

Unlocking the Door

An Implementation Evaluation of Supportive Housing
for Active Substance Users in New York City



The second paper from CASAHOPESM (full version)



COLUMBIA

The National Center on
Addiction and Substance Abuse
at Columbia University



Acknowledgements from the Authors

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CASAColumbia is a science-based, multidisciplinary organization focused on transforming society's understanding of and responses to substance use and the disease of addiction. Founded in 1992 by Former U.S. Secretary of Health, Education, and Welfare Joseph A. Califano, Jr., CASAColumbia remains the only national organization that assembles under one roof all of the professional skills needed to research and develop proven, effective ways to prevent and treat substance abuse and addiction to all substances — alcohol, nicotine as well as illegal, prescription and performance enhancing drugs — in all sectors of society.

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INTRODUCTION

CASAHOPESM (Housing Opportunities Program Evaluation)

In November 2005, Mayor Bloomberg and Governor Pataki announced the New York/New York III (NY/NY III) agreement, a \$1 billion commitment between the City and State to develop 9,000 new units of supportive housing in New York City. NY/NY III is larger in scope than the previous two NY/NY agreements and is the first to include housing for people without serious mental illness (SMI). While the scale of the commitment and the expanded target populations of NY/NY III signal the City and State's promotion of supportive housing as an effective intervention, the optimism behind supportive housing is most clearly exemplified by the addition of a housing category, often referred to as 'Population E', for chronically homeless individuals whose substance use is a primary barrier to independent living. NY/NY III's supportive housing for Population E does not require tenants to enter treatment or stop using alcohol or drugs. While there are a number of programs in the country that have moved away from sobriety as a prerequisite for housing, this is the first large-scale, public-sector investment of its kind.

The Conrad N. Hilton Foundation funded CASAHOPE (Housing Opportunities Program Evaluation) to evaluate the unique work being done by the Population E scattered-site supportive housing programs. Additional units within single-site supportive housing developments for Population E are planned, but are not the focus of this evaluation. CASAHOPE's aim is to study whether it is feasible to develop non-abstinence based scattered-site supportive housing programs for this population; which program features (among those implemented) appear most promising; the resources (e.g., costs) and organizational capacity (e.g., staff training) required to implement such programs; and tenant characteristics and service usage after receiving one year of housing. CASAColumbia has partnered with the Corporation for Supportive Housing (CSH) to assess program implementation and to provide technical assistance to the programs housing Population E.

THE CURRENT PAPER

This paper is the second in a series produced by CASAHOPE on supportive housing for Population E and will examine program implementation. The first paper, *Characteristics of Persons Housed by NY/NY III's Supportive Housing for Active Substance Users*, presented findings on tenant characteristics from baseline interviews conducted between 2008 and 2009. Papers that follow will describe tenant outcomes, government services utilization, and economic impacts. All CASAHOPE papers, including a brief version of the current paper, can be found at www.casacolumbia.org/CASAHOPE.

Focusing on the first three years of program practice, this paper is organized as follows:

- **Section 1** offers an overview and history of the NY/NY III agreement and the inclusion of Population E;
- **Section 2** describes the methods used to collect the findings presented in this paper;
- **Section 3** provides a complete picture of the motivation and objectives behind housing for Population E, as well as its development and structure;
- **Section 4** presents the lessons learned, challenges, and promising practices that emerged during the first three years of housing, as well as an assessment of program implementation using intended program components identified by NY/NY III stakeholders; and
- **Section 5** presents conclusions and recommendations for municipalities and organizations that may be considering a similar approach to housing chronically homeless individuals for whom substance use is a primary barrier to independent living.

The realities of implementing complex supportive housing programs are often not evident in discussions of tenant characteristics, outcomes, or costs. With that understanding, the central aim of this paper is to share heretofore tacit knowledge about providing supportive housing for chronically homeless individuals whose substance use is a primary barrier to independent living. The current paper is designed specifically for a policy audience, particularly government administrators and housing organizations who are considering creating similar programs in other parts of the country.

SECTION 1: BACKGROUND AND HISTORY OF POPULATION E SUPPORTIVE HOUSING

WHAT IS POPULATION E?

Supportive housing for Population E was created as part of the New York/New York III (NY/NY III) Supportive Housing agreement, a commitment by the City and State of New York to invest in and create 9,000 units of supportive housing in New York City over a ten year period. The term ‘Population E’, or sometimes ‘Category E’, refers to one of the nine eligible population groups targeted by NY/NY III—specifically, chronically homeless single adults without serious mental illness (SMI) who have a substance abuse disorder that is a primary barrier to independent living. For the purposes of this paper, ‘Population E’ will also be used to refer to the specific programs providing supportive housing to this group.

Like other supportive housing, housing for Population E is permanent, heavily subsidized, and linked to flexible case management services. These services are designed to help homeless individuals exit homelessness, attain housing stability, and through connections to an array of services, improve their health and overall quality of life. Although prior supportive housing models in New York City serve people with active substance use disorders, these existing ‘Housing First’ models—supportive housing models that serve homeless people with behavioral health conditions (typically including substance use issues) without requiring them to first undergo treatment, achieve sobriety, or achieve stability—focused on people with a co-occurring SMI. Population E supportive housing is unique in its inclusion of tenants without SMI and, consequently, had no direct precedents. At the same time, Population E supportive housing draws heavily from other ‘Housing First’ models.

The NY/NY III agreement included financing to create both single-site supportive housing for Population E—where tenants are offered housing units within newly developed supportive housing buildings with on-site services—and scattered-site housing—where tenants are placed into subsidized private market apartments and provided with services through mobile case management teams. In total, 574 units of scattered-site Population E supportive housing units were awarded to nine New York City housing agencies (in alphabetical order—BRC, The Bridge, CAMBA, Common Ground, The Doe Fund, Project Renewal, Turning Point, Urban Pathways, Volunteers of America of Greater New York), 74 more units than originally intended. These additional 74 units were part of already existing Housing First scattered-site supportive housing programs operated by two of the awarded agencies. While this paper focuses on the implementation of Population E’s scattered-site units, this section will first provide a wider programmatic and historical context for the entirety of Population E supportive housing.

NEW YORK/NEW YORK III AGREEMENT OVERVIEW

In signing the NY/NY III Supportive Housing agreement, Governor George E. Pataki, Mayor Michael R. Bloomberg, and the Commissioners of ten State and City agencies entered into the fifth such agreement to invest in and create supportive housing, and the third such agreement to carry the ‘New York/New York’ moniker. Thus, NY/NY III was built upon a fifteen-year history of intergovernment and interagency collaboration, and the policies and processes established within that history. At the same time, NY/NY III departed from its predecessor agreements in some significant ways.

First, in calling for the creation of 9,000 units valued at \$1 billion in capital and \$150 million annually in operating and services funding, NY/NY III far surpassed the unit development goals and investment levels of all prior agreements combined, not to mention far surpassing any investment in supportive housing made by any other State or municipality anywhere. In terms of its volume and scale, NY/NY III set a new precedent for what a State or municipality could do to invest in the creation of supportive housing.

NY/NY III also departed from prior City-State agreements in its scope. Whereas all prior supportive housing agreements had limited the focus and eligibility to homeless individuals with serious mental illness (as defined by the State Office of Mental Health), NY/NY III extended the supportive housing model to a wider range of homeless populations, including families with children, transition-age young adults, people living with HIV/AIDS, and people whose primary clinical diagnosis was an addiction disorder or substance abuse (see table below). The term ‘NY/NY’ has been a veritable household name among personnel working in homeless assistance or other human services in New York City; however, NY/NY III broke new ground by no longer restricting supportive housing to the domain of the mental health system. With NY/NY III, ‘NY/NY’ became associated with the supportive housing intervention itself, not just the seriously mentally ill population.

NY/NY III Housing Unit Production Goals by Population			
Population	Single-Site	Scattered-Site	Total
A. Chronically homeless single adults who suffer from a serious and persistent mental illness or who are diagnosed as mentally ill and chemically addicted (MICA)	3,200	750	3,950
B. Single adults who are presently living in NYS-operated psychiatric centers or State-operated transitional residences and who could live independently in the community if provided with supportive housing and who would be at risk of street or sheltered homelessness if discharged without supportive housing	500	500	1,000
C. Young adults, ages 18-25, who have a serious mental illness being treated in NYS licensed residential treatment facilities, State psychiatric facilities or leaving or having recently left foster care, and who could live independently in the community if provided with supportive housing, and who would be at risk of street or sheltered homelessness if discharged without supportive housing	200	0	200
D. Chronically homeless families, or families at risk of becoming chronically homeless, in which the head of the household suffers from SMI (severe mental illness) or a co-occurring Mental Illness and Chemical Addiction (MICA) disorder	400	0	400
E. Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living	250	500	750
F. Homeless single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness, and who need transitional supportive housing (that may include half-way houses) to sustain sobriety and achieve independent living	250	500	750
G. Chronically homeless families, or families at serious risk of becoming chronically homeless, in which the head of the household suffers from a substance abuse disorder, a disabling medical condition, or HIV/AIDS	750	0	750
H. Chronically homeless single adults who are persons living with HIV/AIDS (who are clients of the New York City HIV/AIDS Services Administration (HASA) or who are clients with symptomatic HIV who are receiving cash assistance from the City) and who suffer from a co-occurring serious mental illness, a substance abuse disorder, or a MICA disorder	600	400	1,000
I. Young adults (aged 18-25) leaving or having recently left foster care or who had been in foster care for more than a year after their 16 th birthdays and who are at risk of street homelessness or sheltered homelessness	100	100	200
Total Units	6,250	2,750	9,000

In a third departure from previous NY/NY agreements, NY/NY III extended responsibility for financing and developing the units to a larger set of City and State agencies. Whereas the prior City-State agreements encompassed only the public mental health agency and a subset of the City and State housing finance agencies, NY/NY III included 10 City and State agencies as signatories for the agreement and as the entities designated to receive the funding appropriations and authority to implement NY/NY III. The full list of State and City agencies designated to implement NY/NY III follows:

Agencies Designated to Implement NY/NY III	
New York State	New York City
Office of Alcoholism and Substance Abuse Services (OASAS)*	Administration for Children’s Services (ACS)*
Office of Children and Family Services (OCFS)*	Department of Health and Mental Hygiene (DOHMH)
Division of Housing and Community Renewal (DHCR)*	Department of Homeless Services (DHS)
Office of Mental Health (OMH)	Department of Housing Preservation and Development (HPD)
Office of Temporary and Disability Assistance (OTDA)*	Human Resources Administration / Department of Social Services (HRA)

** Not previously involved in implementing supportive housing as part of City-State agreement*

The timetable for NY/NY III implementation projected the creation of all scattered-site units within the first four years, with single-site units becoming available over a ten year period as development projects are completed. The agreement also established an Oversight Committee, consisting of one representative from each City and State agency, which would oversee the implementation process, ensure the timely and successful production of units as scheduled, and make modifications to the implementation process as needed. In addition, certain agencies were designated to play specific roles in implementation. Capital funding was to be provided for the development of single-site units by DHCR, HPD, OTDA, and OMH. Three agencies—OMH, DOHMH, and OASAS—would have the responsibility for contracting with nonprofit agencies to operate and provide services in NY/NY III supportive housing. HRA would have responsibility for screening and determining eligibility for individuals and families along the nine population categories.

A fourth way that NY/NY III departed from its predecessors was in the adoption of new processes intended to reduce “creaming”, wherein tenant selection procedures by programs tended to favor less vulnerable, more highly motivated, and substance-free individuals. Recent national research found that the most vulnerable subset of homeless individuals were chronically homeless people who tended to remain homeless for extended periods due to their complex service challenges. Combined with the City’s interest in reducing their sheltered and street homeless census, NY/NY III used this research to prioritize chronically homeless individuals and families for placement into supportive housing. Five of the nine target populations were restricted to the ‘chronically homeless’ as defined here:

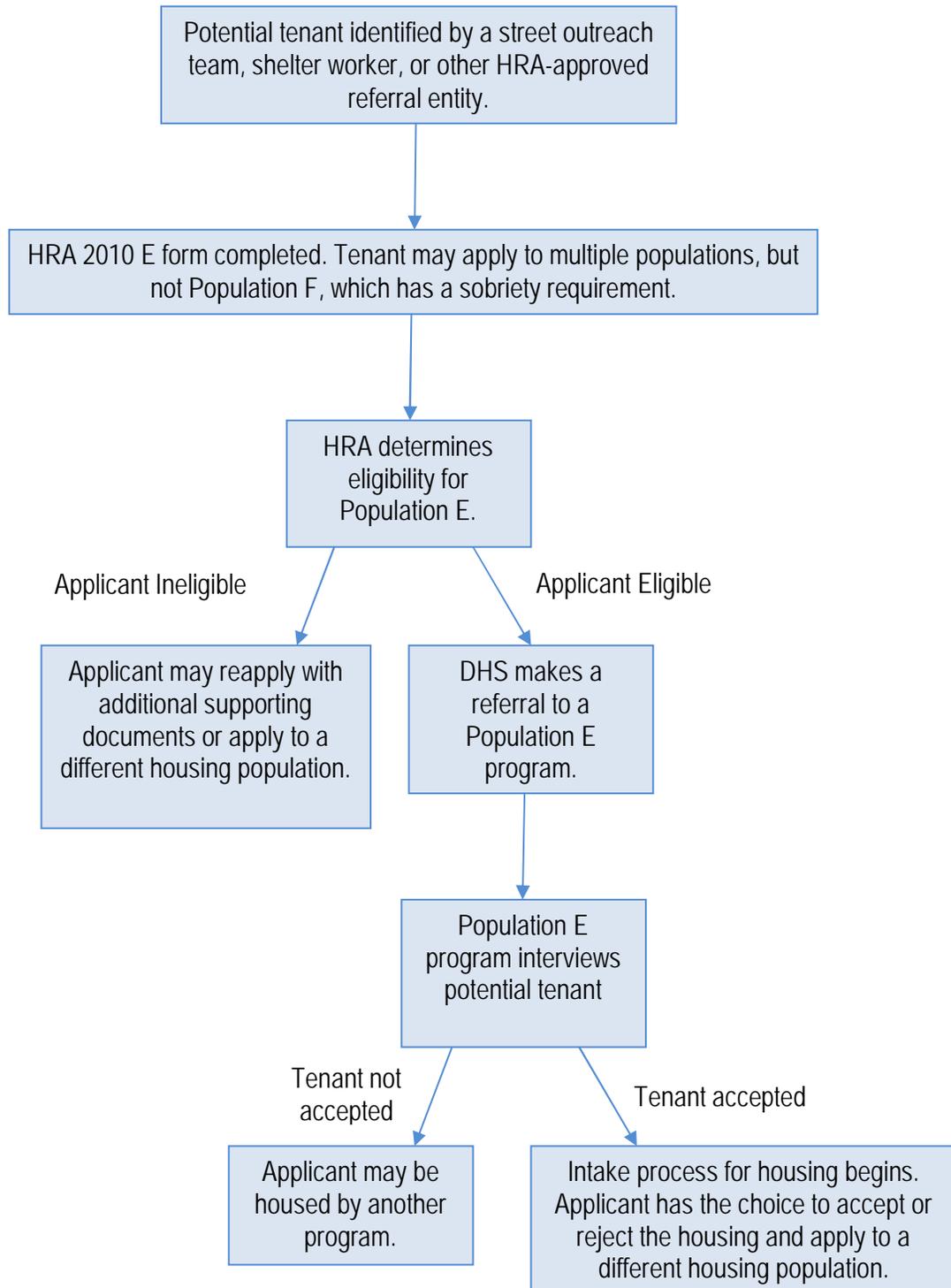
- A single adult who has spent at least two of the last four years in a homeless shelter or living on the street
- A single adult who is disabled and has spent at least one of the last two years in shelter or living on the street

- A family which has lived in a homeless shelter for at least 365 days of the last two years, not necessarily consecutively.

In April 2009, in order to address slow referral flow, the eligibility requirements for NY/NY III's Population E, were changed in two ways: (1) potential tenants with active substance use no longer needed a co-occurring disabling clinical condition to be considered for Population E and (2) the definition of chronic homelessness was changed to include individuals who have been homeless only six of the previous 12 months.

The NY/NY III Oversight Committee also put in place a new referral process to ensure that the most vulnerable individuals would not be screened out of eligibility for supportive housing by programs. In this new referral process, certain City and State agencies became designated as 'referring entities' and became responsible for making referrals of eligible NY/NY III individuals or families to the programs. In this new process, individuals or families seeking supportive housing under NY/NY III first apply by completing HRA's electronic application form, the HRA2010e. HRA then screens all applicants for eligibility along one of the nine possible categories. Once eligibility is determined, HRA makes the lists of eligible applicants available to the following referring entities: DHS for Populations A, D, E, F, and G; ACS for Population I; HRA for Population H; and OMH for Population B and C. For their respective populations, these referring entities determine which eligible individuals or families should receive priority and make referrals to programs accordingly. In addition, DHS and ACS instituted a policy in which three referrals are made for every vacant unit, and contracted NY/NY III programs are required to accept at least one of the three referrals.

Centralized Eligibility Review and Referral Process for NY/NY III Population E



Still another way that the City and State sought to ensure that the most vulnerable subset of the homeless were housed was by contracting into the agreement the inclusion of a specific approach to supportive housing known as Housing First. Specifically, this can be seen in supportive housing for Population E, which serves people with active and untreated substance use conditions and was intended to incorporate the key principles and practices of the Housing First model. The inclusion of Housing First through the Population E units is arguably the boldest and most innovative aspect of the New York/New York III agreement, signifying the willingness of its signatories to adopt a new strategy to achieve their policy goals. Indeed, at the time when NY/NY III was established, Housing First was not only not widely used by many of New York City's nonprofit supportive housing agencies, but also somewhat controversial. At the same time, the Housing First model is, in many ways, a revival of some of the original principles and motivations at the origin of supportive housing in New York City.

HOUSING FIRST IN THE HISTORY OF SUPPORTIVE HOUSING IN NEW YORK CITY

Understood in its historical context, the supportive housing created for NY/NY III's Population E is innovative yet completely consistent with the original intent of supportive housing in New York City. On the one hand, these programs were the first attempt by any jurisdiction to systematically invest in and create Housing First supportive housing for people whose substance use is a primary barrier to independent living at an unprecedented and unmatched scale of 750 units. At the same time, this housing was also a kind of successor to the earliest supportive housing models, in many ways embodying the original intent and principles that led to supportive housing's invention in the first place. Supportive housing for Population E must be understood in the context of the histories of homelessness and supportive housing in New York City and the emergence of Housing First as an approach to extending supportive housing to vulnerable homeless individuals.

The Origin of Supportive Housing in New York City

Although it is most often thought of as a homelessness intervention, supportive housing's origins in New York City in the late 1970s actually predate the emergence of homelessness as a specific policy arena (the term 'homeless' as a special population was not in wide use until the 1980s). It was during the late 1970s that social workers, advocates, and City and State officials alike became concerned about the growing number of poor individuals and families that had been living in the City's then plentiful stock of commercial Single Room Occupancy (SRO) hotels. These commercial SRO hotels were associated with crime, violence, and the devaluation of properties—some described its residents as “drug addicts, persons with criminal records or discharged mental patients”. Public pressure mounted to close the City's commercial SRO hotels. Just as State and City officials considered ways to close down and vacate commercial SRO hotels, an alternative solution arose: acquire, renovate and convert commercial SRO hotels into nonprofit-managed, low-cost housing with on-site services to address the needs of existing tenants and people facing similar challenges. In 1980, two Franciscan Friars founded St. Francis Friends of the Poor, acquired the Beechwood Hotel and converted it into the St. Francis Residence. Soon after, in 1983, the first jointly City-State financed supportive housing project, known as The Heights, was rehabilitated.¹

With no precedents or 'evidence based practices' to look to, the provider of housing and services in the St. Francis Residence, the Heights, and other early supportive housing drew upon what skills and knowledge they had from social work practice and training, but relied on improvisation and trial-and-error to respond to the complex needs they found among tenants, including: untreated and serious mental illnesses; low to no incomes; lack of access to (or refusal to take) medications; high rates of drug and alcohol use; and resistance to participating in services. A model began to form: participation in services was not made a condition of tenancy, but workers were assertive in

¹ Houghton, T. (2001) *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals*. Retrieved from http://www.csh.org/wp-content/uploads/2011/12/Report_NYNY.pdf.

engaging and building relationships with tenants; drug and alcohol use among tenants was accepted as a reality, rather than treated as a problem behavior or rule violation in itself. Responding to the immediacy of the needs found among SRO tenants, these buildings “made the subtle but significant shift from clinical and treatment-oriented services to a focus on providing the supports necessary to maintain the tenants’ long-term stability in housing, thereby ensuring that those receiving services were ‘tenants first and clients second.’”² Unrefined as the approach may have been, it was highly attuned and tailored to tenant need.

At around the same time, growing numbers of people were living on the streets and in public settings exhibiting behavioral health conditions. Legal advocacy mounted to force the City to respond to this new “homelessness” crisis. The settlement of a resulting lawsuit culminated in a consent decree in 1979 known as *Callahan v. Carey* which required the City to provide emergency shelter to all homeless single adults seeking it. As a result, the City’s number of shelters nearly tripled. Meanwhile, more specialized housing units for homeless and deinstitutionalized individuals were being created through SRO conversion funded with City and State resources, but the need for this housing far outpaced supply. By the end of the decade, political pressures, public concern, and efforts by advocates for the homeless had reached new levels. The City and State entered into discussions about how to more systematically create housing with services for the homeless. These discussions eventually resulted in the enactment of the New York/New York agreement to House Homeless Mentally Ill Individuals (NY/NY I) on August 22, 1990, which committed State and City funding to create 3,314 units of supportive housing and transitional residential programs known as ‘licensed housing’ for homeless persons with mental illness.

NY/NY I was both largely driven by and viewed as the domain of the State Office of Mental Health (OMH) and its existing set of housing models. Nonetheless, it achieved the unimaginable—a large-scale investment of State and City resources (made cooperatively by a Governor and Mayor) to finance the capital, operating, and services costs of thousands of supportive housing units. Moreover, NY/NY I marked the first time that OMH had invested its resources in the creation of permanent housing; all prior OMH housing had been transitional, licensed, and heavily programmatic in nature. Studies have now shown that NY/NY I was cost-effective, preventing returns to homelessness and nearly paying for itself by reducing tenants’ use of emergency public services like shelters, psychiatric hospitals, prisons, and jails.³ In addition, NY/NY I gave supportive housing a public endorsement and a policy vehicle, thereby elevating the model from its origins as a home-grown community experiment to its current place as a central part of the public response to the crisis of homelessness.

In making this shift, however, supportive housing in New York City became an intervention closely associated with, and linked to, the public mental health system. Eligibility for NY/NY I supportive housing required that all homeless individuals needed to meet OMH’s threshold of serious and persistent mental illness. Furthermore, NY/NY I attracted more and more nonprofit community mental health service providers to the creation and provision of permanent supportive housing. These providers brought to the supportive housing many of the services and case management approaches rooted in community mental health practice—with both positive and mixed results. On the one hand, services in supportive housing reached a new level of professionalism and consistency. On the other hand, in some instances, individuals in supportive housing were not always viewed as tenants first and clients second, and programmatic goals sometimes held primacy over the goal of housing stability. The official adoption of

² Houghton, T. (2001) *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals*. Retrieved from http://www.csh.org/wp-content/uploads/2011/12/Report_NYNY.pdf.

³ Culhane, D.P., Metraux, S., & Hadley, T. (2002). Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing. *Housing Policy Debate*, 13(1), 107- 163.

supportive housing into State and City policy resulted in a slight departure from the raw, improvised, need-driven nature of the original model.

Nowhere was this more evident than in the approach to substance abuse. Whereas the early providers of supportive housing working with residents in commercial SRO hotels had little choice but to confront and contend with substance abuse among the residents, many of the newer generation of supportive housing agencies adopted a stance that was prevalent in the community mental health system at the time. Namely, substance use was viewed as a condition outside the domain of mental health services and often grounds for exclusion from supportive housing. As a result, more and more supportive housing agencies began imposing selection criteria requiring applicants to demonstrate three, six, or nine months of sobriety in order to obtain housing, along with adherence to rules which stated that relapse into addiction could be grounds for termination of services and eviction.

This recasting of supportive housing to align with the mental health system continued with a second New York/New York II agreement (NY/NY II) in 1999, which funded capital, operating, and services for the creation of 1,500 units of supportive housing. NY/NY II increased the share of permanent supportive housing units over licensed units, updated project models (replacing single-room occupancy units with larger self-contained studio units), and for the first time included scattered-site units (units leased on the private market with services provided through mobile case management teams). However, eligibility for NY/NY II supportive housing retained the same exclusive focus on homeless persons with serious mental illness. In two subsequent smaller supportive housing agreements, referred to as the 'High Service Needs' (HSN) Initiatives I and II, enacted in 2000 and 2003, the City and State extended eligibility to people leaving psychiatric centers as well as correctional facilities, but similarly limited the units to people with serious mental illness.

By the time discussions regarding a third New York/New York agreement began in 2004, the term 'NY/NY' had become almost synonymous with serious mental illness. Many agencies continued to require 'clean time' as an entry requirement for NY/NY supportive housing, and to view substance use, addiction, and relapse as grounds for termination of services and eviction. Meanwhile, City and State officials watched with concern as the number of individuals in homeless shelters and on the streets continued to rise. Field experience indicated that the individuals who remained homeless for long periods of time were unable to enter housing because their primary clinical challenges were substance abuse disorders, addiction so complicated that they had not been responsive or open to treatment.

Emergence of Housing First

While supportive housing was being created through the NY/NY and HSN agreements, other nonprofit supportive housing agencies in New York City and in other communities began to experiment with models and approaches that neither denied housing to homeless individuals due to substance use, nor viewed substance use as program non-compliance or grounds for eviction. Instead, these models drew their inspiration, service philosophy, and approach from a public health approach in which the goal of services was to confront and reduce the harms associated with substance use, as opposed to enforcing and requiring abstinence. Collectively, supportive housing that did not predicate housing on service enrollment became known as 'Housing First.' Housing First supportive housing placed the emphasis above all on ensuring housing stability, since leaving individuals to remain homeless would only exacerbate their substance use and mental health conditions. Similar to the earliest supportive housing models, individuals became "tenants first and clients second." In this way, Housing First grew as a response to the licensed mental health residential programs and NY/NY supportive housing models that were increasingly viewed as restrictive, since they denied housing to individuals on the basis of their substance use, limited tenant choice and autonomy, and required participation in treatment and services as a condition for obtaining and maintaining housing.

The organization most associated with pioneering the Housing First model is Pathways to Housing. Pathways to Housing was founded in 1992 when Dr. Sam Tsemberis, frustrated at the current paradigm found within the public mental health system in New York, began offering scattered-site apartments to street homeless individuals with mental illness, who were visited by an interdisciplinary team of clinicians known as an Assertive Community Treatment (ACT) team. Pathways to Housing conducted street outreach to approach and offer housing to street homeless individuals who exhibited psychiatric symptoms. Tenants were not denied housing on the basis of substance use, and were not required to discontinue the use of drugs or alcohol, but were only required to be visited by members of the ACT team twice a month. Over nearly two decades, Pathways to Housing has expanded their housing portfolio to over 300 units in New York City, and has begun replicating the model in other cities including Washington, DC and Philadelphia. Studies of Pathways to Housing's program have shown impressive results in terms of housing retention (85 percent) and tenant satisfaction.⁴

In northern New York State, in the City of Troy, an organization known as Joseph's House created its own version of Housing First. Beginning as a provider of shelter and emergency homeless services, Joseph's House responded to the needs of shelter residents and the street homeless individuals its staff encountered by creating single-site supportive housing. Recognizing the significant substance use and alcohol issues among their shelter residents and other homeless clients, Joseph's House adopted a philosophy with respect to alcohol and drug use in which use was neither a grounds for rejection nor eviction, and where the focus of services was on engagement, motivational enhancement, client-centered services, and the reduction of behaviors that jeopardize housing and contribute to poor health.

Around the same time, Housing First supportive housing models also emerged specifically for homeless individuals living with HIV/AIDS. Reflecting their original intent as housing for people facing terminal illnesses, along with their ties to the public health arena, these HIV/AIDS supportive housing programs adopted Housing First principles early on. In many ways, the view that people with addiction issues should obtain housing that was not contingent on treatment completion or sobriety was less controversial among HIV/AIDS agencies like Housing Works, Bailey House, and Harlem United.

Meanwhile, far on the other side of the country, communities began creating Housing First models of their own. The City of San Francisco launched a Housing First supportive housing initiative known as Direct Access to Housing, in which the City Department of Health master-leased or purchased commercial SRO hotels and other buildings and then offered, through its City-operated Federally Qualified Health Center, intensive case management services to formerly homeless residents with mental health disorders. In Los Angeles, organizations like Lamp Community and Skid Row Housing Trust created and operated low-threshold models of supportive housing for homeless individuals in the City's infamous Skid Row neighborhood. In Seattle, organizations like Downtown Emergency Service Center (DESC) and Plymouth Housing Group created their own Housing First models. In 2007, DESC captured national media attention when it opened a supportive housing building that provided housing and services to 75 homeless individuals who were identified as the City's most chronic users of alcohol crisis services.

Pathways to Housing and other pioneers helped to set off a growing national movement around Housing First models of supportive housing. The Housing First approach reached new levels of legitimacy when it received the endorsement of the United States Interagency Council on Homelessness, which used its bully pulpit to urge communities to adopt Housing First supportive housing models as part of local and State efforts to end homelessness. More importantly, these Housing First models and the innovators who created them recaptured and

⁴ Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*, 94(4), 651–656.

reanimated the original spirit of supportive housing, where the approach to housing and services is driven by the practical necessity of ‘doing whatever it takes’ to achieve housing stability, as opposed to dogmatic adherence to treatment principles and protocols.

Yet despite growing national attention and its federal endorsement, Housing First models continued to represent a small subset of New York City’s supportive housing. The Housing First models that did exist were limited to individuals with serious mental illness (e.g. Pathways to Housing) or persons living with HIV/AIDS (e.g. Housing Works or Bailey House), and the Housing First model remained out of reach for the sizeable number of homeless individuals with addiction issues who had neither a serious mental illness nor HIV/AIDS. It was not until 2003 that New York City would obtain its first Housing First supportive housing program for homeless individuals with active substance use issues, who did not have a serious mental illness or HIV/AIDS. In that year, Project Renewal, a provider of comprehensive services for homeless individuals, received a grant through the federal Collaborative Initiative to End Chronic Homelessness demonstration program, and used it to create 60 units of scattered-site supportive housing for individuals identified as chronically homeless who had active addiction issues. This program, In Homes Now, was New York City’s first Housing First supportive housing project specifically targeted at homeless people who were active users of drugs and/or alcohol. The program was later incorporated into and expanded through the NY/NY III’s supportive housing for Population E.

With the enactment of NY/NY III and the inclusion of Population E, the City and State of New York would adopt Housing First as an official part of their canon of interventions to end homelessness in New York City. In so doing, the City and State set a new precedent, being the first in the nation to commit to publicly financing and creating a large inventory of Housing First supportive housing. At the same time, the City and State further revived the original spirit of supportive housing and its focus on reaching the most vulnerable subset of persons experiencing homelessness.

While the promise is that this approach is a more humane way to help homeless individuals with substance use issues, the purpose of the CASAHOPE evaluation is to examine whether this housing is practicable and effective in securing lives and saving taxpayer dollars. The following sections of this paper will specifically address the question of practicability by making clear the intent, goals, and Theory of Change behind this housing; examining the programs’ practice regarding key components of Housing First supportive housing models and of overall supportive housing quality; and summarizing the key lessons learned through program implementation.

SECTION 2: METHODS

DATA COLLECTION AND ANALYSIS

The findings presented in this paper are drawn from multiple sources: 1) interviews with key NY/NY III stakeholders; 2) interviews with program directors and focus groups with program case managers; 3) official public and program documents, 4) questionnaires administered to program staff, and 5) site visits and learning collaboratives. In combination, these sources of data provide a thorough and informed picture of each agency, their housing programs, program structure, staffing, and service delivery. Throughout this paper, the particular methods of data collection used to inform the findings in each section will be noted. All procedures involving data collection from the nine housing programs were approved by the governing Institutional Review Board (IRB) at CASAColumbia.

Interviews with Key Stakeholders

To identify the original program objectives behind supportive housing for Population E, interviews were held in Winter 2009-2010 with key stakeholders (i.e. policymakers, public administrators, experts, and advocates involved in the enactment and framing of the New York/New York III agreement). A qualitative semi-structured questionnaire was used to capture the impetus and intent driving the creation of this housing, gather expectations regarding the goals and outcomes of this program, and determine how stakeholders planned to establish whether or not the program had successfully achieved these goals (Appendix A).

In total, 8 informants were identified for interview participation through a review of public program documents, along with the research team's knowledge regarding the planning of New York/New York III. In alphabetical order, these participants included Laura Grund, the Director of New York City's Department of Health and Mental Hygiene's (DOHMH) Office of Housing Services; Daliah Heller, Ph.D., MPH, the Assistant Commissioner of DOHMH's Bureau of Alcohol and Drug Use Prevention, Care and Treatment; Frank Lipton, M.D., the Executive Deputy Commissioner of New York City Human Resources Administration; Robert Myers, Ph.D., the Executive Deputy Commissioner of New York State's Office of Mental Health; George Nashak, the Deputy Commissioner of New York City's Department of Homeless Services; William Panepinto, LMSW, the Director of New York State's Office of Alcoholism and Substance Abuse Services Bureau of Housing and Employment Services; Anne Siegler, the Harm Reduction Coordinator of DOHMH's Bureau of Alcohol & Drug Use Prevention, Care & Treatment; and Connie Tempel, the Chief Operating Officer of the Corporation for Supportive Housing. Note, the roles and agencies listed here for each stakeholder may have changed between the time interviews were conducted and the release of this paper.

Interviews were recorded and transcribed with the verbal consent of participants. Transcriptions were reviewed and responses were synthesized into the following categories: policy goal or intent behind inclusion of Population E, definition of success, desired outcomes, measures of success, core ingredients for success, acknowledged constraints and barriers to success, and concerns or doubts regarding success.

Interviews with Program Directors and Focus Groups with Program Case Managers

Individual interviews were held with each of the nine Population E program directors in Spring 2010. The qualitative semi-structured interview guides were designed using one industry-wide definition of supportive housing quality, CSH's *Seven Dimensions of Quality Supportive Housing* (see box below), and focused on multiple domains, including the philosophy of the housing agency and program, administrative structure, apartment management, social services, tenant rights, and documentation (Appendix B). Special emphasis was placed on the lessons learned, challenges, and best practices that emerged during the initial years of Population E program implementation. On average, interviews took 1.5-2 hours and were held at the CASAColumbia offices or at the program site. Interviews were recorded and transcribed with the written consent of participants.

In addition to individual program director interviews, two focus groups were held with program case managers in May 2010. All 31 case managers employed by the Population E programs at the time were invited to participate. In total, 28 case managers, representing all 9 programs, attended one or the other focus group. The qualitative semi-structured guide designed for the individual program director interviews was adapted for use with the case managers in a focus group setting (Appendix C). Nearly identical to the program director interview guide, questions were based on CSH's *Seven Dimension of Quality Supportive Housing*; however, the emphasis was placed on domains specific to the case managers, such as supervision and direct service provision. The focus groups were held at CASAColumbia and lasted 2-2.5 hours. Interviews were recorded and transcribed with the written consent of participants.

Transcribed notes from the interviews and focus groups were reviewed and analyzed through coding. Coding was completed in two stages, consistent with the coding-recoding approach recommended by Strauss⁵, Lincoln and Guba⁶, and Miles and Huberman⁷. In the first stage, segments of interview responses were coded to identify: a) statements indicating the level of adoption or adherence to particular practices or principles associated with CSH's *Seven Dimensions of Quality Supportive Housing*, b) key challenges of adopting or implementing a practice, and c) promising approaches or strategies. For this report, the seven Dimensions were adapted to the specific context of NY/NY III and Population E. Since the Population E programs observed were all scattered-site supportive housing, where apartments on the private market are leased and subsidized by the programs, Dimension 2 (Physical Environment) and Dimensions 5 (Property and Asset Management) were collapsed into a single dimension. Ultimately, this change and other adaptations resulted in six modified *Dimensions of Quality*:

- 1) Administration and Management
- 2) Housing Search, Housing Quality, and Landlord Relations
- 3) Access to Housing, Tenant Selection, and Eviction Prevention
- 4) Supportive Services Design and Delivery
- 5) Tenant Rights, Choice, and Participation
- 6) Tracking Outcomes and Defining Success

As an example of how interviews were coded according to the *Seven Dimensions of Quality Supportive Housing*, during the interviews and focus groups participants were asked about their program's approach to linking tenants with substance abuse treatment, which falls under 'Dimension 4: Supportive Services Design and Delivery'. Participants' described their program's approach as one that requires substance abuse treatment, forcefully encourages tenants to enter substance abuse treatment, or offers substance abuse treatment as an option. Responses were subsequently coded as an example of adoption or adherence, such that the former two responses would indicate divergence from an indicator of *Quality Supportive Housing*, which holds that all service enrollment should be driven by the tenants, whereas the third response would indicate adherence.

For interview transcriptions, coding also identified the program to determine each program's degree of adherence to various essential components of Population E as identified through the interviews with key stakeholders. The stakeholders' intended components are listed here and described in detail in Section 3:

- 1) Programs will emphasize and routinely offer staff training and skill building around motivational interviewing and other relevant skill areas.

⁵ Strauss, A.L. (1987). *Qualitative Analysis for Social Scientists*. Cambridge, UK: Cambridge University Press.

⁶ Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.

⁷ Miles, M.B. & Huberman, A.M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.) Thousand Oaks, CA: Sage.

- 2) Agencies will have prior experience with providing housing that is not contingent on tenant abstinence from alcohol and drugs.
- 3) Program directors and supervisors will provide quality supervision.
- 4) Programs will rarely deny housing to applicants based on substance use, criminal history, or lack of motivation to change.
- 5) Programs will use a client-centered and non-judgmental approach, service plans will be driven by tenants, and enrollment in a substance abuse treatment program will not be an assumed or enforced service.
- 6) Programs will provide specific services intended to minimize possible consequences of substance use such as sexual health education, overdose prevention, substance use management, and safe injection procedures.
- 7) Programs will actively engage and openly communicate with tenants about substance use.
- 8) Services will be comprehensive, encompassing many domains and responsive to individual needs.
- 9) Agencies will have access and strong linkages to primary and mental health services.
- 10) Programs will be well-equipped and effective around crisis intervention.
- 11) Programs will have skills and expertise in connecting tenants with benefits and entitlement systems.

We then reviewed the coded segments and original transcripts to identify and synthesize themes regarding a) adoption, b) challenges, and c) promising strategies. For instance, statements from multiple interviews that discussed conflicts in perspectives and philosophies between program staff and senior staff in agencies were grouped using a common thematic code signifying 'Agency-Program Misalignment'. Themes that emerged were then tested against the transcripts for their "fit" and prevalence, using an approach similar to what Lincoln and Guba describe as "discriminant sampling."⁸ Through this process, themes were refined, collapsed, and abandoned, until a sense of "saturation" and coverage was attained with respect to the nesting of information collected through interviews into themes. In other words, we tested and revised the synthesized themes through repeated review and recoding of the transcripts until we reached a sense that the themes were sufficiently and prominently supported by the transcript text, and until we had exhausted the text for all possible meaning and themes regarding adoption, challenges, and promising strategies.

Data analysis was also informed and strengthened through triangulation.⁹ We used both triangulation of multiple data sources, as well as triangulation of investigator perspectives. Data triangulation involved the comparison and verification of open-ended interview responses, close-ended responses to the pre-interview questionnaires, review of program documents, and our observations of the programs in meetings, learning collaboratives, trainings, and onsite visits that took place over the three-year period in which implementation guidance was provided. Thus the synthesis of themes from interview responses was informed by prior knowledge of the programs, and verified against information presented in other program documents and the close-ended responses to the pre-interview questionnaires. Second, coding was performed by multiple investigators. The first stage of coding was performed by staff at CASAColumbia, who coded the interviews into the categories described above. This coding was then reviewed and in some cases, modified by staff at CSH, who then performed the second and more interpretive stage of coding to identify themes.

⁸ Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

⁹ Denzin, N. K. (1978). Triangulation. In N. K. Denzin (Ed.), *The research act: An introduction to sociological methods*. New York: McGraw-Hill.

CSH's *Seven Dimensions of Quality for Supportive Housing*

Through communication with supportive housing tenants, providers, funders, and other stakeholders - and through involvement in successful supportive housing projects around the country - CSH has identified the following Seven Dimensions of Quality that can serve as a common framework among developers, property managers, service providers, and funders for assessing – and investing in – the quality of supportive housing units:

Dimension #1: Administration, Management, and Coordination

All involved organizations follow standard and required administrative and management practices, and coordinate their activities in order to ensure the best outcomes for tenants.

Dimension #2: Physical Environment

The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, sustainable, functional, appropriate for the surrounding community, and conducive to tenants' stability.

Dimension #3: Access to Housing and Services

Initial and continued access to housing opportunities and supportive services is not restricted by unnecessary criteria, rules, services requirements, or other barriers.

Dimension #4: Supportive Services Design and Delivery

The design and delivery of supportive services facilitate access to a comprehensive array of services, are tenant-focused, effectively address tenant needs, and foster housing stability and independence.

Dimension #5: Property Management and Asset Management

Property management activities support the mission and goals of the housing and foster tenants' housing stability and independence, and appropriate asset management strategies sustain the physical and financial viability of the housing asset.

Dimension #6: Tenant Rights, Input, and Leadership

Tenant rights are protected within consistently enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff - tenant relationships are characterized by respect and trust.

Dimension #7: Data, Documentation, and Evaluation

All involved organizations reliably capture accurate and meaningful data regarding the effectiveness, efficiency, and outcomes of their activities, and use this data to facilitate, and improve, the performance of those activities on an ongoing basis.

CSH has identified multiple indicators of quality which are described in the publication, "*The Seven Dimensions of Quality for Supportive Housing: Definitions and Indicators*," available for download at www.csh.org/dimensionsofquality.

Official Public and Program Documents

The research team reviewed public documents to determine the explicit program elements and approaches identified by the City and State agencies that oversee NY/NY III. These documents included the NY/NY III agreement itself, the DOHMH concept paper (Appendix D), and the DOHMH Request for Proposals (Appendix E). In addition, programs provided the research team with internal program documents, namely grant applications and blank copies of leases and tenant rights.

Questionnaires Administered to Program Staff

CASAColumbia and CSH asked the nine program directors to complete two written questionnaires developed to collect important details about program structure and service delivery. The first was the Housing Options

Information Form (HOIF), designed by the Center for Urban Community Services. In fall 2008, all 9 program directors completed this form, answering close-ended questions about staff number and structure, housing location and type, application and eligibility process, and service provision. In Spring and Summer 2010, 7 program directors completed a questionnaire in which the program directors and supervisors were asked to rate their program's degree of adoption of elements of quality Housing First supportive housing as designated by CSH's *Seven Dimensions of Quality Supportive Housing* (Appendix F). Respondents were provided with a series of statements that corresponded to CSH's indicators of quality supportive housing and asked to rate their agreement or disagreement with each statement as it related to their program.

Site Visits and Learning Collaboratives

The research team's understanding of the agencies, housing programs, program structure, staffing, and service delivery does not rely solely on formal data collection. To support the implementation of Population E, CASAColumbia contracted with CSH to provide technical assistance and training to the programs implementing Population E supportive housing. CSH approached the delivery of technical assistance through a learning collaborative model, wherein programs would reflect on their practice, identify implementation issues, discuss and share promising approaches, and collaboratively problem-solve around common challenges (see Appendix G for a complete description of CSH's learning collaboratives). From December 2007 through December 2010, CSH held 22 learning collaborative sessions. In 2009, at the request of programs and with the approval of CASAColumbia, CSH began offering and facilitating a separate learning collaborative for case managers and front-line staff. Among other benefits, the case managers learning collaboratives allowed for the sharing of effective approaches and strategies. In addition, a number of site visits were conducted between 2007 and 2010 to provide technical assistance on an as-needed basis. While an assessment of program implementation was not built into the technical assistance provided by CSH, the three years of interaction between the research team and program staff informed and strengthened the findings presented in this paper.

SECTION 3: IMPETUS AND INTENDED GOALS OF POPULATION E SUPPORTIVE HOUSING

Understanding why Population E was originally included in the NY/NY III agreement and how it was designed offers a useful framework for understanding its implementation. As described in Section 2, to capture the impetus and intended goals of Population E, the research team interviewed key stakeholders—policymakers, public administrators, experts, and advocates— and examined relevant documents regarding the original goals and intent of supportive housing for Population E as created through the NY/NY III agreement.

IMPETUS BEHIND POPULATION E SUPPORTIVE HOUSING

Interviews with key stakeholders of NY/NY III confirmed that the inclusion of Population E was driven by a similar motivation as that which drove the earliest supportive housing models—that is, the commitment to respond to the complex needs of a set of homeless individuals with behavioral health conditions. This time, however, the set of individuals were not the unnamed denizens of commercial SRO hotels, but the growing cohort of homeless individuals with untreated addiction issues who remained in shelters and on the streets for extended periods of time. And this time, the group responding to these needs was not only a set of clergy, advocates, and social workers but also City and State officials, who watched with concern as the numbers of homeless individuals continued to grow, along with the City’s homeless services budget.

The interviewed NY/NY III stakeholders pinpointed three specific reasons that propelled the inclusion of Population E into NY/NY III. The first stated impetus was the City’s desire to reduce the number of people experiencing chronic homelessness. This coupled with the second stated impetus, namely the recognition that a large number of chronically homeless individuals were individuals with untreated and active substance use issues. Executive Deputy Commissioner Robert Myers recalled Former DHS Commissioner Linda Gibbs, after examining DHS-collected data, finding that a large percentage of the City’s chronically homeless population was actively using substances. The view was that these long-term homeless individuals had been “left behind,” as it were, because most of the supportive housing opportunities were targeted specifically to individuals who had serious mental illness. DHS Deputy Commissioner George Nashak reflected, “[I]t was great that we had done a lot of permanent supportive housing for the mentally ill, but what was also clear was that the population of chronically homeless people were more diverse...[A] huge proportion of needs were people without an Axis I diagnosis but who were chronic substance abusers.”¹⁰ If housing could be made available for these chronically homeless individuals with active substance use issues, the City could make further progress towards its goal of reducing its homeless shelter census. As HRA Executive Deputy Commissioner Frank Lipton plainly stated: “The driving force [behind the inclusion of Population E into NY/NY III] was to bring the size of the single adult shelter census down.”¹¹

As discussions about the targeting of NY/NY III units were taking place, the City was developing a renewed focus on street homelessness: “DOHMH was really involved in analyzing street outreach teams, what they did, who they encountered, and what their needs were.”¹² Confirming previous findings, the data indicated that a significant number of street homeless individuals had substantial addiction issues, especially alcoholism. It was thought that what was needed for these individuals was a form of supportive housing that did not require abstinence or even a desire to seek treatment as a precondition for entry, but that could nonetheless help keep street homeless

¹⁰ Nashak, G. (Deputy Commissioner, New York City Department of Homeless Services). Personal interview. December 7, 2009.

¹¹ Lipton, F. (Executive Deputy Commissioner, New York City Human Resources Administration). Personal interview. December 21, 2009.

¹² Grund, L. (Director of Housing Bureau, New York City Department of Health and Mental Hygiene). Personal interview. December 17, 2009.

individuals stably housed. NY/NY III created the opportunity to make such low-demand, Housing First supportive housing available to people who had been chronically street homeless.

The third reported impetus behind the inclusion of Population E into NY/NY III was the need to shift the practice and perspectives of the supportive housing provider community as a whole. Before NY/NY III, the majority of supportive housing agencies tended to have tenant selection processes that excluded people who were actively using drugs or alcohol. Connie Tempel, then Director of the New York Office of the Corporation for Supportive Housing, recalled the state of agency practice prior to NY/NY III: “Providers used to require [tenants to demonstrate that they were] four-to-six months clean-and-sober and selected those who were only short-term homeless.”¹³ HRA Executive Deputy Commissioner Lipton reflected, “Most providers had a sobriety rule, which was problematic.”¹⁴ Policymakers at the City and State knew that “there were people with substance abuse problems who were not ready to be engaged in care,” but that there was significant resistance and skepticism towards the notion of providing housing without precondition to such individuals. By including a specific set of low-threshold supportive housing units into NY/NY III, the interviewed stakeholders reported seeking to demonstrate to the larger provider community that active users of drugs and alcohol could indeed be housed, and therefore, that requiring applicants to first demonstrate sobriety was an unnecessary and exclusionary barrier that, if removed, could help end chronic homelessness in New York City. Population E’s inclusion was not only about serving a specific subset of chronically homeless persons, but was also about building the evidence for a new paradigm in supportive housing practice: “If this proves to be a valid experiment, this needs to be an integral part of any housing portfolio.”¹⁵

In sum, the inclusion of Population E housing into the NY/NY III Initiative was indicative of the stakeholders’ willingness to see the potential of supportive housing to effectively address even the most challenging and complex needs. Given the limited evidence regarding supportive housing’s effectiveness for chronically homeless individuals that are actively using alcohol and drugs, this was no small leap of faith. As HRA Executive Deputy Commissioner Frank Lipton acknowledged, “Of all the nine categories of housing, Category E had a big question mark.”¹⁶ The stakeholders expressed significant fears about the potential risks: “The concern was about congregating units for substance users in a building and causing problems. The facts are that we have not found this to be the case.”¹⁷ Such fears were not unfounded: “We had had some experiences in NY/NY I where there were a couple of supportive housing sites that took in clients who were MICA [Mentally Ill and Chemically Addicted] clients some of whom were actively abusing. They could have turned into crack dens... There was a concern that you could create a supportive housing environment that would become a drug den.”¹⁸ In the end, the ethical need to try the model won out over fear. As DOHMH Housing Bureau Director Laura Grund explained, “There was a recognition that supportive housing works and saves money, but that a lot of people who were actively using alcohol or drugs are excluded from supportive housing.”¹⁹ HRA Executive Deputy Commissioner Lipton took this idea further: “In my mind, supportive housing works with people who have special clinical needs to provide case

¹³ Tempel, C. (Chief Operating Officer, Corporation for Supportive Housing). Personal interview. November 20, 2009.

¹⁴ Lipton, Frank (Executive Deputy Commissioner, New York City Human Resources Administration). Personal interview. December 21, 2009.

¹⁵ Nashak, G. (Deputy Commissioner, New York City Department of Homeless Services). Personal interview. December 7, 2009.

¹⁶ Lipton, F. (Executive Deputy Commissioner, New York City Human Resources Administration). Personal interview. December 21, 2009.

¹⁷ Nashak, G. (Deputy Commissioner, New York City Department of Homeless Services). Personal interview. December 7, 2009.

¹⁸ Lipton, F. (Executive Deputy Commissioner, New York City Human Resources Administration). Personal interview. December 21, 2009.

¹⁹ Grund, L. (Director of Housing Bureau, New York City Department of Health and Mental Hygiene). Personal interview. December 17, 2009.

management and other services that link clients to the community-based supports they need. Supportive housing should be able to work with anybody with clinical conditions, so why wouldn't it work for substance using clients?"²⁰

INTENDED GOALS AND OUTCOMES OF POPULATION E SUPPORTIVE HOUSING

Given the practical, financial and ethical reasons the key stakeholders cite as being behind the inclusion of Population E in NY/NY III, the reported intended goals and outcomes were primarily about preventing returns to homelessness among those housed. All of the interviewed public agency administrators of NY/NY III listed 'housing stability and retention' as the primary goal and outcome of interest for Population E. The logic at work here is that a direct inverse relationship exists between the number of chronically homeless individuals placed into Population E programs and the number of chronically homeless individuals remaining in shelters and encountered by street outreach teams. As Robert Myers explained, "If you have 30-40% of adult singles who use a shelter bed for a whole year, and you move them out, you have a whole bed that can be used for other people."²¹

While housing retention was a goal for all nine populations of NY/NY III supportive housing, this goal has unique significance for the Population E programs. Many individuals with untreated and severe addiction were not expected to remain in housing long, so some administrators reported that it would be a major achievement to simply keep individuals housed. Housing retention was also viewed as especially important to the Population E programs because of its perceived role as a mediator and necessary precondition for the achievement of other health and social outcomes. One administrator summarized this causal relationship well: "Getting into housing will lead to trust with a case manager. People will realize that this is a good thing and will want to keep it. As a result of staying in housing, people distill enough ego strength and enough ability to change their behavior and lifestyle."²²

Interestingly, stakeholders did not feature behavioral change or sobriety at the top of the list of outcomes of interest. Instead, the second most important outcome and goal was reducing use of emergency public services, specifically: hospitalizations, emergency room visits, jail and prison incarceration, and medically supervised detoxification stays. The likely emphasis on this outcome was the need to justify the cost and public investment associated with NY/NY III supportive housing, and the belief that the Population E tenants were a particularly expensive subset of homeless individuals given their high utilization of emergency public services.

A third set of outcomes of interest to stakeholders was the connection of tenants to needed mainstream services including mental health treatment, substance use services, and physical health care. Next, stakeholders noted that chronically homeless persons with severe substance use issues had significant physical health problems related to their substance use. A 2005 study of the health of the homeless in New York City found that substance use was the leading cause of death among single adult sheltered homeless men, and one of the leading causes of death among women.²³ Thus, the fourth and related outcome of interest was the improvement of health, particularly physical health problems, among tenants. One administrator specifically mentioned the prevention of opioid overdoses, serious suicide attempts, and psychiatric decompensation.

²⁰ Lipton, F. (Executive Deputy Commissioner, New York City Human Resources Administration). Personal interview. December 21, 2009.

²¹ Myers, R. (Executive Deputy Commissioner, New York State Office of Mental Health). Telephone interview. December 3, 2009.

²² Panepinto, W. (Director of Bureau of Housing and Employment Services, New York State Office of Alcoholism and Substance Abuse Services). Telephone interview. November 19, 2009.

²³ New York City Departments of Health and Mental Hygiene and Homeless Services (2005). *The Health of Homeless Adults in New York City*. Retrieved from <http://www.nyc.gov/html/doh/downloads/pdf/epi/epi-homeless-200512.pdf>.

Fifth, stakeholders reported that they intended for the Population E supportive housing to reduce harm and risk behaviors among tenants, both in terms of the amount and level of risk of drug use, as well as violence and sexual risk. A sixth stated outcome of interest to stakeholders was improvement of quality of life among tenants.

Lastly and somewhat surprisingly, two administrators indicated that increasing employment among Population E tenants was also an intended goal. Increased employment was viewed as positive for its impact on the economic self-sufficiency of tenants as well as for its therapeutic benefits. However, interviews indicated that this outcome was a more recent interest, and not one of the originally intended outcomes.

Population E's Intended Goals & Outcomes

- Prevent returns to homelessness and increase housing stability/retention
- Reduce use of emergency public services: hospitalizations, incarcerations, emergency room and detox visits
- Increase connection and use of mainstream health and other services
- Improve health
- Reduce risk behaviors
- Improve quality of life
- Increase employment

INTENDED DESIGN OF POPULATION E SUPPORTIVE HOUSING

Two separate sources of information and data were synthesized to provide the following description of the intended design of Population E. First, the research team reviewed official program documents to identify the explicit program elements and approaches identified by the public agencies that oversaw the creation of NY/NY III. These included the NY/NY III agreement itself, the DOHMH concept paper, and the DOHMH Request for Proposals. Second, interviews with key stakeholders —policymakers, public administrators, experts, and advocates— were conducted to determine additional and implicit program elements or considerations.

City and State's Process for Designing Population E

The scarcity of local precedents for Population E presented a problem for the stakeholders tasked with implementation of NY/NY III, particularly DOHMH, the entity responsible for the administration and design of Population E. While clear on the desired goals and outcomes, policymakers reported having less clarity about the components and operational approaches needed to achieve the intended outcomes. Complicating the design further was the fact that, due to rules regarding the procurement of public funds, DOHMH was unable to solicit the input and expertise of local supportive housing agencies in the design without possibly disqualifying them from seeking funds. For this reason, DOHMH requested the assistance of the Corporation for Supportive Housing to help solicit local agency expertise and perspectives in the design.

The process for designing Population E entailed a review of literature and national program models, a focus group with consumers who experienced homelessness firsthand, and a focus group with agencies. The process aimed to identify the core program elements and components that were believed to lead to the intended program outcomes. This information was provided to DOHMH to inform the development of the Request for Proposals released for the City's share of NY/NY III housing, which included all Population E units.

Staff appointed by the City and State agency members of the NY/NY III implementation committee reviewed the literature and national models. This review resulted in the identification of supportive housing from across the country that could be used as models for Population E, as well as studies and program evaluations of these models. Not surprisingly, the review did not result in a large number of models, but did identify a select group of programs and projects that could serve as models for Population E. These included Direct Access to Housing in San Francisco, LAMP Community in Los Angeles, and 1811 Eastlake in Seattle. All three of these examples served tenants similar to the Population E target population, and all three were known to use a low-demand, Housing First approach. However, all three programs were structured as single-site supportive housing

developments and therefore had limited application to the scattered-site Population E programs that NY/NY III administrators sought to develop.

To obtain consumer perspectives regarding the design of Population E, DOHMH convened a focus group of consumers in March 2006. In attendance were shelter residents and tenants of some Housing First supportive housing programs including Pathways to Housing and Bailey House. Participants were asked about their residential and life histories, their time spent homeless, and substance use issues, along with available services, the services they use most often, and services they need but cannot access. Many had remained homeless and actively using even after attending residential programs on multiple previous occasions. Several spoke of hospitalizations, use of detox services, and persistent mental health conditions. Participants also discussed the anxiety and stress associated with the constant fear of losing housing, and the importance of tenancy that was not jeopardized by continued addiction or relapse.²⁴

The CSH-convened provider focus group also took place in March 2006 and included organizations experienced with supportive housing that targeted individuals with active and disabling substance use conditions and/or used non-abstinence based principles in their services philosophy. The individuals in attendance served people living with HIV/AIDS, persons with co-occurring mental illness and addiction, along with individuals with expertise in the delivery of low-threshold services for homeless individuals with substance use issues. Participants in the focus group discussed the service needs of the target population, challenges related to delivering services, and the programmatic features, components, and elements needed to keep individuals with active substance use issues stably housed (Appendix H).

Following the City's official contracting process, DOHMH used information gathered from the focus groups and the review of literature and national program models to develop a 'Concept Report,' which outlined the basic structure of three of the NY/NY III scattered-site supportive housing populations including Population E (Appendix D). DOHMH released the report for public comment in August 2006, giving members of the public approximately one month to submit official comments and questions on the outlined structure and design. After considering and incorporating comments on the outlined program, DOHMH finalized the program design and released funding applications for Population E, along with two other NY/NY III program categories, through a Request for Proposals in February 2007 (RFP; Appendix E). DOHMH received eleven responses to their RFP, and nine agencies— BRC, The Bridge, CAMBA, Common Ground, The Doe Fund, Project Renewal, Turning Point, Urban Pathways, Volunteers of America of Greater New York— were ultimately selected to receive awards.

Program Structure, Approach and Components

As public documents reveal, the basic structure of Population E does not differ drastically from that of other categories of NY/NY III scattered-site supportive housing. In terms of its programmatic approach and orientation, however, Population E supportive housing has several unique features that distinguish it from other supportive housing, including other NY/NY III supportive housing.

Program Structure and Funding

NY/NY III Population E housing is structured as scattered-site supportive housing. Apartments are leased on the private market using rental subsidies and then linked to services that are provided by contracted organizations. Like other supportive housing, Population E is permanent and tenants have leases along with the usual obligations and rights afforded by legal agreements. The rented apartments are subject to inspection and must meet some

²⁴ Grund, L. (Director of Housing Bureau, New York City Department of Health and Mental Hygiene). Personal communication. September 10, 2010.

indicated standards. Tenants pay no more than 30% of their income toward rent and utilities, which in the case of most disabled individuals, is the housing allowance portion of their public assistance benefit or disability insurance income. The public subsidy funded by NY/NY III then covers the difference between the actual market rent and the portion covered by the tenant's individual contribution.

Like other scattered-site supportive housing, contracts between DOHMH and qualified agencies link Population E tenants to supportive services. Programs are meant to assess tenant need and coordinate appropriate services; referring individuals to medical and mental health care, substance abuse treatment, benefit programs, vocational services, and other community resources. In addition, programs are expected to offer basic counseling and assistance with activities of daily living. Given the challenges that many formerly homeless tenants face once housed, programs also assist tenants to integrate into a building and neighborhood by mediating conflicts with landlords, neighbors, and other members of the tenants' community, as well as by intervening in cases of crisis. Service contacts can take place both within program offices through appointments made with tenants, at tenants' apartments, and at other settings agreed upon by client and program. While services need to be available during regular business hours, program staff are also expected to be "on call" during evening and weekend hours. Surprisingly, little guidance or requirements are made regarding the specific staffing of the services teams. However, in most instances, the teams are comprised of a program director to oversee the program, a masters-level clinician to provide clinical supervision and some direct case management, and case managers who serve as the primary points of contact with clients. Staff-to-client ratios typically range from 1:10 to 1:25. Some programs may also, depending upon funding, supplement this staffing pattern with additional professionals. Notably, the staffing of Population E programs, like most supportive housing, is largely comprised of non-clinical staff, with the assumption that clinical, medical, and behavioral health services would be provided through linkages and referrals to mainstream organizations.

Population E, like all of NY/NY III's scattered-site supportive housing, is funded through a single contract that covers both the cost of rental subsidies as well as the supportive services. Funding for NY/NY III Population E, administered by the New York City DOHMH, is awarded at a level of \$450,000 for a minimum of 25 units, equivalent to a rate of \$18,000 per unit. (Applicant agencies were encouraged to propose housing more tenants with this same funding level, with proposals serving more tenants being viewed as more competitive.) The specific use of the funds is then left to the agencies to determine the share covering rental subsidies versus supportive services costs. In NY/NY III as a whole, agencies are neither strongly encouraged nor strongly discouraged from seeking additional funding to supplement the funding from DOHMH. However, in the event that agencies obtain a source of alternative funding to cover rent, for instance from Section 8 Housing Choice Vouchers or Shelter Plus Care, their funding amount would be reduced by \$3,200 per year for every rental subsidy voucher leveraged.

Under NY/NY III, contracted programs obtain apartments by master-leasing them from private landlords and then sub-leasing to tenants. This arrangement, known as "sponsor-basing," is one of two models used in many scattered-site supportive housing programs, the other involving tenant-based subsidies linked to a contracted services provider. Sponsor-based subsidies and master-leasing arrangements place the program in an intermediary role between the landlord and the tenant, as well as in a position of direct financial liability with respect to private landlords. The program then becomes both the landlord and services provider for the tenant. This structure is typically used in instances when there is concern about finding landlords willing to house a particular tenancy or in order to ensure that services will continue to be delivered to tenants. The drawbacks to this structure are that it may limit tenant choice because tenants are unable to simply move to another apartment using their subsidy without the permission or consent of the programs (sponsor), and that it may lead to role conflicts and confusion among the program staff given their dual role as landlord and services provider. Another risk that arises with sponsor-based models is that the program may simply find all of the units within a single building, thus creating

a de facto single-site supportive housing building. To avoid this risk, DOHMH required all NY/NY III scattered site programs to rent no more than 20-25% of the units within any one apartment building.

Supportive Service Program Approach and Components

A review of the planning documents, the Request for Proposals, Program Standards, and the interviews conducted with policy makers identified a number of program components and approaches to supportive service delivery that were clearly part of the stakeholders' intended design of Population E housing. The eleven program components, integral to supportive housing for individuals whose substance use is a primary barrier to housing, are as follows:

- **Stakeholders' Component #1: Programs will emphasize and routinely offer staff training and skill building around motivational interviewing and other relevant skill areas.**
Population E supportive services will have a strong emphasis on relationship and trust building with tenants. This will translate to both a greater number of client contacts, especially earlier in tenants' housing tenure, and the employment of creative strategies for engaging clients, including the convening of informal or recreational gatherings. In addition, although service plans will be client-driven, programs will play an active role in encouraging clients to achieve their full potential. To do so, programs will employ a motivational, client-centered counseling style for helping clients explore and resolve their own ambivalence about behavior change. Training and skill-building opportunities around these skills will be provided to staff at all levels, and reinforced by quality supervision.
- **Stakeholders' Component #2: Agencies will have prior experience with providing housing that is not contingent on tenant abstinence from alcohol and drugs.**
Agencies will have demonstrated competence working with individuals who have experienced chronic sheltered or street homelessness, individuals who actively use substances, and/or individuals with multiple health and mental health issues. Agencies will also have an understanding of the effects and culture of drug and alcohol use, the disease of addiction, the stages of change, and how to work with ambivalence and apparent resistance to change. This includes recognizing the different service needs of people based on their different stages of addiction and use. The hiring and employment of staff that have relevant professional experiences and life histories will strengthen the ability of programs to engage clients.
- **Stakeholders' Component #3: Program director and supervisors will provide quality supervision.**
In addition to supporting staff on day-to-day tasks (e.g., required paperwork, ensuring tenants public assistance cases are active, addressing apartment maintenance issues), program directors and supervisors will create a common culture with regard to how staff speak about and support tenants who use substances, help staff distinguish between their personal motivations and their professional responsibilities to serve tenants' needs, and provide a space for case manager reflection and communication. Supervision will focus on how to refer tenants for appropriate services outside of supportive housing, ways to encourage candid disclosure from tenants, and how to instill boundaries while still building rapport.
- **Stakeholders' Component #4: Programs will rarely deny housing to applicants based on substance use, criminal history, or lack of motivation to change.**
In addition to a new centralized referral process put in place by the NY/NY III agreement to prevent "creaming" and adverse selection of tenants by programs, the Population E programs will not deny housing to applicants based on their substance use or other factors related to their substance use, including their criminal history or perceived lack of motivation to change behaviors.

- Stakeholders' Component #5: Programs will use a client-centered and non-judgmental approach, services plans are driven by tenants, and enrollment in a substance abuse treatment program is not an assumed or enforced service.**

Individualized services plans will encompass both acute and longer-term needs. The plans will be revisited and updated on a periodic and routine basis in order to both guide progress and to respond to changing needs. A focus on substance use reduction, substance use treatment, or movement to sobriety will not be automatically assumed by programs (even if perceived as the primary service challenge), but will be encouraged if clients express an interest and willingness to pursue such goals. In this way, clients will not be judged, punished, or discouraged about not wishing to pursue service goals related to their substance use, or for that matter, if the focus of their service goals differs from those of case managers.
- Stakeholders' Component #6: Programs will provide specific services intended to minimize possible consequences of substance use such as sexual health education, overdose prevention, substance use management, and safe injection procedures.**

Population E programs will provide those services related to reducing harm, minimizing high-risk behaviors, and encouraging safer practices with regard to substance use. Programs are expected to have competency around, and provide either directly or through linkages, services related to safer injection, naloxone use to prevent opiate overdose, safer sex education and paraphernalia, needle exchange, health education, and infectious disease prevention. (See sidebar next page, "Harm Reduction in Supportive Housing")
- Stakeholders' Component #7: Programs will actively engage and openly communicate with tenants about substance use.**

Population E case managers will engage clients around their substance use, openly communicating about drug and alcohol use with the assumption that greater rapport regarding use allows for a greater preparedness on the programs' part to respond to clients' substance use-related needs. Staff will build trust with clients by allowing clients to speak freely about the nature, amount, and frequency of their drug and alcohol use.
- Stakeholders' Component #8: Services will be comprehensive, encompassing many domains and responsive to individual needs.**

Supportive services will be made as accessible as possible, in terms of location, time, and personnel. Programs will have case management and other services during regular business hours, but also to be available "on-call" on a 24 hour/7 day basis. In addition, client contacts will take place both at program offices as well as in clients' homes. Given the scattered-site nature of the housing, staff visits to client homes will be an essential component of services. The services will also be accessible in terms of personnel. Although clients will have an assigned case manager, they will be able to obtain assistance by contacting any of the program staff. Population E services will also be flexible, responsive and adaptive to clients' changing needs and goals, and as little as possible unconstrained by rigid routines or processes. Given the client-driven approach, the range of supportive services will also be comprehensive in nature, encompassing multiple service domains. The anticipated list of services includes health and medical, mental health, benefits and entitlements enrollment and advocacy, individual and group counseling, home visits, recreational opportunities, employment services, substance abuse treatment, Alcoholics/Narcotics Anonymous, community building, peer counseling, Daily living skills training, referrals to other community-based services, and advocacy/conflict resolution. However, the primary emphasis will be on those services needed to help tenants retain their housing, both because of the policy goals of Population E, as well as because of the assumption that housing stability is a precursor to the achievement of other service goals.

- **Stakeholders' Component #9: Programs will have access and strong linkages to primary physical and mental health services.**

Long histories of homelessness coupled with chronic and significant addiction is likely to have significant impacts on physical and mental health, including higher mortality risks. A key function of the services in Population E supportive housing will therefore be focused on helping tenants access quality health and mental health services. This will include encouraging tenants to develop a sense of self-care and concern regarding their own healthcare needs, connecting tenants to mainstream health and mental health services through local hospitals and clinics, and facilitating follow-up and services coordination.

- **Stakeholders' Component #10: Programs will be well-equipped and effective around crisis intervention.**

Given their long-term homelessness, health challenges, and substance use issues, Population E tenants are anticipated to experience moments and episodes of crisis. Population E supportive housing, perhaps more than other similar supportive housing, will be prepared to respond and intervene in situations of crisis including, but not limited to: medical emergencies (including overdoses), suicide attempts or ideation, arrests and incarceration, mental health decompensation, and fights and conflicts. Programs will be aware and prepared that such crises may happen at any time, but with greater likelihood earlier in housing (e.g., within the first year). Contracted programs will also be required to have set-asides of contingency funds to cover housing costs in the event of hospitalizations, incarcerations, or other temporary absences where tenants are unable to pay rent, but where they are expected to return to housing. Such incidents will not be viewed as grounds for eviction or termination, but rather the programs will make every effort to preserve the client's housing.

- **Stakeholders' Component #11: Programs will have skill in working with benefits and entitlement systems.**

Key to ensuring housing stability will be ensuring that clients have sufficient income to not only meet their basic needs, but also to pay their portion of rent. Given the number and complexity of health and behavioral health challenges among Population E tenants, income from earnings is not likely to be a significant source of income. Therefore, achieving housing stability requires that programs will ensure clients' access to and enrollment in benefit programs like New York's public assistance (PA) program. Population E supportive housing programs will have experience and knowledge with benefit and entitlement programs and the systems and regulations governing them, in order to help their clients navigate those programs, and to effectively advocate on behalf of clients.

These key components are integral to our understanding of the intended design for Population E housing and will be used as the basis for Section 4's assessment of actual program implementation compared to how the initiative was originally formulated.

Harm Reduction Sidebar

"Harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence. Harm reduction strategies meet drug users 'where they're at,' addressing conditions of use along with the use itself."

—Harm Reduction Coalition, www.harmreduction.org

In simple terms, harm reduction supportive housing means the removal of sobriety as a prerequisite either for entry into housing or for permanent tenancy. This does not mean that substance use is ignored; it means that programs offer services to help tenants manage the responsibilities of tenancy, including the management of their substance use to meet those responsibilities.

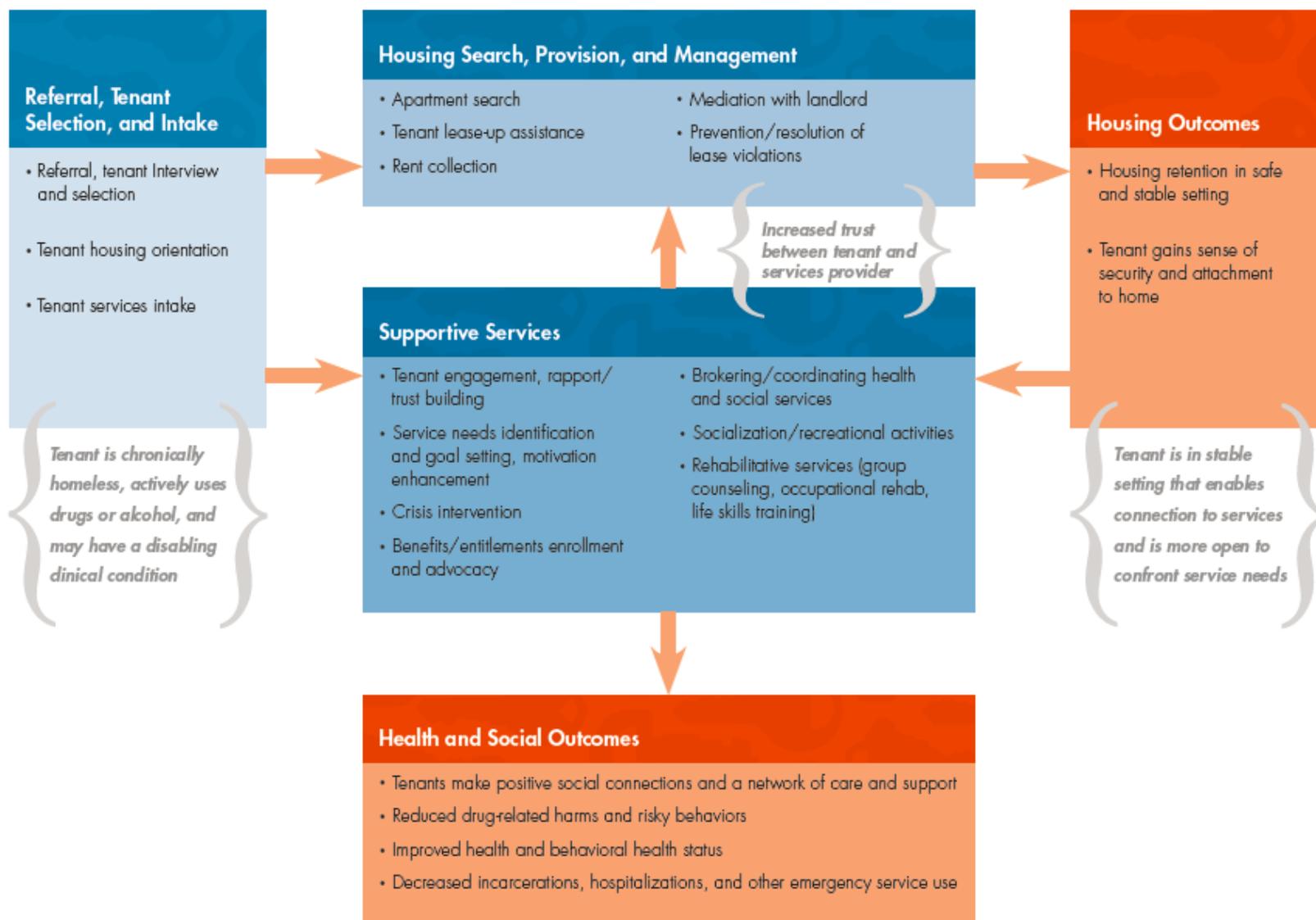
People often mistakenly conceive of harm reduction as situated on one end of a spectrum with abstinence on the other end. Viewed this way, harm reduction looks like a way to engage clients while they use, in order to move them incrementally toward sobriety. However, harm reduction is not restricted to changes in how much or how often people use; that spectrum is called the “spectrum of use,” describes patterns of consumption, and ranges from no use, to experimental use, occasional use, regular use, heavy use and, at the far end, chaotic use. The distinction between strategies that reduce harm and strategies that reduce consumption is important; not distinguishing the two has implications for rapport building and treatment planning with clients.

In contrast to the spectrum of use, which describes how much people use, the spectrum of harm reduction strategies is about *how people use*, specifically the process of lessening harm as they use. The spectrum includes switching to a less physiologically or psychologically addictive substance, using safer routes of ingestion, exchanging used injection equipment for sterile equipment, overdose prevention, as well as lowering consumption, experimenting with abstinence, and other process changes that constitute incremental shifts in one’s relationship to substance use, thereby lessening the risk of death, disease and other harms. Offering many options to reduce harm, including but not limited to reducing consumption, is a helpful tool of engagement. But the ultimate goal may not be abstinence, because in the harm reduction model the consumer of services determines goals and changes of interest, not the provider. The provider is merely a consultant to the client, helping with information, resources and encouragement. Of course, as people manage their use and reduce harm over time, their goals may change; a tenant who initially seems disinterested in sobriety may surprisingly voice interest in or simply demonstrate abstinence at some future point.

POPULATION E SUPPORTIVE HOUSING THEORY OF CHANGE: HOW THE MODEL WORKS

Through a process of collaborative inquiry with program directors, case managers, and other staff, a Theory of Change was constructed that defined the essential activities for Population E, and identified the causal relationship between these activities and intended outcomes. The resulting Theory of Change is depicted in the following figure. This diagram identifies the program activities, the changes and outcomes among tenants that these activities are intended to bring about, and also considerations for the quality of program activities necessary to successfully achieve outcomes.

Theory of Change Behind Population E



As shown in the Theory of Change diagram, program activities in supportive housing for Population E conceptually fall under three categories: Recruitment, Tenant Selection, and Intake; Housing Search, Provision, and Management; and Supportive Services:

- **Referral, Tenant Selection, and Intake**

Tenants are first found eligible for NY/NY III Population E and referred to housing programs as described earlier. Population E programs then review the referral packets containing the prospective tenants' NY/NY III application and psychosocial history. Programs interview tenants, and based on review of the application and the interview of the tenant, either accept or reject them for housing. A key consideration for successful achievement of outcomes in tenant selection is that programs do not deny applicants based upon substance use, motivation, or a perceived lack of 'housing readiness'. Once a prospective tenant is accepted, programs then conduct an 'intake' into the services program. This services intake should take place following - and separate from - the tenant selection process so as to avoid potential violations of fair housing laws wherein inappropriate questions are asked of potential tenants at housing interviews.

- **Housing Search, Provision, and Management**

The second category of activities is related to the provision of affordable housing to tenants, and includes conducting apartment searches and leasing apartments from private landlords. As described earlier, the sponsor-based, master-leasing structure used in Population E means that apartment searches are typically done prior to housing placement. Leased apartments should be high quality, well maintained, and in safe and desirable neighborhoods. Accepted tenants are then placed into leased apartments and enter into a sublease agreement with programs. Programs then work on an ongoing basis to ensure that both tenants and landlords fulfill the terms and obligations of their leases, to ensure timely payment of rents to landlords and collection of tenants' contribution to rent, and to resolve housing issues and crises, such as lease violations, conflicts between tenants and landlords, or tenants and neighbors. Programs should be proactive in their ongoing housing quality assurance efforts and regular housing quality inspections, attempting to anticipate problems and lease violations before they happen, and be responsive in their resolution of problems and crises.

- **Supportive Services**

Seven different sets of activities were identified that fall under the Supportive Services category. These include tenant engagement and rapport building, identifying service needs and developing services plans, brokering and coordinating services, crisis intervention, benefits and entitlements assistance, other specialty services, and socialization/recreational activities. Chronologically speaking, tenant engagement and rapport building precede, and in most cases, are a prerequisite, to the other activities. To build this rapport, programs must be non-judgmental and non-punitive in their communication and interaction with their tenants, and create an environment welcoming of open communication about day-to-day circumstances and substance use. Such a rapport then allows the programs to identify and assess tenant service needs and goals. Services plans are then developed around identified service needs and goals. Service planning in a Housing First model must be done in collaboration with tenants, allowing tenants to identify their own service goals with encouragement and skillful motivational enhancement by programs, and should be a dynamic process where service goals are continually reviewed, discussed, and modified as determined by the tenant. Service planning is as much a process of empowering tenants to become more self-aware as it is about identifying specific goals and targets. Once goals are identified, programs will either directly offer specific services or broker these services from other community-based organizations. Whether offered directly or brokered in the community, agencies should have at the ready a rich array of services, including health, mental health, and substance use services, employment services, nutritional counseling, etc. Thus, the ability of programs to operate with quality depends upon the

availability and quality of existing services in the surrounding community. Given the extreme poverty among chronically homeless individuals with substance use issues, tenants often need help obtaining benefits and entitlements including public assistance, Medicaid, Supplemental Security Income and other cash and non-cash benefits. Lastly, given the need to help tenants establish positive social connections as well as to overcome the loneliness that may come from living in independent apartments, programs should offer opportunities for informal interaction through regular recreational and socialization activities.

While all three sets of activities are needed to achieve the intended outcomes, the Theory of Change indicates a more complex relationship between the activities and outcomes, wherein the process of change is iterative and cyclical, having positive feedback loops. Activities related to housing search, placement, and management directly lead to increased housing retention and stability. Housing stability, in turn, can contribute to or mediate behavioral changes including the reduction of drug-related harms and risk behaviors associated with poor health outcomes and mortality, decreased substance use, improved health and decreased hospitalizations, incarceration, and other emergency services use. Tenure in housing, for instance, can lead to greater feelings of security and reduced anxiety, and in turn, allow tenants opportunities to pursue alternatives to high-risk behaviors and the use of drugs or alcohol. The assumption here is that homelessness contributes to anxiety and stress and that tenants use drugs or alcohol to cope with this anxiety. A second plausible explanation is that tenants begin to feel attached to housing and therefore become afraid to lose housing. The fear of loss of housing would encourage tenants to make changes and adjustments to lifestyles and behaviors that may jeopardize housing. A key assumption in this causal chain is that tenants are able to recognize which behaviors threaten to jeopardize housing retention. A third possible connection between housing stability and other outcomes is that tenure in permanent housing allows tenants to feel the emotional and psychosocial security to confront their behaviors, their health and mental health needs, and their addiction issues. In other words, permanent housing allows tenants to move along the “Stages of Change” from pre-contemplation to contemplation. (See sidebar next page, “The Stages of Change”)

The relation between the cluster of Supportive Services activities and outcomes is complex. The delivery of services directly leads to intended behavioral, health, and service utilization outcomes. However, the ability of Population E programs to effectuate these outcomes is dependent upon the identification of service needs, which is further enhanced as they gain the trust of tenants. Trust can be gained when programs demonstrate that they can respond to expressed service or housing needs to the satisfaction of tenants. In addition, socialization activities further contribute to tenants’ experience of positive social connections, which can help support positive outcomes related to behavior, health, emergency services utilization as well as housing stability.

The Theory of Change also reveals that Population E housing is, at the same time, two semi-distinct interventions—subsidized housing and supportive services—operating in parallel to influence two sets of outcomes—housing stability and health/psychosocial outcomes. Each of these intervention tracks separately contributes to the production of its corresponding set of desired outcomes. However, because of the complex inter-dependence between the two intervention components, effective implementation can generate a synergistic effect in which housing outcomes contribute to improved health/psychosocial outcomes and vice versa. One might further assume that if the two tracks are uncoordinated, operating with varying quality, or in conflict with one another, one would see a deleterious effect on both the housing and health/psychosocial sets of outcomes. For example, if programs did not work to ensure housing quality, tenants might be put in high-risk or dangerous situations (such as having their apartments taken over by drug dealers) regardless of the quality of supportive services provision. Similarly, if the quality of supportive services is poor, tenants might wind up incarcerated or hospitalized, and therefore, lose their housing due to long-term institutionalization. For purposes of this report, however, it suffices to say that close examination of both the housing and supportive services sides of the intervention, and coordination between the two, is warranted.

Stages of Change Sidebar

The Transtheoretical Model of Behavior Change (TTM) identifies a series of predictable stages that people pass through as they change behavior. Also called the Stages of Change, the model can be useful when considering how to communicate with tenants about substance use. The model describes five stages that people go through in the process of changing behavior, with corresponding styles of intervention to match each stage. By recognizing the stages, a practitioner can see where a tenant is in the process of change (not thinking about change, thinking about change, preparing for change, taking action to change, or maintaining change), and correspondingly communicate and offer services in ways that match a person's readiness, willingness and ability to reduce drug related harm. The take home message of the Stages of Change is that supportive services providers can facilitate change by tailoring their style of intervention to meet tenants "where they're at" in relationship to reducing drug related harm. Likewise, providers can do the opposite: mismatching an intervention style can create resistance to services. For example, if a tenant is not thinking about changing her crack use and a provider pressures that tenant to enter treatment, the tenant is more likely to avoid the provider than to avoid smoking crack. If the provider uses the Stages of Change, the focus would instead be on engaging in a relationship with the tenant, developing trust and rapport, and eventually, with permission from the tenant, exploring crack use from the client's perspective, looking at both the benefits and harms the tenant experiences.

For more on the TTM:

Prochaska, J. O., DiClemente, C.C., & Norcross, J.C. (1992). In Search of How People Change: Applications to Addictive Behaviors. *American Psychologist*, 47(9), 1102–1114.

Rosengren, B. (2009). *Building Motivational Interviewing Skills: A Practitioner Workbook*. Guilford Press. New York.

SECTION 4: EXAMINATION OF POPULATION E SUPPORTIVE HOUSING IMPLEMENTATION

This section presents the key challenges, lessons learned, and promising approaches that emerged during the first three years of Population E program practice. The findings presented herein are neither intended to make statements about individual program performance nor influence funder decisions regarding contract or program compliance. Therefore, where applicable, programs are not identified by name, but rather by a randomly assigned numeric code.

As described in Section 2, to capture this information, CASAColumbia and CSH conducted interviews with program directors, held focus groups with case managers, and asked the programs to complete a questionnaire that inquired about program practice. These sources of information were supplemented with official program documents, as well as knowledge of the programs developed through the learning collaboratives, trainings, and site visits. The research team examined the programs' overall execution in regards to CSH's *Seven Dimensions of Quality in Supportive Housing*, adapted to six dimensions. Accordingly, this section will start with a brief overview of the nine Population E programs and will then be organized following the six dimensions.

THE BOXES: Assessing Program Practice Using the Stakeholders' Components

In addition, thorough understanding of program implementation requires that actual program operations and activities be observed and compared against original program intent. To meet this aim, we also conducted an assessment of program practice against the eleven program components that are particular to supportive housing for chronically homeless individuals whose substance use is a primary barrier to independent living. These eleven "stakeholders' components", are described in detail in Section 3 and were uncovered through a review of the planning documents, the Request for Proposals, Program Standards, and the interviews conducted with stakeholders. Specifically, the Population E programs were assessed around the degree to which they incorporated each of these eleven components. The findings of this assessment are presented in boxes along with corresponding observations related to the *Seven Dimensions of Quality Supportive Housing*. A summary of assessment findings is included at the end of this section.

PROGRAMS AT A GLANCE

As described in Section 3, to operate the units for Population E, the New York City Department of Health and Mental Hygiene released a Request for Proposals in 2007 and received responses from eleven local service agencies. Through a collaborative proposal review process involving personnel from other City and State agencies, nine agencies were ultimately selected to receive awards (in alphabetical order):

- BRC
- The Bridge
- CAMBA
- Common Ground Community
- The Doe Fund
- Project Renewal
- Turning Point
- Urban Pathways
- Volunteers of America of Greater New York

The following table provides a quick overview of the organizations. As described above, programs are not identified by name, but rather by a randomly assigned numeric code. Additional agency and program information is included in Appendix I:

Select Key Program Characteristics		
# of Units Awarded		
Small (<30 units) 2, 7	Medium (31-80 units) 6, 8, 9	Large (>81 units) 1, 3, 4, 5
Client-to-Case Management Ratios		
Small (<10:1) 2	Medium (11-20:1) 1, 3, 8, 9	Large (>21:1) 4, 5, 6, 7
Specialized Staff for Housing Search & Landlord Relations		
No 7, 8	Yes, At Startup 2	Yes 1, 3, 4, 5, 6, 9
Agency's Overall Supportive Housing Portfolio/Inventory		
Small (<499 units) 2, 4, 6, 7, 9	Medium (500-999 units) 3, 5, 8	Large (>1000 unit) 1

DIMENSION 1: ADMINISTRATION AND MANAGEMENT

Program management and administration is critical to the effective provision of supportive housing. Beyond its importance for ensuring that programs are in solid financial standing and in compliance with program requirements, the management and administration of supportive housing program can directly impact tenant outcomes. Key staff must be hired, supported, and supervised to operate the programs; effective communication practices and habits must be cultivated; and program culture and philosophy must be supported and reinforced. Our examination of supportive housing for Population E found that program management and administration varied from program to program, with some programs facing continuing challenges.

- Staff number, composition, and skill sets were wide-ranging.**
 The nine Population E supportive housing programs varied not only in terms of their staff size, but also the composition and credentials of their teams. Client-to-staff ratios ranged from a low of 1:10 to a high of 1:25. Programs with a lower client-to-staff ratio tended to report encountering fewer management and administration related struggles. However, composition, credentials, and skill sets of staff were observed to be greater program facilitators than staffing numbers and ratios. Several programs had, in addition to a program director and case managers, specialty staff on their teams such as health care coordinators, housing specialists, mental health/substance abuse specialists, entitlements specialists, nurse practitioners, and a psychiatrist. For the programs that retained such specialty staff, these specialists were observed to have greatly expanded the team's knowledge and skills, afforded improved access to primary and behavioral health care, and helped troubleshoot difficult cases such as disenrollment from benefits or disgruntled landlords.

Beyond staff credentials, hiring and retaining staff members who were described as having motivation, compassion, empathy, patience, open-mindedness, and interpersonal skills was observed to be key to program implementation. Possession of practical problem-solving skills was also identified as an important trait needed to tackle the serious issues staff encounter on a daily basis. Most importantly, program directors and case managers alike noted that individuals doing this work need to be passionate and committed to the Housing First philosophy, as they often struggled themselves with how to be supportive during tenants' severe and ongoing addiction.

staff reported that senior officials in the organizations with program-agency misalignment expressed frustration at the lack of apparent progress.

"[The agency administrators] want things done right now. Harm reduction is not really about the immediate results, it's about doing things through the steps. So the time limit the agency puts on us doesn't allow the harm reduction approach to get done what we have to do."

Program directors within these agencies faced the difficult task of managing these conflicting philosophies. In one of the three cases, the program director was effective in resolving this conflict. The program director spoke of shielding the program from the larger agency culture and finding a way to communicate about the program such that other departments in the organization better understood the supportive housing design for Population E. However, the program director also described feeling that the program was not provided sufficient support from senior staff. In the third program experiencing misalignment, conflicts in philosophy led to ongoing and unresolved challenges, and as a result, the program largely failed to adopt many of the key components associated with Housing First. By contrast, among the programs that did not experience these philosophy conflicts, at least one received notable prestige from the agency as a whole, being viewed as a kind of 'flagship' program.

"[Our supportive housing for Population E] is even more consistent with and supportive of [our agency's] mission than [the agency's] other programs... [Our Division Director] has said that she is very satisfied with our program."

Another Population E program director reported that this Population E housing had positively influenced the agency's other programs to adopt a more low threshold and client-driven services orientation.

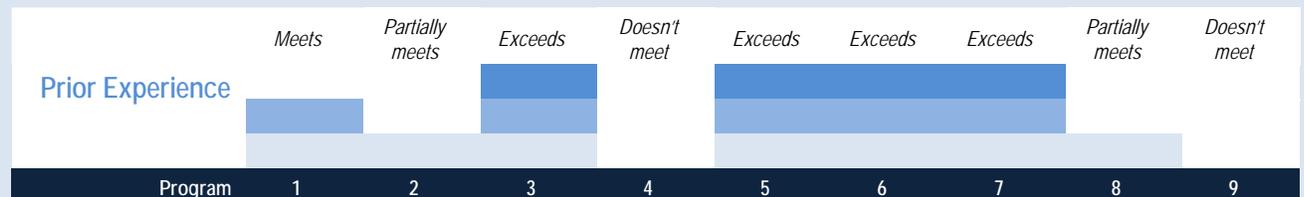
STAKEHOLDERS' COMPONENT #2

Agencies will have prior experience with providing housing that is not contingent on tenant abstinence from alcohol and drugs

Despite the importance of prior experience with Housing First and working with chronically homeless persons with active substance use, only five of the nine agencies had prior direct experience or comparable existing programs that either used a Housing First approach or that involved providing housing for homeless people with active substance use and addiction issues (1, 3, 5, 6, and 7). Three of the five agencies with prior experience actually had existing Housing First supportive housing programs (1, 3, and 6), which were created through other funding streams or federal grants.

"[Population E was] an easy fit. [Our agency] has prior work with actively using clients with HIV/AIDS, and facilitating groups in a supportive housing program... [Our agency] does not run any abstinence-based housing programs."

The other two agencies had related experiences; one operating a low threshold non-medically supervised detox center for street homeless alcohol users (5) and the other operating a Safe Haven model (7), a highly flexible and low threshold model of semi-permanent housing for long-term street homeless individuals. Of the four agencies that had little to no prior experience or related programs, two (2 and 8) had experience with working with homeless persons with addiction issues through their street outreach or homeless shelters. The remaining two agencies (4 and 9) had virtually no experience providing housing or services to people with active addiction issues. Interestingly, while agencies with prior experience delivering housing or services to people with active addiction issues adopted the service philosophy and approaches more quickly, it does not appear to be a determinant of successful implementation: one of the agencies (4) who had no prior experience was successful in all other components, while the other agency that lacked experience struggled with implementation.



- **Effective and capable program directors were seen as “jack of all trades,” fulfilling various roles and functions ranging from overseeing operations, supervising staff, team building, resolving conflicts and crises, and interfacing with the larger organization.**

As with other supportive housing, Population E program directors played a key role in overseeing and managing program operations. For Population E supportive housing, this role entailed additional layers of complexity and function, as the Housing First approach was new to most of the agencies. One of the most important roles for the program directors was therefore to be the bearer of this service philosophy, modeling non-judgmental interaction with tenants and techniques such as motivational interviewing; monitoring, reinforcing and correcting practice; and providing opportunities for staff to refine and hone their skills. Among the nine Population E programs, five program directors were observed to have developed a competency and comfort with the Housing First services approach and were able to help convey this philosophy to their teams. In contrast, at least two program directors not only struggled to convey this philosophy and culture, but had difficulty adopting it themselves.

Another important function of the program directors was that of overseeing overall program operations. Population E programs reported fewer implementation related challenges when they had program directors that were highly attentive to all aspects of program operations and able to rapidly respond to situations that arose.

"At the end of the day it's just communication, keeping everyone on the same page. Organization is key. [The program director] is very, very on point. She catches the issue at the beginning, rather than letting it fester."

In order to better understand the day-to-day issues facing tenants and staff, as well as to gain the respect of staff, some program directors also managed a small caseload or otherwise directly assisted in service delivery for tenants. Consider the following observations from a program director and case manager in one of the programs:

"I like to be in on everything. I want to know what is going on. The fact that I'm hands-on and do lower-level work is nice for case managers morale."

"My supervisor does home visits and service plans. She does everything that we do...She collects rent, does home visits, one-on-one counseling. We can learn from her."

Supervision and team building were also core functions of program directors. For most of the programs, supervisors reported meeting quite often with staff, usually once a week as a team and once a week individually. Supervisors were also available by phone, when case managers were out in the field visiting tenants. A number of Population E programs appeared to have a strong team dynamic that facilitated strategy sharing and the provision of emotional support among colleagues. Program directors appeared to have direct responsibility for the creation of this team dynamic. For example, one program had a monthly breakfast meeting with staff and regular social outings in the evening to help case managers build positive relationships.

Finally, the program director's role included interfacing with the agency organization as a whole, whether vertically ("managing up" to senior staff) or horizontally (securing cooperation and support from other departments.) A number of program directors reported effectively playing both roles, securing the support of senior staff, as well as securing the assistance of other departments such as housing management staff, medical/psychiatric professionals, or program evaluation staff. As described earlier, in some instances, program directors discussed having to manage potential conflicts between agency and program service philosophy. One program director stated that she was able to effectively shield the program from these conflicts, but this came at the expense of having accurate perceptions of the program from other departments, who reportedly mistook the Population E program as being for highly medically vulnerable individuals.

STAKEHOLDERS' COMPONENT #3

Program directors and supervisors will provide quality supervision

In five of the nine programs (3, 4, 5, 6, and 8), program directors and supervisors were observed to provide quality supervision to staff, helping case managers and other staff to improve and enhance their delivery of services to tenants. In these five programs, supervisors achieved this through formal individual and group supervision, during which tenants' cases were reviewed, special challenges were raised and resolved, and case managers were supported in their work. Program directors described a need to make supervision as accessible as possible, informally by phone or drop-in, so that staff felt they could always find support and perspective. In addition, group supervision happened once a week or twice monthly, with individual supervision by clinically trained staff available at several but not all programs. This formal supervision was supplemented in these programs by modeling the behavior and approach they hoped and told their staff to use by holding small caseloads themselves. This allowed these supervisors to "walk the talk." As one program director explained:

"It's a new approach. The transition to harm reduction from other models is difficult. I gave my own example and my staff saw that I was struggling. My staff said, "Okay, [my program director] is in the same stage. We all need to learn how to use the harm reduction approach."

In turn, supervisors in these five programs were acknowledged by staff as being authorities in terms of skill and expertise:

"[Our clinical supervisor] has been here for three years, and had previous experience with harm reduction in Philadelphia. He has been a guiding force in maintaining fidelity to the philosophy. He brings it back in focus when the staff are frustrated."

In three other programs (1, 2, and 9), supervision was adequate in some areas, but lacking in others. Program directors and supervisors in these programs appeared to provide satisfactory support and nurturing of staff, but were observed to be inconsistent in modeling and conveying the Housing First approach. As a result, staff was sometimes confused about how to implement the model.

"[The] biggest problem with supervision is that the supervisors may have experience with other models but not with this one. The supervisors need to know how to answer questions about the model. What are we supposed to do here? If the supervisor doesn't know, how can we?"

Very often, case managers in these three programs echoed the sentiment that supervisors needed training as much as case managers did.

"I've been doing motivational interviewing since the [CSH-sponsored] learning collaborative trainings. Still haven't talked to my supervisor about it but I've implemented it and it is working. I see very small changes but these changes are occurring. My supervisor hasn't really touched base with regard to motivational interviewing or harm reduction. The reason for that is that we need training in those areas. That's the reason why she doesn't feel comfortable."

Sufficient information was not available from interviews or direct observations to assess the quality of supervision in program 7.



- **Turnover among program directors was associated with implementation challenges.**
Given the important role played by program directors in setting the philosophy, providing direction, managing operations, and supporting staff, it is not difficult to understand how turnover in that position could lead to significant implementation challenges. The two programs that did experience staff turnover at the program director level—in both cases experiencing this turnover more than once—appeared to have difficulty developing a cohesive model and coordinating operations.

“We’ve been through 4 management staff turnovers in the past year.”

The specific reasons why program directors left their positions is not known, and moreover, it is unknown whether overall problems with administration led to the program directors’ departures, or whether the persons vacating those positions were not suited to this position.

DIMENSION 2: HOUSING SEARCH, HOUSING QUALITY, AND LANDLORD RELATIONS

In supportive housing for Population E, as with other scattered-site supportive housing, the quality of housing and the physical environment is assured through the leasing and subsidizing of safe, quality private market apartments located in safe, desirable neighborhoods with adequate amenities. While this entails ensuring that the tenants themselves have positive feelings about their apartments and neighborhoods, and whether they were afforded choice in their housing, this assessment is limited to assessing program practices with regard to apartment search and selection/leasing, housing quality assurance, and interactions with landlords, which all contribute to housing quality.

For Population E scattered-site supportive housing private apartments are generally “master-leased” by the selected programs and then sub-leased to tenants, placing the programs in an intermediary role between the private landlords and the tenants. In this arrangement, the programs would have a more direct relationship with private landlords with respect to ensuring that the terms of the lease agreement would be upheld—on both the landlord’s and tenant’s ends. Programs would ensure that landlords made timely repairs, fulfilled other maintenance and safety obligations, and did not overstep their legal boundaries, while also ensuring that rent was paid on time, and that tenants did not disturb neighbors, maintained upkeep of apartments, and followed other terms of tenancy.

- **Master-leasing structure may have increased access to apartments, but possibly reduced tenant choice and satisfaction.**

The sponsor-based, master-leasing structure used in Population E was designed to mitigate potential risks and concerns that private landlords and property owners might have about renting directly to tenants whom, on the surface, would appear to be high-risk, having no or poor credit histories, no recent history of tenancy in rental housing, no references, no employment, and very limited incomes. By placing a non-profit program as an intermediary between the tenant and landlord, this sponsor-based structure would help alleviate landlord’s potential concerns and reticence by: a) ensuring that the landlord would be able to contact a non-profit in the event of any critical incidences, and b) ensuring that, at a minimum, the majority of rent owed would be paid by the non-profit through the NY/NY III subsidy. Indeed, communications with program staff confirmed that this structure likely did increase the willingness of private landlords to rent apartments to Population E eligible individuals.

“Landlords like us because they get the rent paid on time. They are more receptive even though they don’t like the population.”

The major drawback of the sponsor-based, master-leasing structure was seen to be its effect on reducing tenant choice with respect to the apartments and neighborhoods. In this structure, programs directly leased apartments from private landlords using their NY/NY III funding, and subleased to tenants. In order to ensure that apartments were available for tenants immediately upon acceptance into housing, programs typically reported conducting apartment searches and inspections and leasing a set of apartments before applicants were accepted. Therefore, once accepted, prospective tenants had to choose from one of the apartments already leased by the program. If a prospective tenant did not like any of these apartments, they were put on a waiting list until other apartments were leased, or they could choose to be housed by another program that might have a different set of apartments.

"We like to give choice based on borough, but that's not always possible."

Due to the amount of subsidy available through the NY/NY III bundled services and housing contract, the apartments that were leased were typically located in neighborhoods where apartments with lower rents could be found. Population E program staff acknowledged that this was a regrettable, if unavoidable, circumstance of their funding, and staff in some programs described feeling unsafe visiting tenants in certain neighborhoods.

"The cost [of housing] presents a challenge, and the apartments are not always in a great location. That can be tricky for substance users."

"The neighborhoods aren't great. Case managers don't feel comfortable bringing laptops to home visits, and going in the evenings can be tricky."

Staff from more than one program recounted that some tenants did not feel safe in their neighborhoods due to crime and drug activity that presented a significant temptation for them. Due to the quality of apartments and additional security offered in new supportive housing developments, some staff indicated that a single-site supportive housing building may have been preferable to many tenants.

- **Programs that used dedicated housing staff or departments to identify and secure apartments, ensure housing quality, and manage landlord relations appeared to have a distinct advantage in regards to performing these activities.**

The level of skill, experience, and sophistication in apartment search, leasing, managing housing, collecting rent, and maintaining landlord relations varied significantly among the nine programs. As with other aspects of implementation, programs appeared to fall into three groups: those who excelled, those who were satisfactory, and those who fared poorly. Across the board, staff noted how time- and skill-intensive the housing search and management activities were. Interestingly, the programs that struggled most in this area described initially viewing these activities as if they were a distraction from their "true" work, as opposed to a core part of their job performance. It is possible that performing housing search and management well first entails recognizing the importance of these activities as essential to effective supportive housing for this population rather than secondary or extraneous.

"Apartment maintenance is draining and hard for case managers...It can be frustrating when repairs are trying to get done, but the client is not in the apartment. In instances like this sometimes the case manager will go out to be there, but it takes a lot of time/energy and is not a clinical issue."

Eventually, all programs recognized the importance of not only finding quality housing, but also of building and maintaining good relationships with landlords, property managers, realtors, and superintendents.

“You have to be a diplomat, to form relationships with management companies, and get back to them quickly when they call you.”

“When a landlord calls with a problem, we address it immediately and follow-up with the landlord so he feels the program is working with him. [It’s about] mutual respect.”

Programs were observed to vary in their ability to perform housing searches, troubleshoot housing quality issues, and manage landlord relationships. The three programs that either had the forethought or the resources to have dedicated housing specialists had a distinct advantage in the form of specialized expertise and additional personnel. One program, in particular, relied heavily on its organization’s housing management department to locate apartments, maintain relationships with landlords and property managers, collect rents, and even perform maintenance and repairs. Two other programs had part-time housing specialists on staff to perform these functions. When the other programs learned of these specialty staff and departments from their peers at learning collaborative sessions, they immediately recognized what tremendous benefit these staff provided.

“We would have asked for a maintenance person so we wouldn’t have to rely solely on the super[intendants].”

“One piece of advice I would give to someone starting another program is to have a maintenance specialist who can make repairs.”

- **A recommended practice is to maintain some separation between supportive service delivery (i.e. needs assessment, service referral, etc.) and housing management (i.e. rent collection, apartment maintenance, etc.).**

In addition to bringing specialized expertise and additional staffing, the use of separate housing specialists also appeared to allow programs to maintain a separation between the dual roles of housing management and supportive service delivery, thereby mitigating some of the potential role conflicts that come with the sponsor-based structure. Many case managers noted their discomfort particularly with collecting the tenant’s share of rent (which often happened at home visits), and their concerns that rent collection responsibilities decreased their ability to develop and maintain trust with clients. As one case manager put it:

“Every time you bring up paying rent, [tenants] disengage. And you have to re-establish. Let someone else talk to them about rent.”

Two programs that did not have separate housing specialists were able to maintain some degree of separation in these roles by assigning the role of rent collection to the program director, rather than case managers. While this separation was somewhat less clear, this role assignment at least relieved case managers of the difficult and awkward conversations around rent payments, where reminders to pay the tenant share of rents could be attributed to pressure from another party. At least one program that made rent collection a case manager duty expressed some level of regret with this decision:

“[We wish we] had someone who’s a little removed from the program deal with property management.”

- **Working with a smaller set of property owners or managers to secure apartments is a double-edged sword.**

Program staff reported that strong relationships with good landlords, management companies, and realtors resulted not only in better housing quality for tenants, but in some cases, led to opportunities in the form of additional apartments. Several programs ended up finding most of their apartments through a small set of landlords and property owners/managers, who recognized the benefits involved in renting apartments to non-profit agencies with rental subsidies.

Overall, working with a smaller number of landlords reportedly reduced the number of new landlord relationships that programs had to cultivate, allowing those programs to quickly lease a larger number of apartments. At the same time, reliance on a smaller set of landlords or property owners could also backfire. In cases where landlords failed to meet obligations, such as making repairs, program staff described sometimes feeling wary about confronting landlords, as doing so might have negative consequences for multiple apartments and tenants. Emerging lessons may be that the programs need to 1) be highly selective in forming partnerships with landlords, as well as 2) ensure that they have sufficient diversity in the landlord partnerships maintained, so as to avoid becoming dependent upon a small set of landlords.

- **Population E programs made attempts to apply quality standards in selecting apartments to lease on behalf of tenants, but could benefit from some standard housing quality standards and assessment.** Most Population E programs described using some measures and standards of housing quality in selecting apartments to rent, some claiming to have very high standards that encompassed safety, maintenance, neighborhood, condition of appliances, and proximity to amenities and transportation. The programs with specialized housing departments or specially trained staff had more capacity to inspect apartments and make a determination regarding suitability for tenants. CSH provided some technical assistance and training around housing search, landlord relations, and inspections, including the introduction of a standardized apartment inspection “checklist” tool. It is unclear, however, if this was ultimately put into use by the programs. All Population E programs could likely have benefited from a standardized checklist or set of housing quality measures, such as Housing Quality Standards that are used by Public Housing Authorities.

- **Attempts at stretching resources by arranging shared two-bedroom apartments for tenants were counterproductive in terms of ensuring housing stability.**

Three Population E programs leased two-bedroom apartments and paired prospective Population E tenants as roommates, which was permitted under DOHMH’s NY/NY III contract. One program—which was also the one program that recounted the most implementation difficulties—initially offered both a mix of one-person and two-person apartments, but due to fiscal considerations, later moved all tenants into two bedroom units and gave tenants no options. In most instances, program staff stated that two bedroom apartment arrangements resulted in conflicts between tenants, decreasing housing satisfaction and quality of life for one or both tenants. One case manager noted:

“The biggest complaint [about housing] is the roommate situation for clients sharing apartments.”

A program director overseeing two bedroom units described regretting leasing the double units because of these conflicts between tenants, and noted that in the future, she would not replicate this practice.

"The double units are where we have the most problems. We have no successful double units."

In addition, a second program director stated:

"We have a lot of two-bedroom apartments and that makes things hard for clients and case managers to have roommates who both have a history of drug abuse. I would only have one-bedroom apartments if possible."

Similar to relying on fewer landlords or renting lower cost apartments, renting two-bedroom units initially seemed a good idea from the standpoint of efficiency or cost savings, but program staff described this practice as ultimately being counterproductive for increasing tenant's housing stability.

- **"Clustering" apartments is an effective way to address some of the isolation and challenges of delivering services to tenants in scattered-site settings.**

In some cases, programs rented "clusters" of apartments within buildings owned by landlords (while complying with their contractual restrictions against concentrating more than 20% of tenants within a single building). Program staff stated that doing so may have increased efficiency with respect to supportive service delivery as case managers would be able to travel to fewer locations to conduct tenant home visits.

"If I'm in a neighborhood, I can visit everyone there, even if they're not due for a meeting."

Staff noted that clustering apartments also created opportunities for clients to build community.

"Some of my clients who live in the same building, they know what's up with each other. They have holiday dinners, or bring food to each other. They also do that with people who aren't clients. It just sort of happens naturally...If something happens to one of them, they call me. They keep me informed."

Program staff did express some degree of concern about whether clustered apartments might have risks and challenges, particularly if tenants were clustered in neighborhoods with high crime rates and drug activity. However, some staff conjectured that this may be less related to the practice of clustering apartments than about selecting safe and quality neighborhoods.

DIMENSION 3: ACCESS TO HOUSING, TENANT SELECTION, AND EVICTION PREVENTION

Ensuring that vulnerable individuals are not denied housing based upon substance use or perceived lack of motivation or "housing readiness" is at the heart of low-demand supportive housing. In addition, continued access to housing opportunities and supportive services should not be restricted by unnecessary criteria, rules, services requirements, or other barriers. Below, we discuss findings regarding the programs' tenant selection and eviction prevention approaches.

- **Program staff admitted to being unable to distinguish at interview those tenants who would be more stable and those who would present greater challenges.**

As described in Section 1, to determine applicant housing eligibility, the City's Human Resources Administration (HRA) centrally screens all applicants for Population E using a uniform online application. This centralized process minimizes the ability of Population E programs to exclude applicants based on anything other than

eligibility for NY/NY III. After HRA has approved an applicant for placement, the City's Department of Homeless Services (DHS) centrally manages and reviews all referrals to Population E programs. Population E programs then review the prospective tenants' NY/NY III application, interview the prospective tenants, and based on review of the application and the interview, either accept or reject them for housing.

When asked about their intake process, program directors reported that they did not screen out referred applicants on the basis of substance use, behaviors, or lack of motivation, though in some instances, they may have accepted some referrals reluctantly. Program staff noted several instances when they thought applicants referred by DHS did not seem appropriate or "ready" for the relative independence that scattered-site supportive housing involved.

"One person was not a good fit, a woman who was street homeless. She came in with layered clothing, she couldn't stand up straight. She interviewed well, but I had reservations in terms of her being able to evacuate her apartment in, say, a fire. She moved too slowly."

Interestingly, several programs reported that whatever hesitance or reservations they had about tenants at intake were often later found to be unwarranted. On the other hand, other individuals who appeared promising at interview were later found to be problematic. As one program director stated:

"It's impossible to say who's going to end up that way during the interview."

In a sense, both NY/NY III's centralized referral system and Population E's program design helped several programs to realize the inherent problems involved in selecting tenants on the basis of their initial appearance at their interviews or their level of substance use, thus reinforcing the notion that nearly all homeless individuals were, in fact, house-able. One program director noted:

"Housing programs have the same problems regardless of the type of population. We're not seeing more drug-related incidences with this population than in any other [of our housing programs]."

STAKEHOLDERS' COMPONENT #4

Programs will rarely deny housing to applicants based on substance use, criminal history, or lack of motivation to change

All of the Population E programs reported maintaining low-threshold admission criteria for tenants, with few to no exclusions for people based on the severity of addiction, criminal histories, or the perceived lack of motivation to change among applicants.

"There are a couple of people who are using to the point where they're unable to function and maintain housing, but they still deserve a chance to try."

Much of this is likely due to the use of a centralized screening and referral process by the New York City agencies overseeing NY/NY III described in Section 1. All but one of the programs, however, cited some criteria that might serve as the basis for rejecting applicants. These included: history of arson (1, 2, 4, 6, and 7), some severe psychiatric symptoms such as delusions, hallucinations, severe thought disorders, and suicidal/homicidal impulses or attempts (1, 2, 3, 7, 8, and 9); cognitive impairments (2); and placement on sex offender registry (7).

"A handful of referrals needed a higher level of care. There was one instance where a client was turned down because the [program] offices are not wheelchair accessible. The apartment was accessible, but we felt the client would miss out if he couldn't come to the office."

At the same time, several programs noted that the centralized eligibility referral process led to a small number of early referrals that were later found not to match the intended target population because the tenants did not have active or current substance use issues. This was widely attributed to the City's initially disorganized effort to fill vacant units quickly—an effort which was eventually fine-tuned and corrected.

"Some of my clients used in the past and aren't using now. They've been clean and sober for quite some time. One was an older gentleman in the shelter who couldn't afford New York rent with SSI [Social Security Income]. He has a history of drug use but wasn't actively using."

CASAHOPE's first report, *Characteristics of Persons Housed by NY/NY III's Supportive Housing for Active Substance Users*, describes the characteristics of a sample of Population E tenants at the time of housing. While it is difficult to know if the tenants interviewed were representative of the most severely substance addicted homeless persons in New York City, broadly speaking, study participant characteristics were indicative of a disenfranchised population with diminished social capital.

	Exceeds								
Few denials of housing									
Program	1	2	3	4	5	6	7	8	9

- **Ensuring housing stability and prevention of evictions requires coordination between supportive services and housing management staff, along with acute awareness of tenant's needs and the ability to generate creative and inventive solutions.**

Program staff noted that having greater information and knowledge of tenants' clinical issues and needs was vital to ensuring housing retention and preventing evictions among Population E individuals. This was described by one program director as "taking a clinical approach" to eviction prevention. Program directors and case managers alike reported that the more trust tenants had with their case managers, the more they revealed the day-to-day issues and behaviors in which they are engaged. Moreover, the more case managers knew

about clients' issues and behaviors, the more they described feeling equipped to anticipate events that might lead to eviction.

"[Eviction prevention] involves intervening as soon as possible when we see that their behavior is not acceptable, like traffic in the apartment, drug-dealing, before it's a huge issue. Having rapport helps a lot, so that case managers can identify behavior changes that may 'red-flag' possible evictions or incarceration."

Discussions with program staff revealed the importance of close coordination between the supportive services and housing management functions of a Population E program. One program director called this a 'good cop/bad cop' dynamic, wherein the housing staff (for those programs that had separate housing staff) would approach the tenant with a strict and hardline attitude around lease compliance, while the service staff would use a more conciliatory approach. Another program director described case conferencing between housing specialists and the clinical staff and case managers as a process of collaborative problem-solving. Such coordination, if successfully achieved, was reported to result in a synergistic effect that kept tenants stably housed. As one program director stated:

"If tenants are in non-compliance, [the clinical supervisor and program director] step in. If the behavior is really bad and risking the relationship with a management company, then [Housing Specialists] might also become involved. With one non-compliant client, they picked him up in the van and case-conferenced with [the housing specialist]. There have been no problems since."

- **Program staff reported that tenants had numerous problems maintaining welfare benefits because of policies around substance use in New York City's public assistance program. These problems were described as prominent and persistent threats to housing stability.**

One of the major barriers to housing stability identified by all nine of the programs was the repeated difficulty tenants had with maintaining enrollment in public assistance (PA). Whereas supportive housing tenants with serious mental illness are typically eligible for Supplemental Security Income (SSI) as a source of income, most Population E tenants (save for those with more severe medical conditions) do not meet the threshold level of disability to qualify them for SSI. As a result, most Population E tenants are heavily reliant on New York State's welfare benefits for income, including the portion of rent for which they are directly responsible, approximately \$200 per month. However, the regulations governing PA in New York require that people with active substance use conditions participate in substance abuse treatment, or else face disenrollment from benefits, which differs from the more client-centered, low-demand philosophy behind Population E housing. In addition, enrollment in benefits frequently requires some level of work to be performed, and beneficiaries must make regular appearances and respond to regular written communication to keep PA personnel updated regarding their compliance with work requirements.

Program directors and case managers often reported how problems with PA and the Human Resources Administration (HRA), which administers PA in New York City, played a role in tenants' housing stability.

"There is one possible eviction. His PA case has been closed since April and there has been no 'face-to-face' in five months."

And while they acknowledged that many of the problems were due to tenants' non-compliance or failure to communicate with public assistance personnel, they also complained about onerous requirements, given their tenants' vulnerability.

"It's challenging to work with other systems that the client has to deal with that are not hospitable to a model like [ours]. HRA is the big one."

It was quite often the case that case managers and other staff were able to successfully intervene in cases where PA enrollment was either terminated or where tenants were sanctioned from benefits. However, resolving such cases was time-consuming, sometimes taking an entire day or several days, and addressing one tenants' PA case could preclude home or office visits with another tenant. Moreover, resolutions were often temporary as some tenants would soon become non-compliant again.

"My case manager went to the HRA center and stayed for the whole day for one client. The client was recertified, but the client may have missed the next appointment. We don't know whether the client shows up or not until their PA gets shut off."

The one program that did have a dedicated entitlements coordinator had an advantage in so far as they had both additional expertise around PA as well as additional staff to resolve issues. For other programs, ensuring compliance with PA simply became an expected part of case management.

"Case managers have an active role in a PA case to make sure that they don't have a 'Failure to Comply.' They escort clients to PA appointments, remind them of requirements."

Several learning collaborative sessions were devoted to discussing PA, including a session with high-level officials at HRA to discuss ways to increase tenant enrollment, or at least allow program the opportunity to perform early intervention around PA non-compliance. One of the strategies discussed with HRA was the possibility of tenants' voluntarily designating Population E housing programs as recipients of all communication regarding tenant PA status, requirements, appointments, etc. from HRA's PA unit. In some instances, tenants might agree to this designation. Benefit checks would still go directly to the tenants and not the programs, but programs would be kept up-to-date regarding tenant case status and would better know when early intervention was needed to keep a tenant's PA case open.

DIMENSION 4: SUPPORTIVE SERVICES DESIGN AND DELIVERY

Of all of the dimensions of supportive housing practice, the design and delivery of supportive services is the one area in which Population E departed most from other NY/NY III supportive housing categories, and the one least familiar to most of New York City's supportive housing community. For this reason, it is unsurprising that the Population E programs displayed varying facility with regard to implementing a low-demand approach to services. Some three years after implementation commenced, the nine Population E programs were at two opposite poles with respect to their adoption of this approach. Six of the nine programs displayed high quality service provision, while three appeared to struggle with the service provision.

- **Several Population E programs agreed with and understood the principles and practices of Housing First, but others exhibited an incomplete or incorrect understanding.**

At the time when implementation began, all but two of the nine agencies had had exposure to Housing First principles and practices, and many staff acknowledged that CSH's trainings were their first encounter with

many of these concepts. Three years later, six of the nine programs were viewed as having a solid understanding of the principles and core elements of the Housing First model and the substance use related practices that are integral to it. This understanding is evident in staff members' clear articulations of the main focus of the model:

"Successful, stable housing without stipulation. [We're] concentrating on the millions of other things that are more important to [tenants] than the drug use."

"Stability as far as not worrying about having a place to sleep. Providing them with the means and support to get on their own feet. Empowering them to become independent."

The degree to which these principles translated to consistent practice is somewhat less certain, but both observation and interviews suggest that these principles were largely adhered to by six programs. This was evidenced by concepts like the Stages of Change and motivational interviewing techniques being incorporated into direct practice, either to inform case managers' assessment of clients or to directly educate clients.

"With one client talking about going into treatment I actually brought out the sheet and said, 'Look, here you are in contemplation and you can get to action or you can fall back into precontemplation.' I explain that it's a process that is in our daily lives, not just in the substance use or rehab world. I used my own experience with weight issues as an example of how Stages of Change works."

"[The Stages of Change] helps you gauge where the client is at, as far as how much farther you should go with them or whether you should pull back. Helps me figure out how I'm going to engage with the client."

"I use motivational interviewing to elicit change talk so that the consumer will have the tendency to change or have a self-directed approach to reducing the harm that they cause themselves."

Observations and interviews with the three remaining programs, on the other hand, revealed an incomplete or incorrect understanding of the model. In some instances, staff exhibited an understanding that they were not to deny housing to applicants nor evict tenants on the basis of substance use, but did not truly comprehend many central tenets of the low-demand model, including methods that regard change as an incremental process, such as the Stages of Change. One program director, for instance, had not participated in CSH's trainings or other trainings on Housing First and indicated a total unfamiliarity with the Stages of Change concept. In other cases, program directors and staff referred to tenants as having "no motivation at all" or "not wanting to change," suggesting a limited competence with motivational interviewing principles, which call for recognition of subtle indications of insight by clients.

Within at least one of these three programs, substance abuse treatment and abstinence were strongly enforced, if not mandated through the program's rules, while at the same time, using some of the rhetoric associated with Housing First.

"Treatment, treatment, treatment. That's what we're about."

One of the case managers in that program acknowledged that there was no consistent stance in the program towards substance use and that the program vacillated between tolerating and prohibiting use among tenants:

“Some [supervisors] are saying you can’t use. Some are saying you can use. And some are saying you can use, but you just can’t use in the apartment.”

Some of this vacillation and lack of consistency may be less a function of program director and case manager’s misunderstanding and more a function of the conflict in perspectives and paradigms between the program staff and the larger agency’s leadership. This underscores the importance of organizational support in influencing implementation.

STAKEHOLDERS’ COMPONENT #5

Programs will use a client-centered and non-judgmental approach, service plans will be driven by tenants, and enrollment in a substance abuse treatment program will not be an assumed or enforced service

The intention of the stakeholders was that these programs would use an approach and service plan that would strengthen alliances between service programs and tenant/clients, increase program awareness of client needs, and enable programs to more effectively respond to needs. Specifically, our assessment sought to determine the extent to which programs were: a) developing service plans driven by tenants’ own goals (where goals would be enhanced by case managers but not predetermined); b) non-judgmental in reaction to tenants’ disclosed thoughts, actions, or behaviors; and c) not assuming or enforcing substance abuse treatment as one of the services to which clients would be referred. From our assessment, most, but not all, of the programs were deemed to have adopted these approaches to a significant degree. Six of the nine programs (1, 3, 4, 5, 6, and 8) met or exceeded our expectations regarding the use of these approaches.

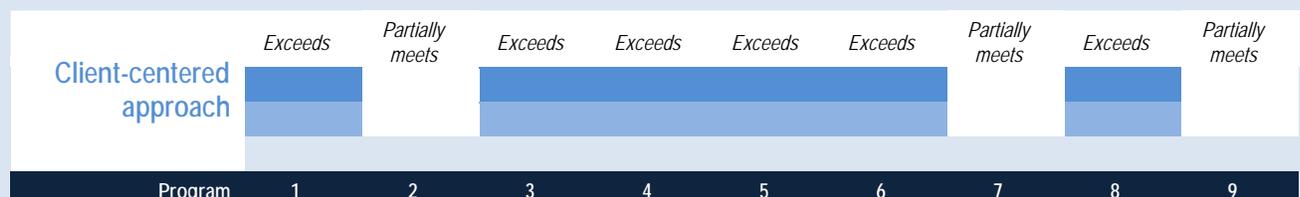
“Talking with clients opens doors to have an honest dialogue with their case manager around drug usage. They know it’s okay [to talk to us about drug use.]”

“Our case manager was the only person who was there to help and support him, and say, ‘I’m not going to judge you.’”

Three programs (2, 7, and 9), however, fell somewhat short in their adoption and employment of these approaches and principles. Two of these programs (2 and 9) were deemed to fall short because of their inconsistency in practice: While some of the staff (including the program director) employed these approaches, other staff frequently departed from this philosophy, censoring and reproaching clients when they disclosed substance use, and imposing services goals upon clients. One program (7) simply failed to correctly adopt a Housing First philosophy, most notably by rigorously encouraging or mandating tenant participation in outpatient substance abuse treatment, resulting in subsequent efforts by the City and CSH to improve their adherence to the model.

“Our supervisor didn’t discuss anything about harm reduction. In fact, [we made tenants] sign agreements not to use drugs in the apartment... When they use we threaten to kick them out.”

“Our program mandates that clients be in our treatment program or we refer them out to an intake for serious use. Clients have to be in outpatient program to be part of our housing program.”

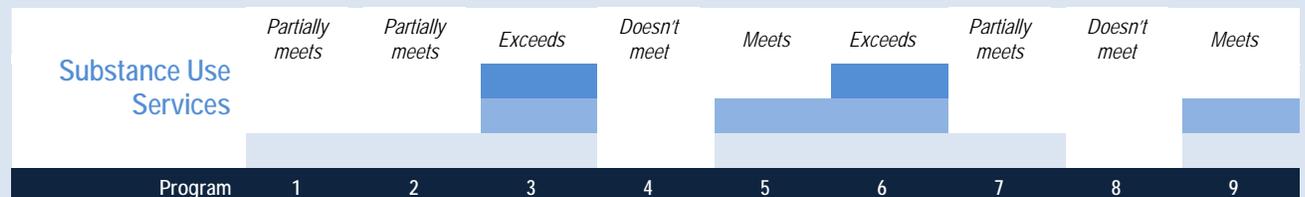


STAKEHOLDERS' COMPONENT #6

Programs will provide specific services intended to minimize possible consequences of substance use such as sexual health education, overdose prevention, substance use management, and safe injection procedures

In addition to informing the services philosophy and the manner in which services are offered to tenants, low-demand supportive housing for active substance users also encompasses the provision of specific services and education such as sexual health education, overdose prevention, use management, and safe injection. Programs were assessed for whether or not staff was trained in overdose prevention, whether or not syringe exchange is accessible onsite or through external referral or not at all, and whether or not sexual health paraphernalia were accessible. Two of the programs (3 and 6) exceeded expectations in implementing and adopting this component, offering all of the above services. Five programs (1, 2, 5, 7, and 9) provided some of these services, and two of the programs (4 and 8) showed no indication that these services were offered.

It should be noted that this assessment is not a measure of the quality of these services or whether services were offered in a client-centered, culturally competent way that made them accessible to tenants. For example, program 9 had trained staff in overdose prevention and offered naloxone onsite to help with use management, but still attempted to coerce tenants into abstinence, thereby deterring tenants from using the services that were technically available. On the other hand, program 4 and 8 did not offer any of the specific services intended to minimize possible consequences of substance use, but otherwise provided case management and other supports in a manner that was non-judgmental, and which sought to motivate tenants to seek positive healthier choices.



- **To build rapport with tenants a number of programs used creative engagement strategies early on and persistently.**

As illustrated in Section 3's Theory of Change, a key tenet of Housing First supportive housing is to anticipate and quickly attend to situations that can lead to the loss of housing. To do so, supportive service agencies need to build trust among tenants and create an environment conducive to open communication regarding substance use and other behaviors that may lead to lease violations and the loss of housing. Staff from a number of programs discussed the importance of this tenet, as well as the importance of effectively pursuing strategies to engage and build trust with tenants and solicit open communication. This included the need to practice assertive engagement as early as possible, even before tenants actually move into units.

"[Case managers] need to start meeting with the client before they actually move in, in order to get what we need done to start building that rapport before we even hand over the keys, because after we hand over the keys there is always the chance that we're not going to be able to meet with that client for a while."

Moreover, these program staff members noted using creative strategies and methods to build rapport and trust with clients. One of these strategies involved establishing activities intended to help tenants orient to their new apartments and neighborhoods, which had the dual effect of affording case managers additional time to get to know their clients. These orientation activities included taking tenants on an initial shopping trip to furnish their apartments, taking tenants on walks around their new neighborhoods to find local amenities, and holding informal social gatherings.

"Shopping the first day is also great bonding. It gives the clients a sense of ownership."

"We're touchy-feely, warm, open. Clients gossip and spread their positive view. The move-in and shopping trip really help to also bring them in."

"After they are accepted, we take them shopping to Target. They receive \$400-500 and are encouraged to get the basic necessities, but can buy whatever they want. "

"We engage clients while waiting for housing with persistence, warmth, coffee, with a friendly staff. We try to do the [intake] interviews on Thursday and encourage them to come to the Thursday night socialization group."

Another engagement strategy program staff described was the "front-loading" of apartment visits during the first few weeks after tenants moved into housing. Doing so allowed staff and tenants to build rapport with one another, as well as provided staff with the knowledge of the tenant's housing situation and local context that could help inform problem-solving in the event of future crises and conflicts.

"Engagement in the first six month period is crucial."

"Having frequent visits in the first couple months is very important. [We] see new clients at least once a week, to make sure our expectations are reinforced."

"We have weekly home visits in the beginning to make clients comfortable and let landlords know that we're not just placing them and leaving them."

Effective engagement and relationship building was not confined to these early orientation activities and home visits, but rather was an ongoing effort, requiring persistence as well as inventiveness. Program directors and case managers reported that this persistence, even in the face of some initial resistance from tenants, would prove invaluable in times of crisis. When such situations arose, staff noted that tenants who had witnessed their case managers going 'out of their way' to offer help would, in turn, be more likely to seek out the assistance of the program.

"When staff don't give up, clients get to see that this is different."

"We will 'over-engage' when a client is struggling. Clients have said, 'I was getting tired of you then, but I'm glad you kept knocking on my door.' They seem to appreciate the staff efforts once out of crisis."

"For engagement, persistence is important. In the beginning we had clients that didn't want anything to do with us and now are a fixture. Clients have history of being bounced around."

"Sometimes you have to prove yourself, follow through on the thing you said you'd do. Going at different times of the day to catch people at home and then talk to them about what's going on. Other clients feel prioritized when you keep a schedule with them. Showing them that you're different than the other people they've dealt with in their life."

Programs described often going out of their way to be accessible to tenants, to make services as low threshold as possible by making staff as accessible as possible.

"There is no wrong door; there's always someone that can assist."

"Empowerment among staff is important. They are collaborative among each other and share work. There is no "I'm not your case manager I can't deal with that". It allows for better services, increased efficiency, and increased engagement. Often a case manager visiting a building will visit other case managers' clients also in the building."

"If one case manager is in the field and her client comes to the office with a problem, whoever is available will help."

Though staff reported that most tenants were amenable to home visits and office visits as contractually required by funders, case managers occasionally had tenants on their caseloads that intentionally avoided home visits or more directly expressed contempt for having to meet with case managers. Engaging and building rapport and trust with these tenants/clients required additional creativity.

"I have a client in his mid-40s who has been extremely resistant and had failed to become engaged by any other case managers. But after meeting with this client and learning that he loves chess, I started playing chess with him and managed to engage him. Now he regularly comes to the office and meets with a psychotherapist."

STAKEHOLDERS' COMPONENT #7

Programs will actively engage and openly communicate with tenants about substance use

A key ingredient to success with Housing First supportive housing for active substance users involves creating an atmosphere of trust and openness such that clients feel safe enough to disclose sensitive behaviors, events, and issues. The premise behind this notion is that by encouraging open communication about such behaviors, especially around substance use, staff would be able to have early knowledge of critical incidences that might jeopardize tenants' housing and stability, and thereby intervene before such incidences irreversibly lead to eviction. Our assessment found that five of the programs (1, 3, 4, 5, and 6) were successful in creating this atmosphere and encouraging this level of communication. This was evidenced by examples case managers gave of tenants speaking openly about types and amounts of drugs and alcohol used, as well as other risk behaviors that tenants might have felt reticent to disclose in sobriety-based programs.

"A lot of clients were resistant to discuss their use because they were afraid of losing their housing, but once they learned that substance use wouldn't impact their housing they became more honest and open. It became more of a dialogue."

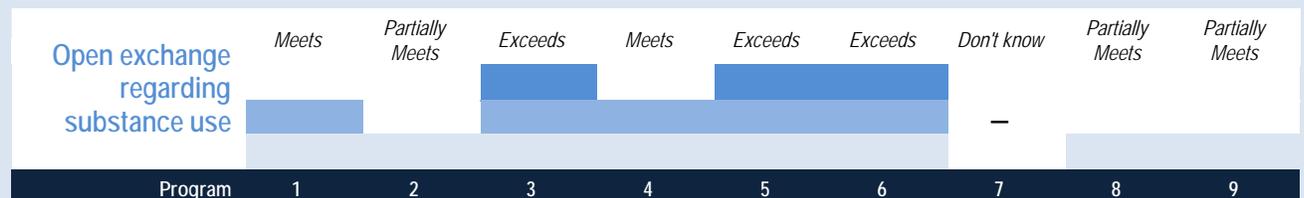
"We work with staff to not ignore use, address it head on. Ignoring it causes it to become something they are uncomfortable with."

One program (3), which also operated a NY/NY III Population F *sobriety-contingent* supportive housing program, noted observable differences in the level of trust and disclosure between Population E tenants and Population F tenants, such that the Population F tenants frequently avoided or were guarded about their drug use or relapse.

"The Population E clients are easier to deal with than the abstinence-based [Population F] clients because they are more honest. They know there won't be consequences. It gives us a starting point. With abstinence-based clients, you have to ask many questions and it goes in circles. Clients are generally skeptical about really being able to drink and use. You have to convince them that housing will remain in place and they should be forthright."

Three other programs (2, 8, and 9) were generally effective in creating an environment conducive to open communication, but were inconsistent in their client-centered response to these disclosures, therefore possibly eroding trust among clients.

"I try to get them to admit to drug abuse and see if there's a program available to help them slow down and eventually stop their use."



- **Supervision reinforced the Housing First approach, and helped case managers cope with the difficulty of seeing tenants struggle with addiction.**

As discussed in Dimension 1, effective program leadership and supervision was integral to supportive housing operation. While important in all supportive housing, clinical supervision appeared particularly critical in the Population E programs where case managers—witnessing tenant behaviors that appear self-destructive or regressive—frequently struggled with boundaries and secondary trauma. In these instances, case managers reported that effective program supervision could have a kind of therapeutic benefit for case managers:

"[While] we like the harm reduction approach ... the hardest thing case managers have to do is sit back and watch someone drink themselves to death or ... domestic violence issues. Case managers ask 'Can't we do something about it?' And we can't, until they're ready to make that step. As a manager it's hard to get case managers to understand that we can be there to provide resources and be there to help clients make moves, which is very important, but until that happens we're very limited in what we can do."

Effective clinical supervision was also perceived to further enhance and improve supportive service delivery by ensuring that case managers were remaining non-judgmental in their communication with and counseling of tenants. By providing a third-party vantage point, supervision appeared to help case managers avoid the often strong impulse to impose their own views of how tenants should behave and provide unsolicited advice to tenants. Supervisors acknowledged that the temptation to give such advice or to make punitive threats to tenants in the hopes of changing their drug using behavior was strong, and that supervision and professional development training helped line staff maintain neutrality.

"It's important that they remain reflective surfaces. This needs to be reinforced with staff. [Our program] has good motivational interviewing trainers who do role playing, et cetera. [They] come every two months and benefit from having familiarity with clients."

In some programs, case managers reported benefitting from reflection on their relationships with tenants, and supervisors espoused the psychological value of letting staff express their successes and frustrations.

"I really utilized my supervision to work on my counselor transference issues."

"We use supervision to discuss frustration, to remind them that we work with a crisis-driven population ... To teach [case managers] not to be overwhelmed but use it as a learning tool for how to help [tenants]."

When slippage from a non-judgmental stance did happen, some supervisors described stepping in to address issues quickly for fear that whatever trust had been built with the tenant in question might be lost by the unwelcome communication from case managers.

"Catch the issue at the beginning, rather than letting it fester."

In a few programs, clinical supervision was reported by case managers to be either inconsistent or deficient among supervisors, leaving them to feel unsupported and low in morale.

"We have to deal with some really intense personalities and it's very intense to deal with people who are using drugs and have been homeless. Some supervisors have been supers for a long time and gotten out of the role of having to deal with intense conflict. We can see when they're scared to deal with clients in an explorational way, but it's so helpful when supervisors can deal with things head on."

- **Case managers in all programs reported that contending with the slowness of change and missed opportunities to make progress among tenants was a significant challenge.** Staff in nearly all of the programs appeared to recognize that Population E tenants would experience behavioral

change in a gradual and incremental fashion, and that major changes and steps towards progress may be seen only after long periods of time.

"[Clients change] at their own pace. When clients don't make progress, it may just need to be rethought or reframed."

Given this, staff in most programs reported understanding their role to be that of supporting tenants to gradually increase their own insights and small movement towards healthier behaviors, along the Stages of Change.

"Very, very delicately, meet the client where he or she is at. Acknowledge there's a problem and just take baby steps to get them to agree to small services as opposed to large changes like sobriety. Baby steps. With that approach of meeting the client where they're at, we've had some success to get them to change a few behaviors."

Meanwhile, staff also generally recognized that progress and positive change would be less possible if tenants lost their housing, and most understood that the focus of supportive services should be to resolve problems and situations that could jeopardize housing retention. Ensuring housing stability, they believed, could in and of itself bring about positive changes in tenants' behaviors and choices.

"I had a client who used every day in the shelter. The shelter depressed him and he self-medicated. Once he got into housing he leveled off. He doesn't use as much, he's in a treatment program that he initiated... The change is little, but it just happens over time. It's like watching a pot boil, it happens when you're not looking."

Staff who embraced this approach and role described a greater sensitivity to subtle progress among tenants.

"Any accomplishment for these clients is an accomplishment ... They don't like to talk to people, so that's an accomplishment ... I have a client who comes [into the office] four days a week and keeps the staff laughing."

While staff may have recognized the slow pace of change among tenants, they appeared to have difficulty dealing with this fact on a day-to-day basis. Not infrequently, staff reported feeling frustrated at what appeared to be self-destructive and self-sabotaging behaviors among their tenants, and would be eager for more visible signs of progress.

"It may take three years or five years to even think about making a change. They don't care about themselves so they don't care about the services. That's frustrating."

"Who are the most frustrating clients? The ones who are content to keep using, [with] no motivation to change."

Staff and case managers described several strategies that were reportedly effective in helping reduce or cope with such frustration. One such strategy was simply to regularly celebrate small successes as a group.

"Celebrate small victories and talk about them as a group. For example, a client who would come only when he needed something and would come disheveled. In the last two weeks, he just stops by the office neatly dressed, shaved, nice haircut."

"If they come for an office visit make them welcome... praise their small success. If they have challenges be supportive."

Some programs talked about making a practice of using positive reinforcement, no matter how incremental the progress.

"Direct care staff submit monthly accomplishments to highlight those clients who have progressed, accomplishments big or small."

"We tracked three clients that came to the most programs and groups, and gave them prizes for being consistent. [It's a] token of our appreciation to let them know we see their effort and commitment."

"[We give] positive reinforcement when clients pay their rent or follow through on their service plan."

Some case managers reported that empathy for the stigma that clients may feel around receiving program help also reduced frustration. In some cases, case managers noted that empathy, patience and consistency paid off over time, literally.

"I have a young adult who came, and he didn't show up for the office visit. He had public assistance opened but as soon as he received the first rent he managed to get cut off... A case manager tried talking to him. He wouldn't come to any of the events. But after four or five months... he finally thought, "At least she cares" and he said, "I'm ashamed to go to public assistance." And he asked his case manager to help him. His case manager went with him to public assistance. Every event he's there (but not groups). He's available for home visits. We're all thrilled to see this one; we thought we would never see him. Recently we received \$3000 [in rent] arrears from public assistance. It was a good feeling."

Staff also noted that patience with tenants could reveal other surprisingly big and long-lasting changes.

"I have a 70 year-old client who had fluid in his lungs and he realized that he needed to stop drinking or die, and now he's been sober for a year."

In general, however, programs indicated that envisioning progress on a small scale was more helpful than expecting huge changes overnight.

- **Program staff recognized that service plans would need to be incremental and flexible, but demands from agency administrators seemed more stringent than funders originally intended.** Consistent with the view that change would be gradual and incremental among Population E tenants, program staff often described approaching service planning as a highly client-driven and dynamic process in which service goal setting reflected the vulnerability of tenants and the complexity of the process of change.

"I let my clients do their own goals: sweep the floor every day, go to the store to buy eggs. They're happier when they have manageable goals and attain them."

On the other hand, staff expressed that such an approach to service planning was not always accepted by senior executives within some agencies, who held expectations that tenants should have specific and more ambitious service goals and be expected to see tangible evidence of major progress around those goals.

“Service planning should be based on what clients want, not what the agency wants. Agencies want clients to get mental health or substance use services but many clients do not want that and just want to socialize.”

“Audits have highlighted the difficulty in meeting contractual requirements and meeting a client where they’re at. [It’s] tough to talk to clients about a service plan if they don’t want to.”

“The nature of the plan is not valued because the plan is supposed to address clients’ needs. The agency wants something else. So sometimes a need is identified [by the agency] and then nothing is done with it because it is not a client priority.”

“Doing the harm reduction model with the agency is a conflict of interests. They [the agency] want things done right now. Harm reduction is not really about the immediate results; it’s about doing things through the steps. So the time limit the agency puts on us doesn’t allow the harm reduction approach to get done what we have to do in a certain amount of time. If you do it right, it is going to take time.”

The apparent incongruence between the Housing First approach to service planning and the expectations and requirements of agency administrators led the programs to find an uncomfortable middle ground in which actual service planning with tenants was dialogic and dynamic, but where service planning protocols were followed as much as possible. Some case managers reported this compromise as being a challenge.

“There may be a lot of steps to get to a goal, and plans could keep you from looking at other options ... I don’t like that we have to fill out a plan in the first week of intake. I think that’s a bit rushed. It doesn’t capture enough of what the client wants and then it isn’t reevaluated for six months.”

In the case of one program, external pressures from agency executives appeared to reinforce an already misguided understanding of the Housing First model. In this program, service plans sought to enforce the goals of sobriety, even when sobriety was not the goal of the tenant and even when case managers tried to advocate for more client-centered service planning.

“They are not allowed to use [substances], and they have to attend our agency’s treatment program. They sign it [the service plan] because they want to be housed. But they don’t comply to it.”

In the end, case managers reported often completing service plans as a means to satisfying agency executives, but approached the process of change very differently when relating directly with clients.

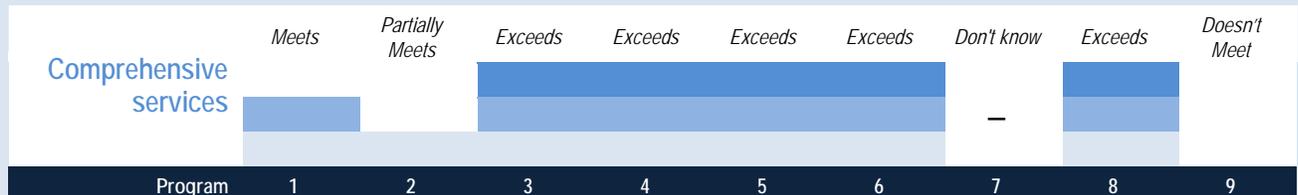
“It [the service plan] feels judgmental. Who am I to assess their progress and how they’re accomplishing their goals? I was never explained the purpose of the service plans, except for funders. I don’t use it at all with my clients. I just know my clients and I focus on more detailed

goals than the broad ones on the service plan. If it was explained and I could see the use of it I might use it.”

STAKEHOLDERS' COMPONENT #8

Services will be comprehensive, encompassing many domains and responsive to individual needs

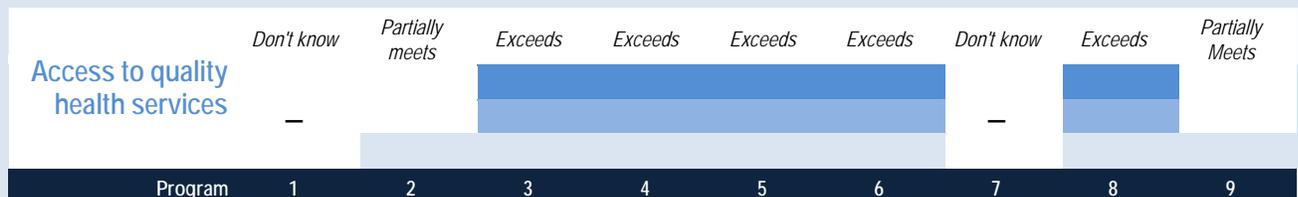
Given that tenants eligible for Population E were, by definition, faced with a complexity of psychosocial problems, program staff was observed to struggle with how to effectively attend to and respond to tenant needs. The degree of program ability to respond to these needs seemed directly related to the program's facility with brokering connections to existing services in the community. The programs most successful with providing a comprehensive scope of services were those housed within large multi-service organizations (3, 5, 6, and 8), with the distinct advantage of being able to connect tenants to other programs and services operated by the organization. Two programs (1 and 4), though lacking other relevant internal services, were able to connect tenants to external services through linkages that the agencies maintained or created specifically for the Population E supportive housing. One program (9) struggled to connect tenants to a comprehensive set of services, and instead, referred most tenants to its own outpatient drug treatment program. In this sense, the main service to which tenants were connected was limited in domain and likely inappropriate given the psychosocial profile of most tenants.



STAKEHOLDERS' COMPONENT #9

Programs will have access and strong linkages to physical and mental health services

The strategies by which the nine programs ensured access and linkages to mainstream primary and mental health services varied between the nine Population E programs. Five programs (3, 4, 5, 6, and 8) had formal linkages to primary and/or mental health services through hospitals or clinics, though these external linkages varied in terms of their strength and ability to connect tenants to quality health services. One of these programs (3) operated its own Health Care for the Homeless Clinic, and was able to provide direct medical, psychiatric, and dental services to its Population E tenants. In addition, this same program included two Psychiatric Nurse Practitioners on its supportive housing staff—with services offered in the field one day a week—and received clinical support and consultation from staff at the clinic. The remaining four programs (1, 2, 7, and 9) did not have formal linkages to primary and mental health care services for their tenants, but instead referred or brought tenants to one or more of the City's numerous municipal or non-profit hospitals. Ultimately, the degree to which tenants were adequately provided with quality health services seemed to depend upon: a) the actual provider of health services to which the program referred tenants, b) the degree of the strength of those linkages, and c) the effectiveness of the supportive housing program in identifying and responding to health and wellness needs among tenants.



- **Preset requirements for home and office visits were viewed as a source of conflict between staff and tenants; most tenants complied with contractual requirements, but staff implied that a more tailored approach to services would make support more accessible.**

Program staff described preset requirements around the number of home and office visits as inconsistent with the low-demand approach. Such requirements were likely intended to ensure a minimum standard of service delivery. Staff considered initial home visits essential to assessing tenant needs, but posited that as needs changed perhaps requirements for visits should change as well.

“Clients need more services at the beginning, but actually access more services at the three to six month marker. In the beginning they are testing the waters and caught up in newness of apartment. There are clients who access more services now, four years later, than before. Also we have tenants whose service needs have reached a plateau, and those for whom services have decreased because there is no longer a big need. There is also a cluster of clients who don’t really need services because they are very stable with employment.”

While New York City’s Department of Health and Mental Hygiene’s intended supportive services to be voluntary apart from biweekly or monthly visits, programs appeared to interpret the requirements in different ways. One program imposed more requirements of tenants: attendance at individual or group counseling, recreational activities, and biweekly support groups. For the most part, however, programs held to the baseline requirement of just one or two visits per month.

“Contractual requirements to visit clients and complete service plans make it difficult to leave services as completely voluntary. Therefore, we strongly urge clients to meet with our staff for home visits ... but other services are optional.”

“Two visits a month is a good number. Some clients get six; some struggle to hit two.”

Programs described different ways of enforcing these requirements. One program clearly communicated violations of the lease when tenants skipped visits, but stayed flexible in their interpretation of the requirements.

“Clients must be there for two home visits per month. That is the only requirement. If a tenant is not agreeing, after the first month [our clinical coordinator] will send a letter with a date, then [the program director] will send a more harsh letter, and then [our property management] will send a letter. Right now only one out of a hundred are in this boat... He likes “phone case management,” so they know he’s okay but there have been very few face-to-face visits.”

Such creative ways of complying with requirements, however, did not appear to mitigate the additional time burden that some case managers described. Because tenants who were most in crisis often demanded more support than tenants who were more stable, service staff reported that they were often overextended in their efforts to meet home and office visit requirements, under which the same level of visits were required of tenants regardless of their level of vulnerability.

“When they have problems you need more staff. Visits spread staff thin, especially when clients are not home. In case of emergency it would be difficult for someone to be there especially if they don’t have phones.”

Staff noted that tenants with complex diagnostic profiles, histories of trauma or foster care, severe mental illness, and domestic violence often required a higher level of attention than other tenants who seemed more stable. In these cases, case managers indicated that they would have preferred an option to regulate visit requirements themselves, to allow for flexibility in how often and in what ways they engaged with tenants to check in about their well-being. Even though visits were an obstacle in some cases, programs found creative ways to connect and build rapport with tenants, to make services enticing rather than just a requirement.

STAKEHOLDERS' COMPONENT #10

Programs will be well-equipped and effective around crisis intervention

Program capacity and responsiveness in intervening in crisis situations is an important component of Housing First supportive housing. Through the learning collaborative sessions and interviews, program staff reported that they were routinely impelled to respond to crisis situations including medical emergencies, encounters with law enforcement, domestic violence, and tenant deaths.

"As long as you anticipate problems and deal with them in a systematic way you can deal with them."

Ultimately, our implementation evaluation is limited in its ability to confirm or adequately assess whether programs performed crisis interventions as effectively as possible. Forthcoming reports will provide some insight regarding the degree to which tenants received crisis-related services, such as emergency room visits and hospitalizations for mental or physical health.

- **The ability of supportive services to help tenants progress towards their goals was often frustrated by system-wide barriers faced by tenants.**

Even when supportive services were delivered effectively, the ability to help tenants achieve their service goals and improve their health and other outcomes was reportedly often limited by the barriers that tenants faced in other public service systems. For instance, tenants seeking to obtain employment often faced difficulty finding jobs due to their histories of incarceration. In more than a few cases, case managers noted that the absence of viable job opportunities often contributed to depression and consequent drug use.

"For clients with a criminal background, they need help getting access to jobs. When they don't get them, they go back to using."

"A lot of my clients can't find jobs. Some have training and want jobs. They just want work. They don't want to do WEP²⁵ assignments. It's hard for people coming out of jail; they need a direct source of jobs."

The lack of employment opportunities also meant that tenants were often reliant on public assistance (PA) as their sole source of income, but, as discussed under Dimension 3, PA was not without its own barriers. While participation in work assignments was sometimes required in order to maintain benefits, programs reported that many tenants who were too physically or psychologically disabled for work might still have their PA benefits stopped for non-compliance with work requirements. One program retained a very knowledgeable and skilled benefits counselor; however even with this benefits counselor, reinstatement typically required months and was

²⁵ WEP assignment refers to the Work Experience Program, which requires public assistance recipients to work in order to maintain their benefits.

often rejected. In all other programs, this task fell to case managers less savvy about the New York City's Human Resources Administration (HRA) mandates system.

"The welfare situation bothers me so much. We give them the apartments, and then they get cut off of [public assistance]."

Staff reported that tenants' benefits were often stopped abruptly and for reasons associated with what qualified them for Population E housing in the first place, chaotic substance use and frustrated relationships with systems of care. Case managers indicated that the back and forth with HRA to resolve benefits problems became a job in itself, reportedly impairing case managers' ability to address other tenant concerns and interests. Many case managers noted that, for tenants, not receiving benefits while not being able to find satisfactory work compounded problems rather than encouraged their resolution.

STAKEHOLDERS' COMPONENT #11

Programs will have skills in connecting tenants with benefits and entitlement systems

Every one of the nine programs spoke at length about the challenges they faced with keeping tenants enrolled in benefits such as New York's public assistance (PA) program, Supplemental Security Income, Food Stamps, and Medicaid, largely because of the fact that PA requires people with addiction to participate in drug or alcohol treatment in order to obtain cash benefits. Indeed, helping tenants remain enrolled in PA and other benefits was the most frequently cited challenge to service delivery by the Population E program staff, who reportedly viewed the competing mandates of PA and Population E supportive housing as the main source of this challenge.

While all of the Population E programs recognized the importance of and contended with ensuring tenant enrollment, programs varied significantly in their ability to help tenants establish and maintain enrollment. One of the programs (3) stood out as having the most capacity and skill with ensuring tenant connection to benefits and entitlements, through the retention of an entitlements coordinator on its Population E team. This entitlements coordinator provided case managers with expertise around understanding benefits and entitlements cases and navigating those systems, as well as directly helping tenants troubleshoot case closures and dis-enrollments. All of the other programs, with the exception of one (7) that did not provide enough information regarding program approach to tenant benefits, quickly learned to navigate this system and its regulations and processes and managed to respond more or less effectively to cases. However, these programs complained about the significant amount of time diverted from addressing more holistic service needs in order to resolve difficult benefits cases, case closures, re-applications, and to negotiate with benefit program staff. Clearly, having dedicated staff who are experts in benefits and entitlements appeared to give the one program a significant advantage in ensuring tenants' continuous enrollment in benefits and entitlements—and afforded more resources to access other more holistic case management services like medical, mental health and substance use linkages.

Program	1	2	3	4	5	6	7	8	9
Skill in working with entitlement systems	Meets	Meets	Exceeds	Meets	Meets	Meets	Don't know	Meets	Meets

- **Less structured recreational and socialization activities were a critical component of Population E supportive services. Program staff viewed these services as helping tenants overcome loneliness, isolation, and the lack of experience with positive social interaction.** Population E program staff discussed loneliness and social isolation as being a service need underestimated

among tenants. In response, the programs increased programming that offered opportunities for informal social interaction.

“My clients’ problems are deeper than just boredom and unemployment. They don’t have the social skills. A lot of clients have personality disorders, mental illness. They don’t know how to make friends; the friends they can make aren’t the type they should be making. They need programs to help them with social skills, because some of them never had them.”

“They want us to do a relationship social where they can meet people. They don’t know where to go to find people for relationships.”

“Clients have burned so many bridges that family and friends don’t want anything to do with them. We are their new support system.”

Deeper frictions with socialization could sometimes be eased through program-sponsored activities. One program collaborated with the Theater for a New Audience; tenants attended playwriting workshops and then put on their plays for other tenants. Although not every program offered social outings, many discussed trying to offer several ways to help tenants socialize.

“For the clients on SSI [Social Security Income], they can’t work, so what can they do? We do support groups every Wednesday. Now that it’s summer we’re trying to get them outside and interact with each other because they’re all dealing with similar problems. We want to take them bowling, pool, baseball games, to get them to network and get them that support.”

“The occupational therapist is doing a relaxation group that’s very helpful. [The] Seeking Safety group has been a big success. ... It’s important to vary the types of groups.”

“They’ll participate in game activities—chess, checkers, trivia—as long as there’s a reward at the end. Movies, cook-outs, social gatherings where they come together with people, where they won’t be labeled or judged.”

DIMENSION 5: TENANTS RIGHTS, CHOICE, AND PARTICIPATION

All effective supportive housing models must uphold, ensure, and maximize tenant rights and tenant choice, as well as solicit tenant’s input and involvement around the operations and quality of housing and services. Supportive housing programs should educate tenants around their rights as tenants, afford tenants with the maximum degree of choice with respect to their housing, and also pursue strategies for obtaining tenant input and involvement, including through formal tenant councils and less formal communications. Doing so helps ensure the legal and fundamental human rights of tenants, but also has the practical benefits of increasing tenants’ sense of ownership over the housing, increasing tenant satisfaction, reducing potential housing management conflicts, and increasing lease compliance and housing retention. These elements are all the more critical in a Housing First supportive housing context, where members of the targeted tenancy have likely experienced a disproportionate amount of stigma, disenfranchisement, institutionalization, racism, and overall infringement of rights and choice. Offering a new environment where individual rights and choice are respected and upheld, and where the use of voice is encouraged, lies at the very core of Housing First’s premise.

- **Tenant choice around housing was constrained by program financing structure, and in some cases, program practices.**

Despite the importance of rights and choice in the Housing First model, our observation of the nine Population E programs found some limitations in the assurance and maximization of tenant rights, choice, and involvement. The first and foremost limitation stemmed from the limited choice offered around housing, as discussed in Dimension 2. In many instances, tenants were offered few choices regarding apartments and some were provided with apartments in less desirable neighborhoods. The limits to housing choice may contribute to a sense of disempowerment among tenants, wherein tenants feel less inclined to exercise their rights to safe and quality housing. Acknowledging problems with this structure, some of the programs tried to be as honest with tenants as possible, informing tenants at the beginning of the referral process of their right to refuse housing, and describing the general neighborhood of the units so that tenants would understand their choices.

A second limitation, stemmed from inconsistent communication regarding whether or not active substance use was grounds for eviction. Case managers in three programs reported occasionally threatening the loss of housing when confronted with tenants' substance use. From the point of view of the Theory of Change for this housing, doing so may not only have decreased tenants' trust, but may have also violated tenants' rights and contributed to tenants' unwillingness to voice views regarding how the supportive housing should be provided.

- **Programs found that effectively educating tenants about their rights and responsibilities as tenants required ongoing efforts.**

The rights and responsibilities of tenancy, as described in the lease and explained to the tenant at time of lease signing, are the primary basis for addressing tenant issues that could lead to eviction for most of the programs. The streamlined lease-up process, which reduced the steps and time involved in tenant selection and lease-up, meant that many tenants did not have a long period of time in which to fully digest and comprehend these rights and responsibilities. Staff reported that simply explaining their rights and responsibilities to them once at the lease signing proved to be insufficient, and Population E programs later found that staff had to reiterate and re-explain lease and program guidelines to tenants.

"Once a year, we have clients in to renew the admission agreement. We cover rules and rights again and reinforce them."

"They sign an agreement, get a copy and get a new copy every year. We bring up rights and responsibilities during our yearly celebration of housing every December."

"[We] help them be aware of their right and responsibilities. As often as possible, refresh their memory about their responsibilities. Some clients don't know their rights, so we put them on the bulletin board."

Almost all programs reiterated the need to revisit the respective rights and responsibilities of tenants and landlords as outlined in lease agreements, both on a routine basis as well as in specific instances where such rights or responsibilities were not being upheld.

Notably, a few Population E programs had explicit policies regarding substance use, which were typically straightforward requirements that barred the sale and public use of illegal drugs. While these policies were in some ways unnecessary, as such requirements were simply restatements of the law, they may have been

useful in conveying to tenants that use itself was not a violation of a lease, while reminding tenants of legal consequences of certain actions. These explicitly written policies may have helped to reinforce the parameters of the low-demand approach for staff and tenants alike. The other programs reported verbally communicating to tenants that substance use was not itself a violation of the lease, but stopped short of having explicit written policies, reportedly out of fear that doing so would encourage use.

“The policy is not written as, ‘You can get high in your apartment.’”

- **Programs used both formal and informal approaches for soliciting tenant input on program operations and quality.**

Almost every program organized a formal gathering like a tenant council or an advisory board to seek tenant input. Some offered quarterly meetings, rather than a formal tenant council.

“We have community meetings once a month (one in Brooklyn, one in the Bronx) which is more or less a forum where clients can share comments, concerns, and resources. We require that a program representative who meets with upper administration on a quarterly basis is there, as a mouthpiece for clients. We present on different topics.”

“We have a quarterly housing meeting. All clients are invited out as their opportunity to discuss challenges and changes they’d like to see.”

Even with a consumer board, program leaders in one program had an ‘open door’ policy that ensured accessibility to decision makers so tenants would feel like their input was valued. Program directors visiting tenants in the field also communicated that tenants were important and that their perspective would be valued.

“Clients feel important and special when the supervisor or director goes into the field with case managers. They realize that there is more than one person they can talk to if they need to.”

During startup, many programs noted struggling to organize tenants’ rights meetings.

“We have tried to work with clients in providing feedback and creating a tenant council, but it is difficult in a scattered-site model. We are continuing to work on this and trying to get feedback from clients through different avenues, since a tenant council was unsuccessful during our first year.”

The relative success in organizing tenant councils and advisory boards may be credited to programs housed inside larger agencies with prior experience in organizing tenant participation or simply a larger portfolio of congregate and scattered-site program from which to draw participation. Programs with a smaller number of units may have been limited in their ability to convene formal tenant councils or board due to the lack of a critical mass of tenants to sustain ongoing participation.

DIMENSION 6: TRACKING OUTCOMES AND DEFINING SUCCESS

The collection and use of data played an important role in Population E program implementation. This is largely due to the programs’ participation in and cooperation with CASAColumbia’s evaluation, along with the overall evaluation of NY/NY III conducted by the City and State, which will rigorously measure the impact of the model on tenants’ housing, health, and social outcomes, as well as the programs’ cost effectiveness. Both evaluations call

for the collection and reporting of data on a routine and regular basis and the provision of direct access (on a consensual basis) to tenants and staff for interviews and focus groups. In addition, all of the programs collected, tracked, and reported on activities and outcomes on their own. Moreover, over time, they developed and expressed strong views about how this success should be measured, how their activities might lead to the desired outcomes, and how traditional measures of success might need refinement for their unique model and population.

- **All of the programs reported collecting data on outcomes for internal purposes, which included tracking tenant progress, making mid-course interventions, and judging program success.**

While the scope of in-house data collection varied from program to program, all nine programs described efforts to track data on activities and outcomes. Eight of the programs reported using a software package called AWARDS (Affordable Wide Area Relational Database Software), though two program directors stated that their program stopped using this system because of its financial cost. The AWARDS software is customizable and supports an array of standard program records, such as client charts, property maintenance files, and service plans. Common tenant outcomes reportedly tracked by programs via AWARDS included: housing retention, substance sobriety or use, ability to perform Activities of Daily Living, public assistance benefit receipt, employment, enrollment in education or work programs, and physical and mental health services receipt. This system also allowed programs to track case manager visits and activities, as well as the types of services provided and the number of tenants taking advantage of these services, a feature many program directors reported as useful.

Whether using AWARDS, an internally created computer-based equivalent, or a basic paper-based system, programs stated that the primary purpose of data collection was to determine whether or not tenants were achieving the goals and requirements set on individual service plans, which were unique to each tenant. In addition, programs described collecting and tracking data related to apartment management, including complaints from landlords, rent payment, and apartment maintenance records. Two programs reported collecting data directly from tenants using standardized questionnaires. These questionnaires included items on tenant satisfaction with the housing program as well as indicators of stability, such as mental or physical health and social support.

While the frequency ranged from monthly to quarterly, all nine programs described tracking data via reports that were used to 1) inform staff of the areas that needed improvement within the program (i.e. increased efforts to help tenants with entitlements), 2) highlight individual tenants who needed help reaching their service plan goals, and 3) report on program activities and outcomes to persons higher up in the agencies. Though a number of program directors stated that it could be stressful to collect and report on program and tenant status in a timely manner, they frequently acknowledged the benefit in doing so. For example, one program director described using data that demonstrated the high attendance of tenant groups to successfully argue for the preservation of a recreational budget in jeopardy of being cut.

- **Program staff described outcomes that captured quality of life improvements ordinarily missed by traditional measurement tools.**

Many program directors and case managers were wary of traditional ways of defining progress in service programs, particularly those that measured progress with stark milestones such as the number of individuals who completed alcohol and drug treatment or the number of months a person remained sober. Given the high degree of vulnerability and complex service needs of Population E tenants, case managers and staff contended that progress in low-demand supportive housing for active substance users required more subtle and nuanced indicators of progress that reflected the incremental nature of change expected among tenants.

One case manager described an instance in which he was able to convince a tenant to modify his drug use behaviors to reduce visibility by the building's superintendent. While the tenant in this example did not stop or reduce his use, he did avoid behaviors that could have led to his potential eviction, thus preserving his housing. Another staff member described how the accompaniment of a tenant to an appointment at the City's public assistance office helped to ease the tenant's anxiety and led to a strengthening of the relationship and trust between the staff and tenant. In both instances, staff suggested that the process of change among Population E tenants is indeed incremental, and that traditional measures of progress might fail to see these smaller positive changes that are prerequisites to larger ones.

Staff also noted the importance of seeing progress in terms of quality of life and tenant satisfaction. This was most clear in the cases of tenants who struggled with chronic illnesses and who eventually passed away.

"A personal success has been the end-of-life care that was given to a client who died of lung cancer."

"[T]he client got his stuff together but a couple of months after that he died. His sister told me that she wanted to thank me for helping him put his life together before he died."

One program employed an in-house evaluator and was surprised by their tenant satisfaction data.

"Our client satisfaction is also in the 90th percentile when we expected the 75th percentile."

For case managers, these more nuanced views of progress also were important in sustaining morale. In many instances, staff had to remind one another to consider what achievements had been attained among tenants, despite the fact that tenants' might remain resistant to making healthier choices. Even tenants' expressions of gratitude were valued by case managers as markers of progress and success.

"Most are thankful and appreciate services. That's the beautiful thing."

- **Program staff noticed several outcomes toward positive change that resulted simply by virtue of tenants' placement into permanent housing.**

Although the staff of Population E programs viewed their case management and supportive services as critical to the achievement of success among tenants, many expressed opinions based on anecdotal evidence that the effective provision of housing alone had a positive impact on tenants' health, behavioral, and social outcomes.

"Just having housing allows a number of changes. For example, reaching out to family, and the self-esteem to do so."

"To see that clients have a positive change in their life and how happy they are in their apartment having their own place, which some of them never had before."

Retention in housing was another common measure of progress that case managers noted, even if tenants still seemed reluctant to participate in services.

"I truly believe that people have these problems because of personal issues and it's not that they don't have capacity to live independently. The fact that they stayed [in housing] as long as they have is a major success."

"Just the fact that some of these guys have been able and proud to be able to maintain their apartments. Some have beautiful apartments."

Program staff also noticed changes in substance use, employment and family relationships, often seemingly made possible by tenants' attainment of permanent housing.

"One client got out of the shelter, remained abstinent from drugs and alcohol, and reunited with her family for the first time in years ... Some guys have maintained involvement in [welfare-to-work requirements]; one guy even got promoted."

"I have a client who is an alcoholic who has been clean since December. He had pancreatitis and the doctors told him if he puts one more drink in his body he will die. He hasn't touched alcohol since December. He keeps his apartment clean and calls every week, comes in twice a month."

"I have a client who's doing great. He was on methadone and lost the rights to see his children. [But now he's] scaled from 60 mg to 5 mg of methadone, is in [an employment program], and got back visitation rights."

Given that these positive changes are frequently not the direct result of service receipt, such achievements among tenants can be missed in progress notes or standard documentation.

- **For the most part, program staff expressed a high degree of confidence in the ultimate promise of supportive housing for Population E.**

One might expect that the high degree of scrutiny given to the programs through the evaluations might lead staff to become anxious regarding outcomes and success. On the contrary, staff in Population E programs almost always expressed hope for the tenant population when given the opportunity to reflect on the larger purpose of their work.

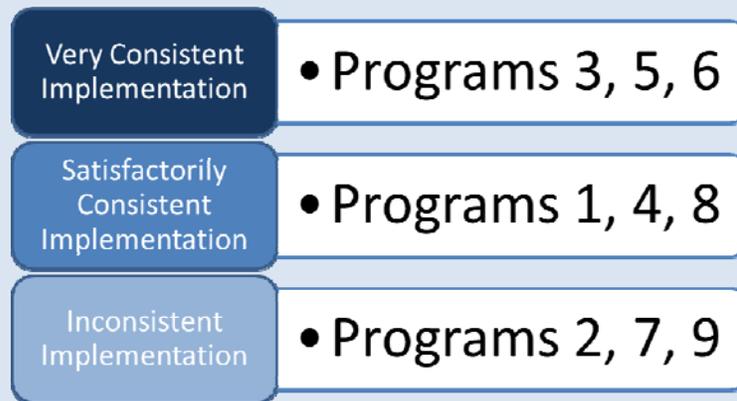
"Even with the day-to-day grind, we're still making an impact on clients' lives."

"Others need to understand that there's hope for this population. Despite our values and beliefs, they can make it if given the opportunity."

Though discouraged and frustrated at times, the staff of the Population E programs by and large reported a high degree of faith that their approach would prevail and result in improved outcomes for their tenants.

STAKEHOLDERS' COMPONENT ASSESSMENT SUMMARY

Overall, three of the nine programs (3, 5, and 6) implemented their Population E supportive housing as the stakeholders intended. These programs employed the principles and philosophy of Housing First, emphasized training and skill building among staff around key practices like motivational interviewing, and brokered a comprehensive array of services for tenants. Of these three, one program (3) stood out among the others due to such program enhancements as access to primary and behavioral health care through its own Health Care for the Homeless clinic, dedicated staff expertise around benefits and entitlements enrollment and compliance, and routine in-house training for staff around motivational interviewing. Three other programs (1, 4, and 8) exceeded or met expectations around most of the key components, but were slightly less consistent in their use of client-centered approaches to services planning, openly communicating with tenants around substance use, and/or linking tenants to primary and behavioral health care. The remaining three programs (2, 7, and 9) were somewhat less faithful in implementation of their Population E supportive housing as the stakeholders intended, facing challenges including not using client-centered approaches to services planning, requiring or mandating participating in treatment, lacking comprehensiveness in terms of the scope of services, not adequately training staff, and creating an environment not conducive to open communication about substance use.



SECTION 5: CONCLUSION AND RECOMMENDATIONS

Our examination of the NY/NY III scattered-site supportive housing for Population E uncovered both challenges and promising practices that emerged during the first two years of implementation. Overall, we found that this housing was largely operated in line with the intent and design of the public agencies that oversaw the NY/NY III agreement. Programs did not report using tenant selection policies that denied housing to applicants on the basis of substance use or addiction severity, criminal histories, or a perceived sense of a lack of motivation to change or engage in pre-specified behaviors. Most of the nine programs also recognized that tenancy in housing was not contingent upon sobriety or participation in services or treatment and that the primary focus of services was to help tenants achieve housing stability, under the premise that housing stability should be a foundation and support for healthier choices and decreased risk and harm. Most programs displayed an understanding of the general premise and principles of Housing First and its associated philosophy and practices.

However, indicators of quality program implementation, as defined by the NY/NY III stakeholders and CSH's *Seven Dimensions of Quality Supportive Housing*, varied significantly across the nine programs, with implications for dissemination of the model. The nine were bi-modal with respect to consistent practice, with six programs being effective in their provision of Housing First and three programs struggling to either maintain stability in practice or demonstrate an understanding of the Theory of Change underlying the approach. Consistent programs were successful in adopting the Housing First philosophy and program elements and implementing core practices (e.g., clinical supervision, training, team meetings), creating a program culture that appeared to reinforce practice considerations such as non-judgmental attitudes toward tenant behaviors, the use of motivation-based interviewing techniques, tenant-directed service planning, and flexible and assertive responses to crisis. In the three struggling programs, staff were observed to have an incomplete or incorrect understanding of the Housing First approach, often manifesting in a disconnect between principles and practice: Whereas staff would say that substance abuse was not grounds for eviction or termination, they nonetheless threatened tenants with the loss of housing when substance use or other behaviors were observed. Interestingly, all three of these programs experienced agency-program misalignment and conflicts in philosophy, and two had significant turnover at the program director level as well as inconsistent participation in CSH's technical assistance and trainings.

SUMMARY OF KEY LESSONS

Several lessons emerged from our findings that might be useful to organizations and governments currently implementing supportive housing for chronically homeless individuals whose substance use is a primary barrier to independent living, or those considering implementing similar housing in the future. These lessons are as follows:

- **The implementation of Housing First for actively substance using individuals entails a significant shift in perspective and practice and requires careful selection of agencies, deliberate program planning, assistance with startup, and ongoing guidance, technical assistance, and reinforcement.**

The good intentions of public agencies—coupled with guidance documents, technical assistance, and training—do not always translate into faithful implementation of Housing First. Our findings suggest the need for more careful selection of agencies to implement this type of housing, as well as more clearly defined models for implementation, including the integration of guidance and oversight by public agencies. One means to improve the selection of agencies might be to require, in solicitations or Request for Proposals (RFP), evidence that the agency as a whole supports and has a basic understanding of the Housing First model and philosophy, as well as concrete, auditable examples of how the agency's administration and senior staff will support effective program implementation. For instance, the RFP could ask agencies to submit a sample 'Policies and Procedures' around tenant selection and substance use, and indicate how these are consistent with the

Housing First model or how they will be adapted to adhere to the model. In addition, public agencies should include and fund intermediary and supporting organizations with expertise to provide guidance and technical assistance around implementation.

- **Creating Housing First units for this population through a larger, structured supportive housing policy and funding initiative was found to be a viable means of supporting effective program implementation, but program standards applied to other supportive housing models should not automatically be imposed on those using a Housing First approach.**

The inclusion of Population E as part of the NY/NY III agreement enabled the City and State of New York to make Housing First units available at an unprecedented scale and accelerated timeframe. Indeed, more than 500 units of scattered-site Population E supportive housing were made available in less than two years from the date that the City's Requests for Proposals was released (February 2007). Moreover, it is likely that embedding Population E within NY/NY III also enabled the City and State to avoid some of the possible negative attention or political controversy associated with the advancement of housing for active substance using persons, such as that which was received by the County of Los Angeles in 2010, shortly after that jurisdiction created its own Housing First models.

At the same time, any effort on the part of government or program administrators to include Housing First strategies as part of a larger supportive housing initiative like NY/NY III should also make use of program standards consistent with, or specific to, the Housing First model. In particular, program standards regarding service planning and home and office visits should not conflict with the highly client-centered approach to goal setting and service delivery used in Housing First.

- **The sponsor-based, master-leased housing acquisition structure was assessed to be a double-edged sword—increasing access to apartments, but generating role conflicts—suggesting the need to find alternative configurations for this population.**

While likely increasing the chances that chronically homeless people with active substance use and addiction could rent private market apartments, the same sponsor-based, master-leased program structure reportedly constrained tenants' choice of unit as well as led to role conflicts among Population E staff as they balanced dual responsibilities of landlord and services provider. This conflict was most evident whenever case managers were responsible for collecting rent payments from tenants, counteracting efforts to build trust and promote open communication.

These conflicts were assessed to be mitigated within programs that managed the landlord role through separate housing specialist staff or in-agency housing management departments, suggesting the need for ensuring the separation of landlord and service provider roles. To achieve this role separation while retaining the basic bundled funding/contract structure, administrators might look to another Housing First program—San Francisco's Direct Access to Housing—for an alternative configuration. In Direct Access to Housing, the San Francisco Department of Public Health contracts with a third-party non-profit organization, known as Delivering Innovation in Supportive Housing (DISH), to master-lease apartment buildings on behalf of the City and then to sublease to tenants. As a mission-driven non-profit organization, DISH is a "benevolent landlord" that functions as the intermediary between the private building owners and tenants, handling typical landlord responsibilities such as rent collection, ensuring apartment maintenance and quality, preventing lease violations, and managing conflicts between tenants and neighbors. DISH then interfaces with the supportive services staff who, relieved from housing management responsibilities, are able to focus on building rapport with tenants, enhancing tenant motivation, identifying service needs, connecting tenants to needed services, and the other

activities of supportive services that can succeed to a much greater degree under this arrangement.

- **Alignment between the service philosophy of the embedded program and that of the overall agency, as well as with the service philosophies of mainstream public service systems, played a key role in program implementation.**

One of the most significant barriers to faithful implementation of Housing First practices was found to be misalignment between overall agency philosophy (including executive staff) and the Population E programs. Executives in some agencies were observed to undermine adherence to Housing First practices by imposing program rules requiring tenant participation in substance abuse treatment or simply by voicing their personal opinions or expectations regarding how many tenants should achieve sobriety or abstinence. In a few instances, program directors were observed successfully navigating these agency-program conflicts; in others, the conflicts prevailed and implementation suffered. As discussed above, one way to avoid agency-program misalignment might be to screen potential agencies for their level of understanding and agreement with Housing First philosophy and practices. Another approach might be to monitor (e.g., through program audits) for agency-program misalignments, and through a technical assistance provider, work with executive and program staff to identify and resolve points of conflict, if possible, or determine whether or not the program should continue to receive funding.

Misalignment and conflict between the Housing First service philosophy and other mainstream service systems was found to be a second significant challenge. The most concrete and oft-cited example of this occurred with the City's public assistance (PA) program, in which individuals assessed as actively using drugs or alcohol were mandated to participate and complete substance abuse treatment or face disenrollment from cash and non-cash benefits. The punitive approach to substance abuse in the PA system runs counter to the Housing First approach to substance use. Staff also noted the difficulty in helping tenants access drug treatment as well as medical and health services that would accommodate their multiple service needs and active addiction. Tenants often reportedly disliked mainstream health services, for instance, because of long wait-times and judgmental attitudes towards substance use they perceived among doctors, nurses, and others. These paradigmatic and philosophical conflicts with larger, mainstream service systems are likely to frustrate Housing First implementation in any jurisdiction, and suggest that implementation of Housing First is significantly boosted by systems-level assistance from public agencies to help ensure alignment of other service systems, along with cross-system training for other mainstream service systems.

- **Program staff competency as well as facility with client-centered interviewing and case management practices were found to be essential to effective implementation.**

Having qualified staff at all levels of the program was observed to be indispensable to providing quality non-abstinence based supportive housing. Moreover, the common asset among successful front-line staff was effectiveness in engaging and building rapport with tenants and in attending to service needs and crisis situations. To most supervisors as well, these staff qualities were unmistakably valuable for this tenant population. The central problem, however, was how to identify candidates with a strong foundation and proclivity toward client-centered motivational counseling techniques during the hiring process. A number of instances were described in which case management staff seemed a good fit 'on paper' or at interviews, but who later proved ill-suited to the program and poor in performance. Rapport with a substance-using population is delicate; a case manager who reveals judgment, condescension or who exerts pressure to change risks not only adversely effecting rapport in the moment but also engagement with the program as a whole. One possible solution would be to make use of a standardized assessment for basic client-centered and rapport-building counseling skills. Such an assessment would evaluate a potential hire's ability to work effectively within the

motivation-based, stages of change framework that is the centerpiece of sound case management under the Housing First model for active substance users.

- **Programs with specialized services staff and direct access to health and clinical services were assessed to have a distinct advantage.**

As described in Section 4, a few of the Population E programs were able to employ specialized staff as well as access health and clinical services within other parts of their agencies. One program in particular retained a nurse practitioner and a benefits specialist as part of its services team, and was able to link its Population E program to important services provided through other parts of its agency, most notably, its medical and dental services through a Health Care for the Homeless clinic. Other programs had access to mental health and substance use services provided within their agencies, as well as peer groups, vocational, and other programs and services. These programs were assessed to have several implementation advantages over those without their own array of in-agency services. First, they were better able to rapidly respond and attend to the variety of needs and goals identified by tenants. Second, programs that had access to a rich array of services internally were also less dependent on services from outside agencies or systems that usually did not share the Housing First service philosophy and approach. Third, by having direct access to these health and clinical services, programs could demonstrate to tenants that offers to help were bona fide and legitimate, and that by seeking help, they would indeed receive it. Doing so reportedly helped to further build trust and strengthen the alliance between case managers and tenants.

- **The scale of programs may affect implementation, as larger programs were observed to have both the “economy-of-scale” and critical mass of staff and resources to leverage agency support and include program enhancements.**

Many of the critical implementation elements described above—agency-program alignment, staff competency, and having specialized services on site—were directly related to program scale. Larger Population E programs—those that had more than 50 units, for instance—had economies-of-scale, specifically larger budgets that enabled the inclusion of additional specialty staff on their teams as well as funding for staff training. Programs of 25 units, on the other hand, reported often scarcely being able to afford a clinical supervisor in addition to a program director. Moreover, larger programs, having larger service teams, were observed to help create team cultures that were self-reinforcing with respect to the Housing First philosophy and approach, assuming that they had a critical mass of staff who understood the approach. In such self-reinforcing team cultures, occasional deviance from the philosophy could be both identified and corrected through positive peer pressure from fellow team members, and staff who did not ultimately share or take to the philosophy quickly realized their own incompatibility with the approach, and therefore the job. In smaller programs with smaller teams, however, such self-reinforcing program cultures and positive peer pressure were observed to be difficult to generate; in a program with only two case managers, a single staff member’s deviance from the philosophy could exert a large, negative influence on the overall program culture. This was indeed the experience of at least one program, where one poorly performing case manager appeared to disrupt the program’s full adoption of the Housing First approach. Lastly, larger programs were also observed to have greater attention and prestige within their agencies overall, and could therefore help leverage agency alignment with the program’s Housing First philosophy and approach.

LIMITATIONS

It is important to note the limitations of our implementation assessment. First, practical considerations prevented the use of direct observation of daily program practice and housing quality. A fully comprehensive assessment of implementation success and housing quality requires observation of case manager-tenant contacts and interaction,

staff and clinical supervision sessions, inspections of apartments, observation of agency-program interactions, and perhaps ethnographic methods that assess program culture and environment. Our assessment was based upon a combination of document review, program site visits, interviews and focus groups with staff, along with our frequent and regular interaction with the nine programs over a three-year period beginning at program inception. We believe the triangulation of these data sources reduced reliability concerns that might come with over-reliance on interview responses or program documents alone, and that our methods provided sufficient basis for assessing implementation success and adherence to specific program elements.

A second limitation was the lack of an existing program model for this non-SMI population against which to measure fidelity. Unlike established and evidence-based program models, Housing First remains a relatively new intervention. In fact, attempts to create Housing First program fidelity scales and measures emerged during the course of assessment. However, these fidelity scales were largely based on Housing First programs originally designed for homeless persons with serious mental illness and were rooted in mental health practice; questions remain regarding their applicability to programs for people with a primary substance abuse disorder. Lacking preexisting fidelity scales or explicated program models, our assessment defined implementation success in two ways: the degree of adoption/implementation of program elements intended by the NY/NY III stakeholders (i.e. policymakers, public administrators, experts, and advocates), and fidelity to CSH's *Seven Dimensions of Quality for Supportive Housing*, adapted for the Housing First approach.

Lastly, our intent in this assessment was not to conduct a comparative assessment of the nine Population E programs. Our report is not an audit of program performance and not intended to inform public funding and contracting decisions. Hence, we do not identify programs by name. At the same time, data and analysis was conducted at the individual program and agency level, and this information may be used in future reports to determine if variations in implementation success are associated with impacts on tenants.

APPENDICES

A: CASAHOPE Key Stakeholder Interview Guide

B: CASAHOPE Program Director Interview Guide

C: CASAHOPE Case Manager Focus Group Guide

D: New York City's Department of Health and Mental Hygiene's Scattered-Site Supportive Housing Programs Concept Report

E: New York City's Department of Health and Mental Hygiene's Request for Proposals for 'New York/New York III Scattered-Site Supportive Housing Programs for At-Risk Young Adults Leaving Foster Care and Homeless Individuals with Substance Abuse Disorders'

F: CSH's Seven Dimensions of Quality Supportive Housing Questionnaire

G: CSH's Technical Assistance and Trainings

H: CSH's 'Supportive Housing for Chronically Homeless Single Adults with Disabling (Active) Substance Use Issues'

I: Programs Providing Population E Supportive Housing at a Glance

CASAHOPE Key Stakeholder Interview Guide

1. What was your involvement in the planning for New York/New York III and Category E (chronically homeless single adults with active substance use conditions and disabling conditions), specifically?
2. Recalling the discussions that led up to the decision to include this population in NY/NY III, what do you think was the original intent or impetus behind including this population? Where did the idea to include this population come from? [Probe: Why wasn't this population included before? What led to the inclusion this time? Were there any precipitating events such as crises, new information, changes in leadership or specific advocacy that led to this?]
3. What do you hope will be the results of the model? What outcomes do you hope to see? [Probe for measures and timeframe.] How do your expectations regarding outcomes for this population differ from some of the other categories under New York/New York III?
4. Who are the key constituencies, entities, or individuals who are interested in whether or not this program succeeds or fails? Who will make key decisions about the future of this program?
5. What constitutes program success or failure in the eyes of these other stakeholders and decisionmakers? How does this notion of success or failure differ, if at all, from your own or that of your agency? What do you think is the reason for this difference?
6. What do you think are the key ingredients or components for achieving success in any individual Category E program? Do you have a sense of whether these ingredients are in place?
7. Were any changes made to the design of the program from between the time of the original idea to include this population from the final RFP? [Probe: Changes in funding levels? Provider qualifications? Physical design?]
8. What do you think stands in the way of programs achieving success or desired outcomes? [Probe: Ask about barriers at client-level, provider-level and system-level.] Are any of these barriers things that can be changed or are they inherent to the population or design of the program?
9. Do you think the current programs will achieve success? Do you think that decisionmakers will feel that they have achieved success? Why or why not?
10. What will happen if the program is found to be successful? Will it be expanded? What happens if the program is found to be not as successful? Will it be modified, terminated, etc.?
11. Is there anything else you would like to add? Is there anyone else you think I should talk to?

CASAHOPE Program Director Interview Guide

I. General Agency and Program Overview (25 minutes)

- Could you briefly describe the work of your agency?
 - What is your guiding mission?
 - How would you describe the overall philosophy of the organization?
 - How many staff members do you have?
 - What other programs do you operate?
- Could you briefly describe this program as it operates within your agency?
 - What are the main goals and objectives of the program?
 - How would you describe the target population for this program?
 - How many people are you currently serving?
 - How many staff members do you have within the program?
- How does the overall philosophy of the organization compare to the philosophy of HRSH (especially as it relates to active substance use)? Does it complement or clash with other agency programs?
- Could you walk me through the typical process you go through to identify, recruit, house, and engage clients with the program?
 - How do you initially identify clients?
 - How do you recruit eligible individuals?
 - How do you work with clients to find housing?
 - How do you assess clients for service needs and engage them in appropriate services?
 - How do you keep clients engaged and services and retained in housing?
- What do you think are the most important aspects/components of a harm reduction model for supportive housing?

II. Seven Dimensions of Quality

a. Dimension #1: Administration, Management, and Coordination (15 minutes)

- What candidate skills, qualifications, and characteristics were considered when hiring for the program director and case management positions? In your opinion, were these the right set of qualities to be looking for in hiring staff for this type of program? What are the most important qualities of successful staff for this work?
- What kind of training was provided to staff?
 - What were the topics of the trainings and how often did they occur?
 - Which staff received the training?
- Please describe the type of supervision that you provide to staff.
 - How often did you meet with staff individually and as a group?
 - How do you help staff work in a harm reduction setting?
 - How do you help them work through difficult cases?
 - How do you help staff manage expectations of clients and/or track progress?

- How do program staff members work together as a team?
 - How does each team member fulfill the roles/responsibilities of implementing the major components of the program?
 - How do team members help each other with difficult cases (i.e. case conferencing)?
- Do you find this program requires additional attention from executive/management staff due to the nature of the work? If so, how do you incorporate them?
- Are there management practices you have implemented that you think have worked especially well?
- What have been the biggest challenges of managing this program? How did you address these challenges?
- What advice would you give someone starting a similar program about how to manage or administer the program effectively?

b. Dimension #2: Physical Environment (10 minutes)

- When looking for apartments, what are the minimum standards/characteristics you are looking for? Are there any unconventional red flags which would lead you to turn down an otherwise acceptable apartment?
- Are there any safety concerns in the apartment buildings or neighborhoods where clients live? If so, how do you address these concerns (both for clients and staff)?
- How do you work with landlords to address any safety and maintenance issues that come up?
- What do clients seem to like most about their housing? What do they seem to like least?
- What do you see as the benefits of using a scattered site approach to housing for your target population?
- What have been the biggest challenges of using a scattered-site approach? How did you address these challenges?
- What advice would you give someone starting a similar program about operating an effective scattered-site housing program?

c. Dimension #3: Access to Housing and Services (15 minutes)

- Do you feel like the people being referred to you meet the eligibility criteria and are appropriate for the program? If not, what are the biggest issues?
- Has the referral system been able to efficiently provide candidates for the program? If not, what are the biggest issues?
- Do you do any additional screening (formally or informally) about the type of person you will accept into the program?
- Are there any clients that you feel are not ready for housing? If so, how would you describe this kind of client? How would you work with such a client?

- Please describe the process you use to locate and choose an apartment to lease.
 - How do you work with private landlords to find available units?
 - How do you help clients explore different housing options and what suits them best?
 - Are there any special challenges in locating/matching housing options in a harm reduction program?
 - Do you have waiting lists for housing? If so, how do you manage them?
- What is the average time between when you start working with a client and when they become housed?
- Do clients have to make a contribution to the monthly rent? If so, how much on average (as a percentage of household income)?
- Do clients have any minimum requirements in terms of participation in services as a condition of tenancy?
- What are the benefits of using a Housing First approach with your target population?
- What have been the biggest challenges of the Housing First approach? How did you address these challenges?
- What advice would you give someone starting a similar program?

d. Dimension #4: Supportive Services Design and Delivery (20 minutes)

- Please describe your overall approach/philosophy for providing services for this population in a harm-reduction context.
- What is your program's approach to clients who are actively using?
- What strategies do you use to facilitate behavioral change with clients?
 - How do you use the Stages of Change model, if at all, particularly as it relates to substance abuse issues?
 - How do you incorporate motivational interviewing techniques into your work with clients?
- What services are available to your clients?
 - Which services are available through your program?
 - Which services are available through your organization?
 - Which services are available through referral to external providers?
 - Case management services
 - Medical Services
 - Mental Health Services
 - Substance Abuse Treatment Services
 - Vocational and employment services
 - Money management services
 - Advocacy
 - Alternative health programming
 - Independent living skills
 - Socialization activities

- MICA
 - Access to entitlements
- How is tenant access to these services within your program/agency facilitated?
 - Are the same services provided to all clients or are service plans individualized?
 - Are there mechanisms in place for linking clients to services outside of the options usually offered, if the need arises?
- How are referrals to outside providers facilitated, if at all? Have there been any problems in getting your clients access to services outside your agency? If so, please describe.
- How would you describe the quality of the services provided outside your agency?
- Do clients tend to need more frequent and intensive services upon first entering the program, or later on after they have been in housing for awhile? How do you accommodate such changing services needs within your program?
- What are some of the most effective strategies you have found to engage clients in a low-demand, harm reduction model?
- What are some of the biggest challenges of this model? How have you overcome these challenges?
- What advice would you give someone starting a similar program?

e. Dimension #5: Property and Asset Management (10 minutes)

- Which staff members are primarily responsible for property management for your program (i.e. case management, program director, housing specialist, separate property management staff, etc)?
 - How well does this arrangement work?
- Please describe how you work with private landlords/property management once your clients are in housing.
 - How, and how often, do you communicate with property management?
 - What is the policy/protocol for addressing specific problems with tenants (i.e. not paying rent, bothering other tenants, property damage, etc)?
- How do you work with clients to prevent possible evictions?
 - How, if at all, do you provide information to new tenants about tenant responsibilities and eviction policies?
 - How do you mediate disagreements and problems between property management and tenants? If so, what are some examples of how a particular conflict was resolved?

- Can you describe how you initiate and structure relationships with private landlords?
 - Have you set up master leases agreements?
 - Do you have regular check-ins with private landlords or property managers?
 - Do you provide landlords incentives to serve your tenants or guarantees of any kind?
- What are some of the most effective strategies you have found to work with landlords/property management?
- What are some of the biggest challenges of working with landlords/property management? How have you overcome these challenges?
- What advice would you give someone starting a similar program?

f. Dimension #6: Tenant Rights, Input, and Leadership (10 minutes)

- What rules and requirements do tenants in your program have?
 - Are there any differences in the tenancy agreements for your clients versus other people living in the same apartment buildings? If so, what are the differences?
 - What are the policies on drug and alcohol use?
 - Are there any limits on the length of tenancy?
- How does your program involve tenants in decision-making as it relates to their housing? Are they involved in tenant councils or other tenant-led organizations?
- What is the grievance process for tenants who have a problem with their housing situation?
- How are clients educated on their tenant rights and responsibilities?
- What are some of the most effective strategies you have found to inform/involve tenants?
- What are some of the biggest challenges? How have you overcome these challenges?
- What advice would you give someone starting a similar program?

g. Dimension #7: Data, Documentation, and Evaluation (10 minutes)

- How do you track data related to the effectiveness and efficiency of both services delivery and property management operations?
 - What outcomes do you measure?
 - What kind of data system do you use? Was there an existing system, or did you create a system specifically for this program?
 - How often do you review your progress toward meeting your outcome goals?
 - Do you share progress toward outcomes with staff on a regular basis?
 - Have you used the data to make mid-course corrections in your program? If so, what changes have you made?

- How do you set and review progress toward goals with individual tenants?
- What has been most effective in the way you track and use data in your program?
- What has been most challenging?
- What advice would you give to someone starting a similar program?

III. Concluding Questions (10 minutes)

[Note to Interviewer: Quickly scan the assessment tool that respondents completed prior to the interview. If there are any inconsistencies with the information they provided in this interview, please follow up with some clarifying questions. If not, proceed with the following questions to conclude the interview.]

- Overall, what have been your biggest successes in implementing this program?
- What have been the biggest challenges and how have you addressed them?
- When you think about each dimension of quality, are there other features or components that we haven't talked about that are essential for the success of a harm reduction supportive housing program? *[Note to interviewer: It would probably be helpful to list the seven dimensions to refresh the interviewee's memory.]*
- What kind of client benefits the most? The least?
- What are some specific examples of clients who have made the most positive changes? What aspects of the program have been most successful for these clients?
- What are some specific examples of clients that have been the most difficult to work with? What aspects of the program could be changed, improved, or added to help you work with these clients?
- Is there anything that we haven't discussed about the program that you feel is important for others to understand about your program?

Population E Case Manager Interview Guide

I. Agenda Setting (5 min)

- Describe the purpose of the Focus Group: to gather information for people who might want to create housing like the kind you work in. Describe how innovative Cat E is because of its scale, its population, its diversity of providers and its continuous evaluation.
- Not like a Learning Collaborative. It's semi-open with some guiding questions; the facilitator is here to make sure that every person has an opportunity to share their feedback in response to all the questions. Facilitation will be more heavy handed than in our typical LC meetings and trainings.
- Try to keep your answers succinct, so everyone gets a chance to share. We'll try to keep the goal in mind: lessons learned.
- Recorded but no identifying information will be shared with your agency or supervisors. Confidentiality amongst one another.
- Ask for any questions before we begin.

II. General Agency and Program Overview (20 minutes)

- What are the main goals and objectives of the program?

III. Seven Dimensions of Quality

a. Dimension #1: Administration, Management, and Coordination (30 minutes)

- Please describe the type of supervision that you receive.
- How have your supervisors helped you work in the harm reduction model? How have they hindered your work? What advice would you give to future supervisors?
- What would keep you in this job for a long time? What would make you want to leave?

b. Dimension #3: Access to Housing and Services (15 minutes)

- Define Housing First for the group. Then ask:
- *Are there any clients that you feel are not ready for housing? If so, how would you describe this kind of client? How would you work with such a client?*
- Do your clients, in general, meet the qualifications for Category E? In other words, are the clients who came in the door the ones we anticipated?
- What advice would you give someone starting a similar program, about using a Housing First approach?

Break (10 minutes)

c. Dimension #4: Supportive Services Design and Delivery (45 minutes)

- What is your program's approach to clients who are actively using?
- On a scale of 0-10, how effective do you think the harm reduction model is in this type of housing? What makes you say _____ and not a lower number?
- *Think about how you felt about harm reduction in the beginning of your work with Category E. What differences do you notice between how you felt in the beginning about harm reduction housing and how you feel now?*
- How do you use the Stages of Change model, if at all, particularly as it relates to substance use?
- What kind of motivational interviewing training have you received? How do you incorporate motivational interviewing techniques into your work with clients? How proficient would you say you are with it?
- Which services are clients most interested in?
- If you could design services for them, what would you offer?
- What advice would you give someone starting a similar program?

d. Dimension #6: Tenant Rights, Input, and Leadership (15 minutes)

- In what ways have you seen tenants develop community norms and community leadership, if at all?
- On a scale of 0-10, how much input do tenants have in the design and implementation of the services and housing they receive?
- What advice would you give someone starting a similar program?

e. Dimension #7: Data, Documentation, and Evaluation (15 minutes)

- How do you set and review progress toward goals with individual tenants?
- What do you like about service planning and what would you change about it?
- If you were looking to measure change over time for your tenants, what would you measure?
- What advice would you give to someone starting a similar program?

IV. Concluding Questions (15 minutes)

- Name one "success story" in implementing this program.
- What would you change about the program, if you could?
- What have been the biggest challenges and how have you addressed them?
- What are some specific examples of clients who have made the most positive changes?
- What aspects of the program have been most successful for these clients?
- What are some specific examples of clients that have been the most difficult to work with?
- What aspects of the program could be changed, improved, or added to help you work with these clients?
- What did you find most rewarding? What was most challenging?

- Is there anything that we haven't discussed about the program that you feel is important for others to understand about your program?



THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Mayor

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Commissioner

nyc.gov/health

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NY/NY III Scattered - Site Supportive Housing Programs Concept Report

A. Purpose of RFP

In November, 2005, Mayor Michael R. Bloomberg and Governor George E. Pataki announced the *New York/New York III Supportive Housing* agreement, a pact between the City and State to develop and fund 9,000 new units of supportive housing in New York City over the next ten years. These units will help fulfill the City's overall commitment to create 12,000 new units of supportive housing for homeless New Yorkers. Supportive housing combines affordable housing with appropriate social services to help people with special needs who are homeless or at risk of becoming homeless achieve housing stability and independence in the community. It is the proven cost-effective solution to homelessness, as it is less costly to provide housing than to expend resources on emergency care such as shelters, hospitals, jails and prisons.

Pursuant to two prior *New York/New York* agreements, the City and State produced over 5,000 units of supportive housing. However, those housing units were solely for single adults with serious and persistent mental illness who had some history of homelessness. *New York/New York III*, on the other hand, targets a much broader range of eligible clients that more accurately reflects the populations of homeless people living on the streets and in shelters today.

New York/New York III provides for the development and funding of both congregate (single-site) and scattered-site models of supportive housing. The New York City Department of Health and Mental Hygiene (DOHMH) will be the lead agency contracting for the ongoing operation and support services in the City's share of *New York/New York III* housing, with the exception of the units designated for individuals with HIV/AIDS for which the NYC Human Resources Administration (HRA) will be responsible.

DOHMH will issue separate Concept Reports and Requests for Proposals (RFP) for the congregate models and for the scattered-site units. For the scattered-site units, DOHMH will issue two separate RFPs: one for the programs scheduled to open in City fiscal year 2006-2007 and another one for the programs scheduled to open in City fiscal year 2007-2008.

Pursuant to the intended 2006-07 and the 2007-08 Scattered-Site RFPs for *New York/New York III*, DOHMH will seek appropriately qualified not-for-profit social service organizations to provide scattered-site supportive housing programs within NYC to the following three target populations:

1. Young adults (ages 18- 25 years) leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthday and who are at risk of street homelessness or sheltered homelessness. (Two awards of 25 units each for a total of 50 units)
2. Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition (i.e., a medical or mental health condition (non-SPMI) that further impairs their ability to live independently.) (Ten awards of 25 units each for a total of 250 units)*
3. Single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing to sustain sobriety and achieve independent living. (Five awards of 25 units each for a total of 125 units)*

*During 2006-2007 up to 50 units in these categories will be targeted to young adults (ages 18-25 years).

For purposes of this Scattered-Site RFP, a “chronically homeless” individual is defined as anyone who has a disability and has been homeless for at least 365 days of the last two years, not necessarily consecutively. “Homeless” is defined as anyone sleeping in an emergency shelter, a drop-in center, in public or other places not meant for human habitation, or living in transitional/supportive housing but having come from the streets or emergency shelters.

Proposers will be permitted to propose to serve more than one target population delineated above and/or to propose programs in more than one borough. However, a separate and complete proposal must be submitted for each proposed target population and/or borough. In the event that a proposer is eligible for an award to serve more than one target population and/or borough, DOHMH will reserve the right to determine, based on the proposer's demonstrated organizational capability and the best interests of the City, how many and for which population(s)/borough(s) the proposer will be awarded a contract.

B. Planned Method of Evaluating Proposals

Proposals will be evaluated pursuant to the criteria set forth in the RFP: demonstrated quantity and quality of successful relevant program experience; demonstrated level of organizational capability; and quality of proposed program approach. Preference will given to proposers who target geographic areas of the City that have the greatest need for homeless housing. The RFP will specify the areas in each of the five boroughs with the greatest need. Contracts will be awarded to the responsible proposers whose proposals are determined to be the most advantageous to the City, taking into consideration the price and such other factors or criteria that are set forth in the RFP.

C. Anticipated Contract Term

It is anticipated that the term of the contracts awarded from the RFP will be for an initial period of up to three years, and will include two three-year options to renew. DOHMH reserves the right, prior to contract award, to determine the length of the initial contract term and each option to renew, if any.

D. Anticipated RFP Timetable

It is anticipated that this FY 2006-07 Scattered-Site RFP will be released in October 2006, and that the deadline for receipt of proposals will be approximately four weeks thereafter. A non-mandatory (but strongly suggested) pre-proposal conference for potential proposers will be held approximately two weeks after the RFP release date. It is anticipated that contractors will be selected beginning in January 2007.

E. Funding Information

The exact annual funding levels available for the rental subsidy and support services to the three target populations are currently awaiting final determination by the City and State. However, the funding source and the City's current estimates of the total annual funding range for each of the target populations (as cited in Section A, above) are set forth in the chart below. As soon as a final funding determination is made, the Department will post an addendum to this Concept Report on its website setting forth the finalized annual funding levels for each target population. In addition, proposers are advised that, should Cost of Living Adjustments (COLA's) for these programs be made available through future City and State budgets, annualized funding rates for each housing unit may be adjusted to reflect these increases.

<u>Population</u>	<u>Funding Source</u>	<u>Estimated Range</u>
1.	City Tax Levy and State Office of Children and Family Services	\$925,000 – \$1,100,000
2.	City Tax Levy and State Office of Alcoholism and Substance Abuse Services	\$3,875,000 – \$5,125,000
3.	City Tax Levy	\$1,812,500 – \$2,312,500

F. Program Information

Generally, these programs would provide scattered-site housing and appropriate support services to individuals in each of the three designated populations in order to enable them to live as independently as possible.

1. Site Considerations

Apartments would be located Citywide in neighborhoods that are in close proximity to public transportation and accessible to other amenities like shopping, health care and other services. Living units should be studio or one-bedroom apartments, which offer clients access to individual food preparation and private bathrooms. Clients would be required to contribute up to a maximum of 30% of their household income toward rent and utilities. Contractors may rent clusters of apartments in a single building for purposes of siting these programs. However, programs would rent no more than 20-25 % of the units in any one building. Whenever possible, providers would include the name of their agency along with the tenant's name on the apartment lease with the landlord.

2. Support Services

The contractor would develop in conjunction with each client an individualized housing-related needs assessment and support services plan, including an action plan with clearly stated goals aimed at assisting clients to achieve maximum functional capacity. In addition, the contractor would coordinate services for each client with the organization's own programs or other appropriate providers in the community.

Core supportive services to be provided to all target populations include, but are not limited to: case management, medication management, rehabilitation, personal assistance that emphasizes learning daily living skills, residential stability in housing, financial management, vocational training, employment placement and retention, and assistance in gaining access to public benefits and services. In addition, the contractor would provide linkages/referrals to: primary medical and mental health care, substance abuse counseling and treatment, HIV prevention services. In the provision of all services, the contractor would ensure sufficient program flexibility during evenings and weekends in order to accommodate the work, training and/or treatment requirements applicable to clients receiving or applying for public assistance.

In addition to their individualized service plans, all clients would have direct input into ongoing program implementation and management through regular community meetings, advisory boards, or other means.

Housing would not be lost due to hospitalization, relapse, or failure to participate in program activities.

3. Specialized program information for each of the three target populations

i. Young adults (ages 18- 25 years) leaving or having recently left foster care

Housing stability, unsubsidized employment, educational gain and homelessness prevention are the primary goals of supportive housing programs for young adults leaving or recently having left foster care. These programs would take into account the developmental needs of young people being served, creatively engage them in services and ensure sufficient program flexibility during evenings and on weekends to accommodate work, training and school schedules as well as clients' changing needs over time. Services would be based on positive youth development principles that recognize and build on the strengths of the participants rather than focusing on their deficits.

Accordingly, in addition to providing the core supportive services prescribed above, the contractor's approach would include services such as: "hard" job skills, job readiness, including resume writing, job search and job retention skills training and employment placement services, GED/ABE/ESL classes, mentoring, and leadership development. Moreover, taking a harm reduction approach, the contractor would offer health and nutritional counseling, health education and infectious disease prevention, relationship skills, crisis intervention, home visits and other community supports. All services would be provided either through the contractor's own programs or through linkages to appropriate community providers. Since some young adults in this population are lesbian, gay,

bisexual, transgender and questioning (LGBTQ), programming and staff need to be responsive, sensitive and reflective of the full range of the population. .

Although there would be no length of stay restrictions, a goal of these young adult programs would be to move clients on to independent, non-programmatic housing or, where appropriate, to other supportive housing settings for adults. Therefore, staff would undertake an assessment of each client's housing and ongoing service needs at least one year prior to each client reaching the age of 26 years, in order to assist them in moving on as described above.

DOHMH currently estimates that the maximum available annual rate to provide support services and cover ongoing operation costs for each unit housing individuals 25 years or younger would be in the range of \$18,500 to \$22,000. The extent to which clients who attain the age of 26 will be funded, if at all, is currently awaiting final determination by the City and State. As soon as a final determination is made, the Department will post an addendum to this Concept Report on its website setting for the funding status for clients who surpass the upper age limit of this program.

ii. Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living

Because a majority of clients in these permanent housing programs will have an active substance abuse disorder upon admission, these programs would adopt a client-centered, non-judgmental and flexible approach whereby sobriety is encouraged and supported, but not enforced or presumed as a primary goal. Rather, the focus of individualized service plans will be the enhancement of housing stability and the avoidance or reduction of high risk and harmful behaviors related to substance abuse. Program emphasis would be on relationship and trust building, where clients are allowed to set the goals of services themselves.

In addition to providing the core supportive services prescribed above, the contractor would provide a wide variety of interventions and services, including, but not limited to: crisis intervention, conflict resolution, Alcoholics Anonymous or Narcotics Anonymous groups, nutrition counseling, community building activities, individual and group counseling, home visits and recreation skills. Contractors would also provide harm reduction services focusing on the avoidance of high risk behaviors and disease prevention, including, but not limited to: safe injection, use of naloxone to prevent death from opioid overdose, safe sex practices, needle exchange, health education and infectious disease prevention. Since many individuals dealing with substance abuse disorders have been victimized or abused either as children or later in life, all supportive services must be trauma-informed in order to address the underlying issues of addiction. All services would be provided either through the contractor's own programs or through linkages to appropriate community providers.

Although there would be no length of stay restrictions, staff would be knowledgeable about housing placement in order to assist clients who would like to move on to a more independent setting.

These programs will also serve up to 50 young adults who have a substance abuse disorder that is a primary barrier to independent living as referenced in Section A above.

DOHMH currently estimates that the maximum available annual rate to provide support services and cover ongoing operation costs for each unit housing this population would be in the range of \$15,500 to \$20,500.

- iii. Homeless single adults who have completed a course of treatment for a substance abuse disorder.

Bridging the gap between intensive substance abuse treatment and the long-term needs of the individual, these transitional programs would support clients in sustaining sobriety and achieving independent living. Recovery planning and relapse prevention founded on individual counseling and support provided by mental health and substance abuse professionals and peer counselors would be the foundation of these programs. High levels of trust and a non-judgmental stance would characterize the relationships between staff and clients. Accordingly, in addition to providing the core supportive services prescribed above, the service plans would include, but not be limited to: community building activities, Alcoholics Anonymous or Narcotics Anonymous groups, home visits and other support services. Since many individuals receiving substance abuse treatment have been victimized or abused, either as children or later in their lives, all supportive services must be trauma-informed in order to address any underlying issues of addiction. All services would be provided either through the contractor's own programs or through linkages to appropriate community providers.

Although there would be no length of stay restrictions, a goal of these programs would be to move clients on to independent, non-programmatic housing or, where appropriate, to other supportive housing settings. Therefore, staff would assess each client's housing and ongoing service needs soon after admission in order to plan for future housing options.

These programs will also serve up to 50 young adults who have completed a course of treatment for a substance abuse disorder as referenced in Section A above.

DOHMH currently estimates that the maximum available annual rate to provide support services and cover ongoing operation costs for each unit housing this population would be in the range of \$14,500 to \$18,500.

4. Eligibility and Placement

Referral sources such as shelters, street outreach teams, drop-in centers, hospitals, etc. will be required to complete and file a housing application for each potential client through HRA. Clients whose HRA applications are approved and who are deemed eligible for the NY/NY III housing based on the criteria in the RFP will be referred directly to housing providers as directed by the Administration for Children Services (ACS) in the case of young adults or by the New York City Department of Homeless Services (DHS) for all other clients. Housing providers will be required to obtain authorization from ACS or DHS as appropriate prior to placing these clients into a NY/NY III unit. In addition, intake criteria would be low-barrier and low-threshold, and would permit reconsideration of clients who initially turned down an apartment.

G. Proposed Vendor Performance Reporting Requirements

In accordance with the provisions of the *NY/NY III Supportive Housing* agreement, the State and the City will develop data collection and reporting systems to evaluate the outcomes and determine the costs and benefits of the services provided under the agreement. These evaluations will include, but not be limited to, the clients' use of Medicaid and other publicly-funded services and facilities such as behavioral health care, shelter, jail and prison, before and after placement into supportive housing. The RFP will request proposers to submit a written assurance of their willingness to submit all data and reports required by the State and the City to evaluate client, program and fiscal outcomes. A determination of eligibility for contract award shall be subject to submission of such a written assurance.

Submission of required documents and information in accordance with the terms of the contract including but not limited to the following:

1. Claims
2. Levels of Service Reports
3. Program and Fiscal Audits
4. General client level information such as demographics, referral source, income source, place discharged to and other outcome data as requested, etc.

H. Comments

Written comments on this concept report will be accepted until September 25, 2006, and must be directed to the following contact person:

Karen L. Mankin, Contracting Officer
Office of the Agency Chief Contracting Officer
New York City Department of Health and Mental Hygiene
93 Worth Street, Room 812
New York, NY 10013
Telephone #: 212 219-5873
E-Mail: kmankin@health.nyc.gov

Date of Issue
February 16, 2007

THE CITY OF NEW YORK
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Thomas R. Frieden, M.D., M.P.H.
Commissioner

Lloyd I. Sederer, M.D.
Executive Deputy Commissioner
Division of Mental Hygiene

REQUEST FOR PROPOSALS

**NEW YORK/NEW YORK III SCATTERED-SITE SUPPORTIVE
HOUSING PROGRAMS FOR AT RISK YOUNG ADULTS
LEAVING FOSTER CARE AND HOMELESS INDIVIDUALS
WITH SUBSTANCE ABUSE DISORDERS**

PIN:08PO 0825

Patricia A. Thomas
Associate Commissioner
Agency Chief Contracting Officer

**THE CITY OF NEW YORK
NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE**

REQUEST FOR PROPOSALS

**NEW YORK/NEW YORK III SCATTERED-SITE SUPPORTIVE HOUSING PROGRAMS
FOR AT RISK YOUNG ADULTS LEAVING FOSTER CARE AND HOMELESS
INDIVIDUALS WITH SUBSTANCE ABUSE DISORDERS
FISCAL YEAR 2007-2008**

PIN 08PO 0825

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AUTHORIZED DEPARTMENT CONTACT PERSON

Proposers are advised that the Authorized DEPARTMENT Contact Person for all matters concerning this Request for Proposals is:

Name:	Karen L. Mankin
Title:	Contracting Officer
Address:	Office of the Agency Chief Contracting Officer New York City Department of Health and Mental Hygiene 93 Worth Street, Room 812 New York, NY 10013
Telephone #:	(212) 219-5873
Fax #:	(212) 219-5890
Email:	<u>kmankin@health.nyc.gov</u>

SECTION I - TIMETABLE

A. Release Date of the Request for Proposals: February 16, 2007

All questions and requests for additional information concerning this RFP should be directed to Karen L. Mankin, the Authorized Department Contact Person using the contact information shown on the Table of Contents page.

B. Pre-Proposal Conference:

- Dates: March 8, 2007
- Time: 1:00 PM
- Location: 22 Reade Street, Spector Hall Auditorium, New York, NY 10007

DOHMH encourages vendors to submit questions by email prior to the Pre-Proposal Conference to facilitate further discussions at the Conference. All responses to questions will be summarized in an Addendum to be released shortly after the Conference. Please e-mail questions to Karen Mankin at the e-mail address kmankin@health.nyc.gov. You may also call Ms. Mankin at (212) 219-5873.

Attendance by proposers is optional but strongly recommended by DOHMH.

C. Proposal Due Date, Time and Location:

- Date: March 26, 2007
- Time: 3:00 PM
- Location: 93 Worth Street, Room 812, New York, NY 10013

Proposals received at this location after the proposal due date and time are late and shall not be accepted by the Department, except as provided under New York City's Procurement Policy Board Rules.

The Department will consider requests made to the Authorized Agency Contact Person to extend the proposal due date and time prescribed above. However, unless the Department issues a written addendum to this RFP that extends the proposal due date and time for all proposers, the proposal due date and time prescribed above shall remain in effect.

Proposals shall be submitted to Karen L. Mankin, Contracting Officer
E-mailed or faxed proposals will **not** be accepted by DOHMH.

D. Anticipated Contract Start Date: July, 2007

SECTION II - SUMMARY OF THE REQUEST FOR PROPOSALS

A. Purpose of RFP

DOHMH is seeking appropriately qualified organizations to provide high quality scattered-site supportive housing citywide for at-risk young adults leaving foster care and homeless individuals with substance abuse disorders as set forth in Section C, below, to enable them to live as independently as possible.

B. NY/NY III Supportive Housing Agreement Overview

In November, 2005, Mayor Michael R. Bloomberg and Governor George E. Pataki announced the *New York/New York III Supportive Housing* agreement, a pact between the City and State to develop and fund 9,000 new units of supportive housing in New York City over the next ten years. Pursuant to two prior *New York/New York* agreements, the City and State produced over 5,000 units of supportive housing. However, those housing units were solely for single adults with serious and persistent mental illness who had some history of homelessness. *New York/New York III*, on the other hand, targets a much broader range of eligible clients that more accurately reflects the people living on the streets and in shelters today.

The *New York/New York III* agreement provides for the development and funding of both congregate (single-site) and scattered-site (apartments rented from private landlords that are spread throughout a community) models of supportive housing. The Department of Health and Mental Hygiene (DOHMH) is the lead agency contracting for the ongoing operation and support services in the City's share of *New York/New York III* housing, with the exception of the units designated for individuals with HIV/AIDS for which the NYC Human Resources Administration (HRA) is responsible. This Request for Proposals (RFP) is for all scattered-site programs for which DOHMH will be contracting during **both** City fiscal year 2006-2007 **and** City fiscal year 2007-2008.

C. Population Options

The three Population Options and number of units targeted for each are as follows:

1. *Population Option I (Total Units - 100)* – Young adults (ages 18- 25 years) leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthday and who are at risk of street homelessness or sheltered homelessness and need supportive housing to achieve independent living.
2. *Population Option II (Total Units -500)* – Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition (i.e., a medical or mental health condition (excluding serious and persistent mental illness (“non-SPMI”)) that further impairs their ability to live independently.)*
3. *Population Option III (Total Units - 250)* – Single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need transitional supportive housing to sustain sobriety and achieve independent living.*

* Up to 50 total units in each of these two Population Options will be targeted to young adults (aged 18-25 years). These units will be in addition to the 100 young adult units in Population Option I. In

order to be placed in Population Options II and III the young adults must meet the applicable eligibility requirements for these Population Options as described in Section III, except that young adults aged 18-25 who are homeless, but do not meet the “chronic” requirement, may be accepted into these units, although chronically homeless young adults will be given priority. Greater consideration will be given to proposers who include young adult units in proposals for Population Options II and III.

Proposers may propose to serve more than one Population Option; however, in such case, the proposer must submit a separate and complete proposal for each Population Option proposed. In addition, proposers must propose a program that will be comprised of a minimum of 25 units, 50 units or 75 units. Greater consideration will be given to proposers that propose additional units above the applicable minimum in combination with a high quality program.

In the case that a proposer is eligible for award to serve more than one Population Option or for an award to serve more than 25 units, DOHMH reserves the right to determine, based on the proposer’s demonstrated organizational capability and the best interests of the City, respectively, for which population(s) and/or for how many units the proposer will receive an award.

D. Housing Considerations

Apartments would be located citywide in neighborhoods that are in close proximity to public transportation and accessible to other amenities like shopping, laundry, health care and other necessary services. Apartments for any single program may be located in more than one borough. Living units should preferably be studio or one-bedroom apartments, which offer clients access to individual bathrooms, kitchens and storage space for clothing and other personal items

Due to the limited availability of supportive housing options in some areas of the City, greater consideration will be given to proposers who propose to operate scattered- housing in the following community districts:¹

Bronx Community Districts: 7, 8,9,10, 11 and 12

Brooklyn Community Districts: 1,4,6,9,10,11,12,13,14,15, 17 and 18

Manhattan Community Districts: 1, 2, 6 and 8.

Queens Community Districts: Any Community District

Staten Island: Any Community District

E. Anticipated Contract Term

It is anticipated that the term of the contracts awarded from this RFP will be for an initial period of three years, commencing on July 1, 2007. The contracts will/ include two, three-year options to renew. DOHMH reserves the right, prior to contract award, to determine the length of the initial contract term and each option to renew, if any.

¹ Based on 2006 inventory of New York City Housing Preservation and Development (HPD) funded Supportive Housing Projects, inclusive of pipeline projects.

F. Anticipated Available Annual Funding

DOHMH will fund the rent subsidy and support services components of the programs through this contract. In addition, proposers may apply for other rental subsidies from any other available sources. In the case of programs that obtain such other rent subsidy funding, the maximum amount per unit from DOHMH will be reduced to fund only the support services provided to the clients. Clients must contribute 30% of their income towards rent and utilities combined, or in the case of a client who is eligible for public assistance through HRA, the applicable amount as required by State regulation.

The total anticipated maximum available annual funding, exclusive of the client rent contribution, for each of the Population Options I – III is set forth in the chart below. In addition, proposers are advised that, to the extent that Cost of Living Adjustments (COLAs) for these programs are made available through future City and State budgets, annualized funding rates for each housing unit may be adjusted to reflect these increases. However, DOHMH makes no guarantee regarding the timing or availability of COLAs.

<u>Population Option</u>	<u>Total Maximum Available Annual Funding (Exclusive of Client Rent Contribution) per each 25 Units</u>
I	\$550,000
II	\$450,000
III	\$400,000

G. Anticipated Payment Structure

It is anticipated that the payment structure of the contract(s) awarded from this RFP will be based on a line-item reimbursable budget with annual performance-based disincentives, as further described in Section III (Scope of Services). DOHMH reserves the right to implement additional performance-based outcome measures and related financial incentives and/or disincentives in combination with or in lieu of a reimbursable budget payment structure. DOHMH will consider proposals to structure payments in a different manner and reserves the right to select any payment structure that is in the City’s best interest.

SECTION III – SCOPE OF SERVICES

A. Department Goals and Objectives

DOHMH's goals and objectives are 1) to create stable housing opportunities combined with appropriate support services that meet the needs of homeless individuals and families and enable them to live as independently as possible, and 2) in so doing, to reduce the rates of incarceration, hospitalization and use of emergency services by the clients of the supportive housing programs funded under this RFP.

B. Target Populations and Programming Goals

1. General Definitions

“Homeless” means anyone who is sleeping in an emergency shelter or drop-in center; in public or other places not meant for human habitation; living in transitional/supportive housing but having come from the streets or emergency shelters; at risk of imminent homelessness due to a pending eviction or discharge with no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing.

“Chronically homeless” means anyone who has a disability and has been homeless for at least 365 days of the last two years, not necessarily consecutively.

Documentation of chronic homelessness is established in one of the following ways:

- a. A client is identified as meeting the above criteria based on his/her lodging history as contained in the Department of Homeless Services (DHS) SCIMS system. Other emergency lodging history (such as time spent in commercial SROs used by the HIV/AIDS Service Administration (HASA) as emergency housing, Human Resources Administration (HRA) domestic violence shelters or Housing Preservation and Development (HPD) emergency shelters) must be documented by a written attestation by an employee of the applicable agency included as part of the supportive housing application.
- b. An outreach team or drop-in program provides a written attestation that their staff has been working with a client for a period of time that satisfies the above criteria.
- c. A combination of shelter lodging history, street engagement and/or HASA documentation that satisfies the above criteria. For an applicant whose period of homelessness has included time spent in an institution (specifically, in a nursing home, a psychiatric hospital or a correctional facility), the relevant period for determining chronic homelessness (i.e., 365 days out of the past two years for someone with a disability or 730 days out of the past four years for someone without a disability) will be extended by the number of days spent in the institution, up to a maximum of three years or 1,095 days. In other words, although time spent in one of the institutions identified above will not count as time spent homeless, that time will not count against an applicant when establishing eligibility for NY/NYIII housing. It will be the responsibility of the referral source to provide verifiable documentation of time spent in an institution and verifiable documentation of the homeless history prior and subsequent to the time spent in an institution, as part of the application.

2. Target Populations:

Population Option I – Young adults (aged 18-25 years) leaving or having recently left foster care or who had been in foster care for more than a year after their 16th birthdays, who are at risk of street homelessness or sheltered homelessness and need supportive housing to achieve independent living.

“Leaving” means preparing for discharge within the next 24 months.

“Having recently left” means having left foster care within the past 24 months.

“At risk of street homelessness or sheltered homelessness” means leaving or having recently left foster care and having no subsequent residence identified and lacking the resources and support networks needed to obtain housing.

Proposers are advised that clients must be no younger than 18 years of age in order to enter this program. In addition, as the expectation is for young adults to move on, services funding from DOHMH will terminate when a client reaches the age of 26 while the rental subsidy will continue. Extended services funding may be requested from DOHMH for clients who reach age 26 and who are diagnosed with a mental illness and/or substance abuse disorder. Such requests would be handled on a case-by-case basis. Approved extensions would be for a limited amount of time while the client transitions into an adult supportive housing program or into another appropriate setting.

The programming goals for these clients are to ensure housing stability in a supportive environment based on positive youth development principles that recognize and build on the clients’ strengths, and to maximize educational and employment opportunities to enable clients to achieve self-sufficiency and, upon attainment of age 26, transition out of the supportive housing program into independent living and integration into the community.

Population Option II – Chronically homeless single adults who have a substance abuse disorder that is a primary barrier to independent living and who also have a disabling clinical condition (i.e. a medical or mental health (non-SPMI) condition that further impairs their ability to live independently).

“Substance abuse disorder” means a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period: recurrent substance abuse resulting in failure to fulfill major role obligations at work, school or home; recurrent substance use in situations in which it is physically hazardous (e.g. driving an automobile or operating a machine when impaired by substance use); recurrent substance related legal problems (e.g., arrests for substance related disorderly conduct); or continued substance abuse despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of use.

“Disabling condition” means a condition that significantly impairs an individual’s ability to function independently which results in a restriction of activities of daily living (ADL) and difficulties in self-care and maintaining social functioning.

“Clinical condition” means a medical or mental health condition which is evidenced by a diagnosis of a (1) mental illness (non-SPMI), (2) a developmental disability or (3) a physical illness.

Contractors are advised that up to 50 units in this Program Option may be targeted to young adults (aged 18 - 25 years). Young adults who are homeless but do **not** meet the chronic requirement may be accepted into these units, but chronically homeless young adults will be given priority.

The programming goals for these clients are to ensure housing stability in a safe, non-judgmental and supportive environment; to avoid or reduce high risk and harmful behaviors related to active substance abuse; and to enable clients to achieve the maximum possible recovery and integration into the community.

Population Option III – Homeless single adults who have completed a course of treatment for a substance abuse disorder and are at risk of street homelessness or sheltered homelessness and who need long-term transitional supportive housing to sustain sobriety and achieve independent living.

“Have completed a course of treatment” means successful completion/participation as attested (in writing) by the provider in one or more of the following substance abuse treatment programs: (1) residential treatment, or (2) outpatient treatment programs including MMTP, Buprenorphine and other approved programs.

“At risk of street homelessness or sheltered homelessness” means having no subsequent residence identified and lacking the resources and support networks needed to obtain access to housing (would require written attestation by the treatment provider).

Contractors are advised that up to 50 units in this Program Option may be targeted to young adults (aged 18 - 25 years). Young adults who are homeless but do **not** meet the chronic requirement may be accepted into the units, but chronically homeless young adults will be given priority.

The programming goals for these clients are to ensure housing stability in a non-judgmental, safe and supported environment; to enable them to sustain sobriety and transition to independent living outside of a supportive housing setting; and to enable clients to achieve the maximum possible recovery and integration into the workforce and the community.

C. Department Assumptions Regarding Contractor Approach

DOHMH’s assumptions regarding which approach will most likely achieve the goals and objectives set forth above are:

1. Contractor Qualifications

The contractor would:

- a. Have successful experience providing housing and/or services to the target population.
- b. Have successful experience locating and managing scattered site apartments and relationships with landlords in the targeted area.
- c. Have linkages with other appropriate not-for profit agencies and/or service providers in the community in which the proposed program will be located or readily accessible through public transportation, that could serve as resources for and/or provide off-site services to program clients.

2. Housing Services

The contractor would:

- a. Locate apartments in the proposed target area in neighborhoods that are in close proximity to public transportation and accessible to other amenities like shopping, laundry, health care and other necessary services.
- b. Rent clusters of apartments in a single building (preferably no more than 20 % of the units in a single building) for purposes of siting these programs. In cases where the provider agency is the lease holder for the apartment(s), a sub-lease that is in easily understandable language shall be provided to the client and a copy of such sub-lease must be maintained as part of the client file. In cases where the client is the primary lease holder, a copy of the lease shall be maintained in the client file.
- c. Rent living units that are preferably studio or one-bedroom apartments, which offer clients access to individual bathrooms, kitchens and storage space for clothing and other personal items. Contingent upon client preference and the availability of appropriate housing in the community, two bedroom apartments in which clients share bathroom and kitchens are also permissible. However, each client must have their own room with storage space for clothing and other personal items.
- d. Require clients to contribute 30 % of their gross household income toward rent and utilities (electric and gas, at minimum).
- e. Ensure that apartments meet New York City building and fire codes and have a current Certificate of Occupancy that is appropriate for the number of clients to be served.
- f. Ensure that apartments meet Federal Housing Quality Standards.
- g. Provide air conditioning, if not otherwise provided.
- h. Provide furnishings and household items that are new, good quality and durable.
- i. Make minor renovations to make the apartment (s) handicapped accessible based on the individual needs of the client.
- j. Consider the clients' medical conditions and/or disabilities when placing them in living arrangements above the second floor.
- k. Ensure that gross rents do not exceed the U.S. Department of Housing and Urban Development (HUD) fair market values.

3. Staffing and Training

- a. The contractor would ensure that the program has an appropriate staffing plan with sufficient numbers of staff with appropriate qualifications and training for the target population and salaries commensurate with these qualifications. The contractor would initially train staff and conduct ongoing training.
- b. Program directors overseeing case managers would be required to have a graduate degree and experience serving the target population or a Bachelor's degree, supervisory experience and experience serving the target population.
- c. The contractor would have the capacity to provide training to staff that would include, but not be limited to: health education and infectious disease prevention, nutrition, relationship skills, crisis intervention, counseling techniques and motivational interviewing, depression screening, street drugs and their effects, symptoms of overdose and withdrawal, best practices in employment services, harm reduction and housing first service approaches, including safe injection, safe sex practices and availability of naloxone to prevent death from opioid overdose, addiction treatment and recovery, the stages of change model, trauma and relapse prevention.

4. Client Eligibility and Placement

The eligibility of an individual seeking housing under *NY/NY III* will be determined by HRA upon electronic submission of the supportive housing application by the client or anyone acting on behalf of the client such as an outreach worker, case manager, shelter or drop-in center staff person, etc. Except for Population Option I, DHS will be responsible for placing approved applicants by sending *NY/NY III* housing providers a limited but reasonable number of eligible clients from which they will be required to select tenants. For Population I, the Administration for Children's Services (ACS) will be responsible for placement in accordance with the same procedure.

5. Supportive Services

To deliver the core services for all Population Options, the contractor would:

- a. In conjunction with each client, develop an individualized housing-related needs assessment and support services plan, including an action plan with clearly stated goals and outcomes. The plan should adequately address client access to preventive, ongoing and emergency services as well as the interval at which the support plan will be reviewed. The plan should be designed to assist the client to remain in housing while the type and intensity of services vary to meet the changing needs of the individual.
- b. Encourage direct client participation into ongoing program implementation and management, through regular community meetings, advisory boards, or other means.
- c. Focus on the multiple service needs of the clients as well as those skills and services that the clients would require to remain stably housed in the community.
- d. Coordinate all support services for each client directly with the contractor's own programs or through appropriate providers located nearby or at a central location that is readily accessible to public transportation.
- e. Directly provide: case management, medication management, rehabilitation, personal assistance that emphasizes learning daily living skills, residential stability in housing, financial management, and assistance in gaining access to appropriate public benefits and services, peer support, 24 hour/7 day on-call staffing, help in the establishment of the household including, if apartment mates are involved, facilitating cooperative apartment mate agreements on bill payments, division of household responsibility and other matters.
- f. Through linkages/referrals to appropriate providers located nearby or that are readily accessible through public transportation, comprehensively address clients' physical and mental health needs in the areas of primary medical, mental health, and dental care, substance abuse counseling and treatment, domestic violence counseling and HIV/STD prevention services, treatment and support services (including access to condoms and rapid HIV/AIDS testing) as appropriate.
- g. Make programming available during evenings and on weekends to accommodate the work, training and/or treatment requirements of clients.
- h. Focus on and promote each client's recovery to his or her fullest potential, by providing educational opportunities, job readiness skills, vocational training and employment placement and retention. Where feasible, actively seek qualified clients to employ as housing support staff.
- i. Train staff in housing placement in order to assist clients who would like to move on to a more independent setting.

- j. For individuals with substance abuse disorders, many of whom have been victimized or abused as children or later in life, ensure that all supportive services are trauma-informed in order to address the underlying issues of addiction.
- k. Provide services in a culturally and linguistically competent and sensitive manner.
- l. Employ low-threshold, flexible intake criteria and utilize a progressive demand approach that encourages clients to engage and participate in supportive housing services. With respect to Population II, proposers are especially advised that neither current sobriety nor a recent history of sobriety may be required as admission criteria.
- m. In cases where the provider agency is the lease holder for the apartment(s), a sub-lease that is in easily understandable language shall be provided to the client and a copy of such sub-lease must be maintained as part of the client file. In cases where the client is the primary lease holder, a copy of the lease shall be maintained in the client file.
- n. Require clients to contribute 30% of their household income toward rent and utilities (electric and gas, at minimum).
- o. Allocate contingency funds in the budget to cover events that may lead to non-payment of rent, such as hospitalization. The contractor should make every effort to preserve the client's/family's housing in the event of hospitalization or relapse.
- p. Establish appropriate procedures for terminating the client's sub-lease if a tenant does not comply with the sub-lease provisions and/or requires assistance beyond the scope of the program. In such circumstances, the contractor would identify alternate appropriate placement. Due process procedures and New York City's landlord/tenant law would be followed. Programs are urged to develop a positive and effective means of transitioning clients to independent or other long-term permanent housing as appropriate.
- q. Track clients who have moved on from the program to non-supported independent housing or other placements by maintaining contact with such clients for a period of one year following their departure from the program. At a minimum, contact with the client would be made at three months, six months and one year after departure.
- r. If/when required by DOHMH, conduct a consumer perception of care survey using a survey instrument to be provided by DOHMH. Failure to conduct the survey (if required by DOHMH) would result in liquidated damages under the contract.
- s. Track, record and report information to DOHMH as required in the contract, including, but not limited to, client demographics, income source, place discharged to, and outcome data, including occupancy rate; housing retention; reduction in hospitalization; and reduction in rate of incarceration.
- t. In addition to the reporting responsibility as may be required under its contract with DOHMH, participate in NY/NY III Supportive Housing Evaluation. In accordance with the provisions of the NY/NY III Supportive Housing agreement, the State and the City will develop data collection and reporting systems to evaluate the outcomes and determine the costs and benefits of the services provided under the agreement. These evaluations will include, but not be limited to, the clients' use of Medicaid and other publicly-funded services/systems such as behavioral health care, shelter, jail and prison, before and after placement into supportive housing. The contractor would participate in this effort by submitting data and reports required by the City to evaluate program and fiscal outcomes.

In addition to the core supportive services described above, for each applicable Population Option cited below, the contractor would:

Population I – Young Adults Leaving Foster Care

- a. Creatively engage the clients in services, ensuring sufficient program flexibility to accommodate work and school schedules as well as the clients' changing needs over time.
- b. Base services on positive youth development principles that recognize and build on the strengths of the participants rather than focusing on their deficits.
- c. No later than one year before a client turns 26, assist the client in planning for and locating appropriate independent housing or, where appropriate, other supportive housing, so that the client's unit may become available for a new young adult age 18-25.
- d. Provide directly or through linkages comprehensive vocational, educational and employment services and resources, to each client including, but not limited to: "hard" job skills, resume writing, job search and job retention skills, employment placement services, GED/ABE/ESL classes, mentoring, and leadership development.
- e. Also provide directly or through linkages the following services, including, but not limited to: health and nutritional counseling; health education; sex education and infectious disease prevention; relationship skills; crisis intervention; and home visits.
- f. Ensure that programming and staff are responsive, sensitive and reflective of the lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth who are likely to be part of this population.

Population Option II – Adults with Substance Abuse Disorder/Disabling Clinical Condition

- a. Use a client-centered, non-judgmental and flexible approach whereby sobriety is encouraged and supported, but not enforced or presumed as a primary goal. Emphasis should be on relationship and trust building where clients are allowed to set the goals of services themselves.
- b. Provide directly or through linkages the following support services for each client including, but not limited to: crisis intervention; peer counseling and advocacy conflict resolution; Alcoholics Anonymous, Narcotics Anonymous and similar groups; nutrition counseling; community building activities; individual and group counseling; home visits; and recreation opportunities.
- c. Also provide directly or through linkages harm reduction services focusing on the avoidance of high risk behaviors and disease prevention, including, but not limited to: safe injection, availability of naloxone to prevent death from opioid overdose, safe sex practices, needle exchange, health education and infectious disease prevention.
- d. Ensure that all units dedicated to young adults (aged 18-25) remain filled with clients meeting that age criteria.

Population Option III – Adults who have Completed a Course of Substance Abuse Treatment

- a. Focus on those skills and services that clients would require to achieve self sufficiency and the ability to eventually move into independent housing in the community, particularly educational, vocational training and employment placement services.
- b. Address the substance abuse recovery-related needs of the clients as well as those skills and services that the clients would require to sustain sobriety and avoid relapse.
- c. Focus on recovery planning and relapse prevention using individual counseling and support provided by mental health and substance abuse professionals and peer counselors.
- d. Assist each client in planning for and locating appropriate independent housing or, where appropriate, other supportive housing placement. Although there would be no length-of-stay restrictions, the program should expect clients to move on.

- e. Provide directly or through linkages the following support services for each client, including, but not limited to: peer counseling and advocacy; relapse prevention; crisis intervention; Alcoholics Anonymous, Narcotics Anonymous and similar groups; social and community building activities; individual and group counseling; home visits; and recreation opportunities.
- f. Ensure that all units dedicated to young adults (aged 18-25) remain filled with clients meeting that age criteria.

D. Department Assumptions Regarding Outcome Indicators

DOHMH's assumptions regarding outcome indicators that will most likely assure that the selected proposer(s) will perform the work under the contract(s) awarded from this RFP in a manner that is cost-effective for the Agency and most likely to achieve the Agency's goals and objectives set forth above are:

- The contractor will be expected to achieve a 95% occupancy rate within six months or less of contract registration and maintain a 95% annual occupancy rate throughout the term of the contract. This six month period includes three months of start-up in order to purchase furniture, linens and other household items as well as hiring program staff and client recruitment. Failure to meet the 95% occupancy rate will result in liquidated damages.

SECTION IV -- FORMAT AND CONTENT OF THE PROPOSAL

Proposal Submission Instructions: All proposals must meet the requirements listed below. The proposal should be typed double-spaced on both sides of 8 ½" X 11" paper. Pages should be paginated. The proposal would be evaluated on the basis of its content, not length. The City of New York requests that all proposals be submitted on paper with no less than 30% post-consumer material content, i.e., the minimum recovered fiber content level for reprographic papers recommended by the United States Environmental Protection Agency (for any changes to that standard please consult: <http://www.epa.gov/cpg/products/printing.htm>). The proposer should state on Attachment A whether its response is printed on recycled paper containing the minimum percentage of recovered fiber content as requested by the City in these instructions. Failure to comply with any of the instructions set forth in this paragraph will not be considered non-responsive.

A. Proposal Format

1. Proposal Cover Letter

The Proposal Cover Letter form (Attachment A) transmits the proposer's Proposal Package to DOHMH. It should be completed, signed and dated by an authorized representative of the proposer.

2. Program Proposal

The Program Proposal is a clear, concise narrative that addresses the matters set forth in items (a) – (c) below.

a. Experience

Describe the successful relevant experience of the proposer, each proposed subcontractor, if any, and the proposed key staff, in providing the program described in Section III: the Scope of Services of this RFP. Specifically address the following:

Program

- i. Indicate the Population Option, the number of units the proposer intends to serve and the borough(s) and community district(s) in which the proposed program will operate. If this proposal is for Population Options II or III, indicate whether or not the program will serve young adults and how many units will be dedicated to this age group.
- ii. Describe the proposer's successful experience providing services to the proposed target population, including the specific nature of those services and when and where they are/were provided. If the proposer has limited or no experience with the proposed population, describe the proposer's successful experience providing services to other populations and demonstrate the relevance of that experience to the proposed population. Include the specific nature of those populations and the services provided and when and where they are/were provided.
- iii. Describe the proposer's successful experience providing supportive housing services in or related to housing settings (either transitional or permanent). Include the specific nature of those services and when and where they are/were provided.

Housing Management

- iv. Demonstrate the proposer's successful experience managing scattered-site supportive housing for the target population. Provide specific examples, if applicable.
- v. In the case of a proposer that has limited or no such experience, describe successful experience managing scattered-site housing for other special needs populations and any other experience relevant to managing scattered-site supportive housing for the target population.

In addition:

- Attach a listing of at least two relevant references (other than employees of the DOHMH or the New York State Office of Mental Health) for the proposer, each other applicable entity cited above, including the name of the reference entity, a brief statement describing the relationship between the proposer/entity and the reference entity, and the name, title and telephone number of a contact person at the reference entity.
- Attach for each key staff position a resume and/or description of the qualifications and experience that will be required. In addition, state extent of staff expertise in relevant cultures and languages.

b. Organizational Capability

Demonstrate the proposer's organizational (i.e., programmatic, managerial and financial) capability to perform the services described in the Scope of Services. Specifically address the following:

- i. Demonstrate that the proposer has an appropriate staffing plan with sufficient numbers of staff for the number of clients to be served and with salaries commensurate with these qualifications.
- ii. Demonstrate that the proposer has an appropriate staff training program.
- iii. Demonstrate that the proposer has an appropriate client record keeping and data management system, in view of both efficient internal management as well as meeting the *NY/NY III Supportive Housing* evaluation and the other client tracking and data reporting responsibilities set forth under subsection C(5) in Section III – Scope of Services of this RFP.
- iv. Demonstrate the proposer's capability to identify the required number of appropriate apartments for the population to be served and to successfully secure leases for studio, one and two bedroom apartments as described in Section II (Housing Considerations) of this RFP.
- v. Describe and demonstrate how the proposer will ensure that all apartments used for the proposed program meet all appropriate New York State and City Codes.
- vi. Demonstrate that the proposer has established effective linkages with other appropriate not-for-profit agencies and/or service providers in the community in which the proposed program will be located or readily accessible through public transportation that could serve as resources for and/or provide off-site services to program clients. Be as specific as possible and attach copies of all relevant linkage agreements.

- vii. State whether or not the proposer has submitted or plans to submit multiple proposals to operate programs for more than one Population Option. If proposing to operate multiple programs, indicate the total number of separate programs for which the proposer has submitted and/or intends to submit a proposal and demonstrate the proposer's capability to successfully operate the total number of proposed programs concurrently. **Please note that proposers who intend to operate programs for more than one Population Option must submit a separate and complete proposal for each proposed target population.**

In addition:

- Attach a chart showing where, or an explanation of how, the proposed services would fit into the proposer's organization.
- Attach a copy of the proposer's **latest** financial audit or certified financial statement, or a statement as to why no report or statement is available.

c. Program Approach

Describe in detail how the proposer will provide the services set forth in the Scope of Services section for each Population Option to be served and demonstrate that the proposer's proposed approach would fulfill DOHMH's goals and objectives. Specifically address the following:

- i. Describe and demonstrate the effectiveness of the proposer's approach for providing directly, or through linkages, the supportive housing services prescribed in the Scope of Services.
- ii. Describe and demonstrate the effectiveness of measures that will be taken to ensure that services are provided in a culturally competent and linguistically appropriate and sensitive manner.
- iii. State and justify each of the outcomes to be achieved by clients to be served and demonstrate how the program would effectively assist them to achieve those outcomes.
- iv. Describe and demonstrate the effectiveness of the contractor's approach to transitioning clients out of the program.
- v. Describe and demonstrate that the proposer has actively participated in community and citywide consortia and networks appropriate to the clients' needs.
- vi. Describe and demonstrate your emergency response plan including response to medical emergencies. Include in your description an explanation of personnel training including assessing risk and safety, handling emergencies, coordination with medical, mental health, law enforcement, and other professionals, and implementing health and safety procedures.

DOHMH's assumptions regarding programmatic approach as set forth in Section III – Scope of Services represent what DOHMH believes to be most likely to achieve its goals and objectives. However, proposers are encouraged to propose an approach that they believe would most likely achieve DOHMH's goals and objectives. Proposers may also propose more than one approach. However, if an alternative approach affects other areas of the proposal such as experience, organizational capability or price, that alternative approach should be submitted as a complete and

separate proposal providing all the information specified in this Section.

3. Price Proposal

The payment structure for the contracts awarded from this RFP will be a combination of a line-item reimbursable budget with annual performance-based disincentives. Outcome indicators will include occupancy rate; housing retention; reduction in hospitalization; and reduction in rate of incarceration. Failure to meet the requisite outcome level for any of the aforementioned indicators will result in liquidated damages. As set forth in Section IV(A)(3)(b), DOHMH will consider proposals to structure payment in a different manner. DOHMH reserves the right to select or modify the payment structure to one that is in the City's best interest.

Proposers are encouraged to propose innovative payment structures. DOHMH reserves the right to select any payment structure that is in the City's best interest. For the purposes of comparison, proposers should submit a Price Proposal that meets the standards of subsections (3) (a) and (3) (b), below.

a. Proposed Pricing

The Price Proposal should include the following for providing the Scope of Services for **each** Population Option being proposed:

- The proposed offering price for each of the budget components in a line item budget included in this RFP as Attachment B.

In addition:

- i. State the proposed annual per unit rate for each population/borough being proposed. If requesting the maximum per unit rate, demonstrate that the proposer has no other source of services and/or operating funds.
- ii. State whether or not the proposer has secured or is applying for other sources of rental assistance/operating subsidies. If so, specify such source and the amount.
- iii. State whether or not the proposer has secured or is applying for other sources of funding for support services. If so, specify each such source and the amount.
- iv. **Itemize the amount of start-up funds** (i.e., non-recurring costs for the first three months of the program, which may include, but are not limited to, furniture, other furnishings and other costs to be incurred by the provider to operationalize the program.
- v. State the proposed **annual** operating and program service expenses for a **typical full year**, which shall not exceed the maximum available annual funding level per unit for services.

b. Performance Outcome Measures and Financial Incentives and/or Disincentives

List and describe potential performance-based payment components (i.e., specific performance-based outcome measures and related financial incentives and/or disincentives, unit payments tied to outcomes, milestone payments tied to outcomes, and/or liquidated damages tied to outcomes) for providing the work to be performed by the proposer under the contract that could potentially be

applied to the contract, in whole or part, as a reliable means for measuring and paying for success, as described in the Scope of Services. DOHMH's determination in Section III D regarding performance-based payment structure represents what DOHMH believes would most likely achieve its goals and objectives. However proposers are encouraged to propose measures, incentives and disincentives that they believe would also achieve DOHMH's goals and objectives in a cost-effective manner. Proposers may also propose more than one approach.

4. Acknowledgment of Addenda

The Acknowledgment of Addenda form (Attachment C) serves as the proposer's acknowledgment of the receipt of addenda to this RFP which may have been issued by DOHMH prior to the date on which the proposer is submitting its proposal. The proposer should complete this attachment as instructed on the attachment.

B. Proposal Package Contents ("Checklist")

The Proposal Package should contain the following materials. Proposers should utilize this section as a "checklist" to assure completeness prior to submitting their proposal to DOHMH.

A sealed envelope containing **one original set and four (4) duplicates** of the documents listed below in the following order:

1. Proposal Cover Letter Form (Attachment A)
2. Program Proposal
 - a. Narrative
 - b. References for the Proposer and, if applicable, each Housing Manager and Sub-Contractor
 - c. Documentation of capital funding commitment, site acquisition and/or capital funding source preliminary appropriateness determination, as applicable
 - d. Resumes and/or Description of Qualifications for Key Staff Positions
 - e. Organizational Chart
 - f. Financial Audit Report or Certified Financial Statement
3. Price Proposal Forms (Attachment B)
4. Acknowledgment of Addenda Form (Attachment C)

The envelope should be labeled as follows:

- The proposer's name and address, the Title and PIN # of this RFP and the name and telephone number of the Proposer's Contact Person.
- The name, title and address of the Authorized Department Contact Person, Karen Mankin.

**SECTION V – PROPOSAL EVALUATION AND
CONTRACT AWARD PROCEDURES**

A. Evaluation Procedures

Proposals will be reviewed to determine whether they are responsive or non-responsive to the requisites of this RFP. Those that are determined by DOHMH to be non-responsive will be rejected. DOHMH's Evaluation Committee will evaluate and rate all remaining proposals based on the Evaluation Criteria prescribed below. DOHMH reserves the right to conduct interviews, site visits and/or to request that proposers make presentations, as DOHMH deems applicable and appropriate. Although discussions may be conducted with proposers submitting acceptable proposals, DOHMH reserves the right to award contracts on the basis of initial proposals received, without discussions; therefore, the proposer's initial proposal should contain its best programmatic and price terms, except as noted in the pricing guidelines.

B. Evaluation Criteria

Demonstrated quantity and quality of successful relevant experience	35%
Demonstrated level of organizational capability	20%
Quality of proposed approach	45%

C. Basis for Contract Award

Final contract awards for the units under this RFP shall be subject to availability of Department funding and will be awarded to the responsible proposer(s) whose proposal(s) is/are determined to be the most advantageous to the City, taking into consideration the price and such other factors or criteria which are set forth in this RFP.

In addition, all contract awards shall be subject to the timely completion of contract negotiations between the DOHMH and the selected proposers, oversight approval, as well as documentation of appropriate insurance.

In the case that a proposer is eligible for award to serve more than one Population Option or for an award to serve more than 25 units, DOHMH reserves the right to determine, based on the proposer's demonstrated organizational capability and the best interests of the City, respectively, for which population(s) and/or for how many units the proposer will receive an award.

DOHMH will award contracts to the responsible proposer(s) whose proposal(s) is/are determined to be the most advantageous to the City, taking into consideration the price, such other factors or criteria which are set forth in this RFP, including the level of services needed, proposers' demonstrated capability to provide the proposed level of services, and proposers' targeted service area(s) in order to ensure the most equitable distribution of services citywide. DOHMH reserves the right to determine, based on the proposer's demonstrated organizational capability, capacity and the best interest of the City, respectively, for how many slots and which community district(s) the proposer will receive an award. Contract award will be subject to the following: 1) in the case of a not-for-profit organization, demonstration of not-for-profit and tax exempt status, if not previously demonstrated; and 2) timely completion of contract negotiations between DOHMH and the selected proposer.

SECTION VI – GENERAL INFORMATION TO PROPOSERS

A. Complaints. The New York City Comptroller is charged with the audit of contracts in New York City. Any proposer who believes that there has been unfairness, favoritism or impropriety in the proposal process should inform the Comptroller, Office of Contract Administration, 1 Centre Street, Room 835, New York, NY 10007; the telephone number is (212) 669-3000. In addition, the New York City Department of Investigation should be informed of such complaints at its Investigations Division, 80 Maiden Lane, New York, NY 10038; the telephone number is (212) 825-5959.

B. Applicable Laws. This Request for Proposals and the resulting contract award(s), if any, unless otherwise stated, are subject to all applicable provisions of New York State Law, the New York City Administrative Code, New York City Charter and New York City Procurement Policy Board (PPB) Rules. A copy of the PPB Rules may be obtained by accessing the City’s website at www.nyc.gov/ppb.

C. General Contract Provisions. Contracts shall be subject to New York City’s general contract provisions, in substantially the form that they appear in “Appendix A -- General Provisions Governing Contracts for Consultants, Professional and Technical Services” or, if the Department utilizes other than the formal Appendix A, in substantially the form that they appear in the Department’s general contract provisions. A copy of the applicable document is available through the Authorized Department Contact Person.

D. Contract Award. Contract award is subject to each of the following applicable conditions and any others that may apply: New York City Fair Share Criteria; New York City MacBride Principles Law; submission by the proposer of the New York City Department of Business Services/Division of Labor Services Employment Report and certification by that office; submission by the proposer of the requisite VENDEX Questionnaires/Affidavits of No Change and review of the information contained therein by the New York City Department of Investigation; all other required oversight approvals; applicable provisions of federal, state and local laws and executive orders requiring affirmative action and equal employment opportunity; and Section 6-108.1 of the New York City Administrative Code relating to the Local Based Enterprises program and its implementation rules.

E. Proposer Appeal Rights. Pursuant to New York City’s Procurement Policy Board Rules, proposers have the right to appeal Department non-responsiveness determinations and Department non-responsibility determinations and to protest a Department’s determination regarding the solicitation or award of a contract.

F. Multi-Year Contracts. Multi-year contracts are subject to modification or cancellation if adequate funds are not appropriated to the Department to support continuation of performance in any City fiscal year succeeding the first fiscal year and/or if the contractor’s performance is not satisfactory. The Department will notify the contractor as soon as is practicable that the funds are, or are not, available for the continuation of the multi-year contract for each succeeding City fiscal year. In the event of cancellation, the contractor will be reimbursed for those costs, if any, which are so provided for in the contract.

G. Prompt Payment Policy. Pursuant to the New York City’s Procurement Policy Board Rules, it is the policy of the City to process contract payments efficiently and expeditiously.

H. Prices Irrevocable. Prices proposed by the proposer shall be irrevocable until contract award, unless the proposal is withdrawn. Proposals may only be withdrawn by submitting a written request to the Department prior to contract award but after the expiration of 90 days after the opening of proposals. This shall not limit the discretion of the Department to request proposers to revise proposed prices through the submission of best and final offers and/or the conduct of negotiations.

I. Confidential, Proprietary Information or Trade Secrets. Proposers should give specific attention to the identification of those portions of their proposals that they deem to be confidential, proprietary information or trade secrets and provide any justification of why such materials, upon request, should not be disclosed by the City. Such information must be easily separable from the non-confidential sections of the proposal. All information not so identified may be disclosed by the City.

J. RFP Postponement/Cancellation. The Department reserves the right to postpone or cancel this RFP, in whole or in part, and to reject all proposals.

K. Proposer Costs. Proposers will not be reimbursed for any costs incurred to prepare proposals.

L. Charter Section 312(a) Certification.

The Department has determined that the contract(s) to be awarded through this Request for Proposals will not directly result in the displacement of any New York City employee.

Agency Chief Contracting Officer

Date

ATTACHMENT A

PROPOSAL COVER LETTER
SCATTERED-SITE SUPPORTIVE HOUSING PROGRAMS

PIN: 08PO 0825

Proposer: _____

Name: _____

Address: _____

Tax Identification # _____

Proposer's Contact Person:

Name: _____

Title: _____

Telephone #: _____ Fax #: _____

E-Mail Address: _____

Is this response printed on both sides, on recycled paper containing the minimum percentage of recovered fiber content as requested by the City in the instructions to this solicitation?

Yes ___ No ___

Population Option Proposed (Check one ONLY)

I II III

Number of Units (Check one ONLY; indicate additional proposed units or check "N/A" in the parenthesis, as applicable)

___ 25 Units (+ ___ Units; ___ N/A)

___ 50 Units (+ ___ Units; ___ N/A)

___ 75 Units (+ ___ Units; ___ N/A)

Proposed Borough(s) and Community District(s) to be Served (Check all that apply)

Manhattan/CD's:___ Bronx/CD's:___ Brooklyn/CD's:___ Queens/CD's:___ Staten Island/CD's:___

Proposer's Authorized Representative:

Name: _____

Title: _____

Signature: _____

Date: _____

ATTACHMENT B
NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Budget Proposal Forms

COMPLETE ALL LINES – USE “n/a” AS APPROPRIATE

Proposer		Program			PIN #		
	EXPENSE ITEM	Start-Up (one-time only)			ANNUAL OPERATING		
		# of FTEs	# of Persons	Budget	# of FTEs	# of Persons	Budget
1	Professionals						
2	Other Direct Service Staff						
3	Program Administration & Support Staff						
4	Sum Ln (1-3) PS SUBTOTAL						
OTHER THAN PERSONAL SERVICE SUMMARY							
5	Equipment						
6	Supplies and Materials						
7	Travel Expenses						
8	Occupancy and Building Expenses						
9	Communication						
10	Fringe Benefits						
11	Other (specify on Schedule D- Explanation Page)						
12	Sum Ln (5-11) OTPS SUBTOTAL						
13	AGENCY ADMIN/OVERHEAD (Attach Methodology)						
14	(Ln 4+Ln 12+Ln 13) TOTAL EXPENSES						
15	APPLICABLE CLIENT INCOME (Sched. C, Ln 5)						
16	BUDGET AGENCY CONTRIBUTION (Optional)						
17	(Ln 14 - [Ln 15+Ln 16] TOTAL CONTRACT AMT.						

THIS SECTION MUST BE COMPLETED FOR ANNUALIZED BUDGET

A. # Unduplicated Person Served Annually:	
B. # Persons Served Per Month:	
C. # Units of Service Per Year (see note) (explain on Schedule E)	
D. Gross Unit Cost Ln (14/Ln C):	
E. Net Cost per Unit of Service (Ln 17/Ln C):	

Note: Agency Contribution: Other sources of revenue which shall be included in annual, on-going budget. It includes fundraising, grants, etc. It excludes funds targeted for a specific use by a governmental entity or other benefactor.
 Start-Up: Includes all expenses required to make program operational (See Scope of Services). Unit of Service: Residential Day.

Schedule A

Personal Service and OTPS Details

Attach additional pages for each expense item, as needed.

PROPOSER	PROGRAM	PIN #

	EXPENSE ITEM	START-UP	ANNUAL
1	Professionals (#FTEs for each position)		
	Sub-Total		
2	Other Direct Service Staff (#FTEs for each position)		
	Sub-Total		
3	Program Admin & Support Staff (#FTEs for each position)		
	Sub-Total		
4	Equipment (Specify on Schedule B) Subtotal		
5	Supplies and Materials		
	Office		
	Program		
	Sub-Total		
6	Travel Expenses		
	Staff		
	Client		
	Sub-Total		
7	Occupancy Expenses		
	Costs (maintenance, cleaning, security, equipment, leases, etc.)		
	Itemize proposed building expense on Schedule D.		
	Sub-Total		
8	Communication		
	Telephone		
	Other (Explain)		
	Sub-Total		
9	Fringe Benefits - Rate -----%		
	FICA		
	Health Insurance		
	Unemployment/Disability		
	Pension		
	Other (Explain)		
	Sub-Total		
10	Other (Specify)[Includes equipment rentals & Minor Rehab]		
	Sub-Total		

Schedule B

Equipment

PROPOSER		PROGRAM	PIN #
	EQUIPMENT ITEM	START-UP	ANNUAL
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20	Equipment Total:		

**Schedule C
Income**

	APPLICABLE INCOME	START-UP	ANNUAL
1	SSI/SSD		
2	Third Party		
3	Client Fees		
4	Other (specify)		
5	TOTAL INCOME:		

Schedule D

Explanation Page

Please use this page to explain program budget as necessary. (Attach additional pages if necessary). Be sure to explain how you calculated the **levels of service** reported on the Budget Proposal Summary Page.

ATTACHMENT C

ACKNOWLEDGMENT OF ADDENDA
PIN 08PO 0825

COMPLETE EITHER PART I OR PART II, WHICHEVER IS APPLICABLE, AND COMPLETE AND SIGN PART III.

PART I. LISTED BELOW ARE THE DATES OF ISSUE FOR EACH ADDENDUM RECEIVED IN CONNECTION WITH THIS RFP:

ADDENDUM # 1, DATED _____, 20____

ADDENDUM # 2, DATED _____, 20____

ADDENDUM # 3, DATED _____, 20____

ADDENDUM # 4, DATED _____, 20____

ADDENDUM # 5, DATED _____, 20____

PART II.

_____ NO ADDENDUM WAS RECEIVED IN CONNECTION WITH THIS RFP.

PART III.

ORGANIZATION _____

SIGNATURE _____
(Authorized Contact Person)

DATE _____



Name of Organization: _____

Assessment of Operational Alignment with the Seven Dimensions of Quality for Supportive Housing (in Harm Reduction Settings)

Through communication with supportive housing tenants, providers, funders, and other stakeholders - and through involvement in successful supportive housing projects around the country – the Corporation for Supportive Housing has identified *The Seven Dimensions of Quality for Supportive Housing* that can serve as a conceptual framework for the planning, development, and operation of high-quality supportive housing. CSH and CASA would like to know more about the extent to which you feel that your organization's harm reduction supportive housing is operated in a manner that is consistent with the *Seven Dimensions of Quality for Supportive Housing*.

For each item, please indicate your agreement or disagreement with the following statement, using the rating scale provided: "This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization"

- A: Yes
- B: In part, but not completely.
- C: No
- D: Not Applicable.

If you wish, you may explain your responses in the "Notes" section below each set of Indicators. You will also have the opportunity to discuss your answers with an Interviewer from CASA.

Dimension #1 – Administration, Management and Coordination: The organization operating the supportive housing follows standard and required administrative and management practices, and coordinates roles within the organization, and with external partners, to ensure the best outcomes for tenants.	
This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization: A: Yes B: In part, but not completely. C: No D: Not Applicable.	
Key Indicators of Quality	Assessment
1. The management of the supportive housing units is managed through an effective partnership among the supportive housing provider and representatives of the landlords, relevant public agencies, and tenants.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
2. The operation of the supportive housing units is performed through an effective working collaboration between the various staff members who a) provide supportive services to tenants, b) lease and manage apartments and landlord relationships, and c) oversee program operations, finances, reporting, and administrative duties.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
3. Roles and responsibilities for all staff involved in the operation of the supportive housing units are specified in a Program Operating Manual or equivalent document.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
4. The organization operating the supportive housing and its staff comply with all applicable local, state and federal laws, regulations, and standards.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
5. The organization maintains, reviews and regularly updates manuals and plans, such as: Scattered-Site Apartment Operations Manual; Services Policy and Procedure Manual; Compliance Manual; Personnel Policies and Procedures Manual; Staff Training and Orientation Manual; and Safety and Emergency plans.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
6. The dual functions of housing operations (apartment leasing, tenant management, rent collection, evictions, etc.) and supportive services delivery are organized with clearly defined roles and decision making responsibilities in a manner that supports effective coordination among staff, in order to maximize tenants' housing stability and independence.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

Notes >>

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Dimension #2 - Physical Environment: The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, sustainable, functional, appropriate for the surrounding community, and conducive to tenants' stability.	
This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization: A: Yes B: In part, but not completely. C: No D: Not Applicable.	
Key Indicators of Quality	Assessment
1. Leased apartments have a home-like, residential appearance on both the interior and building's exterior, and its size, appearance, design, and quality are consistent with other apartments in the neighborhood and reflect (or exceed) local community standards.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
2. Leased apartments provide adequate living space for essential daily activities (such as cooking, eating, sleeping, and studying), include an adequate number of bedrooms for the households' compositions, and the sharing of apartments by non-related single adult tenants only takes place at the desire and consent of tenants.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
3. When feasible, each apartment has a private bathroom and kitchen; when not feasible, the sharing of bathrooms and kitchens is minimized as much as possible.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
4. Leased apartments and their buildings include appropriate security features, which might include buzzers on doors, a limited number of entrances, security cameras, adequate interior and exterior lighting, and a secure front desk, to ensure the safety of tenants.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
5. Leased apartments are located in neighborhoods and areas that facilitate tenants' actual and perceived level of safety and security, and within close proximity to basic amenities such as mass transit, grocery stores, pharmacies, hospitals or clinics, etc.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
6. Tenants are given a reasonable degree of choice in the apartments and neighborhoods into which they will be placed.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

Notes >>

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Dimension #3 - Access to Housing and Services: Initial and continued access to the housing opportunities and supportive services is not restricted by unnecessary criteria, rules, services requirements, or other barriers.	
This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization: A: Yes B: In part, but not completely. C: No D: Not Applicable.	
Key Indicators of Quality	Assessment
1. The housing is available to and intended for a person who is, or a family whose head of household is, homeless or at-risk of homelessness, and has multiple barriers to housing stability and employment, which might include mental illness, chemical dependency, and/or other disabling or chronic health conditions.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
2. The eligibility screening process does not include "housing readiness" criteria and reflects a commitment to housing tenants with no current income, histories of homelessness, histories of criminal justice involvement, prior housing failures, poor credit histories, disabilities, past or current substance abuse and/or other obstacles to accessing or maintaining housing.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
3. There are no significant barriers to access to housing and services for people resulting from race, color, language minority status, national origin, religion, sex, family status, disability or sexual orientation.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
4. Services are voluntary, such that tenants may choose whether or not to participate in services without impacting their eligibility to remain in the housing.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
5. The tenant household ideally pays no more than 30% of household income toward rent and utilities, and never pays more than 50% of income toward such housing expenses.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
6. Efforts to ensure cultural competency impact organizational practices and decision making regarding: development and review of policies and written materials, hiring practices, initial and ongoing training of staff, content of supervision sessions, gathering of input from stakeholders and design of supportive services programming.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

7. Multi-lingual staff, translated materials, and/or interpretation and translation services are available to tenants, as needed.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
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Notes >>

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Dimension #4 - Supportive Services Design and Delivery: The design and delivery of supportive services facilitate access to a comprehensive array of services, are tenant-focused, effectively address tenants' needs, and foster tenants' housing stability and independence.

This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization:
A: Yes B: In part, but not completely. C: No D: Not Applicable.

Key Indicators of Quality	Assessment
1. All members of tenant households have easy, facilitated access to a flexible and comprehensive array of supportive services designed to assist the tenants to achieve and sustain housing stability and independence.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
2. Supportive services available to tenants include, but are not limited to: case management services; medical services; mental health services; substance use management and treatment services; harm and risk reduction education and services; vocational and employment services; money management services; life skills training; and advocacy.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
3. The supportive services philosophy and design promotes and supports: housing stability; independence; community building and the development of support networks; and participation in meaningful activities, including employment, within the broader community.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
4. Supportive services staff use a variety of proactive and creative strategies to engage tenants in on-site and/or community-based supportive services, but participation in such services is not a condition of ongoing tenancy.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
5. Supportive services staff are respectful, non-judgmental, and professional in their interaction with tenants.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
6. Supportive services are provided in a variety of settings so as to maximize tenants' access to services and contact with staff, including but not limited to home/apartments visits, service office contacts, structured recreational activities, group counseling. When tenants are expected to travel outside of their home for services, they are provided with transportation assistance.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
7. The supportive services provider uses a team approach to service delivery by using team supervision, case conferencing, or group problem-solving, and/or a "no wrong door" approach that allows tenants to access services or assistance by contacting any staff members.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
8. Supportive services and property management strategies include effective, coordinated approaches for addressing tenant issues resulting from substance use, relapse, and mental health crises, and focus on fostering housing stability.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

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Dimension #5 - Housing Management and Operations: Housing management and operations activities support the mission and goals of the housing and foster tenants' housing stability and independence; ensure the quality, maintenance, and safety of apartments; and manage relationships and lease holding arrangements with private landlords.

This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization:
A: Yes B: In part, but not completely. C: No D: Not Applicable.

Key Indicators of Quality	Assessment
1. Staff maintain, review, and regularly update appropriate Policy and Procedure Manuals and Plans, such as: Leased Housing Operations Manuals; Safety & Emergency Plans; Staff Orientation & Training Manuals; and Personnel Policies & Procedures Manuals.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

2. Housing management policies, procedures and activities fully comply with applicable laws, regulations, and standards, including Fair Housing laws, Landlord - Tenant laws, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act (if federally-funded).	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
3. Delivery of housing management and operations is consistent with the philosophy and goals of the supportive housing opportunities being provided.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
4. Housing management duties are coordinated with supportive services delivery to implement effective, coordinated approaches for addressing issues resulting from substance use, relapse, and mental health crises, with a focus on fostering housing stability.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
5. Staff are responsive to the needs of both tenants <u>and</u> private landlords, and effectively respond to concerns, address problems, and mediate conflicts.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
6. Staff advocate on behalf of tenants to ensure that their tenant rights are upheld, and fulfill their obligations as master-lessees and sub-letters as stated in lease agreements and in accordance with local Landlord-Tenant laws.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
7. Staff members adhere to a comprehensive, written plan and schedule for monitoring and reporting on financial performance in order to ensure financial sustainability.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

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Dimension #6 - Tenant Rights, Input, and Leadership: Tenant rights are protected within consistently-enforced policies and procedures, tenants are provided with meaningful input and leadership opportunities, and staff - tenant relationships are characterized by respect and trust.

This indicator accurately describes the operational practices within the Harm Reduction Supportive Housing units operated by my organization:
A: Yes **B:** In part, but not completely. **C:** No **D:** Not Applicable.

Key Indicators of Quality	Assessment
1. Each tenant household has a lease granting the same rights as those granted to other lease-holders in the community, including the right to determine whether to participate in supportive services or not, with no limits on length of tenancy, as long as the terms and conditions of the lease or agreement are met. Sub-leases are treated and upheld as fully legally enforceable leases.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
2. Prior to lease signing, tenants are given a full and complete explanation of their rights and responsibilities as tenants, and the rights and responsibilities of landlords and provider master-lease holders.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
3. The terms of leases are consistently applied and enforced with all tenant households.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
4. All involved organizations have tenant and consumer rights policies and procedures that comply with applicable laws, regulations, and standards, including Fair Housing laws, Landlord - Tenant laws, the Americans with Disabilities Act, and with Section 504 of the Rehabilitation Act (if federally-funded).	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
5. All involved organizations actively seek tenant input in decision-making at their highest organizational levels, support tenants in forming tenant councils, and meet regularly with any tenant-led organizations.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D
6. All involved organizations have appropriate written complaint and grievance policies that are provided and explained to tenants and that are consistently implemented.	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D

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Corporation for Supportive Housing’s Technical Assistance and Trainings

To support the implementation of Population E, CASA Columbia contracted with the Corporation for Supportive Housing (CSH) to provide technical assistance and training to the selected programs implementing Population E supportive housing. Recognizing that the implementation of a Housing First approach to supportive housing under Population E was not a simple replication of a known model with available guiding resources, CSH approached the delivery of technical assistance through a learning collaborative model, wherein knowledge, skills, and practices would be built and generated through a series of facilitated peer-to-peer discussions. For each of these sessions, CSH would convene the leadership (program directors and/or clinical supervisors) of each of the programs around one or more topics, identified by the programs themselves (though sometimes informed by CSH’s understanding of necessary topics). Program staff would reflect on their practice, wherein they would identify implementation issues, discuss and share promising approaches, and collaboratively problem-solve around common challenges. For some sessions, CSH invited experts or officials to present on specific topics. During the early months of implementation, CSH held learning collaboratives on a monthly basis in order to provide regular and routine support to the provider agencies. As implementation progressed, learning collaborative sessions decreased in frequency, taking place bi-monthly in the second year of implementation, and quarterly by the third year.

From December 12, 2007 through December 9, 2010, CSH held twenty-two (22) learning collaborative sessions. As reflected in the following table, the topics tracked the process of implementation somewhat chronologically, with early sessions focused on tenant recruitment and selection and housing search and placement, and later sessions focused on services delivery, supervision, and addressing system challenges.

Date	Learning Collaborative Topic(s)
December 12, 2007	Kick-off Meeting Overview of CASAHOPE Population E Evaluation Overview of CSH’s Technical Assistance/Training through Learning Collaboratives
January 23, 2008	Understanding the Population E Supportive Housing Model Identification of Learning Collaborative Topics Featured Speaker: Laura Grund, DOHMH
February 27, 2008	Tenant Application, Referrals, and Placement Featured Speaker: Kathleen Kelly, HRA
March 20, 2008	Tenant Selection (continued) Apartment Search and Landlord Relations Featured Speaker: Renee Bueller, CUCS
April 22, 2008	Successfully Housing People with Substance Use Issues
May 20, 2008	Referrals, Tenant Selection, and Lease-up process
June 24, 2008	The Housing Interview, Tenant Selection vs. Services Intake Balancing the Roles of Service Provider and Landlord in a Scattered-Site Setting Featured Speaker: Sue Smith, Center for Urban Community Services
July 22, 2008	Identifying and Addressing Bottlenecks in NY/NY III Application, Approval and Referral Process Occupational Therapy for Population E Tenants Featured Speaker: Emily Raphael, Columbia University

September 16, 2008	Improving Flow of Population E Referrals Understanding Harm Reduction in Supportive Housing Featured Speaker: Bryan Kutner
October 14, 2008	Articulating Six Underlying Principles of Harm Reduction in Supportive Housing Understanding and Recognizing Client Success in Housing First Featured Speaker: Bryan Kutner
December 9, 2008	First Year Reflections, Lessons, Challenges
February 24, 2009	Technical Assistance, Training, and Evaluation Plans for 2009
April 28, 2009	DOHMH's Office of Program Review and Evaluation (OPRE) Audit Standards and Process Featured Speaker: Kimberly Jones, DOHMH
June 23, 2009	Understanding and Addressing Issues for Clients with Long-Term Street Homelessness Experiences Featured Speaker: Sheryl Silver, Pathways to Housing
September 8, 2009	Developing a Theory of Change for Population E Supportive Housing I: Overview and Identifying Outcomes and Activities
October 13, 2009	Developing a Theory of Change for Population E Supportive Housing II: Mapping the Sequence of and Relationships between Outcomes
November 24, 2009	Client Engagement and Relationship Building Building Client Self-Awareness
January 19, 2010	Building Client Self-Awareness Brokering Connections to Mainstream Public Services
April 6, 2010	Discussion Promoting Health and Decreasing Risk Behaviors Increasing and Ensuring Tenants Enrollment in Public Assistance Featured Speaker: Elise Tosatti, Entitlements Coordinator, Project Renewal
May 4, 2010	Population E Client's Public Assistance Enrollment Challenges Featured Speaker: HRA Executive Deputy Commissioner Frank Lipton, MD
November 2, 2010	Program Updates and Collaborative Problem Solving
December 9, 2010	Final Learning Collaborative: What Have We Learned? (with Case Managers)

In addition, CSH provided trainings to Population E staff around key practices that were known to be central to Housing First. These structured trainings were largely focused on skills and practices needed by case managers and front-line staff and included the following topics:

Date	Training Provided
April 3-4, 2008	Successfully Housing People with Substance Use Issues 101
June 19-20, 2008	Successfully Housing People with Substance Use Issues 101
April 8-9, 2008	Successfully Housing People with Substance Use Issues 201
November 16-17, 2009	Working with Ambivalence and Resistance (for Case Managers)
March 24-25, 2010	Working with Ambivalence and Resistance (for Case Managers)
May 10, 2010	Working with Ambivalence and Resistance (for Program Directors and Supervisors)

In 2009, at the request of programs and with the approval of CASA Columbia, CSH began offering and facilitating a separate Learning Collaborative for case managers and front-line staff. Slightly less structured than the Program Director's Learning Collaboratives, the Case Managers Learning Collaboratives allowed for both the sharing of effective approaches and strategies, as well as to provide an informal support network for staff. During 2009 and 2010, CSH offered 10 Learning Collaborative sessions for Case Managers focused on the following topics:

Date	Case Managers Learning Collaborative Topic(s)
June 2, 2009	Kick-off: Discussion of Case Manager Experiences during the Startup Year
July 9, 2009	Developing a Theory of Change for Population E Supportive Housing I: Overview and Identifying Outcomes and Activities
August 27, 2009	Motivational Interviewing: Rolling with Resistance
October 6, 2009	Developing a Theory of Change for Population E Supportive Housing II: Mapping the Sequence of and Relationships between Outcomes
January 28, 2010	Grief and Loss
April 29-30, 2010	Wellness Workshop: Sleep Hygiene, Nutrition, Cooking Class, Ear Point Acupuncture, Reiki, and Chair Massage.
June 30, 2010	Review of Motivational Interviewing
July 27, 2010	Motivational Interviewing: Recognizing Change Talk
August 24, 2010	Motivational Interviewing: Eliciting Change Talk
September 29, 2010	Motivational Interviewing: Reflection and Responding to Change Talk
November 12, 2010	Motivational Interviewing: Complexifying Reflections and Equipose
December 9, 2010	Final Learning Collaborative: What Have We Learned? (with Program Directors and Supervisors)



Supportive Housing for Chronically Homeless Single Adults with Disabling (Active) Substance Use Issues

A. Understanding the Target Population

What are the unique barriers to housing stability faced by members of the target population?

Chronically homeless single adults with disabling and active substance use issues face a myriad of barriers and challenges that threaten their ability to achieve stability in permanent housing settings. While some of these barriers are similar to those faced by other chronically homeless individuals (e.g. lack of experience with maintaining responsibilities of tenancy, tendency to avoid services, etc.), there are several barriers unique to members of this subpopulation:

- Physical/medical health conditions related to substance use – People with active and disabling substance use conditions are likely to have a range of physical health conditions. These can include both conditions directly related to their drug use, such as venal damage, infectious diseases such as Hepatitis C and HIV/AIDS, or overdoses, as well as conditions indirectly related to their drug use such as poor nutrition, participation in higher risk sexual behaviors, lack of medication compliance or general lack of access or avoidance of primary medical care. Many actively using chronically homeless individuals have multiple co-occurring health conditions that can lead to increased risks for health conditions as well as further contribute to the persistence of homelessness.¹
- Poor or under-diagnosed mental health conditions – Chronically homeless individuals with disabling substance use conditions are likely to have poor mental health. Some studies have even found the prevalence of serious mental illness to be higher among high-risk drug users than among the homeless in general.² Despite this estimated higher prevalence, chronically homeless drug users are likely to be under-diagnosed for serious mental illness and therefore, may remain underserved by the public mental health system. Moreover, many have mental health conditions that do not meet the eligibility threshold of a ‘serious and persistent mental illness’ that would qualify them for public mental health services. These include individuals with Axis II disorders, or those with Axis I disorders that lack evidence of sufficient severity or duration.
- Frequent money management problems – Most chronically homeless people with active and disabling substance use face a significant problem with income maintenance and

¹ Galea, Sandro and Vlahov, David. (2002) “Social Determinants and the Health of Drug Users: Socioeconomic Status, Homelessness, and Incarceration,” *Public Health Reports*, Volume 117, Supplement 1: S135-S145.

² Mandell, Wallace, Kim, Joohyung, Latkin, Carl, and Suh, Tongwoo. (1999) “Depressive Symptoms, Drug Network, and Their Synergistic Effect on Needle-Sharing Behavior Among Street Injection Drug Users,” *American Journal of Drug and Alcohol Abuse*, Volume 25, Number 1: 117-127.

money management, both due to the expense associated with drug and alcohol use as well as lack of access to public assistance benefits due to mandatory drug screening by public welfare agencies. New York State's Welfare Reform Act of 1997 requires that all applicants for public assistance be screened for alcoholism and/or substance abuse problems and that those found positive be assessed by a Certified Alcohol and Substance Abuse Counselor (CASAC) and possibly required to complete a course of treatment. Those who refuse to participate in such treatment are denied benefits. As a result, chronically homeless people with disabling substance use conditions who are unable or unwilling to complete a course of treatment have difficulty paying rent, even when their expected rent contribution is only the public assistance shelter allowance. In fact, the limited access to public assistance has been attributed with a higher propensity to resort to illegal behaviors to earn income, which leads to increased criminal justice system involvement.³

- Difficulty accessing and maintaining enrollment in benefits and entitlements – A related barrier to housing stability among chronically homeless serious drug users is difficulty accessing and navigating services and maintaining enrollment in benefits, such as public health insurance. This is sometimes related to their substance use itself, which often results in their failure to comply with conditions of enrollment in services or benefits. For example, many substance users fail to respond to notices from their public agencies regarding their benefits and have their benefits terminated, thus limiting their income or access to health services. At other times, some of the challenges they face in navigating and maintaining services engagement are the result of the stigma and rejection that they face from service providers and public agencies regarding their substance use.⁴ Both reasons suggest that actively and seriously using chronically homeless individuals need a great deal of assistance with navigating benefits and services and maintaining enrollment in these programs.

What are the critical challenges to services engagement for members of the target population?

Supportive housing providers may face a dual set of challenges in successfully engaging chronically homeless individuals with disabling and active substance use. On the one hand are challenges that are related to individual behaviors and attitudes and on the other are “system” challenges. Individual factors include a tendency towards service avoidance, distrust of service providers, tendency to mask or hide service needs, a pattern of disorderly conduct, history of criminal justice involvement and a history of residential instability. While some of these behaviors are directly related to chronic substance use, some (i.e. service avoidance) are simply survival adaptations to the public human service system's treatment of active users. In other words, many of the challenges to serving chronically homeless individuals with disabling substance use in supportive housing stem from the stigma against substance use prevalent among public service systems and professionals. Providers of supportive housing will likely face this stigma when seeking to help their tenants to access and navigate systems of care. This stigma manifests itself in terms of either reluctance to offer and extend care to substance users or even outright exclusion and denial from needed services and benefits. One of the more serious consequences of this stigma is the lack of

³ Focus group with supportive housing providers, March 2, 2006.

⁴ Focus group with supportive housing providers, March 2, 2006.

available income sources for active substance users (given the drug treatment requirements for public assistance in New York City).

B. Supportive Service Design and Delivery

What are the supportive service goals in supportive housing for chronically homeless individuals with disabling and active substance use?

Existing projects serving chronically homeless individuals with active and disabling substance use issues were designed for the purposes of serving as an alternative to the “streets” and the dangers and harms associated with street living among people with serious substance use issues. Several projects even refer to their function as “housing of last resort,” where the goals of the services are to reduce harm and prevent death.⁵ Most supportive housing projects for active substance users have adopted a harm reduction philosophy, in which sobriety may be encouraged and supported, but is not enforced or presumed as a primary goal of the service plan for all tenants.

The most commonly stated service goal in supportive housing projects serving chronically homeless individuals with active and disabling substance use conditions is to increase housing stability, measured as the length in stay (retention) in permanent housing.⁶ A related goal to housing stability is to prevent returns to sheltered or street homelessness. In addition to housing stability and homelessness prevention, many supportive housing projects for active substance users also consider the goal of their service plan to be the avoidance of high-risk and harmful behaviors related to substance use. These high-risk behaviors may include the amount or type of substances used, the manner of substance use (e.g. not sharing needles for injection drug users), illegal behaviors that lead to criminal justice involvement, and high-risk sexual behaviors. Many projects have been subject to formal impact evaluation studies wherein success is defined in terms of the avoidance of emergency public system utilization, including emergency rooms, psychiatric hospitalizations, crisis/detoxification services, and criminal justice system involvement, and increased involvement in mainstream services. Thus, an implicit goal of the services in supportive housing for active substance users is the avoidance of high-cost public services, in favor of mainstream services, such as primary care.⁷

What core services are essential to ensuring housing stability and retention for members of this target population?

Because of the tendencies of homeless persons with disabling and active substance use to avoid traditional services and to have long histories of residential instability, the path toward housing stability may be more gradual and interrupted than compared with other homeless single adults. Engaging this population may be labor intensive, at least at first, as they stabilize their lives and begin to build awareness and concern for their own health and housing stability. A key characteristic of supportive housing targeted towards these tenants

⁵ Anishanabe Wakiagun.

⁶ Anishinabe Wakiagun, Direct Access to Housing, Lamp Lodge, Joseph’s House and Shelter, and Housing Works’ E. 9th Street Residence.

⁷ Anishinabe Wakiagun, Direct Access to Housing, and Lamp Lodge.

is a recognition on the part of providers that tenants' service needs and goals will change over time. **A highly flexible and responsive approach to services delivery and engagement is necessary** to successfully promoting improved health and housing stability; providers of supportive services should be capable of responding and adapting to changing needs and service goals.⁸

This flexible and responsive approach to services begins with an individualized service plan. Although individualized services planning is not unique to chronically homeless active users, supportive housing models for actively using individuals typically has even broader ranges of service goals and an emphasis on allowing tenants to determine their goals of the services themselves. In particular, abstinence from drug and alcohol use is typically not automatically assumed as part of a tenant's social services goals.⁹

Although not a formal or discrete "service," another critical element to a supportive services approach for chronically homeless active users is **crisis intervention**. Supportive housing providers should be prepared to respond to various crises that result from tenants' lack of housing stability history and active use of substances. The frequency of these crises is inversely related to length of tenure in supportive housing and housing stability. In other words, the frequency of crises declines as tenants' housing stability is increased. Moreover, such crises may not take place immediately upon placement into supportive housing, but rather may "spike" approximately two to three months after placement of actively using tenants, once tenants have become settled in. Skilled and experienced providers of supportive housing for this population should be aware of, anticipate, and be able to effectively respond to the emergence of these crises. The types of crises that may arise include medical emergencies, especially overdoses, tenant arrests and incarceration, mental health decompensation, fights between tenants, etc.

A critical aspect of anticipating the dynamic needs of tenants, including the patterns of crises, is **a dedicated focus on relationship and trust building**. Such trust and confidence between tenants and services staff allows for staff to anticipate and rapidly respond to service needs and challenges to housing stability. A tenant who trusts her service provider would likely inform the provider directly of situations that might jeopardize her tenure in housing. For example, a tenant may have recently experienced a personal crisis (i.e. the death of a family member or friend) that led to increased substance use. As a result, the tenant spent all of his or her money on drugs and therefore, may not have money for rent that month. Since the provider is aware of this problem, the provider can inform the property manager of the situation and can work with the tenant to solve the problem by developing a plan for paying the rent arrears. On the other hand, a tenant who distrusts his or her service provider would not have informed the provider of this situation and would likely have become evicted.

An equally critical ingredient to relationship and trust building in supportive housing models for active users is the service plan's **emphasis on health and medical needs**, in order to address the physical health complications that arise from substance use, as well as to further engage and build trust among tenants. As a result, the majority of supportive housing for

⁸ Focus group with supportive housing providers, March 2, 2006.

⁹ Anishanabe Wakiagun, Joseph's House and Shelter, and Pathways to Housing.

active substance users typically incorporates primary medical services, either at an affiliated clinic or through on-site availability of part-time medical staff such as a nurse or physician, as well as other holistic healthcare providers including acupuncturists and homeopathic practitioners. In this way, successful service delivery for homeless individuals with disabling and active substance use attempts to inter-weave both professional/medical and non-clinical types of supports.

Part of these medically-focused services are a range of **harm reduction services**, which focus on health education around avoiding high-risk behaviors, as well as concrete services that promote safer practices. For example, supportive housing projects may provide tenants with education on safe injection, safe sex, and avoidance of drug use practices that lead to infectious diseases, other physical conditions, and overdosing. Supportive services may also link tenants to needle exchange and other existing harm reduction programs, as well as make condoms and other prevention supplies available to tenants.

In addition to medically-focused supports, supportive housing for homeless adults with active and disabling substance use issues also offer other specialized services such as **substance use treatment, nutrition counseling, and mental health treatment—within the context of substance use**. These targeted services may be provided directly by the provider, through dedicated staff with specialized credentials and skills (typically Masters-level licensed social workers or certified counselors) or through existing services available in the community brokered for tenants by the supportive housing staff. Most supportive housing for members of this target population offer addiction treatment services, such as Narcotics Anonymous groups, either on-site or through linkages.

The brokering of these medical and behavioral health supports is highly contingent upon clients' health care coverage. However, as described above, actively using chronically homeless individuals face numerous challenges with accessing and maintaining their enrollment in benefits and public health insurance (Medicaid). For this reason, supportive housing providers for this population emphasize **benefits and entitlements advocacy** as a critical service area. Benefits advocacy is provided through specially trained case managers or dedicated staff positions, and involves assisting clients with understanding, navigating, applying for, and maintaining enrollment in public benefits, entitlements, and health insurance programs.

Nearly all known supportive housing projects targeted towards chronically homeless individuals with active and disabling substance use include services focused on **training and assistance with activities of daily living**, with a particular focus on **medication management, money management, and recreation skills**. Chronically homeless active substance users are likely to lack or be deficient in basic living skills, including personal hygiene, household management, and money management. One supportive housing project for chronically homeless individuals with active substance use conditions uses a **representative payee system** to help tenants manage their money. Individuals actively using substances may also have complications complying with medication regimens. Moreover, many providers of supportive housing for active users discuss the importance of recreational activities and skill building, both for purposes of community building among tenants, as well as to teach tenants alternative methods of recreation other than substance use.

Since many chronically homeless substance users were transient prior to their stays in supportive housing, they may lack existing productive social supports and relationships. One result of the lack of social supports may be loneliness and social isolation, for which tenants may cope by using substances. To promote the building of peer supports and healthy social relationships, supportive housing for individuals with active and disabling substance use typically incorporates a wide array of **community building activities**, both formal and informal. Formal community building activities may include group recreation activities, such as organized outings to movies or sporting events, and even community dinners. Some supportive housing projects offer on-site group activities, such as arts and crafts classes or writing groups. Informal community building activities may take place in **individual and group counseling sessions**. In addition, because tenants of supportive housing projects that use a harm reduction philosophy typically may range across a spectrum of service needs and substance use status, conflicts are likely to arise between tenants, for example, between those in recovery and those who are in a ‘pre-contemplation’ stage, to borrow a term from the ‘Stages of Change’ model. Therefore, both service staff and property management staff in supportive housing for these tenants are frequently called upon to resolve conflicts, and should have the requisite training and skills to perform effective **conflict resolution**.

What is a typical or recommended staffing pattern for delivering these services? What particular skills, credentials, or areas of expertise should be represented in this service delivery team?

As with supportive housing for other homeless populations, the foundation of service delivery is case management and service coordination, typically performed by non-credentialed staff (Bachelors’ level or below.) It is the experience of existing service providers that peer counselors are crucial to engaging and delivering services to homeless persons with disabling and active substance use.¹⁰

A division of labor is typically established in which the direct line service staff (e.g. case managers and peer counselors) function as the primary relationship builders with tenants, as well as the coordinators of services, and wherein credentialed clinical staff both provide more specialized services as well as interface with external systems and advocate on behalf of clients.

Although staffing patterns vary widely across contexts and regions, the typical core staffing pattern includes the following:

- A site or program director
- A clinical supervisor (typically a Masters-level licensed social worker)
- Case managers or service coordinators (Bachelor’s level, or high school diploma, sometimes peer counselors)
- Benefits/entitlements specialist (may be one of the case managers)
- A licensed substance abuse counselor or mental health social worker

¹⁰ Focus group with supportive housing providers, March 2, 2006.

Case manager-to-tenant ratios vary, depending upon the scale of the project, but in general, the ratio falls in the range of 1:10 for smaller projects to 1:20 for larger buildings. Scattered-site programs often fall in the higher end of the ratios: 1:18 to 1:20.

In addition to these core staff, various part-time specialists and clinicians are called upon to make regular visits to tenants. In other projects, these services might be provided through community-based services, such as a dedicated health clinic, via a formal linkage to the housing. These might include:

- A registered nurse
- A nutrition specialist
- Psychiatrist
- Vocational specialist

What service delivery philosophies, approaches, techniques, or training are critical (best practices) to ensuring housing stability and retention for members of this population?

As discussed above, a key ingredient to services engagement is **the development of trust and open communication between tenants and supportive services staff**. Such trust and open communication allows staff to anticipate and rapidly respond to problems before they lead to further housing instability and eviction, and therefore, are ultimately a means of preventing returns to homelessness. Creating this atmosphere involves the incorporation of a non-judgmental orientation towards illegal drug use and other high-risk behaviors, along with skills for communicating and working with tenants to address these problems. A non-judgmental orientation can be established regardless of whether the supportive housing project focuses on sobriety and abstinence as an official program goal or whether it uses a harm reduction philosophy, in which abstinence from drugs or alcohol is not necessarily a goal for all tenants. In other words, the development of an atmosphere of acceptance and trust has less to do with official program goals or house rules than with the specific communication skills and techniques used by staff, such as the use of open-ended questions, reflective listening, and motivational interviewing.

The **harm reduction philosophy** offers some key principles for establishing an atmosphere of acceptance. First, the tenant's decision to use drugs is accepted as a fact. This does not imply the providers' approval of the decision to use drugs, but rather simply that drug use is at present, reality for the tenant. Related to this is the attempt to remove judgments about drug use and users, since such judgments may contribute to their feeling of alienation from and unwillingness to confide in the service provider. Second, the tenant should be treated with dignity as a normal human being regardless of whether or not he or she is using drugs. By the same token, there is an expectation that the tenant will behave "normally" and that he or she is responsible for his or her behavior. Third, harm reduction is neutral regarding the long-term goals of intervention. That is, rather than determine the goals of services for the tenant, harm reduction allows tenants to set their own long-term goals for services, and involves an openness to a diversity of long-term goals that may include eventual abstinence or that may include continued use. Moreover, since tenants have a variety of goals, harm reduction must develop and incorporate a wide variety of interventions and services to attend to these self-actualized needs. Ultimately, harm reduction's "bottom line" is that any

reduction in harm is a step in the right direction and that quality of life and well-being should be the primary criteria for measuring success rather than quantity of drugs used.¹¹

Another component to harm reduction is **a focus on positive rather than negative reinforcement**. *Motivational interviewing* and *active listening* are commonly used practices in communicating with tenants. Motivational interviewing involves inquiring about and building upon tenants' strengths and aspirations rather than focusing on weaknesses and failures. Active listening involves talking with and building relationships with tenants, and listening carefully for tenants to express desire for change or service needs, however subtly this is expressed.

Despite widespread misconceptions, harm reduction does not mean that any behaviors are condoned and that supportive housing enforces no rules. In fact, all of the supportive housing projects for actively using tenants have a set of house rules that prohibit violence against other tenants, neighbors, or staff. The main grounds for eviction from these projects are acts of violence committed by tenants. Some projects also prohibit the use of substances or alcohol in the common and public areas of the building, and may restrict the number and length of stay of overnight guests.

Moreover, harm reduction is not synonymous with a 'low-demand' model. Many supportive housing projects that incorporate a harm reduction philosophy are actually 'high-demand' in that they require tenants to engage and participate in some supportive services as a condition of tenancy; they just do not require tenants to participate in drug treatment unless tenants express the desire to do so. Housing Works, for example, requires tenants to participate in a set number of hours of services a week. Pathways to Housing requires of its tenants a minimum of six face-to-face sessions per week. The terms of these requirements may be negotiated with tenants and adapted as service needs change.

At the same time, while the house rules may require participation in services, the supportive services staff focus heavily on creative engagement strategies. As one experienced provider of supportive housing to actively using homeless individuals explains, staff must "make services so attractive that they are irresistible to tenants."¹²

Where will these personnel be located and where will these services be provided?

Services to homeless persons with disabling and active substance use must be delivered when and where they are needed. Staff must be trained to be flexible and hours of operation must be beyond normal business hours. While there must be many engagement opportunities provided on-site, including home visits, staff will spend a great amount of time escorting the tenants to other services. This service functions as both an advocacy and educational service for tenants.

What critical service expense items, other than personnel, are essential for delivery of the above services?

¹¹"Effective Communication Techniques: Open-Ended Questions and Reflective Listening", *Toolkit for Developing and Operating Supportive Housing*, Corporation for Supportive Housing, 2006.

¹²Focus group with supportive housing providers, March 2, 2006.

In addition to staff salaries, there are several other service expenses that are typical in supportive housing for chronically homeless adults who have active and disabling substance use conditions. These include:

- Supplies (medical, harm reduction) – Supportive housing projects that offer on-site harm reduction services use a range of medical and health-related supplies. These can include condoms, clean IV needles, biohazard waste equipment, bleach kits, and first aid kits.
- Emergency rent funds – Some supportive housing includes reserves for rent losses and emergency rent payments.
- Food – Two supportive housing projects offer daily or weekly prepared meals for the purposes of both promoting nutrition as well as for services engagement and community building.
- Recreation – Allows supportive services staff to teach productive or healthier recreational activities than drug use.
- Training – It is the experience of existing providers that *all* staff must be re-educated upon hiring around working with people who are actively using. They must be trained in harm reduction and acculturated in its non-judgmental approach. Each staff person is expected to be able to interface with tenants and communicate tenant needs with each other. Staff will also be trained in active listening and motivational interviewing.

Other than housing stability and retention, what additional service outcomes are expected for the proposed supportive housing model?

In addition to housing stability and retention, supportive housing for actively using individuals strives to achieve the following outcomes:

- Level of services engagement and trust - This can be measured by number of voluntary services participants, number of individual case management sessions, number of group counseling sessions, etc.
- Reduced harms, such as fewer detox episodes, fewer overdoses, less risky use and sexual and other behaviors, etc.
- Increased physical and mental health outcomes, measured with health providers
- Tenant insight into use and concern for well-being
- Tenant satisfaction
- Degree of community built among tenants, such as attendance at community events, tenant meetings, neighborhood activism, etc.

What services will be provided to achieve these additional desired outcomes? How will these services be funded?

Harm reduction-focused services: Harm reduction refers to measures aimed at reducing the harm associated with drug use without necessarily requiring a reduction in consumption.¹³ The user's decision to use drugs is accepted as a fact. This does not imply the approval to use drugs. The user is treated with dignity as a normal human being. By the

¹³ Alex Wodak, 1994, Australia.

same token, there is an expectation that the user will behave “normally”, i.e., within the law. Thus, the drug user is responsible for his or her behavior. Harm reduction is a vital first step in towards the reduction of, and even cessation of, drug use. By treating the user with dignity rather than as a criminal, harm reduction programs have been successful in bringing addicts into treatment programs. Harm reduction involves a prioritization of goals, in which immediate and realizable goals take priority when dealing with users who cannot be realistically expected to cease their drug use in the near future, but it does not conflict with an eventual goal of abstinence.¹⁴

Medical services can be provided through linkages in the community, including mental health treatment. Groups such as Hepatitis C, diabetes, and HIV/AIDS management can be provided on-site or through linkages with community health clinics or adult day treatment centers. External clinics should be able to fund these services, with assistance from housing staff to get tenants active Medicaid cases.

Client advocacy and community building are large parts of the case manager and peer counselor’s roles. It is through these activities that tenants will become stabilized in their housing and begin to take steps to manage their health and substance use.

C. Housing Configuration

What are critical considerations for providing congregate supportive housing projects for this population?

Congregate or single-site housing is more common than scattered-site settings for members of this target population, though this may be driven more by resource availability than programmatic considerations. Single-site housing is believed to have certain conveniences over scattered-site housing in that staff can identify issues more quickly and more easily respond to tenants’ crises and needs. Also, providers note that a single-site setting facilitates the building of community, encouraging peer support and modeling healthy recreational activities.¹⁵

One challenge associated with single-site housing is the potential for inter-tenant conflicts to arise. While supportive housing for actively using individuals does not differ in this respect from other supportive housing, additional conflicts between tenants might arise given tenants’ differences in their stages of change. For example, tenants in recovery may find actively using tenants to be more disorderly or disruptive. Providers manage these conflicts as they would in another other supportive housing—through their community building and mediation functions as well as by instilling in the building an overall philosophy of non-judgment and mutual respect.¹⁶

Is there a recommended minimum/maximum number of units to be provided in the same building?

¹⁴ “Introduction to Harm Reduction Concepts”, *Toolkit for Developing and Operating Supportive Housing*, Corporation for Supportive Housing, 2006.

¹⁵ Focus group with supportive housing providers, March 2, 2006.

¹⁶ Focus group with supportive housing providers, March 2, 2006.

There seems to be no recommended or requisite minimum or maximum number of units in any single-site building serving chronically homeless individuals with active and disabling substance use. Existing projects reviewed range in size from 30 to 92 units in any single-site.

Are there particular challenges/considerations involved in mixing tenancies? How will these challenges be overcome?

While it can be done, there can be more conflicts if some tenants are in recovery and others are not. Mixing homeless persons with disabling and active substance use with other populations requires very committed and active staff so they can build a solid community and instill a philosophy of respect for diversity of goals and individual paths.

What are the critical considerations for providing scattered-site supportive housing for this population?

While the goals, core services, and service philosophy is the same for single- and scattered-site housing, scattered-site housing differs from single-site housing in three respects. First, since the tenant is likely be living off-site from supportive services staff, the supportive housing provider must have the capacity to deliver and coordinate services at the tenant's apartment through a mobile service team. Providers of scattered-site supportive housing to members of this population often use such mobile interdisciplinary service delivery vehicles as Assertive Community Treatment or targeted case management. Services delivered by this team are said to “wrap” around the tenants. Direct line staff must work to build a relationship and trust with the tenant, since much of the client contacts must be arranged and scheduled over the phone.

Second, scattered-site housing involves a unique kind of “property management,” in which the provider is not managing an entire building, but is rather managing individual units, both physically and financially. In most scattered-site housing models targeted towards chronically homeless individuals with active and disabling substance use, the provider is the master-lease holder of the units and under this master-lease, is responsible for responding to the tenant's property needs directly (e.g. setting up and managing utilities, replacing light bulbs) or by assisting the tenant with interfacing with the private landlord. Providers of scattered-site housing to members of this target population therefore often have in-house staff with expertise in housing management and landlord relations.¹⁷

Third, scattered-site housing involves a different approach to community building than in single-site housing because tenants in scattered-site housing do not have the benefit of an on-site community. Providers of scattered-site housing often assist the tenant with building and managing relationships with the community and the other tenants with which the tenant is situated, as well as with navigating the local neighborhood. In this way, supportive services delivery in scattered-site housing settings may be slightly more time-intensive initially upon placement of each tenant than in single-site settings, since more work needs to be done to situate and “settle” the tenant into his or her environs.¹⁸

Do some members of the population fare better in scattered-site versus congregate apartments?

¹⁷ Pathways to Housing, Direct Access to Housing.

¹⁸ Pathways to Housing.

Scattered-site housing may be most appealing to members of the population who have anti-social disorders or those who have lived on the street for many years and who prefer not to live in a setting where interaction with other tenants is expected.¹⁹ In this way, the provision of both scattered- and single-site housing is more about maximizing tenant choice and matching to tenant preferences, rather than responding to different needs among members of the community.

However, providers of supportive housing to members of this target population make certain generalizations regarding certain subsets of their tenancies. For example, providers claim that people leaving prison tend to prefer (or fare better in) congregate settings, perhaps due to their needs for peer supports, conflict management, and crisis intervention.²⁰ Single site may also be better for people with violent pasts so that tenants can be monitored more closely and management can have better control over space (e.g., sprinklers for arsonists).²¹

How will the provider promote the building of community among scattered-site tenants?

Creating a sense of community is more challenging for people living in scattered-sites. As described above, staff tend to spend more time with each new tenant during the first few weeks or months after placement than they might in single-site settings. Ideally, providers should offer a central gathering place for people to receive services such as group discussions, tenant meetings, and social events. These settings can be a clinic or health center operated by the provider directly, or made available through a linkage with another provider.²²

¹⁹ Focus group with supportive housing providers, March 2, 2006. Pathways to Housing.

²⁰ Focus group with supportive housing providers, March 2, 2006.

²¹ Focus group with supportive housing providers, March 2, 2006.

²² Pathways to Housing, Direct Access to Housing, Housing Works.

Appendix I Programs Providing Population E Supportive Housing at a Glance

	BRC	The Bridge	CAMBA	Common Ground	The Doe Fund	Project Renewal	Turning Point	Urban Pathways	VOA
Homepage	brc.org	thebridgeinc.org	camba.org	commonground.org	doe.org	projectrenewal.org	tpdomi.org	urbanpathways.org	voa-gny.org
Central Office Borough	Manhattan	Manhattan	Brooklyn	Manhattan	Manhattan	Manhattan	Brooklyn	Manhattan	Manhattan
Operates Shelter	Yes	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Operates Street Outreach Teams	Yes	No	No	Yes	No	No (but does operate a mobile medical van)	No	Yes	Yes
Operates Licensed Drug Treatment Program	Yes	No	No	No	No	Yes	Yes	No	Yes
Form of Supervision	Meet 1 time/week for individual supervision, twice/month for team supervision, and 1 time/month for an all-staff meeting	Structured weekly individual supervision with daily supervision as necessary	Weekly all staff and meet individually once per week	Monthly group supervision and weekly individual	Program Director meets with Clinical Coordinator for formal supervision once per week; Program Director conducts weekly team meeting which is half clinical-half administrative; Clinical Coordinator meets with each clinical case manager for weekly individual supervision.	Team meetings 3 times a week. Clinical coordinator meets with staff individually twice per month. Informal supervision daily.	Twice a month individually, 3-5 times a month joint supervision (varying between months)	Weekly supervision with director and social worker; weekly staff meeting	Twice per month individually, once per month staff meeting, once per month social service meeting; informal supervision in the morning
Borough of Units	Bronx and Brooklyn	Bronx and Manhattan	Brooklyn	Bronx, Brooklyn, Queens	Manhattan, Bronx and Brooklyn	Bronx, Brooklyn, Manhattan	Brooklyn	Bronx, Brooklyn	Bronx
2-bedroom units	Yes	No	Yes	No	Yes	No	Yes	Yes	No
% of Tenants Who Come from Agency's Own Shelters, Street Outreach or Other Programs	50-75%	less than 25%	less than 25%	50-75%	less than 25%	75-100%	less than 25%	75-100%	less than 25%
# of interviews required prior to tenancy	1	2	1	1	1 to 2	1	1	1	1
Special Target Criteria Beyond Population E, if at all (i.e. youth, veterans, etc.)	adult couples okay, though not specifically targeted	-	-	-	tried to prioritize parolees and veterans	Veterans	youth	youth	youth
Home Visits	2 visits per month required	2 visits per month required	1 visit per month is required	2 home visits and 1 office visit required per month	2 visits per month required	2 visits per month required	1 home visit and 1 office visit per month required	1 per month	1 home visit and 1 office visit per month required
Do Case Managers Collect Rent Directly from Tenants?	Occasionally	Occasionally	No	No	Occasionally	Yes	Yes	No	No