beds.

6/9/98: First long-term shelter user moves into housing.

7/2/98: CUCS submits preapplication for renewal of first HUD grant to DHS.

2. Program Building Blocks: Physical and Organizational Structures

The opening of the Kelly and the recruitment of new residents from the long-stay population of the City shelters constitutes a further expansion and development of a program that began in 1983 as a drop-in program for clients contacted through outreach and neighborhood referrals when CUCS was located in the Columbia University area. The move of the Drop-in Center to the West 126th Street site in 1994 and the subsequent leasing of a wing of the Old Broadway SRO across the street for use as a TLC laid the groundwork for the current program, which was designed to integrate program components (outreach, drop-in and TLC), staff functions (housing and case management), and populations (street and shelter). This description presents the Drop-in Center, the TLC, and organization of staff and services across the program components as they evolved over six months (December, 1997 through May, 1998) after the opening of the new building.

The Drop-in Center

The CUCS drop-in center is located in the basement of St. Mary's Episcopal Church on West 126th Street in Manhattan. The narrow street runs parallel to 125th Street, one of Harlem's major cross-town commercial strips and thoroughfares. To the north lie the Manhattanville Houses, a set of high-rise housing projects that covers an area equivalent to eight square city blocks. St. Mary's shares its side of 126th Street with the "Sheltering Arms" Park (which contains handball courts, a playground, and pool), and a NYC Department of Health Center. On the other side of West 126th Street are the NY Police Department's 26th Precinct Station House, a supportive residence and day/health care program operated by St. Mary's Episcopal Center for people with HIV illness, the Old Broadway SRO, and several small commercial establishments (grocery stores, a beauty salon, dry cleaner and shoe repair shop). The main entrance to the church is through

a garden patio set off from the street by wrought iron fencing with open gates that make the area accessible to community members — including drop-in center clients. The Drop-in Center, however, is entered directly from 126th Street. A side door to the church opens on a stairway leading down to the church basement, where the Drop-in Center is located.

Program services are directed at helping clients obtain permanent housing. The drop-in center program provides clients with concrete services (meals, showers, use of a telephone, tokens, escort to appointments, laundry facilities and assistance), clinical services (psychiatric services and medication management, substance abuse groups, counseling), and a range of case management and supportive services, including budgeting and money management, housing services (a weekly housing group, tours of supportive housing programs, applications and referrals), a Transitional Employment Program (TEP), and referrals to outside agencies for services not provided by the program. Additional recreational activities include barbecues, movie rentals, parties for TLC graduates, holiday celebrations, and outings.

The Center contains a large, undivided space at the front. It is furnished with two to three dozen chairs, a television set, and several round tables. To the rear of this large room is a hallway with male and female bathrooms (including showers) on the left, and the kitchen on the right. The hallway connects to a second major room, which provides office space for the staff. It contains file cabinets, staff desks, an oval-shaped meeting table, and a partitioned space in the rear where the drop-in center supervisor or program psychiatrist can meet privately with clients. The open office space is shared by eight staff members (case managers, outreach specialist, etc.) who are based at the Drop-in Center; the program director, TLC supervisor, housing specialist, substance abuse specialist and case manager with offices at the Kelly also make use of the general office in the Drop-in Center during part of the day, when most clients are expected to be at the drop-in program if not attending other programs or activities.

The Drop-in Center opens its doors to clients from 9:30 A.M. to 3:00 P.M. Monday through Friday. At 9:30 breakfast is served. There are daily group activities — with more clinically-focused groups (“Ask the Doctor”, housing group, rap group, addictions group, mental health group, community meeting) usually scheduled for the mornings and recreational groups (music, art, movies, games) in the afternoon. For additional recreation, the Drop-in Center has a color TV, a Ping-Pong table, and provides cards and table games for clients who wish to play. Two days a week the program psychiatrist is on site at the Drop-in Center, where he sees clients individually from 9:00 A.M. to 3:00 P.M. From noon to 1:00 P.M.,

the focus shifts to preparing and serving a hot lunch to those present. During the afternoons, most clients participate in groups or watch TV; a few (one to three) are involved in cleaning the Drop-in Center as part of the Transitional Employment Program. Drop-in clients who reside at the Kelly usually return to the TLC at 3:00 P.M., when the Drop-in Center closes. While staff generally remain at the Center to do paper work and participate in scheduled meetings, workers also use this time for outreach in the shelters.

The TLC

The Kelly Hotel is composed of two newly-renovated adjoining buildings on 127th Street, just east of St. Nicholas Avenue. Although the block includes several rundown or abandoned properties, the renovations at the Kelly have been followed by the upgrading of other neighboring buildings. As part of a designated "Empowerment Zone," the area is expected to undergo further development of housing and commercial space in the coming years. Though further from the Drop-in Center than the Old Broadway had been (it takes about ten minutes to walk the three long blocks from the Kelly to the Drop-in Center), transportation to other parts of the city is more readily accessible with an entrance to the subway station at the corner of 127th and St. Nicholas.

The Kelly's two buildings are four-story walk-ups that have been joined to form a single structure. The main entrance/exit is in the east building. It is monitored by the receptionist at the front desk, which is attended on a 24-hour basis. Clients do not have front door keys and must be buzzed in by the front desk attendant. They are required to sign in or out every time they enter and exit. Security is further enhanced by four cameras with TV monitors that CUCS has installed to watch the front sidewalk, front door, the patio, and the roof (where lights have also been installed).

On the TLC's ground floor, there are four offices near the front of the building for the Program Director, the TLC Supervisor, the Housing Specialist and Case Managers. In the back are two air-conditioned TV lounges. The larger of these is divided from the dining room/kitchen area by a glass sliding door. This lounge also has a back door that opens onto a pleasant patio furnished with comfortable chairs, tables and a barbecue. There are also two bathrooms for residents and two for staff on the first floor; and most rooms on the floor are air conditioned. The second floor of the TLC houses the laundry room and two additional offices, one used by the Substance Abuse Specialist; the other sometimes occupied by one of the program's consulting psychiatrists. Otherwise, the second, third and

fourth floors are mainly taken up with rooms for residents. Seven of the rooms have their own bathrooms. In addition, each of the three upper floors has two full bathrooms and two or three additional rooms with tub and/or shower and/or toilet facilities. The third and fourth floors also each have a small smoking room.

The TLC's 40 residents occupy 25 rooms. Three triple rooms house nine residents; nine double rooms house 18 residents; and 13 residents have single rooms. Rooms are equipped with beds, dressers, closets or hanging shelves, lamps and ceiling fans. Bed linens and towels are also provided. Shared rooms are occupied by same-gender roommates, and floors are divided by gender, but shelter clients and those in the general population share common spaces and in some cases are roommates. Bathrooms are not assigned, but residents are expected to use the one nearest their rooms. Each resident has a mailbox on the ground floor, and all have access to a private phone line until 10:00 P.M. each night, when it is disconnected. There is a laundry room equipped with two new washers and dryers that is open from 3:00 to 10:00 P.M. on weekdays and has a varied weekend schedule. Residents do not have lockers but can use the basement for storage. Coffee, tea, juice, and a water cooler are always accessible, although residents do not have open access to the kitchen. Coffee is prepared every morning, as well, but residents are expected to go to the Drop-in Center for breakfast and lunch. Dinner is delivered daily by an outside vendor and is heated by staff and served between 5:00 and 6:00 P.M. Several evenings each week there are activities at the TLC, including a community meeting, Bingo night and Monopoly night each week. Sometimes tickets to community activities are distributed to clients.

Staffing the Program

Although the staffing of the drop-in and TLC components of the program are closely coordinated, each component requires some distinct staff functions. The program as a whole is headed by a Program Director, whose office is at the TLC but who usually spends major daytime hours at the Drop-in Center. The Program Director supervises two of the specialists (Substance Abuse and Outreach) as well as the Drop-in Center Supervisor and the TLC-Supervisor, who each in turn have supervisory responsibilities over the case management and specialist staff.

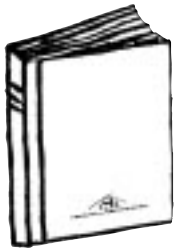
Drop-in Center Staffing. Regular Drop-in Center staff work from 9:00 A.M. to 5:00 P.M. In addition to the Drop-in Center Supervisor, staff based at the Drop-in Center include four Case Managers, the Outreach Specialist, a Peer Counselor, Administrative Assistant, and a Program

Psychiatrist, retained on a consulting basis. Four of the staff members are bilingual in Spanish and English. An additional psychiatrist was added during the spring of 1998 to augment the psychiatric services. Consultants are hired to provide weekly music and art groups as well.

TLC Staffing. The staff based at the TLC consist of the Program Supervisor, TLC Supervisor, Substance Abuse Specialist, Housing Specialist, and one full-time Case Manager. In addition, 24-hour, 7-day a week coverage is provided by eight Front Desk Attendants, supervised by the Housing Specialist, and eight *per diem* Case Managers supervised by the TLC Supervisor.

At a minimum, one Front Desk Attendant and one Case Manager are on site at the Kelly at all times. Staff are assigned to three major shifts: (1) From 9:00 A.M. to 5:00 P.M., the Program Supervisor, TLC Supervisor, Housing Specialist, Substance Abuse Specialist, and one Case Manager are based on site at the TLC (although they are likely to spend a significant portion of their time at the Drop-in Center). One Front Desk attendant is also assigned to a 7:00 A.M. to 3:00 P.M. day shift. (2) The second shift , from 3:00 to 11:00 P.M., is covered by one Front Desk attendant and two Case Managers. The Case Managers during this period are responsible for groups and recreational activities, as well as for responding to clients' needs, counseling, and "keeping the house safe." (3) The third (overnight) shift runs from 11:00 P.M. to 7:00 A.M., and is covered by one Front Desk attendant and one Case Manager.

The supervisory staff all have master's degrees and several years of experience working with mentally-ill homeless adults, and Specialists have bachelor's degrees plus additional relevant experience. Some of the Case Managers have bachelor's degrees, others have some college credits, while the Front Desk Attendants have varied educational backgrounds.



CSH Publications:

In advancing our mission, the Corporation for Supportive Housing publishes reports, studies and manuals aimed at helping nonprofits and government develop new and better ways to meet the health, housing and employment needs of those at the fringes of society.

Under One Roof: Lessons Learned from Co-locating Overnight, Transitional and Permanent Housing at Deborah's Place II *Commissioned by CSH, Written by Tony Proscio. 1998; 19 pages.* **Price: $5**
This case study examines Deborah's Place II in Chicago which combines three levels of care and service at one site with the aim of allowing homeless single women with mental illness and other disabilities to move towards the greatest independence possible, without losing the support they need to remain stable.

Work in Progress…An Interim Report from the *Next Step: Jobs* Initiative *1997; 54 pages.* **Price: $5**
This report provides interim findings from CSH's ***Next Step: Jobs*** initiative, a three-city Rockefeller Foundation-funded demonstration program aimed at increasing tenant employment in supportive housing. It reflects insights offered by tenants and staff from 20 organizations based in Chicago, New York City, and the San Francisco Bay Area who participated in a mid-program conference in October, 1996.

Work in Progress 2: An Interim Report on *Next Step: Jobs* *Commissioned by CSH, Written by Tony Proscio. 1998; 22 pages.* **Price: $5**
Work in Progress 2 describes the early progress of the ***Next Step: Jobs*** initiative in helping supportive housing providers "vocationalize" their residences—that is, to make working and the opportunity to work part of the daily routine and normal expectation of many, even most, residents.

A Time to Build Up *Commissioned by CSH , Written by Kitty Barnes. 1998; 44 pages.* **Price: $5**
A Time to Build Up is a narrative account of the lessons learned from the first two years of the three-year CSH New York Capacity Building Program. Developed as a demonstration project, the Program's immediate aim is to help participating agencies build their organizational infrastructure so that they are better able to plan, develop, and maintain housing with services for people with special needs.

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing *Written by Sue Reynolds in collaboration with Lisa Hamburger of CSH. 1997; 146 pages.* **Price: $15**
Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults *Commissioned by CSH, Written by Susan M. Barrow, Ph.D. and Gloria Soto of the New York State Psychiatric Institute. 1996; 103 pages.* **Price: $15**
This evaluation examines low-demand interim housing programs, which were developed by nonprofits concerned about how to help homeless people living on the streets who are not yet ready to live in permanent housing. Funded by the Conrad N. Hilton Foundation, this report is a 15-month study of six New York interim housing programs.

In Our Back Yard *Commissioned by CSH, Directed and produced by Lucas Platt. 1996; 18 minutes.* **Price: $10, nonprofits/ $15, all others.**
This educational video is aimed at helping nonprofit sponsors explain supportive housing to members of the community, government representatives, funders and the media. It features projects and tenants in New York, Chicago and San Francisco and interviews a broad spectrum of supporters, including police, neighbors, merchants, politicians, tenants, and nonprofit providers.

Design Manual for Service Enriched Single Room Occupancy Residences *Produced by Gran Sultan Associates in collaboration with CSH. 1994; 66 pages.* **Price: $20**
This manual was developed by the architectural firm Gran Sultan Associates in collaboration with CSH and the New York State Office of Mental Health to illustrate an adaptable prototype for Single Room Occupancy residences for people with chronic mental illnesses. Included are eight prototype building designs, a layout for a central kitchen, recommendations on materials, finishes and building systems, and other information of interest to supportive housing providers, architects and funding agencies.

Next Door: A Concept Paper for Place-Based Employment Initiatives *Written by Julianne Dressner, Wendy Fleischer and Kay E. Sherwood. 1998; 61 pages.* **Price: $5**
This report explores the applicability of place-based employment strategies tested in supportive housing to other buildings and neighborhoods in need of enhanced employment opportunities for local residents. Funded by the Rockefeller Foundation, the report explores transferring the lessons learned from a three-year supportive housing employment program to the neighborhoods "next door."

Understanding Supportive Housing *1997; 58 pages.* **Price: $5**
This booklet is a compilation of basic resource documents on supportive housing, including a chart which outlines the development process; a description of capital and operating financial considerations; tips on support service planning; program summaries of federal funding sources; and a resource guide on other publications related to supportive housing.

The *Next Step: Jobs* Initiative Cost-Effectiveness Analysis *Written by David A. Long with Heather Doyle and Jean M. Amendolia. 1999; 62 pages.* **Price: $5**
The report constitutes early findings from a cost-effectiveness evaluation by Abt Associates of the ***Next Step: Jobs*** initiative, which provided targeted services aimed at increasing supportive housing tenants' employment opportunities.

Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services *Commissioned by CSH, Written by Basil Whiting. 1994; 73 pages.* **Price: $5**
Funded by the Rockefeller Foundation, this report explores the advisability of implementing a national employment demonstration program for the tenants of supportive housing. The paper is based on a series of interviews with organizations engaged in housing, social service, and employment projects in New York City, the San Francisco Bay Area, Washington, D.C., Chicago, and Minneapolis/ St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

Connecticut Supportive Housing Demonstration Program — Program Evaluation Report *Commissioned by CSH, Prepared by Arthur Andersen LLP, University of Pennsylvania Health System, Department of Psychiatry, Center for Mental Health Policy and Services Research, Kay E. Sherwood, TWR Consulting. 1999; Executive Summary, 32 pages. Complete Report, 208 pages.*
Executive Summary Price: $5 Complete Report Price: $15
This report evaluates the Statewide Connecticut Demonstration Program which created nearly 300 units of supportive housing in nine developments across the state in terms of tenant satisfaction, community impact — both economic and aesthetic, property values, and use of services once tenants were stably housed.

Miracle on 43rd Street *August 3, 1997 and December 26, 1999.*
60 Minutes feature on supportive housing as embodied in the Times Square and the Prince George in New York City. **To purchase VHS copies, call 1-800-848-3256; for transcripts, call 1-800-777-8398.**

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - California Edition
Commissioned by CSH. Prepared by the Law Offices of Goldfarb and Lipman. 2000; 217 pages.
Price: $15 or download for FREE at www.csh.org
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Landlord, Service Provider…and Employer: Hiring and Promoting Tenants at Lakefront SRO *Written by Tony Proscio and Ted Houghton. 2000; 59 pages.*
Price: $5 or download for FREE at www.csh.org
This essay provides a close look at Lakefront SRO's program of in-house tenant employment, as a guide for other supportive housing programs that either hire their own tenants or might want to do so. The lessons of **Landlord, Service Provider...and Employer** are also of potential interest to affordable housing programs whose tenants could become valuable employees given sufficient encouragement, training, and clear policies.

The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the *Next Step: Jobs* Initiative
Written by Wendy Fleischer and Kay E. Sherwood. 2000; 73 pages.
Price: $5 or download for FREE at www.csh.org
The ***Next Step: Jobs*** initiative tested the premise that a range of employment services targeted to supportive housing tenants can help them access employment. It used supportive housing as the focal point for deploying a range of services to address the multiple barriers to employment that tenants face. It also capitalizes on the residential stability and sense of community that supportive housing offers.

Vocationalizing the Home Front: Promising Practices in Place-Based Employment *Written by Paul Parkhill. 2000; 79 pages.* **Price: $5 or download for FREE at www.csh.org**
Accessibility; inclusiveness; flexibility; coordinated, integrated approach to services; high quality, long-term employment; and linkages to private and public sectors are hallmarks of a new place-based strategy to help people with multiple barriers to work, find and keep employment. The 21 place-based employment programs featured in this report represent some of the most comprehensive and innovative approaches to employing persons who are homeless, former and current substance abusers, individuals with HIV/AIDS, those with physical and psychiatric disabilities and other challenges.

Supportive Housing and Its Impact on the Public Health Crisis of Homelessness *Written by Tony Proscio. 2000; 40 pages.*
Price: $5 or download for FREE at www.csh.org
This publication announces the results of research done between 1996 and 2000 on more than 250 people who have lived at the Canon Kip Community House and the Lyric Hotel. It also looks at pre-occupancy and post-occupancy use of emergency rooms and inpatient care.

Forming an Effective Supportive Housing Consortia; Providing Services in Supportive Housing; and Developing and Managing Supportive Housing *Written by Tony Proscio. 2000; 136 pages.* **Price: $5 each or download for FREE at www.csh.org**.
These three manuals are designed to assist local communities and service and housing organizations to better understand the local planning consortium, service delivery and funding, and supportive housing development and financing.

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir. 2000; 276 pages.* **Price: $5 or download for FREE at www.csh.org**
This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving Health, Housing and Integrated Services tenants where they live.

Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel *Written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez. 2000; 65 pages.*
Price: $5 or download for FREE at www.csh.org
Evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engage them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community, developed by the Center for Urban Community Services with first year funding from the Corporation for Supportive Housing, is one pioneering effort to help mentally-ill long-term shelter residents obtain housing.

COMING SOON:

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - National Edition
Commissioned by CSH. Prepared by the Law Offices of Goldfarb and Lipman.
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Guide to Developing Family Supportive Housing *Written by Ellen Hart Shegos.*
This manual is designed for service providers and housing developers who want to tackle the challenge of developing permanent supportive housing for chronically homeless families. The manual will provide information on the development process from project conception through construction and rent-up. It also discusses alternatives to new construction such as leased housing. It contains practical tools to guide decision making about housing models, picking partners, and service strategies.

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Mission Statement…

CSH supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance use, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy, and dignity, and reach for their full potential.

We work through collaborations with private, nonprofit and government partners, and strive to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.

Susan M. Barrow, Ph.D. is an anthropologist who works as a Research Scientist in the Epidemiology of Mental Disorders Research Department at the New York State Psychiatric Institute. Over the last twenty years, she has carried out research on homelessness in shelters and on the streets and has conducted several studies of innovative approaches to housing and services for men and women who are homeless. Her recent work has included studies of mortality and homelessness, housing alternatives for homeless people with severe mental illness, and interim housing for homeless clients of outreach and drop-in center programs.

Gloria M. Soto Rodruíguez is a Ph.D. Candidate in Social Psychology. For the last five years, her work has focused on evaluations of community-based programs, including several studies with Dr. Barrow evaluating housing and services for homeless single adults.