FINAL REPORT
ON THE EVALUATION OF
THE CLOSER TO HOME INITIATIVE

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When we first discussed this study with CSH, most of the programs in the evaluation were ideas that had not yet been implemented, partially empty buildings not yet master leased, or job descriptions waiting for an incumbent. In the five years since then, we have had the privilege of witnessing the emergence and maturing of the programs in this study. In the process, many people helped us get our bearings, guided our tours of programs and agencies, met with us to explain the history and philosophy of the work being done, joined in focus group discussions about how things work, or spent numerous hours helping us fill out data forms and document in detail the mundane and heroic work that keeps programs functioning and flourishing. Some have moved on to new or different challenges within the agencies or elsewhere; others continue as repositories of program lore and historical memory; and yet others have newly joined these works in progress, bringing fresh perspectives and energy. All have contributed to helping us become much wiser about programs and housing that can support and provide homes for people struggling to hold on to familiar shelter or lodging house routines or whose pathways through emergency shelter and care systems have lacked exit ramps.

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at the programs, and hopes for the future. We present this report in the hope that it will contribute in some way to realizing the hopes of all who face similar struggles with homelessness, all who are still waiting to come home.

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New York City,
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Executive Summary

Introduction

This is the final report on the evaluation of the Closer to Home Initiative, a program developed by the Corporation for Supportive Housing and the Conrad N. Hilton Foundation to foster new approaches to helping homeless people with multiple problems and disabilities. The research focuses on six programs that aim to engage and house people whose combinations of disabilities, long histories of homelessness, and repeated use of emergency services have marked them as "difficult to serve." The study was designed to describe the program models, document their implementation and development over time, and assess outcomes achieved by an initial cohort of individuals. We report here the findings and conclusions of this research.

PART I The Programs and the People They House and Serve

The programs in the evaluation represent diverse ways of intervening in long-term homelessness. A major contrast underlies this diversity. Three programs, based in shelters or lodging houses, worked to engage and house those who had become near-permanent residents of these sites: **Deborah's Place** (DP) focused on long-term residents of its overnight shelter in Chicago; **Project Homeward** (not supported by CTHI but using a complementary approach for a similar population) worked with long-term residents at a women's shelter operated by Lenox Hill Neighborhood Association in New York; and the **Bowery Residents' Committee** (BRC) offered housing placement to lodgers living in cubicles at the Palace Hotel in New York.

The other three programs provided housing to homeless adults referred from varied service settings: **West Side Federation for Senior and Supportive Housing** (WSFSSH) reserved units for long-term shelter residents at its 129th Street Adult Residence in New York; the San Francisco Department of Public Health's **Direct Access to Housing** (DAH) program provided subsidized SRO housing at two sites in the city's Tenderloin area; and **Lamp** worked with two SRO providers in Los Angeles' Skid Row to house homeless adults with mental illness.

Contrasting Program Models

The goals of the shelter/lodging programs were to engage long-term residents in services and encourage them to move to housing, and a lengthy stay at the shelter or lodging sites was the main criterion for services. Program staff focused on engaging long-term residents; identifying unmet needs, preferences, and goals; and encouraging and referring residents to services and housing. In contrast, the housing programs sought to provide settings and services needed to sustain housing for people with unstable residential histories and other problems. The programs drew from diverse homeless service settings, targeting individuals with health and mental health problems, long homeless histories, and heavy use of shelters and emergency services.

Characteristics of Program Residents

Data on individual histories and characteristics showed diversity at all sites. Profiles of the populations at the shelter/lodging programs indicate distinctive constellations of gender, age, problems and disabilities, reflecting specific contexts from which residents were drawn as well

as the social geographies of their locales. But as a group, shelter/lodging residents were older adults with numerous health problems, untreated mental disorders, more than four years of homelessness, little or no recent employment, and minimal contact with family members.

Characteristics of housing tenants also varied, but across all housing programs, tenants were predominantly male, African American, in their mid-forties, never married, and had little contact with relatives. Most were high school graduates but had not worked in recent years; they were supported by entitlements programs; and they had been homeless two years or more. Tenants had numerous health problems and serious psychiatric diagnoses; most were on medication when they moved into housing; many had abused substances; dual diagnosis was common. Overall, housing tenants were younger, with shorter homeless histories and more connections to treatment and support systems than shelter and lodging house residents.

PART II Shelter and Lodging Programs: Engagement, Services and Housing Outcomes
The three shelter/lodging house programs in this study were developed to enhance service engagement for their long-term residents and move them to housing.

Program Approaches
Despite their shared focus, the shelter and lodging programs varied in goals, in the way engagement and housing strategies were organized, and in their use of low demand and more proactive service strategies. Program goals varied most notably in the prominence of housing. Deborah's Place emphasized improving the quality of life for long-term residents by discovering and responding to unmet needs. This included offering housing information and referrals, but housing was not the primary focus. At Project Homeward, program staff engaged long-term residents through hygiene regimens while social workers and administrators linked them to permanent settings. BRC focused on helping lodgers move from the Palace, and it was at this site that engagement and housing were most closely linked.

Organization of services and engagement strategies also varied. Both DP and BRC assigned a single worker to engage, provide services and obtain housing for long-term residents. The DP case manager's low demand approach was consistent with agency philosophy and supported by DP administrators. At BRC, low demand engagement by the housing specialist was complemented by the agency's aggressive legal action to put lodgers on the rent rolls or evict them. At Project Homeward, program aides and social workers combined low demand and directive strategies to involve women in hygiene regimens or link them to services and housing.

At all sites workers overcame barriers to relationship building through persistent outreach and eventually formed relationships with many previously isolated residents. But even residents who were highly engaged with staff often remained unable to accommodate the admission processes, eligibility criteria, and requirements of existing housing; and many steadfastly refused to accept the stigmatized identities that the housing process required. These barriers to housing lay outside the worker-resident relationship; programs had less ability to control them.

Analysis of Services, Engagement, and Housing Outcomes
The programs developed relationships with most residents, provided a range of direct services, and initiated housing referrals for a substantial proportion of the individuals at the sites. But

engagement in complex services and housing remained low, and most residents still lived at the sites two years later. Moreover, the predictive analyses failed to confirm that building relationships with long-term residents would improve housing outcomes – a key premise of these programs – but did show better outcomes for residents who had entitlements and who became engaged around housing. They also confirmed that residents referred for health care (usually hospitals) were likely to be in long-term settings after two years. But those who had been homeless longest were least likely to be housed, indicating a need to prevent long-term homelessness at earlier stages.

BRC ultimately resolved its ongoing struggle with the lodgers when it developed new permanent housing which was on site, had few admission requirements or conditions of residence, and allowed residents to maintain their dignity and autonomy. While "converting" temporary shelter/lodging space into low demand permanent housing is not typically an option for agencies, the impending conversion of Deborah's Place overnight shelter into a safe havens program may offer a similar low barrier housing alternative for long-term residents.

PART III Housing Programs: Engagement, Services and Housing Outcomes

Housing programs did not have to persuade people to accept housing; engagement and services at these sites focused on keeping people housed. Tenants entering the programs were briefed during admission interviews on services available and what the programs would expect of them. Differences in services and expectations gave rise to contrasting engagement strategies.

Program Approaches

All sites used similar strategies for engagement – being visible; using casual conversation and brief encounters to get to know tenants; offering concrete help and food, tokens or other items, responding to events or crises that led tenants to seek help. They also met with tenants more formally in the program offices, and offered service-focused and recreational groups. At WSFSSH and DAH's Pacific Bay Inn, case managers had individual caseloads and were responsible for engaging and serving a defined group of tenants. At DAH's Windsor site, support staff used a team case management approach. Lamp tenants also worked with several staff members, though there was not an explicit team structure.

Level of Demand. All housing programs described their engagement approach as "low demand," but the service intensive program at the 129th Street Residence screened residents for willingness and ability to accommodate the program's structured "clean and sober" environment and expected residents to be involved in treatment and services. In contrast, the DAH and Lamp programs emphasized harm reduction and all services were optional.

Balancing Individual and Community Needs**.** The programs used diverse strategies to keep vulnerable individuals housed without compromising the quality of life for others at the site. WSFSSH's structured housing milieu and intensive program of required services contained potentially disruptive tenant behavior. DAH's recruitment from varied service settings leavened concentrations of problems. DAH also divided responsibilities for tenant support and building management between two agencies and actively advocated for tenants who had problems with property managers. Lamp advocated for tenants vis-a-vis building managers, but also used Lamp's shelter/transitional programs as respite settings when crises occurred at the

housing site, thus preserving the agency's relationships with property managers while keeping tenants involved in the Lamp community.

Community**.** The programs approached community-building in distinctive ways. WSFSSH viewed the 129th Street Residence as a lifelong home and community, a supportive environment with structure, rules and predictability that made residents feel secure. DAH programs valued the diversity of their populations, which offered raw materials for tenants to fashion a building-based community, incorporating people with varying degrees and types of problems while avoiding the stigma of housing segregated by disability. Staff supported tenant organizing efforts but viewed their own roles as enabling rather than defining. Lamp staff created a protected environment for their tenants within the Pershing, rather than promoting integration into the community of non-Lamp tenants there. At the same time, the agency fostered tenants' involvement with the larger Lamp community, seen as a supportive, stigma-free space with options for work, independence, support, leisure, and community life.

Analysis of Services, Engagement, and Housing Outcomes

The housing programs engaged a majority of tenants in relationships, concrete assistance, and housing issues, while a large minority were engaged in complex clinical or social services. The programs also succeeded in stabilizing tenants' housing situations: after two years, 77% remained housed. Those with the most severe psychiatric disorders were at higher risk of housing loss, but even in this group, a large majority remained housed. Moreover, mental health referrals significantly increased housing stability. Across diverse housing approaches for homeless individuals with long-term homelessness and other barriers, housing works.

PART IV Summary of Key Findings and Conclusions

A. Key findings on differences between shelter and housing groups:
   1. The population with long-term homelessness, multiple disabilities and barriers is diverse.
   2. Entrenched residents of shelter/lodging sites are older, have been homeless longer, and rarely have recent employment, income, or psychiatric treatment; but it is their social estrangement and not their disabilities that distinguishes them from the larger population.

Conclusion: Specially targeted programs can engage these residents but will not prevent others who are less estranged from graduating to this extremely long-term status.

B. Key findings on engaging and housing entrenched shelter and lodging residents:
   1. Barriers to building relationships with long-term shelter/lodging residents (mistrust, isolation, communication) can be overcome with patient, low-demand outreach efforts.
   2. Engaged relationships do not predict housing for long-term shelter/lodging residents.
   3. Among shelter/lodging residents, those with entitlements and less extreme homeless histories, and those engaged around housing issues are more likely to move to housing.
   4. Complex and stigmatizing admissions procedures and program requirements that undermine autonomy are barriers to housing long-term shelter/lodging residents not effectively addressed by individual engagement; they require reconfigured housing options.

Conclusions: Individuals who are less entrenched in homelessness can be engaged around housing issues and move to permanent housing settings.

Successful engagement will not lead to housing for extremely long-term homeless individuals unless appropriate low barrier housing options are available.

C. Key findings on housing tenants with long-term homelessness and multiple disabilities:
   1. Most tenants who enter housing programs remain in permanent housing.
   2. Homeless individuals with diagnoses of psychotic disorders are at higher risk for losing housing, though most do remain housed.
   3. Tenants who are referred to mental health services are more likely to remain housed.
   4. Substance Abuse does not predict housing loss when tenants are housed in settings committed to keeping them housed despite relapse.
   5. Housing programs all address the tension between incorporating tenants with high risks for housing instability and fostering a stable and supportive environment for all residents.
   6. Major approaches include screening for willingness to participate in treatment, while structuring the program to set limits to disruptive behavior; dividing responsibilities between property managers (who maintain health and quality of life in the building as a whole) and support service providers (who work with individual tenants, and advocate on their behalf during periods of relapse); and providing tenants with ease of movement between the permanent housing and sites that can accommodate or treat relapse.

<u>Conclusions</u>: Individuals with significant disabilities and long homeless histories can move directly from homeless settings to housing with supportive services and remain stably housed.

Diagnosis of a psychotic disorder is a bigger threat to housing than active substance abuse, though most tenants with psychotic diagnoses achieve housing stability.

Once people are housed, linking them to psychiatric treatment is both possible and effective for maintaining housing.

Screening and structure can create supportive environments for disabled, long-term homeless individuals who will agree to structured environments and participation in treatment and services, but harm reduction approaches that house a diverse mix of tenants, divide responsibilities for support services and property management, and offer ongoing access to treatment and support during relapse are effective and will be necessary to ensure stability for broad segments of the homeless population with significant barriers to housing.

INTRODUCTION

A. Evaluating the Closer To Home Initiative

The Closer to Home Initiative (CTHI) was a five year program – funded by the Hilton Foundation and administered by the Corporation for Supportive Housing – devoted to developing new approaches to helping the "hardest to serve" among the homeless make the transition from homelessness to housing. The initiative focused on homeless individuals with serious psychiatric disabilities, medical conditions, or substance abuse problems; extensive histories of homelessness; and heavy use of emergency services for shelter, health or mental health. Over a five-year period from 1998-2003 it contributed support to over twenty programs in six metropolitan areas. This report describes findings from an evaluation of five innovative programs that were among the first to receive CTHI support in four metropolitan areas – New York City, Chicago, San Francisco, and Los Angeles, along with a sixth program in NYC that was not developed as part of the Initiative but was included in the evaluation because its target population and programmatic approach complemented the others, enhancing what we could learn from and about the CTHI models:

- Deborah's Place (DP) provided specialized case management for long-term residents of its overnight shelter in Chicago;
- Project Homeward (PH) – not supported by CTHI – worked to engage long-term shelter residents at the Park Avenue Women's Shelter, operated by Lenox Hill Neighborhood Association (LHNH) in New York;
- The Bowery Residents' Committee (BRC) offered case management and housing placement services to Lodging House residents living in 4' by 6' cubicles at the Palace Hotel in New York;
- West Side Federation for Senior and Supportive Housing (WSFSSH) served long-term shelter residents in the Long-Term Shelter Stayers Project based at its 129th Street Adult Residence in New York;
- The San Francisco Department of Public Health (DPH) implemented Direct Access to Housing (DAH) which provided subsidized SRO housing at two sites in San Francisco's Tenderloin area;
- Lamp developed permanent housing at two sites in Los Angeles's Skid Row area for members of the Lamp community of homeless and formerly homeless adults with mental illness.

The study was designed around three specific aims: to describe several innovative approaches to service engagement and housing for people who experienced long-term homelessness and other complex problems; to examine how these approaches were implemented and developed over

time; and to assess their effectiveness by documenting the outcomes achieved by their initial cohorts of individuals. To this end we closely followed both the *programs* as they developed and changed and the *individuals* they targeted and served as they responded to program efforts to meet their needs. Along the way, we have annually reported preliminary findings, first with descriptions of key program dimensions and their similarities and differences (Barrow & Soto Rodriguez 2000), subsequently in analyses of the characteristics of the people served, the practice and process of engagement by staff across the various programs (Barrow 2001), and the extent to which individuals became engaged, received services, and obtained and/or remained in housing (Barrow & Soto Rodriguez 2002). This is our final report on the evaluation of the CTH Initiative. It incorporates many of the results previously reported, but introduces as well an update on the status of program development more than four years after we began our observations, along with new analyses of program outcomes. It also attempts to synthesize the findings on program models, engagement and housing in order to extract learnings that have bearing on the bigger question of models for ending homelessness.

B. Research Approach and Methods

The issues of concern to this evaluation require a combination of research perspectives, data sources and analytic methods. Thus the study design entailed both descriptive case studies and cross-program comparative analysis; both program-level and individual-level data; and both qualitative and quantitative strategies for collecting and analyzing data. For each of the study's major aims (description of models, documentation of program implementation, assessment of individual outcomes), we have used a different mix of approaches, data types, and analytic strategies.

Description of Program Models

To document the particularities of each model, we used a multiple case study approach, in which each program is described in relation to its particular local and agency context. We focused on program history and philosophy, the services provided, and the resources and constraints that stemmed from the broader agency and community. We combined the case study approach with an explicitly comparative perspective that focused on shared and differentiating elements, common and divergent solutions to similar problems. Both perspectives – the former emphasizing unique features of each site, the latter examining similarities and differences in a common set of dimensions – are needed to describe the sites within a common conceptual framework without losing sight of distinctive elements and practices.

Program Implementation

The descriptions of the programs clarify how each model is conceptualized, the assumed connections among program elements, and the ways these were hypothesized to relate to desired outcomes. However, when programs are implemented in real world contexts, they often must adapt to unanticipated factors that affect their fidelity to the original model or result in redefining the model or particular elements of it. By examining program implementation, the evaluation has been concerned with assessing the congruence between intended and actual versions of each model and with understanding how and why program development and change occurred.

Program Participants' Characteristics, Service Engagement, and Outcomes

As programs designed to assist the most vulnerable and underserved within the homeless population, the providers included in the CTH Initiative all aimed to engage clients in services that would improve their living situations and enhance their quality of life. Most also defined permanent housing as a key long-term goal. Thus engagement and housing status, as well as changes in these two domains, were the major individual-level outcomes of interest in the evaluation. They have broad applicability despite variations in relative emphasis, and they could be examined in programs serving long-term residents who remained at a particular site as well as those providing permanent housing. In programs focusing on long-term residents who had come to view a shelter or transitional site as "home", engagement and other service delivery goals were often more salient than permanent housing placement. At others, program engagement, linkage to off-site services, or willingness to consider housing alternatives reflected proximate aims that marked progress toward program goals. In either case, measures of engagement and service use are of interest both as outcomes in their own right and as mediators of residential changes. Movement to permanent housing and housing stability are also important outcomes at all programs, and the evaluation has sought to understand how organization, philosophy, and context of the programs, as well as engagement and service delivery, has affected housing stability.

A detailed discussion of the study's methods of data collection and analysis is included in Appendix A.

PART I

THE PROGRAMS AND

THE PEOPLE THEY HOUSE AND SERVE

CHAPTER 1
MODELS, IMPLEMENTATION AND CHANGE

The programs included in the Evaluation of the Closer to Home Initiative represent diverse ways of intervening in long-term homelessness. A major contrast underlies this diversity: three of the programs were based in shelters or lodging houses, and worked to engage and move on to housing those who had become entrenched residents at sites that were intended as temporary accommodations; the other three programs provided permanent housing to homeless adults referred from a variety of homeless settings. If we consider homeless interventions as spanning a continuum ranging from various forms of homelessness through transitional settings to various types of housing, half of the programs in the Evaluation worked at the homeless end of the span, the other half were at the opposite end providing permanent housing[1]. All attended in a central way to engagement – building a relationship of trust between program participants and service providers – as a means for involving participants in services; and all were concerned with enhancing residential stability, by helping people move from homelessness to housing or by helping them sustain housing once it was achieved. Along the way, they addressed psychiatric, medical, substance abuse, education, employment, and a host of other issues.

In this section, we describe the programs' varied approaches to engagement and housing services. Within the two overarching categories of "homeless interventions" and "housing interventions," we present brief profiles describing each program's background and context (that is, the history, philosophy, and organization of the program and the agency in which it is embedded); the program model and how it was implemented (the target population, engagement and recruitment processes, types of services and housing provided, and the policies and practices involved); and the major changes that occurred over the course of the study. We summarize commonalities and contrasts within and between the major categories by focusing on dimensions that have important implications for both engagement processes and housing outcomes: which portion of the population each program targeted for services; the programs' goals, philosophies, and relationships to the agencies and contexts in which they are embedded; and the practices through which they addressed common barriers to engagement and housing stability (e.g., income, substance abuse, psychiatric and health care treatment issues). Appendix B presents more detailed profiles of the individual programs, comparisons of subgroups within the populations they serve, and program-specific data on engagement and housing outcomes.

A. Homeless Interventions: Shelter and Lodging House Programs

Two of the CTHI programs (DP and the BRC Lodging House Program) and the one non-CTHI program included in the study (Project Homeward) focused on long-term residents of shelter or lodging house settings. Each developed specialized services to engage those who had been least able or willing to move to housing. While housing was a concern at the two shelter sites, the

[1] We originally expected the evaluation would include a transitional shelter BRC is developing at the Palace Hotel for men with long histories in NYC's shelter system. However, because of construction delays at the site, that program has not yet been implemented and had to be dropped from the evaluation.

lodging house program faced a more urgent imperative, since the planned renovations at the site would require the destruction of the lodging cubicles. Thus housing was far more strongly emphasized in service engagement efforts with lodgers. Nonetheless, there was an overall similarity in what these three programs undertook – a low-demand, non-conventional approach to engaging an entrenched subgroup of residents. In focusing on those whom the programs had previously failed to engage and house, the three sites also highlighted several core issues surrounding long-term homelessness: What mix of internal and external barriers kept shelter residents or lodgers from seeking or accepting housing? What engagement strategies worked? Whose goals should/did prevail? Are there untried housing approaches that would match residents' needs better than existing options?

DEBORAH'S PLACE (CHICAGO). The CTHI program at Deborah's Place consisted of intensive case management for twelve women who had used the agency's overnight shelter over several years but remained unengaged in the services that had helped others move towards housing. DP hired a full-time case manager to work with the twelve women, who comprised over a third of the shelter's guests at any given time. Her tasks were to build relationships with the women, address obvious unmet needs, discover how they viewed their own needs, work toward housing with those willing to consider it, and develop ideas about how DP might better serve the others.

Agency Context: History, Organization, Philosophy

Deborah's Place originated in 1984 as an emergency shelter organization providing overnight accommodation for women who were homeless. Though in subsequent years, DP added a day shelter, short and longer-term transitional housing, and permanent supportive housing, as well as case management, educational and employment programs, the agency continued to focus on a core constituency – women who are homeless – and worked to maintain communication and a sense of community across its program components. Links across program sites were fostered by the movement of the women themselves (overnight shelter guests received services at DP's Daytime Support Center; those who moved to housing sometimes returned to the overnight or day programs for meals, visits, or services) and by a centralized case management approach, in which case managers moved across sites rather than being assigned to a single DP program.

The agency's philosophy emphasizes self-determination and community as core values. While DP's programs range from very low demand to highly structured transitional housing, all programs use a flexible, individualized approach, in which women's choices are respected. At the overnight and daytime shelters, services are optional but plentiful: the overnight shelter provides beds, shower, meals, a number of groups and recreational activities; the day program also offers meals and showers as well as laundry, clothing, use of phones, and group activities ranging from art therapy, outings, movie rentals to groups on substance abuse, issues concerning children, and current events. Women also receive help with housing applications, advocacy for housing or entitlements, escorts to appointments, on-site nursing services and health care referrals. Case management services occur at all sites. Educational and vocational services and a stipend work program are also provided, and the agency has developed a craft business that employs a number of the women.

CTHI Target Population, Program Model, Program Implementation

Target Population. Despite the comprehensive service offerings at Deborah's Place, about a dozen shelter guests became relatively permanent residents, and these women were the focus of CTHI's specialized services. As a group, they were defined more by their long-term but minimally engaged relationship to the program than by particular needs or characteristics. All were part of the DP community for seven or more years[2], many had health problems, and almost all displayed some symptoms of mental illness. The shelter's low demand, supportive atmosphere offered these women a safe space where basic needs were met with minimal requirements for providing information or participating in service or treatment programs. DP staff believe most would have left more demanding settings for the streets. However, their needs and preferences were not readily accommodated in DP's more structured transitional housing programs (the agency's short-term service-intensive transitional program required a formal intake interview and participation in case management, medication, and community activities; the longer-term transitional residence required successful completion of the short-term program) or in the agency's permanent housing, which involved admissions interviews and a waiting list. Most had consistently rebuffed efforts to refer them to other housing programs or to assist them in finding independent apartments.

Program Model. The CTHI program at DP provided intensive case management for the twelve long-stay women. Because of their difficulty articulating their needs and disinclination to participate in services, engagement required more attention and time than existing staff were able to provide. Within the shelter, the enhanced CTHI case management service was not identified as a distinctive program and the twelve women were not publicly designated as participants in a special initiative. The approach emphasized relationship-building and a commitment to respecting the women's own decisions (even when they rejected housing, treatment or services that would appear to benefit them), while looking for openings to engage them around their interests and, when feasible, introduce housing and service ideas for their consideration.

Program Implementation 1999-2001. DP hired the CTHI case manager in November, 1998. Initially she spent her time talking with those who were willing, and sitting with those who would not talk, while using observation or information from staff or other guests to learn what they might need and be willing to accept. She drove women who would agree to get into a car to where they need to go; bought clothes, socks, shoes, or jackets for others; and treated still others to food or cigarettes. In pursuing leads on interests or needs that might offer a basis for conversation and engagement, she stored one woman's possessions in her car, cleaned the apartment of a client who obtained housing, loaned money to others or offered them rides to parks or other daytime hangouts. She also looked up information on the internet for one client; invited another to play pool after learning that she liked the game; and responded to yet another's care about her appearance by buying her colorful hair barrettes.

Though most of the women offered few openings to discuss housing, key barriers to housing them became apparent early on. While half had no regular source of income and were unwilling or unable to apply for benefits, Chicago's market-rate housing rents were well beyond reach

[2] One woman stayed at another shelter during most of the study, although she had been a long-term resident at DP's overnight shelter and continued to be a regular at the agency's the day shelter.

even for those with SSI or other entitlements. Subsidized supportive housing was more affordable, but even housing providers with low demand philosophies sought tenants who functioned at higher levels or imposed multiple interviews or other application hurdles that made it difficult for those interested in moving to access existing housing. Most of the women rejected options that required treatment participation, having an income, or moving to "affordable housing" – usually in poorer areas or in buildings owned by unscrupulous slum landlords. Thus existing supportive and independent housing options, including those run by DP, did not match the vulnerabilities and needs of DP's long-term guests.

By July 2001, the CTHI case manager had developed relationships with all twelve women and had helped two move into subsidized supportive housing, though one returned to the shelter soon after. Extensive support and advocacy from the case manager averted several threats of eviction by the SRO where the other woman remained housed.

Program Development and Change 2002-2003

DP as an agency grew over the period of this study and had to grapple with the implications of expansion for the close-knit Deborah's Place community. However in its approach to the long-term shelter guests, the program format developed at the beginning of the CTH Initiative – a single case manager focused on engaging and housing a long-entrenched group of shelter guests – continued throughout the five years of CTHI. Over the last two years, the program had to accommodate both internal change (staff turnover) and external policy shifts (a city decision to phase out shelters). The original CTHI case manager moved to a new position within Deborah's Place. Her successor was a former staff person at DP's day shelter program. When the second case manager moved out of town, the women who remained were added to the caseload of another DP case manager. Both transitions went smoothly, and the third case manager was reportedly able to further increase the women's engagement and involvement in services. After five years, three women were housed (two in DP permanent housing programs), one woman had been in a local psychiatric facility for a number of months, and another had died. Most, however, continued to stay at DP's overnight shelter. This is of particular concern because as Chicago implements a "housing first" approach to homelessness, funding for DP's overnight shelter will end by July, 2004. At the end of 2003, DP had stepped up efforts to find housing for the shelter's current roster of 25 women, including the seven long-stayers who remained. Planning was underway to open a 15-bed "Safe Haven" program when the shelter closes. While the Safe Haven will have a similarly low-demand structure and open-ended length of stay, it will require a confirmed Axis I psychiatric diagnosis, and referrals must come through local street outreach teams that serve people who are homeless and have mental illnesses. Whether it will be an option for the long-stay women is unclear.

PROJECT HOMEWARD (NEW YORK) was developed by Lenox Hill Neighborhood House (LHNH) to provide enriched services for 20 women who had become long-term residents at the agency's100-bed Park Avenue Women's Shelter for women with severe mental illness. Four program aides worked on ADL skills with the designated residents as a means of engaging them, improving their quality of life, and encouraging them to pursue housing. Through this process, the agency hoped to gain a better understanding of the barriers to housing for this group and to conceptualize more appropriate alternatives.

Agency Context: History, Organization, Philosophy

For a decade beginning in the mid-1980s, the 100-bed Park Avenue Women's Shelter, located in the Park Avenue Armory on New York's Upper East Side, was a city-operated shelter for older women, offering on-site services for those with mental health needs. In 1996, when NYC began to contract shelter operations to not-for-profit agencies, LHNH took over operations and services at Park Avenue, which was designated as a mental health shelter for older women with an Axis I diagnosis of serious mental illness.

Lenox Hill Neighborhood House is a community-based settlement house founded over 100 years ago to serve immigrant children in NYC's Upper East Side. Like other agencies in the settlement house tradition, LHNH addresses a broad range of community needs. In addition to serving children and families, LHNH offers programs for seniors, community advocacy, work on housing rights, classic social services, and a low-cost health club for neighborhood residents, an outreach team for the frail elderly, and a vocational program for homeless adults that became a consumer-run business.

LHNH also operates homeless programs that range along an entire continuum of care – street outreach, shelter, transitional housing, permanent supportive housing, and vocational services. They serve somewhat discrete subgroups within the homeless population, and individuals enter each of the programs from a variety of sources and may be referred on for services and housing either within or outside the agency. NYC's centralized assessment shelter identifies homeless women who are over 45 and have serious psychiatric disorders and refers them to Park Avenue. The basic services provided to all women at the shelter include three meals a day, showers, and a range of social services (on-site health and mental health services, case management; groups focused on various treatment issues; recreational activities; and assistance with daily living activities).

Providing homeless services in what is now one of New York City's wealthiest areas requires balancing competing needs within the community – responding to the needs of homeless people while educating the broader community about homelessness and ways of addressing it. Agency administrators report considerable neighborhood support for the shelter, which is housed in the Seventh Regiment Armory building, along with a variety of cultural, governmental, and military organizations, creating an unusual mix of co-occurring activities and cultures. In 2000, New York State solicited proposals for rehabilitating and operating the armory building, raising concerns about the future of the shelter and the women who stay there. LHNH activism and community support contributed to a revised plan that includes the shelter.

Project Homeward: Target Population, Program Model, Program Implementation

Target Population. In 1998, LHNH received foundation funding to develop Project Homeward (PH), designed to provide concentrated attention to those women who remained relatively unengaged despite long stays in the shelter system. The group targeted for PH consisted entirely of women referred to Park Avenue before 1996, including several who had spent lengthy periods of time in other city shelters. Among 55 women who met this criterion, the PH program initially focused on those whose problems with basic living skills like bathing and grooming required more support and attention than could be provided to the general shelter population. On average, these women had spent between six and seven years in city shelters.

Program Model. Shelter staff saw PH as a means of directing attention to long-stay, unengaged women. Program aides developed a regimen of hygiene activities that provided structure for the residents and opportunities for engagement, while the relationships between the aides and PH clients enhanced their quality of life.

Program Implementation. Twenty of the 55 eligible women were prioritized to receive PH services from one of four program aides who provided assistance with activities of daily living – primarily bathing, grooming, and keeping their bed areas clean. The program aides also kept a medication log for PH women taking medications. In addition to their work on ADL skills, the aides used their own ingenuity to find ways to engage the long-term women, taking them shopping or to lunch, sometimes buying them toiletries or other small items. Although originally conceived as an effort to develop housing readiness for long-term residents, the day-to-day emphasis of PH was on smaller goals that shelter staff believed had an impact on a woman's quality of life. The decision to target the long-stayers to some extent rippled out to other areas as well. The volunteer psychiatrists at Park Avenue made particular efforts to contact all the PH women, though many women continued to refuse medication or other psychiatric interventions. By July of 2000, 20 of the women who had participated in the program had left the shelter for a mix of clinical, transitional and housing settings. Those on the PH waiting list who replaced them were less likely to need the same level of help with ADL services, and the PH emphasis shifted to more general engagement in services.

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Program Change 2002-2003

Project Homeward came to an end in the Fall of 2001, when it was succeeded by the Shelter Mental Health Service Program, a year-long program that provided engagement and mental health services for a group of shelter residents who needed extra attention beyond the services routinely provided. It was staffed by a single program aide who provided services for 10 participants, but it also entailed more active involvement of the shelter's staff psychiatrist. Though the new program used less stringent length of stay criteria for eligibility, it included several women who would have qualified for Project Homeward.

By the Fall of 2002, the shelter's administrators shifted the program emphasis to housing placement, developing a variety of incentives for residents and staff. There was further administrative turnover in the Evaluation's final year. In the summer of 2003, NYC's Department of Homeless Services added funding for a Director of Housing Placements and Services at Park Avenue and the shelter inaugurated a new push to house women who had resided there for two of the last four years.

BRC'S PALACE LODGING HOUSE PROJECT (NEW YORK) was created to provide outreach and housing placement services to approximately 35 men living in small cubicles at the Palace Hotel, which BRC was planning to renovate to accommodate a mix of shelter, service, and housing programs. The agency contracted with a housing specialist whose task was to engage the lodgers and help them move to supportive or independent housing.

Agency Context: History, Organization, Philosophy

The Bowery is New York's skid row. Though the area no longer serves to contain homelessness the way it did for the thirty years after World War II, it continues to be the site of several agencies and programs serving the homeless population. The Bowery Residents' Committee was founded in the 1970s as a self-help program for "public inebriates." As it expanded in the 1980s, the agency's clientele and the nature of its services diversified. BRC now operates over twenty distinct programs arrayed along a continuum of care that encompasses emergency services (HIV/AIDS treatment, non-medical detox; outreach and respite services, reception center, transitional shelter), housing programs (supportive SROs, community residence programs for people with mental illness and dual diagnoses) and day treatment programs for targeted subgroups (people living with AIDS, homeless substance abusers, mentally ill adults, seniors age 60 and over). Although a few BRC programs are sited in Brooklyn, Harlem, or other neighborhoods, the agency's administrative offices and many service programs remain Bowery-based. The diversity of populations served precludes movement by individuals through the entire array of programs, but people can and do move between particular sites – for example from reception center to community residence to apartment program, while attending BRC day treatment or vocational programs.

In 1993, BRC took a 45-year lease on one of the Bowery's most notorious lodging houses, the Palace Hotel, which had provided "flop house" lodging for over 600 men nightly in 4' x 6' cubicles. While media exposes of dangerous conditions and illegal activities in the late 1980s had led the NYC shelter system to formally stop using the Palace as a site where city vouchers could be exchanged for shelter, men who could pay $4.50 to $6.00 a night were permitted to stay in the cubicles on the three floors above CBGB, one of lower Manhattan's better known rock music clubs. During the mid-1990s, BRC co-located a range of additional outreach, shelter, treatment and vocational programs at the Palace and planned to develop permanent housing units there as well. The agency reworked its plans for the Palace several times before finalizing the present building configuration encompassing shelter, transitional, and permanent housing along with outreach, case management, and employment services. The construction of 24 units of SRO housing began in 2002 and was completed in the first part of 2003; other changes (removal of the cubicles, construction of transitional shelter space) were targeted for completion in 2004.

According to agency administrators, BRC's overall goal is to instill in people a sense of responsibility for their lives. This has entailed helping people achieve stable recovery and housing. In recent years, BRC has also emphasized work and functioning in the mainstream. Staff and administrators described the agency's service philosophy as emerging from practice, rather than academic or clinical theory, but noted that BRC program approaches were consistent with "stages of change" models.

The CTHI Program: Target Population, Program Model, Program Implementation

Target Population. Although between 60 and 100 men were living in the Palace cubicles when BRC took over the building in 1993, the lodging house no longer accepted new admissions,[3] and by the beginning of the CTHI program at the Palace in late1998, about 35 men remained. These men constituted the program's target population. All but one were there since at least 1993, and

[3] Although officially no new admissions took place after 1993, one man had "transferred" to the Palace after that date from another Bowery cubicle hotel that was being closed and redesigned as permanent housing.

most for much longer. While many had obvious symptoms of mental illness, substance abuse, or chronic medical illnesses, all lodgers were the focus of engagement and housing efforts, regardless of particular characteristics or disabilities. Defined as they were by their status as "remainers," rather than particular clinical or length-of-stay characteristics, they varied in other attributes. Thus they spanned a range of ages but were concentrated at the older end of the range; they had stayed at the Palace for at least six years, but many were there much longer; several had multiple medical issues and/or extensive substance abuse histories; a small number had acute psychotic symptoms. A few of the lodgers had extensive work histories – some on the margins of the formal economy.

Program Model. BRC approached the effort to move the remaining lodgers to permanent housing with a dual strategy focused on active efforts by the housing specialist to engage the men in a search for alternative housing, at the same time the agency took administrative measures and legal actions to allow the reconstruction of the Palace to move forward.

Program Implementation. Engagement efforts occurred against the background of a contested effort by BRC to evict the men when the agency first acquired the Palace in 1993. Successful outreach, in this context, required the housing specialist to take a stance that distanced him from the agency and acknowledged the validity of lodgers'complaints about how BRC previously treated them. While he reported to BRC's executive director, he had considerable freedom to devise procedures, record keeping and service approaches that were tailored to the context. These included some initial community-wide events to explain BRC's plans for the Palace and offer relocation help, followed by one-on-one engagement techniques – for example, making small personal loans, being accessible beyond typical business hours, or being responsive when unanticipated issues (hospitalization, death of a lodger) arose. He offered each lodger $10 for completing a housing interview, which gave him an assessment of housing needs and barriers while providing the men with a rationale for participating (money) that was accepted by their peers. He also negotiated a blanket eligibility for the lodgers for the City's homeless housing programs and arranged visits to housing sites after coaching some of the men, who did not view themselves as homeless, about the kinds of questions to expect in housing interviews.

BRC's construction plans for the building would eventually require demolition of the cubicles, so while the housing specialist worked to engage the men, the agency also prepared for the possibility of evictions. In October, 1999, NYC approved the Palace Lodging House cubicles as rent-regulated units with specified rights and obligations for both landlord and tenant. This allowed BRC to require all lodgers to pay rent and to move to evict any who refused. This was also intended to prepare those who would not accept housing elsewhere to move into the about-to-be constructed permanent SRO units at the Palace. By July, 2001, non-payment proceeding had been filed against several tenants, though no evictions had occurred. The housing specialist accompanied lodgers to court, where he served as their advocate, and seven were able to work out payment agreements with BRC that would put them back on the rent rolls and safeguard their tenancy. Throughout these events, the housing specialist maintained an occasional presence at the Palace, focusing his involvement on court advocacy for those undergoing eviction proceedings, since many of the other remaining lodgers were expected to move upstairs upon completion of the permanent SRO units. By the summer of 2001, he had phased out his involvement at the Palace, where approximately 20 of the original group of lodgers remained.

Program Development and Change 2002-2003

No lodgers left the Palace for housing (though one lodger died and one was temporarily placed in a nursing home) during 2002. By the end of 2002, program efforts focused on establishing the remaining lodgers' eligibility for Section 8 subsidies that would support the SRO units under construction at the Palace. An entitlements specialist was hired to work with the men two days a week on applications for benefits, while BRC pursued eviction proceedings against those with significant rent arrears or who were unwilling or unable to address income issues. Nineteen SRO units were completed in the Spring of 2003 (the additional five units planned have initially been used as office space for BRC administrators displaced by the construction of shelter and program space). In May, lodgers began to move in and by the Fall of 2003, 13 lodgers resided at the new Palace SRO, though one died soon after. Six lodgers left the Palace during this transition (only two were evicted by BRC through court proceedings) and the lodging house was finally closed. The SRO rooms that are not occupied by lodgers currently house men who were referred from NYC shelters or from other BRC programs. BRC will eventually recruit from similar sources to fill the five additional units that will be available when they are no longer needed for office space.

B. Housing Interventions: Long-Term and Permanent Housing

While the shelter and lodging house programs worked at the homeless end of the continuum, the other programs in the CTH Initiative developed housing for those whose multiple disabilities and/or long-term homelessness made them poor candidates for other existing options. The three housing programs in the evaluation – WSFSSH's Long-term Stayers Project at the 129th Street Residence in New York, San Francisco DPH's Direct Access to Housing program in two Tenderloin SROs, and Lamp's permanent housing programs in LA's Skid Row -- offered long-term housing to people who were homeless and had multiple disabilities. Though housing people who were cycling through emergency shelter and service systems required some flexibility regarding admission criteria, the agencies all sought to accommodate residents with fairly extensive needs who would have difficulty qualifying for housing elsewhere.

Approaches to accommodating individuals with long-term homelessness and heavy use of emergency services varied. WSFSSH did this at its 92-unit 129th Street Residence by setting aside 20 units for men and women with serious psychiatric diagnoses who had been homeless for at least two years. In the DAH program, DPH master leased two SRO buildings and worked with a host of referral sources to recruit people who were homeless, had multiple diagnoses and were heavy users of emergency services. At one of these sites, the 75-unit Pacific Bay Inn (PBI), the Department contracted with a multi-agency consortium of providers led by Episcopal Community Services (ECS) to operate the building and provide services. At the Windsor Hotel, which was renovated to provide 76 long-term units plus a 16-bed short-stay respite unit, the DPH unit that administers DAH initially designated another DPH program, the Tom Waddell Health Center, as the lead agency. In Los Angeles, Lamp collaborated with two other agencies to house men and women who were being served in Lamp's Outreach, Day Center, Shelter, or Village transitional housing programs. At the Ballington Plaza apartments, Lamp master leased 10 units of permanent housing (plus 7 units used for shelter and 2 for office space) from the Volunteers of

America, which operates the 270-unit building complex. And at the 67-unit Pershing Hotel, Lamp partnered with Skid Row Housing Trust in an evolving arrangement that has provided 15 units to house members of the Lamp community.

In their efforts to house homeless individuals whose histories and disabilities provide special housing challenges, these programs highlight several significant housing issues: what strategies can programs use to keep individuals with uncertain psychiatric, medical and substance stability housed? Do engagement and service delivery approaches make a difference? Are there recurrent difficulties that tenants face? What alternative ways of handling these difficulties to the programs offer?

WSFSSH's PROJECT FOR LONG-TERM SHELTER STAYERS (NEW YORK) provides permanent housing for older, formerly homeless men and women with serious mental illness and long histories of homelessness. The program carried out "inreach" in shelter and drop-in centers to recruit long-term stayers for the agency's 129th Street Adult Residence, where they received enriched case management services.

Agency Context: History, Organization, Philosophy

WSFSSH was formed in 1976 by a coalition of social agencies, religious institutions, and community organizers to create new housing to meet the diverse needs of older people and persons living with handicaps. In 1983, the agency expanded its mission to include providing housing and supportive services to homeless adults, and by the time the agency began to operate the 129th Street Residence, it was housing more than 1,500 persons in over 1,200 units. WSFSSH occupies a unique place where low income housing development intersects with services for frail elderly, handicapped, homeless and mentally ill people. The agency's housing programs, targeted at groups with various combinations of these needs and issues, include independent apartments for elderly and/or handicapped persons with very low incomes; permanent supportive SROs for formerly homeless adults; a congregate transitional shelter for older persons who are homeless; and several Adult Residential Care facilities. The programs do not form a continuum, as all programs except the transitional shelter provide permanent housing, and people are not expected to move on.

As an agency, WSFSSH has its roots in social activism and religion. The Board of Directors, administration, and staff include community planning board members, housing activists, and a number of ordained ministers, priests, pastoral counselors, and religiously affiliated lay persons. Unifying themes across the agency's varied programs include a commitment to social justice and an emphasis on providing safe and supportive homes for frail and disabled single older adults.

In 1997, New York State asked WSFSSH to take over both building management and service delivery at the 129th Street Residence, which had been operated by another agency as a licensed adult residence housing 92 older, formerly homeless adults with serious mental illness. WSFSSH restaffed the building, completed a variety of needed repairs and renovations, and implemented several changes in policies and practices. Under WSFSSH management, all residents at the site receive three meals a day; security and supervision; housekeeping in all common areas of the building and in the rooms as needed; and laundry facilities and assistance as needed. Health and mental health services include individual support for treatment, on-site

nursing consultations, groups and activities, crisis intervention; medication monitoring and supervision, on-site psychiatric treatment with volunteer psychiatrists, and money management and budgeting assistance. The program also provides residents with a structured environment. All residents are expected to follow medication regimens, maintain sobriety, meet regularly with their case manager, and adhere to a set of comprehensive house rule that cover issues of safety, room assignment, keys, reporting needed repairs, guest policies, prohibitions (of excess noise, verbal or physical abuse, illegal activities, unsanitary behavior), and a variety of behavioral expectations in the room and in the building. However, service plans are individualized and staff seek creative ways to encourage and support residents through periods of psychosis or relapse.

Long-Term Shelter Stayers Project: Target Population, Program Model, Implementation

Target Population. At the end of the transition to WSFSSH management, the 129th Street Residence had about thirty vacancies. Twenty of these units were set aside for the CTHI "Long-term Shelter Stayers Project," which was intended to house men and women who had spent at least two years in city shelters or drop-in centers. In addition to their history of homelessness, the target group consisted of people meeting the "adult residence" criteria – that is, people with serious mental illness who needed a fairly high level of services (all meals and snacks, supervised medication, housekeeping services) but not skilled nursing care. While many of those who entered the 129th Street Residence before the long-stayers project began had similar histories of long-term homelessness, the additional case management resources provided by the project allowed the agency to risk accepting more individuals with higher levels of need.

Program Model. As a licensed residential program, the 129th Street Residence was atypical among the supportive housing programs included in the study. It was also distinctive among housing sites for homeless people with mental illness in NYC in offering permanent housing to residents recruited directly from the long-term homeless population. The men and women in the Long-Stayers Project at 129th Street participated in the structured milieu that the program provides for all its residents, while also receiving individualized case management. All were screened for willingness to receive psychiatric treatment and health care, take medications, remain clean and sober, and adhere to other conditions required by the program, so issues that deter many people with long-term homelessness from pursuing structured housing options were not such major barriers for this group. However, the Long-Stayers Project entailed expanding case management resources to include four case managers, since the targeted group of long-term homeless adults were expected to need considerable support around these issues.

Program Implementation. Initial "inreach" efforts focused on two large city shelters with long-stay populations, but lack of follow up by shelter staff in one case and lack of interest by shelter residents in the other led to a broader recruitment effort. While 38% of the residents from the initial cohort of long-stayers came directly from shelters or drop-in centers, another 38% had long shelter histories but had been in transitional programs before coming to 129th Street, and 25% were referred by hospitals and mental health programs. After the initial recruitment period, the focus of the project shifted to engagement and case management. Though most participants in the Long-Stayers Project were initially assigned to one case manager specifically hired to staff the project, they were subsequently dispersed among the case loads of all case managers. Staff reported that working with project participants required more time and effort and the modification of some routine practices in order to develop trust and encourage service use.

Program Development and Change 2002-2003

By 2002, the CTHI project participants who remained at the site were well-integrated into the residence's larger population. No special services distinguished participants in the "Long-Term Shelter Stayers Project" from other residents. With the completion of the initial CSH contract, WSFSSH renewed its commitment to serve people with long-term homelessness through a new contract specifically targeting individuals who lived in NYC shelters for at least 730 days in the last four years. Fifteen beds scattered across three WSFSSH housing programs were reserved to house this group, and by Fall of 2003, eight of the individuals recruited through the new contract were staying at the 129th street Residence; four were at other WSFSSH housing programs.

DIRECT ACCESS TO HOUSING (SAN FRANCISCO) was developed by the San Francisco Department of Public Health to "fast-track" into housing homeless individuals with multiple disabilities and a history of heavy use of emergency clinical and homeless service programs. The program master leases vacant or underused buildings from private landlords, renovates them to provide space for services and activities, and develops on-site programs to provide case management, advocacy, and other supportive services for tenants who choose to use them. The two original DAH projects – the Pacific Bay Inn (PBI) and the Windsor Hotel – are included in the Evaluation of the Closer to Home Initiative. Both are in San Francisco's "Tenderloin" area, one of the city's main concentrations of homeless people and homeless service programs.

Agency Context: History, Organization, Philosophy and Services Provided

The Department of Public Health describes the central goal of the DAH program as improving residential stability and health status through the provision of service-enriched housing to homeless persons who have been living on the streets and revolving through emergency care settings. DPH started DAH after finding that low turnover and long waiting lists of permanent supportive housing made it extraordinarily difficult for the Department's clients – people with AIDS, people with mental illness – to exit from the emergency services system. DAH was envisioned as a bridge that would expedite moves from the high-cost emergency services sector by helping agencies acquire long-term leases on underutilized buildings, moving landlords out of the picture while bringing in service providers, and subsidizing needy tenants for the two years it generally took to move to the top of Section 8 or Shelter-Plus-Care waiting lists. DAH was also part of a broader DPH effort to make consumer needs rather than funding stream the driving force for housing development by blending funding sources so that housing programs would not be defined by disability.

Distinctive features of the DAH program included the use of master leasing as an approach to acquiring housing sites; multi-agency collaboration in providing support services; the provision of a long-term but transitional housing subsidy; and a well-specified referral process in which designated agencies are offered a specified number of "slots" in exchange for referring appropriate tenants. DPH implemented several variants of the program, including one operated directly by DPH and others in which not-for-profit agencies took the lead role.

The philosophies of the several agencies involved in carrying out the DAH programs reflect their distinctive missions, experiences and orientations as well as their locations in the broader system of services and housing. At the PBI, the two agencies that were involved in support services –

Episcopal Community Services (ECS) and Baker Places (BP) – had philosophical approaches that were complementary, though not identical. ECS traces the origin of its homeless services to the early 1980s, when the Episcopal Diocese opened a small 10-bed shelter in the basement of Grace Cathedral on Nob Hill, in response to the increasingly visible homelessness crisis. ECS subsequently broadened its focus to include affordable housing plus services, developing experience with educational, vocational, job training and social services for a diverse clientele. Service delivery is individualized and rooted in the goals articulated by clients, and ECS programs take a proactive but voluntary approach to the services. Harm reduction is an important part of the philosophy but is actualized differently in the various programs ECS operates. When the PBI opened as a DAH site, ECS staff included the Support Services Director, two case managers, and an employment specialist.

Baker Places provides an extensive continuum of residential treatment programs and services for people with dual and triple diagnoses of psychiatric disabilities, substance abuse problems, and HIV/AIDS. These programs range from highly structured medically oriented detox programs to on-site service delivery in supportive housing programs. The agency works with a social rehabilitation model as developed in the mental health treatment field. BP programs have traditionally been relatively structured and focused on abstinence, though work with formerly homeless clients challenged BP to integrate harm reduction with its social rehabilitation approach by continuing to work with clients through relapse. Baker Places contributed two case managers to the support services team at the PBI.

At the Windsor Hotel, the Tom Waddell Health Center was designated as the lead agency and the only provider of support services. TWHC was one of nineteen original Health Care for the Homeless (HCH) projects developed by the Robert Wood Johnson and Pew Foundations in the mid-1980s. Like other HCH projects, the program took its multi-disciplinary team to the streets, shelters or clinical sites in the community. Eventually, the HCH program merged with the city's Central Emergency Unit and, as Tom Waddell Health Center, became one of San Francisco's several District Health Centers. It has expanded to cover thirty sites, including shelters, storefronts, street teams, and supportive SRO housing programs. TWHC's approach incorporated street-based work, urgent care, and focused efforts to move people into primary care. The same providers work both in the community sites (e.g., shelters, special project teams) and in the primary care clinics, ensuring continuity of care that is unusual in homeless service delivery. The staffing and service focus at the Windsor reflected HCH's model of multidisciplinary clinical services, health advocacy, and a harm reduction approach to substance abuse and other risky behavior. The Windsor support services team included a psychiatric social worker, two nurses, a part-time physician, two health advocates serving as case managers, and an entitlements specialist. In addition to 76 Windsor units designated as long-term transitional housing, the program includes a 16-room short-term (two to eight weeks) respite unit where homeless people with acute medical needs can receive day-time clinical services until medically more stable. Individuals are referred to both respite and long-term housing at the Windsor by other DPH and TWHC providers.

The DAH Program: Target Population, Program Model, Program Implementation

Target Population. DAH was intended to serve homeless people with disabilities who had cycled through emergency services without attaining residential stability. Eligibility for DAH at

both sites requires that applicants be homeless residents of San Francisco with extremely low incomes. The program targets people released from institutional, acute care, or transitional settings with a history of rotating through the social services and/or criminal justice system without prolonged stabilization in their housing or health status. While long-term homelessness was not an explicit DAH focus, the other criteria ensured DAH would include people with long histories on the streets or in shelters. Each site had some tenants who were living there before DAH was developed. In addition to these, a number of tenants at each site were clients of the Tenderloin Housing Clinic, which was offered units in each DAH building in exchange for managing third party rent payments. The allocation of units at each DAH site to different types of referral agencies has ensured further variation in the tenant population. Staff, administrators, and tenants cite the diversity of history, experience, ethnicity, disability, and patterns of service use among tenants as a distinctive and positive aspect of the program, despite the service delivery challenges it can produce.

The Windsor's respite floor targets homeless people with acute medical needs who require a temporary period of acute care, often following hospitalization, to achieve stability. Income criteria do not apply to the respite beds, but respite patients must follow rules (remaining clean and sober, meeting with staff, following a treatment plan) not required of long-term tenants.

Program Model. DAH's key features – master leasing, multi-agency service collaborations, designation of multiple referral agencies with ongoing responsibilities to tenants, and long-term subsidies – all served to build an extensive community network of support for the projects and the tenants they house. In acquiring housing sites by master leasing, DAH took responsibility for the environment of whole buildings, while bringing underutilized buildings back into service and expanding the total supply of affordable housing. Through multi-agency collaboration in both referrals and support services, DAH was expected not only to offer tenants diverse expertise but also to facilitate links to a broad array of service providers and foster continuity of care. The long-term but transitional rent subsidy, set at 50% of a tenant's income, was intended to bridge the time required to access more generous federal Shelter Plus Care and Section 8 subsidies for permanent housing.

Within this common framework, the two DAH buildings entailed differing approaches to master leasing and the organization of support services. At PBI, the lead agency (ECS) holds the master lease and contracts directly with Mercy Services for property management, while at the Windsor, the DPH Housing Office (later known as Housing and Urban Health), which developed and administers DAH, handled the contracting of property management services to the John Stewart Company. At PBI, ECS leads the support services team, but it was staffed jointly with Baker Places, with each agency providing two case managers. The ECS Support Services Director supervised all case managers on site, but BP provided additional supervision for its own case managers. In contrast, all Windsor support services staff were clinicians and health workers employed by Tom Waddell, giving the program there a more clinical and public health emphasis.

Program Implementation. In 1998, the Housing Office in DPH identified the PBI and the Windsor – two tenderloin buildings operating as low-budget tourist/transient hotels – as DAH sites. ECS was selected as lead agency at the PBI and signed a ten-year lease on the building which took effect in January of 1999; tenants began moving in during March of 1999. The

Windsor's location next to a park well-known for drug activity deterred not-for-profit providers from submitting proposals, and DPH's Tom Waddell Health Center was eventually designated to take the lead, while DPH itself took on the ten-year master lease for the building; rent-up occurred between September, 1999, and March, 2000.

By early in 2000, the programs at both sites, including the respite unit at the Windsor, had become fully operational. Early program development involved resolving a number of physical plant issues and beginning efforts to foster a sense of community at both sites. Lead agencies at each program worked with property managers to develop "house rules" that would be consistent with DAH's philosophy of harm reduction and voluntary services while attending to issues of safety and security. While particular rules generated some controversy (at both PBI and Windsor, policies regarding visitors became a point of contention), both sites worked on developing mechanisms for problem solving to address differences between management, service staff, and tenants. Tensions between property management and support services remained more pronounced at the Windsor.

Overall, the DAH model was successfully implemented at both sites, though with some differences. While staff at both sites worked to engage and provide services for tenants, PBI developed a more extensive program of group activities and invested considerable effort in working with individual tenants on applying to permanent housing. At Windsor, the high levels of additional service need among the respite patients absorbed much of the support services staff time and attention, resulting in less focus on community-building or helping tenants plan for permanent housing. Moreover, the plan for respite services at the Windsor evolved significantly over the course of implementation. Though originally using the same voluntary services and harm reduction approach taken in the rest of the building, the respite unit was subsequently designated a "clean and sober" program and a fairly extensive set of house rules was developed, prohibiting a range of disruptive behaviors, requiring respite patients to agree to participate in treatment, and generally imposing a greater degree of structure than in the long-term housing program.

While DPH initially expected a two-year transitional housing subsidy would cover the time homeless individuals typically spent on waiting lists for subsidized housing, a tightening SF housing market inhibited new non-profit housing development, severely limiting DAH tenants' options for moving on. Because the DAH housing subsidy was funded from General Revenues, DPH had considerably flexibility in defining the terms of the subsidy. In recognition of the new realities of the SF housing market, DPH decided in 2001 to transform the temporary DAH housing subsidy into an open-ended one. The change from transitional to permanent housing took pressure off both tenants and staff, and was generally greeted with enthusiasm. Administrators noted, however, that case managers lost the "leverage" for encouraging tenants to consider alternative housing that the time-limited subsidy provided, while tenants lost eligibility for the more generous subsidies Shelter Plus Care subsidies. To offset this, DPH worked out a transition for people who were already on waiting lists for Shelter Plus Care at the time the change was implemented.

Program Development and Change 2002-2003
By 2002, the programs at both sites had matured, having weathered a number of start up and implementation issues. The most significant changes during 2002 involved staffing. Turnover in support services staff due to medical leaves and other departures burdened the remaining staff members and stretched the service capacity at both sites. At PBI, the entire "first generation" of support services staff moved on or was on leave; at the Windsor, a similar level turnover occurred, though some of the original nursing staff remained. Both programs noted that one consequence of staff shortages is that the neediest tenants consumed the lion's share of staff time, limiting the programs' ability to extend help to those with less urgent service needs, including some who might be candidates for moving on to more independent settings.

At both sites, the tenant population remained fairly stable. While this may have been affected by the removal of time limits from DAH housing, the declining local economy and continued tight housing market severely limited tenants' alternatives. During 2003, two additional developments modified the DAH model. The first was a shift in the agencies providing support services. At the Windsor, Housing and Urban Health (the overall administrator of the DAH program) has replaced the Tom Waddell Health Clinic as the lead agency and provider of support services. At the PBI, the multi-agency collaborative approach to support services was replaced by a single provider model: BP phased out its involvement at PBI, and ECS is now the sole provider of support services. And at newer DAH sites, only one agency provides support services, though property management services continue to be provided by a separate agency at all DAH sites. DPH has also developed a Behavioral Health Team that provides two days of clinical substance abuse services at all DAH sites, including PBI and Windsor. This to some extent offers an alternative way of expanding the range of on-site expertise and linkages to community resources that DAH initially tried to accomplish through multi-agency involvement in support service.

New DAH programs have produced additional changes that have not been incorporated at the original sites. Most notable are required third party rent payments, and a modification of the terms of the DAH subsidy, which at newer sites require participation in services as a condition of the subsidy, much like Shelter Plus Care. Finally, although the Windsor continues to operate its 16-bed Respite Unit, none of the new DAH buildings include Respite Units. Instead, DPH is developing a free-standing 100-unit Respite program that will not share space with DAH.

LAMP'S BALLINGTON AND PERSHING HOUSING PROGRAMS (Los Angeles) offer permanent housing at two Skid Row sites to members of the Lamp community. These programs entail differently structured partnerships with two local housing providers, thus expanding the variety of shelter, housing, and employment services the agency provides in LA's Skid Row to homeless men and women with diagnoses of mental illness. At the Ballington site, Lamp also leases additional units to expand the agency's emergency shelter capacity, but the shelter units are administratively distinct from the housing program at the site.

Agency Context: History, Organization, Philosophy
While many US cities have "skid row" areas that have been home to "down and out" or disaffiliated populations (Bogue 1963; Bahr 1973), the growth of homelessness throughout the 1980s tended to overflow such niches. In Los Angeles, in contrast, city "containment" policies

sustained Skid Row as the site where homeless individuals and the agencies that emerged to serve them are concentrated. Lamp was founded in 1985 as Los Angeles Men's Place, a store front drop-in center where homeless men could get off the street and receive voluntary and accessible help with basic needs (food, clothing, showers, toilets), as well as health screening, payee and advocacy services (Lowery 1992). From the beginning, Lamp focused its efforts on people with serious mental illnesses and over time has taken on the issues of substance use and dual diagnosis as well. As it grew over fifteen years, Lamp rethought an initial commitment to abstinence and sobriety and now integrates harm reduction approaches into all of its program components. Other changes have involved serving women as well as men; and the development of Lamp Village as the site of a transitional housing program along with several businesses that provide employment for Lamp guests and other neighborhood residents as well as services (linen service, commercial laundry, public toilet and shower, and a market) to the Skid Row community. The agency also operates Lamp Lodge, which provides permanent housing in 43 studio and seven one-bedroom apartments. In the late 1990s, the agency purchased a ranch, located several hours north of Los Angeles, where groups of participants from all Lamp sites, accompanied by staff, take brief or longer vacation trips.

Lamp expanded over fifteen years from a storefront staffed by three workers to a large community with a staff of 100 individuals, of whom close to half are current or former Lamp guests. The agency's services respond to an array of conditions between street homelessness and permanent housing. Lamp's various sites are in close proximity, which has facilitated movement from homelessness to housing, but also between settings – in any direction – as people's needs for support change. Across the agency's constituent programs, all services – including psychiatric and substance abuse treatment – are voluntary, with harm reduction an underlying value, along with respect, diversity, and tolerance.

Ballington and Pershing Programs: Ttarget Population, Program Model and Implementation

Target Population. Lamp's programs at the Ballington and Pershing programs draw tenants from within the Lamp community, which is made up of homeless men and women with mental illnesses who live in Lamp shelters or transitional housing programs, work in Lamp's businesses, or attend the Day Center or other programs. Many are also struggling with substance abuse problems and many have spent years on Skid Row, but neither dual diagnoses nor duration of homelessness are criteria for entering the Ballington or Pershing, and there are no formal criteria for admission to the housing programs beyond those that define the Lamp community. However, program administrators suggest some site-specific considerations in Lamp referrals to each building. The Ballington is adjacent to Lamp's Day Center and Shelter, and initially Lamp expected that this would make Ballington's housing units ideal for people needing staff support. However, as the program was implemented, complaints from the agency that operates the site created pressure to reserve Ballington units for individuals who could accommodate to that agency's rules and concerns. Other factors affected referrals to the Pershing: its distance from other Lamp programs made it more desirable for tenants who did not need a great deal of daily support from Lamp staff; and a steep entry staircase precluded housing people with limited mobility at the Pershing.

Program Model. The Ballington and Pershing housing programs entail Lamp's collaboration with other providers in the Skid Row area, though the structure of that collaboration differs at the

two sites. The Ballington, a three-building complex immediately adjacent to Lamp's Day Center and Shelter, is owned and operated by Volunteers of America (VOA). Difficulties in maintaining full occupancy led VOA to enter into an agreement with Lamp to master lease 34 rooms, 25 as permanent housing and 9 for shelter. At the Pershing, an SRO owned and managed by Skid Row Housing Trust (SRHT), a housing developer with numerous other buildings in the neighborhood, Lamp contracted for 17 rooms, which included 15 single housing units (five subsidized by Shelter Plus Care, and ten for rental at the market rate), a community room, and a room for a resident staff member. While Lamp participated in the intake process, tenants rented directly from SRHT. The process of negotiating everything from admission and eviction policies to house rules with another agency served to throw into relief each group's core mission and defining values. Since these agencies generally target a broader low-income population for their housing programs, Lamp staff members engaged in considerable advocacy with the host agencies regarding how members of Lamp's community, who all have mental illness, were treated by property management staff and other tenants. Lamp's Director of Housing Services, who oversees the housing programs, was assisted by a Housing Manager who moved across Lamp's three permanent housing programs, working with individual tenants while also offering support the resident advocates who staffed the housing sites, where they provided on-site case management, counseling, groups, advocacy, escorts to activities and appointments, and referrals. Tenants who receive services at the sites also remain part of the larger Lamp community, where they may be involved in work, treatment programs, and other activities.

Program Implementation. Program start-up occurred at the Ballington in February, 2000, and by the end of June, 2001, Lamp was leasing and using ten permanent housing units, seven units that provided shelter for thirteen Lamp guests, and two units that accommodated a resident advocate and a Lamp office. Lamp tenants began moving into the Pershing in November, 2000, and by mid-2001, 15 were residing in Lamp's designated units, while the remaining two designated rooms housed Lamp's resident advocate and an office/community room. Several additional rooms at the Pershing were occupied by tenants who met criteria to receive Lamp services (formerly homeless individuals with mental illness), and they were encouraged to participate in Lamp services as well.

During 2001-2002, only one additional permanent housing unit became available to Lamp at the Ballington. Despite its proximity to other Lamp programs at the Day Center, the on-site presence of Lamp staff was limited. No overnight housing staff were on-site at the Ballington; in the event of emergency, tenants received assistance from the VOA front desk staff or contacted a Lamp resident advocate who was a long-term tenant in another part of the Ballington housing complex. At the Pershing Hotel, Lamp continued to house tenants in the fifteen designated units. Several additional tenants with Lamp affiliations were also housed at the Pershing and were served by the Lamp support services team. Because of both the size of the Lamp population at the Pershing and the building's distance from other Lamp sites, Lamp assigned two housing advocates to the program there.

Lamp's collaboration with VOA and SRHT was complicated by contrasting values, priorities and organizational cultures (the conflict between harm reduction and 12-step approaches to substance addictions; the different needs and perspectives of support service providers and property managers). At the Ballington, Lamp master leased the available units, and VOA staff

dealt with Lamp as the tenant. Initially, the major issue between Lamp and VOA involved tenant behavior, and VOA pressed Lamp to pre-select tenants who could manage without intensive support. During 2001-2002, a proposed rent increase emerged as an issue which was resolved between the two agencies. In the early stages of program development at the Pershing, where tenants entered into leases directly with the Skid Row Housing Trust, the lack of rental income when any Lamp unit was vacant created tension between SRHT and Lamp. During 2001-2002, however, a more productive collaboration between the agencies began to emerge as SRHT added a staff position devoted to developing the supportive housing model across SRHT properties.

Program Development and Change 2002-2003

During 2002-2003, Lamp carried out a series of administrative and program reorganizations. A new Clinical Director was hired to develop group and individual counseling at the various Lamp program and housing sites. The Lamp ranch was sold and the program there was disbanded, while the agency concentrated on securing ownership of its Skid Row sites. By Fall, 2003, a long-planned renovation of Lamp's shelter and day center site was underway, necessitating temporary relocation of shelter and service program activities to other Lamp venues. The housing sites were also reorganizing the support services provided by housing advocates.

Over the course of their collaboration, Lamp's relationship to both VOA and SRHT was redefined. At the Ballington, the additional rooms that Lamp expected to master lease did not materialize. The units already leased remain under Lamp's purview, though one permanent housing unit was turned into a shelter unit to accommodate shelter participants displaced by renovations at Lamp's main shelter site. Rather than pushing VOA to add units to the master lease, Lamp has instead begun to refer individuals directly to VOA as regular tenants, and plans to continue in this manner rather than extending the units covered by the master lease. At Pershing, Lamp and SRHT have ended the contract designating 17 units for Lamp (15 for housing and two for office purposes). Instead, Lamp has become a service provider for all Pershing tenants interested in services, and Lamp staff at the site work closely with SRHT's designated "lead advocate." By November, 2003, 20 Lamp members lived in the Pershing. Lamp and SRHT had arrived at a division of responsibilities (property management for SRHT, provision of support services for Lamp) similar to the DAH buildings as well as many other supportive housing venues. In addition, Lamp and SRHT agreed to replicate this structure in another SRHT building. While Lamp's Ballington and Pershing tenants continue to work with advocates at various Lamp program sites, the agency is in the process of staffing each housing program with one or two clinically experienced "lead advocates" and one or more "support advocates."

C. Summary of Common Issues and Contrasting Approaches

The Contrast between "Homeless" and "Housing" Programs

Over the last two decades, efforts to intervene in homelessness have given rise to a continuum of services ranging from homeless-oriented programs (shelters, street outreach teams) through transitional services to long- term and permanent housing. Three of the programs in this study are working at the homeless end of the continuum in shelter and lodging house settings with individuals who have been long-term residents there and who have been unable or unwilling to

move on. At two of these sites, this is despite the on-site presence of case management services that have successfully engaged and housed other residents of the setting. Targeting services at these sites to a specific group of people who have not responded to prior offers of housing assistance creates an extremely difficult challenge; there is no possibility of lightening the task by including a selection of individuals who are less entrenched.

Our original evaluation design included one interim program situated mid-way between homelessness and housing – BRC's not-yet-operational transitional shelter being developed at the Palace Hotel for long-term shelter residents. While interim programs do not usually have to struggle with a fixed population of non-movers, they face the double task of recruiting (and uprooting) people who are entrenched in a given homeless setting to bring them in to the interim site; and then once again uprooting them to move them on to permanent housing after the interim period (Barrow & Soto 1996; Barrow & Soto Rodriguez 2000). Though the delayed development of the Palace program precluded its inclusion in this study, it bears mentioning as a reminder that the programs described here, which fall at the two the extremes of the homeless-housing continuum do not exhaust the range of possibilities in the effort to end long-term homelessness.

Finally, three of the CTHI programs worked at the housing end of the continuum, developing whole buildings or specialized programs within larger buildings, intended for those who had been previously unable to find settled living situations and provide the support they needed to sustain housing. Approaches to engagement in the housing context varied. While WSFSSH staff made fewer demands on the long-term shelter stayers than on other residents at 129th Street, their efforts to persuade residents in the long-stayers project to meet with staff, address medical and psychiatric issues, and follow prescribed medication regimens were more proactive than the completely optional service offerings at the DAH and Lamp programs. However, there was variation within these sites too: the Windsor placed higher demands for program participation and contact with staff on respite clients than on the long-term residents at the site. The programs working at the housing end of the continuum had the additional consideration of integrating those recruited from the least stable and most disabled segments of the homeless population into a long-term community. Thus each point of intervention in long term homelessness poses challenges that are specific to where it is situated and the differing nature of the tasks and barriers that arise. While positioning of programs at the homeless or housing end of a continuum is particularly useful in thinking about the goals and outcomes of programs so situated, some dimensions of program similarity and difference cross cut this major axis. Tables 1.1 through 1.3 summarize how the shelter and housing programs look on three other major dimensions: target populations; characteristics of the key agencies involved in each program; and the way services and housing are organized.

Target Population

The programs in the CTHI study all described their focal populations as those who were not readily engaged and housed in existing settings. This common target, however, was by no means homogeneous (see Table 1.1). The specific criteria programs used included gender, age, mental illness, dual disabilities, time homeless, time at the site, and history of emergency services use, but only a few of these were employed at any one site. Thus at DP, where gender (women only) defined the larger population served, length of stay (long-term) and service engagement (not

engaged) defined those targeted for special engagement services; at Park Avenue, gender (women), age (older), and mental health status (serious mental illness) defined the larger shelter population, while service engagement (not engaged) and need for ADL assistance distinguished those targeted for Project Homeward services; and at BRC's Palace Hotel Lodging House program, gender (men) and duration of stay (since at least 1993) defined the entire lodging house population, all of whom were the focus of CTHI services.

In contrast to the shelter and lodging programs, the housing programs drew from a broader field. For WSFSSH, which recruited from various shelter and drop-in settings, individuals entering the long stayer project had to meet the criteria in use at the site in general, which included age (older), mental health status (mentally ill), and functioning status (needing fairly intensive on-site services). They also had to have been homeless for two years or more. In the DAH programs, some units at each site were occupied when DPH took on the master lease, and all pre-existing tenants were eligible to receive DAH assistance. Each DAH site also had a number of tenants referred and screened by the Tenderloin Housing Clinic, which managed the third-party rent payments at both sites and filled its allocation of units with tenants participating in San Francisco's Personal Assisted Employment Services (PAES) program. The remaining tenants at the PBI and the Windsor were referred by a designated set of referral agencies, which had each been allocated a specific number of units to fill. Eligibility criteria for the DAH tenants included homelessness, San Francisco residence, and extremely low income. While long-term homelessness was not an explicit criterion for DAH, the program targeted individuals released from acute settings and with a history of rotating through the social services and/or criminal justice system without prolonged stabilization in their housing or health status. And Lamp, which drew Ballington and Pershing tenants from within its own community, had no formal criteria beyond those of homelessness and mental illness that made individuals eligible to join Lamp's larger community. As Table 1.1 indicates, then, across the CTHI programs, there was considerable variation in the criteria for selecting those "most difficult to engage and serve."

Eligibility criteria provide only a partial picture of the group served at each site, since programs that did not require that residents meet particular criteria such as long-term homelessness or diagnoses of serious mental illness did not thereby exclude people with those characteristics. In Chapter 2 we will describe the actual variation in who was served by the various programs.

Agency and Broader Service Context

The programs operated in diverse service contexts (see Table 1.2). Critical differences included whether the program was operated by a single agency (DP, PH, BRC, WSFSSH) or multiple agencies (the DAH programs, Lamp); whether these were public agencies (DAH at the Windsor) or not-for-profit (all other sites). More complex variation occurred in agency type, specialization and expertise (e.g., settlement houses, homeless shelter and services providers, mental health and substance abuse agencies, health care providers); their community-building efforts; and the extent to which these focused within a building, a wider agency, or a neighborhood. In addition to these features of the immediate service context, programs were affected by aspects of the broader environment. Some of these reflected national level policies – for example the availability of Section 8 and Shelter Plus Care housing subsidies; others were more local in origin or impact – for example, housing markets and economies, the municipal political context,

the organization of major service domains such as health, mental health, substance abuse, and local variants of managed care.

Organization of Housing and Services

The programs also varied in the type of housing and services they offered and how they organized the housing and service delivery effort (see Table 1.3). The shelter or lodging house programs offered housing placement services through referrals to a variety of settings, including in some cases those operated by the same agency. Housing programs, at least initially, included long-term transitional (DAH) and permanent (WSFSSH, Lamp) housing; they might offer residents leases and full tenancy rights (DAH, Lamp) or operate as licensed service-intensive facilities (WSFSSH). Units and facilities like bathrooms or kitchens might be shared or individual; and congregate facilities for meals and other activities might or might not be provided. Other services were provided on- or off-site, and might include services to access or maintain income and entitlements, educational and vocational programs, health and mental health referrals, medication prescribing and/or monitoring. All provided service coordination, advocacy, or case management, but expectations for service participation varied, reflecting contrasts in program goals and philosophies.

Program Histories, Philosophies and Goals

The programs in the study were shaped by several traditions of social activism – religious, settlement house, social rehabilitation, self-help, and homeless/housing advocacy. Thus in addition to variations in target populations and location on the homeless/housing continuum, the CTHI programs drew from different though overlapping streams of thought regarding how the needs of those disadvantaged by homelessness and disability could best be met. While they concurred on many elements – e.g., individualized, flexible services, starting from "where the client is," identifying and working with client goals – the agencies arrived at this convergence through distinctive routes. Thus as they implemented shared principles, their services also reflected agency-specific emphases on particular communities and constituencies (women who were homeless at Deborah's Place, for example), and agency-wide philosophies or themes (e.g., fostering personal responsibility at BRC; harm reduction at Lamp). In multi-agency collaborations such as DAH and Lamp's housing programs that linked diverse agencies, collaborators also had to find areas of common ground, as ECS and BP sought to do with harm reduction and social rehabilitation approaches, and as Lamp pushed for with SRHT. The reports on quantitative and qualitative analyses that follow will elucidate what the concepts used to describe various client-centered approaches – including "stages of change," or "harm reduction" – mean in specific program contexts, and how broadly defined philosophies translated into services and outcomes at the individual level.

A Note on Program Development and Change

In our effort to describe program models and their implementation, we have also attempted to also describe complex processes of program development and change, particularly in providing updates on developments at the programs after the period reflected in our main qualitative and quantitative data analysis. The summaries of program status at the end of our evaluation should serve as reminders that the time-frame for data collection may not capture processes that occur at a different pace or over longer time spans. They also document that change is on-going, and while some of the shelter/lodging programs have run their intended course, one shelter and all

the housing programs continue to pursue improved housing stability for their residents while trying new approaches and adapting to changes in the larger environment.

By the end of the evaluation, two of the original participating shelter/lodging and housing programs – Project Homeward and the BRC lodging house – had come to an end. PH had completed its grant period, and had been succeeded initially by a program targeted at women with mental illness, regardless of length of stay and subsequently by a shelter-wide emphasis on housing placement. At the Palace, 19 lodgers had remained in cubicles at the site more than four years after CTHI began, but in May, 2003, with the opening of the Palace's new SRO units, thirteen men were accepted as SRO tenants, though one died before moving in. In the end, only two of the thirty-three lodgers that BRC sought to move from the cubicles were evicted through the courts, a few had disappeared, and a large majority had relocated to permanent supportive housing at the Palace or elsewhere. The DP program continued to work with the small group of women originally targeted. In November, 2003, five years after CTHI services were initiated, most remained at the shelter, but the planned closing of DP's overnight shelter in July, 2004, has introduced an urgency around housing that was not characteristic of DP's approach to its long-term residents. However, as at the Palace, where the development of housing units in the same building offered an alternative for those who had been unwilling to leave for housing elsewhere, DP may be able to accommodate some or all remaining long-term shelter guests in the new Safe Havens program that will replace the overnight shelter.

In contrast to the more time-limited goals of the shelter/lodging programs, which each targeted a particular cohort of residents, the housing programs were intended to provide long-term accommodations to people who had been unable to achieve residential stability, with an expectation that they would operate on an ongoing basis. The housing programs in the evaluation have by now matured, and most of the recent changes they have experienced reflect relatively routine organizational processes such as staff turnover along with adaptations to larger economic and system changes. WSFSSH integrated the long-term homeless group served by CTHI into the general population of the 129th Street Residence and has implemented services for a new group of long-term shelter stayers. The DAH programs continue to develop, and following the shift from a transitional to open ended subsidy, the most salient modifications of the DAH model have entailed changes in the structures of collaboration – between DAH administration at DPH's Housing and Urban Health unit, the agencies that provide supportive services in the DAH buildings, and the agencies that manage the DAH properties. At Lamp, too, the working out of collaborations between property management and supportive services has been the dominant theme of program development and change.

With this reminder that any description of actual programs will capture a limited slice of time, we turn now from the programs as wholes to consider the individuals that they served during the initial period of implementation and development.

Table 1.1 Target Population at Participating Programs

Program	Gender	Age	Mental Health Status	Dual Dis-ability	Homeless duration	Stay at Site	Service Engagement at Baseline
Shelter Programs							
DP – General	Women	Varied	Varied	Varied	Varied	Varied	Varied
CTHI	Women	Varied	Varied	Varied	Long term	Long term	Minimal
Park Avenue General	Women	Older	SMI	No SA	Varied	Varied	Varied
PH	Women	Older	SMI	No SA	Pre-1996	Pre-1996	Minimal
BRC Lodgers	Men	Varied	Varied	Varied	At Palace Pre-1993	At Palace Pre-1993	Minimal
Housing Programs							
WSFSSH General	Varied	Older	SMI	Varied	Varied	N/A	Varied
Long stayers	Varied	Older	SMI	Varied	2 Years	N/A	Varied
DAH-PBI & Windsor	Varied	Varied	Varied	Varied	Varied	N/A	Varied
LAMP Ballington & Pershing	Varied	Varied	SMI	Varied	Varied	N/A	Varied

Table 1.2 Organizational Characteristics of Participating Programs

	Single/Multiple Agencies	Public/Not-for-Profit	Agency Type and Expertise	Primary Community or Constituency
Shelter Programs				
Deborah's Place	Single	Not-for-Profit	Shelter, Housing, Employment services; Women	Women who are homeless
LHNH Park Avenue Shelter	Single	Not-for-Profit	Settlement House; Entire Neighborhood	NYC's Upper East Side/Lenox Hill Community
BRC Lodgers Program	Single	Not-for-Profit	Emergency Services; Day Treatment; Housing; Bowery area	NYC City-wide but centered in the Bowery area
Housing Programs				
WSFSSH 129th St. Residence	Single	Not-for-Profit	Housing and Services for frail older and handicapped people	NYC's Upper West Side
DAH – PBI (ECS, BP, Mercy Services, THC)	Multiple	Not-for-Profit	ECS: Shelter and Housing BP: Residential treatment **Mercy: Property Management** THC: Tenant Organizing	People who are homeless; People with mental illness, substance abuse; HIV/AIDS; Tenderloin area
DAH–Windsor (TWHC, John Stewart Inc., THC)	Multiple	TWHC: Public JS, THC: Not-for-Profit	TWHC: Health Care for the Homeless; JS: Property Management; THC: Tenant Organizing	People who are homeless with health needs; Tenderloin area
LAMP Ballington (Lamp, VOA)	Multiple	Not-for-Profit	LAMP: Homeless Mentally Ill- VOA-Housing & General Social Services	LA Skid Row National
LAMP Pershing (Lamp SRHT)	Multiple	Not-for-Profit	LAMP: Shelter, Housing, Employment, etc. SRHT – housing for low income populations	Skid Row

Table 1.3 Organization of Housing and Services at Participating Programs

	Conditions, Length of stay	Units and Facilities	Services and Supports	Expectations for Service Participation
Shelter/Lodging House Programs				
Deborah's Place – CTHI Case Management Program	No time limit; Residents can be barred for only the most serious rule infractions	Congregate facilities: dormitory sleeping areas, congregate bathrooms, meals	Participants have access to all DP services at shelter and day program (includes case management, and varied groups); CTHI focuses on low demand engagement and case management, both on-site and "in vivo" in community	None required.
Park Avenue Shelter – Project Homeward	No program time limit	Congregate facilities: dormitory sleeping areas, congregate bathrooms, meals	Participants have access to all shelter on-site services; PH staff provide ADL services to support engagement, case management	PH staff very proactive in encouraging ADLs
BRC – Palace Hotel Lodging House Program	Lodgers have tenancy rights. Duration will be limited by renovation timetable and plan, which entails demolition of cubicles	Individual cubicles; shared bath; individual table-top cooking (not provided by BRC)	Housing placement assistance and whatever case management that entails (e.g., help with entitlements, job searches, treatment referrals)	None required

Table 1.3 Organization of Housing and Services, continued...

	Conditions, Length of stay	Units and Facilities	Services and Supports	Expectations for Service Participation
Housing Programs				
WSFSSH – 129th Street Long-Stayers Project	Licensed Adult Home. No limits on length of stay.	Single and shared rooms, shared bathrooms, congregate meals	Structured, supportive milieu; counseling, case management, group activities, monitoring, meds supervision, psychiatric treatment on site, money management, budgeting. CTHI augments staffing, enhances services.	Medication, treatment services are required; case management contact required
DAH – Pacific Bay Inn	Long-term transitional housing with DPH housing subsidy; individual lease, all tenancy rights.	All single rooms with private bathrooms. No cooking facilities. No congregate meals.	Case management and vocational services on site; referrals off site for treatment. Third party rent payment; tenant organizing on site.	All services optional
DAH – Windsor	Long-term transitional housing with DPH housing subsidy; individual lease, all tenancy rights. 16-bed respite unit has 2-8 wk limit; no tenancy rights	Most single rooms, half with private bathrooms. One shared kitchen. No congregate meals.	Case management and medical assessment, some treatment services on site; third party rent payment; tenant organizing on site. Some acute care in Respite unit	All services for regular tenants optional Respite clients required to meet with staff and to follow treatment plan
LAMP Ballington	Long term housing with individual sublease tenancy rights	Single Room, private bath, standard kitchen	Resident advocate and office on site; most services at LAMP	All services optional
LAMP Pershing	Long term housing with subsidy and standard lease; tenancy rights	Single rooms, some with private and some with shared bath. Common kitchen.	Resident advocate and community room on site; some groups, most services at LAMP.	All services optional – but tenants with S+C subsidy required to meet with CM

CHAPTER 2
CHARACTERISTICS OF PROGRAM PARTICIPANTS

The programs in this evaluation targeted their services at homeless populations with significant barriers to housing. A given program's eligibility criteria reflected the larger client population served by the sponsoring agency, the subgroups of that population available at a given site, and the agency or program emphasis on and experience in addressing particular kinds of needs. But as noted in Chapter 1, programs that do not require participants to meet particular criteria such as long-term homelessness or mental illness do not thereby exclude people with those experiences. Thus we need to determine whom the programs actually served and housed – not only to consider whether specific programs actually served the groups they targeted, but also to assess whether the diverse interventions described here were implemented for similar or different populations. To the extent that the programs served markedly different groups, comparisons of their outcomes are likely to confound program differences with differences between the programs' participants.

To describe and compare participants of the six programs, we collected data on the social and demographic characteristics, personal histories, and clinical descriptors of the first cohort[4] of individuals at each site. Methods for data collection and analysis were spelled out in detail in the original study design and are summarized in this report's Appendix B. Results from these analyses are presented below.

A. Shelter and Lodging House Residents at Three Sites

At the shelter and lodging house programs, the population focus was largely "given." Each of these programs served single-gender populations (women at Deborah's Place and at Project Homeward; men at BRC's Palace Hotel Lodging House) and long-term residents at the site (since 1996 for Project Homeward; since 1993 at the Palace; and several years at Deborah's Place, though DP had no specific criterion for being a long-term resident). The Palace used no further criteria for targeting the efforts of the housing specialist, which were addressed to all men occupying cubicles in the lodging house. At Deborah's Place, women receiving specialized case management services through CTHI were selected from the general population on the basis of their lack of engagement in services despite long-term exposure to the various forms of assistance DP mades available. The long-term shelter residents selected for Project Homeward were also identified by staff as unengaged in services and in particular need of assistance with basic hygiene and grooming. Like the shelter population as a whole, all were older women with psychiatric diagnoses.

Tables 2.1a through 2.1c present data on the characteristics of the first cohort of individuals served by these three programs. The data confirm that all three programs focused efforts on the

[4] At Deborah's Place and the BRC Lodging House, the size of the cohort was determined by the programs' criteria. At Park Avenue, the capacity of PH was 20 women, but as they moved on, PH services were extended to a "waiting list" of long-term residents. Our sample there exceeded the first group chosen for services. At the housing sites, our numbers also exceeded the number of housing slots because of turnover that occurred before all units were filled.

population they intended to serve but also indicates some differences in the groups that had become entrenched at the three sites.

Social and Demographic Characteristics and Personal History

The single-gender focus of these programs reflected the congregate nature of shelter and lodging house settings, where privacy could be extremely limited and storage, sleeping, and/or bath facilities were shared. The preponderance of women in our overall shelter/lodging sample is not typical of the single homeless population, in which men typically outnumber women by as much as three or four to one (Burt 2001). However, some research suggests that older, single women with long-term homelessness are particularly difficult to engage in services (Cohen et al., 1997), implying they may be disproportionately included among those who become entrenched in shelter or other homeless program sites. Project Homeward's clients at the Park Avenue Shelter, the only shelter where age was a criterion, had the oldest mean age (64.33 years) of the three shelter/lodging house programs. While the shelter only accepts women over 45 years – younger than the mean age not only at the Palace (52.61 years) and at DP (51.25 years), but at all three of the housing programs participating in the CTHI Evaluation as well (see Table 2.1a), data provided by shelter administrators show the average age in the Park Avenue Shelter population as a whole was 56 years, indicating that PH participants were drawn from the shelter's older residents.

African-Americans and other non-Hispanic Blacks comprised a large majority (82%) of the Palace lodgers, and somewhat more than half (56%) of the Project Homeward clients at Park Avenue. In contrast, non-Hispanic Whites formed a sizeable majority (75%) at Deborah's Place and a significant minority (42%) in Project Homeward. Latinos, Asians, and Native Americans were all but absent from the three programs, though Latinas made up nearly a quarter of the Park Avenue shelter population as a whole during that period[5].

All residents at the shelter/lodging sites were living as "single" adults, and most had little contact with family members. At Deborah's Place, where over half the women had been married at some point, only 9% had regular contact with relatives. Among Project Homeward women, over half (56%) had been married. Only 8% were in regular contact with one or more family members but close to one third (31%) had occasional contact with relatives. Among lodgers at the Palace, most (76%) had never married. Less than one fifth (15%) were known to be in regular contact with any family members and another 19% had occasional contact.

Educational and occupational attainments varied. At Deborah's Place and among PH women, at least a plurality were high school graduates, and more than a quarter more had some college education (25%). At the Palace, most of the men whose educational history was known had not completed high school. While more than half of the men had not been employed in the past five years, 25% had worked within the prior year, while only 14% at Deborah's Place and none of the Project Homeward participants had such recent employment, and a large majority at both sites had not worked in the past five years. At the point the CTHI and Project Homeward programs began, close to one quarter of the women in Project Homeward and one third of the long-term group at Deborah's Place had no source of income, while only 7% of the lodgers had no income.

[5] Information on overall population was provided by Park Avenue Women's Shelter administrators.

Another third at DP relied on benefits such as SSI, social security, or public assistance. Three quarters of the lodgers and a similar proportion of PH women received entitlements..

Residence histories of shelter residents and lodgers were hard to piece together, and the programs often had only sketchy information about where residents had lived previously, but all had extended stays at the shelter or lodging sites where the programs were based. All of the Palace lodgers had been staying there for more than four years at the time the housing specialist began work, and over 90% of the women at Deborah's Place, and three quarters at Park Avenue had been in residence that length of time. Over one quarter of the lodgers were known to have been incarcerated in jail or prison at some point, though length of time and charges for most were unknown. Small proportions of the PH and DP residents had jail or prison histories.

Health, Mental Health, and Substance Use Problems

Serious health problems abounded in the long-term shelter and lodging house populations. At DP, over 90% had one or more serious medical problems, with one-quarter of the women reporting stomach problems, and smaller proportions affected by diabetes, asthma, and TB. At the Park Avenue shelter, 79% of the women were found to have one or more serious condition. Hypertension was most prevalent (28%), followed by diabetes (14%) and cancer (11%). Among the lodgers at the Palace, over half had at least one serious condition. Hypertension was the most commonly identified (18%), followed by diabetes (9%); heart disease, bronchitis, HIV/AIDS, circulatory problems, and liver disease each affected one or two individuals.

There were greater contrasts between the sites in mental health status. The Park Avenue Shelter was designated to serve only women with severe Axis I psychiatric disorders, and in fact all the PH women were assessed by the program psychiatrists as having an Axis I disorder, 81% diagnosed with severe disorders such as schizophrenia, schizoaffective, bipolar, delusional, or other psychotic disorders; and 19% diagnosed with dementia and other organic psychiatric disorders. Notably, only 22% were taking medication at the time Project Homeward became operational. At Deborah's Place, where having a psychiatric disorder was not a criterion for admission and psychiatric evaluations were not performed on site, observational assessments by the CTHI case manager and supportive evidence from records identified 42% of the women as having severe Axis I disorders such as schizophrenia, bipolar, schizoaffective, delusional or other psychotic disorders; but the case manager also noted that almost all of the women displayed some symptoms of functional or organic mental illness but information on specific psychiatric diagnoses was not routinely available. None were taking psychotropic medications at the CTHI program's inception. The Palace, also, did not screen for psychiatric disorders. Assessment by the housing specialist – using clinical records, when available – identified most of the men as having probable Axis I diagnoses, with 15% assessed with schizophrenia, bipolar, delusional or other psychotic disorders; 9% with depression or dysthymia, and 3% with dementia or other organically-based psychiatric disorders. Just 10% of the lodgers were taking psychiatric medications when the housing specialist began working at the Palace. Case managers and other workers at all sites sometimes described residents as having Axis II personality disorders, but these assessments were usually based on impressions rather than diagnostic assessment and will not be presented here.

Just as the Park Avenue Women's Shelter screened in residents with psychiatric disorders, those with concurrent substance use disorders tended to be screened out to other shelter programs that specialized in serving people who were dually diagnosed with substance and non-substance psychiatric disorders. Nonetheless, 14% of the Project Homeward women at Park Avenue were assessed as having current problems with alcohol; 6% had abused drugs. All told, 8% were given dual diagnoses of major psychiatric and substance use disorders. At Deborah's Place, where there was no policy of excluding women with substance use problems, they were nonetheless rare among the women served by the CTHI case manager: 17% had current or past problems with alcohol, and none were assessed as having problems with other drugs; only 8% combined psychiatric and substance abuse problems. At the Palace, approximately one third of the lodgers were judged to have current or past problems with alcohol, and 37% had past or current problems with other drugs. Despite the higher prevalence of substance problems at the Palace, only 3% of the men had both psychiatric and substance use disorders.

Each of the shelter and lodging programs, then, served residents with a somewhat distinctive combination of gender, age, problems and disabilities, reflecting the differing contexts from which residents were recruited as well as the varied social geographies of their locales. But residents of the three sites also had important similarities as older adults with numerous health problems and a variety of serious mental health disorders that were largely untreated. They had extremely long histories of homelessness, very limited recent employment histories, and minimal contact with family members.

B. Tenant Populations at Three Housing Sites

At the other end of the span between homelessness and housing, several of the CTHI programs provided housing with supportive services to formerly homeless men and women with multiple disabilities and/or long-term homelessness that exacerbated their difficulties in exiting from homelessness. As in the shelter/lodging house programs, characteristics of the residents in the housing programs reflected both the CTHI focus on long-term and multiply disabled homeless adults and the particular populations from which participating programs recruited tenants.

In New York City, at WSFSSH's 129th Street Residence, where 20 beds were set aside for individuals with long-term (i.e. two years or more) histories of homelessness, those who qualified also had to meet the residence's criteria for age (over age 45) and psychiatric diagnosis (Axis I disorders other than or in addition to Substance Use Disorders). In the Direct Access to Housing program in San Francisco, the Pacific Bay Inn and Windsor Hotel worked with a variety of providers of homeless, mental health and other social services to recruit dually diagnosed homeless individuals (qualifying diagnoses included psychiatric disorders, substance use disorders, and HIV/AIDS). Duration of homelessness was not a specific criterion for obtaining housing in a DAH program. Lamp's housing programs at the Ballington and Pershing recruited from within the population of homeless people with mental illness staying on Skid Row and using Lamp services. No additional criteria (e.g., age, duration of homelessness, dual or multiple disabilities) were required for these sites.

Tables 2.2a-c present data on the characteristics and personal histories of the men and women who met criteria for the "Long Stayers" program at WSFSSH, for DAH's housing programs at PBI and Windsor, and for Lamp's Ballington and Pershing housing programs[6]. As a licensed facility funded to provide fairly extensive services, WSFSSH collected a great deal of information on residents through its application and intake process, which required documentation of psychiatric and medical histories, psychosocial assessment and psychiatric evaluation. In contrast, screening for the DAH programs was limited to verification of income and eligibility for the DAH subsidy. The San Francisco Department of Public Health accepted the referral agency's assessment that prospective tenants were homeless and had multiple problems with mental health, medical conditions, and substance use, and did not conduct additional screens for these criteria. Service intake at the sites focused on tenants' self-reported service needs, and support services workers limited their requests for information to that which was pertinent to immediate services requested. Lamp tenants included some who had long histories with the agency and were thus well-known to workers, as well as some newer members of the Lamp community recruited through outreach in the jail population. Less was known about the history of this latter group.

Demographics and Personal History

Table 2.2a shows that as in the single homeless population more generally, men predominated at all three housing sites. At the 129th Street Residence, they comprised 88% of those in the Long Stayers project. The WSFSSH residence served an older population, consistent with it's designation as an Adult Home for older homeless adults. A large majority (75%) of Long-Stayers Project residents there were African-Americans and others of African descent. About one third had been married at some point. Close to half had no contact with relatives, but 13% had occasional and 39% had regular family contact. Table 2.2b indicates that while half had completed high school or more, only 9% had worked in the past five years, and all relied on entitlements (mainly SSI) as their main source of financial support. Homeless histories were consistent with the program's emphasis on long-term shelter stayers: 92% had been homeless for more than one year and two-thirds for more than two years. One-fifth had been incarcerated in jail or prison at some point in their lives.

At the two DAH programs, men comprised a substantial majority (66%), though smaller than at WSFSSH (see Table 2.2a). Unlike WSFSSH, neither of the DAH sites had an age criterion, yet most tenants were middle aged (average was 48.51 years); Only 15% of those entering were under 40 years of age. The largest racial/ethnic group at both DAH sites were African Americans and other people of African descent, who made up 41% of the tenants at these programs. About one-third of the DAH tenants non-Hispanic Whites; Latinos accounted for 16%, and Asians and Native Americans were represented in small numbers. About half of the DAH tenants were known to have ever had a spouse or domestic partner; and 45% had either

[6] As in the shelter programs, data were provided by program staff and records, and the contrasting needs and practices of the programs result in uneven data on some issues. We therefore limit the descriptions and comparisons presented to items which were routinely available at all sites. The focus here is on the core constituencies at each program: the "long stayers" at WSFSSH's 129th Street Residence; DAH tenants (but not Windsor Respite patients or the PAES or pre-existing tenants at the PBI and Windsor DAH sites); and members of Lamp's community who occupied permanent housing at the Ballington and Pershing sites (excluding those staying in Ballington units used as emergency shelter). The characteristics of the other groups at the DAH and Lamp sites are included in the site profiles that make up Appendix B).

occasional or regular contact with family members. Table 2.2b shows that most DAH tenants had high school diplomas. As at the 129th Street Residence, DAH tenants relied primarily on SSI, SSDI and local welfare programs as their major sources of financial support, but a small number at these sites (20%) were currently or recently employed. Homelessness histories varied in duration, but about two-thirds had been homeless for two years or more. Less than one-quarter were known to have been incarcerated.

The Lamp housing programs both drew largely from within the Lamp community. We see in Table 2.2a that about two-thirds were men, average age was 43.05, and 50% were African American; whites made up 41%. About three-quarters had never been married, over half had no contact with their families. Most Lamp tenants had completed high school or more; a majority had been employed in the past five years, 30% in the past year, though almost all (90%) were receiving entitlements benefits at the point they moved into the Ballington or Pershing (see Table 2.2b). About half of those whose homeless histories were known had been without housing for more than two years, and half had experienced incarceration at some point in their lives.

Health, Mental Health, and Substance Use

Table 2.2c shows that the residents at 129th Street had a variety of health and mental health problems. Over one quarter had hypertension and a similar number had diabetes. Heart disease affected 17% and 13% had HIV or AIDS. Most residents (75%) had been diagnosed with severe Axis I psychiatric disorders (schizophrenic, schizoaffective, bipolar, delusional and other psychotic disorders), and smaller numbers suffered from depression, dementia, and other Axis I disorders. Virtually all residents took psychotropic medications, and 88% had been taking such medications at the point they moved into the residence. Though the building was a clean and sober facility which did not permit residents to drink or use drugs, and all but a few were abstinent when they moved in, two-thirds of the Long Stayers at 129th Street had a history of alcohol problems 38% had histories of drug abuse. And two-thirds had dual diagnoses of psychiatric and substance use disorders.

Tenants in the two DAH programs had varied clinical profiles. As at WSFSSH, hypertension, diabetes, and HIV/AIDS were among the most prevalent medical problems. In addition, tenants suffered from a large array of other physical disabilities and diseases (for example, chronic obstructive pulmonary disease, hepatitis C, seizure disorders, glaucoma) that are included in Table 2.2c as "Other Health Conditions." While many DAH tenants had psychiatric diagnoses, this was not a requirement for admission, and over a quarter had no Axis I disorder. However, close to one third of the DAH group had major psychotic disorders, another 25% were diagnosed with depression, and 20% had other Axis I diagnoses. Substance abuse problems were also prevalent at the DAH sites: 60% of DAH tenants were identified as having current or past problems with alcohol and 45% had abused drugs. One third of the tenants at the DAH sites were dually diagnosed with psychiatric and substance abuse disorders.

Most tenants at the Lamp sites had at least one serious health problem, and several had multiple health problems. At the two sites combined, three quarters had been diagnosed with serious psychotic psychiatric disorders, and at the point they entered the housing programs, a large majority (85%) had been taking psychotropic medications. Substance abuse problems were common at Lamp sites, and about one-third of Lamp tenants had dual diagnoses.

The modal tenant at the three housing sites was an African American man in his late forties, never married, and not in contact with relatives. He was a high school graduate but had not worked in recent years and was supported by entitlements programs. He had been homeless for over two years. He also had a large number of health problems, was likely to have a serious psychiatric diagnosis, and was taking medication when he moved into housing. He had a history of substance abuse and was likely to be dually diagnosed with psychiatric and substance disorders. There was some variation between sites, with WSFSSH housing a group that was older, less educated, with longer homeless histories, less recent employment, more health problems, and more past substance abuse than the other sites. The DAH sites had more tenants without psychiatric diagnoses than the other sites but also had the highest levels of active substance abuse. Lamp tenants were a bit younger than the others, had more substantial recent employment histories, somewhat less extensive histories of homelessness, but included more people with histories of incarceration than the other sites.

C. Comparison of Shelter/Lodging Residents versus Housing Tenants

While all sites focused their efforts on homeless individuals who had not been successfully housed or served, the long-term residents of the shelter and lodging house sites comprised a fixed pool of individuals selected because of their longevity at these "temporary" sites. The housing programs, in contrast, recruited individuals from a variety of agencies, programs, or facilities, suggesting there might be more diversity in the housed than the sheltered population. Table 2.3 compares these two groups. We limit the focus here to the 81 long-term residents who were the focus of specialized services in the shelter/lodging house programs, and the 153 housed individuals who were the primary focus of program efforts – that is, the "Long-term Shelter Stayers" at WSFSSH, the DAH tenants at PBI and Windsor, and Lamp's permanent housing tenants at the Pershing and Ballington. (At the DAH sites, respite patients, pre-existing tenants, and Tenderloin Housing Clinic's PAES tenants are excluded, as are Lamp's Ballington shelter guests.)

Table 2.3 reveals fairly striking contrasts between the populations served by the shelter/lodging and the housing programs: shelter/lodging house residents were significantly older, had been homeless longer, and were less likely to have recent support from employment or entitlements programs. There is also a non-significant tendency for shelter/lodging residents to have had less family contact. (They were also more likely to be African American, which appears to reflect the overall shelter populations of cities where they are located; and to be women, which is an artifact of the inclusion of two women's shelters in the study and is not typical of unaccompanied homeless adults in general.) Notably, there are no significant differences in health or mental health problems, although shelter/lodging residents were less likely to be taking psychotropic medications. And somewhat surprisingly, the shelter/lodging house group was significantly less likely to have lifetime diagnoses of alcohol or drug abuse or to be dually diagnosed with psychiatric and substance abuse. The differences identified are highly significant statistically, with most having less than a 1% likelihood of occurring by chance.

It is notable that while virtually all individuals served by both shelter/lodging and housing programs would meet current federal criteria for "chronic homelessness" (a disabling mental, physical or substance abuse condition and one year of continuous homelessness or four episodes in the past three years), the residents of shelter/lodging programs were in many ways a distinct population from the individuals recruited from diverse homeless service settings into the permanent housing programs. While no more likely than housing tenants to have had major health and mental health problems, they were far less likely to have had substance abuse problems or dual diagnoses, they appear to have been more estranged from supports and treatment and more entrenched in their homelessness. This is not surprising, given that the programs targeted them for services on the basis of their inability or unwillingness to participate in other program offerings at the sites where they were staying, while housing tenants had taken some active role in the process of applying for accommodations at WSFSSH, DAH and Lamp. In the remaining sections of this report, we will consider what distinctive services and engagement strategies were used in the programs serving these contrasting groups and how both groups fared in terms of homelessness and housing status over the course of the follow-up period.

Table 2.1 Resident Characteristics at Shelter and Lodging Program Sites

a. Social and Demographic Characteristics

	Deborah's Place CTHI N=12	Project Homeward N=36	BRC Palace Lodgers N=33	Shelter/ Lodging Programs Total N=81
	%	%	%	%
Gender				
Female	**100**	**100**	**0**	**59**
Male	**0**	**0**	**100**	**41**
Transgender	**0**	**0**	**0**	**0**
Age Group				
20-29	**0**	**0**	**0**	**0**
30-39	**17**	**0**	**6**	**5**
40-49	**25**	**8**	**24**	**17**
50-59	**33**	**25**	**48**	**36**
60-69	**25**	**31**	**15**	**23**
70+	**0**	**36**	**6**	**19**
Race/Ethnicity				
Non-Hispanic Black	**25**	**56**	**82**	**62**
Latino/Hispanic	**0**	**3**	**3**	**2**
Non-Hispanic White	**75**	**42**	**6**	**32**
Asian	**0**	**0**	**0**	**0**
Other	**0**	**0**	**9**	**4**
Marital Status				
Ever Married/ Domestic Partner	**55**	**56**	**24**	**45**
Never Married	**45**	**44**	**76**	**55**
Family Contact				
None	**91**	**61**	**60**	**65**
Occasional	**0**	**31**	**12**	**19**
Regular	**9**	**8**	**28**	**15**

Mean Age	51.25 years	64.33 years	52.61 years	57.62 years

Table 2.1 Resident Characteristics at Shelter and Lodging Program Sites

b. Personal History

	Deborah's Place CTHI N=12	Project Homeward N=36	BRC Palace Lodgers N=33	Shelter/ Lodging Programs Total N=81
	%	%	%	%
Education				
< HS Grad	**14**	**31**	**64**	**41**
HS Grad/GED	**57**	**41**	**27**	**38**
Higher Ed	**29**	**28**	**9**	**21**
Last Employed				
Within last yr	**14**	**0**	**25**	**13**
1 – 5 Yrs	**0**	**0**	**21**	**9**
More than 5yrs	**86**	**90**	**54**	**73**
Never	**0**	**10**	**0**	**5**
Primary Means of Support				
Benefits	**36**	**74**	**76**	**69**
Employment	**0**	**0**	**14**	**6**
Other	**27**	**3**	**3**	**6**
None	**36**	**23**	**7**	**19**
Months Homeless				
< 12 months	**0**	**8**	**0**	**4**
12-23 months	**0**	**8**	**0**	**4**
24-47 months	**8**	**8**	**0**	**5**
> 47 months	**92**	**75**	**100**	**87**
Ever Incarcerated	**8**	**11**	**27**	**17**

Table 2.1 Resident Characteristics at Shelter and Lodging Program Sites

c. Health, Mental Health and Substance Abuse

	Deborah's Place CTHI N=12	Project Homeward N=36	BRC Palace Lodgers N=33	Shelter/ Lodging Programs Total (N=81)
	%	%	%	%
Health Conditions				
Hypertension	8	28	18	20
Heart Disease	0	6	6	5
Diabetes	17	14	9	12
Asthma	17	0	0	2
Bronch/Emphysema	0	3	6	4
Cancer	0	11	0	5
TB	17	6	3	6
HIV/AIDS	0	0	6	2
Circulatory	0	6	6	5
Stomach	25	3	0	5
Liver/Cirrhosis	8	0	6	4
Other	92	58	33	52
Total Number of Health Conditions				
None identified	8	21	37	25
1	50	32	26	33
2	17	38	26	30
3	8	6	7	8
4 or more	17	3	4	5
Axis I Psych Dx				
None	08	0	49	20
Psychotic Dx (Sz, BP)	42	81	15	47
Depression	0	0	9	4
Other Axis I	58	19	27	28
Psych Meds at BL	0	22	10	14
Substance Abuse: BL				
Alcohol Abuse at BL	0	6	18	10
Drug Abuse at BL	0	0	26	9
Any Sub Abuse at BL	0	6	33	15
Subst Abuse: Ever				
Alcohol Abuse Ever	17	14	33	22
Drug Abuse Ever	0	6	37	16
Any Subst Abuse Ever	17	14	52	28
Dual Dx (Psy + SA)	8	8	3	6

Table 2.2 Resident Characteristics at Housing Program Sites

a. Social and Demographic Characteristics

	WSFSSH 129th St Long Stayers N=24	DAH PBI & WIN (N=87)	LAMP Ball. & Pers (N=42)	Housing Programs Total (N=153)
	%	%	%	%
Gender				
Female	**13**	**32**	**36**	**30**
Male	**88**	**66**	**64**	**69**
Transgender	**0**	**2**	**0**	**1**
Age Group				
>20	**0**	**0**	**2**	**1**
20-29	**0**	**5**	**5**	**3**
30-39	**8**	**10**	**26**	**14**
40-49	**29**	**40**	**43**	**39**
50-59	**29**	**33**	**14**	**27**
60-69	**25**	**9**	**10**	**12**
70+	**8**	**2**	**0**	**5**
Race/Ethnicity				
Non-Hispanic Black	**75**	**41**	**50**	**49**
Latino/Hispanic	**13**	**16**	**7**	**13**
Non-Hispanic White	**13**	**33**	**41**	**32**
Asian	**0**	**3**	**2**	**3**
Other	**0**	**6**	**0**	**3**
Marital Status				
Ever Married/ Domestic Partner	**35**	**49**	**26**	**40**
Never Married	**65**	**51**	**74**	**60**
Family Contact				
None	**48**	**55**	**53**	**53**
Occasional	**13**	**22**	**24**	**21**
Regular	**39**	**23**	**24**	**26**
Mean Age	54.00 years	48.51 years	43.05 years	47.87 years

Table 2.2 Resident Characteristics at Housing Program Sites

b. Personal History

	WSFSSH 129th St Long Stayers (N=24)	DAH PBI & WIN (N=87)	LAMP Ball. & Pers (N=42)	Housing Programs Total (N=153)
	%	%	%	
Education				
< HS Grad	50	40	30	39
HS Grad/GED	33	30	48	36
Higher Ed	17	30	21	26
Last Employed				
Within last yr	0	20	30	19
1 – 5 Yrs	9	18	27	19
More than 5yrs	77	45	33	48
Never	14	17	9	14
Primary Means of Support				
Benefits	100	87	90	90
Employment	0	7	0	4
Other	0	3	7	4
None	0	2	2	2
Months Homeless				
< 12 months	0	18	21	15
12-23 months	8	17	25	17
24-47 months	25	38	17	31
> 47 months	67	27	38	37
Ever Incarcerated	21	22	50	29

Table 2.2 Resident Characteristics at Housing Program Sites

c. Health, Mental Health and Substance Abuse

	WSFSSH 129th St Long Stayers (N=24)	DAH PBI & WIN (N=87)	LAMP Ball. & Pers (N=42)	Housing Programs Total (N=153)
	%	%	%	%
Health Conditions				
Hypertension	29	12	24	16
Heart Disease	17	5	10	8
Diabetes	29	11	10	14
Asthma	4	6	12	7
Bronch/Emphysema	0	3	2	3
Cancer	8	1	5	3
TB	4	2	2	3
HIV/AIDS	13	8	5	8
Circulatory	0	0	5	1
Stomach	4	2	0	2
Liver/Cirrhosis	0	3	2	3
Other	67	56	29	50
Total Number of Health Conditions				
None identified	8	29	36	27
1	46	43	28	39
2	13	21	19	19
3	29	8	17	14
4 or more	4	0	0	1
Axis I Psych Dx				
None	4	24	2	15
Sz, BP, other Psychotic Dx	75	31	74	50
Depression	8	25	19	21
Other Axis I	13	20	5	14
Psych Meds at BL	88	37	85	60
Subst Abuse: Baseline				
Alcohol Abuse at BL	4	25	14	19
Drug Abuse at BL	4	21	26	23
Any Subst Abuse BL	8	37	31	31
Subst. Abuse: Ever				
Alcohol Abuse Ever	67	60	29	52
Drug Abuse Ever	38	45	40	43
Any Subst Abuse Ever	71	79	50	70
Dual Diagnosis	63	33	31	56

Table 2.3. Comparison of CTHI Shelter and Housing Populations*

	Shelter Programs N=81	Housing Programs N=153	Totals N=234	X^2 , *df*, p value
Characteristics	%	%	%	
Sociodemographic				
Age 50 or more	**78**	**42**	**54**	**X^2=27.577, *df*=1, p=*.000***
Female	**60**	**31**	**41**	**X^2=18.904, *df*=1, p=*.000***
Ever married	46	40	42	Not Significant
HS grad or more	59	61	60	Not Significant
African American	62	49	54	Not Significant
Housing and Support				
Homeless > 4yrs	**87**	**37**	**57**	**X^2=46.984, *df*=1, p=*.000***
Employed in last 5yrs	**22**	**37**	**32**	**X^2=4.561, *df*=1, p=*.033***
Receiving SSI or PA at BL	**61**	**87**	**78**	**X^2=21.412, *df*=1, p=*.000***
Receiving Any Entitlements at BL	**67**	**90**	**82**	**X^2=19.910, *df*=1, p=*.033***
Any Family Contact	19	33	28	Not Significant
Health, Mental Health				
2+ Health problems	43	33	36	Not Significant
Any Axis I Diagnosis	80	85	83	Not Significant
Psychotic Disorder	48	50	49	Not Significant
Taking meds at BL	14	60	42	**X^2=40.760, *df*=1, p=*.000***
Substance Abuse				
Alcohol Abuse at BL	10	19	16	Not Significant
Drug Abuse at BL	10	20	16	Not Significant
Any Substance Abuse at BL	**15**	**31**	**25**	**X^2=6.452, *df*=1, p=*.011***
Alcohol Abuse ever	**21**	**52**	**42**	**X^2=21.379, *df*=1, p=*.000***
Drug Abuse ever	**16**	**43**	**34**	**X^2=15.313, *df*=1, p=*.000***
Any Substance Abuse ever	**28**	**70**	**56**	**X^2=33.989, *df*=1, p=*.000***
Dual Dx: Psychiatric + Substance Abuse	**6**	**37**	**27**	**X^2=26.272, *df*=1, p=*.000***

*All variables were represented as dichotomies (yes/no) in 2x2 cross-tabulations. For ease of presentation, only positive responses are displayed in the table.

PART II

SHELTER/LODGING PROGRAMS:

SERVICES, ENGAGEMENT, AND HOUSING OUTCOMES

INTRODUCTION

Part II of this report focuses on the three shelter or lodging programs which, as described in Part I, differed from the CTHI housing programs in the populations they focused on and in the nature of their interventions. They targeted relatively fixed groups[7] of more or less permanent residents at the shelter or lodging sites, where at any given time they made up a substantial portion of residents (about 40% of women staying at Deborah's Place; 20% of those at Park Avenue; and 100% of the lodgers who remained at the Palace). Designed to go beyond usual service efforts, all emphasized finding new ways to connect with their clients and engage them in trusting relationships in order to better identify and address their service and housing needs.

Our examination of these three programs addresses several descriptive questions: how did the programs approach engagement? What did they hope to accomplish? What services did the programs provide? What barriers did they encounter? How successful were they in moving people into housing? The four chapters in Part II draw on both qualitative data and quantitative analyses to answer these questions. We begin in Chapter 3 with a qualitative description of each program's approach to services and engagement, followed by a cross-site comparison of the goals of engagement articulated by staff and administrators, the strategies and barriers they identified, and the features of program context that shaped engagement and service processes. Chapter 4 turns to the quantitative data for a summary of services the programs provided to the long-term residents they targeted and the levels of engagement they achieved during the first two years of program operations. Chapter 5 presents a description of housing outcomes and a correlational analysis of their relationships to services and engagement. Chapter 6 concludes Part II with a synthesis of the data analyses of services, engagement, and housing outcomes in the shelter and lodging programs and identifies additional factors that the qualitative data suggest shaped the course and outcome of engagement and service efforts.

The quantitative data on services provided, levels of engagement, and housing outcomes presented in Chapters 4 and 5 describe the first two years of operation of the specialized CTHI/PH programs for long-term residents[8] – a period when all three programs focused most intensively on engaging long-term residents.[9] Qualitative data from the staff narratives of individual engagement cover the same period, but this is supplemented with interview and focus group data that span the entire period of the evaluation and allow us to update program-level events and processes through more than four years of the study.

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[7] At Park Avenue Women's Shelter, where the initial list of long-stayers exceeded Project Homeward's capacity, the women most in need of help with hygiene were selected to receive services first. As they left the shelter, they were replaced with other long stayers; those with hygiene needs were given priority as replacements.

[8] Our original study design entailed a one-year follow-up period. However, after the study was underway, it became apparent that the process of engagement and housing at these sites would require a longer time frame and the programs agreed to extend the individual-level data collection over the second year.

[9] At BRC, the two years coincided with the period of active, routine involvement at the Palace by the housing specialist. At Park Avenue, it spanned the duration of Project Homeward, which was subsequently replaced by the Shelter Mental Health Service Program. Only at Deborah's Place did intensive engagement efforts with long-term residents continue in much the same manner, though even there, the long-term residents who remained at the site were eventually added to the caseload of a case manager who served other DP clients as well.

Establishing the Baseline: Services Provided Before CTHI

The long-term residents served by the shelter and lodging house programs are a special subgroup of the long-term homeless population. The agencies operating the programs had undertaken a host of earlier efforts – ranging from co-locating transitional and permanent housing at the same site as the DP overnight shelter, to the enhanced social work and case management staffing that LHNH brought to Park Avenue when it took over the shelter, to BRC's attempt to evict all lodgers when the agency first took over the building. Long-term residents who were the focus of the programs examined here remained after successive "winnowing" of the population, and thus represent those with the greatest barriers to alternative housing.

Since the men and women in the shelter and lodging house programs had long histories at the sites where they resided, all were known to staff at the sites prior to the start of the CTH Initiative and PH, and all had received basic shelter services – at minimum, a bed to sleep in. Data on the proportion of residents at the sites who had previously received additional services (included in site profiles that make up Appendix B) indicate that at the DP and Park Avenue women's shelters, most women had received the direct services that were available as part of the basic shelter package: food, clothing and showers. Since DP's shelter was closed during daytime hours, most DP women also used the agency's day shelter program at another location as a drop-in site. While BRC's lodging house did not provide men who lived there with services other than a cubicle and shared shower facilities, some received home-delivered food from the senior center program BRC operated in the neighborhood. Services available through other BRC programs at the Palace – drop-in facilities, clothing – were used only rarely by lodgers.

The agencies also counseled residents about health, mental health, and entitlements. The two women's shelter programs made social and clinical services available to residents on-site: over one third of long-stay women at DP and over half of the PH participants had previously received counseling or assistance regarding entitlements and medical help or first aid; and most of the PH women had received psychiatric evaluations performed by the shelter's psychiatrist, though few had been engaged in ongoing psychiatric treatment. At the Palace, only one or two lodgers had availed themselves of clinical or other services offered by BRC programs in the building or at other BRC sites. At all sites, a small number of those in the targeted population had previously accepted medical and psychiatric referrals, usually in emergency situations, rather than as linkages to on-going health and mental health care. Thus the new efforts to engage and serve long-term residents that we document here began against a background of residents' participation in the shelter or lodging house routines but their minimal further service involvement, despite lengthy stays at the sites.

CHAPTER 3
APPROACHES TO ENGAGEMENT AND SERVICE DELIVERY: A QUALITATIVE ANALYSIS

A. Description of Program Approaches to Engagement and Services

The three shelter/lodging house programs in this study were developed to enhance service engagement for their long-term residents. In this chapter we draw on interviews with case managers, group discussions with program staff and administrators, and workers' narratives of efforts to engage and serve individual residents to describe each program's approach to engagement; the goals, barriers, and strategies that staff at the sites identified; and the features of context that have shaped these efforts and their outcomes[10].

Deborah's Place

Prior to the CTH Initiative, Deborah's Place had tried in several ways to offer women residing in the overnight shelter an easy transition to housing that did not require a sharp break with the safety and nurturing environment of the DP community. The co-location of shelter, transitional housing, and permanent supportive housing "under one roof" at Deborah's Place II was one such effort (Proscio 1998). DP's client-centered approach to case management also was designed to support women throughout the various transitions involved in moving to housing. But approximately a dozen women became "regulars" at the overnight shelter despite these approaches. To address their needs, agency administrators held a series of meetings in 1998 to consider developing a "Safe Havens" program offering long-term accommodations with minimal barriers. However, concerned that this would deflect staff energies into new outreach and service delivery, DP administrators decided instead to pursue a targeted effort to identify what the long-term DP residents themselves wanted and find ways to respond. Thus DP hired the CTHI case manager with the goal of building relationships with the women. Some had barely talked to anyone at the shelter in years; others had offered little information about themselves, their needs or their desires; and most had remained reluctant to accept concrete assistance, social services, or help in obtaining housing, though they considered the shelter as their home. The CTHI case manager described her early contacts with some of the women[11]:

> *"She's incredibly difficult to engage, isolated, and doesn't talk to anybody. It's as if she has a problem understanding and hearing – maybe it's organic."*
>
> *"She's seriously disabled, not responsive. Most times it is like you are not even there. She just sits in a corner and doesn't ask for anything....I always have to stand there longer, it's like her eyes won't register you."*
>
> *"She's difficult to talk to because she's deaf."*

[10] The staff at these sites felt that direct data collection with residents through interviews or focus groups would not be feasible, given their tenuous involvement with the programs at the point the study began. We did, however, talk informally with some of the women in both PH and the DP program for long-term residents during our visits to the sites to meet with staff. At all three sites, however, we have focused primarily on staff reports of both their own activities and the residents' responses.

[11] Quotations in this and subsequent chapters come from verbatim notes recorded during data collection sessions with workers, site visit meetings, and focus groups."

The first CTHI case manager at DP used various low-keyed tactics to connect with the 12 women targeted for special assistance and to discover what they felt they needed or wanted. With a small caseload and the focused goal of relationship-building, she initially spent time just sitting with the women – in the smoking room, watching TV, outside the building, or wherever they were willing to tolerate her company. With some, there was little conversation, just a sharing of space; for others this eventually led to talk and perhaps trust. When they would agree, she took women on shopping trips, for lunch, to doctor's appointments, or on her routine errands to the different DP sites. She used these occasions of one-on-one contact to discover and respond to women's interests – old music, playing pool, talking about "the old days," – or to track down requested information (obituaries from New York and Chicago, the winner of the national spelling bee). She gave small practical gifts (loans, cigarettes, lunch, watch strap, stockings, scarves) or more substantial ones (personal stereo, reading glasses, shoes, clothing, phone cards, a camera, a flute, birthday presents). And she advocated with DP administrators to bend rules to accommodate special needs (for example, permission to stay in the shelter during daytime when sick).

The case manager usually took the initiative, offering to provide goods, do tasks, or spend time sitting with women or accompanying them when they left the shelter:

> *"I spend time [with her] in the smoking room....We talk about clothes and weather. After awhile she smiles. She asked me for an aspirin and I gave her one. I've spent a lot of time eating, smoking, drinking coffee."*

> *"I try to talk to her at the day shelter and the overnight. Hello and how are you. She usually doesn't answer, unless you stay there for a long time. I serve her lunch to ask her – her needs; I get involved in everyday activities to get her to participate."*

> *"Sometimes I would sit by her without talking and if I talked, she would say, 'I think you got me mixed up with someone else.'"*

Progress in engagement was measured in a woman's willingness to allow or accept these favors and gifts:

> *"I bought her shoes. I tried to give her a coat but she wouldn't accept it. I've given her socks and she accepts sometimes. I tried to give her a fleece jacket – she wouldn't look at me. She said 'I've seen you three times today' and mumbled she didn't want to talk to me."*

> *"Once I gave her clothes, and a writing pad, soda, and cigarettes. She didn't accept it for awhile, but [she did] after I think she understood it wasn't out of my own pocket and I didn't expect anything in return."*

> *"She accepted clothes and boots [I had] given her. Socks. She did not accept for me to go to the zoo with her...Car rides neither....Once or twice in the beginning she told me to go away, but after that, she's been very welcoming, even when she's in a bad mood."*

"I have to take things really slowly. I tried to rush once, giving her socks, and it wouldn't work. It has to be constant and slow. Now she sees me as someone she can ask for stuff, she won't brush me off."

A few of the women, however, generated such requests themselves, setting an ongoing series of tasks for the case manager. Occasionally a woman's insistence on something she wanted allowed the case manager to negotiate behavioral trade-offs (e.g. addressing hygiene issues), but generally the case manager sought trust and information rather than leverage:

"She wanted me to get busy into some stuff....Wanted me to get in touch with [a local] hospital to get records for fifteen years ago; she wanted haircut appointment; she wanted me to look up all the obituaries in New York and Chicago to see if her husband had died. She thought she might have a pension coming to her."

"*She would come to me for things she needed, approaching me at the day shelter and even calling me on the phone. She asked for help with hospital bills and asked for new shoes – I provided both. Now on the second Tuesday every month we go for lunch and to a bookstore."*

Though the CTHI engagement effort was not identified as a distinctive program to the long term residents or others within the shelter, these efforts served to acquaint even the most isolated women at DP with the role of a case manager and her availability to respond to their needs. This seemed to facilitate a transition to a new case manager that occurred after three years.

Both the original case manager and her successor in the position continuously pursued opportunities to discuss housing, offer information about options and application processes, and arrange visits to housing programs managed by DP and others. Most of the women, however, remained uninterested in alternative lodgings. Some dismissed any discussion of housing; others objected to the neighborhoods, requirements, or costs that housing would entail:

"I talked to her about some information I had on apartments, but she responded she wants to buy a house in the South. She said she felt responsible for her kids and didn't want to move [to the South] even though they were grown."

"I showed her a flyer of [DP's new] Rebecca Johnson apartments and DPII [housing program], and she thought about it. Later she refused, saying 'God doesn't have housing plans for me'."

"I showed her the flyer for the Rebecca Johnson apartments. She refused, saying she didn't have an ID. I offered to get her an ID and she refused because she didn't want to carry an ID."

"We spoke about the Rebecca Johnson apartments and she said she liked

where the shelter neighborhood is. She feeds the birds in the park and talks about that....There was a tour of Rebecca Johnson apartments and she said she'd think about it but didn't go. Later she asked me who went to the tour."

"*She talked about going to see the Rebecca Johnson apartments, but later she did not show up for the tour. She complained about how little money would be left if she had to pay one third of her General Assistance for rent."*

Even at housing programs known for their flexibility, the application process was a deterrent for some women. Others weathered it but found themselves rejected:

"*A lot of the women in my case load can't go to [Supportive SRO] because you go through four hours of waiting and interviewing with the case management first and then the property management. A lot of my clients don't make it. Though they are flexible in their interview. They've rejected women from Deborah's Place claiming they had an eviction on record or they couldn't get ID or a divorce certificate or they can't get all the references. And this is the easiest [of the housing programs]!"*

While DP's CTHI case managers continued to discuss housing with the long-term women over the course of the program, Deborah's Place was willing to provide shelter indefinitely. Thus the case managers were able to accept program participants' goals and preferences as the aim of engagement rather than a starting point for negotiating program-defined goals such as housing or other services.

"It's part of the philosophy to let them be, however long it takes to heal from their traumas."

"This is a safe environment. There's nothing mandatory. You don't have to do anything to participate. We offer choices but the women decide what they want. They make their choices."

Thus DP was able to minimize what emerged as an ongoing tension at most of the other programs, and by the end of this study CTHI case managers were describing the long-stay women as highly engaged in relating to staff and accepting concrete help from staff, though most still remained at the shelter.[12] However, the city administration in Chicago had recently adopted a "housing first" perspective and announced that overnight shelters would be de-funded. Staff at DP responded by lobbying to extend to date for shelter closing (now planned for June, 2004). Currently, planning is underway to replace the shelter with a Safe Havens program, and DP is exploring ways in which the long-stay women might qualify to remain at the site when that occurs. However, staff have also geared up to arrange housing placements for the current shelter guests, including those remaining from the original CTHI caseload. A new potential for tension may arise when the shelter option disappears from the choices that DP offers long-term residents.

[12] Though Deborah's Place staff did not refer to their approach in terms of "harm reduction," it's emphasis on client-driven, voluntary services and support for individual choices was closely related to the model of harm reduction implemented at some of the housing sites, minus their focus on substance abuse.

Project Homeward

When NYC's Department of Homeless Services contracted the operation of the Park Avenue Women's Shelter to Lenox Hill Neighborhood Association, the agency reduced the security personnel and augmented clinical staffing in order to provide the services women needed to move on to housing. But after more than two years, over half of the shelter's 100 beds were occupied by women who had been there prior to LHNH's administration. Within this group, those with problems in personal care were seen as particularly unlikely to be placed in housing, at the same time they affected the quality of life for all residents at the site. Project Homeward was developed to work with the long-term residents who were thought to need help with personal care problems. While shelter staff knew them, they had been unable to connect with many of them for a variety of reasons:

> *"You can't catch up to her to help. She leaves the shelter early and comes in after 10:30 pm. She refuses to sleep in bed, sleeps sitting up in the couch area."*
>
> *"She is delusional and does not trust anybody. She used to talk to the doctor but later stopped and doesn't talk to anyone at all."*
>
> *"She has a delusional system, thinks she owns the building and can fire any of us."*

Project Homeward focused on helping women with personal care as an approach to engagement. While it was hoped that improved hygiene and engagement would also facilitate housing placement, the day to day focus of the program was on more immediate quality of life goals. The core of Project Homeward was the provision of assistance with daily living activities by program aides. The program was mainly structured around a regimen of bathing, grooming, and cleaning out the bed area, and the intimate contact with the program aides that these tasks involved was expected to result in both improved hygiene and a more engaged relationship with the program:

> *"Project Homeward structures their days more. It helps people structure their day or time. Now we have more than groups. We have showers, hair care, clothes…"*
>
> *"[PH addresses] the quality of life issue, the value of helping people do the best they can do. The compliments they get after showering help their self esteem. And you need that in housing or in quality of life."*
>
> *"The goal is essentially to provide whatever services are needed for a client to reach her highest potential. Thus the goal may be smaller than housing. Housing is not the number one goal....It doesn't mean we don't think about housing, but we do the smallest goals – small for us but great for them."*
>
> *"We focus on ADL issues. But some don't need or don't accept help with ADL skills, so we have a program aide approach the client once or twice a week to try to develop a relationship with them. If the client doesn't talk to anybody or does not have any connections, then the PA will approach them around other things, like doing the laundry,*

or smoking, or whatever holds their interest, to see if over time the relationship will allow for other things, like getting a coat, or going to the doctor."

Social workers and program aides described tailoring their engagement efforts with individual women through trial and error. While they cajoled, lectured and insisted on the ADL activities, they also used some of the tactics described for Deborah's Place to identify and respond to a woman's perceived needs – sitting with her; taking her shopping or to lunch; buying presents; and generally attending to her in whatever ways she would allow:

"We'll try anything and whatever we can. We'll bribe them, plead with them....We will go around and everybody [on the staff] will have a shot [at persuading them]".

"We're close to the clients, but we also have to tell them what they can and can't do. It's like you have them and then you lose them for awhile. It's a hard position to be in, because we stay on top of them so much, now they want to do it on their own just to get us off their backs."

"We teamed up on her. We called her family when she was sick. The most effective way to engage her was bossing her around, being stern and authoritarian."

"She had been taking meds. We brought the meds to where she was or brought her in. She did not like to go to appointments but she would go. But it would torment her. After awhile she started liking the services....We had to teamwork on her. She needed a lot of attention and consistency. The best approach with her was being friendly and patient. You could not bribe her. She liked to talk, and she always apologized after she cursed you out."

"Food, cookies, and donuts can begin the engagement process. Consistency, the building of trust, the ability to listen, being open, relating to them as women and not as 'other', and allowing them dignity."

In addition to one-on-one efforts, the project also teamed program aides with each other, with social workers, and with shelter administrators in pursuit of engagement. Program aides sometimes developed contrasting but coordinated strategies in working with a single client, developing a variant of a "good cop/bad cop" routine. Administrators and social work staff also took action to enhance engagement: moving a woman's bed assignment to an area where she could not avoid contact with staff; becoming a resident's rep payee to foster interactions with staff when she obtained money from her benefits checks; informing a woman that she was selected for a "transfer" to a transitional housing program; use of hospitalization episodes as occasions for housing placements.

"We did two things [for a woman with limited mobility] – we moved her bed to [the floor where activities and staff offices are located] and we move her seat during the day every so often....Although she's initially fussy about moving her chair, she will do it, and [one of the program aides] encourages her, highlights the effects of the new scenery. Now

that she's placed in the center of the shelter, she's obviously near more staff but also more inclined to talk, request help."

"*The first thing we did is control her money. Although she hated it, we got rep payee status in order to keep her sober and interacting with staff. She's recognized or reconciled with the money management....It gives her structure and allows her to be more interactive because she has to come to us for cigarettes and clothing."*

Though some social workers restricted their engagement efforts to weekly meetings with their clients, others used more varied approached:

"*I was the only one she would talk to. I fussed over her. I would call her on my day off to remind her to take her meds, wish her happy birthday, ask if anything happened last night. Though she wouldn't come to the phone, she liked the attention. I sat with her and we talked while she ate lunch or drank soda, followed her around and gave her money as needed."*

"To support her sobriety, I go to AA meetings with her."

Most of the social workers limited their engagement efforts to their scheduled meetings with women. In contrast, the program aides had informal encounters with the women in varied settings throughout the day, spent time escorting them to appointments, and interacted across smaller social distances. Thus while the social workers and administrative staff could create conditions for engagement – e.g. by where they located women in the shelter or by insisting on money management – more often it was the program aides who found the common ground (old-time music, shopping for clothes, putting together a scrapbook) to forge relationships in the space opened up by the administrative maneuvers.

One of the program aides described the contrasting approaches:

"Nobody likes to be told what to do. That puts a red flag up. Sometimes the social workers come too much with their own agenda and they face resistance. You get more of a response working with what the client likes – like drinking juice in the morning....The social workers should be less directive and more trying to be where the client is at."

While the program aides focused on engagement and personal care, the social workers worked on housing referrals. A few women would not even discuss housing or had other issues that made them "unplaceable":

"Housing is not a goal due to her documentation problems."

"She ducked us every chance she got. You had to search for her. It took all of us to find her. She would hide in the toilets, exits, groups, the basement. Whenever she was approached about housing services, she'd just say 'My lawyer's working on it.'"

More often, women did not reject housing as a goal but objected to the specific options presented to them:

> *"A senior home would be an appropriate place for her, and I called around for these types of services, but she didn't want them and was agitated."*

> *"She doesn't think about housing because she fears going to an adult home because of her past experience and instead wants her own apartment."*

> *"I went ahead and made a housing appointment without her knowing at the transitional program, and then told her. She said fine, but then backed out bit by bit. She's had a history of doing that."*

Occasionally social workers applied more "hands on" engagement tactics to persuade residents to consider housing they initially rejected or agreed to a compromise between what they thought was best for a client and what she wanted:

> *"The goal for this client was to move her into a nursing home, but she was not happy with this option. I used her regular meetings with me and the process of signing her up for SSI benefits as an opportunity to engage her and convince her of the positive side of living at a nursing home. I would go with her personally on all the benefits meetings, follow-up duties, and also toured and visited the nursing home with her. This lessened her distress and made her more open to considering it."*

> *"She didn't really want supportive housing. She planned to get a home attendant because our argument around supportive housing was that she could not take care of herself. She viewed supportive housing as an insult and could not really see why she needed it. Rather than fight a losing battle, I tried to enlist her to receive a home health aid. I had to work with her stigma. Persistence would have been counterproductive. But then after she agreed, she was denied a home attendant."*

For at least one woman, PH served in unintended ways as a catalyst for finding housing:

> *"The bed area cleanings made her very upset. It was an invasion of her privacy and prompted her to look for housing. She began going on tours and searched for a place so she could have a place to put her stuff in….She was all ready to go into housing, just needed staff to push her. We worked as a team with the same message: you have to move."*

In combining low demand with more pro-active engagement and service strategies, PH was able to move some women who seemed particularly unlikely housing candidates, though not all responded well to the pressure and structure that PH sometimes entailed. In general, the approach was pragmatic, using whatever seemed to work to address the hygiene, service and housing goals the program sought to achieve. In dispersing various elements of engagement among several staff members, Project Homeward provided a distinctive approach to the tension between program and resident goals.

BRC's Lodging House Program at the Palace Hotel

BRC's efforts to engage lodging house residents were part of the agency's ongoing effort to relocate the lodgers in order to develop the building as a site for multiple service, shelter and housing programs. BRC had initially attempted to move all lodgers from the site in 1993, shortly after acquiring the Palace. At that time, the agency issued eviction notices to all lodging house residents. With help from a legal advocacy group, the lodgers effectively resisted and the redevelopment plans were put on hold. When BRC revisited the issue in 1998, the agency contracted with a housing specialist to do outreach that would enlist the lodgers' cooperation in the process of relocating them to alternative housing. At the same time, the agency also took administrative and legal action to prepare for eviction of those who would not or could not be relocated. Thus the engagement efforts were framed by a history of conflict between BRC and the lodgers as well as an agency goal and timetable in which efforts at persuasion would ultimately give way to legal pressure.

The housing specialist initially approached the lodgers collectively, throwing a pizza party to introduce himself, describe BRC's plans for the Palace, and offer his services in helping them relocate. When he followed up by contacting the men individually, some were adamant in their unwillingness to deal with anyone associated with BRC:

> *"I tried to approach him by his cubicle to talk about housing, but he believed BRC staff should not be allowed in the cubicle area. He constantly complained, told me about my mother, and when I saw him [in another part of the building] he threatened me."*
>
> *"I tried to talk to him, but he said 'Get away from me.' He's usually not at the Palace when I'm there."*
>
> *"He reacts violently when approached. We've asked Protective Services for Adults to come and assess him because he may be a danger to himself or others."*

For men who could be approached, engagement work required a low-keyed stance:

> *"They totally distrust social services....They respond to me because I can distance myself from BRC and my job. They respond to my actions that are not directly linked to housing, such as the funeral [that I arranged for a lodger who died], giving them a blanket, lending them money, fixing windows. To them, it's like, 'hey, this guy is doing me a favor'....Sometimes I can sell too hard. I can spend too much time selling a new place for them to live in and they begin to smell a rat. I have to pick my moments and evaluate their moods."*

Engagement occurred mostly in one-on-one interactions – socializing informally over coffee, conversing and interacting as a colleague or friend who respected their opinions and areas of expertise, or helping out when crises (health, financial, family) came up:

"I approached him as an equal, talking about politics and general issues. I talked to him as an advisor rather than as an authoritarian figure. I didn't go to him with housing issues directly."

"Engagement revolved around [the lodger's] interest in talking about baseball and trains....Later the conversations moved to topics such as a GED and preparing a housing application."

"I was able to consult with [lodger] on computer matters and engage him. We went to his cubicle and he helped me fix the problem. But he has refused interviews about housing and does not want to discuss moving out."

"The first thing I did was help him iron out some details with his Medicaid and food stamps benefits by making a whole afternoon of phone calls with him. There was some progress with the phone calls and he was grateful. We made a follow-up appointment but he never showed up. When I saw him later and asked him about moving out, he got extremely upset, angry, and refused any more contact."

While the one-on-one strategies were similar to those used with women in the DP and Park Avenue Shelters, they occurred against the backdrop of BRC's impending renovation of the building, which made housing alternatives a primary focus of engagement efforts. However, the lodgers had already staved off one BRC effort to relocate them and some were skeptical that BRC would see it through this time. Moreover, while only some of the men had paid rent regularly throughout their tenure, most considered the cubicles a home and did not see themselves as either homeless or in need of social or clinical services.

"*These guys see themselves as tenants not as 'the homeless'. There is more self pride for them in having the tenant status. [When they go for housing interviews] they think they are 'apartment hunting' while the SROs think of them and treat them as 'homeless.' Because of this gap in perception, the men often feel insulted during interviews and will even storm out in the middle of an interview."*

"Cage [front desk] staff will provide 'escort services' for the men to housing interviews. They will go with the men because they are already familiar with each other. It also takes away the stigma of the social worker relationship because many times, it's as if mutual friends are helping each other out."

While BRC contracted with the housing specialist to enlist the lodgers' cooperation in relocating to alternative housing, the housing specialist's credibility with the men depended on establishing his independence from the agency and its past actions, being sensitive to the high visibility of his interactions with each lodger, and finding ways to bolster the non-homeless and non-client identities most of the men sought to maintain.

BRC's construction timetable gave efforts to find housing for the men an urgency that was lacking at the two women's shelters. The housing specialist opened discussion of housing early on by offering the lodgers a ten dollar payment for completing a housing assessment interview,

which gave them a face-saving rationale for interacting with him (money) that was acceptable within the social world of the Palace. The individual contacts with the men who agreed to the interview allowed the housing specialist to identify and work with those who were amenable to moving, and during the two years when he had a fairly regular presence at the Palace, his emphasis was largely on encouraging and helping these lodgers leave the Palace for better housing conditions elsewhere.

> *"When I was able to catch him in the cubicles, I told him about the rent and arrears and set up an appointment to fill out a housing application. He was cooperative and expressed that he wants better housing."*

> *"Engagement was hard but straightforward because of his delusional system and inability to focus on conversation. Instead, I sat with him drinking coffee while he smoked. He was generally happy to talk but scattered. I talked with him about his 'parallel worlds.' Eventually we had to hospitalize him involuntarily – he was infested with lice and appeared to be anemic. After that, I spent a lot of time with him and prepared housing applications. He decided it was time to move and when he saw the place, he liked it."*

The housing specialist also served as their advocate in dealing not only with landlords, entitlements offices, and housing programs, but also with NYC agencies – most notably in negotiating a blanket eligibility for lodgers in NYC housing programs for homeless people with mental illness, despite most lodgers' refusal to say they were homeless or had mental health problems.

For a number of lodgers, however, other barriers remained.

> "*He has an active alcohol problem. I've talked to him about treatment but our conversations have been negative and unconstructive. I've been trying to get him to pay rent so he might be able to move upstairs, but he has income problems."*

> "*He's a substance abuser. I'm looking for housing programs that accept substance abusers or treatment programs. I don't see any housing options for him. His drinking problems need to be addressed first."*

> *"He initially ran away when I approached....Now, there will be up to ten minutes of conversation related to paying rent. I don't raise mental health issues with him. He is consistent in his delusion that he owns the building and doesn't need to pay rent."*

BRC administrators and the housing specialist explicitly rejected "harm reduction" as a characterization of the program philosophy. However, as at PH, where directive approaches were sometimes counterproductive, the housing specialist used low demand efforts as a means of opening communication with lodgers, and avoided pressing on substance abuse or treatment issues that they were not willing to consider. In looking for alternative housing for the lodgers, however, the housing specialist encountered admission criteria that included a period of stable sobriety and program policies requiring abstinence, which were unrealistic for some lodgers.

Though BRC had hoped that the majority of lodgers would agree to move elsewhere, two thirds of the men were still at the Palace two years into the program. Two options were available to those who remained: court-ordered eviction for those who were not current on their rent; or remaining at the Palace and eventually moving to the new SRO units that were under construction on the building's top floor. Thus while efforts at housing placement proceeded, BRC successfully applied to have the Palace certified as a rent-regulated building, making it possible to initiate court proceedings against non-payers. While BRC was prepared to follow through with evictions if necessary, administrators also hoped that receiving eviction notices would push lodgers to engage with the housing specialist and either find other housing before eviction occurred or become rent payers and qualify to move to the SRO units.

At the time the first eviction notices were served, the housing specialist was phasing out his regular presence at the Palace and shifted his focus to helping the remaining lodgers secure an income and become rent payers. For a few this entailed offering job-seeking advice or help with entitlements applications, but he spent most of his time advocating for lodgers in and out of court and negotiating payment agreements with BRC. By the time the SRO units neared completion, the housing specialist had moved on, and BRC retained an entitlements specialist to assist those who still had no regular source of income in qualifying to stay at the Palace, while pursuing further eviction proceedings against a small number who remained non-payers.

Over the period of our observations, the changes at the Palace and the agency's progress in developing the site for permanent housing continually reframed the efforts of the housing specialist and the entitlements worker who succeeded him. An initial period devoted to connecting with the lodgers, building rapport, and assisting those who were willing to relocate was followed by an emphasis on helping the remaining lodgers qualify for the permanent housing being constructed at the Palace through advocacy to develop payment plans and avert eviction. This shift reflected the departure of those lodgers who had been successfully engaged and were persuaded to move on, but it also mirrored BRC's shift over this period to more aggressive efforts to push non-payers to either rejoin the rent rolls or leave the Palace. The process of engagement at this site cannot be understood outside the context of the administrative actions occurring at the same time. The tension between engaging lodgers around their own interests and imposing the agency's agenda was a particularly acute form of a pervasive tension that virtually all of the programs in the study addressed.

B. Goals, Barriers, and Strategies of Service Engagement in Contrasting Contexts

Both similarities and differences are evident in the three programs' approaches to engagement and service delivery. While all three programs were developed with engagement as a program goal, the focus of engagement, at both an individual level (what the workers hoped to accomplish with a particular resident) and program level (what the agency hoped the program as a whole would accomplish through service engagement of residents), was somewhat distinctive at each site, as were the related strategies and barriers.

Program Goals and the Level of Demand

At the most general level, the three shelter/lodging sites implemented the CTHI or PH programs with the common hope that by focusing on engaging residents who had remained at the site for many years, the programs would be able to identify their needs, provide them with services, and move them into more appropriate long-term or permanent settings. However, contrasting program goals and philosophies were reflected in the ways they organized the engagement efforts and service delivery, as well as in the emphasis they placed on moving residents to housing. At Deborah's Place, the primary goal of the CTHI program was to build relationships with unengaged women in order to identify ways of better meeting their needs. Throughout the study, the case managers' focus continued to be on identifying what the women themselves wanted, and while the original case manager and her successors informed women of new housing options, they took their leads from the women's own expressions of interest. The few who moved to housing received extensive support from DP in maintaining tenancy, but relationship-building efforts and quality of life enhancements predominated for those who remained at the shelter.

During the period that PH operated at the Park Avenue Women's Shelter, the one-on-one engagement efforts undertaken by the program aides were mainly directed at improving the hygiene of the women identified as needing help. This was intended to enhance their comfort and quality of life, but also to improve the quality of life for other shelter residents. Though the relationships the program aides developed with the PH women sometimes facilitated their efforts to impose a hygiene regimen, there was little scope for program aides to use their relationships with the women to suggest other services or housing. These came under the purview of the social work staff, who were responsible for the referrals and placements that did occur -- usually into transitional housing programs, hospitals or nursing homes. While staff reported that when program aides developed close relationships with residents, this sometimes "spilled over" in their relationships with social workers, the personal care work by the program aides and the housing placement efforts by the social work staff were for the most part parallel efforts to work with the long-term residents, only loosely linked through occasional meetings of the team of program aides and social workers involved with the women in the PH project. While both program aides and social workers used low demand strategies to encourage the women to accept the hygiene regimens as well as service referrals and housing placements, both were also likely to take more directive approaches when women resisted their persuasion. Many of the placements in transitional programs or nursing homes represented residents' acquiescence to goals defined and carried through by the program staff.

Only at BRC was the engagement effort closely tied to the goal of housing placement, which was an urgent priority for the agency. Thus while the housing specialist engaged in many of the same kinds of informal interactions and concrete help that were part of the relationship-building process at all sites, he also undertook a more formal housing assessment with the lodgers and, with the impending conversion of the lodging house to other uses, he used advocacy and case management to relocate a significant minority to supportive housing settings elsewhere. For lodgers who remained despite these efforts, he shifted his activities from engagement to advocacy, as he helped many of them negotiate payment agreements with the agency to avoid eviction and become candidates for the new SRO units at the Palace. Though unresolved substance abuse would have excluded some of the remaining lodgers for other similar supportive

SROs in New York, BRC was flexible on this issue for lodgers who were not disruptive and otherwise qualified. The entitlements worker who succeeded the housing specialist eventually helped most of the men who remained meet the income requirements for moving upstairs.

While Deborah's Place used engagement primarily to develop relationships with women and learn what they wanted, the other two sites used it to encourage cooperation with agency goals. At Park Avenue, these goals were improved hygiene and eventual housing placement. At the Palace, the housing specialist used both persuasion and advocacy to bridge the gap between what the agency wanted (relocation) and what the lodgers wanted (to remain on site). In the end, the agency worked out criteria for the new permanent housing units on-site that allowed the lodgers to qualify, making it possible to eliminate the conflict between goals.

Strategies and Barriers in Building Relationships

At all sites, workers' efforts to develop relationships with residents were closely linked to the provision of concrete services. Workers described giving goods and building trust as mutually reinforcing activities: friendly interactions and gifts helped to build trust; and trust allowed residents to accept needed items (shoes, coats, food, transportation). Both the items, which met real needs, and the interactions between workers and residents, which diminished their isolation, were viewed as enhancing residents' quality of life.

In their accounts of their efforts to build relationships with residents, workers at different sites described similar barriers: accessibility (some residents' comings and goings occurred at times the workers were not at the site), communication (sometimes inhibited by language differences, residents' speech or hearing problems, cognitive disabilities, or acute psychosis), and the stigma many residents perceived as associated with being at the receiving end of service delivery. All reported using similar low-demand one-on-one approaches to overcome these barriers to relationship-building: informal interaction and conversation, spending time "hanging out," finding common interests, offers of gifts and goods, and being responsive when crises or issues arose. Over time workers often managed to find creative ways of establishing relationships with residents who initially resisted their overtures.

Strategies and Barriers in Engagement in Housing and Services

While resolving accessibility and communication barriers was usually necessary before engagement in housing and other complex services could occur, successful relationship-building or getting residents to accept concrete services did not readily leverage engagement in other service domains: a resident's willingness to talk with a worker or accept a meal did not imply or necessarily lead to her willingness to accept treatment or apply for entitlements benefits. In describing their efforts in these different domains, workers identified barriers and strategies for engagement around housing, entitlements or clinical services that differed from those involved in relationship-building.

Several themes recurred in workers' accounts of their efforts to persuade residents to apply for entitlements, obtain psychiatric treatment, or move to independent or supportive housing programs: housing program requirements prevented some residents from qualifying for what was offered because of immigration status, addiction, or functioning issues; others who might qualify were unwilling to accept the stigmatized identities these service offers entailed

(homeless, mentally ill, going "on welfare", living in worse neighborhood); and many resisted exchanging the fragile autonomy of the shelter or lodging house settings for services or housing that would require agreeing to medication, services, sobriety, losing control over money, or moving to an unfamiliar building and neighborhood.

While the growth of trust between worker and resident might open up room to discuss housing and services, the workers had little control over most services in these domains. Though workers counseled residents on making changes that would help them qualify for housing programs, they also engaged in advocacy with the gatekeeping agencies. At all sites, this occurred at the individual level, when workers would troubleshoot issues that arose in individual residents' encounters at the social security offices or in clinics; but only at BRC was advocacy successful in changing the terms of access to housing and Section 8 subsidies for the group of long-term residents as a whole. The housing specialist there was able to pre-qualify lodgers as a group for supportive housing programs that normally required documentation of time spent in shelters or on the streets, along with psychiatric evaluations and medical clearances. At the same time, he coached the lodgers to prepare them for questions in admissions interviews about homelessness and mental illness in order to minimize the likelihood they would walk out in indignation. BRC also eventually negotiated a flexible and streamlined process of establishing eligibility that facilitated lodgers' acceptance into the new Palace SRO housing. The agency thus was able to offer housing that entailed minimal admissions barriers, service requirements, or stigma; it did not require the lodgers to move from the building; and in the end, the offer was accepted by most of the men. During the period of our data collection, the staff working with PH women and with the long-term residents at DP had few options to offer that didn't involve stringent admission criteria, stigma, or loss of autonomy. Whether the planned Safe Havens program at Deborah's Place can become a viable option for the long-term residents there remains to be seen.

Contrasting Contexts

Workers at the three shelter and lodging sites faced similar barriers to building trust and involving residents in housing and other complex services. And they used similar ingenuity and tactics to overcome these problems. Yet significant differences in the contexts in which these one-on-one efforts took place – particularly contrasts in the external constraints as well as agencies' goals and their willingness to use administrative approaches to pursue them – led to different processes and outcomes. At DP, both the CTHI program and the larger agency consistently accommodated the women's preferences and goals, building strong engaged relationships that clearly improved their quality of life but moved few into complex services or housing. But by the end of the Closer to Home Initiative, decisions made by city administrators were compelling the agency to find alternatives to the shelter for those women who still remained there.

In the PH program, where the program aides were charged with conflicting tasks of enforcing hygiene regimens while building relationships with the women, there was tension between the agency's efforts to improve quality of life for the women and others in the shelter and many women's resistance to the imposed routines. LHNH made administrative decisions intended to foster staff contact and engagement, and some women over time came to accept the idea of leaving the shelter. But when they did not, the shelter administrators and staff were willing to move women to transitional programs, hospitals, or nursing homes despite their ambivalence or

objections. At the time Project Homeward was coming to an end, the public corporation that managed the Armory where the shelter was located contracted for renovations that excluded the shelter and raised the possibility that the shelter would be forced to close. However, the time frame was not immediate and even during the period when it remained a possibility (lobbying by LHNH and others in the local community led to revised plans that included the shelter), the prospect had little impact on daily shelter routines and activities.

At the Palace, the agency's goals of relocating the lodging house residents framed the housing specialist's engagement efforts. Engagement around housing was successful for a group of men who left in the first years of the program, while a larger group remained uninterested until both the housing (independent units in the Palace building) and the terms under which it was offered (minimum admission criteria or requirements) were more acceptable.

The qualitative data on the programs' efforts to engage and house long-term residents reveal the ways engagement and services were structured at various points during the study period, as well as the goals, processes and barriers that shaped these efforts. To gauge the extent to which the programs were able to deliver services, engage residents, and move them to housing, we present, in the next chapters, an analysis of the distribution of services, engagement, and housing outcomes within and across programs and the relationships between them.

CHAPTER 4
SERVICES AND ENGAGEMENT AT THE SHELTER/LODGING SITES: A QUANTITATIVE DESCRIPTION

Engagement and service delivery are overlapping processes. In the course of their efforts to engage long-term residents, the three shelter/lodging programs in the study provided various direct services – including counseling, getting information, escorting to appointments, hands-on provision of first aid, on-site psychiatric evaluation by a project psychiatrist, or recreational and other social groups. They hoped that both the relationship-building efforts and the direct services would encourage residents to accept referrals to other programs or agencies for SSI and other financial benefits, housing programs, outpatient psychiatric treatment or medical care, or other services.

Both DP and BRC deployed a single worker (the case manager at DP, the housing specialist at BRC) to connect with the residents and deliver whatever direct and referral services they would accept. PH divided these tasks between program aides and social workers, with the former providing direct services, the latter responsible for counseling and referrals. We collected data at each site on the services the programs provided to individual residents, and we summarize that data here to describe the extent to which the targeted residents at these sites actually received the direct and referral services the programs hoped to provide. Our unit of analysis is the individual resident, rather than each service delivered, because the questions guiding our analysis concern individual resident outcomes. Consequently, these results do not fully capture the levels of service activity that occurred at the sites, since residents received some types of services on multiple occasions, consuming more staff time and energy than is apparent from the data presented here.

As we noted in the introduction to Part II, although we collected qualitative data on program processes and change over the entire period of the study, the time frame covered by the quantitative data on individual residents is the two year period after the programs began operations. Although our initial evaluation design entailed only one year of follow-up on individual residents, it became apparent once we began work at the sites that the pace of engagement in the shelter and lodging programs would require a longer period of observation. With agreement by the programs, we extended the follow-up time frame at these site to two years.

A. Services Provided at Program Sites During Two-year Study Period

Direct Services

Table 4.1a shows the types of direct services that residents received through the CTHI and PH programs at the shelter and lodging house sites. For all sites combined (right hand column), a large majority (89%) of the residents received direct services related to housing (usually counseling to encourage residents to pursue housing, as well as obtaining information on housing), over half received help with money management (56%) – which might involve representative payee status or help with budgeting, and entitlements (58%) – including helping residents obtain reduced transit fare cards, advocacy and trouble-shooting with welfare or SSI

offices to resolve bureaucratic problems). Close to two-thirds received health care (68%) and mental health (63%) services, which frequently consisted of counseling about the need to obtain services, but also included escorts to appointments, advocacy with clinicians, or on-site evaluation and treatment by the program psychiatrist or volunteer physician). Substantial numbers also received socialization services such as group activities or socializing with case manager (49%) and family services, which might include obtaining information about or from family members, counseling residents on locating or contacting family(41%). Fewer residents received vocational training or employment, substance abuse, or legal services – reflecting limited need for and availability of these services at the shelter and lodging program sites.

The differences between programs in the direct services provided reflect contrasts we previously noted in the populations served at the sites – for example, substance abusers tended to be excluded from the Park Avenue Shelter and thus from Project Homeward, limiting the need for and provision of substance abuse services at that site where only 6% of residents received these services, compared to a quarter or more at the other sites. There were also some differences in the services available on site. For example, DP offered all shelter guests – including the long-term residents – access to the DP learning center, which provided skill and vocational training, and these are reflected in "training/work" services received by 58% of the women at DP. At the Park Avenue Shelters, where 92% of the PH women received mental health services, a staff psychiatrist was available to provide psychiatric evaluations and treatment on site; and the high proportion of long-stay women at the shelter sites who received socialization services reflected the large number of group and recreational activities that occurred at both women's shelter programs, in contrast to the lodging house, where no group activities were offered.

While a high proportion of residents directly received "complex" services[13] such as entitlements, mental health, health care, and housing, these often consisted of counseling by workers, as they attempted to persuade residents to consider moving from the shelter or lodging program into some form of long-term housing. The direct services provided should thus be seen as reflecting the program efforts, while the level of engagement, discussed in a subsequent section, indicates how residents responded.

Referral Services

Table 4.1b summarizes the referral services staff initiated for residents at the shelter and lodging house sites. Many fewer residents received referral services than had received direct services. Across all programs, the most frequent type of referral – and the only one received by a majority – was for housing, which was initiated for 56% of all shelter/lodging house residents. This clearly reflects the significant effort all sites devoted to helping long-term residents move to more appropriate accommodations, though referrals made by workers were often not consummated, particularly in the area of housing. At Deborah's Place, for example, though a substantial majority of women were referred to the new permanent housing program that DP opened during the study, data on referral outcomes (not shown) indicates that most of the women subsequently refused to pursue the referrals (56%) or did not follow through (17%). One quarter of the combined sample were referred for entitlements (DP's higher rate reflects the local

[13] We refer to these services as "complex" because they usually required extensive persuasion, and entailed multiple steps that could include making appointments, obtaining applications, securing proof of identity and income or insurance coverage.

procedure for obtaining reduced transit fares); and one third were referred for health care. No other type of referral was provided to more than a small number of individuals at any site. The data on services represent the efforts the programs made to serve the long-term residents and show that all three programs invested significantly in services for this group. As in the period prior to the CTHI or PH programs, more services were provided directly than through referrals, though across all sites, housing referrals were initiated for a majority of residents.

Table 4.1 Services Provided to Shelter and Lodging House Residents
a. Direct Services

	DP (N=12)	PH (N=36)	BRC (N=33)	Total All Sites (N=81)
Received Any Direct Services	**%***	**%***	**%***	**%***
Housing	100	75	100	89
Money Mgt	83	69	30	56
Entitlements	92	58	46	58
Training/Work	58	6	0	17
Health Care	100	83	39	68
Mental Health	92	92	21	63
Substance Abuse	25	6	27	17
Legal	17	11	6	10
Family	83	36	30	41
Socialization	100	67	12	49
Other	100	72	42	70
*Categories are not mutually exclusive, since residents receive services in multiple categories. Percentages therefore do not add to 100%.				

b. Referral Services

	DP (N=12)	PH (N=36)	BRC (N=33)	Total All Sites (N=81)
Received Any Referrals	**%***	**%***	**%***	**%***
Housing	75	47	58	56
Money Mngt	8	0	0	1
Entitlements	75	17	15	25
Training/Work	8	0	3	3
Health Care	58	42	15	33
Mental Health	8	14	15	14
Substance Abuse	0	0	9	4
Legal	0	3	12	6
Family	0	0	0	0
Socialization	8	0	0	1
Other	8	0	3	3
*Categories are not mutually exclusive, since residents receive services in multiple categories. Percentages therefore do not add to 100%.				

B. Levels of Engagement

The literature on engagement in services frequently refers to small incremental changes in worker/client relationships through which engagement proceeds (Erickson and Page, 1999). The effects of engagement efforts with people who are homeless and have mental illnesses have not been readily detected by conventional mental health outcome measures (Axelroad 1987; Barrow et al. 1991; Erickson and Page 1999), and it has been equally difficult to find appropriate measures of the process itself. Number of outreach contacts or duration of engagement efforts give some indication of how engagement proceeds, but as measures they are limited by variability in what constitutes a contact and in levels of intensity of contacts over time. Recently-developed measures of "therapeutic alliance" with case managers (Tyrell 1999; Chinman et al., 1999) focus on client perceptions of having a trusting relationship, but such measures usually presume a single case manager and are difficult to apply to the early stages of the engagement process, when the potential clients may be unwilling to talk with program or research staff. In their study of services and housing for homeless people leaving psychiatric hospitals, Mowbray and colleagues (1993) used a consensus of the outreach staff to measure engagement status on a three-point scale (not engaged, limited engagement, fully engaged), with completing an assessment process and/or agreement on a service plan for housing and support services used as an indicator of limited engagement, and accepting project services indicating full engagement.

Our measures of engagement are also based on staff ratings of levels of involvement in services, but our qualitative data indicated the need for less global assessments. In the narratives we collected on the engagement process, workers emphasized that residents' engagement varied across different domains of services. Residents who would talk with a worker would not necessarily accept offers of food, clothing, or transportation; and those who accepted these concrete services often remained unwilling to consider housing or health care. While this implied a hierarchy of engagement (relationship-building and concrete services were usually seen as prerequisites for engaging residents in seeking housing or other complex services), workers emphasized that it was not strictly linear. Building on the qualitative data, we asked workers at each site to rate residents' level of engagement in each of four domains (relationship with worker, willing to accept concrete services, willing to accept complex social and clinical services, willing to seek housing) at the end of the follow-up period, with 1 reflecting no engagement and 5 reflecting full engagement.

Table 4.2 summarizes the data on levels of engagement in each domain at the end of the two-year follow-up period. For all programs combined (right-hand column), it is apparent that levels of engagement did, indeed, vary across domains. In the relationship domain, 15% were assessed as not engaged at all, while 35% of residents were assessed as being engaged at the two highest levels. Residents were somewhat less willing to accept concrete services (27% were assessed as not engaged at all while 27% were rated at the highest two levels); and they were considerably less willing to accept complex social or treatment services (close to two-thirds were not at all willing to accept these services, and only 12% were engaged at the top two levels). Levels of engagement in the housing domain were very similar to complex services: 69% were not at all willing to accept housing; 16% were assessed at the highest levels of engagement.

Table 4.2 Levels of Engagement at Follow-up
Shelter and Lodging House Sites

	DP (N=12)	PH (N=36)	BRC (N=33)	Total All Sites (N=81)
Level of Eng (Relationship)	%*	%*	%*	%*
1 (not eng)	0	25	9	15
2	17	44	24	32
3	42	14	15	19
4	**25**	**8**	**30**	**20**
5 (engaged)	**17**	**8**	**21**	**15**
Willing to Accept Concrete Services				
1 (not willing)	0	28	33	27
2	25	36	18	28
3	33	17	12	18
4	**17**	**8**	**3**	**7**
5 (willing)	**25**	**11**	**27**	**20**
Willing to Accept Complex Services				
1 (not willing)	50	75	58	65
2	33	6	10	11
3	8	8	16	11
4	**8**	**8**	**3**	**6**
5 (willing)	**0**	**3**	**13**	**6**
Willing to Accept Housing				
1 (not willing)	42	86	61	69
2	17	3	9	7
3	25	0	9	7
4	**17**	**0**	**6**	**5**
5 (willing)	**0**	**11**	**15**	**11**
* Not all percentages add to 100% due to rounding.				

Within each of the programs, there was a similar progression, with the highest levels of engagement in the relationship and concrete services domains, and lower levels of engagement in complex services and housing. This was quite striking for Deborah's Place and BRC, where 42% and 51% respectively were assessed at the highest two engagement levels for relationships, and 42% and 30% were at the highest levels for concrete services. In contrast, 8% and 16% respectively were highly engaged in complex services, and 17% and 21% were highly engaged in housing. Project Homeward had lower levels of relationship and concrete service engagement (which may reflect the dual role of program aides as enforcers of the PH regimen while building relationships with residents, along with the variability in social workers' approaches to engagement), resulting in only minor differences between ratings in the relationship and concrete service domains on the one hand, and the housing and complex service domains on the other.

C. Summary of Service Delivery and Engagement Levels

Our data on the direct and referral services provided to shelter and lodging residents shows that the programs invested considerable service effort in providing a broad array of direct services to their residents. We also found that when intensive effort was devoted to engaging residents in one-on-one relationships with few demands, workers were successful in creating rapport and many residents became engaged in relationships with the workers and were willing to accept some of the concrete assistance or goods that were offered to them. While the data showed that staff also made significant efforts to refer residents, particularly to housing programs, the referral outcomes and the engagement levels achieved indicate that far fewer residents were persuaded to accept the housing or complex services (obtaining income or clinical services) to which staff were trying to link them. This was most evident at DP and PH, the sites that did not focus primarily on housing placement, but was also true at BRC where housing was a more explicit aspect of engagement efforts. We turn now to data on the housing status of shelter/lodging residents for the two-year period covered by our service and outcome measures.

CHAPTER 5
HOUSING OUTCOMES AT THE SHELTER AND LODGING HOUSE PROGRAMS

A. Description of Housing Outcomes

The descriptive analyses of engagement and services in Chapter 4 showed that all programs expended effort on engagement, counseling and referrals to alternative accommodations. To measure the outcomes of these efforts, we used two variables: destination at exit from program; and residence at (two-year) follow-up. Tables 5.1a and 5.1b summarize these two measures of housing outcome for the three shelter/lodging programs in the study. As Table 5.1a shows, for all sites combined (right-hand column), more than half of the residents (55%) did not exit from the shelter or lodging house during the two year follow-up period. Those who did leave the sites went to other temporary settings (18%) and to long-term settings (25%) that included permanent housing, transitional housing, adult homes and nursing homes.

Table 5.1 Housing Outcomes at the Shelter and Lodging House Sites

a. Destination at Exit*

	DP (N=12)	PH (N=36)	BRC (N=33)	Total All Sites (N=81)
	%	%	%	%
Still at site	**92**	**33**	**66**	**55%**
Exit – Not Housed				
Other shelter	0	3	0	1
Residential Tx	0	0	3	1
Hospital	0	28	6	15
Other	0	3	0	1
Total Exits from Site – Not Housed	**0**	**34**	**9**	**18%**
Exit to Long-tem Residential Setting				
Nursing Home	0	3	0	1
Adult Home	0	8	0	4
Transitional Housing	0	14	0	6
Permanent Housing (Supportive, Family, or Independent)	8	8	22	14
Total Exit to Long-Term Res	**8**	**33**	**22**	**25%**
Deceased	**0**	**0**	**3**	**1%**
*Note: Some totals do not add to 100% because of rounding.				

Both the proportion of the cohort that exited from the sites and the specific destinations of those who left differed somewhat at the three sites. Project Homeward had by far the largest proportion of residents leaving the shelter (67%). Over a quarter (28%) of PH women were hospitalized and did not return to the shelter[14]; another 14% went to transitional housing, while

[14] In NYC, hospitals were legally constrained from discharging people directly to shelters.

adult homes and supportive housing each accounted for 8%. The destinations of the PH women are consistent with the high levels of infirmity and health problems in this group, making hospitals and nursing homes a "next step" for many. At BRC, one third of the lodgers left the Palace during the two-year follow-up period, and most of those went directly to permanent housing[15]. The long-term residents at Deborah's Place were not under the same pressure to move on during the follow-up period as residents at the Palace and Park Avenue. Only 8% of the long-stay group moved on to housing from Deborah's Place during the two-year follow-up.[16]

Table 5.1b examines where residents were living at the end of the two-year follow-up period. While the two year locations of those who exited had not changed markedly from their destinations at the time of exit, the shifts that did occur warrant comment. As noted above, for the shelter/lodging house sample as a whole, somewhat more than half (54%) remained at the site throughout the follow-up period. A small number (4%) remained homeless in other settings.

Table 5.1 Housing Outcomes at the Shelter and Lodging House Sites

b. Housing Outcomes at Follow-up*

	DP (N=12)	PH (N=36)	BRC (N=33)	Total All Sites (N=81)
	%	%	%	%
Homeless				
Still at site	83	33	67	54
Other homeless situation	8	6	0	4
Total Homeless	**91**	**39**	**67**	**58**
Long-term Residential Setting or Permanent Housing				
Nursing Home	0	17	0	8
Adult Home	0	22	3	12
Transitional Housing	0	11		5
Family Housing	0	3	0	1
Supportive Housing	8	6	20	12
Independent Housing	0	0	7	3
Total Long-Term Res or Housing	**8**	**59**	**30**	**41**
Deceased	**0**	**3**	**3**	**3**
*Note: Some totals do not add to 100% because of rounding.				

But the sizeable proportion that had exited the programs when hospitalized had moved on to long-term settings by the end of the follow-up period. All categories of long-term

[15] Many of those who remained at the site at the end of the two-year follow-up were candidates for the new supportive housing units subsequently completed on the building's top floor, and in fact, 59% of that group ultimately moved upstairs

[16] One woman moved to housing but quickly returned to the shelter and is not included in the 8%.

accommodation (nursing homes, adult homes, transitional housing, and the three types of permanent housing) in fact increased, so by the end of follow-up, 41% of the residents at the three sites had moved to long-term settings elsewhere[17]. In fact, most of the changes occurred within the Park Avenue group, though a small number of BRC lodgers also shifted from transitional or treatment programs into longer-term accommodations.

B. Relationships between Characteristics, Engagement, Services and Housing Outcomes

The quantitative descriptions of services provided, levels of engagement, and housing status over two years revealed distinctive patterns at the three programs. Deborah's Place and, to a lesser extent, BRC showed high levels of engagement in the relationship and concrete services domains, with lower levels of engagement in complex services and housing. The contrast in domains was less striking for the PH women, for whom levels of engagement in both relationships and concrete services were similar to the relatively low levels of engagement in complex services and housing. However, PH had by far the highest proportion of residents that exited the shelter, and by follow-up, a large proportion of PH women were in permanent or long-term settings.

The data on services provided also show some site-specific differences. Deborah's Place and PH provided the highest levels of direct and referral services. In keeping with the more focused role of the housing specialist at BRC's Palace program, somewhat fewer lodgers received direct services. But the data on housing outcomes show that BRC's lodgers were the most likely to obtain permanent housing, while PH residents were most likely to move to alternative long-term settings such as transitional housing or nursing homes.

The data thus suggest that there are complex relationships between levels of engagement or services provided on the one hand and housing outcomes on the other, while the contrasting patterns at the sites suggest differences in characteristics and experiences of the populations served may also be related to housing outcomes. Based on our qualitative data and findings from other research, we expected that several characteristics would affect housing outcomes. We expected younger age and less extensive homeless histories would be associated with better outcomes, while having more serious health problems or severe psychiatric disorders would have negative effects on becoming housed. Having a means of support and taking medications for psychiatric problems would overcome two of the barriers to housing among people with long-term homelessness and would be expected to improve the likelihood of obtaining housing.

In order to assess the role of these resident characteristics, we used logistic regression analysis to tests their effects. The outcome of interest was housing status at the two-year follow-up, and for these analyses, we classified residence in any long-term residential setting (including nursing homes and long-term transitional housing) as "housed," while those remaining at the shelter or

[17] Our quantitative data reflect a two-year follow-up period, which may be too short to see the effects of efforts with extremely long-stay populations. However, updates at BRC and DP indicated that at the end of the CTHI initiative, when the new supportive SRO units at the Palace had opened, BRC had managed to house 70% of the original group in independent or supportive housing, while at DP, 25% were housed, though the prospect that the DP shelter would close created a new push for housing those remaining.

lodging site, in other shelters or in hospitals were classified as not housed. A preliminary analysis examined the bivariate relationships of the proposed predictors to housing status and showed that several of the proposed predictors were significantly associated with housing outcomes (Table 5.2). Specifically, being older, having a greater number of serious health conditions less, and receiving entitlements benefits were all positively associated with being housed at follow-up, while having a longer homeless history was negatively associated with being housed.

Table 5.2 Bivariate Associations Between Resident Characteristics and Housing Outcomes at the Shelter/Lodging House Sites

	Housed in Long-Term Setting at Follow-Up	
Resident Characteristics	**Pearson correlations**	**Significance p**
Age	**.326**	**.003**
Gender	.178	n.s.
Duration of Homelessness	**-.355**	**.001**
Number of Health Condit'ns	**.289**	**.013**
Dx: Psychotic Disorder	.048	n.s.
Major Entitlements at BL	**.377**	**.001**
Psychiatric meds at BL	.047	n.s.
Note: n.s.=not significant		

We included all proposed predictor variables in the logistic regression analysis to test their independent effects on housing outcomes at follow-up for all shelter and lodging sites combined. The results, shown in Table 5.3, confirm independent effects for only duration of homelessness (longer duration is negatively related to outcome) and receiving entitlements benefits (which is positively related to outcomes), which remain significant when all other variables in the model are controlled.

Table 5.3 Effects of Resident Characteristics on Housing Outcomes

Variables in the Equation	Coefficient B	Estimated Odds Ratio	95% C.I for Exp(B)	
			Lower	Upper
Age	.052	1.054	.991	1.120
Sex	-1.147	.318	.038	2.668
Duration Homelessness	**-4.311**	**.013***	**.001**	**.269**
Health Conditions	.566	1.762	.900	3.448
Diagnosis of Psychotic Disorder	1.133	3.105	.261	3.105
Receiving Entitlements Benefits	**2.842**	**17.144****	**2.004**	**146.640**
Taking Psychotropic Meds at Baseline	-.411	.663	.111	3.961
* Odds Ratio Significant at .05; ** Odds Ratio Significant at .01.				

We conducted separated analyses to test hypothesized relationships of engagement measures and services to housing outcomes. Given the centrality of relationship building to all programs' work with the long-term residents at the sites, we hypothesized that willingness to be engaged in a relationship with program staff would be related to housing outcomes. We also expected that residents who were willing to accept housing services would have better housing outcomes than those who were not engaged with housing services. We also expected that referrals in multiple domains would be related to being housed at follow-up, and deemed the types of referrals (housing, health care, and medical) most closely connected to housing particularly likely to enhance housing outcomes.

In preliminary bivariate analyses, shown in Tables 5.4, we found that housing engagement was indeed significantly associated with living in transitional or permanent housing at follow-up. Referrals for health care and referrals for housing were also significantly associated with housing outcomes.

Table 5.4 Bivariate Relationships of Engagement and Services to Housing Outcomes at the Shelter/Lodging House Sites

	Housed in Long-Term Setting at Follow-Up	
	Pearson correlations	**Significance p**
Domains of Engagement		
Engaged in Relationship	.094	n.s.
Willing to Accept Housing Servs	**.324**	**.003**
Services		
Number Types of Referrals	.201	n.s.
Housing Referral	**.244**	**.028**
Health Care Referral	**.299**	**.007**
Mental Health Referral	.059	n.s.
Note: n.s.=not significant		

We then used logistic regression analysis to test a model that included all the proposed engagement and service predictors. We found that both housing engagement and referral for health care continued to have independent effects on housing after controlling for all other variables in the model (see Table 5.5). The odds ratios indicate that with each additional point on the housing engagement scale, the likelihood of being housed at follow-up almost doubled, while residents who received health care referrals were almost nine times as likely to be housed at follow-up as those who did not receive such referrals.

Table 5.5 Effects of Engagement and Services on Housing Outcomes

Variables in the Equation	Coefficient B	Estimated Odds Ratio	95% C.I for Exp(B)	
			Lower	Upper
Engaged in Relationship	-.250	.779	.471	1.286
Willing to Accept Housing Services	**.683**	**1.980***	**1.166**	**3.361**
Number of Types of Referrals	-.653	.521	.228	1.192
Housing Referral	1.275	3.578	.736	17.396
Health Care Referral	**2.185**	**8.894****	**1.989**	**39.774**
Mental Health Referral	.566	1.762	.287	10.832
* Odds Ratio Significant at .05; ** Odds Ratio Significant at .01.				

As a final step in the predictive analyses, we posited a combined model, which included both the resident characteristics and the engagement and service variables that were found to affect outcomes. As Table 5.6 shows, all variables continued to have a significant independent effect on housing status at follow-up. It is notable that the individual characteristics that predicted housing outcomes in the separate and combined models were not direct reflections of illness or disability. In fact, health care referrals, which often entailed hospitalizations, were related to better, not worse, housing outcomes, possible because of legal strictures against hospitals discharging patients to shelters in New York. We also find it warrants comment that even within a population with extraordinarily long homeless histories, those who had been homeless longer were more likely to remain homeless. And finally, the findings indicate that although the proportion of residents who were rated as highly willing to accept housing services was low, as shown in Chapter 4, those who did become more engaged in such services were likely to be housed by the end of the follow-up period.

Table 5.6 Combined Model:
Effects of Resident Characteristics, Engagement and Services
on Housing Outcomes

Variables in the Equation	Coefficient B	Estimated Odds Ratio	95% C.I for Exp(B)	
			Lower	Upper
Duration of Homelessness	**-3.576**	**.028****	**.003**	**.268**
Receiving Entitlements Benefits	**2.847**	**17.234****	**2.997**	**99.111**
Willing to Accept Housing Services	**.722**	**2.058****	**1.259**	**3.364**
Health Care Referral	**1.382**	**3.982***	**1.105**	**14.350**
* Odds Ratio Significant at .05; ** Odds Ratio Significant at .01.				

C. Summary: Description and Prediction of Housing Outcomes

The results of the descriptive analyses of housing outcomes indicate that close to half the residents across all sites (45%) left the shelter or lodging program before the end of the follow-up period. The immediate destinations for many (18%) residents were hospitals, other short-term treatment settings or shelters. A quarter of the sample left the programs for long-term settings that included transitional housing, nursing homes and adult homes (11%) as well as permanent housing (14%). By the end of the follow-up period, the proportion of the sample were in long-term transitional or permanent settings had increased from 25% to 41%: 5% of the total sample in transitional housing, 20% in adult homes or nursing homes, and 16% in permanent supportive, family, or independent housing. Given their long periods of residence at the shelter/lodging sites (ranging from about four years to several decades), this is a significant shift. It is sobering, however, that among those who did not remain homeless, those who ended up in permanent housing (family, supportive, or independent) were outnumbered by those in other kinds of long-term settings (nursing facilities, adult homes, and transitional housing), with many who'd been hospitalized being sent by the hospitals to adult homes. Recent investigations into the quality of care in the private adult home industry in NYC raise questions about whether such settings are an improvement over shelter life and underscore the extreme paucity of quality housing alternatives for the more elderly and infirm among the long-term shelter population.

Our analyses of the associations between individual characteristics, engagement, services and housing outcomes for the shelter/lodging programs indicate that the relationships among these are complex. It is particularly notable that our analyses failed to confirm expected associations of clinical status, substance abuse, or treatment with housing outcomes. Shelter and lodging residents with the longest histories of homelessness were the <u>least</u> likely to be housed after two years. This finding underscores the importance of acting not only to address long-term homelessness once it occurs but to actively work to prevent it. While residents who were already receiving entitlements at baseline were more likely to be housed at follow-up, referrals for entitlements during the study period were not associated with becoming housed. It is possible that our measure of entitlements referrals, which included not just referrals for major benefits such as SSI, but also referrals for smaller entitlements such transit cards in Chicago, may have obscured the effect of major entitlements referrals that occurred during the study. Although all the programs had indicated that they expected that engagement efforts focused on relationship-building would eventually translate into housing outcomes, the analyses failed to support this expectation. The analyses do, however, suggest the importance of engagement efforts focused on housing: those who were successfully engaged around housing issues were living in long-term settings at follow-up.

The good news in our housing findings is that a substantial number of people moved on to permanent settings after extremely long periods as near "permanent" residents of shelters and lodging houses designed as temporary accommodations. But it is also notable that after two years of intensive efforts, more than half remained at the shelter/lodging sites, and most had <u>not</u> been able to go to the kinds of independent or supportive housing settings that would indicate clear improvements in their quality of life.

CHAPTER 6
ENGAGING AND HOUSING LONG-TERM SHELTER AND LODGING HOUSE RESIDENTS: SUMMARY AND DISCUSSION

The preceding chapters in Part II of this report have addressed a set of descriptive questions about how the three shelter and lodging house program approached the task of engaging and housing long-term residents and the outcome of their efforts. In this chapter we review the findings and summarize what we have learned. We will consider their implications for services and policy in Part IV, the concluding section of the report.

Although the programs shared a focus on engaging long-term residents in services and housing, our qualitative data revealed variations in program goals, in the way engagement and housing strategies were organized, and in the mix of low demand and more proactive strategies used in the service process.

Program Goals varied most notably in the prominence of housing. Goals of the CTHI effort at Deborah's Place emphasized discovering and responding to the needs perceived by the long-term residents in an effort to improve their quality of life. This included encouraging and pursuing any interest they expressed in housing, but did not make housing a primary focus. For Project Homeward, the work by program aides was directed at the long-term residents' hygiene problems in order to enhance their comfort and improve the quality of life for those who shared space with them in the shelter. At the same time, social workers at the shelter focused on moving them to permanent settings. BRC's goal was to use engagement to enlist the lodgers in the plans to relocate them to more appropriate housing, and it was at this site that engagement and housing were most closely linked.

Organization of engagement and service strategies at sites reflected the variation in program goals. A single case manager at DP was responsible for engaging, providing services and obtaining housing for the long-term residents of the shelter. She worked at building relationships but also followed up with direct services as well as referrals for entitlements, clinical care and housing when women were willing to pursue them. Project Homeward entailed a division of labor between program aides, social workers and administrators, who had responsibilities for different aspects of engagement, direct services, and housing placement. Social workers focused their engagement efforts on linking women to entitlements, treatment, and housing, while program aides pursued engagement to involve women in hygiene regimens. And social workers collaborated with administrative staff to assign bed locations or services that would enhance engagement or to transfer residents who seemed otherwise unlikely to accept placements. BRC resembled DP in giving one person – initially the housing specialist and later an entitlements specialist – responsibility for engaging long-term residents, providing direct services, referring them to housing, and advocating for them within the agency and in other contexts. But unlike DP, BRC's administration took legal action to reframe the conditions for men to stay in the Palace or be evicted.

Level of demand varied in ways that reflected the differences in goals and organization of services, as programs used different combinations of low demand relationship-building, more directive case work, and administrative sanctions in pursuit of engagement and housing. DP

consistently took a low demand approach to relationship building and services, which was consistent with the program's goals and the agency philosophy. In Project Homeward, both program aides and social workers combined low demand with more directive approaches, while administrators used shortcuts such as transfers to low demand transitional housing programs to facilitate the housing goals. And at BRC, administrators used legal sanctions while the Housing specialist took a low demand approach to persuade men to move, followed by advocacy to help them qualify to stay. While the difference in level of demand partly reflected program philosophies, they also were influenced by the alternatives available to program administrators.

The quantitative data analyses confirmed that the sites using a single case manager for low demand engagement and advocacy achieved some level of engagement with most residents, provided a range of direct services, and initiated housing referrals for a substantial proportion of the individuals at the sites. But engagement in complex services and housing remained low, and for all programs combined, most residents remained at the sites two years later. Moreover, relationships between engagement and housing were not simple. Project Homeward, where assessed levels of engagement in relationships were lowest, nonetheless had the largest proportion of residents exit from the site, and while many went initially to treatment or care facilities, a majority of the women were in long-term settings by the end of follow-up. Furthermore, our analyses of housing outcomes showed no significant association between levels of engagement in relationships and leaving the shelter or becoming housed, thus failing to confirm the shared premise of these programs that building relationships with long-term residents would increase the likelihood that they would become housed. The predictive analyses did, however, show that engagement efforts targeted on housing were effective. They also confirmed that residents referred for health care (usually hospitals) were likely to be in stable residential situations after two years. Those with the longest homeless histories were least likely to be housed, indicating the importance of preventing long-term homelessness at earlier stages.

Our qualitative data on barriers to housing offers some insight into these quantitative findings. Though persistent, respectful, low demand efforts on the part of workers eventually allowed them to form relationships with residents who had initially been inaccessible or walled off from contact by psychosis or communications problems, even those who were successfully engaged in relationships with workers often remained unable to accommodate the admission processes, eligibility criteria, and requirements of available housing options; and many steadfastly refused to accept the stigmatized identities that the housing process required. Unlike the barriers to relationship building, many of the barriers to housing lay outside the dyadic relationship between worker and resident. While workers sometimes focused on the psychological underpinnings of residents' rejections of what they are offered (fear, paranoia, a belief they didn't deserve better), few were in a position to directly address the issues posed by housing programs themselves. These included complex application processes (multiple visits and interviews, extensive documentation, waiting lists), admission criteria that required applicants to demonstrate high levels of "housing readiness" (medication, sobriety) and accept stigmatized identities (as homeless, mentally ill, on welfare); and conditions of residence that impinged on residents' autonomy (requirements for treatment, abstinence, money management, or curfews). In sum, the housing that was available and deemed optimal by those trying to relocate long-term shelter/lodging house residents might offer improved living conditions but often required what many residents deemed too high a price in identity, dignity and autonomy. While certain

combinations of health emergencies and pressure from the programs sometimes overrode residents' resistance and preferences, the resulting hospital or nursing home placements were not always clear improvements in residents' quality of life.

While the quantitative analyses focus on the first two years of program activities, our qualitative updates at the sites revealed that further changes occurred over time, though they were not the result of continued engagement and service efforts alone. Given the limited options, it is notable that BRC ultimately resolved its ongoing struggle with the lodgers when it developed new permanent housing which was accessible, did not set high admission requirements or conditions of residence, and allowed residents to maintain their dignity and autonomy. It had the added benefit of being on site, allowing the men to remain in a familiar place. The co-occurrence of the housing specialist's engagement and advocacy efforts, BRC's legal strategy to permit evictions, and the decision to facilitate lodgers' admission to the new housing makes it impossible to determine what role engagement, legal pressure and lowering of housing barriers each played in the final outcome at BRC. The consistency with which the same barriers were identified at all sites suggests that housing which minimizes them may be particularly important in the effort to convert long-term residents' engagement with staff into becoming housed. While the possibility of "converting" temporary shelter/lodging space into low demand permanent housing is not typically an option, the impending conversion of Deborah's Place overnight shelter into a safe havens program may offer a similar opportunity to house long-term residents without imposing undue hurdles.

We conclude that workers' patient, respectful, low-demand engagement efforts were successful in building working relationships with those who had become entrenched residents at these sites, and these relationships were important in improving the quality of life for those who had previously been more isolated and underserved. But while there were instances at all sites of long-term residents who developed good relationships with workers and were ultimately persuaded to accept housing, parlaying an engaged relationship into changing residents' perspectives and behavior is at best an extremely lengthy process. Overall, engaged relationships did not usually in themselves lead to housing. Based on the kinds of barriers workers identified, along with BRC's ultimate success in housing the lodgers, we conclude that engagement efforts need to be complemented by the development of housing that places fewer barriers to admission, imposes fewer conditions of residence, and requires fewer compromises of autonomy, identity and dignity than many of the available options.

We will return to the implication of this for practice and policy in Part IV of this report, following the presentation of the experience and outcomes of the CTHI housing programs, to which we now turn.

PART III

HOUSING PROGRAMS:

ENGAGEMENT, SERVICES AND HOUSING

OUTCOMES

INTRODUCTION

In Part III of this report, we focus on three housing programs implemented at five sites in New York, San Francisco, and Los Angeles. Unlike the shelter and lodging house programs, which served a fixed group of exceptionally long-term residents at the sites, the housing programs recruited individuals from diverse service settings – including shelters, hospitals, drop-in centers and transitional programs, selecting tenants who had extensive periods of homelessness, heavy use of emergency services, or multiple problems and barriers to housing. At each site, those housed as part of the CTH Initiative shared the building with pre-existing tenants or others who had fewer barriers to stable housing and had moved in under different auspices and criteria. The core group of tenants who were the focus of CTHI efforts constituted under a quarter of the residents at WSFSSH's 129th Street residence, less than half the tenants at the DAH sites, and a quarter or less of the tenants at the Lamp housing sites. The service providers' responsibility for the larger tenant population varied across programs.

We showed in Part I that, as a group, the tenants of the housing programs were somewhat younger than the shelter/lodging house residents; their histories of homelessness, though lengthy, were not as extensive as the fixed populations at the shelter/lodging sites; and although they had similar levels of mental health problems, they had significantly higher rates of substance abuse and dual diagnosis.

As Part I also described, these programs occupied the opposite end of the service spectrum that stretches from homelessness to housing. The housing programs shared with the shelter/lodging sites a focus on engagement and housing stability for individuals with multiple difficulties in obtaining and sustaining stable residence. But they differed in the baselines from which they worked, the organization and focus of services provided, and the issues that emerged as the programs matured. Moving individuals into housing – the aim and endpoint of the shelter/lodging programs – was the starting point for the CTHI housing programs. While engaging tenants in services was part of the process of fostering individual stability, the housing programs also had to be concerned about the housing environment. The programs' commitment to bringing individuals with complex histories and multiple barriers into large housing sites that accommodated diverse groups of tenants entailed certain risks for both the CTHI tenants and the larger housing settings. If the central issue at the shelter/lodging sites was how to balance the long-term residents' goals and preferences with program mandates to provide temporary shelter, a central issue for the housing programs was how to incorporate a large number of "high risk" residents with multiple needs, while maintaining the quality of life in the larger community.

Our examination of the housing programs addresses several descriptive questions: how did the programs approach the task of maintaining housing for tenants with uncertain psychiatric, medical and substance abuse stability? What services did they provide? What barriers did they encounter? How successful were they in keeping tenants housed? The four chapters in Part II draw on both qualitative data and quantitative analyses to answer these questions. We begin in Chapter 7 with a qualitative description of each program's approach to housing stability, followed by a cross-site comparison of the program goals and service philosophies articulated by staff and administrators, specific strategies and barriers they identified, and the major dilemmas they had to address in the process. Chapter 8 turns to the quantitative data for a summary of

services provided to the CTHI tenants and the levels of engagement they achieved during the first year of program operations. Chapter 9 presents a description of housing outcomes and a multivariate analysis of tenant characteristics, services and engagement as predictors of housing stability. Chapter 10 concludes Part III by synthesizing the analyses of individual-level data on services, engagement, and housing outcomes with qualitative individual and program-level data to identify the implications of program goals, structures and contexts on efforts to keep individuals from returning to homelessness.

The quantitative data on services provided and levels of engagement presented in Chapters 8 and 9 reflect program activities during the first year of operations, as do the staff narratives on individual service engagement. Because rent-up at the housing sites occurred over a considerable period from 1999 through 2001, we designed the study to document one year of services and outcomes to ensure equivalent data at all sites. Though at the shelter/lodging sites we were able to expand the timeframe for all individual-level data to two years, this was not feasible at the housing programs because of the larger sample sizes and significant staff turnover at some sites, though we did obtain two-year updates on housing status that we have included in the descriptive analysis of housing outcomes in Chapter 9. Moreover, as at the shelter and lodging sites, interviews with service provider and administrators, as well as focus groups with tenants and staff spanned the entire period of the evaluation, allowing us to update program-level events and processes through more than four years of the study.

Establishing the Baseline: Services Provided Before CTHI

Unlike shelter and lodging house residents, most of the tenants who moved into the housing programs were not previously known to staff on site. At WSFSSH and the DAH programs, there were exceptions when the agencies providing services hired workers from shelters or clinics that referred clients to the housing programs. Thus data on pre-baseline services at each site (shown in the individual site profiles in Appendix B) indicates that 17% of WSFSSH's tenants who entered the 129th Street Residence as part of the long-term shelter stayers project had received numerous services in a shelter the agency operates, while a third of the DAH tenants at PBI and 15-20% of those at the Windsor had previously received direct services from ECS, Baker Places, or the Tom Waddell Health Center in shelters or treatment settings. At these sites, however, the proportion with prior referral services from the agencies (other than the housing referrals that brought them to the site) was even smaller. In contrast, almost all of Lamp's tenants at the Ballington and Pershing were referred from within the agency, and over 80% had previously received basic services from Lamp (food, showers, clothing, drop-in), while 45-65% had received other direct services such as counseling and advocacy on entitlements, health, mental health or substance abuse, and close to half had prior medical or mental health referrals. Moreover, many tenants maintained contact with staff at the Day Center, Outreach, or Lamp Village programs where they had previously stayed or received services. However, while most of the housing advocates who staffed the housing sites were drawn from within Lamp, many had not had prior contact with the individuals who moved into the housing units. At all the housing sites, then, even when tenants had previously received services from the agency, workers had to develop relationships in order to facilitate service delivery. As in the shelter and lodging programs the contexts in which they did this shaped the processes and outcomes.

CHAPTER 7
APPROACHES TO ENGAGEMENT AND SERVICE DELIVERY: A QUALITATIVE DESCRIPTION AND ANALYSIS

A. Approaches to Engagement, Services, and Housing Stability

Housing programs did not have to persuade people to accept housing. At all sites, engagement and services were focused on helping people remain housed. Tenants entering housing at WSFSHH, DAH and Lamp were briefed during the admission process on what assistance and resources would be available and what the programs would expect of them, but the differences in both services and expectations gave rise to contrasting engagement strategies.

WSFSSH's 129th Street Residence

WSFSSH's 129th Street Residence offered the most structured setting and intensive services of the three housing sites. Serving an older population assessed as needing a significant level of medical and psychiatric care, the residence provided all meals, linen and housekeeping services, and daily supervision/administration of medications to ensure adherence to medical and psychiatric treatment regimens. Residents were also expected to stay "clean and sober," meet regularly with their case managers, and attend off-site day programs – though these were areas in which staff might opt for a more flexible, low demand approach to foster engagement, rather than forcing the issues of service participation. Optional recreational and group activities were held on site and these too were used to nurture a sense of community while encouraging residents to engage with staff.

The administrators of the 129th Street Residence viewed the program milieu, and both the community and structure it provided, as critical to engaging residents and making them feel safe and secure. The program aimed to provide a permanent home for men and women with severe mental illnesses, high need for care and support, and an experience of long-term homelessness. The predictability of the environment, in which meals and medications were provided at particular times, where rules were clearly articulated, and where staff at all levels were expected to be responsive, was intended to make people feel at home, valued, and supported.

> *"Our goal is to keep clients housed at 129th street. That's simple, but it has 20,000 other things in it. Giving them the support they need to feel safe and feel at home. It's a triumph to just keep them housed. The goals within that are to increase independence, but in small increments."*

> *"The structure of the place, the milieu, is part of the engagement and a means of sustaining housing. The routine and regularity makes people feel taken care of in a safe environment."*

> *"The community is very important because it is what holds everything. Community building makes the healing happen."*

> *"He flourishes here because of the rules of the place. He can follow them."*

While the 129th Street Residence had accepted applicants with extensive homeless histories before CTHI, as a licensed adult home with a highly structured program and requirements for service participation, medication, and money management, it was not an obvious match for the long-stay population in NYC shelters. However, with CTHI support for the addition of a full time case manager, WSFSSH was able to offer permanent accommodation to 20 men and women who had been homeless for at least two years and who might have been more difficult to incorporate into the residence's structured environment without the additional resources.

> *"He was a risky referral because he did not have a history of sobriety in a community setting and he had years of street homelessness, but we took a calculated risk... I would not have admitted him if we didn't have the long-stayers program that has more resources and staff available."*

> *"The truth is the [long stayers] project allows us to take more risks...because we can hire more staff."*

While men and women entering the site as part of the "Long Stayers Program" had all agreed to accept the structure and services provided at the site, the adjustment was difficult for some and others were unable or unwilling to follow through.

> *"When he first moved in, he needed to establish that he could trust the staff with his money. He wanted to know that everything was correct and asked questions about the procedure. At first he was not happy with the money management because he wanted to have all his money at one time. Later he agreed that it was not the best way."*

> *"He refuses referrals to all substance abuse, mental health or day treatment programs. Engagement continues around those issues. He attends his medical and psych appointments and takes meds, though he had an episode of refusing meds as well. But now he takes them everyday. He refuses [substance abuse] treatment, but 90% of the time, the rules and expectations of the building help him stay sober."*

> *"He had a hard time going downstairs for meals.... I would accompany him to the dining room when it was not crowded. Then we would go a little bit earlier and then earlier. So the crowd grew with time. But he still wasn't comfortable and just recently started going down by himself."*

> *"She has reacted positively to the low demand approach. The staff do not seek her out. Saying hello is A LOT. We are working on starting conversations with her. The best approach with her is giving her space."*

> *"The milieu of the building (regularity, routine, greeting him) engaged him. I'd invite him to participate in activities. Relatively low demand, but we got him in a day program, and once he had stability with the social worker, he was able to allow more demands. He loves the program and he loves the van that picks him up. The day program also gives him structure."*

While program administrators emphasized the importance of the structure that defined the program milieu, it was not rigidly imposed. Engagement efforts by staff could involve flexible and individualized modifications to program requirements that residents meet regularly with case managers, attend day programs, take medication, and abstain from drugs and alcohol:

> *"All interactions at first were short (10 minutes) and concrete. We had daily engagement – several times. I'd meet with him a lot...for short amounts of time to listen to him at unscheduled times in my office....and chase after him for medication – that was the only demand we made. If he didn't want meds, he had to talk to the doctor to take him off.*
>
> *"We did not require him to do a lot, for example attend a day program. His transition from drop-in center to permanent housing here was vulnerable and we decided not to pressure him and push him."*
>
> *"We did constant engagement on medical care and hoarding for months, and finally, he agreed. But we save our battles, we didn't push the medication for mental health, but we did push him for the medical."*
>
> *"We did a lot of work on referrals to day programs. After he refused and was resistant for a while, he agreed to visit some places and currently goes to [a local day program] and enjoys it a lot."*
>
> *"He stopped getting drunk every day. Now he just uses sporadically, a few times a week. He's medically frail so we were trying not to do harm reduction. But we end up doing it because it's a success to have him drunk less often."*

Identifying and responding to individual interests and needs was also a critical part of WSFSSH's approach to engagement.

> "*We asked him, 'What are you going to do about Ramadan, are you fasting?', and he was surprised we knew about Ramadan. When we made arrangements for him to get medication and meals at 4:30 – 5:00 am, he was impressed and felt more welcomed."*
>
> *"We talked about murder mysteries and he bonded with me over it. Now he trades books with me."*
>
> *"A big piece of engagement was that [administrator] is Haitian and they can speak Creole often."*
>
> *"[Caseworker] engaged him by going to all the appointments with him. Usually that's done by the home health aide or frontline staff. It was how the relationship got built up."*
>
> *"I treat him as a whole person. The other clients don't. He sees it as an insult if you just talk to him about what he has to do. Now I have this thing with him where we start off*

every day with a joke. Then he gets his meds, his money, I ask him 'How are things with your mom.'"

These efforts to forge an individualized tie with residents resemble those used in the shelter/lodging programs. Staff at WSFSSH hoped that the relationship initially fostered by staff flexibility and low demand supportiveness would eventually lead residents to conform to program expectations in those areas they resisted at first, while also encouraging them to identify 129th Street as "home" and themselves as members of the community at the residence. This was seen as a critical part of the effort to keep people in housing at the site:

"He sees this as his home and wants to stay."

"This is his home and he likes it. There are things he wishes were different, but he's not going anywhere. He sees himself as the chaplain of the building."

"Having housing is a big deal for her. She doesn't want to leave. Changing roommates is an option, but leaving is not an option. She trusts that the meds and meals are going to be there. She has a flight history."

"His engagement came gradually. He eats here more. He's still here absolutely because of the relationship here. He's the type of person who can survive on the street [but] he wants to stay due to engagement."

"He's flourishing. He was amazed by us giving him a Christmas present. He smiles after being here a month. He's compliant with services. He likes the housing and he wants to stay. He's not a flight risk."

WSFSSH emphasized that keeping people housed entailed fostering a sense of "home" and "community" at the site. Administrators described the structure and rules as essential to maintaining residents' sense of being part of a safe, secure community. Threats to community emerged from behaviors that could "break" community and have an impact on others:

"The community does not tolerate things that harm people in the community. We have a drug and alcohol free building to keep that community, because whenever you have substance abuse you have lies. Lies break the community....People who bring alcohol or crack into the building like to share, it becomes a communal activity. And that is more likely to bring people out of recovery. People here are on medications, so alcohol use often leads to medical emergencies. But because we are permanent housing, we can't impose real consequences for breaking that rule like they can do in the shelters and places where you are required to be clean in order to stay. Here they can't be evicted or kicked out for the night, we can't restrict their money."

"Because he is isolative, he does not bring other people into his drinking so he's not implicating other residents. The biggest disruptions to the community are the medical breakdowns (seizures)....There is an element of blame covertly by staff and overtly by

residents. 'Stop drinking so I don't have to go through it again.' Residents are hesitant to engage, they don't want to get too close."

Though WSFSSH administrators viewed the structure and rules at 129th Street as essential to maintaining people's sense of being at home, some residents seemed to reject the notion of home and community that WSFSSH sought to create at the Residence:

"He was very isolative. He spent a great deal of time in bed and had to be encouraged to get up and eat. He was extremely difficult to engage. He shut everything down with sleep. He was extremely reluctant to accept concrete services, not even meals. He saw this place as a bed as opposed to his home. Staff changed his meds to keep him from sleeping all day, and he got upset and disappeared shortly thereafter. He's the only person in the agency we have lost."

"He doesn't want a home, he just wants a place to crash. A flop house would keep him off the street, they would not take his money or stress medical issues. That's the life he'd like to lead. A place with no attempt to build community."

"He spent much time outside of the building, returning after 5:00 pm; it was hard to catch him. He was going to his day program but also spending a lot of money. He would spend all his money in a few days. He didn't want anything other than to go places and do things. He wouldn't share where or what [he was doing], the only thing he reported wanting was money. [After a few weeks here] he reported he was moving out because he needed/wanted his whole check. We tried to talk to him into staying, but after a week, we let him leave. His ICM worker moved him into [a shelter]."

While WSFSSH used its extensive array of individual services and group activities to foster involvement in services and community, many residents received additional services from Home Health Aides, Intensive Case Managers (ICM), or Assertive Community Treatment (ACT) teams affiliated with outside agencies. The health aides generally worked closely with WSFSSH staff, but there was considerable variation in relationships between Residence staff and ACT or ICM workers. In some cases collaborative efforts worked well, but more often these workers' efforts were viewed by WSFSSH as at best duplicating services already provided, and at worst undermining engagement efforts because their availability diminished residents' need to relate to staff at 129th Street. A few residents left on their own; others moved to more independent settings arranged by these other workers, usually without consultation or agreement from WSFSSH staff:

"He wanted his own apartment to pray, meditate, study. I did not think he was ready due to addiction, difficulty with money, incidents that kept happening to him like being robbed. But he was tenacious and was able to get his own apartment through [a scatter site housing program]."

"I would tell him, 'You can't keep on going to your mother.' Before he moved back with her he was going every weekend. It was frustrating that he turned to a situation that is not best for him."

WSFSSH admitted individuals with the expectation that they would remain as permanent residents, and in focus group discussions, most of those who had moved in under the auspices of the Long Stayers Project described 129th Street as their home. Others insisted it was a stepping stone to more independent housing:

> *"This is transitional housing."*
>
> *"I'm at the residency until I get a better place to go."*

Some of their co-residents were skeptical:

> *"They're trying to project an image. It ain't happening."*

Asserting plans to move on may indeed have been a way to claim competence and membership in mainstream society. But even some of the residents who expected to remain at 129th Street expressed ambivalence about identification with the residence-based community and tried to distance themselves from the stigma of living in a setting with many disabled people:

> *"The people have changed. There's a different class of people here now. Some are sicker than others, both medical and psychiatric."*
>
> *"It seems like they take anybody regardless of how sick they are. Some of those people don't belong here."*

According to staff, these sentiments were most often expressed by a group of residents who had lived at the 129th Street Residence before WSFSSH took over the building. These pre-existing residents moved into the building when it housed a somewhat younger population that included active substance abusers. Some had been activists in the effort to replace the prior agency, filing complaints with city and state agencies and supporting WSFSSH's efforts to improve conditions at the residence. Though initially viewed as saviors of the building, some found themselves disempowered by the client role the agency expected of them. They also stirred some dissatisfaction among other residents with WSFSSH's insistence that people attend day programs and participate in treatment and social services. The social field in which dyadic relationships of staff and residents occurred thus exerted its own pull on the engagement process.

WSFSSH case managers approached engagement initially through low demand, one-on-one efforts to build relationships with residents and foster their involvement in the structured and service intensive program at the site. With limited leverage to influence community-breaking behaviors once a resident moved into the 129th Street Residence, WSFSSH screened applicants for willingness to accept rules and requirements and to identify those whose substance use or resistance to program requirements might destabilize the residence-based community and undermine the sense of safety and security that its rules and structure were intended to foster. Augmenting the on-site staffing with CTHI resources allowed WSFSSH to enhance engagement and service efforts and thus take somewhat greater risks in admitting long-term homeless individuals who might otherwise have been screened out. The other housing programs used

somewhat different approaches to maintaining a balance between serving high risk tenants with multiple needs and maintaining quality of life for all at the site.

The DAH programs

The DAH programs served a more varied population – less than a third of our sample at each DAH site were diagnosed with severe mental disorders, while larger proportions had acknowledged current or past substance use issues and/or HIV/AIDS. As independent housing with optional supportive services, both PBI and Windsor expected DAH tenants to be able to handle basic living needs without routine assistance, though individuals admitted to the Respite unit at the Windsor sometimes required more intensive medical or psychiatric care. Unlike at the 129th Street Residence, where WSFSSH operated both the building and the supportive services, at the DAH sites, separate agencies were responsible for property management and support services. Thus support services staff were not the enforcers of leases and building rules, and responsiveness to services was unconnected to tenancy status. While this removed whatever leverage might accrue as a result of an agency's say over a resident's continued tenure, it also offered case managers and other support staff the opportunity to engage tenants by being their advocates when problems arose around rent or other property management issues.

The referral structure set up for the DAH programs ensured that everyone coming to live at these sites had a prior service connection with a shelter, case management, medical, psychiatric, or social service program, and some of the referral agencies continued to do case management after their clients moved into a DAH building. The particular agencies that referred to PBI and the Windsor differed, with corresponding contrasts in the kinds of tenants housed at the two programs as well as in the extent to which the referral agencies remained involved. Contrasts in prior experience and philosophies of the lead agencies at the two sites also shaped service and engagement processes at the PBI and Windsor.

At the ***Pacific Bay Inn***, the goal of keeping people housed did not necessarily mean keeping people at the site. Initially, the transitional nature of the DAH subsidy led staff to focus on helping tenants increase their income or obtain permanent subsidies and housing elsewhere. However, though ECS and BP case managers were active in their efforts to involve tenants, they placed considerable emphasis on the optional nature of support services:

> *"Services are completely voluntary. There are no requirements. A tenant moves in and we are assigned to outreach. But they have to sign up with us in order to receive case management services. Some, especially pre-existent tenants and some new ones have not signed up. There's a consent form they sign giving permission for services."*
>
> *"This is a voluntary service and client-based. It's client driven. It's about respecting clients' strengths and where they're at. I don't do aggressive case management; that's not what the program is about."*
>
> *"We do intensive outreach without being intrusive, without knocking on people's doors. For example, we might leave a note under the door for a client as a welcome, but it is up to the tenant to decide if they want services."*

Initial engagement efforts followed a fairly typical pattern: a support services case manager would send a letter to each tenant at the time of move-in describing the services available and extending an invitation to visit the case manager at the support services office to receive a welcome kit (mainly hygiene items) and to sign up for services. If the tenant did not respond, the case manager would send follow-up letters, along with announcements of events, group activities and service offerings. Workers also used casual encounters in the building's common areas to introduce themselves and invite tenants to sign up for services:

> *"By talking and interacting, they have a different perception of case managers. We describe services in a non threatening and supportive way. Eventually they will come up for assistance."*

> *"I go to the lounge, outside, I sit and talk to tenants. Sometimes it's good for other tenants to just observe us and get an idea of what it is we are doing and what we are like – to see that we are okay. You are less threatening."*

> *"A couple of tenants started here and refused services but once they got to know me they are now more engaged. Then there are others who were interested before and later dropped out. We send letters to them or see them outside."*

In addition, support service staff organized a regular schedule of groups focused on services (e.g., housing alternatives) or social and recreation activities (e.g., coffee hour, music group). These were announced through postings and fliers as well as staff invitations and provided opportunities for staff to encourage tenants to come in for a one-on-one chat. In some instances a case manager would contact the referring agency to ask staff there to encourage the tenant to come to the support service office. They would not, however, knock on doors or phone tenants without being given permission to do so by the tenant.

> *"She moved in and didn't respond to the outreach letter. I called the case manager at [the referral agency] and they intervened. One month later, she came to the office and signed up for services."*

> *"She was extremely hesitant about talking to people or sharing. I knew her history of substance abuse and incarceration. She had low trust. I sent her a welcome note but lay low, let her watch me for awhile. A month later I bumped into her in the elevator and offered her shampoo. She said she would pick some up for her daughter. She came the next day and talked to me about her daughter, but she refused to talk about her substance abuse. She came to the office once or twice a month and spoke with me about housing and family and problems with benefits."*

> *"She did part of the intake interview and expressed her desire not to have a case manager or medication or any labels. I approached it by treating it as a social interaction – no referrals or talking about meds. I do counseling, engage with her about her plan of reality, help her with money management, show her how to get the bus to go to [agency that is her payee] to get her money. She came to the office voluntarily. She'd*

cut off services with other providers who were more persistent about getting her to take medication."

Support services staff discussed the holiday celebrations and recreational groups as offering tenants a chance to come together, but they primarily described such events as occasions for service engagement and indicators of individual tenants' service involvement. In contrast to WSFSSH's emphasis on creating a community, one ECS administrator described "community" as something that occurred more spontaneously among tenants, without program intervention:

"The community to a large extent is invisible to staff until a crisis comes up and then you see the leaders, the vocal people and other roles. Support services is not the fabric. We see it when someone dies, or something gets stolen or such, then the program gets glimpses of the community."

Consistent with this view, some ECS support staff viewed the program's role as facilitating the development of a community by providing the raw materials – a diverse population, tenant organizers from the Tenderloin Housing Clinic who were responsible for forming a tenant council – while empowering tenants to take responsibility for the building's social environment:

"There is a broader range of tenants. DAH has homeless and low income people. And the specific referral agency for specific types of tenants. This makes for more diversity. Some are chronic Emergency Room users, some are from shelters for Spanish homeless men, some are in the PAES program....At [another ECS building], there is less diversity. It is not as pronounced. The diversity makes it more real and people can help each other. Not all the tenants need high levels of service. They do what they can do – the tenant council. It's how people get along and maintain the building."

During the program's first two years, case management efforts revolved around housing issues. Since all PBI tenants were informed at entry that the DAH subsidy was temporary and that they would be expected to find other housing by the end of two years, many tenants responded initially to offers of assistance finding permanent housing:

"We do service plans, assess strengths and weaknesses. In everyone's plan there is one goal related to housing. We use it as a way to talk about services and the tenants find it useful. I use it as a tool or a check point."

"Shortly after move-in he asked about case management and requested an appointment. We met and I did an intake and psychosocial assessment. He wanted to get his Section 8 certificate renewed. He shows up in the office to check up on how the Section 8 is going."

"He attends the housing group twice every month. He came to the office and filled out over six applications for permanent housing – Shelter Plus Care and Section 8."

"I sent the outreach letter, then caught a glimpse of her in the hall when I was running a group. I ran out and asked her to come and meet with me. She came after work. She

filled out the intake and service plans and grievance procedures, but she declined all support except for the help with housing."

"I sent a letter and he didn't respond right away, but then came to the office to talk about his current status on the Shelter Plus Care waiting list and discuss housing. He's cordial but doesn't ask for anything else."

Impending expiration of subsidy provided many tenants with an incentive to link up with the support services staff. For some that initiated a relationship that extended to help with other problems such as rent arrears or health, mental health, or substance abuse.

"I sent the outreach letter and he responded, came to the office. He was very receptive. He wanted permanent housing. I run a housing group and a coping group and he attends both. He was not going for his [medication injections] and I reminded him. He's turned off if I get too personal in his history, he'll tell me 'I don't want to talk about that,' but we've connected."

"When he came for services he didn't attend many groups but one housing search group. He was coming regularly, continued to focus on housing. Then in a few months he started to discuss job issues as well."

"Right after he moved in he started checking in with staff about housing. A month later he signed up for case management. He talked with me about benefits, came in about three times a month. We discussed medical issues, meds, hospital bills. He got very involved in the community here and tenant organizing. He started coming to the office 4 or 5 times a week."

When DPH policy changed the DAH subsidy from temporary to open-ended, it had a marked effect on engagement and services. On the one hand, it took pressure off both the support services staff and tenants, who had expressed considerable anxiety about finding housing before tenants lost their subsidy.

"It's given us a bit of relief. And allowed us to focus on longer term issues."

"Now that PBI is permanent housing, we're revisiting the Service Plan, which has been heavily focused on getting housing or getting new income to afford the market rate."

"I have lots more time to make longer contacts and to bring some changes on the perspective or attitude. Also it makes for a more relaxed atmosphere, there's not the same urgency. [We can work with people on] not only housing, but other steps in life."

"As far as housing plans, people were very happy they don't need to figure out where to go next."

"[Since] the shift from transitional to permanent housing, now case management comes from different circumstances: longer term relationships for dealing with longer term

issues. Before, we were dealing on crisis mode and moving on in the next two years. Not now."

At the same time, the change had a down side for both staff and tenants. In the absence of the pressure imposed by the time limits for the subsidy, case managers lost leverage in their work with tenants. Moreover, once their housing at PBI was no longer defined as transitional, many tenants forfeited eligibility for programs such as Shelter Plus Care, which subsidized housing at a more generous rate (rent is 30% of income) than the DAH subsidy (rent is 50% of income).

"I saw people become complacent. Kind of 'I don't need you, I'm here' and the incentive is gone. It requires creativity by staff to find innovative ways to reach tenants."

"It presents the challenge to staff to maintain motivation on another level. Several clients are still looking for other alternatives in or out of the Tenderloin, or cheaper – 30% of their income instead of 50% like they pay here."

"It will depend on the client. Some of the [housing waiting] lists were only for homeless people [and now they don't qualify]. It's still unclear how the lists are going to work."

With the diminished urgency of finding alternative housing, case management activities shifted to emphasize engaging people around issues of health, mental health, relationships, substance abuse or family issues. However, some tenants turned to support services only when these issues were reflected in eviction notices because of rent arrears or incident reports:

"When the eviction process started, I advocated with property management to let her continue to live at PBI. She was counseled and referred to a rental assistance program [to pay back rent], but the eviction process went ahead and she left."

"After the rent issues began staff did a lot of outreach letters and face to face. He didn't respond and was resisting. I suggested a meeting with property management but he refused. He also refused referrals to agencies that could help with rent payment. At the end he seemed not very responsive to services. He was polite and would be responsive to concrete stuff. He didn't attend groups. He stopped paying rent and gave up, and by then we couldn't help him. He got evicted."

"She came into the service office because she was being evicted for non-payment of rent. She started attending groups, discussed issues with her relationship with her boyfriend. I talked to her about rent payment and referrals to agencies to help her pay rent. I advocated for her with property management and got her eviction revoked. But she stopped attending groups and was coming in to see me sporadically. She got another eviction notice and went to court without me. I was still doing advocacy and referrals for legal services as well as other housing. I was focusing on preparing for eviction and finding other housing. Eventually the eviction went through."

While services were tailored to the needs of the DAH group, tenants who pre-dated the inception of DAH, and those who were referred to PBI through THC were also offered services. Almost

all tenants eventually were contacted by a worker at PBI. A few came to the office and, upon discovering that the services were optional, formally decline to participate. Others agreed to participate and signed off on a service plan, but only sought out the case manager after repeated invitations to attend groups (written and when seen in passing) or when a crisis arose.

> *"In my experience, the people that come here under [the DAH] subsidy know that the case manager is involved. Those who were here before don't know. For them, we invaded their home."*

> *"I sent [tenant] an outreach letter explaining the services and he responded to this by mailing me a typed up letter requesting his name be removed from the files. Said he's been a working tax payer for ten years. Nevertheless, on a couple of occasions he came to the coffee hour and community meeting, and he responded to a few mailings by asking for more information on housing referrals."*

When PBI was in its first years, ECS administrators felt that the diversity of the tenant mix (pre-existing, PAES, and DAH) along with the variety of DAH referral sources and the flexible eligibility criteria strained staff resources less than in other Tenderloin buildings operated by the agency in which all tenants were dually diagnosed. However, even though the pressure to find housing alternatives abated when the DAH subsidy was made permanent, there was considerable staff turnover in the programs' second and third years, and support services staff reported feeling overextended because of high-need tenants in their case loads who absorbed their time in ways that precluded continuing to help less needy tenants look for better housing alternatives.

While PBI support services staff scrupulously observed both the spirit and the letter of a harm reduction, low demand approach, near the end of the CTHI period support staff voiced a desire to find new points of leverage to engage tenants before their problems led to eviction. Though the newer DAH buildings have attached to the subsidy agreement a requirement that tenants with extremely disruptive or unsafe behavior will lose their subsidy unless they agree to regular involvement with support services staff, this has not been applied in the early DAH buildings like PBI and Windsor. Administrators at PBI who are interested in such a change cite the Shelter Plus Care model and maintain that such a change would not alter the focus on tenant-defined goals, but would offer a point of intervention early enough to avert eviction.

> *"We want to keep our people housed, but it's an extra step before eviction.... It would only apply for extreme behavior. Like with Shelter Plus Care. It hardly happens and they have tenants' rights and could get back in. It's rare that it goes through. Tenants confer or leave.*

> *"It would be about the small percentage in the building that would get the message, the percentage for whom this is a problem. This would put support services in a position to bargain with property management to help the tenant get her act together. In theory, they could stay in the building if they come up with the money [that is currently covered by the subsidy]."*

Some administrators acknowledge, however, that tying the subsidy to participation in services would heighten a tension already felt within supportive housing programs:

> *"It's an inherent tug of war of goals – the housing is built for independent living but [it offers service providers] the opportunity to intervene in their lives. The burden shifts from what did the person do to what did you do to help them."*

> *"It would be a huge change. Staff and tenants would have feelings about that."*

With the removal of the time limits on the DAH subsidies, the tension between tenant-driven services based on harm reduction principles and the need to work with needy tenants who drain staff energies and impinge on quality of life at the site surfaced as a significant concern at PBI, leading staff to seek alternative ways of leveraging service cooperation. While the staff continued to describe their practice in terms of harm reduction and tenant-defined goals, there was increased cooperation between support services and property management and a greater willingness to acknowledge that staff sought to influence those goals through more proactive intervention than the early staff at the site were comfortable with.

At the ***Windsor Hotel***, which was staffed with a clinical team of nurses, a physician, psychiatric social workers and health workers, the focus of services and engagement was somewhat different. Unlike the PBI, where services initially focused on providing practical help for obtaining permanent subsidized housing, at the Windsor Hotel, staff emphasized their clinical efforts to prepare people to move to more permanent settings.

> *"The goal is to empower the clients to be autonomous and be on their own."*

> *"We provide in-house support to [formerly] homeless people – getting them stabilized medically and psychiatrically and connecting them to primary care – so they would be in a position to move on to independent housing and be able to maintain it. [Our aim is] for them to attain higher independence, so they're able in the future to find housing on their own. To get them the benefits they are entitled to. To address the substance abuse issues while they are in stable housing."*

Even after the time limits were removed from the subsidy, staff continued to view their efforts as helping the transition:

> *"Staff all along advocated that it was impossible to move them in two years. It's a relief for the case manager. We will still keep the idea that our job is to transition people."*

The Windsor support services team was also distinctive in that it was staffed with clinically trained personnel (health workers, nurses, a doctor, and psychiatric social worker), was administratively located under the aegis of the Department of Public Health's Tom Waddell Health Center, and used the multidisciplinary team model developed by Health Care for the Homeless programs:

"*No other program has the strong and aggressive medical component. Two nurses and a doctor…the nurse is the point person. First people tell us about their medical problems and then the rest [of the information] comes.*"

"It's not individual, it's a team effort. The nurses have very limited hours, so we [the health workers] try to assist the nurses in outreaching to clients and referring back to nurses and vice versa. We have 94 residents, and we have to case manage all the clients."

Tenants at the Windsor included the three groups served at the PBI: DAH referrals, PAES clients of the Tenderloin Housing Clinic, and pre-existing tenants. In addition, the Windsor included a 16-bed Respite Unit for individuals leaving acute care facilities who had both acute medical or psychiatric needs that might require daily attention (for example, changing dressings, administering medications) and longer-term needs for housing and ongoing treatment or rehabilitation services. Some Respite patients received services primarily from the case managers at their referral agencies, who continued to work on permanent housing placements to follow departure from Respite. As at PBI, the diversity was initially seen as limiting the intensity of services needed on site:

"The building runs smoothly because of the diversity. There are pre-existing retirees that are high functioning, kind of mainstream. And the PAES tenants are higher functioning and highly motivated. The DAH tenants are coming from situations that have led them to deteriorate and have major problems....The in-house medical piece is needed."

"PAES [tenants] are working, so we're home when they're home. But they are functional enough to go through the [service] labyrinth on their own. The pre-existent tenants have problems, but they manage to hang on to housing; they're retired vets, or working class. The DAH [tenants] are more acute. They come in homeless, chronically abusing substances, with psych and medical issues – but they are already on SSI for their disability."

The typical process of engagement at the Windsor both resembled and differed from PBI. Windsor support services staff first had contact with tenants during an intake interview conducted by a support services worker, who obtained information and explained the services available. Some tenants followed up by coming to the staff offices to request concrete services or help with problems that came up. If a tenant did not follow up on her own, workers might knock on her door, inquire about how she's doing, and invite her to come in for further services. It sometimes took several such invitations before a tenant would appear in the staff area. Some of the DAH and pre-existing tenants became engaged with support staff when problems arose with property management, prompting the case manager to send a letter offering assistance and providing an occasion for the team to intervene on a tenant's behalf. The availability of medical staff also drew in a number of tenants, who sought help from the nurses when they become ill or had health care needs.

"*I did the intake interview. We give people a lot of space, which is a good thing with homeless people. I see her in the lobby and hallways and I say hi. She has a phone so I*

call her. She decompensated because of crack use within her first month....She began breaking the rules, not escorting guests out, asking front desk staff for crack. After that we got a little more pushy because she was breaking the rules. We would call her on the phone two or three time a week. She would respond or call down to complain. She's keeping in touch."

"At intake he was coherent and responsive. A few weeks after he was here, he became elusive. He avoided the staff. He started using and got off his meds. Neighbors were complaining so we tried to intervene, left notes, knocked on his door, but he never responded. He got arrested but we're holding his bed."

"I did the intake. I have to run after her. She's resistant to taking her blood pressure. I have to catch her in the hallway, or see her on the way to the store. The nurses outreached and she made appointments and complied. She's always agreeable, pleasant. The reason she wasn't too engaged is because she's always immersed in what's going on in her head. The voices keep her busy. Though the meds have done good to the point of bringing her inside, she's still distracted."

"I went to his room and introduced myself. He was friendly but shy. He's active, goes out everyday…He'll come down here for concrete services – tokens, to make or confirm appointments, use the phone. He talks to me, to [health worker], and to the nurses."

"Nurses are often the first ones to be in someone's business. He was sitting on a couch in the lobby and I introduced myself five days after he moved in. He complained about a problem with the front desk. He wanted an elder female friend to come and help him read his mail but the front desk staff wouldn't let her in because of lack of ID. I advocated with the Front Desk staff and got her in. Later he asked me to help with the mail and I did that for a long time. I also went to his room every day to administer eye drops....Most of his needs are medical, so mostly [the other nurse] and I deal with him."

"He would speak to me randomly as I saw him outside. But he had a fire in his room and had to change units until his room was fixed. He came for furniture and stuff and stayed and shared more with me. He talks about how he's doing....He seeks me out. He also talked to [nurse] about his back problem. He admits to substance abuse but refuses referrals."

"We did some outreach, knocked on everyone's door. We offered him services and he seemed receptive. Mostly the content of the contacts is not therapeutic but superficial. He comes here to ask for tokens and I see him in the building at least 3-4 times a week. He also sees the nurse at least twice a week to take his vitals. He seems responsive and often requests stuff. He sees the nurses and the doctors, talks to pretty much everyone."

Though staff employed specific tactics that PBI case managers eschewed as too intrusive (knocking on doors, seeking out tenants in their rooms), the Windsor support services staff used low-demand harm reduction strategies similar to those employed at PBI:

"It's a harm reduction approach. They are allowed to use in the building in their rooms. We approach it from behavior and health. If using is affecting their health or jeopardizing their housing we [intervene around that]."

"It's mostly behavioral. If they get high on their room…only if they're deteriorating, then we do a clinical intervention. But as long as they don't do it in public."

"This is not a punishing program. No shame or guilt factors. Even those labeled paranoid schizophrenia come to us."

"I'm ambivalent because we are a program, but not. This is their housing. We're not to take the sense of authority from them. I think it's working out. The needs are some identified by tenants – in keeping with the philosophy. Harm reduction and behavior modification."

In focus group discussions, tenants spoke positively about the building and the supports provided, though as in all the permanent housing sites, some chafed at rules they found demeaning and others sought to distance themselves from tenants with obvious disabilities:

"The support they have, I'm grateful for being here, from being homeless."

"The medical services are good. It's a good transitional place, from the streets to here. A lot of help and support."

"It makes you independent again, it's a good feeling."

"Sometimes they feel they are dealing with children – not all the time."

"There are so many rules. Kitchen rules that don't make sense for adults...."

"They need to have more screening of the people that come here; some seem like better at a hospital or nursing home. They need more psychiatric and medical screening."

The double task of providing services for both brief Respite patients and long-term DAH tenants distinguished the Windsor program from PBI and other DAH undertakings.

"We're here to get the [Respite patients] a little better off. If we can connect them with entitlements, case management, with primary care and doctors, time to clean up -- they end up better off. With the reality of the housing limitations, it is very hard to place them. Also people have such chronic problems that they need support in their housing. They probably couldn't make it elsewhere. Our goal is to get them more stabilized. The time length is two to eight weeks. Ideally, they would move from Respite to transitional or permanent housing, but nothing is available."

As the Respite program evolved, it developed a more structured approach to working with the Respite group, requiring that they agree upon entering the program to follow a treatment plan

and adhere to a more stringent set of rules (the floor was designated as "clean and sober"; visiting policies became more restrictive).

> *"Over time the idea of Respite changed. The duration of time, because of the complexity of the problems; so many medical concerns. The nurses can use help to see if they are hooked up with benefits. Respite patients want to know where they will go after here. Housing is very problematic for all."*

> *"The Respite originally was 'wet' beds but now it's changed to 'clean and sober' and no smoking. We changed our minds after a hardcore drinking tenant in the Respite went medically wrong. So the floor is clean and sober, but they could go outside and drink and smoke. We won't kick them out, because it's still harm reduction."*

At the same time, the demands of serving an acutely ill Respite population stretched the case management capacity of the program and required a kind of triage to focus resources on those individuals in greatest immediate need. Therefore, in contrast to PBI's persistent outreach through letters and casual encounters to all groups of tenants in the building, the Windsor staff made fewer active efforts to engage non-DAH tenants who did not seek them out. For similar reasons, Windsor staff did not routinely pursue alternative housing placements.

> *"I feel like we're two distinct programs: the Medical Respite and the program for the DAH residents. One draws more than the other. When Respite started, it stopped DAH. We're trying to run two programs at the same time. As a program, we just started to do stuff [for the DAH tenants] that we should have been doing all along, like groups and other support services that we need to provide."*

> *"We've been working in crisis mode; we dealt with the ones with the issues and neglected those that are doing well. Now we want to approach everyone and work more preventively."*

Engagement around housing issues involved resolving conflict between tenants or, more often, advocacy with the property manager around rent or tenant behavior and rule violations. Although there was considerable tension between the two agencies around rules and evictions, support services staff also saw tenants' problems with building management as occasions for engagement:

> *"Property management is the rule holder. They have tough rules, it's very strict. The clients have a right to complain, they are sensitive issues. It's good clinical intervention to help clients to change those rules – the empowering piece. They have the power to change it."*

> *"I had two clients that I had to step in and advocate with the property management. The good cop/bad cop routine, helps us to get our clients to trust us."*

> *"After he moved in he got work as a security guard. The way it works, he calls in daily and they send him places to work. Then he got sick and had surgery, so he lost a lot of*

work and missed part of that month's rent and the next. He received a notice of eviction and has missed more work by going to court and seeing lawyers, so now he goes to the bottom of the list and won't get work again until the end of the month....When I saw the eviction, I approached him and we've now done a lot of advocacy for him....There's a possibility we'll get an agency to pay his back rent."

The property manager looked to the support services staff to work with tenants who caused problems in the building and expected the team to intervene with tenants under threat of eviction:

"Even when we [property management] are in the eviction process we try to work with support services and the resident. But they have to be pro active. There's a settlement conference before the eviction – the judge encourages this – unless [the eviction is for] something very violent."

Over time, evictions became a major point of contention between property management and the support services team, who complained that they were not aware of tenants' problems with property management until it was too late for effective intervention:

"The whole issue of evictions or potential evictions [came up when] a handful of people were evicted for non-payment of rent. We [support services] were finding out by the time they were going to court. There was poor communication, wrong assumptions."

"He received a 30-day eviction notice for non-payment of rent. Staff advocated for him and gave a referral to the Homeless Advocacy Program attorney and Eviction Defense Collaboration. He was also given a referral to [foundation] for assistance with rent payment and to Catholic Charities. There were between four and seven encounters or case conferences that month. He moved out before he was evicted."

"I did the intake and offered services. He came a few times because he couldn't pay back rent, wanted referrals for sources to help him pay the rent. He was using so bad at the end, he wanted to prolong housing as long as he could. The eviction process started after non-payment of rent. Also he was getting people into the building and stealing/breaking into rooms. Thirty days after they started the eviction process, he moved out."

At the two DAH sites, efforts to engage tenants in services were both enhanced and circumscribed by the optional nature of support services. Neither the administrative interventions to foster engagement undertaken in some of the shelter/lodging sites, nor the clinically-based program requirements (e.g. for receiving treatment, taking meds) at WSFSSH and in the Windsor's Respite Unit were available to staff to use as leverage for engaging DAH tenants in services. Staff at PBI found that during the period when the DAH subsidy was time-limited, its impending expiration encouraged tenant involvement with the support services team; but at both PBI and Windsor, staff engaged tenants through advocacy with property managers when tenants were penalized for rule breaking or threatened with eviction. Pre-existing DAH tenants at both sites voiced concerns not unlike those heard at the Palace that the social services offered on site stigmatized all tenants. It is notable, however, that the health service focus of staffing and services at the Windsor seemed to offer a more acceptable rationale for tenants to seek assistance than other types of support services that could mark recipients as part of a

"special needs" population. And tenants at both sites indicated that they valued their ability to define the terms of their engagement with the programs.

Lamp's Housing Programs at the Ballington and Pershing

Unlike WSFSSH and DAH, Lamp recruited housing tenants almost entirely from within the agency's other programs. Some had been members of the Lamp community for many years and continued to work closely with Lamp advocates at the Village or Day Center programs; a few had previously been housed at Lamp's Lodge program. Even newer members of Lamp, including a group recruited through a recently-implemented Lamp program of jail outreach, were known to the advocates involved in the initial outreach or service delivery. This made engagement at the Lamp Housing sites somewhat different from the other housing programs, as most Ballington and Pershing tenants were already participants in the larger Lamp community. While WSFSSH sought housing stability by keeping people at 129th Street and DAH emphasized obtaining more permanent subsidies or accommodations, Lamp sought to match tenants' changing needs for support or independence by moving them to various transitional or permanent sites within the Lamp community.

For housing advocates assigned to work at particular sites, the task of engagement entailed developing a supportive relationship with the individual. However, since tenants often had long-standing relationships with advocates at other Lamp program sites, the housing advocate was not always the "primary advocate" for a given tenant, though he or she was the "point person" for issues that came up at the housing site.

> *"There are a lot of eyes on her. She sees [a counselor at Lamp] weekly, and she sees a money management person there every day, participates in groups at the Village. So she doesn't really need my engagement, just to make myself available, [because] there hasn't been a crisis since she moved into the Ballington."*

> *"He has been with Lamp since way back. I knocked on his door every day, and he was okay with that. And I also talked to him about his paranoia and would try to get him to understand his thoughts, talk them out and understand their nature. He always asked me about my dog and would play with him when I brought him, so that helped engage him. But after a couple months at the Ballington, he started distrusting us, disconnected. But he still goes to the Village and gets services and counseling there. He comes about once a week to talk with [advocate] or have coffee at the Ballington. We're just waiting for him to come around."*

Lamp's housing advocates usually began the engagement process at the point a member of the Lamp community was identified by Lamp staff in one of the other programs as a candidate for a vacancy at either the Ballington or Pershing housing programs. The potential tenant would then meet with a housing advocate, fill out the relevant application (which differed at the two sites), provide "intake" information for the Lamp database, and visit the site to view the room that was available. Advocates intervened if the process was bogged down in bureaucratic delays, and by the time tenants moved in, they had usually had a number of contacts.

In building one-on-one relationships with tenants, Lamp's housing advocates used engagement strategies similar to those documented at the other housing sites, including being visible and available, finding out about tenants' interests, and offering material items (e.g., bus passes, vouchers, meal tickets, tokens). Lamp's housing advocates often drew on their own lives and resources in the effort to connect with tenants: advocates who were themselves in recovery reported that disclosing their own experiences fostered trust and engagement; others used their cars to give tenants rides to appointments, opening an opportunity for one-on-one discussion. One advocate brought her dog to work, building ties with some tenants around love of animals.

> *"I noticed that he would go over to the Village for breakfast, but he complained about the breakfast there, so I invited him to make breakfast [in the communal kitchen] at the Ballington. While we were preparing food, he mentioned he was lonely so I asked if he'd like to help me plan monthly community dinners at the Ballington. He likes the meals and we talk about music, share trivia on musicians."*
>
> *"I introduced myself, told her about myself and self-disclosed my history [with drugs and homelessness]. This loosened her up – it works every time. She opened up to me even though she was evasive."*
>
> *"My background as a former addict was important in building trust with him. I told him, 'I've been there, in your position," and it opened him up tremendously. I told him to be careful of his money and warned him about the temptation to buy drugs with it rather than paying rent."*
>
> *"We share the same interests and enjoy comedy together, music in the '50s and '60s, and cars and racing."*

While staff worked to open up discussion that would encourage tenants to address substance abuse, health, mental health, or relationship issues, they spent much of their time dealing with problems that arose with building managers at both sites. Advocates complained that property managers had limited knowledge about and tolerance for mental illness, and much of their work involved troubleshooting impending evictions – sometimes for non-payment, but often because of behaviors related to mental illness (hoarding, unsanitary housekeeping practices, destruction of property, noise) or addiction (using or selling drugs, prostitution, violating visitation rules).

> *"Then he left the water on and flooded his apartment, and VOA wanted him out of the Ballington. We advocated for him to stay and made an arrangement for him to go to the Village if he needed to [in order to feel safe from his delusions and paranoia]. He's continued to live at the Ballington but stays at the Village 2-3 times a week as well."*
>
> *"After seven months at Ballington, he had outbursts and was aggressive. They were threatening his housing. He pounded a hammer on the doors, and we negotiated with VOA to transfer him to the Village for ten days. He disappeared from there for two and a half weeks but returned. We're holding his unit at the Ballington for him."*

These issues were particularly prominent at the Pershing, where Lamp tenants were dispersed among the building's larger population. The site had a reputation as a center of drug activity, and several Lamp tenants with substance use histories relapsed soon after moving in[18]. Lamp advocates collaborated with tenants to maintain their housing by preparing them for building inspections and contesting eviction notices. When eviction appeared inevitable, some tenants left on their own; when possible Lamp staff helped arrange alternative accommodations, often working with advocates at other Lamp programs.

> "*The police came for him with a warrant. He went to court and they mandated that he do drug treatment. We were working on trying to get him into a rehab programs. We were trying to keep him compliant but...he would only go for outpatient if we drove him there. Though he was engaged with staff, he was very addicted and Lamp and SRHT staff were working on issues with him and it was hard. SRHT told us he would have to move out and turn in his key. He left the Pershing without us knowing and went to the Day Center, where an advocate referred him into another Skid Row hotel."*
>
> *"Sometimes SRHT would write him up and threaten to evict him. We'd do lots of advocacy and negotiation – contracts with him, lots of defusing....Maybe somewhere else he would do less drugs, but because the Pershing is very tolerant, they put up with his behavior and outbreaks. I don't think other places would [put up with it]. He's still housed at the Pershing."*
>
> *"Sometimes he got behind in his rent and SRHT would move to eviction. We would advocate and contract with him to pay double by the first of next month and he would do it. Also every month he was threatened with eviction because of cleaning inspections... Eventually he was going to be evicted and he moved back into the Day Center [shelter] to avoid having an eviction on his record. He agreed to pay back damages and back rent."*
>
> *"SRHT tried to evict him because of lack of rent payment. We advocated. Also that month his parole officer got a positive urine test and we advocated strongly as well and worked out a contract. We see him daily and if we don't, we'll go knock on his door. When he's high, he messes up his room, so when we know there will be a room check we warn him, and if his room is bad we clean it or help him clean it."*
>
> *"His room was a major issue for Management at the Pershing. He allowed [another advocate] and me come into his room to help pick things up and throw things out. My relationship with him was mainly trying to make sure he didn't rock the boat for Pershing Management....He was evicted without notifying Lamp, which led to a lot of tensions between Lamp and SRHT."*

At the Ballington, situated adjacent to Lamp's Day Center and a short walk from Lamp Village, community-building activities were not a prominent part of engagement efforts, though periodic community breakfasts and dinners were held, and tenants did develop working relationships with the housing advocate based there.

[18] Near the end of the study period, Lamp's Housing Director reported that the agency was waiting a bit longer before moving new people coming to Lamp through the outreach program into the Pershing.

"There isn't a sense of community at the Ballington. There's no place to see people. She wanted a place with a community atmosphere like the Lodge. But she spends a lot of time at the Village eating, visiting with friends, doing her money management."

At the Pershing, housing advocates were active in developing an on-site community of Lamp members, furnishing the on-site office with comfortable sofas and using the TV and VCR to draw tenants into the room. The community-building efforts within the Pershing were undertaken in part because the site was on the edge of Skid Row, at some distance from other Lamp programs. In addition, many Pershing tenants had been recently brought into Lamp through the jail outreach program and had limited ties with the agency. Advocates saw the "community room" at the Pershing as an alternative to the more drug-infused culture of the site and a tool of engagement for those with limited ties to Lamp:

"I went ahead and invited him like everyone else to the office, offering trips, sodas. He did not come to the office immediately, but eventually he poked his head in to say, 'Wow, this is nice.' I invited him in and he ended up staying an hour and a half. He smoked and talked freely and now he's a 'regular,' coming in daily."

"He's part of a group from the Pershing that goes together to the YMCA for the sauna and sports. [The advocate based at the Pershing] has been going to the YMCA and has been successful in building up a community of residents at the Pershing."

"At the Pershing, where a lot of drug addicts and dealers and non-Lamp people live, the main topic of conversation is how to score drugs. The office offers a space that is free of that talk and she has really taken advantage of that [to help her stay clean]."

Lamp's harm reduction philosophy and voluntary services resembled the DAH programs. And as in DAH, engagement and case management work often involved advocacy with property management staff around tenant behaviors that put them at risk of eviction. However, unlike at DAH, tenants who left Lamp housing usually did not leave the agency, and in many cases, LAMP averted a formal eviction (which might prevent a tenant from obtaining SRO housing in Skid Row in the future) by moving the tenant to another Lamp program. While keeping people housed was a major Lamp goal, if problems arose at the housing site, both staff and tenants viewed a return to Lamp's Village or Shelter programs as appropriate temporary options. While DAH worked to avoid tenants' return to homelessness, Lamp often saw a temporary stay in its transitional housing or shelter programs as a stabilizing process and preferable to moving outside the Lamp community. These contrasting approaches underscore a key difference between Lamp and DAH: at the DAH sites, engagement was directed at providing tenants with services that would keep them housed; for Lamp, engagement was about membership in the broader Lamp community, ensuring ongoing support for whatever needs emerged over the long-term trajectory of an individual's recovery.

B. Engagement and Services: Contrasting Approaches to Keeping People Housed

At the CTHI housing programs, both staff and tenants hoped that tenants would, at a minimum, remain housed. However, as at the shelter and lodging sites, the programs used diverse approaches to maintaining housing, which reflected contrasting interpretations of the shared goal, distinctive contexts for pursuing it, and resulting differences in strategies and barriers.

Program Philosophies and the Level of Demand

All of the housing programs viewed their engagement approach as "low demand," but this had different meanings at the various sites. WSFSSH described the structured milieu at 129th Street as a "high support, low demand" setting that made residents feel safe and at home. Staff narratives on the engagement process there offered many instances of low demand strategies and program flexibility around particular requirements. But in its expectations for residents' compliance with treatment regimens, abstinence from drugs and alcohol, case management contact and involvement in outside treatment programs, the 129th Street Residence clearly had the highest "level of demand" of the programs in the study. Though "harm reduction" strategies were occasionally used to retain tenants who were unable to remain abstinent but whose substance use was not exceedingly disruptive, the agency disavowed "harm reduction" as an overall approach and emphasized the destabilizing effects of substance abuse on the tenant community. The ability to maintain a structured program with a "clean and sober" environment, however, required screening for residents who would be willing and able to accommodate both the program rules and the kinds of demands it imposed on those who lived there. Such selection factors are essential to the program's viability but may limit its generalizability to the larger population of disabled individuals who have accumulated extensive homeless histories.

The DAH and Lamp programs were developed around a philosophy of harm reduction. At the PBI and Windsor sites, DAH tenants who entered the program were screened only to verify they met basic residence and income eligibility criteria, leaving it to the referral agencies to insure that they qualified as "heavy users of emergency services." All DAH services were voluntary, and tenants were not required to accept case management services, abstain from drugs and alcohol, take medication, or participate in off-site programming. (The Respite Unit at the Windsor operated under a much more extensive set of rules and requirements.) In this context, support services staff made their services available and encouraged tenants to meet with them, but staff respected the wishes of those who asked not to be contacted or who refused services. Lamp shared the harm reduction, low demand approach in its housing programs at the Ballington and Pershing. Since tenants were referred from within Lamp, they tended to be connected to service providers at the agency, but as in the DAH programs, services were optional, and those who did not wish to receive them were not required to. The property management agencies who controlled the housing admissions process at these sites primarily screened for housing-related issues (for example, a history of prior evictions); once they moved in, tenants were expected to comply with general "good neighbor" rules that are typical in standard leases.

The harm reduction approach and voluntary services allowed both DAH and Lamp to house individuals often screened out of housing programs for homeless individuals – particularly those with unresolved substance abuse issues. But it also ensured a struggle between service providers who were committed to continuing to work with tenants despite psychiatric or substance relapses

and property managers who wanted to minimize disruptions at the site and expected service staff to control tenant behavior related to mental illness or substance use. The tensions between support service providers and property managers reflected their contrasting priorities: supporting individual tenants versus maintaining the entire building's physical plant, financial health and quality of life. While the target groups for these programs were entering housing with little history of stability and thus constituted a risk for the building management, two aspects of program organization offset this: the mixed populations of the DAH and Lamp buildings ensured that not all tenants at a site would require extensive support or have difficulties abiding by the terms of their leases, while the division of labor between support services and property management provided a means of managing the tension between keeping order at the site and supporting tenants through decompensation and relapse. In addition, Lamp used its broader community and the residential resources within it to provide alternatives for tenants who were having difficulties, keeping them within the program though not always in permanent housing. Both programs found that the effort to keep unstable tenants housed at times stretched support service resources and damaged cooperative relationships with property managers, but through concerted work, it was possible to improve cooperation and communication between agencies.

Housing and Community

The contrasting philosophies regarding the structured milieu and harm reduction were cross-cut by the programs' approaches to the issue of "community" and how that was linked to housing. While the notion of "community" was in different ways central to the philosophies of all the programs, the locus of community-building processes and the role of service staff differed.

WSFSSH made the notion of a building-wide community central to its focus on the residence as a permanent home. The program structure and the encouragement of staff shaped the social world of the building as one that was tolerant and supportive. The admission process was used to screen out tenants who might pose a threat to the sense of safety and quality of life in the community as a whole.

In the complex social worlds of the DAH buildings, "community" was enacted at various levels. The property management agency was responsible for each building as a whole, for establishing rules and mechanisms for enforcing them that maintained the quality of life for all tenants. Building managers looked to support services staff to foster community through groups and recreational activities and to manage individual tenant behavior that impinged on others at the site. At the same time, tenant councils – formed with support from the social service teams and the tenant organizers from THC – allowed tenants to contest specific rules and policies and gave some tenants a venue for exercising leadership skills. While the support services teams encouraged the tenant councils and emphasized their potential for empowerment, their own efforts focused on advocacy for individual tenants. Even when the PBI support staff sponsored recreational activities, holiday celebrations, and events, they described these activities as occasions for building trust between tenants and workers, rather than for galvanizing community sentiment. One PBI administrator described "community" as something that goes on among tenants, regardless of input from program staff. With a referral process that ensured diversity of the tenant population, DAH programs offered tenants the raw materials for developing social networks, relationships, and a sense of community that could approximate the processes that obtain in less contrived social settings.

Lamp, also, made "community" central to its mission, but here the focus was on the wider community that encompassed participants in all Lamp programs. With an emphasis on harm reduction and life long support, the agency offered housing slots for members of the Lamp community who were interested in moving on from the more structured transitional program at the Village or the less private congregate shelter setting at the Day Center, but did not thereby expect tenants' social worlds to revolve around the housing site. For a time, the Pershing's distance from other Lamp programs, along with the limited ties to the agency of many of many Pershing tenants recruited through the jail outreach program, fostered the development of an on-site community of Lamp guests there. However, the agency more recently moved toward a slower process of placement at that site, offering outreach clients a longer period of engaging with the agency as a whole before referring them to the Pershing. Along with this, the emphasis again shifted to the broader Lamp community, signaled in the recent change in terminology from describing participants in the agency's programs as "guests" – a label that referenced the agency's drop-in and shelter origins – to use of the phrase "members of the Lamp community." This focus on the broader community also reflected the fluidity of movement between Lamp sites when tenants had problems with building rules or faced eviction. Moving from one of these Lamp buildings to the Village or Day Center was viewed as an adaptation to the relapsing nature of psychiatric and substance abuse disorders and the changing needs for support at different points in the trajectory.

Strategies and Barriers for Service Engagement

Despite differences in philosophy, level of demand, and notions of community, the sites were remarkably similar (to each other and to the shelter/lodging programs) in the one-on-one engagement strategies described by staff: being visible; using casual conversation and brief encounters to get to know tenants; offering concrete help and food, tokens or other specific items, responding to events or crises that lead tenants to seek help. Staff at the housing programs mixed these informal strategies with more formal appointments or meetings in the program offices. As they moved about the buildings, workers at all the housing sites also took advantage of chance meetings in building hallways or lobbies to catch up with tenants they had not seen or remind others of activities or appointments.

While these individual interactions between a worker and a tenant predominated in descriptions of engagement, and at WSFSSH and PBI the workers had individual case loads, some of the sites used additional strategies: at the Windsor, support services staff used a team case management approach, with several staff members getting to know an individual tenant. A tenant's particular needs or preferences might lead to a more engaged relationship with one or another of the team members, but team members could and did stand in for each other and supported each others' efforts with particular tenants. Tenants in the Lamp programs also were likely to have contact with more than one advocate, though there was not an explicit team structure. Since Lamp advocates were based in particular programs (Day Center, Village, Housing sites), the "primary" advocate during the period of the study[19] was likely to be the one who had the longest-standing relationship or most regular contact. Housing advocates could work with tenants in either a

[19] A new structure for Housing Services was being implemented near the end of the study, in which each site would include a "lead advocate" and "support advocates." The process by which these housing advocates work with advocates at other Lamp sites is still taking shape.

primary or supportive role. Communication between Lamp advocates at the housing and other program sites about individual tenants was not formally structured but tended to occur on an "as needed" basis, which could be quite frequent.

Groups played a role in the engagement process at several sites as well. WSFSSH described recreational events and holiday celebrations as well as voluntary group activities (for example, meditation group, art group) as ways for residents to become involved in the community at 129th Street, and participation in these was seen as an indication of engagement. PBI offered tenants a mix of recreational and service-oriented groups. Some of these had direct service functions (for example, the housing group provided tenants with information on alternatives available and distributed application forms); others such as the music group gave workers an opportunity to get to know tenants and to encourage them to come for individual meetings. At Lamp, housing advocates ran a small number of educational groups on topics of interest to residents such as wildlife. They also involved tenants in preparing community meals; and at the Pershing, during much of the CTHI study period, the Lamp office became a social center for Lamp tenants within the building.[20] While tenants at the Pershing commented favorably on the community-building activities, many Ballington tenants went to the Village for groups and informal socializing, and housing-based community activities played a less significant role in service engagement.

The barriers to engagement and services that workers at the housing programs identified overlapped with those described for the shelter/lodging house settings. At the individual level, accessibility was an issue, particularly at the DAH programs, where support services staff sought to involve all segments of the diverse tenant population, including the pre-existing tenants and the PAES group, most of whom were regularly employed and were away from the sites during the hours when support services staff were available. Staff also reported that tenants who were using drugs often avoided contact with the support services teams as well. Individual disabilities, including cognitive impairments and psychosis affected the pace of engagement with some individuals at all sites, and paranoid ideation made some tenants' engagement with the programs cyclical. But the most frequently cited impediment to engaging with tenants was active substance abuse. Even at WSFSSH, this sometimes emerged as an issue despite screening efforts, though the program's structure served to set limits on problem behavior. At the DAH and Lamp sites, those who were actively using drugs often became evasive and avoided contact with advocates or support services staff, sometimes spending days at a time away from the site or even in a few cases moving out without informing anyone. While the harm reduction philosophy at these programs precluded imposing sanctions for substance use, the property managers in the buildings issued warnings and eviction notices when the behavior associated with active addiction exceeded what the basic house rules allowed. This could spur tenants to seek services to avoid loss of housing, though by then it was sometimes too late for effective intervention.

To describe how engagement and service efforts were distributed within the populations housed at the sites, we turn to a quantitative description of services, engagement and housing outcome.

[20] During the last year of the study, Lamp shifted away from using the Pershing office space for community-building activities, removing the television set and couches that had fostered informal socializing.

CHAPTER 8
SERVICES AND ENGAGEMENT AT THE HOUSING PROGRAM SITES: A QUANTITATIVE DESCRIPTION

As we noted in Part II, engagement and service delivery are closely related processes. For the housing programs, as at the shelter/lodging sites, direct concrete services were offered to address particular needs, but at the same time they provided a means of establishing a trusting relationship; group activities served therapeutic and social service functions and enhanced life in the building community but also provided a context for getting to know tenants and engaging them in the service process. Our data on service delivery at the housing programs reflect the activities that workers at the sites undertook in their efforts both to meet tenants' needs and to engage them in services. The data on engagement levels provide indicators of the tenants' responses to the service efforts.

Services at all the housing sites were focused on helping tenants maintain housing by addressing problems that might threaten residential stability. The issues that arose and the ways the programs approached them reflected program-specific features such as the particular populations served, each program's expertise and emphasis, and its general approach and philosophy. In the sections that follow, we present quantitative data that describes the services the housing programs provided to tenants; the levels of engagement tenants achieved in four domains; and the relationships between engagement and services in the three programs combined.

We note two methodological decisions we made with respect to the data presented here. First, the analyses described in this and the remaining chapters of Part III include only those tenants who were admitted as part of the target populations at the sites – that is, for the DAH programs, we have excluded the pre-existing tenants and those enrolled in the PAES welfare to work program, as well as the Respite patients at the Windsor. This is because the overall goals of the DAH programs were focused on meeting the service and housing needs of the core group, and the evaluation has focused on the extent to which the target groups achieved the desired outcomes at all of the sites. However, a fair amount of DAH staff time was devoted to working with the other groups at the site as well, and in the program profiles in Appendix B, we have included data on services, engagement, and housing outcomes for all groups at each DAH site.

Second, as planned in our original study design, we collected data on services delivered to each tenant over one year following that individual's move-in date; our measure of levels of engagement and primary housing outcomes were also based on that one year period. We were able to supplement the outcome data with information on the destination of tenants who left the programs in the subsequent year as well, but the later start-up and larger samples at the housing programs precluded collecting two-year services and engagement data as we had at the shelter and lodging sites. Thus our services and engagement data cover only the first year of an individual's tenancy in the housing programs, while the housing outcomes were measured at one year and again at two years.

A. Service Delivery at the Housing Programs

Direct Services

A variety of services were provided on site at the housing programs. Table 8.1a presents descriptive data on counseling and other services provided directly by housing program staff. For all sites combined, a majority of tenants received direct services in all categories except training/employment and legal services, and more than three quarters of tenants received direct housing (77%), health care (81%), and mental health services (80%).

There were some differences between programs in direct housing services, money management, training and work services, and socialization. Direct housing services, which could include help finding housing alternatives as well as advocacy and supports for tenants in their dealings with property managers, were provided to large majorities of DAH (83%) and Lamp tenants (100%), but neither of these issues had much salience at the 129th Street Residence (13%), where WSFSSH provided both services and property management, and where the program's goal was to retain people at the site. Money management was less often provided directly by DAH (47%) than at WSFSSH (100%) or Lamp (65%), as the DAH programs arranged with Tenderloin Housing Clinic to handle third party rent payments off site. The high rates (62%) of training and work services at Lamp's sites were a function of tenants' involvement in the businesses the agency operated at Lamp Village. And the lower involvement of DAH tenants in socialization activities (53% compared to 83% at WSFSSH and 81% at Lamp) reflects the minimal development of group activities at the Windsor during the program's first year.

Referral Services

While referrals were provided less often than direct services, substantial referral activity occurred at all sites. Table 8.1b shows that for all programs combined, the most common type of referral was for health care (66%), while large minorities received referrals for housing(40%), entitlements (40%) and mental health services (37%) as well. Like direct services, referral services differed somewhat across the various program sites as a result of contrasts in the populations served and the organization of services. For example, the high rates of referrals for money management at the DAH sites (57%) reflect staff efforts to connect tenants to the Tenderloin Housing Clinic for third party rent payments; the lower rate of mental health services at the DAH programs (26%) seems to be a result of the diversity of the DAH target population, compared with WSFSSH (71%) and Lamp (41%) which only served people with severe mental disabilities. And the relative prominence of housing referrals for DAH tenants (49%) occurred largely at PBI (see Appendix B for program-specific services), while DAH tenants who were in trouble with building management over rent or behavioral issues were frequently referred to legal advocacy programs (21%). It is notable that WSFSSH, where residents were prescreened to exclude active substance abusers, had the highest rate of direct (67%) and referral (29%) services for substance abuse. Our qualitative data indicate that this was related to the effort to maintain a "clean and sober" milieu and the program's requirements for treatment and service participation, in contrast to the harm reduction approach used at the other housing sites, which provided direct substance abuse services to 51-55% and referrals for 12-23%.

More notable than these program-specific differences is the high proportion of housing tenants who received direct and referral services in almost every category, compared to the frequency of referrals among shelter/lodging residents.

Table 8.1 Services Provided – Housing Programs

a. Direct Services

	WSFSSH (N=24)	DAH (N=87)	Lamp (N=42	Total All Sites (N=262)
Received Any Direct Services	**%***	**%***	**%***	**%***
Housing	13	83	100	77
Money Mgt	100	47	81	65
Entitlements	100	46	33	51
Training/Work	33	33	62	41
Health Care	100	84	64	81
Mental Health	100	70	91	80
Substance Abuse	67	55	51	56
Legal	25	30	26	28
Family	50	47	64	52
Socialization	83	53	81	65
Other	71	85	88	84
*Categories are not mutually exclusive, since residents receive services in multiple categories. Percentages therefore do not add to 100%.				

Table 8.1 Services Provided – Housing Programs

b. Referrals

	WSFSSH N=24	DAH N=87	Lamp N=42	Total All Sites (N=153)
Received Any Referrals	**%***	**%***	**%***	**%***
Housing	4	49	41	40
Money Mngt	4	57	2	34
Entitlements	33	44	36	40
Training/Work	17	9	12	11
Health Care	75	78	36	66
Mental Health	71	26	41	37
Substance Abuse	29	23	12	21
Legal	4	21	5	14
Family	0	1	2	1
Socialization	8	1	0	2
Other	4	30	2	18
*Categories are not mutually exclusive, since residents receive services in multiple categories. Percentages therefore do not add to 100%.				

B. Levels of Engagement at the Housing Program Sites

While the service delivery data indicate staff effort, the data on levels of engagement tell us about tenant willingness to receive the services the programs offered. Table 8.2 shows that, as expected, levels of engagement for tenants in the housing programs were generally higher than in the shelter and lodging sites: for all programs combined, at least half of the tenants (50-54%) were rated as engaged at the two highest levels in three of the four domains (relationship, concrete, and housing services). Moreover, while there were somewhat lower levels of engagement in complex services (40% at the top levels), the data for the housing sites did not show the sharp contrast we noted for most shelter/lodging programs between relationship-building and concrete services on the one hand, and complex and housing services on the other.

Table 8.2 Levels of Engagement - Housing Program Sites

	WSFSSH (N=24)	DAH (core) (N=87)	Lamp (N=42)	Total All Sites (N=153)
Level of Eng (Relationship)	%*	%*	%*	%*
1 (not eng)	4	13	10	11
2	17	16	26	19
3	29	21	14	20
4	**33**	**22**	**29**	**26**
5 (engaged)	**17**	**28**	**21**	**24**
Willing to Accept Concrete Services				
1 (not willing)	4	23	20	19
2	21	14	7	13
3	21	14	10	14
4	**29**	**19**	**24**	**22**
5 (willing)	**25**	**30**	**39**	**32**
Willing to Accept Complex Services				
1 (not willing)	17	21	31	23
2	26	14	24	19
3	17	16	21	18
4	**17**	**24**	**14**	**20**
5 (willing)	**22**	**25**	**10**	**20**
Willing to Accept Housing Services				
1 (not willing)	8	26	23	22
2	0	9	13	8
3	17	17	18	17
4	**25**	**18**	**28**	**22**
5 (willing)	**50**	**30**	**20**	**31**

* Not all percentages add to 100% due to rounding.

Tenants were not only willing to engage in relationships with workers and accept several types of concrete help (toiletries and help with furnishings at move-in; transportation vouchers or tokens), but they also responded to the programs' emphasis on housing stability – though the specifics varied: at WSFSSH, assessments of housing engagement reflected residents' accommodation to the basic routines, activities, and milieu at the129th Street residence; for DAH and Lamp, housing engagement usually entailed responding to staff efforts to resolve problems with management and/or involvement in the process of seeking permanent housing elsewhere. While engagement around complex (usually clinical) services was somewhat lower than the other categories, it was substantially greater than we found for the shelter/lodging programs.

Not surprisingly, an analysis of the relationships between levels of engagement in the four domains and the number and range of direct and referral services found strong associations between engagement and services provided (see Table 8.3), though housing referrals were not associated with engagement in any domain other than housing services. This analysis cannot determine the direction of these associations, and the qualitative data suggest a bidirectional relationship in at least some domains, with engagement as both a condition and a consequence of providing services.

8.3 Relationships between Engagement and Services - Housing Programs N=153

	Levels of Engagement in:			
	Relationship	**Concrete Svcs**	**Complex Svcs**	**Housing**
Services				
# of Types of Direct Services	**r=.468 p=.000**	**r=.497 p=.000**	**r=.390 p=.000**	**r=.445 p=.000**
# of Types of Referral Services	**r=.263 p=.001**	**r=.254 p=.002**	**r=.355 p=.000**	**r=.257 p=.002**
Any Entitlements Referrals	**r=.179 p=.027**	**r=.218 p=.007**	**r=.169 p=.041**	**r=.198 p=.015**
Any Health Care Referrals	**r=.198 p=.014**	n.s.*	**r=.225 p=.006**	**r=.188 p=.023**
Any Mental Health Referrals	**r=.202 p=.013**	**r=.215 p=.008**	**r=.225 p=.023**	**r=.189 p=.020**
Any Housing Referrals	n.s.*	n.s.*	n.s.	**r=.191 p=.021**
* n.s. = not significant				

CHAPTER 9
RESIDENTIAL STABILITY AT THE HOUSING PROGRAM SITES

A. Description of Housing Outcomes at One and Two Years

The CTHI housing programs were developed to interrupt the residential instability, heavy use of emergency services, and long-term homelessness experienced by the individuals they recruited. Once tenants moved in, the major task for service providers was to help them remain housed either at the site or in another permanent housing alternative. To measure the programs' success in these efforts, we examined housing status[21] at the end of the one-year follow-up period and again after two years.

As Table 9.1 shows, for all programs combined, almost three quarters (73%) of housing tenants remained at the program sites one year after they moved in, and an additional 10% had moved on to other permanent settings (including adult homes, supportive housing, living with family members, or independent apartments). In total, over four fifths (83%) remained housed. Another 14 %, mainly from Lamp, had left the programs to go to residential treatment, shelters or transitional housing programs, or to institutional settings such as hospitals or jails[22]; and 3% were deceased.

Tenants of the DAH programs and WSFSSH were distributed in the various settings in extremely similar ways. Lamp tenants were in more varied settings, with less than half (44%) remaining at the sites after one year. Of the others, over one-fifth had moved to other permanent housing in the first year; and many of the 34% of Lamp tenants who left for transitional settings during the first year had gone to stay at Lamp Village, which the agency sees as an alternative long-term accommodation.

Updates on tenants after the second year (Table 9.2) indicated continued movement from all program sites to other permanent housing: at the end of the two years, 77% were housed – approximately half (52%) remained in place at the three sites, and another 25% had moved on to other permanent settings. Those who were not in housing included those who remained in jail or other institutional or transitional settings (18%). Also included in the transitional category were a number of Lamp's tenants (15%) from the Ballington and Pershing who were staying at the transitional program at Lamp Village. In keeping over 75% of their tenants in their own or other housing over two years, these programs compare favorably with other housing programs for homeless populations (Goldfinger et al. 1999; Hurlburt et al. 1996; Lipton et al. 2000).

[21] Because all tenants were in permanent housing settings, we set a higher standard for "remaining housed" at these sites than at the shelter/lodging programs, where we had classified residents who moved into a transitional housing program as "housed" to reflect the improvement in their housing status (see Chapter 5). Tenants who left the permanent housing programs for a transitional setting were not considered to have remained housed.

[22] Qualitative data indicate that when individuals were incarcerated, it usually resulted from a parole violation or outstanding warrant, rather than new charges.

Table 9.1 One-Year Housing Outcomes at the Housing Program Sites*

	WSFSSH N=23**	DAH N=81**	Lamp N=41**	Totals N=145**
	%	%	%	%
Still Housed at Site	**87**	**84**	**44**	**73**
Exit to Permanent Housing				
Adult Home	0	0	2	1
Perm Housing (Family, Supportive, or Independent)	4	5	29	9
Total Exits to Perm Housing	**4**	**5**	**22**	**10**
TOTAL HOUSED	**91**	**89**	**66**	**83**
Exit to Transitional or Institutional Setting				
Shelter	4	0	5	2
Residential Tx	0	0	7	2
Hospital	0	1	0	1
Transitional	0	1	10	3
Nursing Home	0	1	0	1
Jail, Other	0	2	12	5
Total Exit to Transitional or Institutional	**4**	**5**	**34**	**14**
Deceased	**4**	**5**	**0**	**3**

*Note: Some totals do not add to 100% because of rounding.
**Individuals whose whereabouts were unknown at follow-up were excluded from analysis.

Table 9.2 Two Year Housing Outcomes at the Housing Program Sites*

	WSFSSH N=23**	DAH N=77**	Lamp N=41**	Totals N=141**
	%	%	%	%
Still Housed at Site	**65**	**61**	**29**	**52**
Exit to Other Permanent Housing				
Adult Home	0	0	2	1
Perm. Housing (Supportive, Family, or Independent)	22	23	27	24
Total Exits to Perm Housing	**22**	**23**	**29**	**25**
TOTAL HOUSED	**87**	**84**	**59**	**77**
Exit to Transitional or Institutional Setting				
Shelter	4	0	5	2
Residential Tx	0	0	7	2
Hospital	4	2	0	2
Transitional	0	1	15	5
Nursing Home	0	1	2	1
Jail, Other	0	3	12	6
Total Exit to Trans or Institutional	**9**	**9**	**41**	**18**
Deceased	**4**	**6**	**0**	**4**

*Note: Some totals do not add to 100% because of rounding.
**Individuals whose whereabouts were unknown at follow-up were excluded from analysis

B. Predicting Housing Outcomes: Tenant Characteristics, Engagement and Services

The effort to tease out the mechanisms by which programs achieved their outcomes is complicated by the fact that the programs not only operate with very different philosophies, organization, and service approaches, but they also draw their tenants from distinct segments of the larger homeless population, vary in their selection procedures and admissions thresholds, and tailor their programs and service strategies to the people they serve. We therefore have not attempted to compare the programs as wholes. Instead, we have examined the role of individual characteristics and services provided for predicting housing outcomes across all sites combined. We were particularly concerned to determine whether psychiatric and substance abuse problems were associated with poorer outcomes, and whether the engagement efforts and referrals to treatment programs addressing psychiatric and substance issues led to improved outcomes. After preliminary analyses of bivariate relationships between tenant characteristics, engagement, and service variables, we used logistic regression analysis to test a model of predictors of housing stability. The outcome variable used in these analyses was remaining in permanent housing (including the study sites or another adult home, supportive housing program, living with family, or in an independent apartment) at one year[23].

The results of the initial analyses of bivariate associations between tenants' characteristics and outcomes are shown in Table 9.3. Among the various socio-demographic and clinical characteristics that we examined, only being diagnosed with psychotic disorder (schizophrenia, bipolar disorder, or another severe psychotic disorder) was associated – negatively – with maintaining housing. It is important to note that a large majority (79%) of tenants who were diagnosed with psychotic disorders, like other tenants, did in fact remain housed after one year. However, among the tenants who lost their housing, people with severe disorders were overrepresented: they made up just about half of those who remained housed, but 83% of those who lost their housing. Notably, we found no association between active substance abuse problems and housing outcomes.[24]

The association of housing outcomes to tenant engagement levels and to several summary measures of services provided are presented in Table 9.4, which shows no significant relationships between housing outcomes and engagement in any of the four domains. Among the services examined, only mental health referrals were significantly associated with living in permanent housing at follow-up.

[23] We repeated the analyses for the two year outcomes (not shown) with substantially similar findings.

[24] Other measures of substance abuse (drug and alcohol use at baseline separately, lifetime substance abuse diagnoses) also were not significantly associated with housing outcomes.

Table 9.3 Relationships between Tenant Characteristics and Housing Outcomes: Housing Programs (N=153)

	HOUSED AT ONE-YEAR FOLLOW-UP	
TENANT CHARACTERISTICS	**Pearson correlation coefficient**	**Significance *p***
Age at baseline	.034	n.s.
Gender	-.093	n.s.
Marital Status	-.074	n.s.
Employed in Last 5 Years	-.015	n.s.
Duration of Homelessness	-.008	n.s.
Number of Health Conditions	.049	n.s.
Diagnosis of Psychotic Disorder	**-.225**	**.005**
BL Substance Abuse	-.140	n.s.
Dual Diagnosis	.011	n.s.
Psychiatric Medication at BL	-.042	n.s.
Note: n.s.=not significant		

Table 9.4 Relationship of Engagement and Services to Housing Outcomes: Housing Programs (N=153)

	HOUSED AT ONE-YEAR FOLLOW-UP	
LEVELS OF ENGAGEMENT	**Pearson correlation coefficient**	**Significance *p***
Relationship with Staff	-.037	n.s.
Concrete Services	-.032	n.s.
Housing Services	-.060	n.s.
Complex Services	-.015	n.s.
SERVICES PROVIDED		
Number of Types of Referrals	.057	n.s.
Any Housing Referral	-.124	n.s.
Any Entitlements Referral	.045	n.s.
Any Health Care Referral	-.040	n.s.
Any Substance Abuse Referral	-.046	n.s.
Any Mental Health Referral	**.151**	**.038**
Note: n.s.=not significant		

The bivariate analyses found few associations between tenant characteristics or services and housing outcomes. In testing a model of predictors of housing status at one year, we retained the variables that our qualitative data or prior research suggested were most likely to affect housing stability in a homeless population, even if they did not appear significant in the bivariate analyses. In the multivariate predictive model we therefore included having a diagnosis of a psychotic disorder and active abuse of substances at the time of entering. The programs sought to minimize the effects of psychiatric and substance abuse issues through involving tenants in receiving services to address these problems, and to assess the effects of these engagement

efforts, we also included in the model our measure of tenant willingness to accept complex services. Finally, we expected that services specifically targeting these mental health and substance problems would also affect housing stability, and we included two service variables – receiving referrals for mental health treatment and receiving substance abuse referrals.

To test the model of individual characteristics and service variables, we used logistic regression analysis, entering as predictors having a diagnosis of a psychotic disorder, active substance abuse at baseline, level of engagement in complex services, mental health referral and substance abuse referrals. The results (Table 9.5) indicate that after controlling for all other variables in the model, having a diagnosis of a psychotic disorder and referral for mental health services each had an independent effect on housing outcomes. Having a psychotic diagnosis negatively affected housing stability: individuals with such diagnoses were more than seven as likely as other tenants to lose their housing by the end of the year of follow-up. Being an active substance abuser at baseline did not have an independent impact housing stability. We also did not find an independent effect for either willingness to receive concrete services or for substance abuse referrals. However, tenants who were referred mental health services were almost six times as likely to remain housed as those who were not referred.

Table 9.5 PREDICTORS OF REMAINING HOUSED AFTER ONE YEAR

Variables in the Equation	Coefficient B	Estimated Odds Ratio	95% C.I for Odds Ratio	
			Lower	Upper
Diagnosis: Psychotic Disorder	**-2.035**	**.131****	**.033**	**.515**
Substance Abuse at Baseline	-.1017	.362	.117	1.116
Engaged in Complex Services	-.045	.956	.656	1.393
Mental Health Referral	**1.667**	**5.296***	**1.455**	**19.290**
Substance Abuse Referral	-.280	.756	.201	2.838
* Odds ratio is significant at <.05; **Odds ratio is significant at <.01				

Our descriptive analyses of where tenants were living at the end of one and two years of follow-up showed that as a group, the CTHI programs succeeded in intervening in the homelessness and heavy emergency service use that had characterized tenants' experiences prior to entering housing. A large majority remained housed both at one and two years after moving into the CTHI housing sites. Though our multivariate analysis of predictors of housing outcomes failed to confirm a significant independent role for either substance abuse (which we expected to negatively affect outcomes) or substance abuse treatment referrals (hypothesized to have a positive effect), nor was engagement in complex services a significant predictor of outcome. We did find that individuals with the most severe psychiatric disorders were at particularly high risk for losing housing, and those who were referred for mental health services were substantially more likely to remain housed than those who were not.

In Chapter 10, the final section of Part III, we synthesize the qualitative and quantitative findings to summarize what these programs have taught us about overcoming barriers to housing stability.

CHAPTER 10
ENGAGEMENT, SERVICES AND RESIDENTIAL STABILITY FOR HOUSING TENANTS: SUMMARY AND DISCUSSION

In Part III, we have drawn on both qualitative data and quantitative analyses to answer a number of descriptive questions about the goals, practices and outcomes of the three housing programs in the Closer to Home Initiative. In this chapter we summarize our findings, identify the issues they raise, and make provisional suggestions about their implications.

The CTHI housing programs were developed to increase housing stability for people with histories of long-term homelessness, heavy use of emergency services, and dual or multiple disabilities. All provided a broad range of on-site services designed to address, either directly or through linkage to appropriate providers, the diverse financial, clinical and other issues that might undermine tenants' housing stability. Our analyses showed that they succeeded in engaging a majority of the target tenants in relating to staff, receiving concrete assistance, and addressing housing issues that arose, while a substantial minority became actively engaged in complex services dealing with financial support, clinical or behavioral problems. Overall, the programs' success in stabilizing the housing situations of the tenants who were the focus of the CTH Initiative was impressive. After two years, over 75% remained in permanent housing either at the CTHI sites or elsewhere. Our analysis of the predictors of housing stability showed that individuals with the most severe psychiatric disorders were at particular risk of housing loss, but also showed that even within this group, a large majority remained housed. Moreover, services – particularly referrals to mental health treatment – greatly increased the likelihood that tenants would remain housed. Contrary to our expectations, substance abuse did not predict housing loss, even though a majority of our sample were in programs with harm reduction philosophies.

All sites focused on groups whose histories, use of emergency services, and barriers to housing put them at risk of continued residential instability. The services provided at the CTHI sites provided extra support for accommodating and incorporating these individuals. While service providers focused on the individual needs of these tenants, building administrators and managers were responsible for operating the housing programs as a whole and ensuring the quality of life for all tenants. Acute medical and psychiatric symptoms or active substance abuse could interfere with the basic tasks required for maintaining housing – paying rent, keeping the room clean, and observing basic "good neighbor" rules prohibiting excess noise, illegal behavior, and safety hazards. Individuals with active psychiatric symptoms or substance use sometimes also had difficulty conforming to site-specific additional "house rules" about visitors, or showing ID, or, at WSFSSH, meeting program requirements for money management, abstinence from drugs and alcohol, and attending treatment programs.

The five housing sites used contrasting strategies to support housing stability for vulnerable individuals without compromising the quality of life for others at the site. WSFSSH combined tenant selection with a structured housing milieu and an intensive program of required supportive services to keep the tension between potentially disruptive tenant behavior and maintaining a stable envirnoment within acceptable bounds. The DAH programs had only minimal selection criteria, they relied on a mixed population to minimize concentration of problems, they divided

responsibilities for tenant support and building management between two agencies; and they developed a service program that offered ample opportunities for tenants to interact with staff, while maintaining a voluntary, harm reduction approach to services and engaging in active advocacy for tenants in their problems with property managers. The Lamp programs housed only individuals who were already members of the Lamp community, selecting individuals for one site or the other to accord with expectations of the (different) agencies that managed the two sites. Harm reduction was combined with strong advocacy for tenants vis-a-vis management, but Lamp also used its temporary and shelter programs as periodic respite settings while tenants kept their apartments or as alternative placements when eviction seemed imminent, thus preserving Lamp's relationships with the property managers while ensuring tenants' continued involvement in the Lamp community and a chance to return to permanent housing at the same or another Lamp site when the crisis abated.

While the housing programs all offered permanent housing in a supportive setting, the social worlds that evolved at the sites had distinctive features and entailed contrasting visions of the communities tenants were being invited to enter. WSFSSH emphasized that the 129th Street residence was a home and community for all who lived there, and program administrators and staff sought to ensure that it was a supportive environment for its residents, with structure, rules and predictability that made them feel secure. Residents were encouraged to view the residence as their life-long home; most were not expected to seek more independent settings. The DAH programs valued the diversity of their mixed populations, which offered the raw materials for the tenants to fashion a community within the building. Though staff supported tenant organizing efforts, they viewed their own roles as enabling rather than defining. The multiple groups these sites included permitted the integration of people with varying degrees and types of disabilities and avoided the stigma of housing segregated by disability. During the period of the study, the community-building efforts that occurred at the Lamp housing sites focused on providing a relatively protected environment for Lamp tenants within the buildings, rather than seeking to integrate them into the broader community made up of the non-Lamp tenants at the sites. At the same time, Lamp continued to foster tenants' involvement with the larger Lamp community, which though limited to people with serious mental illness, was a collaborative effort of Lamp program participants, administrators and staff – at least half of whom were themselves formerly homeless and/or in recovery from substance disorders or mental illness. Lamp saw the world it had devised in Skid Row as a supportive space where individuals could pursue their lives, recovery, work and relationships without the weighty stigma they encountered in other settings, but with options for work, independence, leisure and community life similar to those available to people who had not experienced homelessness, psychiatric disabilities, and addiction.

The results of the outcome analysis point to the overall success of the programs as interventions addressing residential instability, while the analysis of characteristics, services and engagement as predictors of individual outcomes showed that the on-site services were able to offset the risk of housing loss for many in the most vulnerable groups. The various housing models we have documented in this study entail distinctive ways of organizing services and managing settings, as well as contrasting visions of the social worlds they offer tenants. But across these diverse approaches, the findings clearly show that as an intervention for homeless individuals with histories of residential instability along with other barriers, housing works.

PART IV

SUMMARY OF FINDINGS

AND CONCLUSIONS

REVIEW OF RESEARCH ISSUES AND RESULTS

The Evaluation of the Closer to Home Initiative was designed around three specific aims: to describe several innovative approaches to service engagement and housing for people who experienced long-term homelessness and other complex problems; to examine how these approaches were implemented and developed over time; and to assess their effectiveness by documenting the outcomes achieved by their initial cohorts of individuals. This report has presented what we have learned about the program models, how they were implemented at the study sites, and how they developed and changed over the period of the study. We have also reported on how the individuals who participated in these programs fared, and how their participation affected the extended homelessness and residential instability that had characterized their experience in previous years. In this final section we summarize the key findings reported in the foregoing ten chapters and consider their implications for program practice and for policies directed at ending homelessness.

In Part I, which described the program models and their implementation, we identified two contrasting approaches to working with the target population of the CTH Initiative. Three of the programs in this study focused on people who were still homeless, working in shelter and lodging house settings with individuals who had been long-term residents there and who remained unable or unwilling to move on even though the existing services had successfully engaged and housed other residents of the setting. The other three programs provided housing, developing whole buildings or specialized programs within larger buildings, and recruited those who had been previously unable to find settled living situations, providing support intended to help them sustain housing.

The origins and overall goals of the shelter/lodging house programs (to find ways to engage long-term residents in services and encourage them to move to more appropriate long-term settings) contrasted with those of the housing programs (to provide the settings and services that would help people with histories of residential instability remain housed), and these were shown to have implications for the populations targeted, the way services and housing were organized, and the outcomes that are relevant at the sites. Yet despite the major contrasts there was considerable variation within each major program type in how services were organized and provided, and in the variety of traditions of social activism and streams of thought regarding how the needs of those disadvantaged by homelessness and disability could best be met.

We noted particularly that all programs used “low demand” approaches in their efforts to persuade residents to address problems or consider housing, but for some programs in each major category, low demand engagement strategies were part of a broader emphasis on voluntary services and/or harm reduction strategies (DP, DAH, and Lamp), while both shelter/lodging and housing programs also combined these low demand approaches with more directive interactions or more structured program requirements (BRC, PH, WSFSSH). There were similar variations that cross-cut the major categories in use of individual workers (DP, BRC, WSFSSH, and PBI) versus team approaches (PH, Windsor, Lamp) to engagement; in combining service and property management functions in a single housing agency (WSFSSH) versus dividing responsibilities between different agencies (DAH, Lamp); and in strategies for community building, which differed among the housing programs.

As reported in Chapter 2, we collected data on personal histories, staff engagement efforts, and services provided for 234 individuals who were the main focus of the six interventions we examined. The shelter/lodging programs served 81 individuals with somewhat distinctive combinations of gender, age, problems and disabilities, which reflected the differing contexts from which they were recruited as well as the varied social geographies of their locales. But the residents of those three sites also had important similarities as older adults with numerous health problems and a variety of serious mental disorders that were largely untreated. They had extremely long histories of homelessness, very limited recent employment histories, and minimal contact with family members.

At the three housing programs, the 153 tenants who were the focus of program efforts were predominantly African American, though younger than the shelter/lodging residents they were on average in their forties, male, never married, and not in contact with relatives. Though most were high school graduates, a majority had not worked in recent years. Most tenants were supported by entitlements programs. Their homelessness was long-term, usually exceeding two years, but notably less extended than that of shelter and lodging housing residents. Tenants also had numerous health problems, were likely to have a serious psychiatric diagnoses, and were likely to be on medication at the time of moving into housing. Many had histories of substance abuse and dual diagnosis was common. There was some variation between sites: WSFFSH tenants were older, less educated, had longer homeless histories, less recent employment, more health problems, and more past substance abuse than the other sites; DAH had more tenants without psychiatric diagnoses than the other sites but also had the highest levels of active substance abuse; Lamp tenants were a bit younger than the others, had more substantial recent employment histories, and somewhat less extensive histories of homelessness, but included more people with histories of incarceration than the other sites. Overall, the housing tenants were younger, had shorter homeless histories, and were more connected to treatment and support systems than the shelter and lodging house residents.

Although we used similar data collection approaches, common measures, and comparable analysis strategies at the two types of programs, they represent fundamentally different kinds of interventions that must each be considered on their own terms. Yet even within these overarching program categories, immense diversity of the programs, contexts and people included in the CTH Initiative, and the ongoing program changes over the course of the study, precluded using a research design that would test the effectiveness of different models against each other. We instead offer detailed descriptions of how the programs defined and approached their major tasks, the common dilemmas they confronted, and their diverse responses, along with cross site statistical descriptions of housing outcomes, and analyses of the tenant characteristics, engagement, and service elements that predicted becoming or remaining housed across the set of programs in each major group.

In Part II we focused on the shelter and lodging house programs, describing in some detail their approaches to building relationships with tenants, providing them with concrete assistance, and urging them to accept complex services to obtain financial support and clinical treatment for medical, psychiatric, and substance abuse problems. We noted key contrasts between the sites in program goals – particularly the prominence of moving people to housing, which was the focus

of engagement at BRC, a prominent concern for PH, and a less urgent issue at DP, where the main focus was building relationships with long-term residents. While all used low demand approaches to connecting with residents, at PH both program aides and social workers combined this with more directive approaches to implementing program housing goals; and at BRC, low demand engagement strategies prevailed, but the agency simultaneously pursued legal action to pressure for lodgers to become involved in seeking alternative housing. Despite creative efforts to overcome barriers tenant raised, housing engagement often foundered because of barriers created by the housing programs being explored as alternatives, in the form of onerous admission processes, criteria that entailed stigmatized identities (as homeless, mentally ill), or housing program rules that restricted autonomy.

Our statistical analysis of engagement and housing outcomes showed that the programs were ultimately able to engage significant proportions of long-term residents in relationships, but this had little effect on housing outcomes during the two years covered by the analyses. Those with the longest homeless histories were the least likely to have moved on, while many exits from the program sites resulted from hospitalizations that ultimately led to placements in other long-term settings such as nursing homes or adult homes. However, those with financial support from entitlements were more likely to move to housing and were included in the minority of residents who moved on to independent or supportive housing in transitional or permanent settings. However, after the period covered by the statistical analyses, all but a few of BRC's remaining lodgers moved from their cubicles to newly built SRO units within the Palace building. The agency had managed to create a streamlined eligibility process and a low demand program approach that made the change acceptable to lodgers, who were able to become housed without leaving the site. At Deborah's Place, where the overnight shelter is slated to become a safe havens program providing an open-ended length of stay for those who meet psychiatric and homelessness eligibility criteria may provide a similar option for some or all of the long-term residents at that site.

In Part III, we described the housing programs, which focused on groups whose histories, use of emergency services, and barriers to housing put them at risk of continued residential instability. The sites represented contrasting strategies for fostering housing stability for vulnerable individuals, while also attending to the quality of life for the building's community as a whole. WSFSSH combined tenant selection with a structured housing milieu and an intensive program of required supportive services to reduce the tension between potentially disruptive tenant behavior and maintaining a well managed building. The DAH programs relied on a mixed population to dilute the concentration of problems, while allocating responsibility for tenant support and building management to separate agencies; their service programs offered tenants opportunities to interact with staff, but all services were voluntary and reflected a harm reduction philosophy. The Lamp programs were developed for members of the Lamp community. Individuals were selected from within the agency's array of drop in, outreach, shelter, or transitional housing programs and referred to one of two housing sites managed by other agencies. At Lamp, a harm reduction approach infused all services. It was combined with strong advocacy for tenants vis-a-vis management, but Lamp also relocated tenants to its own temporary and shelter programs when they encountered problems at the housing sites that might lead to eviction. Though our qualitative data document the tensions around individual and community quality of life in housing programs with harm reduction philosophies, our

quantitative findings did not find that active substance abuse led to housing loss, suggesting that despite the difficulties inherent in the effort, harm reduction permits programs to maintain housing for people who are often screened out of supportive housing programs.

The programs not only differed in how they balanced individual and community priorities, but they also had contrasting visions of the communities that tenants were joining. At WSFSSH, program administrators and staff sought to ensure that 129th Street was both "home" and "community" for its residents, with structure, rules and predictability that made them feel secure; most were not expected to move on or seek more independent settings. For the DAH programs, the diversity of mixed populations offered the tenants the raw materials for community. Staff supported tenant organizing efforts, but viewed their own roles as supporting rather than defining how community took shape. The multiple sub-groups at the DAH sites allowed the integration of people with varying degrees and types of problems and avoided the stigma of housing segregated by disability. Community-building efforts at the Lamp housing sites focused on providing a relatively protected environment for Lamp tenants within the buildings, rather than seeking to integrate them into the larger building. At the same time, Lamp continued to foster tenants' involvement with Lamp's agency-wide community, which had evolved as a supportive space where individuals could pursue their lives, recovery, work and relationships without the stigma they encountered in other settings, but with ample options for work, independence, leisure and community life.

Analyses of housing outcomes for the three programs showed that they succeeded in engaging a majority of tenants in relationships with staff, receiving concrete assistance, and responding to housing issues that arose. A substantial minority became actively engaged in complex entitlements or clinical services. Overall, the programs succeeded in stabilizing the housing situations of the tenants who were the focus of the CTH Initiative: over 70% remained in permanent housing either at the CTHI sites or elsewhere two years after they first moved into the programs. Our analysis of housing stability showed that individuals with psychotic disorders were at high risk of housing loss, but we found that even within this group, a large majority remained housed. Moreover, services – particularly referrals to mental health treatment – greatly increased the likelihood that tenants would remain housed. The various housing models we documented offered distinctive ways of organizing services and managing sites. They also entailed social worlds and somewhat distinct notions of community. But across these diverse approaches, the findings clearly show that housing with supportive services is effective in bringing residential stability to homeless individuals with multiple barriers to stable housing.

Our evaluation confirms that there are several ways of approaching long-term homelessness and residential instability and serves as a warning against facile generalizations about "chronic homelessness" and its solutions. At the same time, the diversity of people and programs in the study makes it likely that the experiences we document have parallels in other settings and cities, and allow us to extract a number of cautious conclusions, enumerated below, about people who experience chronic long-term homelessness or residential instability and the programs designed to serve them.

Summary of Key Findings and Conclusions

1. The population of individuals with long-term homelessness and multiple barriers to housing stability is diverse. Although the sample drawn from the study sites does not "represent" that larger population, it does indicate some of the diversity it contains. We note particularly the contrasts between those who had become entrenched in the shelter/lodging and those recruited to enter the housing programs: shelter/lodging house residents were significantly older, had been homeless much longer, and were less likely to have recent support from employment or entitlements programs. Notably, there were no significant differences in health or mental health problems, although shelter/lodging residents were less likely be in treatment for psychiatric disabilities (as measured by use of medications) and were less likely to have lifetime diagnoses of alcohol or drug abuse or dual diagnoses. The specific contrasts are important, because they reveal that the shelter/lodging residents differ less in intrinsic characteristics or disabilities than in their disconnection from supports, which may both result from and exacerbate their extremely lengthy homeless careers. One implication of this is that specially targeted programs that focus on relatively fixed populations within shelter, lodging, or other homeless venues will not prevent others who are less estranged from graduating to this extremely long-term status. ***We conclude that it is important to develop housing that addresses the needs of those who have not yet settled in to permanent residence at particular shelter sites to avoid replenishing the extremely long-term portion of the homeless population.***

2. Our data show considerable success by case managers, housing or entitlements specialists, and program aides at the shelter/lodging programs in developing relationships with even those with fewest connections to the programs. These relationships appeared to enhance the quality of life for these very long-term residents, though this did not, by itself, have an effect on their housing status. Individuals within these sites whose homelessness was less extensive, and those who had acquired the financial resources (entitlements benefits) to support housing, were more likely than others to become housed. Targeted efforts to involve long-term residents at the sites in seeking housing also had a positive effect on housing outcomes. But our qualitative data on housing barriers and BRC's ultimate success in housing the lodgers indicate that a critical barrier to housing engagement for the long-term residents at the shelter/lodging sites is the kind of housing that is offered and the disruptions of fragile stability as well as the demands, identities, and stigma it entails. ***We conclude that engagement efforts need to be complemented by the development of housing that places fewer barriers to admission, imposes fewer conditions of residence, and requires fewer compromises of autonomy, identity and dignity than many of the available options.***

3. The housing programs in the study provided accommodations to a diverse set of individuals who were less entrenched in their homelessness than those in the shelter and lodging programs, but had histories of housing instability and a variety of barriers to remaining housed. ***We conclude that the task of incorporating these tenants into the community at the sites entailed certain risks for housing providers and required each program to find ways to balance the maintenance of quality of life in the building as a whole with the commitment to serve individuals whose psychiatric or substance abuse could have a destabilizing influence on others and the site.***

4. The participating housing programs offered a variety of strategies for balancing the needs of the program community while accommodating individual tenants: screening for willingness to participate in treatment, while structuring the program to set limits to disruptive behavior; organizing the program around a division of responsibility between property managers (who maintain the financial and physical health of the building and establish and enforce rules to circumscribe destabilizing behavior) and support service providers who work with individual tenants during periods of psychiatric or substance abuse relapse and advocate on their behalf; and providing tenants with ease of movement between the permanent housing and sites that can accommodate and better contain behavior that can become destabilizing or disturbing to others. ***We conclude that screening and structure can create supportive environments for disabled, long-term homeless individuals who will agree to structured environments and participation in treatment and services, but harm reduction approaches that house a diverse mix of tenants, divide responsibilities for individual tenant support and property management, and offer ongoing access to treatment and support during relapse are effective and will be necessary to ensure housing for broad segments of the homeless population with significant barriers to stable housing.***

5. The large majority of tenants who entered the housing programs remained in permanent housing either at the site or elsewhere. ***We conclude that individuals with significant disabilities and long homeless histories can move directly from homeless settings to housing with supportive services and remain stably housed; that having a diagnosis of a psychotic disorder poses a bigger threat to housing than active substance abuse, though even among those with psychotic diagnoses, most achieved housing stability; and that once people are housed, engaging them in psychiatric treatment is both possible and effective for maintaining housing.***

The results argue for the feasibility of housing diverse tenants with long homeless histories or considerable residential instability without requiring extensive preparation for housing. Accommodating at a single site a large proportion of tenants who have high needs for support can be difficult for support services staff and for building management, but the Closer To Home Initiative offers a variety of models for doing it successfully.

References Cited

Axelroad S and Toff G (1987). *Outreach services for homeless mentally ill people.* Washington, DC: George Washington University.

Bahr HM (1973) *Skid Row: An Introduction to Disaffiliation.* New York: Oxford University Press.

Barrow S and Soto Rodriguez G (2002) *Evaluation of the Closer to Home Initiative: Third Progress Report.*

Barrow S (2001) *Evaluation of the Closer to Home Initiative: Second Progress Report.* New York.

Barrow SM & Soto Rodriguez G (2000) *Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel,* (pp. 1-66). New York: Corporation for Supportive Housing.

Barrow S and G Soto Rodriguez (2000) *Evaluation of the Closer to Home Initiative: Progress Report.*

Barrow SM & Soto Rodriguez G (1996) *Closer to Home: An Evaluation of Interim Housing for Homeless Adults*. New York: Corporation for Supportive Housing.

Barrow SM, Hellman F, Lovell AM, Plapinger JD & Struening EL (1991) Evaluating outreach services: Lessons from a study of five programs. *New Directions for Mental Health Services*, No. 52:29-46.

Bogue D (1963) *Skid Row in American Cities*. Chicago: University of Chicago Press.

Burt M (2001). Homeless families, singles, and others: Findings from the 1996 National Survey of Homeless Assistance Providers and Clients. *Housing Policy Debate*, 12 (4):737-780.

Chinman M, Rosenheck R, and Lam J (1999). The development of relationships between people who are homeless and have a mental disability and their case managers. *Psychiatric Rehabilitation Journal* 23(1): 47-55.

Cohen C, Ramirez M, Teresi J, Gallagher M & Sokolovsky J (1997). Predictors of becoming redomiciled among older homeless women. *The Gerontologist 37(1)*, 67-74.

Erickson S. and Page J (1999). To dance with grace: outreach and engagement to persons on the street. In LB Fosburg and DL Dennis (Eds.), *Practical Lessons: the 1998 National Symposium on Homelessness Research* (pp. 6.1 – 6.24).

Goldfinger SM, Schutt RK, Tolomiczenko, GS, et al (1999) Housing placement and subsequent days homeless among formerly homeless adults with mental illness. *Psychiatric Services* 50:674-679.

Hurlburt MS, Wood PA, Hough RL (1996) Providing independent housing for the homeless mentally ill: a novel approach to evaluating long-term longitudinal housing patterns. *Journal of Community Psychology* 24:291-310.

Hurlburt MS, Hough RL & Wood PA (1996) Effects of substance abuse on housing stability of homeless mentally ill persons in supported housing. *Psychiatric Services*, 47(7): 731-736.

Lipton FR, Siegel C, Hannigan A, Samuels J & Baker S (2000) Tenure in supportive housing for individuals with severe mental illness. *Psychiatric Services* 51(4):479-486.

Mowbray C, Cohen E, Bybee D (1993) The challenge of outcome evaluation in homeless services: Engagement as an intermediate outcome measure. *Evaluation and Program Planning* 16:337-346.

Proscio T (1998). *Under One Roof: Lessons Learned from Co-Locating Overnight, Transitional and Permanent Housing at Deborah's Place II, A Case Study Commissioned by the Corporation for Supportive Housing*. New York: Corporation for Supportive Housing, 1-19.

Tyrrell CL, Dozier M, Teague GB, Fallot RD (1999). Effective Treatment Relationships for Persons With Serious Psychiatric Disorders: The Importance of Attachment States of Mind**.** *Journal of Consulting and Clinical Psychology*. 67(5) 725-733

APPENDIX A:

STUDY METHODOLOGY

STUDY METHODOLOGY

General Approach

The issues of concern to this evaluation have required a combination of research perspectives, data sources and analytic methods. Thus the design entailed both descriptive case studies and comparative analyses of program and resident descriptors across all sites. We have collected both program-level and individual-level data, and have employed both qualitative and quantitative strategies for data analysis.

In the initial phases, several types of descriptive methods were employed. To document the particularities of each model and to describe how the programs were implemented, the study used a multiple case study approach. Each program was described as part of its particular local and agency context. The program's history and philosophy, the resources available within the agency and community, as well as the constraints that resulted from that context were documented. The case study approach was combined with a cross-site study that took an explicitly comparative perspective, considering each program in relation to the other sites in the Initiative, identifying shared and differentiating elements, common and divergent solutions to similar problems. By combining these perspectives – the former emphasizing the unique features of each site, the latter examining similarities and differences in a common set of dimensions – the evaluation has been able to describe the sites within a common conceptual framework without losing site of distinctive elements and practices. Both the case studies and the cross-site comparisons combined qualitative data on program structure and organization, policy and practices with quantitative descriptors of resident and program characteristics, the services provided, and the flow of individuals into, through and beyond the programs.

Data Sources

Qualitative data on program models and implementation were derived from documents describing program goals, history and philosophy, structure, staffing and operating policies/procedures. In addition, the evaluators made at least three site visits to each program over the course of the evaluation. Interviews and group discussions with administrators and program staff during these site visits elicited a timeline of program implementation and obtained information on program goals and history, organization and practices (regarding, for example, recruitment, admission, service delivery, length of stay, psychiatric treatment, substance abuse), problems and issues that arose, and problem solving activities undertaken to address them.

Individual-level data on residents' sociodemographic and clinical characteristics, indicators of homelessness history, service utilization, and residential status and service linkages at follow-up have come primarily from program staff, who also utilized records. The data were collected for the fixed samples of residents at the shelter/lodging sites and for the first cohort of tenants at each of the housing sites. The research team worked with service/clinical staff at each program to record data items on each individual included in the sample. Using research forms developed by the evaluator in consultation with staff and administrators at the programs, a member of the research team recorded the data on each person in the sample during "data visits" to each program, which occurred between two and two dozen times during each year of data collection – more often at the programs serving larger numbers. At these "data visits," the researcher completed the data forms in the course of "debriefing" sessions with case managers or other

service staff. Where relevant, staff members consulted case records or other program files to provide information needed for the research forms. Ongoing review of the forms by the evaluation team identified missing or inconsistent data which was clarified through follow-up phone calls or visits.

All data on individuals was recorded anonymously, and the evaluation team did not have access to any unique identifying information on program residents/tenants included in the sample. However, in order to permit clarification of inconsistent data and to obtain follow-up data on sample members, it was necessary to assign each sample member a code number that staff members at the program could easily "decode." Where possible, this consisted of identification numbers already in use by the program. If a program had no existing system for assigning unique identifiers, a simple coding system was devised for the evaluation and one or more staff members maintained a list linking coded IDs to client names or other identifiers. This protected confidentiality of the program's information on residents while ensuring that the evaluation team was able to link follow-up data on resident status to the baseline descriptive information.

Data Analysis

Qualitative data collected through interviews and discussions with program personnel during annual site visits was recorded in fieldnotes and entered into a QSR N6 (Non-numerical Unstructured Data Indexing, Searching and Theory-Building) database. N6 is a data analytic software application designed to facilitate qualitative data analysis. The initial strategy for coding the qualitative data entailed indexing the data entries by pre-determined categories that characterized data source and type as well as substantive concepts and constructs. N6 also allowed for recoding of segments of data as new issues emerged in the course of a field study. Through subsequent indexing and retrieval of coded data, it was possible both to create individual program profiles and to examine cross-site variability on issues of consequence for the evaluation.

Quantitative data was entered into an SPSS database for analysis. Analysis of data on program and resident characteristics and statuses at baseline and follow-up used descriptive statistics to summarize and present descriptive data on each program and its residents/tenants. Descriptive statistical analysis were also used to examine variability of resident and program features across selected sites or in some cases all sites. Assessment of outcomes relevant across subgroups or all sites (residence status; levels of engagement) also entailed descriptive analyses of the numbers and characteristics of residents who achieved different types of outcomes within and across sites. Within the major program groupings (shelter/lodging house programs, housing programs) we also pooled data across programs to analyze how similar residents fared in contrasting program contexts and to identify program elements that predicted outcomes.

A. Description of the Program Models

Program Descriptors, Dimensions and Measures

Descriptions of the program models were constructed from data on each site's target population; the philosophy, goals and assumptions that informed the model; its background and development; key elements of program structure and organization; and operating policies and practices. The dimensions and measures for each of these domains are described below.

The target population.

The programs funded under the CTH Initiative focused on different segments of the larger population of mentally ill homeless. Since each tailored its approach to address the issues arising for its target group, understanding the variations among the populations the programs were designed to serve was a starting point for identifying the significant similarities and differences in the models that comprised the CTH Initiative. Program administrators and staff were asked to define the program's target population as well as the program's admission or eligibility criteria, recruitment strategies, and assessment procedures.

Program philosophy, goals, and assumptions.

Although all sites in the Initiative shared overarching goals that included engaging residents in services and enhancing the residential stability of their target populations, the specific ways these goals were conceived and operationalized varied across the models. Program philosophy and goals were elicited in semi-structured interviews with program administrators and senior staff. Additional data sources included agency documents and group discussions with administrators and staff.

Description of program background and development.

A comprehensive description of the program models required attention to local and agency history and context (including the legal and regulatory context) within which the models developed, as well as the kinds of expertise and resources available to the program in the agency and wider community. Semi-structured interviews with administrators and program reports and documents were the primary sources of data on: the type of agency or agencies that operated each program (e.g., public, private, non-profit; health care, mental health, housing development, vocational; community-based vs. national); their prior experience with the target population and with related groups (e.g., previous and current programs); and how each program fit into the structure of the larger agency or agencies. The interviews also elicited a chronology or timeline for program development and implementation.

Description of program structure and organization.

The dimensions of program structure that were of interest to the evaluation were the housing and service elements that we expected, on conceptual grounds, would have an impact on outcome. These included *housing variables* such as type of housing site (e.g. SRO, single-site apartments, scattered apartments) and its relationship to the larger housing context (e.g., stand alone, co-located, dispersed); terms of the program's access to housing units (e.g., ownership of building; master leasing of building, rental of individual units from private or not-for-profit landlords); conditions of tenure for residents (leases, subleases, occupancy agreements, contract with program, etc.) and local regulations that define tenancy rights (e.g., rent control, right to housing

laws, etc.). *Service variables* included types and amount of services provided (case management, health care, employment, psychiatric, substance abuse, etc.), the location of service delivery (on site program rooms, off-site offices, "in vivo" in the community), the expectations for service participation (low demand, actively encouraged, required) and how these expectations were monitored or enforced. Service variables also included staff organization (e.g., whether service and housing were provided by the same versus separate agencies; staff education and experience; and team versus individual approaches), service linkages, and resources (within agency; to other service/housing agencies; to other public, non-profit or private agencies). Together, housing and service variables made up each program's profile.

Instruments and Procedures for Data Collection

A combination of methods was employed to collect the data necessary to describe key features of the models supported by the CTH Initiative. To document the program features listed above, the evaluation team met with administrators at each program and reviewed each of the "program profile" items during an initial site visit. This information was supplemented with several other qualitative data collection methods, including a review of program and agency documents (such as project proposals, periodic and annual reports, tables of organization, brochures and program descriptions, policy and procedures manuals, staff job descriptions), semi-structured interviews with agency and program administrators, and meetings or focus groups with program staff. At sites where program staff and the evaluator agreed that it was feasible, brief group discussions were also conducted with residents/tenants who consented to participate.

Summary and Analysis of Descriptive Data on Program Characteristics.

The program profile data were reviewed by the evaluator in conjunction with program personnel during baseline site visits that were scheduled with each program during Evaluation Years 1 and 2. During the site visits, the evaluator also obtained program documents, and conduct semi-structured interviews and focus groups with staff and administrators. All information from both the profiles and these additional sources was entered into an N6 database, a program for qualitative data analysis which facilitates combining and retrieving data from multiple sources. Analysis of the data entailed creating summary descriptions of each program by compiling and triangulating data on each program dimension drawn from all sources. Comparison of descriptors at Time 1 and Time 2 was used to document how each program changed over time. The analysis also identified and examined similarities and differences in individual dimensions or in clusters of dimensions across all programs or the major subsets of programs. This will provided an empirical basis for classification of the programs represented in the Initiative.

B. Description of Program Implementation

The descriptions of programs and models described above was intended to clarify how each model was conceptualized, the assumed connections among program elements, and the ways these were hypothesized to relate to desired outcomes. However, when programs are implemented in real world contexts, they often must adapt to unanticipated factors that affect their fidelity to the model as it was originally conceived or which result in redefining the model or particular elements of it. By examining program implementation, the evaluation was able to assess the congruence between intended and actual versions of each model program. In

describing program implementation, the evaluation focused on the domains covered in the model descriptions (target population, program goals, program context, structure and organization, and operating policies and practices), assessing for each, how the intended elements were operationalized and with what results.

To assess program implementation, we collected and analyzed both person-level data on who each program actually served or housed and the services they received; and program-level data how residents/tenants were recruited, engaged, and housed. We documented the extent to which the programs met their avowed targets for becoming operational, providing services and housing to clients, and assisting them in moving on to more permanent housing settings.

Person-level Data Collection

Sampling.
Because of variation in the duration of stay and amount of turnover at different sites, two sampling strategies were employed. At those sites that focused on long-term residents at that site, the pool from which clients were recruited for the program was relatively fixed and was not augmented with newcomers. At the two shelter programs (Park Avenue and Deborah's Place), and for the lodgers at the Palace Hotel, the evaluation sample consisted of the long-term group. At Park Avenue, where a "waiting list" of long-term residents was used to replace shelter residents who moved on from Project Homeward, minimal descriptive data were also collected on individuals on the waiting list, though they were not part of the sample that was followed up over time. At the shelter and lodging sites, baseline data referred to resident status at the point the CTHI program (or the PH program at the Park Avenue Shelter) began operating at the site. Follow-up data covered the two-years after baseline.

At the housing program sites, the core samples consisted of individuals who moved in as part of the CTHI program. At WSFSSH, the evaluation sample was limited to the residents who were recruited to the residence as part of the "Long Term Shelter Stayers Program." For Lamp, the study sample consisted of the permanent housing tenants recruited through Lamp at the Ballington and Pershing sites. Lamp was not expected to provide services to other permanent tenants at these sites, who were admitted under different criteria and procedures, and we did not include them in the evaluation sample. (We did collect limited baseline data on approximately 20 members of the Lamp community who were sheltered in units at the Ballington, but these units were administered by Lamp's shelter director as an expansion of the agency's shelter and were not followed-up as part of the housing program at the site.) The housing sites in the DAH programs each accommodated multiple groups. In addition to tenants recruited as part of DAH's target group, both sites also included a subgroup of long-term tenants who resided in the buildings before its conversion to DAH housing, as well as a sizeable group of tenants who came into the DAH buildings through the Tenderloin Housing Clinic's work training programs. The Windsor included an additional group recruited for the site's acute care Respite Unit. After extensive discussion with service providers at both programs, it was decided that all groups at the Pacific Bay Inn and the Windsor Hotel would be included in the sample; not all subgroups were included in all analyses.

At each site, sample members were added until all available "slots" or units in each program were full. In some instances, there was turnover before all units were occupied, and as a result, the "first cohort" which comprises the sample at each housing site was larger than the number of units designated for the program. For the core housing program samples, baseline data describe their characteristics and status at the time they entered the program and follow-up data were recorded 12 months after baseline.

Measures.

A Resident Profile Form was completed for each member of the sample selected at each site. Items recorded included demographic and clinical characteristics, homeless histories, where residents/tenants were staying at time of (just prior to) entry into the program, income amount and source, program or treatment involvement, and services provided by the provider agency before the program baseline. Resident Profiles were updated with information on current status at one year after the baseline profile was completed, along with additional measures of level of engagement in four domains (relationship with program, concrete services, complex services and housing); services provided directly and by referral after baseline; and resident/tenant location and housing status at follow-up. At the shelter and lodging house programs, where there was little movement in the year after the programs began, a second year of data collection was added. At the larger housing programs this was not feasible, but two-year data on housing status were obtained.

Program-level Data Collection

The evaluation collected program-level data on implementation and operations using a combination of quantitative and qualitative approaches.

Quantitative Measures.

Resident movement into and from the programs was recorded on *Resident/Service Tracking* forms that documented dates of entry and exit for each resident/tenant. For each exit, we also documented length of stay, type/reason for exit, and destination. Services rendered were measured for the program samples by aggregating numbers of residents/tenants who received particular categories of assistance during the follow-up period. Program efforts and success in moving residents on to permanent housing were summarized aggregating person-level measures of housing assistance, referral and placement activities or services during the follow-up period, as well as number of placements in other (permanent) housing; and number returning to homelessness.

Qualitative Data: Description of operating policies and practices.

While the dimensions of program structure outlined above constituted a kind of scaffolding that supported the ongoing operations of each program, it was the operating policies and practices that substantially determined how the programs actually worked. We documented policies and practices in several key areas: staff training, job descriptions and schedules; daily activity schedules; service planning processes; house rules and sanctions; discharge and eviction policies and practices; policies regarding substance use (e.g. clean and sober vs. "damp"), and other

problem behaviors (conflict and violence, illegal activities) and how these were enforced; policies regarding medication and money management; and community-building activities.

Throughout the evaluation, qualitative data on program implementation was collected during annual site visits to each program, as well as in the course of data meetings with staff to record individual level data on residents. Interviews with program administrators and focus groups with selected staff reviewed how each program was pursuing its stated goals, any changes in goals or strategy, and contextual factors (e.g., changes in agency policies, addition or loss of resources, passage of new local laws or administrative actions) that affected program implementation. Focus groups and meetings with staff explored both routine and out-of-the-ordinary incidents and problems that arose at the sites and the kinds of problem-solving activities and responses they elicited from staff at the site.

Summary and Analysis of Program Implementation

Baseline and follow-up data from the Resident Profile Forms were reviewed by the evaluation team and entered into an SPSS database for statistical analysis. Implementation analyses of person-level data consisted of descriptive statistics that characterized and compared baseline data on the samples drawn from the various programs in the Initiative. These analyses addressed the question of whether the programs were serving the populations they initially targeted; and whether the sites were focusing on similar or different segments of the larger target population of mentally ill homeless individuals.

Data from the Resident/Service Tracking Form were reviewed with staff at each program during the annual site visits. The tracking data for each program was entered into the N6 database and compared to descriptors of the relevant elements of each program model. Interview and focus group data on goals, structure, and problem-solving activities collected during the site visits was also entered into the N6 database for examination in relation to the model descriptions. Analyses also compared implementation data across the several programs, drawing on qualitative data to interpret similarities and differences in implementation.

C. Program-level and Person-level Outcomes

Program-level measures and analysis

At the program level, we used aggregate measures of outcome (e.g., the number of individuals who moved to longer-term or permanent housing settings; the number who left on their own, the number who were hospitalized and did not return, returned to street or shelter, found other housing on their own, etc.) to characterize each program's success in achieving or maintaining housing stability for its residents. The aggregate measures were recorded in the N6 database for analysis with other program-level data. The outcome data were summarized within and across programs over time to provide an outcome profile for each participating program.

Person-level measures and analysis

As programs designed to assist the most vulnerable and underserved within the homeless population, the providers included in the CTH Initiative all aimed to engage residents/tenants in services that would improve their living situations and enhance their quality of life. Most also defined permanent housing as a critical long-term goal. Thus service engagement and housing

status were important dimensions of individual-level outcome examined in the evaluation. Service engagement was of interest as both an outcome in its own right and a mediator of changes in housing status. In some programs focusing on long-term residents who had come to view a shelter or transitional site as "home", service engagement, service retention and other service delivery goals had greater salience than permanent housing placement. At other sites, engagement with program staff, linkage to off-site services, or willingness to consider housing alternatives reflected proximate aims that indexed progress toward program goals. In either case, measures of program engagement and service utilization were important indicators of program success across the entire range of sites.

On the basis of initial site visits and baseline data collection, we developed a set of scales to measure service engagement in each of four domains (engaged in a relationship with staff, engaged in receiving concrete services, engaged in complex social and clinical services, and engaged in housing services). We also measured frequency with which individuals received direct or referral services in ten domains (housing, entitlements, money management, employment, health, mental health, substance abuse, legal, socialization, family services).

The key outcome variable at all sites was housing status at follow-up. We recorded specific types of locations where residents were located at follow-up (shelter, transitional residence, family home, own apartment, SRO). In the shelter/lodging sites, individuals who remained at the sites or left for other homeless situations were classified as not housed; those who moved to longer-term settings (nursing homes, adult homes, transitional or permanent housing) were classified as "housed in long-term settings"; at the housing sites, we set a higher standard for housing outcome, considering individuals who left the housing programs for transitional or temporary settings to be no longer housed. Those who moved to independent, family or supportive housing and those in adult homes, as well as those who remained at the housing sites were classified as "housed in independent/permanent settings."

Outcome data at the individual level was recorded on a Resident Profile Follow-up form, which documented housing and service statuses at 12 months after baseline for housing tenants and at 24 months for shelter/lodging residents. In addition to "snapshot" measures of status at the point of follow-up, the instrument included the engagement scales along with a set of open-ended questions about the process, strategies, and barriers to engaging each resident, and about the reason for each scale rating; services provided directly and by referral in each domain; housing status changes over the follow-up interval. For those who exited from the program before the end of the follow-up period, housing and service statuses up to the time of exit were be recorded, as well as reason for exit and destination.

The qualitative data on engagement and services were recorded on narrative form on the Resident Profile Follow-Up Form and subsequently entered into the N6 database for indexing and thematic analysis. Specific measures of resident outcomes were added to the SPSS database and analyzed in two ways. Within and across programs, descriptive statistics were used to summarize outcomes for each program sample and for all programs together. Logistic regression analysis was used on the shelter/lodging and the housing subsamples, to test models using resident characteristics, services provided, and levels of engagement in various domains as predictors of housing outcomes.

APPENDIX B:

PROGRAM PROFILES

PROFILE OF DEBORAH'S PLACE PROGRAM FOR LONG-TERM RESIDENTS

I. PROGRAM DESCRIPTION

The CTHI program at Deborah's Place consisted of intensive case management for twelve women who had used the agency's overnight shelter over several years but remained unengaged in services that had helped others move towards housing. DP hired a full-time case manager to work with the twelve women, who comprised over a third of the shelter's guests at any given time. Her tasks were to build relationships with the women, address obvious unmet needs, discover how they viewed their own needs, work toward housing with those willing to consider it, and develop ideas about how DP might better serve the others.

Agency Context: History, Organization, Philosophy

Deborah's Place originated in 1984 as an emergency shelter organization providing overnight accommodation for women who were homeless. Though in subsequent years, DP added a day shelter, short and longer-term transitional housing, and permanent supportive housing, as well as case management, educational and employment programs, the agency continued to focus on a core constituency – women who are homeless – and worked to maintain communication and a sense of community across its program components. Links across program sites were fostered by the movement of the women themselves (overnight shelter guests received services at DP's Daytime Support Center; those who moved to housing sometimes returned to the overnight or day programs for meals, visits, or services) and by a centralized case management approach, in which case managers moved across sites rather than being assigned to a single DP program.

The agency's philosophy emphasizes self-determination and community as core values. While DP's programs range from very low demand to highly structured transitional housing, all programs use a flexible, individualized approach, in which women's choices are respected. At the overnight and daytime shelters, services are optional but plentiful: the overnight shelter provides beds, shower, meals, a number of groups and recreational activities; the day program also offers meals and showers as well as laundry, clothing, use of phones, and group activities ranging from art therapy, outings, movie rentals to groups on substance abuse, issues concerning children, and current events. Women also receive help with housing applications, advocacy for housing or entitlements, escorts to appointments, on-site nursing services and health care referrals. Case management services occur at all sites. Educational and vocational services and a stipend work program are also provided, and the agency has developed a craft business that employs a number of the women.

The CTHI Program Model

Target Population. Despite the comprehensive service offerings at Deborah's Place, about a dozen shelter guests became relatively permanent residents, and these women were the focus of CTHI's specialized services. As a group, they were defined more by their long-term but minimally engaged relationship to the program than by particular needs or characteristics. All were part of the DP community for seven or more years, many had health problems, and almost all displayed some symptoms of mental illness. The shelter's low demand, supportive atmosphere offered these women a safe space where basic needs were met with minimal requirements for providing information or participating in service or treatment programs. DP staff believe most would have left more demanding settings for the streets. However, their needs and preferences were not readily accommodated in DP's more structured transitional housing programs or in the agency's permanent housing, which involved admissions interviews and a waiting list. Most had consistently rebuffed efforts to refer them to other housing programs or to assist them in finding independent apartments.

Program Model. The CTHI program at DP provided intensive case management for the twelve long-stay women. Because of their difficulty articulating their needs and disinclination to participate in services, engagement required more attention and time than existing staff were able to provide. Within the shelter, the enhanced CTHI case management service was not identified as a distinctive program and the twelve women were not publicly designated as participants in a special initiative. The approach emphasized relationship-

building and a commitment to respecting the women's own decisions (even when they rejected housing, treatment or services that would appear to benefit them), while looking for openings to engage them around their interests and, when feasible, introduce housing and service ideas for their consideration.

Services and Staffing. DP hired the CTHI case manager in November, 1998. Initially she spent her time talking with those who were willing, and sitting with those who would not talk, while using observation or information from staff or other guests to learn what they might need and be willing to accept. She drove women who would agree to get into a car to where they need to go; bought clothes, socks, shoes, or jackets for others; and treated still others to food or cigarettes. In pursuing leads on interests or needs that might offer a basis for conversation and engagement, she stored one woman's possessions in her car, cleaned the apartment of a client who obtained housing, loaned money to others or offered them rides to parks or other daytime hangouts. She also looked up information on the internet for one client; invited another to play pool after learning that she liked the game; and responded to yet another's care about her appearance by buying her colorful hair barrettes.

Though most of the women offered few openings to discuss housing, key barriers to housing them were apparent. While over half had no regular source of income and were unwilling or unable to apply for benefits, Chicago's market-rate housing rents were well beyond reach even for those with SSI or other entitlements. Subsidized supportive housing was more affordable, but even housing providers with low demand philosophies sought tenants who functioned at higher levels or imposed multiple interviews or other application hurdles that made it difficult for those interested in moving to access existing housing. Most women rejected options that required treatment participation, having an income, or moving to "affordable housing" – usually in poorer areas or in buildings owned by unscrupulous slum landlords. Thus existing supportive and independent housing options, including those run by DP, did not match the vulnerabilities and needs of DP's long-term guests.

By July 2001, the CTHI case manager had developed relationships with all twelve women and had helped two move into subsidized supportive housing, though one returned to the shelter soon after. Extensive support and advocacy from the case manager averted several threats of eviction by the SRO where the other woman remained housed.

II. PROFILE OF LONG-TERM RESIDENTS

Characteristics of Long-Term Residents

- Gender: 100% female
- Average age: 51.25 years
- Race/Ethnicity: 25% Non-Hispanic Black; 75% Non-Hispanic White
- Family contact: 91% had no family contact
- Education: 86% at least high school diploma or GED
- Employment: 14% employed in last five years
- Primary means of support: 36% benefits; 27% other, 36% none
- Homelessness: 92% homeless more than 4 years
- Criminal history: 8% previously incarcerated
- Health conditions: 42% had 2 or more serious health conditions
- Psychiatric and Substance Abuse Problems:
  - Diagnosis of psychotic disorder: 42%
  - Current or Past Substance Abuse : 17%
  - Psychiatric Diagnosis and Substance Abuse: 8%

Services Received by Residents Prior to CTHI

- Services provided directly by the program agency
  - Food/shower: 100%
  - Drop-in services: 83%
  - Entitlements: 42%
  - Legal:0%
  - Healthcare: 25%
  - Mental health: 17%
  - Substance abuse: 0%
  - Other services: 92%
- Service referrals to other agencies
  - Clothing: 8%
  - Legal: 8%
  - Medical treatment: 25%
  - Other services: 8%

Services Received by Residents During CTHI

- Services provided directly by the program agency
  - Housing: 100%
  - Money management: 83%
  - Entitlements: 92%
  - Training/work: 58%
  - Health care: 100%
  - Mental health: 92%
  - Substance abuse: 25%
  - Legal: 17%
  - Family: 83%
  - Socialization/other: 100%
- Service referrals to other agencies
  - Housing: 75%
  - Money management: 8%
  - Entitlements: 75%
  - Training/work: 8%
  - Health care: 58%
  - Mental health: 8%
  - Socialization: 8%

Resident Outcomes

Engagement

- 42% highly engaged (rated 4 or 5) in a relationship
- 42% highly willing (rated 4 or 5) to accept concrete services
- 8% highly willing (rated 4 or 5) to accept complex services
- 17% highly willing (rated 4 or 5) to accept housing services

Housing outcomes

- destination at exit: 8% to permanent supportive housing
- housing status at two years: 92% at DP; 8% housed

III. PROGRAM STATUS 2003

The program format developed at the beginning of the CTH Initiative – a single case manager focused on engaging and housing a long-entrenched group of shelter guests – continued throughout the five years of CTHI. Over the last two years, the program had to accommodate both internal change (staff turnover) and external policy shifts (a city decision to phase out shelters). The original CTHI case manager moved to a new position within Deborah's Place. Her successor was a former staff person at DP's day shelter program. When the second case manager moved out of town, the women who remained were added to the caseload of another DP case manager. Both transitions went smoothly, and the third case manager has reportedly further increased the women's engagement and involvement in services. At the end of five years, three women were housed (two in DP permanent housing programs), one woman had been in a local psychiatric facility for several months, and another had died. Most, however, continued to stay at DP's overnight shelter. This is of particular concern because as Chicago implements a "housing first" approach to homelessness, funding for overnight shelters will end by July, 2004. DP has stepped up efforts to find housing for the shelter's current roster of 25 women, including the seven long-term guests who remained. Planning is underway to open a 15-bed "Safe Havens" program when the shelter closes. In this format, the site will have a similarly low-demand structure and open-ended length of stay, but it will only serve homeless individuals with a confirmed Axis I psychiatric diagnosis who are referred through local street outreach teams. Whether it will be an option for the long-stay women is unclear.

PROFILE OF PROJECT HOMEWARD

I. PROGRAM DESCRIPTION

Project Homeward was developed by Lenox Hill Neighborhood House (LHNH) to provide additional services for 20 women who had become long-term residents at the agency's 100-bed Park Avenue Shelter for women with severe mental illness. Program aides worked on personal care skills with the designated residents as a means of engaging them and improving their quality of life, while social workers and administrators pursued referrals for treatment and housing. Through this process, the agency hoped to gain a better understanding of the barriers to housing for this group and to conceptualize more appropriate alternatives.

Agency Context: History, Organization, Philosophy

In 1996, when NYC began to contract shelter operations to not-for-profit agencies, LHNH took over operations and services at Park Avenue, which was designated as a mental health shelter for older women with an Axis I diagnosis of serious mental illness. The shelter is housed in the Seventh Regiment Armory building, along with a variety of cultural, governmental, and military organizations, creating an unusual mix of co-occurring activities and cultures.

Lenox Hill Neighborhood House is a community-based settlement house founded over 100 years ago to serve immigrant children in NYC's Upper East Side. Like other agencies in the settlement house tradition, LHNH addresses a broad range of community needs. In addition to serving children and families, LHNH offers outreach and programs for seniors, community advocacy, work on housing rights, classic social services, and a low-cost health club for neighborhood residents, and a consumer-run business. LHNH also operates homeless programs that include street outreach, shelter, transitional housing, permanent supportive housing, and vocational services. Homeless women who are over 45 and have serious psychiatric disorders are referred to Park Avenue by NYC's centralized assessment shelter. The basic services provided to all women at the shelter include three meals a day, showers, and a range of social services (on-site health and mental health services, case management; groups focused on various treatment issues; recreational activities; and assistance with daily living activities).

Project Homeward: Target Population, Program Model, Program Implementation

Target Population. Project Homeward was designed to provide concentrated attention to those women who remained relatively unengaged despite long stays in the shelter system. The group targeted for PH consisted entirely of women referred to Park Avenue before 1996, including several who had spent lengthy periods of time in other city shelters. Among those who met this criterion, the PH program initially focused on those whose problems with basic living skills like bathing and grooming required more support and attention than could be provided to the general shelter population. On average, these women had spent between six and seven years in city shelters.

Program Model. Shelter staff saw PH as a means of directing attention to long-stay, unengaged women. Program aides developed a regimen of hygiene activities that provided structure for the residents and opportunities for engagement, while the relationships between the aides and PH clients enhanced their quality of life. Social workers focused on linking them to treatment and housing.

Services and Staffing. Four program aides provided the women designated for PH with assistance with activities of daily living – primarily bathing, grooming, and keeping their bed areas clean. The program aides also kept a medication log for PH women taking medications. In addition to their work on ADL skills, the aides used their own ingenuity to find ways to engage the long-term women, taking them shopping or to lunch, sometimes buying them toiletries or other small items. Although originally conceived as an effort to develop housing readiness for long-term residents, the day-to-day emphasis of PH was on smaller goals that shelter staff believed had an impact on a woman's quality of life. The decision to target the long-stayers to

some extent rippled out to other areas as well. The volunteer psychiatrists at Park Avenue made particular efforts to contact all the PH women, though many women continued to refuse medication or other psychiatric interventions.

II. PROFILE OF PH RESIDENTS

Characteristics of Long-Term Resident Sample

- Gender: 100% female
- Average age: 64.33 years
- Race/Ethnicity: 56% Non-Hispanic Black; 42% Non-Hispanic White
- Marital Status: 56% ever married or domestic partner
- Family contact: 61% had no family contact
- Education: 69% high school diploma/GED or more
- Employment: 0 employed in the past five years
- Primary means of support: 74% benefits; 23% none
- Homelessness: 75% homeless more than 4 years
- Criminal history: 11% had been incarcerated
- Health conditions: 47% had 2 or more health conditions
- Psychiatric and Substance Abuse Problems:
  - Diagnosed with psychotic disorder: 81%
  - Current or Past Substance Abuse: 14%
  - Dual Diagnosis: 8%

Services Received by Residents Prior to PH

- Services provided directly by the program agency
  - Food/shower: 100%
  - Drop-in services: 0%
  - Entitlements: 61%
  - Legal: 6%
  - Healthcare: 47%
  - Mental health: 61%
  - Substance abuse: 0%
  - Other services: 19%
- Service referrals to other agencies
  - Entitlements: 3%
  - Medical treatment: 42%
  - Mental health: 17%

Services Received by Residents During PH

- Services provided directly by the program agency
  - Housing: 75%
  - Money management: 69%
  - Entitlements: 58%
  - Training/work: 6%
  - Health care: 83%
  - Mental health: 92%
  - Substance abuse: 6%
  - Legal: 11%
  - Family: 36%
  - Socialization: 67%

- Service referrals to other agencies
  - Housing: 47%
  - Entitlements: 17%
  - Health care: 42%
  - Mental health: 14%
  - Legal: 3%

Resident Outcomes at the Time of Follow-up

Engagement

- 16% highly engaged (rated 4 or 5) in a relationship
- 17% highly willing (rated 4 or 5) to accept concrete services
- 11% highly willing (rated 4 or 5) to accept complex services
- 11% highly willing (rated 4 or 5) to accept housing services

Housing Outcomes

- destination at exit from shelter: 28% hospitals; 33% transitional, long term residence
- housing status at two years: 39% in shelter; 59% in long-term residence or housing

III. PROGRAM STATUS 2003

Project Homeward came to an end in the Fall of 2001, when it was succeeded by the Shelter Mental Health Service Program, a year-long program that provided engagement and mental health services for a group of shelter residents who needed extra attention beyond the services routinely provided. It was staffed by a single program aide who provided services for 10 participants, but it also entailed more active involvement of the shelter's staff psychiatrist. Though the new program used less stringent length of stay criteria for eligibility, it included several women who would have qualified for Project Homeward.

PROFILE OF BRC's PALACE LODGING HOUSE PROJECT

I. PROGRAM DESCRIPTION

BRC's Palace Lodging House Project was created to provide outreach and housing placement services to 33 men living in 4' x 6' cubicles at the Palace Hotel, which BRC was planning to renovate to accommodate a mix of shelter, service, and housing programs. The agency contracted with a housing specialist whose task was to engage the lodgers and help them move to supportive or independent housing.

Agency Context: History, Organization, Philosophy

The Bowery is New York's skid row. Though the area no longer serves to contain homelessness the way it did for the thirty years after World War II, it continues to be the site of several agencies and programs serving the homeless population. The Bowery Residents' Committee was founded in the 1970s as a self-help program for "public inebriates." As it expanded in the 1980s, the agency's clientele and the nature of its services diversified. BRC now operates over twenty distinct programs arrayed along a continuum of care that encompasses emergency services (HIV/AIDS treatment, non-medical detox, outreach, reception, and shelter services), housing programs (supportive SROs, community residence programs) and day treatment programs for people living with AIDS, homeless substance abusers, mentally ill adults, and seniors). The agency's administrative offices and most of its service programs remain Bowery-based.

In 1993, BRC took a 45-year lease on one of the Bowery's most notorious lodging houses, the Palace Hotel, which had provided "flop house" lodging for over 600 men nightly in 4' x 6' cubicles. After media exposes of dangerous conditions and illegal activities in the late 1980s, the NYC shelter system formally stopped using the Palace as a site where city vouchers could be exchanged for shelter. But men who could pay $4.50 to $6.00 a night were permitted to stay in the cubicles on the three floors above CBGB, one of lower Manhattan's better known rock music clubs. During the mid-1990s, BRC co-located a range of additional outreach, shelter, treatment and vocational programs at the Palace and planned to develop permanent housing units there as well. The agency reworked its plans for the Palace several times before finalizing the present configuration encompassing shelter, transitional, and permanent SRO housing along with outreach, case management, and employment services. The construction of 24 SRO housing units was completed in 2003.

Agency administrators describe BRC's overall goal as instilling in people a sense of responsibility for their lives. This has entailed helping people achieve stable recovery and housing. In recent years, BRC has also emphasized work and functioning in the mainstream. Staff and administrators characterized the agency's service philosophy as emerging from practice, rather than academic or clinical theory, but noted that BRC program approaches were consistent with "stages of change" models.

The CTHI Program Model

Target Population. Although between 60 and 100 men were living in the Palace cubicles when BRC took over the building, the lodging house stopped accepting new admissions, and by late 1998 when the CTHI program began, 33 men remained. These men constituted the program's target population. All but one had been there since at least 1993, most for much longer. While many had obvious symptoms of mental illness, substance abuse, or chronic medical illnesses, all lodgers were the focus of engagement and housing efforts, regardless of particular characteristics or disabilities. Defined as they were by their status as "remainers," rather than particular clinical or length-of-stay characteristics, they varied in other attributes.

Program Model. BRC approached the effort to move the remaining lodgers to permanent housing with a dual strategy: a housing specialist actively worked to engage the men in a search for alternative housing, while the agency took administrative measures and legal actions to allow the reconstruction of the Palace to move forward.

Services and Staffing. A consultant with extensive housing placement experience was retained to engage the men and help them relocate to more appropriate housing. However, because a previous effort by BRC to evict the lodgers left many angry and distrustful of the agency, the housing specialist sought to distance himself from BRC. His engagement efforts included community-wide events to explain BRC's plans for the Palace and offer relocation help, followed by one-on-one engagement work – making small personal loans, being accessible beyond typical business hours, or responding when unanticipated issues (hospitalization, death of a lodger) arose. He offered each lodger $10 for completing a housing interview, which gave him an assessment of housing needs and barriers while providing the men with a rationale for participating (money) that was accepted by their peers. He also negotiated blanket eligibility for the lodgers for the City's homeless housing programs and arranged visits to housing sites after coaching some of the men, who did not view themselves as homeless, about the kinds of questions to expect in housing interviews. After about two years of these efforts, one-third of the lodgers had left the Palace.

While the housing specialist worked to engage the men, the agency also prepared for the possibility of evictions, obtaining rent regulated status for the cubicles, which allowed BRC to require all lodgers to pay rent. When the agency moved to evict those who refused, the housing specialist accompanied them to court, where he served as their advocate, and helped seven to work out payment agreements that would put them back on the rent rolls and keep them eligible to move into the SRO housing units planned as part of the Palace renovations. When he phased out his involvement at the Palace in 2001, approximately 20 of the original group of lodgers remained.

II. PROFILE OF BRC LODGING HOUSE RESIDENTS

Characteristics of Residents

- Gender: 100% male
- Average age: 52.61 years
- Race/Ethnicity: 82% Non-Hispanic Black; 6% Non-Hispanic White
- Marital Status: 24% ever married or domestic partner
- Family contact: 61% had no family contact
- Education: 36% high school diploma/GED or more
- Employment: 46% employed in the past 5 years
- Primary means of support: 76% benefits; 14% employment; 3% other
- Homelessness: 100% homeless more than 4 years
- Criminal history: 27% had been incarcerated
- Health conditions: 37% had 2 or more health conditions
- Psychiatric and Substance Abuse Problems:
  - Diagnosed with psychotic disorder: 15%
  - Current or Past Substance Abuse: 52%
  - Dual Diagnosis: 3%

Services Received by Residents Prior to CTHI

- Services provided directly by the program agency
  - Food/shower: 52%
  - Drop-in services: 3%
  - Entitlements: 3%
  - Legal: 0%
  - Healthcare: 9%
  - Mental health: 6%
  - Substance abuse: 3%
  - Other services: 15%

- Service referrals to other agencies
  - Legal: 3%
  - Medical treatment: 6%
  - Mental health: 6%
  - Substance abuse: 6%

Services Received by Residents During CTHI

- Services provided directly by the program agency
  - Housing (counseling, information): 100%
  - Money management: 30%
  - Entitlements: 46%
  - Training/work: 0%
  - Health care: 39%
  - Mental health: 21%
  - Substance abuse: 27%
  - Legal: 6%
  - Family: 30%
  - Socialization: 12%
- Service referrals to other agencies
  - Housing: 58%
  - Entitlements: 15%
  - Health care: 15%
  - Mental health: 15%
  - Substance abuse: 9%
  - Legal: 12%

Resident Outcomes at the Time of Follow-up

Engagement

- 51% highly engaged (rated 4 or 5) in a relationship
- 30% highly willing (rated 4 or 5) to accept concrete services
- 16% highly willing (rated 4 or 5) to accept complex services
- 21% highly willing (rated 4 or 5) to accept housing services

Housing Outcomes

- destination at exit: 22% to long-term settings; 9% to treatment settings
- two-year housing status: 67% at BRC; 30% in housing; 3% deceased

III. PROGRAM STATUS 2003

After the housing specialist left the program, BRC hired an entitlements specialist to help the remaining lodgers establish eligibility for the SRO units under construction at the Palace, while pursuing eviction proceedings against those who had significant rent arrears or were unwilling or unable to address income issues. The SRO opened in May, and by the fall of 2003, 13 lodgers had moved in. One lodger died and six left the Palace (only two were evicted through the court) during this transition, and the lodging house was finally closed.

PROFILE OF WSFSSH's PROJECT FOR LONG-TERM SHELTER STAYERS

I. PROGRAM DESCRIPTION

The Long-Term Shelter Stayers Project provides permanent housing for older, formerly homeless men and women with serious mental illness and long histories of homelessness. The program carried out "inreach" in shelter and drop-in centers to recruit long-term shelter residents for the agency's 129th Street Adult Residence, where they received enriched case management services.

Agency Context: History, Organization, Philosophy

WSFSSH was formed in 1976 by a coalition of social agencies, religious institutions, and community organizers to create new housing to meet the diverse needs of older people and persons living with handicaps. In 1983, the agency expanded its mission to include housing and supportive services for homeless adults, and by the time the agency began to operate the 129th Street Residence, it was housing more than 1,500 persons in over 1,200 units. WSFSSH's housing programs are targeted at older adults and people with mental illness, and include independent apartments; permanent supportive SROs; a transitional shelter; and several Adult Residential Care facilities. The programs do not form a continuum, as all programs except the transitional shelter provide permanent housing, and people are not expected to move on. As an agency, WSFSSH has its roots in social activism and religion. Unifying themes across the agency's varied programs include a commitment to social justice and an emphasis on providing safe and supportive homes for frail and disabled single older adults.

In 1997, New York State asked WSFSSH to take over building management and service delivery at the 129th Street Residence, which had been operated by another agency as a licensed adult residence housing 92 older, formerly homeless adults with serious mental illness. WSFSSH restaffed the building, completed a variety of needed repairs and renovations, and implemented several changes in policies and practices. Under WSFSSH management, all residents at the site receive three meals a day; security and supervision; housekeeping in all common areas of the building and in the rooms as needed; and laundry facilities and assistance as needed. Health and mental health services include individual support for treatment, on-site nursing consultations, groups and activities, crisis intervention; medication monitoring and supervision, on-site psychiatric treatment with volunteer psychiatrists, and money management and budgeting assistance.

The program also provides residents with a structured environment. All residents are expected to follow medication regimens, maintain sobriety, meet regularly with their case manager, and adhere to a set of comprehensive house rule that cover issues of safety, room assignment, keys, reporting needed repairs, guest policies, prohibitions (of excess noise, verbal or physical abuse, illegal activities, unsanitary behavior), and a variety of behavioral expectations in the room and in the building. However, service plans are individualized and staff seek creative ways to encourage and support residents through periods of psychosis or relapse.

Long-Term Shelter Stayers Project: Target Population, Program Model, Implementation

Target Population. At the end of the transition to WSFSSH management, the 129th Street Residence had about thirty vacancies. Twenty of these units were set aside for the CTHI "Long-term Shelter Stayers Project," intended to house men and women who had spent at least two years in city shelters or drop-in centers. In addition to their history of homelessness, the target group consisted of people meeting the "adult residence" criteria – that is, people with serious mental illness who needed a high level of services (all meals and snacks, supervised medication, housekeeping services) but not skilled nursing care. While many of those who entered the 129th Street Residence before the long-stayers project began had similar histories of long-term homelessness, the additional case management resources provided by the project allowed the agency to risk accepting more individuals with higher levels of need.

Program Model. As a licensed residential program, the 129th Street Residence was atypical among the supportive housing programs included in the study. It was also distinctive among housing sites for homeless people with mental illness in NYC in offering permanent housing to residents recruited directly from the long-term homeless population. The men and women in the Long-Stayers Project at 129th Street participated in the structured milieu that the program provides for all its residents, while also receiving individualized case management. All were screened for willingness to receive psychiatric treatment and health care, take medications, remain clean and sober, and adhere to other conditions required by the program. By excluding individuals who rejected structured housing options, WSFSSH focused on those for whom rules and structure were not major barriers.

Staffing and Services. The Long-Stayers Project entailed expanding case management staff from three to four case managers, since the targeted group of long-term homeless adults were expected to need considerable support. Initial "inreach" efforts focused on two large city shelters with long-stay populations, but lack of follow up by shelter staff in one case and lack of interest by shelter residents in the other led to a broader recruitment effort. While 38% of the residents from the initial cohort of long-stayers came directly from shelters or drop-in centers, another 38% had long shelter histories but had been in transitional programs before coming to 129th Street, and 25% were referred by hospitals and mental health programs. After the initial recruitment period, the focus of the project shifted to engagement and case management. Though most participants in the Long-Stayers Project were initially assigned to one case manager specifically hired to staff the project, they were subsequently dispersed among the case loads of all case managers. They participated in Residence's structured milieu, receiving the same services as others at the site, though case management for this group often required greater flexibility and a more gradual induction into the program's requirements for treatment and service participation.

II. PROFILE OF WSFSSH LONG-TERM SHELTER STAYERS PROJECT

Characteristics of Long-Term Shelter Stayer Sample

- Gender: 88% male
- Average age: 54.00 years
- Race/Ethnicity: 75% Non-Hispanic Black; 13% Non-Hispanic White, 13% Latino
- Marital Status: 35% ever married or domestic partner
- Family contact: 48% had no family contact
- Education: 50% high school diploma/GED or more
- Employment: 9% employed in the past five years
- Primary means of support: 100% benefits
- Homelessness: 67% homeless more than 4 years
- Criminal history: 21% had been incarcerated
- Health conditions: 48% had 2 or more serious health conditions
- Psychiatric and Substance Abuse Problems:
  - Diagnosed with psychotic disorder: 75%
  - Current or Past Substance Abuse: 71%
  - Dual Diagnosis: 63%

Recruitment Source

- Referred by
  - Street outreach team: 13%
  - Shelter or drop-in center: 25%
  - Transitional Housing Program: 38%
  - Medical hospital or clinic program: 0%

Skilled nursing facility: 0%
Mental health hospital or program: 25%
Substance abuse or residential treatment program: 0%

Services Received by Residents During Long-Stayers Project

- Services provided directly by the program
  - Housing: 13%
  - Money management: 100%
  - Entitlements: 100%
  - Training/work: 33%
  - Health care: 100%
  - Mental health: 100%
  - Substance abuse: 67%
  - Legal: 25%
  - Family: 50%
  - Socialization: 83%
- Service referrals to other agencies
  - Housing: 4%
  - Entitlements: 33%
  - Health care: 75%
  - Mental health: 71%
  - Legal: 4%

Resident Outcomes at the Time of Follow-up

Engagement

- 50% highly engaged (rated 4 or 5) in a relationship
- 54% highly willing (rated 4 or 5) to accept concrete services
- 39% highly willing (rated 4 or 5) to accept complex services
- 75% highly willing (rated 4 or 5) to accept housing services

Housing Outcomes

- one-year housing status: 91% at site, 4% to other permanent housing; 4% to shelter
- two-year housing status: 65% at site; 22% in other permanent housing; 4% shelter; 8% deceased

III. PROGRAM STATUS 2003

By 2003, the CTHI project participants were well-integrated into the residence's larger population. No special services distinguished participants in the "Long-Term Shelter Stayers Project" from other residents. With the completion of the initial CSH contract, WSFSSH renewed its commitment to serve people with long-term homelessness through a new contract specifically targeting individuals who lived in NYC shelters for at least 730 days in the last four years. Fifteen beds scattered across three WSFSSH housing programs were reserved to house this group, and by Fall of 2003, eight of the individuals recruited through the new contract were staying at the 129th street Residence; four were at other WSFSSH housing programs.

PROFILE OF DIRECT ACCESS TO HOUSING

I. PROGRAM DESCRIPTION

Direct Access to Housing (DAH) was developed by the San Francisco Department of Public Health (DPH) to "fast-track" into housing homeless individuals with multiple disabilities and a history of heavy use of emergency clinical and homeless service programs. The program master leases vacant or underused buildings from private landlords, renovates them to provide space for services and activities, and develops on-site programs to provide case management, advocacy, and other supportive services for tenants who choose to use them. The Pacific Bay Inn (PBI) and the Windsor Hotel – the two original DAH programs – are both in San Francisco's "Tenderloin" area, one of the city's main concentrations of homeless people and homeless service programs.

Agency Context: History, Organization, Philosophy

DPH describes the central goal of the DAH program as improving residential stability and health status through the provision of service-enriched housing to homeless persons who have been living on the streets and revolving through emergency care settings. DPH started DAH after finding that low turnover and long waiting lists of permanent supportive housing made it extraordinarily difficult for the Department's clients – people with AIDS, people with mental illness – to exit from the emergency services system. DAH was envisioned as a bridge that would expedite moves from the high-cost emergency services sector by helping agencies acquire long-term leases on underutilized buildings, moving landlords out of the picture while bringing in service providers, and subsidizing needy tenants for the two years it generally took to move to the top of Section 8 or Shelter-Plus-Care waiting lists. DAH was also part of a broader DPH effort to make consumer needs rather than funding stream the driving force for housing development by blending funding sources so that housing programs would not be defined by disability.

In 1998, the Housing Office in DPH (now Housing and Urban Health) identified the PBI and the Windsor Hotel – two Tenderloin buildings operating as low-budget tourist/transient hotels – as DAH sites. Episcopal Community Service (ECS) was selected as lead agency at the PBI and signed a ten-year lease on the building which took effect in January, 1999; tenants began moving in during March, 1999. The Windsor's location next to a park well-known for drug activity deterred not-for-profit providers from submitting proposals, and DPH's Tom Waddell Health Center (TWHC) was eventually designated to take the lead, while DPH itself took on the ten-year master lease for the building; rent-up occurred between September, 1999, and March, 2000.

The philosophies of the several agencies involved in carrying out the DAH programs reflect their distinctive missions, experiences and orientations as well as their locations in the broader system of services and housing. At the PBI, the two agencies that were involved in support services – ECS and Baker Places (BP) – had philosophical approaches that were complementary, though not identical. ECS traces the origin of its homeless services to the early 1980s, when the Episcopal Diocese opened a small 10-bed shelter in the basement of Grace Cathedral on Nob Hill, in response to the increasingly visible homelessness crisis. ECS subsequently broadened its focus to include affordable housing plus services, developing experience with educational, vocational, job training and social services for a diverse clientele. Service delivery is individualized and rooted in the goals articulated by clients, and ECS programs take a proactive but voluntary approach to the services. Harm reduction is an important part of the philosophy but is actualized differently in the various programs ECS operates. When the PBI opened as a DAH site, ECS staff included the support services director and two case managers.

Baker Places provides a continuum of residential treatment services for people with dual and triple diagnoses of psychiatric disabilities, substance abuse problems, and HIV/AIDS. These range from highly structured medically oriented detox programs to on-site service delivery in supportive housing programs. The agency

works with a social rehabilitation model as developed in the mental health treatment field. BP programs have traditionally been relatively structured and focused on abstinence. Work with formerly homeless clients challenged BP to integrate harm reduction with its social rehabilitation approach by continuing to work with clients through relapse. Baker Places contributed two case managers to the support services team at the PBI.

At the Windsor Hotel, the TWHC was designated as the lead agency and the only provider of support services. TWHC was one of nineteen original Health Care for the Homeless (HCH) projects developed by the Robert Wood Johnson and Pew Foundations in the mid-1980s. Like other HCH projects, the program took its multi-disciplinary team to the streets, shelters or clinical sites in the community. Eventually, the HCH program merged with the city's Central Emergency Unit and, as Tom Waddell Health Center, became one of San Francisco's several District Health Centers. It expanded to cover thirty sites, including shelters, storefronts, street teams, and supportive SRO housing programs. TWHC's approach incorporated street-based work, urgent care, and focused efforts to move people into primary care. The same providers work both in the community sites (e.g., shelters, special project teams) and in the primary care clinics, ensuring continuity of care that is unusual in homeless service delivery.

Long-Term Shelter Stayers Project: Target Population, Program Model, Services

Target Population. DAH was intended to serve homeless people with disabilities who had cycled through emergency services without attaining residential stability. Eligibility for DAH at both sites requires that applicants be homeless residents of San Francisco with extremely low incomes. By selecting tenants by referral from a diverse set of local agencies and institutions that serve homeless disabled individuals, the program targets people released from institutional, acute care, or transitional settings with a history of rotating through the social services and/or criminal justice system without prolonged stabilization in their housing or health status. While long-term homelessness was not an explicit DAH focus, the other criteria ensured DAH would include people with long histories on the streets or in shelters. Each site had some tenants who were living there before DAH was developed. In addition to these, a number of tenants entered each site as clients of the Tenderloin Housing Clinic, which was offered units in each DAH building in exchange for managing third party rent payments. The allocation of units at each DAH site to different types of referral agencies has ensured further variation in the tenant population. Staff, administrators, and tenants cite the diversity of history, experience, ethnicity, disability, and patterns of service use among tenants as a distinctive and positive aspect of the program, despite the service delivery challenges it can produce.

The Windsor's Respite Unit targets homeless people with acute medical needs who require a temporary period of acute care, often following hospitalization, to achieve stability. Income criteria do not apply to the respite beds, but respite patients must follow rules (remaining clean and sober, meeting with staff, following a treatment plan) not required of long-term tenants.

Program Model. DAH's key features – master leasing, multi-agency service collaborations, designation of multiple referral agencies with ongoing responsibilities to tenants, and long-term subsidies – all served to build an extensive community network of support for the projects and the tenants they house. In acquiring housing sites by master leasing, DAH took responsibility for the environment of whole buildings, while bringing underutilized buildings back into service and expanding the total supply of affordable housing. Through multi-agency collaboration in both referrals and support services, DAH was expected not only to offer tenants diverse expertise but also to facilitate links to a broad array of service providers and foster continuity of care. The long-term but transitional rent subsidy, set at 50% of a tenant's income, was intended to bridge the time required to access more generous federal Shelter Plus Care and Section 8 subsidies for permanent housing.

Staffing and Services.

Within this common framework, the two DAH buildings entailed differing approaches to master leasing and the organization of support services. At PBI, the lead agency (ECS) holds the master lease and contracts directly with Mercy Services for property management, while at the Windsor, the DPH Housing Office (later

known as Housing and Urban Health), which developed and administers DAH, handled the contracting of property management services to the John Stewart Company. At PBI, ECS led the support services team, but it was staffed jointly with Baker Places, with each agency providing two case managers; ECS also added an employment specialist. Case managers each had individual case loads, and the ECS Support Services Director supervised all case managers on site, but BP provided additional supervision for its own case managers. The staffing and service focus at the Windsor reflected HCH's model of multidisciplinary clinical services, health advocacy, and a harm reduction approach to substance abuse and other risky behavior. Support services at the Windsor were provided by a multidisciplinary clinical team that included a psychiatric social worker, two nurses, a part-time physician, two health advocates serving as case managers, and an entitlements specialist. The same staff provided services to tenants in the 76 permanent housing units and to patients in a 16-room short-term (two to eight weeks) Respite Unit where homeless people with acute medical needs received day-time clinical services until medically more stable. Individuals were referred to both respite and long-term housing at the Windsor by other DPH and TWHC providers.

While staff at both sites worked to engage and provide services for tenants, PBI developed a more extensive program of group activities and invested considerable effort in working with individual tenants on applying to permanent housing. At Windsor, the high levels of additional service need among the respite patients absorbed much of the support services staff time and attention, resulting in less focus on community-building or helping tenants plan for alternative permanent housing. Moreover, the plan for respite services at the Windsor evolved significantly over the course of implementation. Though originally using the same voluntary services and harm reduction approach taken in the rest of the building, the respite unit was subsequently designated a "clean and sober" program and a fairly extensive set of house rules was developed, prohibiting a range of disruptive behaviors, requiring respite patients to agree to participate in treatment, and generally imposing a greater degree of structure than in the long-term housing program.

While DPH initially expected a two-year transitional housing subsidy would cover the time homeless individuals typically spent on waiting lists for subsidized housing, a tightening SF housing market inhibited new non-profit housing development, severely limiting DAH tenants' options for moving on. Because the DAH housing subsidy was funded from General Revenues, DPH had considerably flexibility in defining its terms. In recognition of the new realities of the SF housing market, DPH decided in 2001 to transform the temporary DAH housing subsidy into an open-ended one. The change from transitional to permanent housing took pressure off both tenants and staff, and was generally greeted with enthusiasm. Administrators noted, however, that case managers lost "leverage" for encouraging tenants to consider alternative housing that the time-limited subsidy provided, while tenants lost eligibility for the more generous subsidies Shelter Plus Care subsidies. To offset this, DPH worked out a transition for people who were already on waiting lists for Shelter Plus Care at the time the change was implemented.

II. PROFILE OF PRE-EXISTING, PAES, DAH, AND RESPITE TENANTS

Characteristics of Tenants at the Pacific Bay Inn

Recruitment Source - PBI

- Street outreach team: 11%
- Shelter or drop-in center: 26%
- Transitional Housing Program: 0%
- Medical hospital or clinic program: 4%
- Skilled nursing facility: 0%
- Mental health hospital or program: 4%
- Substance abuse or residential treatment program: 12%
- Work program (PAES): 17%
- Resided at site prior to program: 24%

Characteristics of Tenants at the Pacific Bay Inn

	DAH Tenants (n=48)	THC/PAES Tenants (n=14)	Pre-DAH Tenants (n=20)
Gender: % male	• 65% male	• 65% male	• 55% male
Average age:	• 47.23 years	• 41.14 years	• 48.05 years
Race/Ethnicity:	• 53 % Black • 21 % Latino • 33 % White	• 64 % Black • 14 % Latino • 22 % White	• 40 % Black • 5 % Latino • 35 % White
Ever married or domestic partner	• 33%	• 50%	• 60% e
Family contact	• 52% no contact	• 20% no contact	• 11% no contact
Education	• 71% high school or more	• 75% high school or more	• 92% high school or more
Employed in past 5 years	• 48%	• 90%	• 100%
Primary support from: entitlements employment	• 92%	• 93%	• 40% • 50%
Homeless more than 4 years	• 23%	• 11%	• 0
Incarcerated ever	• 23%	• 7%	• 10%
Serious health conditions	• 23% 2 or more	• 7% 2 or more	• 20% 2 or more
Dx: Psychotic disorder	• 42%	• 11%	• 20%
Lifetime Substance Abuse	• 84%	• 77%	• 50%
Dual diagnosis	• 33%	• 7%	• 0%

Services Provided to Tenants at the Pacific Bay Inn

Direct Services

DAH Tenants	THC/PAES Tenants	Pre-DAH Tenants
• Housing: 83%	• Housing: 79%	• Housing: 60%
• Money mgt: 58%	• Money mgt: 43%	• Money mgt: 45%
• Entitlements: 46%	• Entitlements: 57%	• Entitlements: 30%
• Training/work: 44%	• Training/work: 64%	• Training/work: 60%
• Health care: 77%	• Health care: 29%	• Health care: 45%
• Mental health: 67%	• Mental health: 36%	• Mental health: 40%
• Substance abuse: 54%	• Substance abuse: 43%	• Subst abuse: 35%
• Legal: 31%	• Legal: 36%	• Legal: 45%
• Family: 50%	• Family: 57%	• Family: 50%
• Socialization: 67%	• Socialization: 57%	• Socialization: 65%

Referral Services

DAH Tenants	THC/PAES Tenants	Pre-DAH Tenants
• Housing: 73%	• Housing: 71%	• Housing: 65%
• Entitlements: 48%	• Entitlements: 29%	• Entitlements: 30%
• Health care: 71%	• Health care: 36%	• Health care: 60%
• Mental health: 23%	• Mental health: 0%	• Mental health: 20%
• Substance abuse: 25%	• Substance abuse: 21%	• Substance abuse: 5%
• Legal: 25%	• Legal: 7%	• Legal: 35%

Tenant Outcomes at the Pacific Bay Inn

Engagement Outcomes

DAH Tenants	THC/PAES Tenants	Pre-DAH Tenants
• 46% highly engaged in relationship	• 36% highly engaged in relationship	• 50% highly engaged in relationship
• 38% highly engaged in concrete services	• 29% highly engaged in concrete services	• 20% highly engaged in concrete services
• 48%highly engaged in complex services	• 29%highly engaged in complex services	• 35%highly engaged in complex services
• 54% highly engaged in housing	• 50% highly engaged in housing	• 30% highly engaged in housing

Tenant Outcomes at the Pacific Bay Inn

Housing Outcomes

DAH Tenants	THC/PAES Tenants	Pre-DAH Tenants
One Year Housing Outcomes		
• 95% still at site • 2% other housing	• 90% still at site	• 100% still at site
Two Year Housing Outcomes		
• 62% still at site • 27% other housing • 3% other • 8% deceased	• 43% still at site • 14% other housing • 43% unknown	• 70% still at site • 5% other housing • 5% other • 20% unknown

Characteristics of Tenants at the Windsor Hotel

Recruitment Source – Windsor

- Street outreach team: 3%
- Shelter or drop-in center: 4%
- Transitional Housing Program: 1%
- Medical hospital or clinic program: 22%
- Skilled nursing facility: 4%
- Mental health hospital or program: 16%
- Substance abuse or residential treatment program: 0%
- Work program (PAES): 30%
- Resided at site prior to program: 21%

Characteristics of Tenants at the Windsor Hotel

	DAH Tenants (n=39)	DAH Respite (n=17)	THC – PAES (n=34)	Pre-DAH Tenants (n=24)
Gender: % male	• 67%	• 65%	• 91%	• 54%
Average age:	• 50.08 years	• 46.18 years	• 44.07 years	• 50.96 years
Race/Ethnicity:	• 49% Black • 10% Latino • 33% White	• 49% Black • 10% Latino • 33% White	• 49% Black • 10% Latino • 33% White	• 49% Black • 10% Latino • 33% White
Ever married or domestic partner	• 49%	• 29%	• 3%	• 53%
No family contact	• 51%	• 29%	• 21%	• 13%
High school education or more	• 43%	• 60%	• 55%	• 25%
Employed in past 5 years	• 29%	• 25%	• 93%	• 88%
Primary support from:				
entitlements	• 82%	• 71%	• 62%	• 46%
employment	• 8%	• 0	• 15%	• 25%
Homeless more than 4 years	• 31%	• 63%	• 22%	• 0
Incarcerated ever	• 21%	• 12%	• 9%	• 4%
Two or more serious health conditions	• 36%	• 35%	• 12%	• 13%
Dx: Psychotic disorder	• 31%	• 56%	• 7%	• 17%
Lifetime subst. abuse	• 74%	• 50%	• 55%	• 28%
Dual diagnosis	• 33%	• 29%	• 0	• 0

Services Provided to Tenants at the Windsor Hotel

Direct Services

DAH Tenants	DAH Respite	THC – PAES	Pre-DAH Tenants
• Housing: 87 • Money mgt: 39% • Entitlements: 46% • Training/work: 26% • Health care: 95% • Mental health: 74% • Substance abuse: 59% • Legal: 26% • Family: 44% • Socialization: 36%	• Housing: 59% • Money mgt: 12% • Entitlements: 29% • Training/work: 0 • Health care: 65% • Mental health: 71% • Substance abuse: 29% • Legal: 0 • Family: 29% • Socialization: 6%	• Housing: 50% • Money mgt: 15% • Entitlements: 6% • Training/work: 29% • Health care: 38% • Mental health: 18% • Substance abuse: 15% • Legal: 3% • Family: 9% • Socialization: 9%	• Housing: 75% • Money mgt: 13% • Entitlements: 13% • Training/work: 0 • Health care: 58% • Mental health: 42% • Substance abuse: 4% • Legal: 0 • Family: 17% • Socialization: 13%

Referrals to Other Agencies

DAH Tenants	DAH Respite	THC – PAES	Pre-DAH Tenants
• Housing: 21% • Money mgt: 67% • Entitlements: 39% • Training/work: 44% • Health care: 87% • Mental health: 31% • Substance abuse: 21% • Legal: 18% • Family: 3% • Socialization: 3%	• Housing: 18% • Money mgt: 12% • Entitlements: 18% • Training/work: 44% • Health care: 53% • Mental health: 18% • Substance abuse: 12% • Legal: 0 • Family: 0 • Socialization: 0	• Housing: 15% • Money mgt: 49% • Entitlements: 6% • Training/work: 44% • Health care: 32% • Mental health: 0 • Substance abuse: 6% • Legal: 6% • Family: 0 • Socialization: 0	• Housing: 21% • Money mgt: 8% • Entitlements: 17% • Training/work: 44% • Health care: 46% • Mental health: 8% • Substance abuse: 0 • Legal: 4% • Family: 0 • Socialization: 4%

Outcomes for Windsor Tenants

Engagement Outcomes

DAH Tenants

- 55% highly engaged in relationship
- 62% highly engaged in concrete services
- 49%highly engaged in complex services
- 41% highly engaged in housing

DAH Respite

- 47% highly engaged in relationship
- 47% highly engaged in concrete services
- 41%highly engaged in complex services
- 53% highly engaged in housing

THC – PAES

- 9% highly engaged in relationship
- 6% highly engaged in concrete services
- 14%highly engaged in complex services
- 7% highly engaged in housing

Pre-DAH Tenants

- 17% highly engaged in relationship
- 23% highly engaged in concrete services
- 18%highly engaged in complex services
- 14% highly engaged in housing

Housing Outcomes

One Year Outcomes

DAH Tenants

- 77% still at site
- 8% trans. housing
- 8% deceased
- 8% unknown

DAH Respite

- 6% still at site
- 12% trans. housing
- 12% deceased
- 71% unknown

THC – PAES

- 95% still at site
- 0 other housing
- 5% other

Pre-DAH Tenants

- 91% still at site
- 4% other housing
- 5% deceased

Two Year Outcomes

DAH Tenants

- 62% still at site
- 8% other hous.
- 5% trans hous.
- 23% deceased
- 13% unknown

DAH Respite

- 6% still at site
- 18% other housing
- 18% deceased
- 59% unknown

THC – PAES

- 39% still at site
- 12% other housing
- 3% deceased
- 46% unknown

Pre-DAH Tenants

- 75% still at site
- 8% other housing
- 4% deceased
- 13% unknown

III. PROGRAM STATUS 2003

By 2002, the programs at both sites had matured, though turnover in support services staff due to medical leaves and other departures burdened the remaining staff members and stretched the service capacity at both sites. Both programs noted that one consequence of staff shortages was that the neediest tenants consumed the lion's share of staff time, limiting the programs' ability to extend help to those with less urgent service needs, including some who might be candidates for moving on to other independent settings.

At both sites, the tenant population remained fairly stable. While this may have been affected by the removal of time limits from the DAH subsidy, the declining local economy and continued tight housing market severely limited tenants' alternatives. During 2003, two additional developments modified the DAH model. The first was a shift in the agencies providing support services. At the Windsor, Housing and Urban Health (the overall administrator of the DAH program) replaced the Tom Waddell Health Clinic as the lead agency and provider of support services. At the PBI, the multi-agency collaborative approach to support services was replaced by a single provider model: BP phased out its involvement at PBI, and ECS became the sole provider of support services. DPH has also developed a Behavioral Health Team that provides two days of clinical substance abuse services at all DAH sites, including PBI and Windsor. This to some extent offers an alternative way of expanding the range of on-site expertise and linkages to community resources that DAH initially tried to accomplish through multi-agency involvement in support services.

New DAH programs have produced additional changes that have not been incorporated at the original sites. Most notable are required third party rent payments, and a modification of the terms of the DAH subsidy, which at newer sites requires participation in services as a condition of the subsidy, much like Shelter Plus Care. Finally, although the Windsor continues to operate its 16-bed Respite Unit, none of the new DAH buildings include Respite Units. Instead, DPH is developing a free-standing 100-unit Respite program that will not share space with DAH.

PROFILE OF LAMP'S BALLINGTON AND PERSHING HOUSING PROGRAMS

I. PROGRAM DESCRIPTION

Lamp's Ballington and Pershing housing programs offer permanent housing at two Skid Row sites to members of the Lamp community. These programs entail differently structured partnerships with two local housing providers, thus expanding the variety of shelter, housing, and employment services the agency provides to homeless men and women with diagnoses of mental illness. At the Ballington site, Lamp also leases additional units to expand the agency's emergency shelter capacity, but the shelter units are administratively distinct from the housing program at the site.

Agency Context: History, Organization, Philosophy

While many US cities have "skid row" areas that have been home to "down and out" or disaffiliated populations, the growing homeless populations in the 1980s tended to overflow such niches. In Los Angeles, in contrast, city "containment" policies sustained Skid Row as the site where homeless individuals and the agencies that serve them are concentrated. Lamp was founded in 1985 as Los Angeles Men's Place, a store front drop-in center where homeless men could get off the street and receive voluntary and accessible help with basic needs (food, clothing, showers, toilets), as well as health screening, payee and advocacy services. From the beginning, Lamp focused on people with serious mental illnesses and over time has taken on the issues of substance use and dual diagnosis as well. As it grew, Lamp rethought an initial commitment to abstinence and sobriety and now integrates harm reduction approaches into all of its program components. Other changes have involved serving women as well as men; and the development of Lamp Village as the site of a transitional housing program along with several businesses that provide employment for Lamp guests and other neighborhood residents as well as services (linen service, commercial laundry, public toilet and shower, and a market) to the Skid Row community. The agency also operates Lamp Lodge, which provides permanent housing in 43 studio and seven one-bedroom apartments. In the late 1990s, the agency purchased a ranch, located several hours north of Los Angeles, where groups of participants from all Lamp sites, accompanied by staff, take brief or longer vacation trips.

Lamp now encompasses a large community with a staff of 100 individuals, of whom close to half are current or former Lamp guests. The agency's services respond to an array of conditions between street homelessness and permanent housing. Lamp's various sites are in close proximity, which has facilitated movement from homelessness to housing, but also between settings – in any direction – as people's needs for support change. Across the agency's constituent programs, all services – including psychiatric and substance abuse treatment – are voluntary, with harm reduction an underlying value, along with respect, diversity, and tolerance.

Ballington and Pershing Programs: Target Population, Program Model and Services

Target Population. Lamp's programs at the Ballington and Pershing programs draw tenants from within the Lamp community, which is made up of homeless men and women with mental illnesses who live in Lamp shelters or transitional housing programs, work in Lamp's businesses, or attend the Day Center or other programs. Many are also struggling with substance abuse problems and many have spent years on Skid Row, but neither dual diagnoses nor duration of homelessness are criteria for entering the Ballington or Pershing; there are no formal criteria for admission to these housing programs beyond those that define the Lamp community. However, site-specific considerations have influenced Lamp referrals to each building. The Ballington is adjacent to Lamp's Day Center and Shelter, and initially Lamp expected that this would make Ballington's housing units ideal for people needing staff support. However, as the program was implemented, complaints from the agency that operates the site created pressure to reserve Ballington units for individuals who could accommodate to that agency's rules and concerns. Other factors affected referrals to the Pershing: its distance from other Lamp programs made it more desirable for tenants who did not need a great deal of daily support from Lamp staff; and a steep entry staircase precluded housing people with limited mobility at the Pershing.

Program Model. The Ballington and Pershing housing programs entail Lamp's collaboration with other providers in the Skid Row area, though the structure of that collaboration differs at the two sites. The Ballington, a three-building complex of over 200 units immediately adjacent to Lamp's Day Center and Shelter, is owned and operated by Volunteers of America (VOA). Difficulties in maintaining full occupancy led VOA to enter into an agreement with Lamp to master lease units in one building, with the expectation that eventually Lamp would lease a total of 25 permanent and shelter 9 units. At the Pershing, a 67-unit SRO owned and managed by Skid Row Housing Trust (SRHT), a housing developer with numerous other buildings in the neighborhood, Lamp contracted for 17 rooms, which included 15 single housing units (five subsidized by Shelter Plus Care, and ten for rental at the market rate), a community room, and a room for a resident staff member. While Lamp participated in the intake process, tenants rented directly from SRHT.

Lamp's collaboration with VOA and SRHT was complicated by contrasting values, priorities and organizational cultures (the conflict between harm reduction and 12-step approaches to substance addictions; the different needs and perspectives of support service providers and property managers). The process of negotiating everything from admission and eviction policies to house rules with another agency threw into relief each group's core mission and defining values. Since these agencies generally target a broader low-income population for their housing programs, Lamp staff members engaged in considerable education and advocacy with the host agencies regarding tenants with mental illness.

Staffing and Services. Lamp's director of housing services, responsible for all Lamp housing programs, was assisted by a housing manager who moved across the sites, working with individual tenants and offering support to resident advocates who staffed the housing sites. Advocates provided on-site case management, counseling, groups, advocacy, escorts to activities and appointments, and referrals. Tenants who receive services at the sites also remain part of the larger Lamp community, where they may be involved in work, treatment programs, and other activities.

At the Ballington, Lamp master leased the available units from VOA. Despite the Ballington's proximity to other Lamp programs at the Day Center, the on-site presence of Lamp staff remained limited. No overnight housing staff were on-site at the Ballington; in the event of emergency, tenants received assistance from the VOA front desk staff or contacted a Lamp resident advocate who resided in another part of the Ballington housing complex. Initially, the major issue between Lamp and VOA involved tenant behavior, and VOA pressed Lamp to pre-select tenants who could manage without intensive support. Program start-up occurred at the Ballington in February, 2000, and after fifteen months, Lamp was leasing and using ten permanent housing units (plus seven units that provided shelter for thirteen Lamp guests, and two units that accommodated a resident advocate and a Lamp office). Over the next two years, only one additional unit became available for permanent housing at the Ballington, far short of the 25 originally planned.

Lamp tenants began moving into the Pershing in November, 2000, and by mid-2001, 15 were residing in Lamp's designated units, while the remaining two designated rooms housed Lamp's resident advocate and an office/community room. Several additional rooms at the Pershing were occupied by tenants who met criteria to receive Lamp services (formerly homeless individuals with mental illness), and they were encouraged to participate in Lamp services as well. In the early stages of program development at the Pershing, where tenants entered into leases directly with the Skid Row Housing Trust, the lack of rental income when any Lamp unit was vacant created tension between SRHT and Lamp. Subsequently a more productive collaboration between the agencies began to emerge as SRHT added a staff position devoted to developing the supportive housing model across SRHT properties.

II. PROFILE OF LAMP TENANTS

Characteristics of Tenants

	Ballington	Pershing
Gender:	• 52% male	• 76% male
Average age:	• 45.24 years	• 40.85 years
Race/Ethnicity:	• 38 % Black • 52 % White • 10 % Latino	• 62% Black • 29% White • 5% Latino
Ever married/domestic partner	• 33% ever married	• 14 % ever married
Family contact	• 43% no family contact	• 52% no family contact
Education	• 64%high school or more	• 74%high school or more
Employment	• 38% employed in past 5 years	• 53% employed in past 5 years
Primary means of support	• 100% entitlements	• 81% entitlements
Duration of Homelessness	• 33% more than 4 years	• 40% more than 4 years
Incarcerated	• 48% had been incarcerated	• 52% had been incarcerated
Number of serious health conditions	• 48% had 2+ health conditions	• 25% had 2+ health conditions
Psychiatric Diagnosis **Substance Abuse** **Dual Diagnosis**	• 86% psychotic diagnosis • 62% ever abused substances • 38% dual diagnosis	• 65% psychotic diagnosis • 38% ever abused substances • 24% dual diagnosis

Services Received from Lamp Prior to Housing Programs

	Ballington	Pershing
Services provided directly		
	• Food/shower: 91% • Drop-in services: 91% • Entitlements: 57% • Legal: 10% • Healthcare: 57% • Mental health: 81% • Substance abuse: 38% • Other services: 76%	• Food/shower: 81% • Drop-in services: 81% • Entitlements: 57% • Legal: 10% • Healthcare: 33% • Mental health: 48% • Substance abuse: 47% • Other services: 67%
Service referrals to other agencies		
	• Entitlements: 14% • Legal: 10% • Medical treatment: 62% • Mental health: 52% • Substance abuse: 14%	• Entitlements: 5% • Legal: 5% • Medical treatment: 43% • Mental health: 38% • Substance abuse: 19%

Services Received by Tenants at Lamp Housing Programs

	Ballington	*Pershing*
Services provided directly		
	• Housing: 100% • Money managem't: 81% • Entitlements: 38% • Training/work: 52% • Health care: 76% • Mental health: 95% • Substance abuse: 48% • Legal: 24% • Family: 71% • Socialization: 76%	• Housing: 100% • Money Managem't: 81% • Entitlements: 29% • Training/work: 71% • Health care: 52% • Mental health: 86% • Substance abuse: 52% • Legal: 29% • Family: 57% • Socialization: 86%
Service referrals to other agencies		
	• Housing: 43% • Entitlements: 48% • Health care: 52% • Mental health: 48% • Legal: 10%	• Housing: 36% • Entitlements: 24% • Health care: 19% • Mental health: 33% • Legal: 0%

Tenant Outcomes

	Ballington	Pershing
Engagement Outcomes		
Highly engaged (rated 4 or 5) in:		
relationship	• 52% highly engaged	• 48% highly engaged
concrete services	• 67% highly engaged	• 60% highly engaged
complex services	• 24%highly engaged	• 24%highly engaged
housing	• 40% highly engaged	• 55% highly engaged
Housing Outcomes		
One-year outcomes	• 40% still at site • 35% other housing • 5% transitional • 20% jail	• 48% still at site • 14% other housing • 14% transitional • 14% jail
Two-year outcomes	• 35% still at site • 50% other housing • 5% transitional • 10% jail	• 24% still at site • 43% other housing • 14% transitional • 19% jail

III. PROGRAM STATUS 2003

During 2002-2003, Lamp carried out a series of administrative and program reorganizations. A new Clinical Director was hired to develop group and individual counseling at the Lamp program and housing sites. Lamp's ranch was sold and the program there was disbanded, while the agency concentrated on securing ownership of its Skid Row sites. By Fall, 2003, a long-planned renovation of Lamp's shelter and day center site was underway, and the housing sites were also reorganizing the support services provided by housing advocates.

Over the course of their collaboration, Lamp's relationship to both VOA and SRHT was redefined. At the Ballington, the additional rooms that Lamp expected to master lease did not materialize. The units already leased remain under Lamp's purview, though one permanent housing unit was turned into a shelter unit to accommodate shelter participants displaced by renovations at Lamp's main shelter site. Rather than pushing VOA to add units to the master lease, Lamp has instead begun to refer individuals directly to VOA as regular Ballington tenants, and plans to continue in this manner rather than extending the units covered by the master lease. At Pershing, Lamp and SRHT have ended the contract designating 17 units for Lamp (15 for housing and two for office purposes). Instead, Lamp has become a service provider for all Pershing tenants interested in services, and Lamp staff at the site work closely with SRHT's designated "lead advocate." By November, 2003, 20 Lamp members lived in the Pershing. Lamp and SRHT had arrived at a division of responsibilities (property management for SRHT, provision of support services for Lamp) similar to the

DAH buildings as well as many other supportive housing venues. In addition, Lamp and SRHT agreed to replicate this structure in another SRHT building. While Lamp's Ballington and Pershing tenants continue to work with advocates at various Lamp program sites, the agency is in the process of staffing each housing program with one or two clinically experienced "lead advocates" and one or more "support advocates."