

Unlocking the Door

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



The second report from CASAHOPESM (brief version)



The National Center on
Addiction and Substance Abuse
at Columbia University

 COLUMBIA



As part of the CASAHOPESM Evaluation, CASA* Columbia and Corporation for Supportive Housing (CSH) have joined together to report on the (real-life) experience of implementing supportive housing for actively substance using individuals without serious mental illness.

Inside this Briefing...

This briefing was designed specifically for a policy-oriented audience, such as government administrators or housing providers who are considering creating similar programs in other parts of the country.

Focusing on the initial years of Population E housing, this briefing provides:

- An overview of the New York/New York III Supportive Housing Initiative and the subset of units targeted at Population E
- An abbreviated summary of the motivation and objectives behind supportive housing for this population, as well as its development and structure
- An assessment of actual program implementation compared to the implementation goals of the initiative's original stakeholders
- The lessons learned, challenges, and best practices that emerged during the first three years of program operation
- Conclusions and recommendations for future publicly-funded initiatives designed for housing similar tenants

CASAHOPESM

The Conrad N. Hilton Foundation funded CASAHOPE (Housing Opportunities Program Evaluation) to evaluate the efforts of nine New York City provider agencies under the NY/ NY III Supportive Housing Initiative to implement supportive housing for chronically homeless people whose substance use is a primary barrier to independent living. The population housed by these provider agencies is often referred to as 'Population E', and for this briefing we will also use the term to refer to the programs themselves. The purpose of CASAHOPE is to study the impact and implementation of the subset of Population E tenants residing in 500 scattered-site supportive housing units.

A Focus on Program Implementation

This briefing is a summary of the full paper which can be downloaded at www.casacolumbia.org/CASAHOPE. The full paper is the second in the CASHOPE series and focuses on program implementation. CASAHOPE's first paper presented findings on Population E tenant characteristics. Papers that follow will describe service provision, tenant outcomes, government services utilization, and economic impacts.

Methods

The findings presented in this briefing are drawn from multiple sources:

1. Interviews with key government stakeholders;
2. Interviews with program directors and focus groups with program case managers;
3. Official public and program documents;
4. Written questionnaires;
5. Site visits and learning collaboratives.

In combination, these sources of data provide a thorough and informed picture of program structure, staffing, and service delivery.

Limitations

The information in this briefing is not an audit of program performance and is not intended to be used for public funding and contracting decisions. Practical considerations prevented the use of direct observation of daily program practice and housing quality. In addition, there was not an existing program model against which to measure fidelity. Our intent in this assessment was not to conduct a comparative assessment of the nine Population E programs, but to better understand the lessons surfacing through implementation of these programs.

*The National Center on Addiction and Substance Abuse at Columbia University is neither affiliated with, nor sponsored by, the National Court Appointed Special Advocate Association (also known as "CASA") or any of its member organizations with the name of "CASA."

New York/New York III Supportive Housing Agreement

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. In its scope and investment, NY/NY III considerably surpassed its predecessor agreements and increased responsibility for financing and developing the units to a set of 10 City and State agencies.

Most notably, NY/NY III extended the supportive housing model to homeless populations without serious mental illness to include families with children, transition-age young adults, persons living with HIV/AIDS, and people with substance use disorders.

Supportive Housing for Population E

While the expanded target populations of NY/NY III signaled the City and State's promotion of supportive housing as an effective intervention, the optimism behind supportive housing was most clearly exemplified by the addition of a housing population category, known as Population E, for actively substance using homeless individuals without a primary clinical diagnosis of serious mental illness.

Like other supportive housing, NY/NY III's housing for Population E is permanent, subsidized housing 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.

To ensure appropriate tenant selection, eligibility and referral to Population E programs is conducted via a centralized screening process administered by New York City's Human Resources Administration and Department of Homeless Services.

The CASAHOPE evaluation focuses on the 500 scattered-site units of Population E supportive housing created under NY/NY III (an additional 250 congregate units are planned, but are not part of this study). In 2007 the New York City Department of Health and Mental Hygiene selected 9 provider agencies to operate these units throughout New York City:

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

A more detailed description of each program is included in the full paper.

Population E , Housing First, and Substance Use

NY/NY III's supportive housing for Population E uses a 'Housing First' philosophy—an approach that provides housing to homeless people with behavioral health conditions (typically including substance use issues) without requiring them to first undergo treatment, attain sobriety, or achieve stability.

Providing services to Population E is the first attempt by any jurisdiction to systematically invest in and create Housing First supportive housing for people without serious mental illness who actively use substances at an unprecedented scale of 750 units. At the same time, by reaching the most vulnerable subset of persons experiencing homelessness with a low-demand approach, this housing is a successor to the earliest supportive housing models.

Understanding why Population E housing was originally included in the NY/NY III initiative and how it was designed offers a useful framework for understanding its implementation.

Theory of Change

Through a process of collaborative inquiry with program directors and other staff, a Theory of Change was constructed and helped guide our assessment. Under this Theory of Change program activities in supportive housing for Population E conceptually fall under three categories:

1. Recruitment, Tenant Selection, and Intake;
2. Housing Search, Provision, and Management; and
3. Supportive Services.

Whereas all three sets of activities are needed to achieve the intended outcomes, the Theory of Change for Population E presents a complex and cyclical relation between the activities and outcomes.

The Theory of Change also stipulates that this housing is two semi-distinct interventions—subsidized housing and supportive services—operating in parallel to influence two sets of outcomes—housing stability and health/psychosocial outcomes.

A diagram and full explanation of the Theory of Change behind this housing is included in the full paper.

Impetus Behind Supportive Housing for Population E

Interviews with the stakeholders and administrators of NY/NY III pinpointed three specific reasons behind the inclusion of Population E in NY/NY III:

- The City's desire to reduce the number of people experiencing chronic homelessness;
- The recognition that a large number of chronically homeless individuals were individuals with untreated and active substance use issues; and
- The need to demonstrate that supportive housing programs can stably house those who actively use drugs and alcohol.

In sum, the inclusion of Population E in the NY/NY III Initiative was indicative of the stakeholders' willingness to see the potential of supportive housing to effectively address the complex needs of tenants.

Intended Goals and Outcomes of Supportive Housing for Population E

In light of the reasons behind inclusion of Population E in NY/NY III, stakeholders and administrators identified the following as the program's intended goals and 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; and
- Increase employment.

Notably, all of the interviewed stakeholders listed 'housing stability and retention' as the primary goal and outcome of interest for Population E.

Intended Design of Supportive Housing for Population E

The housing being evaluated by CASAHOPE is structured as scattered-site permanent supportive housing. The contracted programs providing this housing obtain apartments by master-leasing them from private landlords and then sub-leasing to tenants. The programs then become both the landlord and services provider for tenants. Tenants pay no more than 30% of their income toward rent and utilities.

The staffing of Population E programs is largely comprised of non-clinical staff, with the assumption that clinical, medical, and behavioral health services will be provided through linkages and referrals to mainstream service providers.

Through stakeholder interviews and document review, we identified 11 program components that were clearly part of the NY/NY III stakeholders' intended design of this housing. These key components were chosen as the basis for an assessment of actual program implementation compared to how the initiative was originally formulated.

Findings

The findings presented herein are neither intended to make statements about individual program performance nor influence funder decisions regarding contract or program compliance. Therefore, programs are not identified by name, but rather by a randomly assigned numeric code.

Stakeholders' Component #1: Programs will emphasize and routinely offer staff training and skill building around motivational interviewing and other relevant skill areas.

All of the programs were offered trainings around the basic principles and practices of Housing First, motivational interviewing, and client-centered counseling from the Corporation for Supportive Housing. Several programs expressed a high degree of enthusiasm around the concepts and skills used in motivation-based counseling to which they were exposed (1, 3, 4, 5, 6, and 8). One of the programs (3) had a dedicated in-house professional development trainer who worked with staff on motivational counseling skills, while at least two other programs (4 and 5) had either contracted externally or worked internally on building the motivational skills of their case management staff.

Stakeholders' Component #2: Provider agencies will have prior experience with providing housing that is not contingent on tenant abstinence from alcohol and drugs.

Only five of the nine provider 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 provider 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. Of the four provider 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 provider agencies (4 and 9) had virtually no experience providing housing or services to people with active addiction issues.

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 three other programs (1, 2, and 9) program directors and supervisors 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 appropriate service provision. Sufficient information was not available from interviews or direct observations to assess the quality of supervision in program 7.

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. 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. 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.

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.

Most of the programs (1, 3, 4, 5, 6, and 8) were observed to have adopted client-focused approaches. Three programs (2, 7, and 9), however, fell somewhat short. Two of these programs (2 and 9) were deemed to fall short because of their inconsistency in practice. In these programs, some staff frequently departed from a client-centered philosophy by imposing goals and criticizing tenants when they disclosed substance use. 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.

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.

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 considered the presence and not the quality of these services or whether services were offered in a way that made them accessible to tenants. For example, program 9 had trained staff in overdose prevention and offered naloxone onsite to help with opioid overdose, but still reported coercing tenants into abstinence.

Stakeholders' Component #7: Programs will actively engage and openly communicate with tenants about substance use.

Our assessment found that five of the programs (1, 3, 4, 5, and 6) were successful in creating an atmosphere of trust and openness such that tenants felt safe enough to disclose sensitive information. 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 chosen not to disclose in sobriety-based programs. 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, possibly eroding trust among tenants.

Stakeholders' Component #8: Services will be comprehensive, encompassing many domains and responsive to individual needs.

The degree of program ability to respond to tenants' complex needs seemed directly related to the program's facility with brokering connections to existing services in the community. Programs housed within large multi-service organizations (3, 5, 6, and 8) had the distinct advantage of being able to connect tenants to services operated by the organization. Two programs (1 and 4), were able to connect tenants to external services through linkages that the provider 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.

Stakeholders’ Component #9: Programs will have access and strong linkages to physical and mental health services.

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.

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

Program capacity to intervene in crisis situations is an important component of Housing First supportive housing. Ultimately, our implementation evaluation is limited in its ability to confirm or adequately assess whether programs performed crisis interventions as effectively as possible. Forthcoming papers 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.

Stakeholders’ Component #11: Programs will have skills and expertise in connecting tenants with benefits and entitlement systems.

Staff from 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. This was largely due to the fact that PA requires people with substance use issues to complete a course of drug or alcohol treatment in order to obtain cash benefits. 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.

Summary of Stakeholders’ Component Implementation Assessment

Overall, three of the nine programs (3, 5, and 6) were assessed to have consistently implemented their Population E supportive housing as the stakeholders intended. Three other programs (1, 4, and 8) were slightly less consistent in their use of client-centered approaches to service 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 assessed to have considerably diverged from the stakeholders’ intent and design. Implementation shortcomings included uneven use of client-centered approaches to service planning, lack of comprehensive service provision, inadequate staff training, coercion of tenants into substance use treatment, and the creation of environments that were not conducive to open communication about substance use.



Dimensions of Quality

To capture the challenges, lessons learned, and promising approaches that arose during the initial years of program implementation, the research team also examined the programs' overall execution in regards to Corporation for Supportive Housing's Seven Dimensions of Quality in Supportive Housing, adapted to 6 dimensions. Accordingly, this section presents key findings organized by dimension.

Dimension of Quality #1:

Administration and Management

- **Staff number, composition, and skills sets were wide-ranging.** Client-to-staff ratios ranged from 1:10 to 1:25. Programs with a lower client-to-staff ratio reported fewer management and administration related struggles. Several programs had specialty staff on their teams such as housing, health, and entitlement specialists that were observed to greatly expand the team's ability to provide quality services.
- **Misalignment between program philosophy and larger agency philosophy frustrated housing and service delivery for at least three of the nine programs.** For programs experiencing misalignment, it appeared that staff had a confused sense of their role and approach to service delivery and engagement.
- **Effective and capable program directors were seen as "jack of all trades".** These program directors performed functions ranging from overseeing operations, supervising staff, team building, resolving conflicts and crises, and interfacing with the larger organization.
- **Turnover among program directors was associated with implementation challenges.** These challenges reportedly centered on difficulty developing a cohesive model and coordinating operations.

Dimension of Quality #2:

Housing Search, Housing Quality, and Landlord Relations

- **Master-leasing structure may have increased access to apartments, but possibly reduced tenant choice and satisfaction.** While staff stated that the master-leasing structure likely did increase the willingness of private landlords to rent apartments to Population E eligible individuals, the major drawback was seen to be its effect on reducing tenant choice with respect to the apartments and neighborhoods.
- **Programs that used dedicated housing staff or departments had a distinct advantage in regards to performing housing search and management activities.** Across the board, staff noted how time- and skill-intensive these activities were. The use of separate housing specialists appeared to allow programs to ease some of the challenges and potential role conflicts that come with master-leasing.
- **Working with a smaller set of property owners or managers to secure apartments was a double-edged sword.** While this approach reportedly allowed programs to quickly lease a larger number of apartments, program staff described concerns about confronting landlords when issues arose, as doing so might have negative consequences for multiple apartments and tenants.

- **Attempts at stretching resources by arranging shared two-bedroom apartments for tenants were seen to be counterproductive.** Renting two-bedroom units initially seemed to be a good idea, but program staff indicated that this practice frequently resulted in conflicts between tenants, decreasing housing satisfaction, quality of life, and stability.
- **Clustering apartments in buildings or neighborhoods was reportedly an effective way to address some of the challenges of delivering services to tenants in scattered-site settings.** Program staff stated clustering apartments may have increased efficiency with respect to service delivery as case managers were able to travel to fewer locations to conduct tenant home visits.

"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." — Population E Staff

Dimension of Quality #3:

Access to Housing, Tenant Selection, and Eviction Prevention

- Program staff admitted to being unable to distinguish at interview between those tenants who would be more stable and those who would present greater challenges. Several programs reported that reservations they had about certain tenants at intake were often later found to be unwarranted.
- Ensuring housing stability and prevention of evictions reportedly required coordination between supportive services and housing management staff, along with acute awareness of tenants' issues and 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.
- Program staff reported that tenants had numerous problems maintaining welfare benefits because of policies around substance use in New York City's public assistance (PA) program. Resolving such cases was time-consuming, sometimes taking several days, and addressing one tenants' PA case could preclude home or office visits with another tenant. The one program that did have a dedicated entitlements coordinator had a considerable advantage insofar as they had both additional expertise around PA and additional staff to resolve issues.

Dimension of Quality #4:

Supportive Services Design and Delivery

- To build rapport with tenants a number of programs used creative engagement strategies early on and persistently. This included practicing assertive engagement before tenants actually moved into units and persistently going "out of their way" to offer help later on.
- Supervision reinforced the Housing First approach, and helped case managers cope with the difficulty of seeing tenants struggle with addiction. Case managers reported that effective program supervision could help ensure that they were remaining non-judgmental in their communication with and counseling of tenants.
- 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. In many instances, staff had to remind one another to consider what improvements had been attained (e.g., coming on time to office appointments, etc.), despite the fact that tenants' might remain resistant to making healthier choices. Staff also noted that patience with tenants could lead to other surprisingly big and long-lasting changes, such as abstinence from drugs or alcohol.
- Program staff recognized that service plans would need to be incremental and flexible and tailored to individual circumstances, but funder requirements imposed a more routine and uniform approach to services planning and tenant contacts. In the end, case managers reported often completing service plans as a means to maintain contractual obligations with funders, but approached the process of change differently when relating directly with tenants.

- Preset requirements for home and office visits were viewed as a source of conflict between staff and tenants. Most programs complied with contractual requirements, but staff indicated that they would have preferred an option to regulate visit requirements to better match tenant needs.
- The ability of supportive services to help tenants progress towards their goals was often frustrated by system-wide barriers faced by tenants. For instance, tenants seeking to obtain employment often faced difficulty finding jobs due to their histories of incarceration.
- Semi-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.

"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.'" — Population E Staff

Dimension of Quality #5:

Tenants Rights, Choice, and Participation

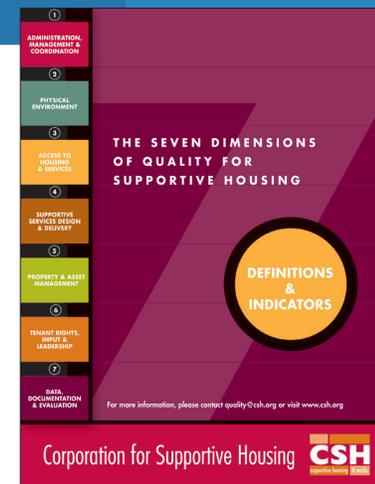
- Tenant choice around housing was constrained by program financing structure, and in some cases, program practices. Acknowledging problems with this structure, some of the programs tried to be as honest as possible about apartment location and quality so that tenants would understand their choices.
- Programs found that effectively educating tenants about their rights and responsibilities required ongoing efforts. A reported best practice was explaining rights and responsibilities to tenants once at the lease signing and then yearly reiterating and re-explaining the information.
- Programs used both formal and informal approaches for soliciting tenant input on program operations and quality. 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 reported relatively greater success in organizing tenant councils and advisory boards.

“We have tried to work with clients in providing feedback and creating a tenant council, but it is difficult in a scattered-site model.” — Population E Staff

Dimension of Quality #6:

Tracking Outcomes and Defining Success

- All of the programs reported collecting data on outcomes for internal purposes. While 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 tracking tenant progress, making mid-course interventions, and judging program success.
- Program staff described outcomes that captured quality of life improvements ordinarily missed by traditional measurement tools. Given the high degree of vulnerability and complex service needs of Population E tenants, staff noted the importance of seeing progress as incremental and in terms of quality of life and tenant satisfaction.
- Program staff noticed several outcomes toward positive change that resulted simply by virtue of tenants’ placement into permanent housing. Many expressed opinions based on anecdotal evidence that the effective provision of housing alone had a positive impact on tenants’ health, substance use, employment and family relationships.
- For the most part, program staff expressed a high degree of confidence in the ultimate promise of this supportive housing. Program staff almost always expressed hope for the tenant population and reported a high degree of faith that their approach would result in improved outcomes for their tenants.



Further information on the Dimensions can be found in the full paper and in The Seven Dimensions of Quality for Supportive Housing: Definitions and Indicators available for download at www.csh.org/dimensionsofquality

Several lessons emerged from our findings that might be useful to those implementing or interested in implementing Housing First approaches for chronically homeless people with active substance use issues without serious mental illness. These lessons are as follows:

- **The implementation of Housing First for this population 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.** One means to improve the selection of agencies might be to require, in solicitations or Request for Proposals, evidence that the agency supports the Housing First model, as well as auditable examples of how the agency's administration will support implementation.
- **Creating Housing First units for this population through a larger 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.** Any effort 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, 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.** 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, indicating the need for separation in landlord and service provider roles.
- **Alignment between the service philosophy of the embedded Housing First 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 way to avoid agency-program misalignment might be to monitor (e.g., through program audits) for agency-program misalignments, and through a technical assistance provider, work with staff to identify and resolve points of conflict. In addition, issues with mainstream service systems underline the need for systems-level assistance from public agencies.
- **Program staff competency, as well as facility with client-centered interviewing and case management practices, was found to be essential to effective implementation.** Programs might consider making use of a standardized assessment for basic client-centered and rapport-building counseling skills to evaluate a potential hire's ability to work effectively within the Housing First framework.
- **Programs with specialized services staff and direct access to health and clinical services were assessed to have a distinct advantage.** Supportive housing agencies considering offering services to this population should strongly consider the inclusion of health and benefits specialists on their staff.
- **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. This suggests a considerable benefit in creating programs with 50 or more units.



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at Columbia University



A Joint Paper

This briefing is a summary of a joint paper created by The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia) and The Corporation for Supportive Housing (CSH).

An expanded description of these lessons and further recommendations can be found in the full paper at www.casacolumbia.org/CASAHOPE.

About The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia)

The National Center on Addiction and Substance Abuse at Columbia University (CASA Columbia) was founded in 1992 by Former U.S. Secretary of Health, Education, and Welfare Joseph A. Califano, Jr. The nonprofit organization aims to inform Americans of the economic and social costs of substance abuse and its impact on their lives, as well as, remove the stigma of substance abuse and replace shame and despair with hope.

CASA Columbia has assembled an interdisciplinary staff of nearly 60 professionals with post-graduate and doctorate degrees, experience and expertise in various fields including substance abuse and addiction, communications, criminology, education, epidemiology, government, journalism, law, marketing, psychology, public administration, health and policy, social work, sociology and statistics to develop proven, effective approaches to keep Americans healthy and drug free. For information about CASA Columbia, please visit www.casacolumbia.org.

About the Corporation for Supportive Housing

For over 20 years, CSH has led the national supportive housing movement. We help communities throughout the country transform how they address homelessness and improve people's lives. CSH develops innovative program models, provides research-backed tools and training, offers development expertise, and collaborates on public policy and systems reform. And, CSH is a certified community development financial institution (CDFI). We make it easier to create and operate high-quality affordable housing linked to services. To date, CSH has made over \$300 million in loans and grants, and has been a catalyst for over 150,000 units of supportive housing. For information about CSH, please visit www.csh.org.