Supportive Housing and Its Impact on the Public Health Crisis of Homelessness

CSH
Corporation *for* Supportive Housing

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CORPORATION *for* SUPPORTIVE HOUSING

Dear Colleague,

We are pleased to be able to share interim results from an evaluation of the Corporation for Supportive Housing's *Health, Housing Integrated Services Network*, an initiative of the California Program. The HHISN brought together nonprofit, government and consumer agencies to develop and operate a new way to both deliver and finance integrated support, health and employment services with affordable housing so that very poor individuals who also face health and mental health issues can live with dignity and stability in the community.

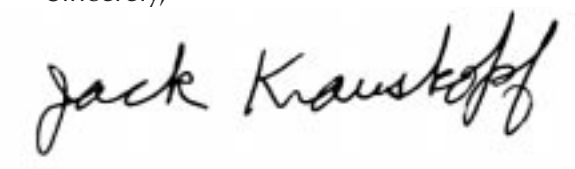
These early results from a study conducted by independent researchers from the Goldman School of Public Policy at the University of California at Berkeley, show a significant relationship between supportive housing and its effects on tenants' health and attendant health care costs. The study tracked HHISN participants' use of San Francisco General Hospital's emergency room, inpatient stays and psychiatric health care costs for one to two years prior to tenancy and compared it to costs incurred one year after moving in.

This report shows that for the more than 250 tenants who were given the opportunity to move from the streets or shelters to Canon Kip Community House and the Lyric Hotel in San Francisco, emergency room use decreased by 58 percent. For those residents who stayed housed at least one year, the number of days in the hospital decreased by 57 percent. For a smaller data set, the only tenants for whom complete information is available, use of residential mental health care went from an average of 2.69 days per person for the year prior to move-in to zero one year after becoming tenants in HHISN buildings.

These results also have significance in that they show that better than 81 percent of the 253 tenants, all of whom had histories of homelessness and nearly all of whom were dually diagnosed with mental illness and chronic substance abuse, were able to stabilize in housing for at least a full year.

While we expect to have a complete report by the end of 2000, we wanted to share these extremely promising early findings as soon as they became available. We hope you find them useful.

Sincerely,



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Executive Summary

Nonprofit and government agencies have been experimenting for nearly 20 years on ways to address the most persistent and disturbing forms of homelessness: people with mental illness, chemical addictions, and chronic illnesses or disabilities, living in public spaces, cycling through jails and prisons, receiving sporadic, emergency care, and incurring enormous public expenses with little or no long-term benefit.

Research now being conducted at the University of California at Berkeley suggests that these experiments have in fact led to an effective solution, combining two key elements. The first is supportive housing — affordable homes and apartments that offer social and mental health services to help residents remain stable and deal with the problems that led them to homelessness. The second is a more recent elaboration on the supportive housing model: the integration and coordination of resident services from several specialized provider agencies working as a team, so that each resident has access to the particular support he or she needs to stay housed, with the greatest possible level of independence. In this combination, supportive housing provides a stable alternative to life on the streets; and integrated services provide an economical alternative to the emergency or fragmented care that most long-term homeless people tend to receive.

Among several promising experiments with supportive housing and integrated services in California is the San Francisco Bay Area's *Health, Housing and Integrated Services Network*, or HHISN. Two of the supportive housing programs served by HHISN — the Lyric in San Francisco's Tenderloin, and Canon Kip Community House in the South of Market neighborhood — are the subjects of the current research, which is still under way. Well over one-third of the residents of the two programs came directly from living on the streets. The remainder were previously in shelters or transitional residences. All were homeless, and more than 95 percent are struggling with mental illness, chemical addictions, or most often, both.

Preliminary results of that study are beginning to be compiled. The first available results compare homeless people's use of emergency rooms, hospitals, and residential mental health programs before and after moving into a supportive residence served by HHISN. The results are dramatic.

For example, within 12 months of moving into supportive housing . . .

- **Use of emergency rooms falls by 58 percent**,
- **Use of hospital inpatient beds falls by 57 percent**, with another 20 percent decline the next year,
- **Use of residential mental-health programs virtually disappears** — from an average of more than 2½ days per person per year to zero, within 12 months.

These findings are based on data from San Francisco General Hospital and Community Mental Health Services. They include all the tenants in the two programs for whom complete data are available at least 12 months before and after moving in — between 95 and 253 people, depending on the database. Some missing records in each database are still to be filled in, and additional data from private hospitals, the criminal justice system, and other programs are likewise still being sought.

The addition of information from more institutions and systems will also make it possible to assemble a nearly complete picture of the cost of *not* providing supportive housing and integrated services. By examining how government and public institutions currently spend money trying to serve homeless people, often with little result, it will be possible to determine exactly how economical, and how effective, supportive housing and integrated services can be.

At this point, the early information is both encouraging and alarming. It tells a story of extraordinary accomplishment and opportunity — but one that today applies only to a small minority of all Californians living on the streets, in emergency facilities, and along the social margin.

Part I: Not a Treatment — a Solution

In California, as across the United States, the debate over homelessness has lately split in two, dividing the issue into distinct, and partly unrelated, fields of concern. On one path is a discussion largely about poverty, in its severest form. Many homeless people — in fact, most of those who are homeless at any given time — are like other very poor people, except that they have lost their housing and have been unable to replace it. Especially in high-cost housing markets like the San Francisco Bay Area, this group can be disturbingly large, but these people tend not to stay homeless for long. Solutions to their crisis usually are comparatively straightforward (even if not always easy to come by): A voucher, a job, subsidized housing, public assistance, or some combination tends to work for them sooner or later.

On the other track, however, is a quite different debate about a smaller but even more disturbing subset of homeless people: those who do not, in the main, find their way out of homelessness with routine or short-term help. Frequently mentally ill, or with long-term addictions, in poor health, and distrustful of programs and institutions, they live in public places, frequently end up in the hospital and are sometimes imprisoned, or cycle through the lives of anxious relatives and friends. Harmful to themselves and disturbing to others, they represent a steadily mounting cost, both economic and social, to people and public systems that try (and usually fail) to help them. When charities and public officials come under intensifying pressure to "do something" about homelessness, this is generally the group at issue.

For this more chronic, chaotic form of homelessness, the following pages offer not just a theory or a treatment, but a *solution* — tested, measured, effective, and economical. The solution consists of two parts: decent, affordable housing, and a carefully managed network of focused medical, social, and psychological services, aimed at preventive care and timely, effective response. In the Bay Area, one way this combination has been carried out is through the Health, Housing and Integrated Services Network (HHISN), whose accomplishments are described in detail in this paper.

The two parts of this equation, the housing and the integrated medical and social supports, are inextricably linked. More than an affordable apartment

but substantially less restrictive than institutional care, supportive housing and HHISN provide a home and essential supportive services — all in a single package, in a combination that vastly reduces the odds of physical or psychiatric emergencies, institutional care, or renewed life on the streets.

The Effects of Housing with Services: Results of New Research

A new, wide-ranging study of homelessness and public health costs in San Francisco, conducted by researchers at the University of California at Berkeley, has begun to document, in growing detail, the benefits of supportive housing and integrated services, not just for homeless people and those who care for them, but for the city's public institutions, government, and residents as a whole. Among the early findings of this research, described more fully in this paper, three stand out as especially significant:

- Supportive housing with integrated services reduces residents' use of San Francisco General Hospital's **emergency room** — *down well over half* in a single year. San Francisco General is the primary source of emergency and hospital care for uninsured and low-income people in the city.
- **Inpatient stays** at SF General fall just as sharply once a person enters supportive housing: a *nearly 57 percent* drop in the first 12 months, and another 20 percent in the following year.
- The need for r**esidential mental-health care** is virtually eliminated in the first year of supportive housing — with average utilization dropping to zero within 12 months, from an average of more than 2½ days per person per year.

Together, these results demonstrate that supportive housing is not only a more stable, decent solution for homeless people with long-term disabilities. Nor is it merely an effective way of taking people from a chaotic life on the sidewalks to a sustainable life in a place of their own. It is also a substantial relief to public hospitals and over-burdened crisis treatment programs, and a smart investment for the state and local governments that pay for them. As it turns out, the humane solution is also fiscally smart.

The research on which these findings are based is still in progress, with likely completion in the late fall of this year. We present here only the preliminary results: a comparison of people's use of emergency health care, hospital services, and specialized residential psychiatric or detoxification

programs, before and after entering supportive housing. The findings are part of a wider study by researchers at the University of California at Berkeley that will eventually include more data on psychiatric and hospital services, plus new information from private hospitals and the criminal justice system.

Although preliminary, the results are bolstered by other research that points to similar trends. In particular, an earlier study of HHISN by the Vanderbilt Institute for Public Policy Studies, using data from 1996–97, found a significant improvement in residential stability and some evidence of reduced use of hospital emergency services. Current research in Alameda County, though less far along, is also finding evidence of reduced utilization and costs for behavioral care services, particularly in locked facilities and hospital care for psychiatric emergencies, based on just a small sample so far. Studies under way in other states — most prominently Minnesota, Connecticut, and New York — are finding comparable trends in health and psychiatric costs. The results of the Alameda and New York research, like the complete version of the Bay Area study, are expected later this year.

Along with academic affirmation of the findings presented here comes a less formal, but equally exacting, review by the people who know the facts best: those who have lived in streets and shelters, and who are now living in supportive housing. The progress of this research, and the findings that emerge from it, are regularly reviewed by HHISN's governing board, which includes tenants as well as service providers and managers. Their approval is an additional sign — in some ways, perhaps the most reassuring one — that the analysis is based in reality, and that it tells a true story about real lives.

Supportive Housing and Integrated Services: Managing the Solution

For the most severely troubled and longest-term homeless people, life on the streets is not just a housing problem, and not just a problem of physical, mental, or behavioral health. These are all inextricably linked: Behavioral problems lead to a loss of housing — especially in a tight housing market where tenants are easy to replace — and life without a home quickly leads to deepening physical and psychological disorder. To break the spiral, the solutions have to be as linked as the causes. That is what supportive housing accomplishes.

The idea has evolved over two decades, beginning with experiments in various kinds of supportive housing in the 1980s. Most of the early efforts, though, were designed for tenants who were already considered "housing ready" — they had recently completed treatment programs, were fully stabilized on medication, clean and sober for at least several months, and willing to participate in a regimen of mandatory services. For this group, supportive housing was quickly recognized as a giant step forward. It provided a way of preserving the effects of treatment and reinforcing the recovery process, by supplying a long-term residence for people who might otherwise have had nowhere to live, or who may otherwise have found themselves back in a harmful environment.

But by the mid-1990s, it was also becoming clear who was *not* being reached by the first generation of supportive housing. Left behind in the public health-care safety net, especially public hospitals and mental health programs, or in penal institutions or simply on the streets, was a smaller group of chronically homeless people who were not yet fully "housing ready" by the prevailing standards. Care and services for this group were not only ineffective, they were alarmingly expensive.

Administrators of health systems and public institutions, under mounting pressure to control costs, began to zero in on the enormous cost of treating medical or psychiatric emergencies for this hardest-to-serve population — particularly homeless people with chronic addictions and mental illness, who were receiving no ongoing community treatment. For them, treatment in institutions or episodic programs was having little long-term effect amid the chaos of life on the streets. The same people, often with the same conditions, were showing up for treatment and re-treatment, time after time, with the severity of their problems deepening year by year. Neither the old methods of short-term treatment and release nor the new approach of supportive housing seemed to hold much hope for them.

Starting in 1994, the Corporation for Supportive Housing, a national nonprofit organization with offices throughout California, convened a group of supportive housing agencies and local public health officials in San Francisco, to look for solutions to chronic homelessness and its crushing effect on public health costs. They determined that supportive housing does, in fact, offer a way of reaching people with current or recent problems of addiction and those reluctant or unready to participate consistently in mental health treatment. It could, at a minimum, provide a safer place for them to live, with constant exposure to opportunities for better health and recovery. And in the process, it could at least reduce, if not eliminate, the high costs associated with ineffectual treatment and re-treatment, arrest and release, hospitalization and discharge, and on and on.

To put an end to life on the streets, this new, more expansive approach to supportive housing offers a place to live on terms that long-term homeless people can accept and live with. It says, in essence: *We'll offer you the help you need to be a good tenant and you can stay as long as you need to*. It builds opportunities for recovery into the stability of a permanent, independent dwelling. For each new tenant, the need for services will be different. Some will need medication, others counseling, others merely patience and opportunities to reintegrate into the wider community. But most, especially those with long-term problems and years of street life, will need a wider mix of specialized support services able to respond promptly or preventively to signs of trouble.

Planning and delivering this mix of responses, and tailoring them to each person's changing needs, requires a collaboration of housing managers with providers of various kinds of support services — those with expertise in addiction recovery, mental-health care, and the integrated treatment of the two together; those specialized in outreach or case-management; in vocational and employment services, and in building skills for independent living. Taken together, this combination of services, both on-site and off, would replace the costly, fragmentary treatment of momentary conditions with a sustained, preventive, and permanent solution to chronic homelessness.

That is the contribution of the Health, Housing and Integrated Services Network — the management and coordinating system that weaves these various specialties into an effective whole that works both economically and clinically, for each person it serves.

Other communities in California also provide integrated services linked to housing using variations on this model, adapted to local needs. What these various approaches have in common is that they combine an effective response to homelessness — that is, the basic elements of supportive housing — with a broad-based, carefully integrated solution to the complex needs of the hardest-to-serve homeless people. Together, they represent the most consistent, tested breakthrough in dealing with chronic homelessness anywhere in the United States.

Assessing the Benefits

The current research examines data from San Francisco General Hospital on inpatient and emergency-room care, and from San Francisco Community Mental Health Services on mental-health care. The analysis

compares people's use of emergency health care, hospital services, and specialized psychiatric programs, before and after entering supportive housing. It is based on a total population of up to 253 people[1] in two supportive housing programs whose services are coordinated through HHISN. Using all available data on this group through March 2000, the research shows *a dramatic reduction in both the instances of trouble and the costs of treatment*.

The data under examination cover people who moved into Canon Kip Community House and the Lyric, two supportive housing programs in San Francisco, at least 12 months before the start of the most recent data analysis (that is, by March 1999). The great majority of those studied — 94 percent — had formerly been living in the margins between institutional care and public crisis, moving between emergency shelters, hospitals, jail cells, detoxification or residential-treatment programs, and life on the streets. In an earlier study of residents at Canon Kip in 1996–97, researchers from the Vanderbilt Institute for Public Policy Studies found essentially the same thing: that 88 percent had moved into the building directly from the streets (25 percent) or shelters (63 percent). When the current study added in tenants from the Lyric, the percentage coming directly from the streets rose to 30 percent, but the percentage from shelters remained about the same.

Before entering supportive housing, most residents in both the Vanderbilt study and the more recent research at Berkeley had placed extraordinary demands on hospitals and emergency services — at an annual public cost that, according to the Berkeley analysis, sometimes amounted to more than $15,000 a year in mental-health programs alone. Across all the residents, the costs for mental-health care alone, for example, averaged some $8,000 per person per year in the two years before they came into the HHISN orbit.[2]

What happened after that is both striking and important: Once people found themselves in a supportive environment, where hygiene, nourishment, shelter, and routine health care were not a daily challenge, *their need for hospital or other 24-hour or emergency care either disappeared or plunged dramatically* — as the numbers cited earlier illustrate. Some, with counseling or peer support or medication, found their way to a completely ordinary life like anyone else's: a job, friends and family connections, and freedom from drugs or other addictive substances. But even when the result was less ideal, supportive housing still produced a substantial, measurable improvement for both the tenant and the public: Life on the street was over. The emergency room was not a routine source of treatment for chronic illnesses. Treatable problems did not fester and grow into medical or psychiatric crises requiring days of hospitalization.

Of those who moved in at least one year ago, 81 percent remained at Canon Kip or the Lyric for at least one year. (And of those who moved in at least two years ago, 62 percent have stayed for at least two years.) Here again, the most recent Berkeley findings are consistent with those in earlier work by Vanderbilt. Among residents of Canon Kip, the Vanderbilt team found a striking improvement in residential stability: In a population of which 88 percent had previously lived in shelters or on sidewalks, the majority were well into their third year of continuous residence at Canon Kip, and nearly 80 percent had been there for at least two years, when the survey was taken in 1996–97. Once in supportive housing, they increasingly used the medical, mental-health, and other supportive services on site — with the vast majority using mental health, case management, or medical services at Canon Kip (between 71 and 92 percent, depending on the service), rather than relying on public or emergency systems.

Preliminary results of studies in other states — most prominently Minnesota, Connecticut, and New York — are finding comparable trends. These studies, like the complete version of Berkeley's research, are expected later this year.

HHISN and Supportive Housing: How It Works

Any given supportive housing site in the HHISN network — for example, the Lyric in San Francisco's Tenderloin, or Canon Kip Community House in the South of Market neighborhood — is the responsibility of a team of housing managers and service organizations working in concert, through their membership in HHISN. The particular partnership at each site is different. The social-service staff and mental health specialists at the site normally have expertise with the primary day-to-day needs likely to arise among the tenants. The housing owner and managers make sure the building runs effectively and provides quality housing for the residents, and the service providers make sure that residents always have somewhere to turn either for reinforcement or to prevent or respond to problems.

Behind these front-line agencies and employees is a still broader array of HHISN specialists, a citywide team of diverse agencies with a wide spectrum of experience and specialties: for example, comprehensive medical services, addiction treatment and recovery support programs, money management, vocational, and employment services. Together, the on-site and off-site programs ensure that each tenant in supportive housing has clear, easy access to whatever mix of services will help keep

that tenant housed, stable, healthy, and independent. The key is to provide *as much* service as needed, but *only* the service that's needed.

The point of that combined goal is not just to minimize costs (though, as we will show, it seems to be working very effectively to that end). Just as important, its purpose is to ensure that tenants are supported, not enveloped, by services — that their environment is as independent and unrestrictive as possible, but never without ready help when required.

HHISN, which began in San Francisco and nearby Oakland, now consists of more than 30 nonprofit housing and service agencies from across six counties of the San Francisco Bay Area. Within the HHISN structure, members organize themselves into smaller Integrated Service Teams, responsible for each of 15 supportive housing sites in San Francisco, Oakland, Berkeley, San Mateo, and Santa Clara Counties, and more than 100 residents of Contra Costa and Marin Counties. Together, the teams have reached more than 1,100 people living in more than 1,000 affordable housing units. HHISN membership in San Francisco includes leading government and nonprofit service agencies like Baker Places, Conard House, Episcopal Community Services, and the San Francisco Department of Public Health's Tom Waddell Clinic, and affordable housing providers like Mercy Housing California and Chinatown Community Development Corporation.

Integrated Service Teams normally consist of staff from three member agencies at each supportive housing site, providing some combination of medical care, case management, mental health or substance-abuse treatment, help with housing retention and independent-living skills, and vocational and employment services. The mix depends in large part on the particular needs of tenants in different locales. The teams combine organizations with long histories of serving homeless people alongside others that deal with broader populations: providers of managed health care, for example, or job-training programs.

Each Team member also comes from a public or private agency with its own wider-ranging referral network, through which the particular needs of individual tenants can be met responsively and efficiently. The result is a program that addresses both the specific needs of long-term homeless people and the general needs of anyone grappling with poverty, disability, chronic illness, addiction, recent crisis, or some combination — all while maintaining a natural housing environment where residents enjoy the same privacy and independence that would come with any apartment anywhere else.

At a given building, the typical pattern would include a group of case managers for day-to-day counseling and referrals, an on-site clinic

for part-time medical services, as well as the property management staff. The three groups meet often to coordinate their work with tenants, resolve potential problems or conflicts, or seek referrals from one another when needed. The result is an on-site blending of specialties that mirrors the larger, region-wide coalition of HHISN.

In San Francisco, HHISN is sponsored jointly by the City's Departments of Public Health and Human Services. Marc Trotz, DPH's director of housing development, says his department particularly values HHISN's versatility and ability to assemble different combinations of agencies and services under different circumstances:

> It allows us to experiment with qualified organizations in a range of buildings. We're able to learn more quickly what works and what doesn't with a number of providers participating in the process. It helps to define the landscape and lets us apply that knowledge to the next project in a way we would never be able to without the Network.

The members of HHISN, the locations of the various supportive housing sites, and other details about the Integrated Service Teams are attached in Appendix B.

Part II: Evidence of a Breakthrough

The study now under way by researchers from U.C. Berkeley, sponsored by the Corporation for Supportive Housing, shows that the HHISN formula is producing substantially better results for the most difficult-to-reach homeless people, at significantly lower cost to state and local government and public institutions. Most significantly, supportive housing appears not merely to have *relieved* homelessness for its residents, but for a substantial majority of them, it has *put an end* to life on the streets and in shelters — a life harmful to them and disturbing to other residents of the community.

Treating the consequences of that life in the usual ways, with episodic emergency services in hospitals and other institutions, has been enormously costly without producing lasting benefits. That was how public programs and institutions dealt, for example, with Derrick Randall[3] during the two years he spent living on San Francisco sidewalks, shelters, and parks, or occasionally crashing with his sister. In the year before he moved into supportive housing, Mr. Randall spent an average of 2½ days *every month* in San Francisco General Hospital for one crisis or another. He'd been treated in the emergency room 10 times that same year. The cost of his mental-health services alone — everything from crisis intervention to medication monitoring to individual therapy — came to nearly $15,000 in just 12 months.

A college graduate and Vietnam veteran diagnosed with major depression and Post-Traumatic Stress Disorder, Mr. Randall had been taking cocaine intravenously for two decades — knowing full well, he says, that he was committing a slow, public suicide. "I was bouncing in and out of hospitals," he says. Relying on drugs "helps sometimes, but then you come down. You wake up and all you think about is where my next hit is coming from." As medical and psychiatric problems mounted and prescriptions went unfilled or unfollowed, the crashes grew worse. Each physical and emotional trough demanded another relief from drugs and drink, until another round of hospitalization, detoxification, or arrest brought a moment of unwelcome clarity. And then it started again.

Now, in two years of supportive housing (and counting), the emergency room visits and inpatient hospitalization have stopped. Community Mental

Health services continue — at nearly half the prior expense, under $8,000 a year — but now the services are preventive and sustaining, not rescue missions. And most of those are case-management services delivered routinely at the residence where Mr. Randall lives. He has not spent a single night in any public place or emergency room — no more benches and shelters, no more gurneys, no more jails. Now, at the first sign of trouble, an emotional low, a bout of nightmares, a craving for drugs, and help is no farther than the lobby.

Here is how a case manager in his supportive housing program describes Mr. Randall's life now: "He has a room that's his sanctuary, so he doesn't need to go to the emergency room just to be safe and off the streets. And if his mental illness escalates, and he begins to decompensate, there's a lot of people he can go to talk to. A lot of times, that's all people want, someone to talk to."

"The good thing about this place," says Mr. Randall, referring to his supportive apartment building, "is that I don't go to the hospital any more — voluntary or involuntary. I was snatched off the bridge once. Now, just being able to come down [to the building's offices and common areas] and talk about stuff makes the difference. Here, we can work it out." These days, Mr. Randall is increasingly part of the solution for other people, one of the peer counselors and resident leaders who encourage and support other residents in their rough spells.

Dealing with Reality

By itself, Mr. Randall's is merely an encouraging story, life-saving for him and inspirational for others. What makes it important for local, state, and national policy is that it is not a story of just one man's struggle against the odds. The turnaround in Mr. Randall's life came from two crucial factors quite apart from his own determination to change his life. One was the stability of an affordable place of his own to live. The other was the steady, carefully coordinated reinforcement of HHISN's constellation of services — available when needed, unobtrusive when not, but always prepared for timely intervention before difficulties become dangerous, costly, and hard to reverse.

In fact, it is essential not to confuse HHISN's achievements with the solitary heroism of some individuals fortunate enough to have overcome addictions or other disabilities on their own. What makes the performance of HHISN and its supportive housing partners remarkable is that it *does*

not depend on people first conquering their behavioral problems. You do not have to be "clean and sober" to enter HHISN's supportive housing programs. Many residents have yet to finish wrestling with the emotional, substance-abuse, or other problems that led them into homelessness. In 1996-97, for instance, the Vanderbilt Institute for Public Policy Studies found that 74 percent of the residents of Canon Kip had arrived with some substance-abuse problems. Of that group, some were already in recovery, and others were just beginning the lifelong struggle against addiction. But experience plainly suggests that the majority were still abusing drugs or alcohol, at least to some extent.

Transitional programs for people committed to recovery from addiction are extremely valuable, but they are not new. What's new, in HHISN, is a solution that also embraces those who are not yet in recovery — who are, for the moment, still among those whose crises land them in public places, receiving ineffectual care often at enormous public expense. Decades of experience with homelessness, mental illness, addiction, and other untended disabilities has shown that it is not enough for public policy to say, "get yourself together and we'll help you." That is a formula for the kind of public failure that a *New York Times* headline recently labeled "Bedlam on the Streets."

The residents of HHISN's supportive housing programs have not all navigated their own way into addiction recovery or developed completely effective strategies for dealing consistently with their mental illness other disabilities. What they have done, in many cases, is begun to get help managing the problems that led them into homelessness, in an environment that encourages and supports their recovery over the long term — beginning wherever they happen to be on the day they move in.

An example is Simon Delgado, son of alcoholic parents who, in middle age, still struggles with alcoholism after 2½ years of life on the streets of San Francisco. Those years, before he moved into supportive housing in 1997, took an enormous physical and emotional toll: "My heart is bad, I couldn't see, I was having blackouts, everything was breaking down." Of the last 12 months when he was on the streets, Mr. Delgado spent 15 days in psychiatric hospitals, racking up nearly $14,000 in Community Mental Health Service expenses.

His first encounter with HHISN came even before he could get a supportive apartment. Through a program at Episcopal Community Services, he started to get counseling for the spiraling effects of combined depression and substance abuse, and was introduced to the city's Tom Waddell medical clinic. "I have a whole lot of respect for Tom Waddell," he says, "because they care, they have patience. Even the office workers and the security guards there treat homeless people well." The atmosphere

of welcome and encouragement — soon followed by a stable place to live where these supports were close to hand — brought Mr. Delgado's drinking and medical problems steeply down from where they had been a year before. Even his weight, which had grown dangerously out of control, is now back nearly to normal — down more than 100 pounds.

Mr. Delgado has not eliminated alcohol from his life. He does not consider his problems "solved." But there is no question that he and the people who used to pass him on the streets are both profoundly better served now than they were three years ago, when he was bouncing between sidewalks and shelters, and suffering with sporadically medicated psychiatric problems, uncontrolled drinking, and disintegrating physical health. It was a slow, frightening death on a public stage. That, at the very least, is over.

Since entering supportive housing, Mr. Delgado has had no further need of psychiatric hospitals. The bill for his Community Mental Health services is down more than 85 percent, to $2,000 a year from $14,000. Meanwhile, the support from HHISN continues. Referring to the agency that supplies HHISN's on-site mental health specialists, Mr. Delgado says, "Baker Places has helped me with my psychiatric problems, with my [medications] . . . they give me reminders, notes, until it became habit. I now go to court, welfare, wherever, on my own. They also made me understand my alcohol use and how to control it better. [A Baker Places case manager] has helped guide me through all my goals, including conquering my alcoholism. I mean, now, I don't want to drink every day."

Reflecting on the same issues, Derrick Randall put the whole argument into one sentence: "I ain't what I want to be" he said, "but at least I ain't what I was."

Quantifying the Effects

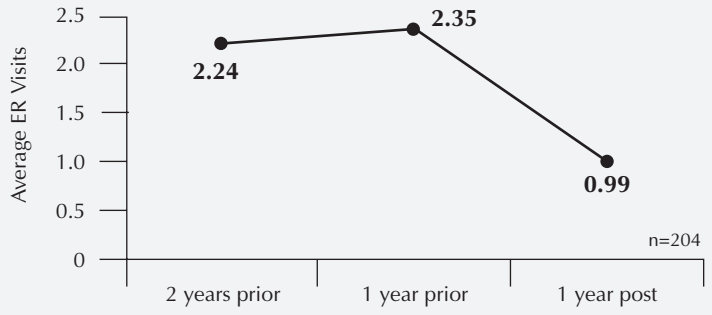
The combination of supportive housing and HHISN's integrated services is now proving itself in the lives of hundreds of San Franciscans for whom other forms of service, shelter, and care weren't working. To examine what happens when people go from public crisis to stable housing with HHISN's supportive services, researchers from U.C. Berkeley compiled medical care data on 253 residents of Canon Kip and the Lyric, and mental health-care data on a smaller subset of those residents, between 1992 and March 2000.[4] Thus far, the data show a steep drop in all major categories of service.

1. A 58 percent decline in emergency room use

Treatment in emergency rooms is a good measure not only of the incidence of crisis in someone's life, but of the likelihood that such crises are being dealt with inconsistently or belatedly, and at great cost. Among the 253 people who had entered Canon Kip or the Lyric as of March 1999, the average resident had previously been treated in the emergency department of San Francisco General Hospital on more than two occasions in each of the two years before moving in (2.08 visits and 2.11, respectively). Within one year of entering supportive housing, the average ER use fell to 1.01 per person per year, and the total number of emergency room visits for this group had declined from 535 in the year before supportive housing to 255 visits in the year after move-in.

When we look more closely at those tenants who remained in supportive housing for at least one year (204 of the 253 people, or 81 percent of those who entered supportive housing), the results are even more dramatic. The average number of emergency room visits for each person dropped from 2.35 in the year before moving in (and 2.24 in the preceding year) to less than one visit (0.99) per person per year in the first year of living in supportive housing — *a 58 percent decrease*. For those tenants who have remained for two years or more, the dramatic reductions in emergency room use during their first year in supportive housing are sustained during the following year.

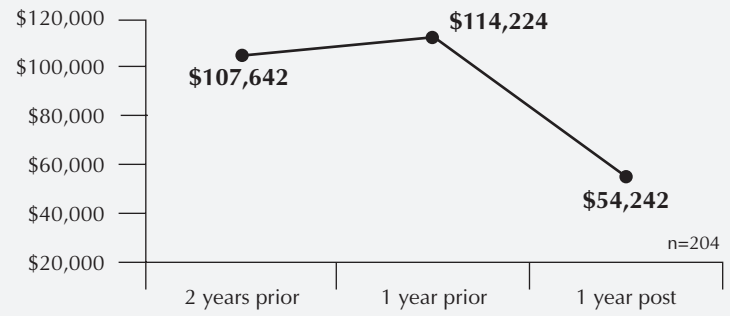
Table 1: Average Annual Visits to SFGH Emergency Room



The cost of a typical emergency room visit is $182, though for a psychiatric emergency the average cost rises to $550. That is only the *hospital* cost — it does not include the costs of medical procedures and tests, doctors' fees,

or any costs for an inpatient admission that may follow the emergency room visit. Focusing just on the hospital ER cost for those who remained in supportive housing for a full 12 months (204 people), the following graph shows the magnitude of the savings:

Table 2: Hospital Emergency Room Costs

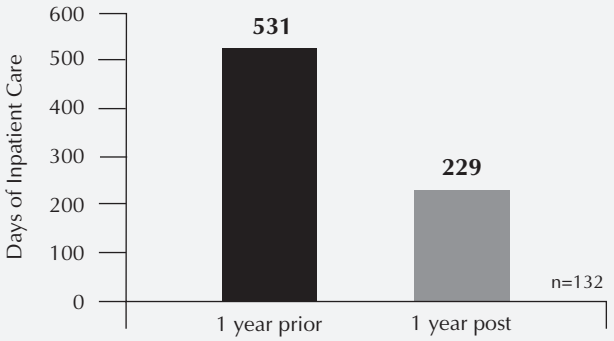


The benefit of this drop is not only in relieved demand on San Francisco General's emergency facilities; the longer-lasting benefit is that people are *healthier*, and being treated consistently, preventively, and without the costly infrastructure of emergency care. These are benefits that accumulate over time.

2. A 57 percent reduction in hospital inpatient days

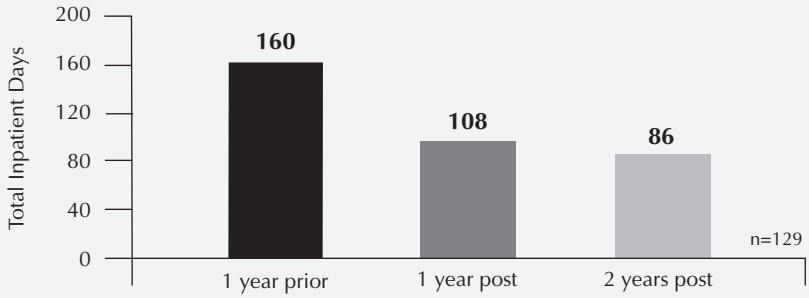
A similar pattern emerges when the study moves from the emergency room to the inpatient wards. Here, because of missing data in San Francisco General's database, it was possible to look at only one year of prior hospitalizations before moving in to supportive housing. Even then, hospital records on some patients were not complete enough to supply information on one full year before and after each patient entered supportive housing. Of the total population of 235 people, 204 had remained in supportive housing for a full 12 months. Of those, it was possible to obtain information on prior hospitalizations for only 132 people. Nonetheless, judging from this smaller group, the reduced demand on the hospital is as dramatic as the decline in ER use. The number of hospital days was down nearly by 57 percent in a single year, to 229 days from 531.

Table 3: Total Hospital Inpatient Days



Of all the tenants included in this study, 129 stayed in Canon Kip or the Lyric for at least *two* full years — long enough to examine the effect of a second year on their inpatient hospital use (even if, for some of these people, the data on inpatient hospital use *before* they entered supportive housing is still incomplete). For this group, the second year in supportive housing brought a further 20 percent decline in hospitalization days.

Table 4: Inpatient Days after a Second Year in Supportive Housing



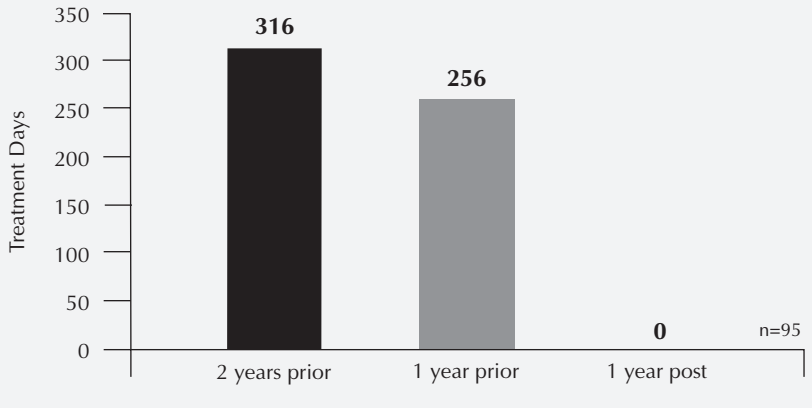
For those tenants who used hospital inpatient services, both the number of admissions and the number of days they were hospitalized each year dropped dramatically. Looking just at the people who had at least one inpatient stay during the year before or after moving into supportive housing (38 people out of 129), the number of hospital admissions declined from 79 to 36, and the average number of days of hospitalization dropped from 13.79 days before to 5.88 days after.

3. A *near total elimination* of residential mental-health care outside of hospitals

Data on mental-health services are subject to particular legal safeguards of confidentiality requiring, among other things, that the data may not be released for study unless each individual in the study first consents in writing. Of those living at the Lyric and Canon Kip during two rounds of recruitment for participation in this study, 157 provided the written authorization that would allow their data to be included in this analysis. Of those, however, some or all of the data on services is missing from the Community Mental Health Services database for many residents. (Researchers and CMHS staff are currently working to correct the problem wherever possible.) Complete information on mental health care during the 12 months after entering supportive housing is therefore available for only 95 of the tenants in these two programs. And for nearly half of these tenants, information is incomplete about inpatient hospitalizations during the 12 months before they moved into supportive housing.

Yet despite the limitations on the data, the results are dramatic. Total use of residential treatment programs among this sub-group fell *to zero* once people entered supportive housing. In the year before entering supportive housing, total use declined somewhat — possibly because some people were on waiting lists for the Lyric and Canon Kip, and thus receiving some amount of advance service from HHISN providers at those sites. Even then, however, their use of these 24-hour treatment programs one year before entering supportive housing had averaged 2.69 days per person per year, for a total of 256 days. One year later, both the average and the total utilization had fallen to zero.

Table 5: Days of Residential Mental Health Treatment



The total costs eliminated in this process are equally dramatic. For just this sub-group of 95 people, the aggregate cost of treatment two years before supportive housing was $39,195. A year later, the slight reduction in total use brought the cost to $28,388. A year later, it had been eliminated entirely.

There are several possible explanations for such a pronounced decline, and the next stages of analysis are likely to shed more light on these. The sharp drop in residential treatment may, for example, be associated with a reduction in the number of inpatient psychiatric hospitalizations. It may also be the result of a quicker return home following a short-term hospitalization, given that many of the supports provided in residential treatment programs are routinely available in supportive housing.

Although complete data on psychiatric hospitalizations are not yet available for analysis (they will be included in the next stages of research), these results on residential treatment programs give some clues about trends in the use of psychiatric hospital beds. In San Francisco, residential treatment is frequently used in conjunction with an inpatient psychiatric hospitalization. During an acute psychiatric crisis, consumers are often transferred to residential treatment after a few days in the hospital, to continue intensive treatment and prepare to return to more independent community living. A reduction in residential treatment would therefore be likely to signal some corresponding reduction in hospitalizations.

A Closer Look at Two Supportive Housing Residences

The Lyric Hotel and Canon Kip Community Residence, where these results were achieved, serve similar populations of formerly homeless people using a combination of federal, state, and local funds.

The Lyric is a 58-unit residence, one of six operated by Conard House, a nonprofit organization specializing in mental-health services. Apartments at the Lyric are tailored to people who have a psychiatric diagnosis — typically paranoid schizophrenia, post-traumatic stress disorder, major depression, or borderline personality disorder — plus one other form of disability, such as HIV, a physical impairment, or an addiction. At the Lyric, Conard House provides core on-site case management, and Baker Places supplements the on-site staff with case-management and social work specialists, besides providing connections to off-site treatment. The building opened in 1997.

Canon Kip, with 104 apartments, opened in 1994. It is the first of two supportive residences developed by Episcopal Community Services of San Francisco (ECS). More than 70 percent of the tenants at Canon Kip have two or more disabilities, including mental illness, HIV and AIDS, or a history of substance abuse. As at the Lyric, ECS's on-site staff are supplemented by employees of Baker Places, which also provides outside treatment as needed.

The average tenant at Canon Kip and the Lyric pays 30 percent of his or her income in rent. The residence collects a federal supplement paid through the Shelter-Plus-Care program to make up the difference between the cost of providing the supportive apartment and the rent each tenant is able to pay.

Both programs welcome people still struggling with the problems that led them to life on the streets. Based on a model known as "harm reduction," these programs start with the goal of reducing tenants' more self-destructive behavior, particularly the harmful use of drugs or alcohol — even if that behavior can't be stopped altogether. Yet at the same time, the program continually offers a vision and opportunity for an ordinary, independent life: training and employment services, opportunities for participating in community life, environments for socializing away from addictive substances.

HHISN reinforces this approach to supportive housing by making available a wide range of social, medical, and training services that meet tenants' needs wherever they happen to be. For example, the Supportive Housing Employment Collaborative, a specialized network within HHISN, operates a skills center that gives tenants and case managers in supportive housing a broad choice of training and job paths for people who are looking for employment or want to improve on their current job. The city's Tom Waddell clinic, in addition to its regular walk-in services, provides an on-site physician or nurse practitioner at both residences to deliver basic medical care and health education, and to help residents manage their psychiatric or other medication. Addiction-recovery programs conduct support groups on site or nearby and generally reinforce those who are trying to end their substance abuse. Baker Places and other service organizations help train peer counselors, provide clinically trained case managers on-site who can help tenants address mental-health or substance-abuse problems, and provide access to detoxification and treatment programs for residents who lapse into more severe substance abuse.

In short, HHISN gives each supportive residence an arsenal of different responses for all the different needs and levels of functioning that tenants present from day to day. One agency could never supply all the forms of experience and staff specialty that this requires. Relying on HHISN, the front-line staff at each supportive residence can concentrate on the particular

tenants at that place, knowing that whatever particular expertise may be needed from day to day is available from the network, no farther than a phone call — or, in many cases, a walk down the hall, or down the street.

Meanwhile, the specialized staff in the various medical and service agencies rely on supportive housing to give them access to people they might never reach otherwise. Said one staff member at the Tom Waddell clinic:

> Harm reduction creates a climate of trust where we can talk honestly to people, often for the first time, about problems they would never admit to in an office or a clinic. When I talk to someone at Canon Kip, I learn things about their drug use or their prior life on the streets that I would never have learned in my office. Suddenly, from that point on, the whole medical relationship is based on *reality*, and we actually start to accomplish something.

Conclusion

The study from which these early findings are drawn is still in progress. Eventually, it is expected to include information from the criminal justice system and from other public support and service programs. By later this year, it will be possible to make a straightforward comparison between the costs of supportive housing with HHISN's services, and the cost of "treating" chronic homelessness in the usual ways: by responding to its emergency side effects, by arresting and jailing people, or by simply ignoring it. All these responses have a cost. Some, like those described in this preliminary report, are enormous. All, it seems, can be reduced by coordinating housing, services, medical and psychiatric care, and addiction treatment in a carefully managed package.

The full test of that assertion will come over the next several months. For now, at least, the initial evidence seems encouraging, often dramatically so. The opinion of supportive housing residents, while less quantitative, reinforces the message of the numbers. Said one resident, on reviewing an early summary of this report: "When I look at those charts, I see my life. That's my story, and I know it's right."

Appendix A

Residents of the Lyric and Canon Kip: Behind the Numbers

This appendix presents profiles of just a few of the residents of the two supportive housing developments whose work is described in the main paper. As in other instances, the names have been changed and the specific place of residence concealed, but all other details are true. The experiences of each of these three people are included among the statistics in the current research.

Edwin Marshall is 48 years old. In the 1980s he was a happily married father of three, a Vietnam veteran with a home and a business of his own. Although he suffered, even then, from Post-Traumatic Stress Disorder (PTSD), the condition was medicated and seemed manageable. In the late '80s, however, a painful disease of the joints made it necessary for him to have both hips replaced. Unable to work, he watched his business suffer and eventually had to sell it. As he struggled with chronic pain, which prescribed medication had failed to control, he began to abuse the prescription drugs and to "self-medicate with alcohol."

After his surgery, the forced idleness and pain, aggravated by substance abuse, drove him deeper into depression and desperate behavior, including more drugs in more volatile combinations. As he lost control of his finances, and the cost of his drug habits deepened, he was forced to sell the family home. His wife, unable to recognize the man she married, soon left him. With his family gone, the last anchor holding him to a stable life disappeared.

"At that point," he says, "I fell into drug use full on." Between 1989 and 1992 he was convicted six times on felony charges of possession and selling drugs. Meanwhile, as he took worse and worse care of himself, his physical condition worsened and one of the hip replacements became infected. In 1992, walking on two canes, Mr. Marshall went to prison again, this time for 22 months, on drug-related felonies.

Although the stay in prison largely ended his drug use, upon release he again found himself homeless. With barely $300 in his pocket, he eventually landed a bed in an emergency shelter in San Francisco.

The shelter was run by an agency that is a member of HHISN. Seven months later, Mr. Marshall was moving into a supportive apartment.

Mr. Marshall is now recovering from his tangle of addictions — even foregoing pain medication, for fear of again becoming dependent. "I've learned to live with a certain amount of pain," he says. "I can't take drugs any more; I have to know what's going on in my body. I'm familiar with my pains, and I need to know when there's a new one. The human body is an amazing thing. It can get used to anything."

Mr. Marshall's next challenge is to re-establish himself in a new career, one that won't require heavy use of his fragile joints. HHISN's employment partnership — the Supportive Housing Employment Collaborative — provided some basic preparation in computer, office, and management skills, and he has since gone on to more extensive training through San Francisco Vocational Services. He uses, and values, the case-management and psychiatric services available on-site, which he says have helped him weather the occasional tough spells that still surface from time to time.

Not long ago, the management and other tenants of Mr. Marshall's supportive housing program surprised him with a lifetime achievement award, presented in person by the mayor of San Francisco.

Ray Vasquez had been living in a privately owned SRO hotel in San Francisco whose owners were about to sell the building. They gave him a referral to another SRO and a sizable cash settlement to terminate his lease. Unfortunately, Mr. Vasquez was a heavy user of crack cocaine at the time, and "I partied real good on that money. For about a week." With his money gone and his habit badly escalated, Mr. Vasquez was back on the streets, or doubled-up in the apartments of other friends with addictions. It wasn't long, though, before he ended up in Vacaville State Prison for six months on a drug-related felony.

Released on parole, he came into contact with a HHISN member agency, where he began to establish a relationship. Over time, the agency placed him on a waiting list for supportive housing, and continued working with him on his drug problem. "They asked me if I was active, if I was smoking crack," he says, still with a tone of amazement. "And I said yes. And they let me in!"

As a condition of his parole, Mr. Vasquez was required to attend regular meetings of Narcotics Anonymous. But his substance abuse continued. The agency managing his supportive residence believed — correctly, it turns out — that there was more hope for Mr. Vasquez if he had a safe place to live and the steady influence of people who could help him recover, than if he returned to the street.

The staff continually engaged Mr. Vasquez at every opportunity, talking about anything he wanted to talk about — baseball, politics, or every so often, his addiction. "They always had something else I could do instead of cracking it up," he recalls, "and every now and then, I'd do it: watch a movie, go on a trip to the zoo, or go to a ball game."

In time, some of his days were drug free. As his periods of lucidity became longer, and he could think more clearly about his situation, he began to talk with staff about the consequences of continuing drug use. "I was going to jail 18 months here and 18 months there, and by the time I was facing the new three-strikes law, I was going on five strikes."

The key to recovery for Mr. Vasquez came from a hobby: He likes to repair bicycles. When a counselor from the Supportive Housing Employment Collaborative saw him fixing bikes near the program's offices, the SHEC Skills Center helped Mr. Vasquez buy tools and start a repair business.

After a little more than a year in supportive housing, Mr. Vasquez stopped using crack. "I did everything I could to keep myself busy," he says. "I worked on bikes. I lifted weights. They have a movie marathon every month on the first, when [benefits] checks come and people get high. I went every time." Today, he is a member of the tenants' council and a peer counselor for those still struggling with addictions.

"I like it here," Mr. Vasquez says. "It's my home. I don't like to see it abused. I like [tenants] to pick up the trash, and I like for the case managers to come up and talk to the tenants. They really can help."

Morgan Cantrell was thrown out of his family's home in 1990 because of crack and alcohol addictions, and because of psychiatric problems that had become profoundly aggravated by drugs and drinking. For years, he lived in shelters and single-room hotels, and worked long hours driving trucks to support his habit. "One night I would be in my own hotel room smoking crack," he remembers, "then when the money ran out I would go to a secluded spot near Twin Peaks where I would camp out. I was so ashamed, I didn't want to be around anybody."

A short incarceration led him to a halfway house operated by one of the agencies in HHISN. That group, in turn, led him into a work-therapy program sponsored by the Veterans' Administration. In the rest of his time, he participated in the halfway-house's drug-free self-help program, where he attended (and still attends) meetings for people with dual diagnoses — that is, with mental illness combined with addiction. After two years in the halfway-house, the HHISN member agency arranged a place for him in supportive housing.

"I've been clean and sober for six years," Mr. Cantrell says now. But that victory came neither easily nor fast. "It took me four or five times of wanting to get off drugs before I did it." The next challenge he has set for himself is to move on from supportive housing because, as he puts it, "there are plenty of homeless people trying to get in." He is working, training, saving money, and planning a future.

Appendix B

Members of the Health, Housing and Integrated Services Network

San Francisco

San Francisco Department of Human Services
    Shelter-Plus-Care Program
San Francisco Department of Public Health
    Tom Waddell Health Center
    Housing Services
Baker Places
Episcopal Community Services
Conard House
Mercy Charities Housing California
Chinatown Community Development Corporation
Community Housing Partnership

Alameda County

Alameda County Health Services Agency
Alameda County Department of Housing and Community Development
Oakland Housing Authority
    Shelter-Plus-Care Program
Lifelong Medical Care
East Bay Community Recovery Project
Building Opportunities for Self Sufficiency
Bonita House
City of Berkeley Mental Health
Alameda County Network of Mental Health Clients
Jobs Consortium
Resources for Community Development
Mercy Charities Housing California
Oakland Community Housing, Inc.

Contra Costa County

Contra Costa County Health Services Department
Contra Costa County Housing Authority
    Shelter-Plus-Care Program
Rubicon Programs
Phoenix Programs
Mental Health Consumer Concerns
Shelter, Inc.

Marin County

Marin Housing Authority
    Shelter-Plus-Care Program
Marin County Department of Health & Human Services
    Division of Community Mental Health
Buckelew Programs
Ritter House
Homeward Bound of Marin

San Mateo County

San Mateo County Human Services Agency
    Office of Housing
    Shelter-Plus-Care Program
San Mateo County Health Services Agency
    Mental Health Services Division
Mental Health Association of San Mateo County
Mid Peninsula Housing Coalition

Santa Clara County

Palo Alto Housing Corporation
Alliance for Community Care
Department of Veterans Affairs Medical Center

Appendix C

Residents of the Lyric and Canon Kip: Basic Demographics

Demographic and prior living situation data are available for 244 individuals. Length of stay and retention rate data are available for 253 residents.

Characteristic	n	(%)
Age at Move-in		
Mean:		45.3
Median:		41.9
Range:		31-75
Gender		
Male	174	71.3
Female	69	28.3
Transgender	1	0.4
Race		
Black	136	55.7
White	77	31.6
Native American	12	4.9
Latino	15	6.1
Asian	4	1.6
Veteran	55	22.5
Mean Income		530.85
Living Situation at Intake		
Shelter	155	63.5
Street	74	30.3
Transitional housing or residential treatment program	15	6.1
Diagnosis		
Severe Mental Illness (SMI)	216	88.5
Substance Abuse (CD)	235	96.3
AIDS/HIV	34	13.9
Length of Stay		
All residents	mean	863 days
Residents who exit	mean	589 days
Retention Rate		
Residents that stay>= 365 days		81.6%

References

1. The research draws from multiple databases maintained by San Francisco General Hospital (SFGH) and San Francisco Community Mental Health Services (CMHS). In some cases, hospital or program data are missing or incomplete for some residents. These gaps are greatest during the years before the earliest HHISN tenants entered supportive housing, largely because of changes in billing systems and in the way publicly funded health services were reimbursed by state and local governments during those years. Therefore, depending on the service being analyzed, the population size may vary, and the variations are explained in the text of this report each time they occur.

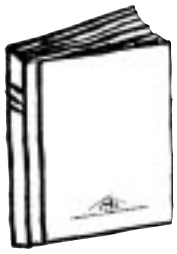
   Data regarding services provided by SFGH are available for a total of 253 individuals who agreed to be included in the study or who provided consent for this information to be provided as part of the Shelter Plus Care Program. Data describing the use of mental-health services are also subject to more restrictive legal safeguards to protect confidentiality, and may be used only with the individual consent of each person to be studied. Written consent to obtain this information was provided by 157 of those who were living at the Lyric and Canon Kip when researchers recruited participants for this component of the study, and records were located for 120 of these people, but not all the data on these 120 people were complete. Consequently, some analysis of mental-health services is based on a population size smaller than 120, and these variations are likewise described in this report each time they occur. Efforts to correct the data deficiencies wherever possible are under way. The final version of this analysis is therefore likely to be based on larger population sizes.

2. Because of the way billing data were maintained prior to 1995, this number does not include mental health care in private hospitals in the earliest year of the study. Nor does it yet include mental health care provided in jails and prisons — a figure expected to be made available in later stages of research. In short, the $8,000 average is almost certainly an underestimate.

3. Throughout this report, residents' names have been changed, and their current residence concealed, to protect their privacy.

All other facts are true, and are being reported with each person's full consent and participation. Other stories of tenants in supportive housing appear in Appendix A.

4. Two hundred seventy-eight people moved into Canon Kip or the Lyric as part of the Shelter-Plus-Care program between October 1994 and December 1999. Of those, 253 had moved in by March 1999 — allowing at least one full year of data to be collected by March 2000. Emergency Room data from San Francisco General Hospital are available for this full group for the full period being studied, but inpatient data are complete on only 132 of this group for 12 months before and 12 months after they entered supportive housing. As in other cases, hospital administrators are working with researchers to correct the problem.



CSH Publications:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COMING SOON:

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

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

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

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir.*
This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving Health, Housing and Integrated Services tenants where they live.

Forming Local Consortia to Develop Supportive Housing Projects *Written by Tony Proscio.*
These three related guidebooks are for those interested in forming local consortia and developing supportive housing projects. Guidebook I discusses the formation and management of the supportive housing consortium. Guidebook II sets out the necessary building blocks for designing and organizing services in developments. Guidebook III provides information on designing, financing, building, and managing housing for people who need ongoing services.

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Mission Statement…

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

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