Developing the "Support" in Supportive Housing

A Guide to Providing Services in Housing

By Tony Hannigan and Suzanne Wagner

Center for Urban Community Services
Made possible by a grant from the Corporation for Supportive Housing
June 2003

CORPORATION *for* SUPPORTIVE HOUSING

June 2003

Dear Colleague,

For too long, homelessness has troubled America's conscience, harmed its most vulnerable people, and cost the public hundreds of millions of dollars for band-aid solutions that have had inadequate results.

But in the midst of this enduring tragedy, there is hope. We now know that supportive housing ends homelessness for people with chronic barriers to health and housing stability, who are cycling through the systems meant to assist them. We know that supportive housing has a positive impact on people's health, employment and stability, and is a cost effective use of our scarce public resources.

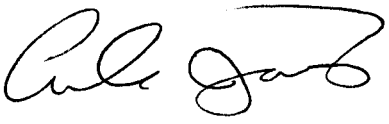
In all of its models and manifestations, what makes supportive housing tick is its combination of permanent, affordable housing and voluntary, supportive services. This manual, Developing the "Support" in Supportive Housing, is a practical guide to developing those voluntary supportive services. It includes an overview of what it takes to put together a supportive services program, as well as some specific suggestions for services related to employment, mental health, HIV/AIDS and sub-stance use issues. It also offers some lessons for promoting good relationships among supportive housing tenants and staff, and with the neighborhoods where we work and live.

I hope that supportive housing providers and advocates can use this manual and its resources to build better homes and communities, and move us toward the day when supportive housing is a standard component of every community's effort to prevent and end homelessness.

My special thanks to Tony Hannigan and Suzanne Wagner of CUCS for putting together this important and useful volume and for their pioneering efforts to create high quality services in supportive housing. Some of the many other people who assisted in the writing and production of Developing the "Support" in Supportive Housing are noted on the Acknowledgements page within. We also acknowledge, with gratitude, the many supportive housing providers and tenants whose hard work and experiences over the past years provide the foundation for the lessons taught within these pages.

Sincerely yours,

Carla I. Javits,



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About the Center for Urban Community Services

Founded in 1979 at Columbia University, the Center for Urban Community Services (CUCS) is a national nonprofit organization based in New York City that provides services for homeless, formerly homeless, and other low-income individuals. CUCS's services include street outreach, a drop-in center, two transitional residences, ten permanent supportive housing programs, and a vocational/employment program. Particular emphasis is placed on specialized services for people living with mental illness, HIV disease, and chemical dependency to increase housing stability and maximize independence and choice. The organization also operates the CUCS Housing Resource Center, a national training, consultation, and information project.

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About the Corporation for Supportive Housing

CSH's mission is to help communities create permanent housing with services to prevent and end homelessness.

CSH strives for a day when homelessness is no longer a routine occurrence and supportive housing is an accepted, understood, and easy-to-develop response. In coordination with broader national efforts to end homelessness, CSH will help communities create 150,000 units of supportive housing during the next decade. To reach this goal, CSH will provide direct assistance to community-based nonprofit organizations, government agencies, and others working to create supportive housing. In all of our work, we strive to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.

In the next ten years CSH will help to create more supportive housing nationwide by:

- Promoting policy reforms and coordinated systems that make supportive housing easier to develop and operate.
- Providing financial and technical assistance to our partners to expand the supply, availability, and variety of supportive housing.
- Enhancing the supportive housing industry's skills and knowledge, so that the field has a greater capacity to deliver high-quality housing and services over the long term.
- Documenting and publicizing supportive housing's positive impacts on tenants, communities and neighborhoods, as well as how it efficiently uses public resources.

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Preface

Providing supportive services in people's homes is uniquely different from delivering other community-based services. For many individuals who have been homeless and/or who have special needs or disabilities, affordable housing combined with supportive services has proven to be the link to stability and an enhanced quality of life. Developing the "Support" in Supportive Housing provides information about shaping and delivering services to meet the particular challenges of delivering supportive services in people's homes.

A hallmark of supportive housing is the ability to adapt services to meet the various needs of tenants. This guide was informed by CUCS' twenty years of experience in delivering services in housing settings and our work with hundreds of supportive housing organizations throughout the nation through our training and consultation program. The guide focuses on strategies to maximize residential stability, quality of life, choice, and independence among tenants. The principles and practices discussed are meant to be applicable to a variety of settings and supportive housing models. The guide is intended as a resource for new and experienced staff members and for program development efforts.

Each of the eight chapters of Developing the "Support" in Supportive Housing addresses a topic central to the design and delivery of supportive services in permanent housing for single individuals. Additional information such as resources and readings is listed in appendixes at the ends of most chapters. We have also included a glossary of terms at the end of the guide.

History and Principles of Supportive Housing

Supportive housing has evolved into a national movement during the last two decades, as the combination of affordable housing and supportive services has proven to be a wise and cost-effective way to meet a diversity of needs and interests. Today, there are tens of thousands of supportive housing units sponsored by nonprofit organizations nationwide, and they range from units in single-family homes to single-site developments of several hundred units each. Supportive housing projects sometimes focus on one population, such as individuals who are psychiatrically disabled, while others serve a mix of groups that may include people living with HIV, older adults, individuals with psychiatric or physical disabilities, the formerly homeless, low-income working people, and, more recently, families.

Supportive housing offers affordability and a stable living environment while helping tenants access services and amenities that promote self-sufficiency and enhance their quality of life. Depending upon the tenancy, supportive services programs in housing provide and/or maintain linkages to individual and family counseling, HIV services, mental health services, alcohol and substance use services, crisis intervention, childcare, medical care, vocational counseling, and job placement, among others. Supportive housing projects also work to foster community-building efforts among tenants and are often engaged with the surrounding neighborhood as well.

This chapter provides an overview of the history of supportive housing and the core principles that have guided its development.

The Emergence of Supportive Housing

Bringing supportive services into housing started in the 1960s as a way of assisting people living in substandard settings, particularly commercially owned single-room-occupancy hotels (SROs). Supportive housing took shape in the ensuing decades as nonprofits acquired and/or redeveloped SROs and other distressed properties in response to the growing problem of homelessness. Many factors contributed to the rise in homelessness, including deinstitutionalization of psychiatric patients from state hospitals, the decrease in the availability of SROs and other affordable housing units, the advent of AIDS, diminished government benefits, and the reduction of job opportunities for unskilled workers.

By 1981, the number of people in long-term psychiatric facilities in the United States dropped from a high of 550,000 to just 125,000. This occurred because the introduction of psychotropic drugs in the late 1950s allowed many long-term psychiatric hospital patients to be stabilized and released to the care of their

families or to more independent living situations. Public outcry about the conditions inside many of the large state institutions at this time hastened discharges and reduced the number of new admissions to state hospital systems. A call for less restrictive and less costly care was heard throughout the nation, as federal funding streams, such as Medicaid and Supplemental Security Income (SSI), began to pay for mental health care in the community.

Many individuals who were deinstitutionalized during the 1950s and '60s moved into nursing facilities and adult homes and others found their way into low-income housing in urban areas. One of the most popular among these housing options was the SRO hotel, which provided basic lodging and typically consisted of small private rooms with shared kitchens and bathrooms. Originally built in response to the turn-of-the-century influx of migrants and immigrants looking for work in cities, SROs provided affordable, convenient, and furnished accommodations.

Following World War II, however, the demographics of many American cities changed and so did housing markets. Many people left cities for the housing being built in suburban areas, and SROs gradually gained a reputation as "poor people's" housing, where deteriorated conditions and overcrowding frequently created dangerous living situations. Sometimes, SROs were used as housing placements following drug or alcohol treatment or upon release from prison. Frequently, older adults, chronic alcoholics, and the psychiatrically disabled made SROs their permanent home.

As the conditions in SROs continued to deteriorate during the 1970s, they were increasingly seen as outmoded, undesirable, and dangerous. Many individuals living in commercial SROs had difficulty accessing services and did not get help until a crisis occurred. In many cases, communities were also putting pressure on local governments to address the violent crime, prostitution, and drug dealing that characterized many of these buildings. In response to these trends, services and supports were brought into some SROs by local welfare offices, community organizations, and medical and mental health clinics, among others.

Eventually, cities instituted moratoriums on the construction of new SRO units and the conversion of apartments into SROs. In many localities, tax incentives were provided to property owners who upgraded their SRO stock to apartments. Urban renewal programs often destroyed SRO housing that was not converted, and the remaining stock continued to deteriorate. More than one million SRO units were lost nationwide during the 1970s. Large cities were particularly hard hit; for example, Chicago lost more than 14,000 SRO units from 1973 to 1985, and New York City lost approximately 113,000 private SRO units or 89 percent of its total stock from 1970 to 1983.

The aftermath of deinstitutionalization and a downturn in the production and availability of affordable housing coincided with economic recessions in the mid-1970s and a steady rise in immigration during the 1980s. During the '80s, the advent of crack cocaine, a highly addictive street drug, also caused profound disruption in some cities, as did the AIDS crisis. Across the United States, streets and emergency shelters became "home" for individuals from many walks of life.

In the 1980s and '90s, to address the needs of massive numbers of homeless people, cities and localities invariably created emergency shelters, food pantries, and soup kitchens. Some went further, however, and created housing preservation and construction programs to increase the supply of affordable housing. New prototypes and models of housing emerged under the leadership of local government and the nonprofit sector. During this time, the development and expansion of supportive housing, which combined affordable accommodations with supportive services, took shape around the nation.

Early Precedents in Supportive Housing

While the culture of commercial SROs often had many negative and destructive elements, there were also positive aspects. Most important, SROs provided affordable accommodations for people who otherwise had minimal access to housing. In some localities, nonprofit organizations looked to replicate the positive elements of SRO life and build upon them to promote desirable living environments.

In New York City, for instance, St. Francis Friends of the Poor acquired and renovated an abandoned SRO building in the early 1980's. Providing affordable, comfortable, and permanent housing with on-site services, the St. Francis I Residence became a prototype in New York City for subsequent supportive housing endeavors. The 101-unit building was developed for individuals with serious mental illness. Unlike other housing programs developed for psychiatrically disabled individuals, however, the St. Francis was designed to be permanent housing, with each tenant having a lease protecting his/her tenancy rights in accordance with state and local statutes. With a principal focus on helping tenants to remain housed in the community, the St. Francis on-site service staff assist tenants to maintain financial and psychiatric stability and develop interests and relationships in the larger community.

In 1983, as the Franciscans began work on a second building, Broadway Housing Communities (BHC, formerly Committee for the Heights-Inwood Homeless) and the Center for Urban Community Services (CUCS) initiated the transformation of an abandoned building in upper Manhattan into supportive housing for homeless individuals. While St. Francis Friends of the Poor relied heavily on private dollars to finance its projects, BHC was among the first supportive housing sponsors to use a complex financing structure that combined government funds, a conventional bank loan, and the establishment of a limited partnership with a for-profit development entity. Named The Heights, the building provides permanent, affordable supportive housing and also introduced an emphasis on a "mixed" tenancy that includes but is not restricted to individuals with disabilities. One-third of the 55 housing units at The Heights are reserved for people with mental illness, while the balance is for other low-income individuals who are homeless. An integrated or mixed tenancy has become a feature of many supportive housing projects around the nation because the practice promotes community reintegration and helps to diminish the stigmas often associated with disabilities and special needs.

Supportive housing initiatives took shape throughout the United States in the 1980s. In the San Francisco Bay Area, for instance, early examples of supportive housing were developed by Baker Places, Conard House, and the Progress Foundation. San Francisco led the nation with the establishment of the first supportive housing program for people living with AIDS, the Peter Claver Community, operated by San Francisco Catholic Charities. In 1989, the Lakefront SRO Corporation opened its first supportive housing site, the Harold Washington Apartments. The Harold Washington was the first permanent supportive housing program in Chicago for a mixed population of formerly homeless tenants.

In 1991, Common Ground Community, in partnership with CUCS, began development of the Times Square, a 652-unit permanent supportive housing program located in midtown Manhattan. The size, grandeur, and success of the Times Square initiative brought enormous visibility and credibility to the supportive housing movement and generated an unprecedented level of interest. Since then, supportive housing has continued to expand at an accelerated rate across the United States.

Supportive Housing Becomes a Movement

Financial support from a wide variety of sources contributed to the nationwide expansion of supportive housing development. The passage of the federal Low Income Housing Tax Credit legislation in 1986, for example, provided the opportunity for private investors to receive tax credits in exchange for direct investments in low-income housing. Similarly, the federal government made a major commitment to housing homeless individuals with the authorization of funding streams sponsored under the Stewart B. McKinney Act of 1987.

Statewide and local supportive housing initiatives have spread across the nation. The New York/New York Agreements to House Homeless Mentally Ill Individuals in New York City resulted in the development of thousands of new units of supportive housing. The Connecticut Supportive Housing Demonstration Program completed 281 units of supportive housing at nine sites in less than three years and has been followed by the PILOTS Initiative, a project that blends a variety of federal, state and local resources for 400 additional supportive housing units statewide. In 1998, California passed the Supportive Housing Initiative Act, which provided $26 million in state funds for the development of supportive housing units throughout the state. The Corporation for Supportive Housing, a national nonprofit intermediary that provides predevelopment funds, bridge loans, and technical assistance, has greatly served to accelerate nationwide production of supportive housing since 1991.

As confidence in supportive housing has grown, so have the size, scope, and variety of new initiatives. Supportive housing has been developed in row houses, apartment buildings, scatter-site apartments, and single- and multifamily homes. While the strengths of the approach are not limited to addressing the needs of formerly homeless people, the growth of supportive housing has had a profound impact on the problem of homelessness in the United States. New York City provides a stunning example, where thousands of units have been targeted to homeless individuals. Indeed, between the late 1980s and the mid-1990s, the municipal shelter population of single adults fell from a high of nearly 10,000 individuals per night to a low of approximately 6,000. Other geographic areas have seen similar outcomes as the stock of supportive housing continues to grow.

Principles of Supportive Housing

In practice, supportive housing programs have been designed to serve a wide range of individuals. Variations in program philosophy, size, location, tenant mix, staffing, and level of support are among the many elements that make each housing site different from the next. A tenancy could, for instance, include working people, the unemployed and underemployed, people living with mental illness or AIDS, physically ill individuals, the formerly homeless, and substance users in recovery or still using, among others. Affordability and the flexibility to adapt services to the needs of the tenants are the greatest strengths of effective supportive housing projects.

Although there are many differences among supportive housing programs, the following core principles have informed and guided the model's development.

Permanence and Affordability: A primary purpose of supportive housing has been to increase the availability of permanent housing to low-income people, particularly those who have been homeless or have disabilities or special needs. Typically, tenants pay rent in an amount that does not exceed 30 percent of their income. Many sponsors rely upon rent subsidy programs such as Section 8 and Shelter Plus Care to make projects affordable and financially viable.

Safety and Comfort: Tenants should be safe and feel comfortable in their homes. Meeting or exceeding building codes and providing extra security and comforts when resources allow are efforts that all tenants appreciate. It is important that safety concerns expressed by tenants are promptly addressed, and both the staff and tenants should feel that they have some collective control over their environment. In housing where people feel part of a larger community, they are also more likely to look out for their neighbors and work together.

Support Services Are Accessible and Flexible, and Target Housing Stability: The tenants' needs and goals should be clearly reflected in the design of the supportive services program. Service programs also require adjustment as the needs and interests of individual tenants and the larger housing community evolve and change. Support services should help ensure stability, maximize each tenant's ability to be self-sufficient, and be appealing and easily accessible.

Projects vary in how they provide or arrange for services, but they uniformly stress housing stability as a basic and primary goal. In promoting housing stability, service providers focus on helping tenants meet their lease obligations, including paying rent, maintaining a safe and healthy living environment, allowing others the peaceful enjoyment of their homes, and complying with basic house rules.

Depending on the interests of the tenants and the type of resources available, services can be shaped to have the widest possible appeal and may range from small support groups to classes in cooking, the arts, high school equivalency, and vocational counseling. Linkages with health and mental health services, legal services, immigration services, and local entitlement benefits offices are usually essential. Although tenants sometimes need to be actively encouraged to use program resources, it is up to the service provider to make the program relevant, available, and inviting to tenants.

Empowerment and Independence: Supportive housing is intended for people who can live independently as well as for those who require some support. Service programs should be designed to empower and foster independence among tenants. Examples of empowerment efforts are:

- Involving tenants in the management of a supportive housing project
- Providing employment opportunities
- Encouraging tenant councils and advisory groups

Empowerment also translates into tenants having control over lifestyle choices, even though they may conflict with the housing sponsor's preferences. Alcohol use and gambling, for example, are issues that can be challenging. Similarly, some tenants will prefer to have limited, if any, interaction with the supportive services staff or other tenants. In the final analysis, tenants are in their homes and service providers are there to be supportive. Independence is expressed in many ways. Developing meaningful structures that empower tenants helps to ensure long-term success.

Appendix I

Resources and Additional Readings

Arthur Anderson LLP et al. *Connecticut Supportive Housing Demonstration: Program Evaluation Report.* University of Pennsylvania Health System, Department of Psychiatry Center for Mental Health Policy and Services Research, Kay E. Sherwood TWR Consulting, Corporation for Supportive Housing, 2001.

This report provides an objective evaluation of the Statewide Connecticut Demonstration Program, which created nearly 300 units of supportive housing in nine developments across the state. The study determines whether stable housing reduces the need for expensive health and social services over time, enhances the quality of life for its residents and allows residents to attend to their employment and vocational needs. In addition, the study evaluates the financial stability of the projects participating in the program over a three-year period.

Carling, P. J. "Access to Housing: Cornerstone of the American Dream." Journal of Rehabilitation 6–8 (1989).

The focus of this article is a cross-disability perspective on such topics as promoting full community integration, responding to housing needs and preferences and practical steps to move this issue forward to a position of prominence on the national agenda. The author discusses these issues in the light of the Fair Housing Amendments Act of 1988.

Corporation for Supportive Housing. *An Introduction to Supportive Housing*. New York: Corporation for Supportive Housing, 1996.

This guide examines the problem of homelessness, provides a definition of supportive housing, and offers possible solutions to homelessness. The impact of supportive housing on communities and on the cycle of homelessness is described. Several specific case studies are presented, and supportive housing studies are reviewed.

Culhane, D. P., et al. "Public Service Reductions Associated with the Placement of Homeless People with Severe Mental Illness in Supportive Housing." Housing Policy Debate 13, no. 1 (2002): 107-163.

This article assesses the impact of public investment in supportive housing for homeless persons with severe mental disabilities. Data on 4,679 people placed in such housing in New York City between 1989 and 1998 were merged with data on the utilization of public shelters, public and private hospitals and correctional facilities. A series of matched controls who were homeless but not placed in housing were similarly tracked. Results reveal that persons placed in supportive housing experiences marked reduction in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated.

Hopper, K., and J. Hamburg. "The Making of America's Homeless: From Skid Row to New Poor, 1945-1984." Critical Perspectives on Housing, R. Bratt et al. (Eds.) Philadelphia, Penn.: Temple University Press, 1986.

This is one of earliest works in the historiography of the homelessness. Hopper and Hamberg trace policies and developments in the housing market and homelessness from the close of World War II through the early 1980s. The new homeless consist of a substantially higher proportion of African American and Latino people as well as women, children, and family groups. They are geographically more dispersed in urban areas than the skid row homeless had been; and they are more publicly visible. The authors also discuss how deinstitutionalization has resulted in a higher percentage of people with mental illness within the homeless population.

Houghton, T. *A Description and History of the New York/New York Agreement to House Homeless Mentally Ill Individuals*. New York: Corporation for Supportive Housing, 2001.

This document provides a description and history of the New York/New York Agreement, signed in 1990 by the city and state of New York.

Lenoir, G. T*he Network: Health, Housing and Integrated Services: Best Practices and Lessons Learned*. New York: Corporation for Supportive Housing, 2000.

This report summarizes the principles, policies, procedures, and practices used by housing and service providers that have proven to be effective in serving tenants where they live.

New York City Human Resources Administration Office of Health and Mental Health Services. *Summary Placement Report of the New York/New York Agreement to House Homeless Mentally Ill Individuals*. New York: HRA/OHMHS, 1997.

The 1990 New York/New York Agreement created a precedent-setting city/state program to provide housing and services for 5,225 homeless individuals into appropriate housing-plus-service settings. In its implementation, the agreement far exceeded its goals: As of September 30, 1997, a total of 8,370 individuals had been housed through it.

Proscio, T. *Forming an Effective Supportive Housing Consortium; Providing Services in Supportive Housing; and Developing and Managing Supportive Housing.* New York: Corporation for Supportive Housing, 2000.

These three related guidebooks are for those interested in forming local consortia and developing supportive housing projects. Forming an Effective Supportive Housing Consortium discusses the formation and management of the supportive housing consortium. Providing Services in Supportive Housing sets out the necessary building blocks for designing and organizing services in developments. Developing and Managing Supportive Housing provides information on designing, financing, building and managing housing for people who need ongoing services.

Proscio, T. *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness*. New York: Corporation for Supportive Housing, 2000.

This publication announces the results of research done between 1996 and 2000 on more than 250 people living at the Canon Kip Community House and the Lyric Hotel. It also looks at preoccupancy and postoccupancy use of emergency rooms and inpatient care.

Salit, S. A., et al. "Hospitalization Costs Associated with Homelessness in New York City." New England Journal of Medicine, 11 June 1998, 338 (4).

The study compares the length of stay in New York public hospitals of homeless and low-income patients in 1992 and 1993. Of nearly 19,000 homeless admissions, Salit found the following: Homeless patients stayed an average 36 percent longer than low-income patients with homes, and they cost an average of $2,414 more per admission; psychiatric patients accounted for 57 percent of extra hospital days among the homeless; one-third of homeless psychiatric patients average stays were 84 days conservatively; an extra cost per admission was $17,500; and nearly half of homeless medical hospitalizations were for conditions related to their living conditions and therefore preventable (respiratory disorders, skin infections, parasites/infections, and trauma). Salit estimates that the total preventable costs associated with homelessness for the New York City public hospital system are $100 million per year.

Shapiro, J. *Communities of the Alone*. New York: Association Press, 1971.

The author invites the reader to observe community life among SRO residents within the building and with the world outside the residence. The chapter Working with Single Room Occupants in the City discusses the complex social community that exists within the building and a lack of connection to the outside world. While some of the language and observations are dated, many of the insights offered are relevant today.

Sommer, H. *Homelessness in Urban America: A Review of the Literature*. Berkeley, Calif.: Urban Homelessness and Public Policy Solutions, 2001.

This report, prepared for a conference on urban homelessness, summarizes who is homeless, the causes of homelessness, and what this country has done to address it.

Stegman, M. *Housing in New York: Study of a City, 1984*. New York: New York City Department of Housing Preservation and Development, 1984.

This statistical and demographic profile study is a comprehensive analysis of New York City's housing stock, residential population, and many other housing-related issues and trends. The report estimates the vacancy rate for rental housing, reports on the supply and condition of housing, and documents the need for continuing the control and regulation of residential rents in New York City. The Report also presents and analyzes data regarding the City's overall population and the changing patterns of rents, household incomes, rent-to-income ratios, employment, and other characteristics of NYC's housing market.

Torrey, E. F. *Nowhere to Go: The Tragic Odyssey of the Homeless Mentally Ill*. New York: Harper and Row, 1971.

In his discussion of the situation of the homeless mentally ill, Torrey argues that the closing of mental hospitals and deinstitutionalization, the exodus of mental health workers into private practice, and the failure of community mental health centers have forced many severely mentally ill patients out on the streets.

U.S. Department of Health and Human Services and U.S. Department of Housing and Urban Development. *Report on Federal Efforts to Respond to the Shelter and Basic Living Needs of Chronically Mentally Ill Persons*. Washington, D.C.: Department of Housing and Urban Development, 1983.

This report discusses the number of chronically mentally ill persons who live in a variety of facilities, both institutional and community based. Highlighted is the need for a continuum of housing options for those who are chronically mentally ill. It concludes with recommendations for state government action and lists activities that HHS and HUD will undertake to assist states in the provision of housing and support services for this population.

U.S. Department of Health and Human Services. *Making a Difference: Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults*. Washington, D.C.: Office of Health and Human Services, 1994.

This five-site, four-year, 896-person survey examined the success of providing flexible support services combined with permanent housing to homeless people with severe mental illness, individuals "often seen as unreachable and difficult to serve." Results included a retention/success rate of 83.5 percent, a decrease in inpatient hospitalization, a decrease in emergency room visits by 50 percent, a decrease in incarcerations by 50 percent, and a decrease in symptoms of schizophrenia and depression.

Developing a Supportive Services Program

As the expertise of an architect is indispensable to the design of a building, the participation of an experienced social service provider is fundamental to the development of a supportive services program for housing. The early involvement of social service expertise can help to ensure the coordination of supportive services and property management and the compatibility of goals, physical design, and resources. This chapter provides a broad framework for designing a supportive services program.

Core Considerations

The development of a supportive services program that works with people where they live is a process that involves multiple levels of decisions in four major areas: the tenants, project goals, resources, and location/physical design of the housing.

Questions to consider include:

Tenants: Who will live in the housing? How will tenants be selected? What kinds of support services will be required for tenants with special needs or disabilities?

Goals: Are the short- and long-term goals of the program clearly defined? Are the goals of the program compatible with the mission of the organization and the needs and interest of the tenants? Is there agreement on broad goals among the funders, sponsoring organizations, and staff?

Resources: Does the organization that is sponsoring the housing have the capacity to develop and operate the supportive services program? Are there adequate resources to finance the operation of the program? What community-based services will be utilized? Will the sponsor operate alone or in partnership with other organizations that have complementary strengths?

Location and Physical Design: What strengths and weaknesses does the location of the housing present for tenants (e.g., transportation, safety, entertainment, shopping)? Will the staff be located on- or off-site? Are the goals of the program compatible with the housing's location, size, and living arrangements (e.g., unit size, meeting rooms, staff offices, and neighborhood resources and amenities)?

Tenants

Who is in the housing affects the types of services to be provided and the staffing pattern of the program. Mental illness, chemical dependency, and physical frailty, for example, each pose different sets of demands.

Tenants may also have more than one special need or disability, and conditions can change and vary considerably over time. A formerly homeless individual may require help to become medically and psychiatrically stabilized during his/her first year in supportive housing, but eventually may be interested in returning to work. To meet evolving needs, services in supportive housing have to be individualized, flexible, and adaptable. (For additional information about the various types of services that may be offered, see Appendix II, Services to be Provided Planning Worksheet, and Appendix III, Responding to Different Populations and Levels of Need.)

Increasingly, single-site supportive housing initiatives include a "mix" of tenants, as sponsors point to various social and economic benefits inherent in these designs. A project that mixes or integrates individuals with different abilities, backgrounds, needs, ages, income levels, and family sizes can ensure greater diversity in the housing environment. These projects also usually blend well with the surrounding neighborhood. Additionally, projects that house people with a range of needs can typically secure funding from a variety of sources, enriching the overall program and types of services offered.

Housing Preferences of Prospective Tenants

Location: The location of housing is usually one of the most important considerations for prospective tenants. Particular interests include proximity to transportation and shopping, family and friends, religious services, health and social services, and employment.

Living Arrangements: Most people prefer living accommodations with a private bath and kitchen. In shared living arrangements, the number of people sharing facilities must be reasonable.

Safety: Feeling safe in the housing and in the surrounding neighborhood is important to most people. To help ensure the safety of tenants, housing sponsors often include extra security features, such as 24-hour front desk coverage, intercom systems, security lighting, and surveillance cameras.

Services: Tenants want support services that are relevant to their needs and goals and may resent services that are unnecessarily invasive or mandatory. Requiring tenants to accept supportive services in permanent housing can also be difficult to enforce and in some localities may violate landlord/tenant law. The presentation of the program and the type of available services will greatly influence the use and overall success of the service program.

Curfew and Visitor Policy: Most tenants want the option to have guests and overnight visitors. Restrictive visitor policies and curfews need to be carefully evaluated. Tenants prefer to have control of their homes and lifestyles.

Goals

Project goals should be reflected in the operation and character of the housing and supportive services program. Goals should be compatible with the mission and philosophy of the sponsoring organization(s), although the need to achieve baseline goals in core operational components is universal and critical to success. A supportive housing initiative cannot be successful, for example, if the housing site is dirty and in disrepair, drug-infested, crime-ridden, and acutely understaffed.

Project goals should be translated into program goals that can be addressed within the day-to-day activities of the supportive services program. Well-defined program goals give focus and direction to the staff. A lack of clarity or agreement about goals can become a source of operational problems and tension. Goals should be clear and measurable to track achievements and evaluate ongoing performance. Programs can establish measurable performance goals in most areas, such as the following:

- Maintaining housing stability among tenants who were once homeless
- Increasing participation in job training and rates of employment
- Increasing participation rates in substance use and mental health treatment services
- Increasing the number of tenants who have annual physical exams

Staff roles and responsibilities flow from an agreement on goals. Programs that are not sufficiently goal-driven lack the rigor, teamwork, and satisfaction that come from working toward clear objectives. Goal establishment requires the ability to work together and to set new goals as the project evolves. (See Appendix IV, Project Goals and Conditions of Occupancy Planning Worksheet, for a tool to use in goal development.)

Resources

Sophisticated financing arrangements are often required to fund the acquisition, construction, and renovation of supportive housing. These usually include some combination of government grants, low-interest loans, tax credit programs, foundation grants, and private donations. Resources to support the ongoing operations of the project and to fund the supportive services program usually require sponsors to tap a variety of different sources as well. At a minimum, adequate resources must be identified to provide essential building services and to provide supportive services that meet the baseline requirements of special needs tenants.

To fund supportive services, organizations often blend a variety of federal, state, and local sources, making use of resources designated for people who are homeless, mentally ill, and/or living with HIV or other special needs. Medicaid reimbursement mechanisms are also used in some states. The U.S. Department of Housing and Urban Development's McKinney-Vento Homeless Assistance program and Housing Opportunities for Person's With AIDS (HOPWA) program have been vital resources in localities across the nation.

Supportive housing programs may have service staff located on-site or may have mobile case management programs or Assertive Community Treatment (ACT) teams linked to the housing. In all arrangements, the staff help to ensure that tenants make use of services and amenities in the community. Frequently, supportive housing programs have formal linkage agreements with other local organizations, such as drug and alcohol treatment programs, mental health clinics, and employment programs.

The extent of need among the tenancy has major implications for the level and type of supportive services that will be required. If a provider plans to serve a population with considerable service needs (e.g., formerly homeless people who are dually diagnosed with serious mental illness and HIV disease), funding must ensure a staff-to-tenant ratio that will allow for adequate levels of service. Some individuals may need considerable support to remain stable and meet the obligations of tenancy, while others need minimal assistance once stabilized. Some services can be staff intensive, such as escorting tenants to appointments, medication monitoring, and budgeting assistance. Insufficient staffing can result in crisis-driven programs with high levels of burnout and turnover. If funding is inadequate, both project and program goals may need to be revisited. At a minimum, it is important to be able to maintain relationships and contact with special needs tenants to identify and address issues as they occur.

Some organizations have the capacity and interest to do it all: develop housing, manage it, and provide supportive services to the tenants. Other organizations can capably perform one or two of these functions but are unfamiliar with administering all of them or simply choose not to assume responsibility for everything. Some service providers choose to collaborate with other entities to build or manage the housing. Similarly, some housing organizations engage experienced service agencies to operate the social services programs, intentionally separating housing and the delivery of social services. Increasingly, organizations are partnering because the collaborative effort allows them to match complementary resources and interests. (For more information on collaborations in supportive housing, see Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing by the Corporation for Supportive Housing.)

Location and Physical Design

The location and physical layout of the housing have important implications for the tenants and staff. Where tenants are located (single-site vs. scatter-site) and where the service staff is located (on-site vs. off-site) have significant bearing on the services to be offered.

Individual needs and preferences regarding living arrangements vary. A majority of supportive housing developed in urban areas for single individuals is in multiunit buildings where tenants either have their own self-contained living spaces or have their own rooms but share kitchens and/or baths. In general, self-contained units are preferred for permanent living arrangements, although sharing baths and/or kitchens may be the only option due to the housing stock or resource constraints.

The Importance of Community Support

The location of the supportive housing project introduces its own set of issues and circumstances, including a relationship with a local community. While it is preferable for tenants to feel at ease with their neighbors, community support is also often necessary to obtain the funding and government approval that may be required to open the project. This support is also helpful in the ongoing operation of the project and in obtaining future resources and assistance.

Wherever a project is located, getting community input at a timely and, in most cases, early stage in the planning process is important. Proactively gathering support for the housing initiative from the local community is usually a preferred strategy.

In managing opposition, providers should gauge the intensity of the opposition, understand the reasons behind it, and develop a plan to respond to or reduce the barriers. For example, the community may be more supportive in exchange for the promise of specific services such as 24-hour front desk staff and emergency coverage. Others may be interested in the general benefits that will be offered to the neighborhood by the supportive housing project, such as improvement of a blighted property and the availability of space for community meetings and events.

Scatter-site versus single-site projects pose different challenges. In scatter-site housing, it may sometimes be more difficult to work with people due to distance, time and other practical constraints. In single-site housing, the staff may have more frequent contact with tenants and natural opportunities for interaction and community-building efforts. On the other hand, scatter-site housing makes use of the available housing stock in the community. These initiatives may result in less community opposition than single-site projects, as they are often rentals and have a lower concentration of individuals with identified special needs. Preferably, service staff have access to private meeting space in either arrangement. Most single-site

projects offer some private meeting areas. In scatter-site projects, the staff usually visit tenants in their homes and may also provide services at a central location. Some of the specific program design considerations of single-site versus scatter-site projects are listed in the chart that follows.

Core Program Components

Although supportive services programs should be tailored to meet the needs of the tenants and goals of the housing initiative, most have common components. First, supportive housing sponsors must ensure that services are designed to help individuals meet the obligations of tenancy and, second, that the structure of the program maximizes the effective delivery of supportive services. The remainder of this chapter discusses these two broad program areas.

Cooking Facilities

Shared kitchens were a common feature of commercial Single Room Occupancy (SRO) hotels that were built in the first half of the twentieth century, as the design was sufficient for transients and allowed owners to maximize the number of residential units. Although many permanent supportive housing programs have shared cooking facilities, more recent trends have been toward private kitchenettes or kitchens. Shared facilities can be a source of conflict for tenants, and cleanliness can be difficult to maintain.

While meal programs may be a necessity for some settings, providing food service is time-consuming and costly. Most permanent supportive housing projects do not provide meals, although many have communal kitchens to prepare meals for special events.

Meeting the Obligations of Tenancy

A distinction of supportive housing programs is that they work with people "where they live". Helping tenants remain housed and meet occupancy requirements is usually of central importance. In this regard, components for staff to focus on include: tenant recruitment and selection, rent payment, lease compliance, maintaining an apartment or living space, and, if applicable, moving on from supportive housing. Each of these components is addressed below.

Tenant Selection: During the selection process, common considerations are a prospective tenant's housing and income history and the ability to maintain a safe dwelling unit and comply with lease and/or occupancy requirements. In general, the role of supportive services staff in recruiting and selecting tenants is to help determine if applicants can meet the obligations of tenancy with the supports available. (See Appendix V, Housing Skills and Supports Checklist.)

Prospective tenants usually have two interviews, one with property management and one with supportive services. In the supportive services interview, the service program is introduced and the applicant is asked about his/her service needs. Although the interview should be guided by standardized questions, discussion can also follow the information provided by the applicant. For example, reasons for repeatedly losing housing in the past might reveal that an individual has a history of gambling. In these cases, offering a representative payee arrangement or other type of support from the beginning can be important.

In supportive housing that serves people with disabilities, the interview and selection processes need to focus on whether the resources of the service program can accommodate an individual's disability. The

Program Design Considerations

Single Site	Scatter Site
■ Appropriate for individuals who want or need on-site support services.	■ Sometimes preferred by individuals who want maximum autonomy.
■ Services are usually stationed at the housing site, promoting increased access and contact between tenants and staff.	■ Services are not stationed on-site, and contact between the service staff and tenants must be arranged.
■ Peer support among tenants can occur readily, particularly if there is a variety of common spaces where people can gather.	■ Sponsors have to ensure that the locations of housing sites do not leave tenants feeling isolated or unsafe.
■ Can accommodate people who are independent or those who require higher levels of support.	■ Can accommodate individuals who are independent or those who require higher levels of support.
■ Siting may require community approval, although the sponsor usually owns and has ultimate control over the property, including building services and amenities.	■ Initial siting process may be easier than for a single-site project, although the permanence of the arrangement depends on the terms of the rental/master lease. The quality of the housing also varies widely.
■ 24-hour beeper coverage by service staff is usually necessary, as is around-the-clock front desk coverage, especially in some urban areas.	■ 24-hour beeper coverage by service staff is usually necessary.
■ Staff and tenants may have scheduled meetings and/or interact more casually, such as in common areas of the building.	■ Sponsors should identify whether services will be delivered in the home and/or off-site and under what conditions. Staff time for traveling between sites must be considered, and casual interactions may be less likely to occur.
■ Roles of social service and property management staff need to be clearly defined. Mechanisms need to be in place to effectively coordinate social services and property management functions.	■ Staff may have to coordinate with multiple landlords/property managers.
■ Office areas and the presence of staff members have the potential to create an institutional environment if not well designed.	■ Lack of staff presence on-site can make it harder to evaluate, monitor, and respond to difficult or complicated situations, such as substance abuse or unruly visitors.

process for determining whether accommodation can be made should be consistent for all applicants and in compliance with the Americans with Disabilities Act.

Sponsors should adhere to Fair Housing and state and local landlord/tenant laws and seek the advice of a qualified attorney to guide the development of criteria for selecting new tenants, if necessary. Clinical and treatment information should be obtained only with the applicant's consent. Given the legal and clinical challenges of tenant selection, service staff who are involved in the process should be seasoned and possess very strong assessment and interviewing skills.

Property Management and Supportive Services

Supportive housing sites vary regarding the structure and relationship of property management and supportive services staff. Often these functions are performed by the same organization and sometimes by separate organizations. In scatter-site housing, multiple landlords may be involved. In all cases, however, good relationships and a clear delineation of roles between property management and supportive services staffs are preferable.

Confidential information regarding individual tenants is provided to property management or others on a "need to know" basis and only with the consent of the individual. For example, in the interest of preserving the tenancy of an individual, service staff may want to tell the property management office that a tenant at risk of eviction has entered a treatment program. In sharing information, however, supportive housing programs must comply with local requirements and applicable federal regulations.

Rent Payment: Supportive housing tenants typically have very low incomes. Paying rent can be a challenge on a limited or fixed income, especially if unanticipated personal needs arise or a crisis occurs. Strategies to help ensure that the rent is paid range from representative payee arrangements to less intensive interventions such as budgeting assistance.

Service staff should be alerted by the rental office as soon as the first rent payment is overdue. Program protocols should be in place for preventing arrears from mounting. In many supportive housing projects, designated service staff members are sent copies of correspondence to tenants regarding late payment notices. Regular meetings between property management and supportive services staff should occur to develop coordinated action plans for individuals in arrears. In situations where back payments of rent are due, service and property management staff may need to meet with the tenant to develop a payment plan.

Complying with Lease/Occupancy Agreements and House Rules: Leases, occupancy agreements, and house rules describe expectations for behavior. In most settings, repeated violations are grounds for eviction. Examples of violations include nonpayment of rent, disruptive behavior, and repeated conflicts with other tenants. While these are problems that require the involvement of property management staff, supportive services staff must also focus on these behaviors and the underlying issues that put the individual's continued tenancy in jeopardy.

Developing House Rules

Following are guidelines to consider when developing house rules.

Purpose: Rules should have a clear purpose and intent that are understood by staff and tenants.

Enforceability: Rules are not effective if they cannot be enforced and/or are not enforced uniformly.

Simplicity: Too many rules are burdensome and make enforcement more difficult.

Legality: Rules have to be consistent with applicable federal, state, and local laws.

Input: Tenant participation in the development of house rules can provide useful input and help to ensure that rules will be incorporated into practice. (Non-negotiable rules should be made clear to tenants from the outset.)

Maintaining an Apartment or Living Space: For some tenants it is necessary to provide instruction about how to maintain their units. Individual premises may become a health or safety hazard due to a lack of cleaning or the accumulation of "stuff". Maintenance staff members who have access to housing units to make repairs can often identify potential problems early. Additionally, routine inspections for Section 8 recertifications as well as local inspection requirements provide opportunities to see how all tenants are doing and to identify those who need help. This information should be communicated to program staff routinely, and interventions should be timely. Typically, when problems occur, service staff members need to work with tenants to maintain their units or assist them to access homemaker or other needed services.

Moving On from Supportive Housing: Some tenants will be interested in moving on to other housing settings because they are ready for more independent housing and/or their lifestyle and needs change. For example, a tenant may want to relocate because he/she has a partner and they want to live together, or the tenant is advancing in his/her career and can afford a larger apartment.

Supportive services staff should help tenants evaluate their interest in or decision to relocate and help them arrange for any necessary supports in their new environment. While some tenants may independently make the decision to move from supportive housing, others will seek the advice and assistance of the supportive services program. In all cases, staff should be prepared to help individuals who want to relocate. This could entail identifying new living quarters, assisting in applying for Section 8 or other rental assistance, arranging for new community-based supports, and providing follow-up for a period of time in the new setting. Whatever the circumstances, the supportive services program should make every effort to ensure continued housing stability.

Structuring the Delivery of Services

Each of the following key program components is addressed below: staffing and supervision, case management, outreach and engagement, goal setting, access to community services, workshops and group activities, program policies and procedures, record keeping, and program evaluation.

Staffing and Supervision: Staffing patterns vary depending on the size of the supportive services program, the needs of the tenants, local requirements, and funding. Programs typically use a staff-to-tenant ratio of 1:10 to 1:30 per case manager or service coordinator. Some programs have "specialist" staff members in addition to case managers. Entitlements and health care specialists, vocational counselors, and community organizers, for instance, bring specialized skills to the team. For some tenants, specialist-staff members

may also be the initial or most frequent point of contact with the service program. (See Appendix VI, Sample Titles and Functions of Staffing Categories.)

Supportive services programs often have staff members present from morning until evening with some coverage on weekends. In single-site programs, there may also be 24-hour front desk coverage or equivalent overnight staffing, in addition to on-call availability of supervisory personnel. As necessary, staff schedules should be arranged to accommodate tenants who work and are at home during the evenings and weekends.

Working in supportive housing can be very demanding. Since much of the work in supportive housing is conducted by paraprofessionals, capable professional supervision is critical. In supportive housing programs where units are targeted for people with serious mental illness, HIV, or other special needs, it is preferable to have at least one professional staff person to provide supervision for every three to six paraprofessional staff members.

Paraprofessional staff should receive regular supervision from qualified professionals who can provide clinical insight and help them be effective in their relationships with tenants. The staff also needs guidance and support to manage the daily complexities of the work, such as when the actions of an individual are pitted against the interests of the larger building community (e.g., relapse to substance use, psychotic behaviors, and hygiene problems). Staff supervision should include:

Education: teaching knowledge and skills

Support: recognizing successes and assisting with challenges

Accountability: ensuring that all individuals are receiving the services they need and the program is in compliance with all contractual and regulatory obligations

Case Management: Case management is fundamental to the design of a supportive services program. Although the definition of case management varies throughout the nation, case managers usually work to ensure that their tenants receive all the services they need. Depending upon the setting, case managers may coordinate the complete array of medical, psychological, and social services used by tenants. By developing working relationships with various systems of care and by advocating for individuals when necessary, case managers help to ensure that tenants are receiving optimum levels of services. Case managers in supportive housing often provide direct services as well, including outreach and engagement, individual support and counseling, crisis management, medication monitoring, and independent-living skills training.

Outreach and Engagement: Engagement is a process, not an event. When a staff member begins a relationship with a tenant, the first order of business is to look for a way of working together. This usually involves a series of interactions, meetings, and shared experiences over time. The length of time it takes to establish a working relationship varies with each individual, his/her circumstances, and the actions of the staff person. Indeed, the wrong outreach strategy can cause some individuals to reject services, at least temporarily, creating strained and potentially problematic scenarios.

One of the difficult aspects of engaging tenants in services is that the approach a staff member uses for one tenant may not be effective with another. Some tenants may welcome home care services, medication monitoring, or a daily visit from a case manager. Others may not want to be identified as using the service program. In other words, a staff member may readily knock on the door of one tenant but be sent away by another who finds the same inquiry invasive. Programs need clear policies and operating procedures for guiding staff interaction with tenants. Although effective outreach and engagement is often dependent on individual skills and relationships, programs need to define the levels of assertiveness that staff people

should have in their efforts to be helpful. Programs that emphasize choice and independence must grapple with the issues and possible consequences posed by tenants who reject or remain only loosely affiliated with the supportive services program.

Gaining an individual's trust takes time, and staff members may be unable to gain some tenants' confidence despite months of outreach efforts. The extent to which an individual is willing to work with staff can evolve and change, however. Each staff person should try to establish an atmosphere of acceptance and trust by defining oneself in purpose and deed as a listener and helper.

Staff turnover can also make engagement more difficult. When a valued relationship between a staff member and a tenant ends, engagement efforts by new staff may not be as warmly welcomed. In fact, excessive turnover can cause fundamental problems because tenants distrust temporary relationships with staff and become reluctant to bond and share information. Programs can anticipate and ease the transition of staff departures by using a team approach, which helps to ensure that tenants have relationships with more than one staff member.

Engagement and Assessment

When meeting someone new, some behaviors make you feel comfortable and more receptive to talking and others make you less receptive:

More receptive...	**Less receptive...**
• Is open to your opinions	• Pushes a point of view
• Listens to you	• Gives one opinion after another
• Makes eye contact	• Displays body language of disinterest
• Responds to you	• Answers phone during a meeting
• Focuses on your needs	• Has own agenda in forefront

During the engagement process, a staff person should try to maintain a broad focus and assess the following about the tenant:

Openness: Determine the level of interest the individual has in talking about him/herself, including topics such as family and social life, background and education, employment history, and health and mental health issues. Understand the elements that influence an individual's lifestyle.

Satisfaction with Current Circumstances: Explore the individual's satisfaction and dissatisfaction with current circumstances, such as housing and home life, social life, health and mental health supports, and employment status. Understand likes and dislikes, intensity of feelings, success and failure to make changes.

Perspectives: Listen to opinions, perspectives, underlying values, preferences, cultural influences/interests, and methods for making decisions and choices.

Goals and Interests: Understand specific goals and aspirations the individual has and the things that he/she would like to obtain.

The engagement process can become the forum to develop a "contract" with the tenant that defines the goals and expectations of working together. As needs change, the contract changes. Relationships with tenants are most productive when the terms and expectations are made clear and everyone is working with a shared understanding and toward a common set of goals.

Setting Individualized Goals: The role of supportive services staff is to work in partnership with the tenant to achieve his/her goals. Goals should be driven by the tenant and related to what he/she wants; otherwise, there is no internal motivation and goals are unlikely to be achieved. Individuals can mistakenly be labeled as "resistant" and "in denial" if they are not interested in the goals that staff set for them.

Goals are desired outcomes, and objectives are the stepping-stones required to achieve goals. Setting objectives is important because small, measurable steps can help tenants and staff see their progress. Aspirations, such as employment, may have a series of goals and corresponding objectives that must be achieved to obtain the ultimate desired outcome. Progress toward goals can be tracked in an individual service plan that is reviewed and updated on a regular basis.

Goals vary widely, and staff members sometimes get frustrated when tenants identify goals that staff members view as unattainable or unrealistic. However, goals that may seem unachievable often require similar steps or objectives as those that staff would have set. Objectives to meet long-term goals, for instance, may include saving money, getting new clothes, attending a class, using mental health services, or participating in a self-help group such as Alcoholics Anonymous. When an objective or goal is not achieved, staff has an opportunity to explore what the obstacles are, thereby opening the door for further discussion.

Helping tenants to set goals involves:

- Exploration and listening
- Achievable steps that allow for successes
- A realistic time frame
- Positive reinforcement
- A re-examination of goals that are not achieved, placing fault with the goal and not the individual

Access to Community-Based Services: Supportive housing service programs have to determine which services are to be provided by program staff and which are to be obtained in the community. Since a common goal of supportive housing programs is to facilitate the integration of tenants into the community, the use of community-based services is preferred whenever possible. Usually, the level of support that tenants receive is determined by the availability of services elsewhere and the opportunities that supportive housing providers have to create new services. In any event, programs should maintain a centralized directory of contacts and organizations as well as access to published directories of medical, social service, and other community-based organizations.

Groups, Classes, Workshops, and Special Events: Activities that bring tenants together and promote the development of relationships and mutual aid are important. Working with people in groups is also an efficient method for providing a service or teaching a skill, in contrast to reaching only one person at a time. Classes and workshops are usually popular and provide opportunities to learn new information and skills on topics such as cooking, yoga, nutrition, and job interviewing. Classes and workshops are excellent vehicles to involve diverse groups, and they can be adapted to a wide range of interests and abilities. These types of activities are usually time-limited and often involve guest lecturers and instructors. Tenants may be required to register for workshops in advance and, in some cases, make a nominal payment to ensure

commitment. Special events such as poetry readings and lectures can also be of interest and provide opportunities to engage tenants who might not otherwise participate in the program.

Groups that focus solely on support can be very useful but difficult to sustain. Understandably, participants can be uncomfortable sharing personal information with their neighbors. It can also be a challenge to identify topics that will be of interest to significant numbers of tenants. Support groups should have a specific purpose and be facilitated by staff with strong interpersonal and group skills.

Case Records: Programs are often required to maintain case records or "charts" that document the work with all individuals who are receiving support or are designated to receive services. Case records are useful tools for recording and transmitting information and for documenting progress toward goals. Requirements vary regarding the amount and type of information that must be documented and how frequently progress notes and service plans should be recorded. Most important, however, is that case records remain current. Programs may also choose or be required to keep track of prescribed medications, physicals, hospitalizations, and collateral contacts with other community services. Computerized record-keeping systems lessen the burden of updating and storing paper records, and they can provide the service organization with comprehensive information about service utilization.

Documentation is important for many reasons:

- Records help with planning and monitoring progress toward goals
- A well-organized record keeping system provides quick access to important information
- Writing progress notes and service plans can help staff to think more clearly about the work that is being done
- Records assist with continuity of service when there is a change in staff
- Supervisors can use records as a tool to monitor and support the work of staff members
- Records can document accomplishments and areas that need improvement
- Records can reveal patterns of effective and ineffective interventions and support
- Records can serve to document that regulatory requirements and agency policies are being met

To release or receive tenant information to or from other organizations requires permission and signed consent from the tenant. Programs are expected to operate in accordance with federal, state, and local guidelines and statutes for sharing confidential information. Failure to adequately protect the privacy of medical, psychiatric, and substance use treatment and other confidential information is a breach of professional ethics and can be subject to legal action.

Case Records

While the extensiveness of case records varies widely with the composition of the tenancy and funder requirements, the following is a sample format with recommendations for the frequency of recording.

Identifying information

- Face sheet with emergency contacts (updated yearly or as circumstances change)

Consent forms/Release of information

- Consent forms (updated every six months or document attempts to obtain signature)

Assessments

- Psychosocial assessment (within first month and annually thereafter)
- Mental status exam
- Substance-use assessment

Service plan

- Comprehensive individual service plan (within first month)
- Service plan review (updated every six months)

Progress notes (usually weekly to monthly)

- Notes reflect progress relative to service plan goals and objectives
- Records date, purpose, signature, and title of worker, setting of service, and any collaterals contacted

Documentation of service participation

- Identifies types of activities used (updated monthly)
- Summarizes attendance at activities and contacts with service staff (updated monthly)
- Documents community-based services used with contact name, address, and phone number

Medical, mental health, and substance use

- General health assessment, including notes on changes in health status
- Medical documents and exams (updated annually)
- Medication regimen forms (updated as medications change)
- Monthly medication log (when medications are monitored)
- Mental health and substance-abuse treatment records

Vocational/Educational

- Vocational assessment
- Career plans
- Employment and educational history
- Military records

Income

- Current income verification (updated annually or with changes in income)
- Entitlements and other benefits received

Miscellaneous

- Incident reports, critical events (such as arrests), discharge summaries, important correspondence, and rent arrears notices

Program Policies and Procedures: A policy and procedures manual provides important support and guidance for staff, and every supportive housing program should have documented policies and procedures that are clearly written and comprehensible to all program staff. Program policies and procedures should describe who does what and when (or how often), how it is done (such as in writing or in a meeting), and what resources to use (such as staff on call).

Having policies and procedures helps programs ensure consistent and predictable responses to important events. At a minimum, policies and procedures should outline the performance of critical functions such as emergency on-call systems, fire safety procedures, and responses to crises. Policies and procedures should also be periodically reviewed and revised throughout the evolution of a program. (See chapter 7, Crisis and Conflict, for more on this subject and sample program policies and procedures.)

Program Evaluation: In recent years there has been a greater emphasis on goal attainment and outcome-based services. Some benefits to conducting outcome evaluations are:

- Focusing efforts on getting things done and improving the program
- Measuring consumer satisfaction
- Analyzing the delivery of services
- Improving cost-effectiveness
- Identifying and establishing new program goals

Ideally, programs evaluate the outcomes of their services on a routine basis and incorporate changes based on this information. In practice, however, programs are not always able to devote consistent time and energy to program evaluation. Symptoms of a program that is probably due for an evaluation are:

- Consistent complaints from tenants or property management staff
- Low participation rates in the service program
- High staff-turnover rates
- Frequent crises

Program evaluations vary in size and sophistication, although it is best for the sponsoring organization(s) to understand as much as possible about the effectiveness of the program. Asking tenants for feedback and conducting consumer satisfaction surveys and focus groups can be helpful. Program strengths and weaknesses can also be determined through a review of service utilization patterns. Feedback from other organizations that work with the supportive services program can be useful as well. (See Appendix VII, Standards for Supportive Services Programs, which can be used as an aid in program evaluation.)

If a program does not collect information about the services it provides in a thoughtful and consistent manner, it is less able to respond quickly and appropriately to important patterns and trends that might not otherwise be evident. A genuine interest in obtaining feedback and knowledge about the service program is, perhaps, the most important element to ensuring that evaluations of the program occur as often as they should. Advancements in computer technology and software continue to make the task of collecting and analyzing data easier.

Appendix I

Resources and Additional Readings

Amherst H. Wilder Foundation. *Strategic Planning Workbook for Nonprofit Organizations*. St. Paul, Minn.: Amherst H. Wilder Foundation, 1998.

Resource manual with worksheets and strategies designed to enable nonprofits to guide staff in making everyday choices. Samples of actual strategic plans are included along with tips for implementing and updating current plans.

Association for the Help of Retarded Children, Center for Urban Community Services, Rubicon Corporation. *Supportive Housing for Individuals with Disabilities: Developing Generic Long-term Residential Options. New York: Association for the Help of Retarded Children*, 2000.

This manual is designed to assist social service organizations in developing supportive housing. Of particular interest to providers in the first year of opening a residence will be the chapter outlining operational issues in housing.

Barnes, K. *A Time to Build Up*. New York: Corporation for Supportive Housing, 1998.

This is an account of the lessons learned from a demonstration project aimed at helping agencies build organizational infrastructures so they are better able to plan, develop, and maintain housing with services for people with special needs.

Blake, J. *The Times Square: A Case Study in Successful Supportive Housing*. New York: Development Training Institute, Inc., 1997.

This publication looks at the development and operation of a large and innovative supportive housing project in New York City. It discusses predevelopment and siting issues, financing, creation of a community, economic development initiatives, and the day-to-day operations of the project, including service provision.

Carling, P. "Supported Housing: An Evaluation Agenda." Psychosocial Rehabilitation Journal 13, no. 4 (1990): 95–104.

This article describes some dilemmas involved in evaluating supported housing programs and presents a systematic strategy for designing evaluation studies of supported housing.

Center for Mental Health Services. *Creating Housing and Supports for People Who Have Serious Mental Illnesses*. Rockville, Md.: Center for Mental Health Services, 1994.

This monograph provides a historical perspective and offers practical advice on developing supportive housing for people with mental illnesses. Topics include supportive services, tenant selection, lease compliance, basic financing, and mechanisms for coordination.

Cogswell, S., et al.. *Sourcebook on Program Evaluation Technique*. Columbus, Ohio: Department of Mental Health, 1986.

This manual contains research evaluation designs, methods, and instruments developed by federally funded community mental health centers in Ohio. Content areas covered include availability, accessibility, acceptability, and awareness; patterns of use; outcome evaluation; cost-outcome analysis; and research dissemination.

Cohen, C., et al. *Sustaining Strong Communities in a World of Devolution: Empowerment-based Social Services in Housing Settings*. Bronx, N.Y.: Phipps Housing, 1999.

This paper is based on studies of Phipps House and its Community Development Corporation in the South Bronx. The paper focuses on the integration of social services in housing and explores how the devolution of the welfare state has affected the manner in which social services need to be conceptualized and delivered.

Culhane, D. P., et al. (1999). "Making Homelessness Programs Accountable to Consumers, Funders, and the Public. Practical Lessons: The 1998 Symposium on Homelessness Research." Washington: US Department of Housing and Urban Development and US Department of Health and Human Services, 1999.

This paper discusses how different types of performance measurement can be used to improve the accountability of homeless program. A distinction is made between the kinds of data used in formal research projects and data that can be practically obtained in a practice setting. Consumer outcomes are discussed in terms of accountability to consumers, program outcomes in terms of accountability to funders, and systems outcomes in terms of accountability to the public. If performance effectiveness is determined by appropriate measures of consumer need, services delivered, and outcomes attained, policy makers and practitioners can gain important insight into what policies have the greatest impact on homelessness and what practices serve homeless people the most effectively.

Gran Sultan Associates and the Corporation for Supportive Housing. *Design Manual for Service Enriched Single Room Occupancy Residences*. New York: Corporation for Supportive Housing, 1994.

This manual was developed to illustrate an adaptable prototype for SRO residences for people with chronic mental illness. Included are eight prototype building designs; recommendations on materials, finishes, and building systems; and other information of interest to supportive housing providers, architects, and funders.

Hough, R., et al. "Supported Independent Housing: Implementation Issues and Solutions in the San Diego Project." San Diego, Calif.: Gordon and Breach Science Publishers, 1996.

The paper provides a description of the San Diego McKinney Demonstration project and the implementation issues that were encountered, including the diverse agendas of the collaborating agencies.

Knapp, M. "Methodological Issues in Evaluating Integrated Services Initiatives." New Directions for Evaluation 69 (1996): 21–33.

This article explores the conceptualization and design of studies that evaluate integrated services initiatives. The article also examines special problems posed by integrated services for evaluators. The author suggests approaches for further evaluation of how these initiatives work and discusses what they are accomplishing.

Law Offices of Goldfarb and Lipman. *Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing: California Edition*. New York: Corporation for Supportive Housing, 2000.

This manual offers information about the laws that pertain to supportive housing and approaches to resolving common dilemmas.

McLean, A. *The Role of Consumers in Mental Health Services Research and Evaluation: A Report and Concept Paper*. Rockville, Md.: Community Support Program, Center for Mental Health Services, 1994.

In late 1988, the Community Support Program, which is now part of the Center of Mental Health Services), began funding thirteen consumer-run service demonstration projects. This report provides information concerning the role of consumers in research and evaluation.

McNamara, C. *Basic Guide to Program Evaluation*. St. Paul, Minn.: The Management Assistance Program for Nonprofits, 1998.

This guide provides a discussion of the hows and whys of program evaluation, including detailed descriptions of different evaluation methods, reporting strategies, pitfalls to avoid, and a discussion of who should carry out the evaluation.

Mize, T., et al. "Managing the Landlord Role: How Can One Agency Provide Both Rehabilitation Services and Housing with Collaboration?" Psychiatric Rehabilitation Journal 22, no. 2 (1998): 117–122.

This article emphasizes the importance of understanding and differentiating between the roles and responsibilities of tenant, landlord, consumer, and worker. The focus is on the provision of relevant services and not using housing as a lever to force compliance with treatment.

Reynolds, S., and L. Hamburger. *Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing*. New York: Corporation for Supportive Housing, 1997.

This manual is a guide to creating successful collaborations between two or more organizations in order to effectively fill the varied roles in supportive housing development and operations. It provides useful worksheets and sample legal documents on disk.

Sullivan, F. *Evaluation and Public Policy*. Cambridge, U.K.: Cambridge University Press, 1996.

The author describes the information needs and interests of the public policy community and the importance of the political process in enhancing mental health programs. The role of outcome data is discussed. The complexity of systems of care in the context of multiple levels of government and multiple sources of support for services is described.

United Way of America. *Measuring Program Outcomes: A Practical Approach*. Alexandria, Va.: United Way, 1996.

This manual offers a step-by-step guide to measuring outcomes. Topics include getting ready, choosing outcomes, specifying indicators for your outcomes, preparing to collect data, trying out your system, analyzing and reporting your findings, improving your system, and using your findings.

Internet Sites

Center for Urban Community Services

http://www.cucs.org

The Center for Urban Community Services (CUCS) provides a continuum of supportive services for homeless and formerly homeless people, including street outreach, a drop-in center, transitional and permanent housing programs, and vocational and educational programs. This web site provides information and links to resources regarding transitional and permanent housing.

Corporation for Supportive Housing

http://www.csh.org

CSH's mission is to help communities create permanent housing with services to prevent and end homelessness. CSH works through collaborations with private, nonprofit and government partners, and strives to address the needs of tenants of supportive housing. CSH's website includes a Resource Library with downloadable reports, studies, guides and manuals aimed at developing new and better supportive housing; policy and advocacy updates; and a calendar of events.

National Alliance to End Homelessness

http://www.naeh.org

The National Alliance to End Homelessness (NAEH), a nationwide federation of public, private, and nonprofit organizations, demonstrates that homelessness can be ended. NAEH offers facts on homelessness, affordable housing, roots of homelessness, and best practices. Publications, resources, and links to private and public agencies that address homelessness can be found on this site.

National Low Income Housing Coalition

http://www.nlihc.org

The National Low Income Housing Coalition (NLIHC) publishes reports and has resources related to low-income housing. NLIHC educates, organizes, and advocates to ensure decent affordable housing. NLIHC provides information and formulates policy on housing needs and strategies for solutions.

National Resource Center on Homelessness and Mental Illness

http://www.prainc.com/nrc

The National Resource Center on Homelessness and Mental Illness provides technical assistance, identifies and synthesizes knowledge, and disseminates information. Users can be linked to findings from federal demonstration and Knowledge Development and Application (KDA) projects, research on homelessness and mental illness, and information on federal projects.

Wilder Foundation

http://www.wilder.org

This web site offers practical guidance for nonprofit agencies, including information on affordable housing, collaborating with partners, and community building.

Appendix II

Services to be Provided Planning Worksheet

This worksheet can be used in planning the specific services to be offered by your supportive housing project. Indicate which services will be available, whether they will be provided on-site or off-site, and who will provide the services.

	✓	On-site	Off-site
1. General Supportive Services		**Who Provides?**	
a. New tenant orientation/move-in assistance	❑		
b. Case management or service coordination	❑		
c. Psychosocial assessment	❑		
d. Individual service planning/goal setting	❑		
e. Individual counseling	❑		
f. Crisis intervention	❑		
g. Grief counseling	❑		
h. Domestic violence intervention	❑		
i. Peer counseling/mentoring	❑		
j. Self-help groups (AA/NA)	❑		
k. Support groups/classes/workshops (list below)	❑		
l. Tenants' rights education/tenants' council	❑		
m. Leadership development	❑		
n. Recreational/socialization opportunities	❑		
o. Legal assistance	❑		
p. Transportation	❑		
q. Nutritional services	❑		
r. Meals	❑		
s. Emergency financial assistance	❑		
t. Food pantry			
u. Other (specify): _____			
_____			

	✓	On-site	Off-site
2. Vocational Services		**Who Provides?**	
a. Job skills training/education	❑		
b. Vocational/career assessment and counseling	❑		
c. Computer classes/training	❑		
d. Job readiness training–resumes, interviewing skills	❑		
e. Job retention services–support, coaching	❑		
f. Job development/job placement services	❑		
g. Transitional employment	❑		
h. On-site employment (describe)	❑		
i. Opportunities for tenants to volunteer	❑		
j. Other vocational services (specify): _____			
_____	❑		
_____			

3. Independent Living Skills

	✓	On-site	Off-site
		Who Provides?	
a. Rent payment and other financial management	❑		
b. Conflict resolution/mediation training	❑		
c. Credit/debt counseling	❑		
d. Money management/representative payee	❑		
e. Entitlement assistance/benefits counseling	❑		
f. Training in cooking/meal preparation	❑		
g. Training in personal hygiene and self-care	❑		
h. Training in housekeeping and apartment safety	❑		
i. Training in use of public transportation	❑		
j. Training in personal and household safety	❑		
k. Other (specify): _____	❑		
_____			
_____			

4. Health/Medical Services

	✓	On-site	Off-site
		Who Provides?	
a. Routine medical care	❑		
b. Medication management or monitoring	❑		
c. Health and wellness education	❑		
d. Family planning	❑		
e. Vision	❑		
f. Dental	❑		
g. Nutrition counseling	❑		
h. Nursing/visiting nurse care	❑		
i. Home health aide services/personal care services	❑		
j. Safe sex education	❑		
k. HIV/AIDS services (specify): _____	❑		
l. Other (specify): _____	❑		
_____			

	✓	On-site	Off-site
5. Mental Health Services		**Who Provides?**	
a. Psychosocial assessment/mental status exam	❑		
b. Individual counseling	❑		
c. Group therapy	❑		
d. Support groups (specify below)	❑		
e. Peer mentoring/support	❑		
f. Medication management/monitoring	❑		
g. Education about mental illness	❑		
h. Education about psychotropic medication	❑		
i. Psychiatric services (specify below)	❑		
j. Clubhouse	❑		
k. Mental health clinic	❑		
l. Day treatment program	❑		
m. Psychiatrist	❑		
n. Psychiatric nurse	❑		
o. Other (describe): _____	❑		
_____			
_____			

	✓	On-site	Off-site
6. Substance-Abuse Services		**Who Provides?**	
a. Recovery readiness services	❑		
b. Relapse prevention and recovery planning	❑		
c. Substance-abuse counseling (individual)	❑		
d. Substance-abuse counseling (group)	❑		
e. Methadone maintenance	❑		
f. Harm reduction services	❑		
g. Detoxification service	❑		
h. Inpatient rehabilitation	❑		
i. AA/NA/CA	❑		
j. Sober recreational activities	❑		
k. Other (specify): _____	❑		
_____			
_____			

Appendix III

Responding to Different Populations and Levels of Need

Supportive housing can accommodate a wide range of individual needs. Following is a brief overview of some of the different groups housed and their service needs. For information on mental illness, substance use and HIV, see chapters 4, 5, and 6.

Homelessness: Homeless people are often shuffled from one shelter or service program to the next. The transition from the streets or shelters usually requires significant adjustments in routine and lifestyle. Similarly, homeless people often lose contact with their families and friends. Making new friends, paying rent, and becoming familiar with a new neighborhood are only a few of the many adjustments that most individuals will have to make. Some people who have been homeless for extended periods of time may have developed behaviors that served them well on the streets but are no longer necessary now that they have moved inside. Examples of such behaviors may include the hoarding of items or failing to bathe as often as necessary.

The staff may need to help tenants who were homeless make the transition from homelessness to housing. Usually, it is useful to begin by helping orient people to their new home and neighborhood. Staff should make information available about stores and services in the area and help tenants develop new routines. The extent to which tenants may also need training and/or assistance with cooking, cleaning, laundry, using household appliances, and paying rent and other bills will become clear with time. The staff should be attentive and help provide easy access to any needed support services. Being sensitive to the enormous disruption experienced by people when they move into housing after being homeless is critical to the individual making a successful adjustment to being a new tenant.

It is important for the staff to understand the reasons why people acquire certain behaviors when they are homeless. In one supportive housing program, a formerly homeless tenant with mental illness continued to panhandle in familiar haunts even though he did not need to. The panhandling continued because it was a familiar routine and filled a primary need he had to interact with other people, which he enjoyed. The predictable social interaction of panhandling, with its limited variations and outcomes, was a reassuring activity he had fully mastered. Staff members responded by discouraging the panhandling and offering him the opportunity to choose from other activities, including vocational training for a retail position requiring many of the same skills used in panhandling. Some localities have outreach teams or case managers working to get housing for homeless people who will work with service staff to help ensure a smooth transition.

Physical Disabilities: Depending on the severity of the physical disability and the circumstance of the individual tenant, varying levels of support can be required. Not all people require assistance. Some may need assistance with activities of daily living and maintaining their apartments. Accommodations will vary depending on the type of disability. Standard accommodations should include wheelchair-accessible entrances, living areas, common spaces, and showers. For a blind person, for instance, staff efforts may include helping a tenant adjust to a new appliance or device and working with specialized services for guidance and support. Usually, the goal of staff support is to assist the individual with a particular task or to acquire an accommodation to help maximize independence. Some localities have home health aides or care attendants who are assigned to help eligible individuals with daily chores and activities of daily living.

Older Adults: Older adults will present a variety of needs to supportive services staff. Some will be healthy, active, and looking for ways to stay productive and involved. Others will have medical problems

and will need assistance navigating health care services and systems. Inadequate medical care, dental care, and a range of miscellaneous unmet needs are common. Staff may need to help individuals with issues of death and dying, which can cause depression and stress.

Specialized services and support groups for older adults may be available in the local community. Additionally, intergenerational groups and activities are effective ways to maintain a lively, positive environment for older adults. These may include organized trips to concerts and plays, political advocacy actions on issues, and workshops about health and nutrition. Tenants may be interested in volunteer work in or outside the residence. Support groups addressing issues related to aging are often highly valued by older tenants.

Young Adults: Providers who work with 18- to 25-year-olds will testify that it is a challenging, yet rewarding group. Support and one-on-one mentoring are key in assisting young adults to develop the independence necessary to function as adults. In particular, those coming from foster care may need extra assistance in developing independent living skills, accessing resources, and developing a support network.

Supportive housing staff must balance the provision of assistance with opportunities for encouraging and developing independence. Many basic tasks associated with maintaining a household, like paying rent or cooking, will be completely new to many young tenants. An emphasis on educational and vocational activities is particularly important. Service programs usually need to focus on the high-risk behavior that occurs during this life stage by providing educational programs on safe sex and counseling on drug and alcohol use. Finally, helping young adults become engaged in healthy and productive activities should be a part of the supportive services program.

Family Support: Although this guide focuses on housing and services for single adults, settings that are designed for single individuals must also consider family issues. A parent may want to be reunited with children who have been in foster care, for instance, or a formerly homeless individual may be ready to visit his/her family after a long period of separation. Additionally, providers are increasingly mixing families and single people as they develop new projects. Providing individuals with the services and support to maintain or re-establish healthy relationships with significant others is a feature of many supportive housing programs. Teaching communication skills can help tenants build these relationships. If children are involved, assistance in accessing day care, school, camps, youth employment, and tutoring or homework help is often required.

Appendix IV

Project Goals and Conditions of Occupancy Planning Worksheet

A. Project Goals	✓	Rank: High, Medium, or Low	How Measured?
1. Provide safe, affordable housing	❑		
2. Offer a permanent housing option	❑		
3. Ensure tenants meet lease obligations	❑		
4. Transition residents into less service-intensive housing options	❑		
5. Transition residents into unserviced housing in the community	❑		
6. Increase housing stability	❑		
7. Improve residents' daily living skills	❑		
8. Increase residents' income	❑		
9. Increase access to employment opportunities	❑		
10. Begin recovery from substance abuse	❑		
11. Maintain recovery from substance abuse	❑		
12. Reduce harm experienced due to substance use	❑		
13. Begin recovery from mental illness	❑		
14. Maintain recovery from mental illness	❑		
15. Promote family reunification	❑		
16. Prevent foster care placement of children	❑		
17. Increase support systems	❑		
18. Improve physical health	❑		
19. Promote adherence to prescribed medical and medication regimens	❑		
20. Promote the use of community-based services	❑		
21. Decrease use of crisis/emergency services	❑		
22. Decrease criminal justice system involvement	❑		
23. Other (specify) _____ _____ _____ _____	❑		

Conditions of Occupancy	✓	Notes
B. Lease		
1. Lease term of one year or more	❑	
2. No lease	❑	
3. Program agreement	❑	
4. Other (specify) _____ _____ _____	❑	
C. Length-of-stay restrictions		
1. There will be no limitations on length of stay as long as tenant is in compliance with the lease	❑	
2. Person will be urged, but not required, to move on after a defined period (specify period)	❑	
3. Person will be required to vacate unit at defined period of time (specify period)	❑	
4. Other (specify) _____ _____ _____	❑	
D. Anticipated average length of stay in the housing regardless of any restrictions		
1. Six months to one year	❑	
2. One to two years	❑	
3. Two to three years	❑	
4. Three to five years	❑	
5. More than five years	❑	
E. Sharing of units		
1. Each individual/family to have own apartment	❑	
2. Each individual/family to have own bedroom, but will share kitchen and bath with other individuals/families	❑	
3. Each individual/family to have own bedroom and bath, but will share kitchen with others	❑	
4. Each individual/family to have own bedroom and kitchen, but will share bath with others	❑	
5. Residents will share bedrooms, kitchen, and bath	❑	
6. Other (specify) _____ _____	❑	

Conditions of Occupancy	✓	Notes
F. Participation in services		
1. Participation in services will not be a condition of residency	❑	
2. Resident will be required to participate in services in order to receive certain benefits in the residence (specify)	❑	
3. Resident will be required to participate in services as a condition of occupancy	❑	
4. Resident will be required to participate in services under certain circumstances (specify) _____ _____ _____	❑	
G. Sobriety requirement in lease/house rules		
1. Alcohol and drug use to be prohibited or restricted on premises	❑	
2."Dry" housing–alcohol and drug use (on and off premises) will not be allowed	❑	
3. Alcohol permitted on site but illegal drug use not tolerated	❑	
4. Alcohol prohibited in common areas but not in private units; illegal drug use prohibited	❑	
5. Alcohol and drug usage will not be addressed in the lease or house rules	❑	
6. Other (specify) _____ _____ _____	❑	
H. Resident/tenant involvement		
1. Resident participation in program management not anticipated	❑	
2. Tenant council or resident association, which advises program and/or housing management, will be established	❑	
3. Residents will be involved in decisions such as house rules, intake and screening, services planning, and program development	❑	
4. Other (specify) _____ _____ _____	❑	

Appendix V

Housing Skills and Supports Checklist

The following skills are necessary, in varying degrees depending upon the housing model, for living in the community. This checklist can be used by staff to assess housing support needs. Use checks to represent the level of assistance needed.

✔ = Almost never needs assistance
✔✔ = Sometimes needs assistance
✔✔✔ = Almost always needs assistance

❑ ❑ ❑ Money management skills and ability to pay rent (keep up with entitlement/benefits paperwork, cash checks, budget)

❑ ❑ ❑ Ability to follow house rules (refrain from violence, keep noise down during hours of sleep, refrain from criminal activity, wear appropriate clothing in common spaces)

❑ ❑ ❑ Housekeeping skills (able to clean space, wash sheets, remove garbage regularly, keep out mice and insects, remove excess clutter, maintain plumbing [remove hairs from drain, keep large items out of toilet])

❑ ❑ ❑ Personal care skills (washing clothes, buying and using toiletries, dress appropriate to weather, bathing)

❑ ❑ ❑ Travel skills (use public transportation, follow directions)

❑ ❑ ❑ Shopping and cooking skills (able to obtain meals by buying or cooking food, store food properly)

❑ ❑ ❑ Social skills (sensitivity to and respect for the needs and rights of others, conflict management skills, ability to maintain positive relationships)

❑ ❑ ❑ Social supports (connections to family and significant others, needs for interaction or time alone)

❑ ❑ ❑ Awareness of service needs and ability to seek and accept help

❑ ❑ ❑ Communication skills (able to make needs known, ask for clarification when not clear about what others have said)

❑ ❑ ❑ Ability to manage health, substance use, and psychiatric care (make and keep appointments, manage Medicaid or health insurance paperwork requirements, take medication as prescribed, advocate and communicate with doctors)

❑ ❑ ❑ Awareness of substance use, relapse patterns, and consequences of use (disruptive behavior, deteriorated health, rent payment, inability to work, relapse triggers)

❑ ❑ ❑ Ability to pursue goals (planning, prioritizing, and accessing needed resources; problem-solving and negotiation skills)

Appendix VI

Sample Titles and Functions of Staffing Categories

Program Directors/Supervisors: Oversee program development, implementation, coordination and evaluation; provide regular supervision to direct service staff; orient new staff to program mission, goals, policies, and procedures; coordinate site coverage; ensure that the development and implementation of service plans are consistent with program goals and of maximum benefit to tenants; monitor and evaluate staff performance; coordinate social services with building management services; develop and modify policies and procedures; identify problems related to resources and personnel management; oversee production of internal and external reports and ensure compliance with funding requirements.

Case Managers: Provide direct services to tenants; prepare assessments; develop and implement individual service plans; assist tenants in achieving goals; facilitate groups and activities; teach and/or assist tenants in developing ADL skills, communication and self-advocacy skills; facilitate resident involvement and community activities; make referrals to community-based services; assist in accessing and maintaining entitlements/benefits; advocate for needed services; assist tenants in meeting the obligations of tenancy.

Substance-abuse/MICA Specialists: May not be assigned their own case load but instead may run groups related to substance use and work directly with tenants who have issues with use; oversee recovery readiness, relapse prevention, and recovery planning services; provide individual counseling; link with community services; educate staff and tenants about approaches to managing substance use; organize sober recreational activities.

Residential Aides: Assist case managers in carrying out their responsibilities; provide support and concrete assistance to tenants; assist/train tenants in the skills of daily living; escort tenants to appointments; provide supervision of tenants and coverage.

Recreation Specialists: Run groups and arrange for various activities on- and off-site, including music, art, or exercise classes; work individually with tenants needing assistance socializing or reducing isolation; plan events and celebrations; identify recreational opportunities in the neighborhood and surrounding community.

ADL Specialists: Assist and teach tenants basic living skills, such as budgeting, cooking, personal hygiene, self-care, housekeeping, use of public transportation, and other community services.

Peer Counselors: Staff who have had life experiences similar to the tenants of the supportive housing program (e.g., homelessness, mental illness, substance use, HIV) provide support and concrete assistance, teach advocacy skills, and apply principles of self-help programs.

HIV Specialists: Serve as expert resources to tenants and staff on the continuum of the HIV disease.

Entitlements Specialists: Assist tenants in securing and maintaining public benefits and entitlements by helping with paperwork, obtaining required documentation, escorting to appointments, advocating with relevant public agencies, and assessing the impact of earned income on benefits.

Appendix VII

Standards for Supportive Services Programs

The social service program of a supportive housing project should demonstrate the ability to:

- Provide ongoing services that meet tenants' needs
- Enable tenants to maintain stable residency in the community
- Help tenants maximize their capacity for independent living
- Promote the development of support systems for tenants

To achieve these ends, the social service component should reflect many of the following characteristics.

Service Program Design and Delivery

The agency has an explicit strategy for the delivery of services that is consistent with agency philosophy, tenants' needs and preferences, and ethical standards for service provision.

- Programming is consistent with the stated philosophy and goals of the service programs and housing models
- Programming is appropriate to the special populations served
- Programming is flexible and responsive to the expressed needs and preferences of tenants
- Programming is culturally sensitive and competent
- All attempts are made to ensure that there is adequate funding to meet staffing plans and program and tenants' needs
- There is adequate space to conduct social service activities, including staff offices, meeting rooms, and private interviewing space
- There is a mechanism in place to evaluate the service program's overall quality and progress toward program goals and outcomes
- The staff coverage schedule is clearly defined
- Caseload assignments are manageable, given resources, program goals, and resident needs
- There is adequate site coverage by supervisory personnel
- Criteria for program eligibility are clearly defined and communicated to referral sources and tenants
- The program's intake process is consistent with program goals and resources and is in accordance with statutory and administrative codes
- Criteria for termination from the program are clearly defined and communicated to tenants
- Outreach procedures reflect consistent efforts to reach out to and engage tenants
- Programming incorporates processes for goal-setting and monitoring progress toward goals

- Programming offers training to build tenants' daily living skills
- Programming provides educational and vocational assessments and training or linkages to such services
- Programming includes job placement services or linkages to such services
- There are clearly defined policies, procedures, and practices in place to address alcohol and other drug use/abuse
- Programming aims to support residential stability by providing and/or helping tenants access necessary services such as medication management, relapse prevention, and budgeting assistance
- Programming links tenants with financial and in-kind benefits and the full range of community-based services
- Regular communication is maintained between program staff and outside agencies
- Programming promotes the development of community and natural support networks
- Mechanisms exist to involve family members and significant others in individual service planning as requested by tenants
- Programming addresses both the causes and effects of crisis situations (e.g., stress and anger management, conflict resolution, community meetings)
- Programming encourages public policy awareness and advocacy (e.g., current events, lobbying trips, voter registration)

Provider/Tenant Relations

The agency has an explicit strategy for fostering positive relationships with tenants and actively seeks their input in decision-making.

- Tenants are actively involved in program planning and development
- Tenants' input is solicited and welcomed at the agency's highest organizational levels, including the board of directors
- Tenants participate in the development of their individual service plans and monitor their progress toward fulfilling stated goals and objectives
- Information about tenants is shared in accordance with legal and regulatory confidentiality guidelines
- The agency supports tenants in forming tenant/resident councils
- Tenant grievance procedures are clearly delineated in writing and include how to access legal services and representation
- Program/house rules are clearly delineated in writing and communicated to tenants
- Tenants are provided with ongoing opportunities to have input into program/house rules
- Program/house rules are consistently enforced
- Standards for leases or occupancy agreements are clearly defined

Community Linkages

The agency has a strategy for working with the community to gain support and successfully integrate tenants into local activities.

- The agency is aware of and knows how to access local health, mental health, substance abuse, mobile crisis, recreational, social, religious, and civic resources as needed by tenants
- The agency is active in linking tenants to community resources and encourages maximum participation by tenants in neighborhood life
- The agency has relationships with local police precincts and community policing forces
- The agency has relationships with the local community board and other neighborhood organizations

The Property Management/Social Services Relationship

There should be a collaborative relationship between social services and property management staff such that coordination is fostered and the roles and lines of authority are clear.

- There is agreement between management and services about the philosophy and goals of the housing model (e.g., permanent vs. transitional, voluntary vs. mandatory services)
- There are clear roles and responsibilities for all staff, preferably specified in a memorandum of understanding
- There are regularly scheduled forums for social services and property management staff to discuss coordination and address gaps in services
- There is agreement about the limitations on information sharing posed by confidentiality guidelines
- There are clearly defined roles and responsibilities for both parties in the tenant selection process
- There is a clearly defined process and time frame for informing applicants of acceptance or rejection from the housing program
- The social service team has input into house rules
- There are clearly defined roles and responsibilities to address house rules violations
- There are clearly defined roles and responsibilities to address rent arrears
- There are clearly defined roles and responsibilities for both parties in the management of evictions/discharges
- Areas of the physical plant that are available for use by property management, social services, and tenants are clearly defined

Crisis Prevention/Safety and Security

Services should be provided in a safe and supportive environment, where crises are minimized through the implementation of comprehensive crisis prevention strategies.

- Programming incorporates prevention strategies for the specific population(s) served (e.g., health and wellness, medication management, relapse prevention, safe sex)

- There is an adequate and effective plan to assure the safety and security of the building (e.g., front desk coverage, security cameras, staff beepers/backup)
- There exists clearly defined and delineated program/house rules that address disruptive behavior, use of common areas, substance abuse/use among tenants, and so on
- Program/house rules are clearly communicated to all tenants and staff and are available in written form
- Program/house rules are consistently enforced
- Staff is aware of the signs of psychiatric crises, intoxication, and withdrawal, and procedures are in place to intervene promptly and appropriately
- Procedures are in place to comply with fire safety codes (e.g., fire drills, evacuation procedures, maintaining facility within code)
- Procedures are in place to comply with public health and safety codes (e.g., maintaining property in sanitary condition, responding to public health issues in a timely manner)
- Staff members are aware of their roles in assuring a safe environment and are familiar with all relevant policies and procedures
- Staff members receive training in crisis prevention techniques and policies and procedures that are relevant to their roles and the special populations served
- Staff members are trained in basic first-aid procedures and practice universal precautions

Crisis and Emergency Protocols and Procedures

The agency has an explicit strategy for promptly responding to emergencies and crises and providing follow-up and support to staff and tenants.

- There are clearly delineated and appropriate roles for property management and social service staff in emergency and crisis situations
- Procedures are in place for responding to psychiatric emergencies, including violent ideation/behavior, suicidal ideation/behavior, homicidal ideation/behavior
- Procedures are in place for responding to medical emergencies
- Procedures are in place for responding to a death on the premises
- Procedures are in place for responding to crises involving the physical plant, such as fire and emergency evacuation
- The agency has clear procedures for addressing and reporting child abuse and neglect, sexual abuse, and physical abuse
- Staff members understand and receive regular training in crisis intervention policies and procedures
- There is adequate provision of supervisory/administrative oversight in emergencies
- The agency has an explicit incident review process that involves relevant staff and tenants in the review of crises, emergencies, and other incidents and the development of follow-up/corrective action plans

Recording and Reporting

The agency should maintain adequate documentation of services delivered, which is in compliance with funding source requirements and administrative and statutory codes and is in accordance with ethical standards for service provision.

- A case record is initiated upon acceptance of a tenant's enrollment in the program
- Initial contact is made within two weeks of a tenant's move into the housing
- All case records include basic identifying information and emergency contacts
- All case records include signed releases of information for confidential information that is updated every six months or as required by law
- All case records include an initial assessment of the tenant's needs and short- and long-term goals
- Assessments and service plans are updated biannually or as required by contractual obligations
- All case records contain evidence of tenant participation in the service planning process
- All case records contain documentation of programming attendance
- Chart notes are entered on a weekly to monthly basis
- Chart notes address progress toward goals and objectives of the service plan
- Ninety percent of case records are up to date
- Case records and related documents are maintained in a secure and confidential manner and in accordance with all applicable statutory and administrative codes
- There is evidence of interdisciplinary collaboration in the case planning process

Employment Services

Work has obvious value in promoting housing stability and improving the quality of tenants' lives. Additionally, the significant changes in eligibility requirements for public benefits instituted in the late 1990s have prompted supportive housing programs to give particular focus to the vocational and employment needs of tenants.

All supportive services programs will likely offer some kind of employment assistance. These services may include linkages to GED programs, help with resume writing, and access to a computer, telephone, and fax line. The size and scope of employment programs vary depending upon the number of people to be served and the program goals. What a program can actually accomplish will also depend upon the amount and type of resources that are available.

This chapter focuses on the major areas to be considered in developing an employment program and the individual elements necessary to create effective programs that result in jobs and career advancement. There is also a discussion of issues in providing employment services for people who have disabilities or special needs.

Developing a Range of Employment Services

Supportive housing can provide numerous opportunities to help tenants become employed and/or advance in their careers. Efforts can range from individualized counseling and support to creating in-house employment opportunities. Following is a discussion of various supports that can be offered.

Vocational Support Services

Vocational support services help to increase motivation and provide the extra assistance that an individual may need to get and keep a job. Following are examples of vocational support services.

- Helping to generate and sustain the motivation to become employed
- Assisting in developing a resume and completing job applications
- Helping to prepare for a job interview
- Planning how to respond to questions and issues regarding disclosure of a disability
- Offering pre- and postemployment support groups
- Developing individual career plans
- Discussing entitlements, health insurance, and rent subsidy issues
- Arranging for English as a second language classes

- Discussing attire and grooming
- Recognizing successes
- Supporting people through setbacks

Vocational supports include a range of practical services that are provided, as needed, before and after an individual enters the workforce. These services should be designed to help individuals achieve success in moving toward their employment goals and career objectives. Staff members working in the role of vocational counselors should have relationships with program participants that allow for an honest exchange about everything related to employment. Good communication between employment staff and other supportive services staff is equally important, and a coordinated team approach is generally most effective. The extra assistance and insight that a vocational counselor gives often make the difference in employment outcomes. A GED program may help individuals pass a high school equivalency exam and add an important credential to a resume, but it does not help with interviewing skills.

Managing the Transition to Work

If an individual has never worked or has been absent from the workforce for an extended time, he/she may face significant challenges in making the transition to the role of an employee. Assistance and support in managing this transition are often needed. Many employment program participants who are in their 30s, 40s, or 50s, for example, are in the position of considering entry-level jobs. This can raise issues about self-esteem because these jobs might not match their expectations. For some individuals, doing entry-level work may be frustrating and leave them feeling undervalued. Discussions about expectations, concerns, and feelings as well as assistance in identifying achievable goals and developing a career plan are important in facilitating the transition.

Career Counseling

Since individual career plans can and do change as a result of experience and motivation, periodic discussions about the future and one's career path are important. Career counseling includes an assessment of interests, motivations, skills, capabilities, education, job training, and work history. (See Appendix II, Employment History and Preferences Self-Assessment.) Following are specific areas to assess and discuss.

- Education and work history
- Level of motivation
- Strengths and skills
- Short-term employment preferences
- Long-term career goals
- Potential obstacles, limitations, and disincentives (such as physical constraints, entitlement and benefit disincentives, history of incarceration)

I Want to Be a Lawyer

Madeline is a 58-year-old tenant who had her last stable job as a secretary about twenty years ago. She came to the employment program asking for assistance to become a lawyer. The vocational counselor worked with her to design a plan for reaching her goal. Steps included getting a GED, new clothing, and office training. After one year of computer classes and an unpaid internship in a law office, Madeline was hired as a legal assistant in a position paying a decent wage and offering comprehensive benefits. Madeline's supervisor and coworkers gave glowing feedback about her job performance, noting her responsibility and thoroughness. Ultimately, she decided to put her goal of becoming a lawyer on hold as she was satisfied with her position and not ready to return to school.

This example illustrates how a vocational counselor can be effective and help an individual identify a clear starting point to advance toward personal goals. When ambitious long-range goals are presented, it is often helpful to identify the steps or objectives to be accomplished. Additionally, it is useful for the counselor to try to understand the range of motivations behind an individual's career goals. In this case, for instance, Madeline's goal to become a lawyer was related to her preference to work in a professional office environment.

The career counseling process should produce a career plan, which lists specific employment goals and tasks required to achieve them. The plan should give participants a clear starting point on the path to advancement. Additionally, plans identify education and skills needed as well as the types of support necessary to access and maintain employment. Staff should point out areas of past experience that demonstrate skills and strengths that can be transferable to the workplace, such as navigating the bureaucracies of public entitlements systems.

If applicable, it is particularly important that the career planning process also include discussions about self-disclosure of personal information, such as a psychiatric disability, to colleagues and supervisors. In some cases, the Americans with Disabilities Act (ADA) will apply, and people should be informed about the accommodations available and the best processes for obtaining them. (See Appendix III, Americans with Disabilities Act.)

The supportive housing setting allows the staff to work with tenants over time to set short- and long-term goals and address obstacles to reaching these goals. Issues of low self-esteem and lack of confidence, for example, are common. Ambitious and far-reaching aspirations are not unusual, however, and staff should be careful about unnecessarily dampening enthusiasm by imposing more constrained or "realistic" perspectives.

Preferably, supportive housing enables the staff to assist tenants in evaluating various options, emphasizing the choices and preferences of the individual. Mandatory welfare-to-work programs, on the other hand, often place individuals in jobs and assignments that are available, though not necessarily preferred. Whatever the starting point, staff can help shape career plans that reflect each individual's interests.

Finding and Developing Employment Opportunities

Finding employment opportunities is the responsibility of both tenants and staff. Searching the want ads and making "cold calls" are often effective, and finding a job may occur with or without assistance from the staff. Employment programs can be helpful in many different ways, and it may turn out to be the encouragement offered by staff or the concrete resources provided by the program that get an individual into the job market. Sometimes, people simply want to get a job and do not want or need ongoing vocational or career counseling.

The staff can maintain job vacancy bulletin boards and can help individual tenants follow up on specific job leads and searches. Programs can offer transportation funds, a clothing allowance, or other short-term funds related to finding a job. Staff can also engage in strategic job development efforts with employers, cultivating linkages with local businesses and retail chains, and serving as a broker when timing and mutual interests align. Maintaining activity on both sides of the equation—job development and job applicants—is usually a major challenge for employment programs, and mechanisms for sustaining interest among all parties can be important to a program's continued success. In the absence of viable job applicants or sufficient jobs, enthusiasm among employers and program participants can fade.

Some organizations create industry-specific training programs that focus on the development of labor pools for specific industries and corporations. By tapping into employment and economic trends (such as growth in the hospitality industry), for instance, enterprising organizations can create partnerships with local and national businesses, matching training to very specific employment needs. Industry-specific programs allow planning for specific types of jobs and for orientation of trainees to specific job markets.

While there are many advantages to having the interdependence of employers and job-training programs within industry-specific arrangements, these relationships can also force employment programs and the individuals they serve into a narrow set of opportunities. Some tenants may not be interested in or eligible for industry-specific training and, therefore, will not participate in the program. Alternatively, organizations that attempt to develop hand-picked job opportunities may lose in efficiency and predictability but gain in other ways, such as higher participant satisfaction and job stability.

Brokering jobs that have appeal and offer a living wage with benefits is a sophisticated and labor-intensive responsibility. Having a job developer on staff to focus on locating viable employment opportunities is clearly an advantage for building a job bank and for keeping a program current and effective. A job developer also serves to sustain connections with employers and to establish a track record of good referrals.

Promoting Training and Employment Options

The Lakefront SRO Corporation in Chicago is a leader in the development of supportive housing and employment opportunities. Following are examples of strategies used by Lakefront.

- Providing in-house training programs in construction, maintenance, and computers
- Maintaining a comprehensive database of available jobs throughout the Chicago metropolitan area
- Developing connections to a range of part-time and full-time employment opportunities as well as to volunteer work and education and training programs

The decision to create a job developer position and other staff lines dedicated to employment has to take place in the context of other programmatic considerations, including the anticipated number of program participants, funding availability, program priorities, and the organization's structure and interests. The background and skills required for job developers and other staff members in an employment program may be very different from the requirements for positions in other programs within the organization. For example, a job developer with a background in business versus the social services may be preferred because a primary function of the role is to work with the business community.

In the final analysis, the number of people who actually obtain jobs and remain employed is the true test of employment programs. Of course, there are always factors to explain why a program might do better or worse: a heated or a cool economy, a larger or smaller number of individuals who have special needs, and unanticipated setbacks due to staffing problems or managerial and administrative obstacles. Nonetheless, tenants and funders are wary of programs that systematically train and prepare people without getting sufficient numbers of individuals into jobs. In short, outcome measures and job placements are very important, and programs must be designed to obtain results.

Just Let Me Work!

Long-term classroom training, prolonged assessments, and other prerequisites to getting a job can discourage some people. Individuals often learn more about themselves and what additional training and skills they need and want by entering the work world. Additionally, getting paid and having the satisfaction of holding a job are often invaluable motivators for self-determination and advancement.

Creating In-House Jobs and Transitional Employment

Many supportive housing sponsors have created in-house employment programs. Sometimes these initiatives are relatively informal and involve hiring tenants to fill part-time jobs, such as reception and front desk services, building maintenance, gardening and grounds work, and administrative support services. Tenants are a valuable labor pool and set a good example for others by working.

Some organizations use in-house positions as transitional employment opportunities that provide a training period and a process for advancement. These programs are intended to build self-confidence and skills while allowing staff to further assess aptitude and performance. In-house transitional employment programs also allow for a "jobs first" approach that is appealing to tenants as well as job development staff who can attest to the employee's ability to perform. Succeeding in a transitional position can restore an individual's self-confidence and, most important, can make the difference to prospective employers who may be reluctant to hire individuals who have a spotty work history.

The amount of time participants will need in transitional employment varies. Though neat on the surface, strict time limits for in-house positions can prove to be problematic all around. A suitable job outside the sponsoring organization may not be available or the individual may not be ready when the time limit is reached. Therefore, flexibility in transitional positions is often preferred, even though this more open-ended practice can sometimes pose other challenges, such as a transitional job transforming into a permanent position. A process to address next steps after the training period is over should be an integral aspect of transitional employment programs and be reflected in individual career plans.

"Working at Home"

Hiring a tenant to work within the supportive housing where he/she lives can add complications that would not exist if the individual worked elsewhere. For instance, a tenant working in a security or front desk position could be put in the uncomfortable position of reporting a neighbor. As such, housing providers often prefer to have individuals work in external settings.

On the other hand, there are very successful programs that see advantages to having tenants work where they live. These programs note that individuals sometimes care more about their work because it affects where they live. Challenges posed by the arrangement must be addressed through proper training and supervision of both employees and job supervisors.

In-house positions for tenants are also generated within businesses that the supportive housing organization sponsors or within tenant-operated microbusinesses. Sponsors have opened bookstores, child-care centers, ice cream shops, printing shops, bakeries, and thrift stores and typically train and hire tenants to work in and manage these operations. Independently sponsored businesses provide unparalleled degrees of freedom to create training slots and job opportunities.

Social Entrepreneurial Ventures

Many supportive housing providers are also engaged in entrepreneurial ventures that provide revenue and real-world business environments that offer training and employment opportunities for tenants. One highly successful example, Rubicon Programs Incorporated in Richmond, California, has developed several nonprofit businesses, including Rubicon Bakery and Rubicon Buildings and Grounds, creating jobs for economically disadvantaged, disabled, and formerly homeless people. Similarly, Rubicon Home Care Consortium trains public assistance recipients to become certified nurse assistants and home-care aides to serve frail older adults and younger disabled individuals.

Ongoing Job Support

After people start working they sometimes need assistance in managing and retaining their positions. In many cases, ongoing job support will be an extension of the supports that were provided early in the vocational counseling process. Sometimes, an issue that required attention prior to employment will continue to pose a problem after the person is employed, such as lateness, substance use, grooming problems, or motivation. The length of time and intensity of follow-up required after job placement will vary with each individual. As the tenant becomes more engaged in work and more pressed for time, however, he or she may not be as agreeable or available to meet with staff. For some people, offering assistance by telephone may be necessary. Ideally, tenants should be able to use the program for ongoing assistance and career planning as needed.

In some employment programs, efforts to help tenants manage their jobs and advance their careers take place in ongoing workshops or training focused on workplace issues and new skills, such as:

- Entering or reentering the workforce
- Managing a disability in the workplace
- Managing supervisor and coworker relationships
- Setting career goals

When applicable, some programs use on-site job coaches to become familiar with individual work locations and to be available to come on the job site to observe and coach participants. While this can be effective with some participants, others are embarrassed by the presence of a job coach at the workplace. The service can also pose practical problems for the employer, such as liability concerns and extra people at the work site. As a result, programs use this intervention only when necessary and appropriate.

In spite of thorough assessments and lots of support, people sometimes have setbacks, experience problems in the workplace, and even lose jobs. Staff should prepare individuals for such possibilities and use these experiences as learning opportunities. Staff members can help by trying to sort out what went wrong and how to better manage next time.

Core Program Components

Defining Goals and Expectations

Since employment programs are commonly evaluated on the number of people who achieve and retain gainful employment, the expectations of program participants, direct service staff, and program managers/administrators should be clear and based on the belief that people can and will succeed at work. A lack of such expectations can lead to confusion and frustration and will ultimately undermine the effectiveness of employment programming.

Depending on the needs of program participants, the length of time required to achieve employment goals can vary greatly. Program goals should be achievable, realistic, and appropriate for program participants. Structuring the program so as to develop skills, confidence, and progress toward career plans helps build staff and tenant motivation. Although effective employment programs result in people getting and keeping decent jobs, full-time employment may not be a desired or practical goal for everyone who participates. In designing the employment program, it is critical to identify jobs that tenants will want and be able to do. Individual employment paths usually consist of a series of outcomes that can be used to monitor progress, including:

- Working part-time
- Increasing hourly wage or total income
- Retaining employment over a period of time
- Developing new skills

Participants must be clear from the beginning about the extent of services offered by the employment program, the possibilities and resources available, and the requirements for program participation. Upon entry into the program, an assessment should be conducted to ensure a match among needs, expectations, and program services.

The staff should have a clear understanding of their respective roles in the employment program. The goals of the program should guide staff interventions and be translated into daily tasks and activities. Staff should understand where they fit in the process of achieving program goals, and they must have the skills and knowledge to successfully carry out these roles.

Eligibility Criteria for Employment Programs

The involvement of tenants in employment services usually includes an intake and assessment process. However, there are wide variations in eligibility criteria and vastly different assessment processes among supportive housing employment programs. There are also differences regarding the requirements for participants. At one end of the spectrum are organizations that require participants to be compliant with services and substance free. At the other end are organizations that believe people have a right to work and should not be prohibited from working for any reason except a lack of competency to fulfill a job's requirements. Employment programs usually require, however, that tenants holding in-house jobs remain in good standing with lease obligations, rent payment, and attendance at required employment meetings and workshops.

In all cases, however, programs should have clear criteria for participation, and all applicants and participants should understand the expectations and purpose of the program.

Creating a Culture that Promotes Work

After individuals are in a supportive housing setting, they typically express some level of interest in exploring educational or employment opportunities. Creating a culture that promotes work begins with an environment in which employment is encouraged and expected. Promoting norms that emphasize the importance of work helps to accomplish this. As supportive housing continues to mature and to expand around the nation, its capacity to address complex social problems, such as chronic unemployment, becomes increasingly sophisticated as well. In many projects, supportive housing providers have made efforts to meet and accelerate interest in work by developing programs that offer specialized employment services, job placement services, and an in-house network of supports and reinforcements that helps participants to advance.

Specific strategies that have helped organizations establish a culture that promotes work include:

- Prioritizing the development of vocational and employment services in the overall design of the supportive housing services program
- Ensuring that the employment program receives a highly visible status in the organization's structure and hierarchy
- Ensuring that the staff position responsible for the overall employment program is filled by a seasoned and experienced individual
- Prioritizing proposals to fund employment services
- Having an income mix among the tenancy to include working people who can be role models and motivators for others thinking about going to work
- Focusing on employment early in the engagement process, such as inquiring about employment goals during housing intake interviews
- Arranging schedules so that the staff are available to tenants who work during the day
- Making optimum use of physical space to enhance an emphasis on employment, such as providing a comfortable location for conducting employment and job searches and having a section of an in-house library devoted to career development and employment-related materials
- Reserving staff positions within the organization for tenants and developing transitional employment and training slots

- Making resources such as computers, telephones, fax lines, desks, and transportation and clothing funds available to those who are seeking employment
- Celebrating employment-related milestones such as graduations and promotions

Defining Staff Roles

The "who, how, and where" of providing employment support services vary with different program designs. Supportive services programs sometimes include employment and vocational services under general case management functions, although this is usually due to the size and/or available resources of the program. Ideally, supportive housing programs can access or operate employment services that offer a range of supports to ensure the quality and continuity of services necessary to help as many tenants as possible to succeed.

Staff roles in employment programs vary depending on the design and size of the initiative. Although specific titles for staff positions will vary from program to program, the following list provides an overview of common titles and job responsibilities.

Case Managers/Service Coordinators: The overall coordination of individualized services is usually the responsibility of the case manager/service coordinator. Typically, the role includes a range of responsibilities, such as providing individual counseling and service planning, helping to coordinate medical and mental health appointments, obtaining benefits and medical insurance, making referrals to community-based services, helping to reunite a tenant with family members, assisting with budgeting, and helping to access legal/advocacy services. Case managers also link individuals to employment and/or employment programs. By integrating employment goals into the individual service plan, case management staff are able to support the tenant and help overcome obstacles to work.

Vocational Counselors: Also called career counselors or employment specialists, these staff members are responsible for working with program participants to develop individualized vocational plans. Vocational counselors focus on information and interventions that directly impact employment. The vocational counselor works with the case manager to integrate the vocational plan into the overall service plan. Vocational counselors identify obstacles to gaining and maintaining employment and provide ongoing assistance in reducing the negative impact of these obstacles to success. This might include, for example, recommendations for additional training or education.

Job Coaches: Some programs use job coaches to provide on-the-job support to program participants. Coaches can assess how an individual is doing on the job in addition to providing immediate feedback, training, and assistance. Job coaches gain an understanding of the needs of the employer and can give businesses the confidence to hire program participants. In most cases, the role of the job coach is most intense when a participant first transitions into a new job.

Job Supervisors: When sponsoring in-house training or employment positions, a job supervisor or boss is usually assigned to oversee the completion of tasks. This role is usually filled by someone who understands the job and the employee's responsibilities. A job supervisor is usually not involved in counseling the employee on personal matters, and it is preferable that different people provide job supervision and supportive services.

Job Developers: Employment programs frequently hire job developers to establish relationships with businesses in the community to help secure jobs for program participants. Job developers may also serve

as liaisons between the program and the job site, addressing problems and issues that come up regarding specific placements.

Program Director: Dedicated to overseeing the development of employment activities, the program director oversees all vocational and employment services.

Managing Entitlements and Public Benefits Issues

An understanding of income limits and the various reporting requirements regarding employment and public benefits/entitlements is important for all employment programs. Though providers may leave the responsibility of reporting earned income with the tenant, it is important to help him/her work out any related issues concerning the impact of income on eligibility for benefit programs, such as SSI and Medicaid. Preferably, there are staff members who are able to assist tenants to calculate the effect of earned income on benefits and help them to remain informed about any relevant changes.

Medical coverage is crucial. Whenever possible, tenants should be referred to jobs that offer health insurance. To protect individuals who are not covered by their employers, some states are developing "Medicaid Buy-In" programs in which people can purchase Medicaid benefits as their income increases above established eligibility levels.

Many people have relied on public benefits for a long time, and potential changes in these arrangements can generate significant fear and anxiety, even causing reluctance to pursue employment at all. For some, despite repeated warnings about the changes in their benefits that will occur if they begin to earn income, the actual loss of these funds can be disruptive and cause some people to think about quitting.

Confidentiality/Sharing Information

The level of disclosure of clinical and diagnostic information about program participants among staff within an organization varies as a function of legal requirements, program philosophies, structure, and staffing patterns. Confidentiality issues often become thorny, however, and programs can prevent mishaps and communication problems by having guidelines from the outset about information sharing.

In the average workplace, employers would not have access to an individual's health and mental health records. Indeed, there are numerous laws and regulations, professional standards, and codes of ethics that are intended to prevent inappropriate disclosure of confidential information. In this regard, when an individual is the recipient of services in a mental health organization that also has an employment program, is all the information about him/her shared between the "service" staff and "employment" staff? Who needs to know clinical and diagnostic information and why? Who should make the determination about information that is shared? Clearly, many situations require special consideration and some may warrant legal counsel. However these questions are answered, they should not be left to the judgment of individual staff members to decide on a case-by-case basis and should be clarified in clear policies at the managerial level.

One model for information sharing is that service staff who have a counseling function (e.g., case managers, vocational counselors) have access to clinical and diagnostic information but nonclinical staff (such as job supervisors) have only limited access as defined by the organization's policies. In some cases, organizations develop a face sheet of information to be made available to nonclinical personnel.

When confidential information is to be shared beyond the organization, program participants must first sign consent forms to release information. In all cases, individuals should know what information about them is being shared, with whom, and why.

Services for People Who Have Disabilities

When developing employment services, supportive housing providers must address issues related to disabilities and special needs. This section discusses additional information and specific considerations for working with people with histories of mental illness, HIV/AIDS, and substance use, and it also includes a brief discussion about homelessness, which is a circumstance experienced by many individuals who enter supportive housing.

Policy Issues

Broad access to jobs for people with disabilities remains limited, and most people with disabilities are not employed. Organizations that are involved with people who have mental illnesses, for instance, are usually well aware of the dramatic differences between the number of people who want to work and the number that do. Many people with mental illness want to work but do not due to stigma, lack of encouragement, lack of training, fear of losing benefits, and a pervasive attitude that disabilities and employment are incompatible.

In recent years, people with disabilities have been more assertive in expressing their interest in employment. In response, more organizations that provide supportive services to these populations have developed programs that facilitate the entry of individuals with disabilities into the workplace. Though much of this programming in supportive housing is relatively new, the results have been very encouraging. To be educated about mental illness or AIDS is to understand that people with disabilities can be very productive employees given reasonable accommodations for their illnesses.

One of the most significant barriers to employment for people with disabilities is that society lags so far behind what is possible. Consider, for example, the improvement that wheelchair-accessible sidewalks provide. Prior to this modest change in curbsides, it was not that people in wheelchairs were not capable of moving around safely and independently but rather that the lack of accommodation prevented it. Unfortunately, equivalent changes have yet to occur in the workplace, and greater levels of systems changes still need to occur.

Program Issues

Many supportive housing programs serve people with a range of special needs and disabilities. The specific issues regarding employment vary with particular needs and disabilities and the impact on individual functioning. There are wide variations in the abilities, aptitudes, and skills of people who have disabilities. An initial step in making a match to a job or employment area is an assessment of how a disability impacts the person's ability to work. Some disabilities may so profoundly affect an individual's functioning that employment options are extremely limited or the level of support required to maintain a job is impractical. Employment program goals should be based on what is reasonable to achieve. Providers must ensure that they have adequate resources and staff to support tenants in meeting their goals and the program in achieving its targets. Being able to offer flexible programming and access to a broad range of jobs including transitional, supported, part-time, and full-time work are preferable.

All programs serving people with disabilities will need to develop structures to conduct specialized assessments, address issues of self-disclosure and accommodation under the ADA, and prepare applicants to discuss intermittent or limited work histories during job search efforts. The ADA prohibits discrimination in employment on the basis of physical and mental disabilities and requires employers to make reasonable accommodations to enable qualified disabled people to fill available positions. Reasonable

accommodations range from specialized communications and computer equipment to adjustments in work hours or assignments. If a participant does require accommodation in the workplace for a disability, he/she will need to inform the employer and may do so during the interview process or after starting work. Program participants and staff should be educated about the ADA and its applications.

In cases where accommodation under the ADA is not sought, the decision to disclose a nonvisible condition or disability to an employer or colleagues is one that must be weighed carefully. It is ultimately the tenant's choice (except in cases where job sites have agreed to dedicate slots for specific populations), but staff should help the individual assess the pros and cons of disclosure and, if needed, plan how to discuss the issue. For many people, disclosure will occur once relationships with coworkers have developed and there has been some degree of success in the job. (See Appendix III, Americans with Disabilities Act.)

Almost all employment program participants will benefit from practice interviews or role-playing before actually applying for a job. Additionally, addressing gaps in work history will usually be required during the interview process, and it helps to rehearse this discussion in advance.

Mental Illness

There is a broad spectrum of mental illnesses, and a mental illness can impact functioning in a variety of ways: cognitively, emotionally, interpersonally, and behaviorally. (See chapter 4, Mental Health Services for more on this subject.) During career planning, it is important to understand an individual's ability to:

- Learn and retain information
- Plan and prioritize tasks
- Follow directions
- Respond to authority
- Communicate
- Manage stimulation
- Process information
- Make decisions
- Resolve conflicts
- Manage stress

If possible, it is often helpful to use in-house and supported job opportunities to gain a thorough understanding of skills, abilities, and problem areas. Individuals may act differently in a job environment, and the therapeutic benefits of work can, in many cases, reduce symptoms and improve functioning.

The nature of chronic mental illness and the way in which it has been addressed in society have robbed many individuals of the formative years of their education and work life. A middle-aged person with mental illness may find him/herself competing for job opportunities that are very different from the career dreams he/she had before becoming ill. This loss should be addressed. Individuals often need to develop new employment paths and have opportunities to rebuild confidence and self-esteem. For some people with serious mental illness, full-time employment may not be an option, and the employment program should have access to other opportunities for work and meaningful activity.

What is true for all employment programs participants is emphasized even more for participants with mental illness: a one-size-fits-all approach to employment services does not always work. Specifically, programs can be particularly helpful by:

- Assisting tenants to advance toward individualized goals
- Understanding specifically how features of a mental illness affect job choices and performance
- Helping to make the best choices each step of the way
- Offering transitional and supported work opportunities
- Preparing for possible setbacks
- Providing assistance to ensure income stability and continued health insurance

HIV/AIDS

Individuals with HIV run the gamut from those who have had extensive work histories and successful careers to people with very limited or no work experience. Due to improvements in medications and treatment, people with HIV disease are living longer, healthier lives and are often able to remain in their jobs or return to the workforce. However, changes in overall health status and the need to manage complex medication regimens on the job often require that the appropriate type of work for an individual be reassessed. Additionally, the drugs used to treat HIV can cause side effects such as nausea, vomiting, and severe exhaustion, making it difficult for some people to work regularly or at all. An increasing percentage of people with HIV disease also have substance use problems, and these issues can complicate the process of finding and keeping a job. (See chapter 5, HIV Services.)

During career planning, it is important to obtain an accurate and detailed work history and information about current health status and prescribed treatments. Given the diversity of work experience among people with HIV/AIDS, a range of work options including part-time employment is important. Additionally, there are still considerable stigmas and fear associated with HIV and AIDS, and careful thought should be given to the issue of self-disclosure. However, many people with HIV disease will be eligible for and require accommodation under the ADA. Similar to people with mental illness, continued health coverage is crucial.

Alcohol and Substance Use

Alcohol and substance use are relatively common barriers to employment among supportive housing tenants. It is also a common problem in the general workforce. Alcohol and substance use result in various costs in the workplace including decreased productivity, poor performance, absenteeism, and lateness. In some industries, employers conduct drug testing to try and ensure a drug-free workplace, although most do not. Nonetheless, repeated work problems due to substance use frequently result in termination.

Staff should understand how an individual's substance use affects or is affected by employment. Staff should raise awareness of the consequences of substance use on a person's ability to work and be mindful that work can be effective in helping people reduce substance use and avoid relapse.

It is helpful to focus on the behaviors associated with substance use that create obstacles to employment and then work to reduce these problems. It is important to remember that the general workforce includes many people who use or are addicted to alcohol and/or other substances. Obviously, many have learned to manage their use (albeit some better than others) and stay employed. Clearly, not all programs can accept this approach since it addresses only the symptoms and not the addiction. (See chapter 6, Substance-Use Services, for more on this subject.)

Reducing Substance Use through Employment

Carlos was a tenant hired to work on the front desk in a supportive housing project on the 4 p.m. to 12 a.m. shift. Carlos would usually begin drinking midafternoon and continue into the evening. Naturally, when he was working, Carlos could not drink or be under the influence. It was difficult for Carlos to avoid having a drink before he started work, and he found himself getting anxious during his shift, wanting to have a drink, and sometimes drinking on the job. He asked to change his hours to the 8 a.m. to 4 p.m. shift. The change in hours was instituted, and Carlos was able to work his shift and not drink during the day.

Homelessness

Homelessness is not a disability, but it is an experience that affects the lives of many people who live in supportive housing. Understanding how an individual came to be homeless and the impact of homelessness on his/her life is important in providing employment support services.

For many people, being homeless was directly linked to work and the economy. The loss of a job, the inability to maintain a job, and a lack of available jobs that pay a living wage are often the reasons why people become homeless. Additionally, once housed, stable work can prevent a return to homelessness. Assistance in helping formerly homeless individuals access work opportunities is a feature of some of the most successful supportive housing projects.

Formerly homeless individuals have a broad range of skill levels, a diversity of vocational interests, and wide variations in education and work histories. They may also have limited education and job skills and intermittent, problematic, or limited work histories. In this regard, a thorough vocational assessment is often very important. Once again, in-house transitional employment positions can be helpful for gaining an understanding of an individual's strengths and weaknesses. Temporary jobs and transitional employment are also low-pressure ways to re-enter the work world.

Appendix I

Resources and Additional Readings

Becker, D. R., et al. "Job Preferences of Clients with Severe Psychiatric Disorders Participating in Supported Employment Programs." Psychiatric Services 47, no. 11 (1996): 1223–1226.

This article discusses the job preferences of adults with serious mental illnesses who were participating in supported employment programs.

Bennett, G., et al. Job Training and Employment Services for Homeless Persons with Alcohol and Other Drug Problems. Washington, D.C.: U.S. Department of Health and Human Services, 1992.

This technical assistance report summarizes relevant research that connects the arenas of homelessness and substance abuse with employment and job training services. It draws on a variety of demonstration projects to provide examples of innovative programs that have made progress in serving this population.

Bond, G. R., et al. "An Update on Supported Employment for People with Severe Mental Illness." Psychiatric Services 48, no. 3 (1997): 335–346.

This article examines the effectiveness of supported employment for people who have serious mental illness and identifies key principles of supported employment programs. Initial findings indicate the importance of an explicit focus on competitive employment outcomes, direct placement, and the integration of vocational and clinical services.

Bond, G. R., and P. S. Meyer. "The Role of Medications in the Employment of People with Schizophrenia." Journal of Rehabilitation 65, no. 4 (1999): 9–14.

The authors write of the integral role played by both medication and vocational rehabilitation in the recovery process for schizophrenia. New medications for schizophrenia, combined with promising research on supported employment, have led to renewed attention to the relationship between the two, which may enable more consumers to benefit from rehabilitation programs and obtain competitive jobs.

Brown, R., et al. Working out of Poverty: Employment Retention and Career Advancement for Welfare Recipients. Washington, D.C.: U.S. Department of Health and Human Services, 1998.

This report explores promising welfare-to-work programs of states and localities as they work to meet the challenge of helping welfare recipients and low-wage workers work their way out of poverty. Topics discussed include the new environment created by changes in the welfare system, the issue of job retention from the perspectives of welfare recipients and employers, career advancement opportunities, and the special needs of welfare recipients.

Camardese, M. B., and D. Youngman. "H.O.P.E.: Education, Employment, and People Who are Homeless and Mentally Ill." Psychiatric Rehabilitation Journal 19, no. 4 (1996): 46–56.

A survey of 100 homeless volunteers living with mental illness regarding employment. Survey responses indicate significant interest in training for diverse and meaningful employment in addition to communication and social skills training.

Carter, C., and G. Izumo. The Career Tool Kit: Skills for Success. Upper Saddle River, N.J.: Prentice Hall, 1997.

The Career Tool Kit is designed especially to help readers develop the skills and attitudes needed to successfully complete their education; search for, find, and win the job they want; transition smoothly from school to work; and build a long, happy, and successful working life.

Emerson, J., and F. Twersky. New Social Entrepreneurs: The Success, Challenge and Lessons of Non-profit Enterprise Creation. San Francisco: The Roberts Foundation, 1996.

This book is designed to help social service providers plan and start microenterprises to address the lack of employment opportunities available to their program participants. It is filled with examples of how agencies responded to the needs of very low-income individuals.

The Enterprise Foundation. Working toward the Future: Profiles of Six Employment Training and Placement Programs. New York: The Enterprise Foundation, 1995.

This information packet describes six employment training and placement programs for homeless persons covering a range of approaches from shelter-based programs for homeless individuals, to alliances between nonprofit service providers and for-profit businesses, to the integration of job skills training and basic educational programs.

Equal Employment Opportunity Commission. EEOC Enforcement Guidance on the Americans with Disabilities Act and Psychiatric Disabilities. Washington, D.C.: Equal Employment Opportunity Commission, 1997.

This enforcement guide explains the EEOC interpretation of the application of the Americans with Disabilities Act of 1990 to individuals with psychiatric disabilities. The guide is designed to facilitate the full enforcement of the ADA, including the definition of a psychiatric disability, disability disclosure, reasonable accommodation, direct threat, and professional licensing.

Fleischer, W., and K. Sherwood. The Next Wave: Employing People with Multiple Barriers to Work. New York: Corporation for Supportive Housing, 2000.

The Next Steps 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.

Hassner, M. "The Law and the Workplace, the Rights of HIV-Positive Employees." Body Positive 12, no. 1 (1999).

The article overviews the employment rights of individuals living with HIV disease. Areas covered include confidentiality, disclosure, reasonable accommodation, discrimination and other relevant areas. The federal ADA and New York's Human Rights Law are referenced.

Peckham, J., and J. Muller. "Employment and Schizophrenia: Recommendations to Improve Employability for Individuals with Schizophrenia." Psychiatric Rehabilitation Journal 22, no. 4 (1999): 399–402.

This article explores the concept of creating positive vocational outcomes for individuals with a major psychiatric disability and discusses barriers to employment, offering recommendations that could contribute to meaningful and continuing employment for people with schizophrenia.

Proscio, T., and T. Houghton. Landlord, Service Provider and Employer: Hiring and Promoting Tenants at Lakefront SRO. New York: Corporation for Supportive Housing, 2000.

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.

Whiting, B. Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services. New York: Corporation for Supportive Housing, 1994.

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.

Wright, A., J. Mora, and L. Hughes. "The Sober Transitional Housing and Employment Project (STHEP): Strategies for Long-term Sobriety, Employment and Housing." Alcoholism Treatment Quarterly 7, no. 1 (1990): 47–56.

This article describes STHEP, which provides alcoholism recovery, vocational rehabilitation, and housing services, and it evaluates their effectiveness with homeless alcoholics. A program summary and preliminary results of a program evaluation conducted between July 1988 and March 1989 are included.

Internet Sites

The Body

http://www.thebody.com

The Body, an AIDS and HIV information resource, is a web site maintained by Body Positive magazine and offers a number of current articles and publications on HIV disease and employment.

Corporation for Supportive Housing

http://www.csh.org

The Corporation for Supportive Housing supports the expansion of permanent housing opportunities linked to comprehensive services for persons with mental health, substance-abuse, and other chronic health challenges. A variety of useful publications are available on-line.

Handling Your Psychiatric Disability in Work and School

http://www.bu.edu.sarpsych/jobschool

This web site is an interactive and informative page designed for persons with mental illness that addresses issues and reasonable accommodations related to work and school. This is the only site designed exclusively to provide information about the Americans with Disabilities Act and other employment and education issues for people with psychiatric disabilities.

Social Security Online

http://www.ssa.gov

This web site provides information about the impact of employment on benefits and can answer a number of employment-related questions and Social Security benefits.

U.S. Department of Labor

http://www.dol.gov

The U.S. Department of Labor is charged with preparing the American workforce for new and better jobs and ensuring the adequacy of America's workplaces. This web site informs visitors on a variety of topics related to employment, including labor statistics and welfare-to-work highlights. There are online publications to download regarding employment and assistance.

Welfare to Work Home Page

http://www.labor.state.ny.us

The Welfare to Work Home Page offers visitors an opportunity to find out what's new in welfare-to-work initiatives, acquire applications, and get information about the U.S. Department of Labor.

Appendix II

Self Assessment:
Employment History and Preferences

You are more likely to have a successful work experience if you find a job that matches your strengths, skills, abilities, and interests. This document is designed to help you think about your prior work experiences, job skills, additional training needs, and work preferences you may have.

Employment History

- Are you currently working? Are you satisfied with your job or are you looking to make a change?

- What are you interested in doing? What career goals do you have now and have you had in the past?

- What are your prior work experiences? This includes full- and part-time positions, volunteer work, internships, and so on.

- What were your likes and dislikes about your past employment experiences? Was there too much overtime, too much or too little supervision, and so on?

- What are your current job skills? What additional training might be needed to meet your employment goals (office skills training, food service preparation, etc.)?

- Do you have former employers who are willing to be references for you?

- Do you have a consistent work history or are there gaps between jobs?

Employment Preferences

- Would you prefer to work full-time, part-time, or on a temporary basis?

- What schedule would you prefer: 9–5 Monday through Friday, at night, on weekends, and so on?

- What amount and type of supervision works best for you?

- Would you prefer to work independently (ex., plumber) or as part of a team (ex., office work)?

- Would you like to work for a large company where there are many employees or do you feel more comfortable in a smaller work environment?

- Would you prefer a more physical job (ex., construction worker) or job in an office (ex., administrative assistant)?

- Are you comfortable with on-the-job training or would you rather receive some training before starting a job?

- Do you like working directly with people (ex., customer service) or would you prefer a job that has limited or no interaction with people?

- Do you prefer more formal or more casual work environments? How would you feel about following a dress code or wearing a uniform?

Appendix III

Americans with Disabilities Act[1]

The Americans with Disabilities Act (ADA) prohibits employment discrimination against "qualified individuals with disabilities."

A "qualified individual with a disability" is

An individual with a disability who meets the skill, experience, education, and other job-related requirements of a position held or desired, and who, with or without reasonable accommodation, can perform the essential functions of a job."

The ADA definition of an individual with a disability is very specific.

A person with a "disability" is an individual who

- Has a physical or mental impairment that substantially limits one or more of his/her major life activities;
- Has a record of such an impairment; or
- Is regarded as having such an impairment.

The ADA specifically states that certain individuals are not protected by its provisions.

Who is not protected?

Persons who currently use drugs illegally are not protected under the ADA when an employer takes action because of their continued use of drugs. This includes people who use prescription drugs illegally as well as those who use illegal drugs. However, people who have been rehabilitated and do not currently use drugs illegally or who are in the process of completing a rehabilitation program may be protected by the ADA.

Reasonable accommodation is a critical component of the ADA's assurance of nondiscrimination.

Reasonable accommodation is any change in the work environment or in the way things are usually done that results in equal employment opportunity for an individual with a disability.

Some examples of reasonable accommodation include the following:

- Making existing facilities used by employees readily accessible to and usable by an individual with a disability
- Job restructuring
- Modifying work schedules
- Reassignment to a vacant position
- Acquiring or modifying equipment or devices
- Adjusting or modifying examinations, training materials, or policies
- Providing qualified readers or interpreters

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1. Excerpted from the Technical Assistance Manual on the Employment Provisions (Title I) of the Americans with Disabilities Act, Equal Employment Opportunity Commission, U.S. Government Printing Office, Washington, DC, 1992

Mental Health Services

Supportive housing has enabled thousands of people with mental illness to live successfully in the community. People with mental illness may need a variety of services ranging from supportive counseling and psychiatric support to job training and employment. Supportive housing projects may have on-site staff or rely on staff located off premises, such as case management services or an assertive community treatment (ACT) program.

Supportive housing projects serving individuals who have serious mental illness must provide access to quality psychiatric services, medication management and comprehensive treatment planning. Similarly, supportive services staff must address related complications that directly impact mental illness, such as health problems, alcohol and substance use, and social and economic issues. Shortcomings in any of these areas can exacerbate an individual's illness and undermine the efforts of the program staff.

The majority of people with mental illness can achieve psychiatric stability and live in the community if they are provided with the right treatments and necessary support. Most successful outcomes occur when psychiatric treatment is combined and coordinated with rehabilitation and other support services. Advances in psychiatric medications and community-based supports have made mental illness more manageable than ever before. In addition to programs often found in the community, supportive housing can provide case management and other individualized services that are specifically adapted to meet individual needs. Frequently, supportive housing programs are in the best position to help individuals pull together all necessary treatment and support. (See Appendix II, Overview of Community-based Mental Health Services.)

This chapter provides fundamental information about working with individuals who have mental illness and discusses strategies for developing and shaping supportive housing programs to promote recovery and self-sufficiency.

Mental Illness

Mental illness includes a broad range of symptoms and disorders that result in disturbances in thinking, perception, emotions, and/or behavior. A serious mental illness can negatively impact an individual's ability to function in major life areas, such as employment and interpersonal relationships, and can cause significant distress through negative mood states such as depression and anxiety. Mental illness may also involve "breaks with reality" (psychosis), as evidenced by delusions and hallucinations.

Mental illnesses are usually caused by a variety of factors including genetic predisposition, chemical imbalances in the brain, environmental stressors, and substance use. The typical age of onset of some mental illnesses, such as schizophrenia, is during the late teens to early 20s, although it can also occur at other

stages of life. The level and type of symptoms an individual has may fluctuate over time and in response to stress.

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM IV), a useful reference for program staff, categorizes and describes fifteen areas of psychiatric disorders. Within each of the broad categories, the manual describes diagnoses that are differentiated by specific sets of symptoms on five different axes. By understanding and working with each aspect of an individual's illness, staff can help shape treatment plans that have maximum impact. The five Axes are:

Axis I: Major psychiatric diagnoses (including substance abuse diagnoses)

Axis II: Personality disorders, mental retardation, and learning disabilities

Axis III: Medical conditions

Axis IV: Psychosocial and environmental stressors

Axis V: Global assessment and scoring of functioning (overall functioning: psychological, social, and occupational)

Types of Mental Illness

The DSM IV divides mental illness into fifteen major areas that are recorded as either Axis I or Axis II. Within each of these areas there are specific diagnostic categories.

- Adjustment disorders
- Anxiety disorders
- Cognitive disorders
- Disorders of childhood and adolescence
- Dissociative disorders
- Eating disorders
- Factitious disorders
- Impulse control disorders
- Mood disorders
- Personality disorders
- Psychotic disorders
- Sexual and gender identity disorders
- Sleep disorders
- Somatoform ("psychosomatic") disorders
- Substance-abuse disorders

A primary goal of mental health services is to address conditions of the Axis I diagnosis, such as schizophrenia, bipolar disorder, major depression, and alcohol abuse. However, a lack of intervention in other areas that are having a significant effect on the individual will negatively impact outcomes. Family, legal, or financial problems, for instance, can interfere with psychiatric stability. Similarly, individuals with personality disorders can have chronic interpersonal problems, such as difficulty forming and maintaining relationships and limited ability to resolve conflict. A major advantage of supportive housing programs is that they provide the opportunity to work closely with people over an extended period of time using a holistic approach, tailoring services and support to each tenant.

Supportive housing programs should be prepared to work with a variety of mental illnesses and behaviors. Frontline staff should be trained to broadly distinguish between major categories of mental illness and related symptoms. Although this guide does not provide in-depth discussion of specific psychiatric disorders, the reader is referred to the DSM IV and other texts on this subject included in Appendix I, which lists additional readings and resources.

Psychosis

Psychosis is a common feature of schizophrenia and other disorders such as schizoaffective, bipolar, and post-traumatic stress, and it may also occur in people who are seriously depressed or in response to substance use.

Since psychosis is a break with reality and often involves hallucinations and/or delusions, people who are psychotic often behave in bizarre ways in response to the internal stimuli that they are experiencing. The most common type of hallucination is auditory (hearing voices), although one can also have hallucinations that involve vision, smell, taste, and touch. Delusions are false beliefs that are held in spite of evidence to the contrary.

Since delusions and hallucinations are real to the person who is experiencing them, people cannot be talked out of them. Directly contesting or denying "the reality" of a person's delusions or hallucinations can be alienating and shut down communication. On the other hand, it is not advisable to agree with an individual's psychotic content either, as confirming the delusion or hallucination can cause the person to engage the worker in the psychotic as opposed to the reality-based dimensions of his/her experience.

A goal in working with people who are experiencing psychosis is to identify and engage around realities that can be shared. Listen for the emotions that are being generated by the delusion or hallucination; for example, if an individual believes that the FBI is coming to take him away, he will likely be very frightened. Staff might respond by saying, "You seem really scared. Let's figure out what will make you feel safer." In doing so, the staff person has not attacked the delusion nor reinforced it but instead responded to the person's feelings.

Dual Diagnosis of Mental Illness and Substance Abuse

Some people may have diagnoses of both mental illness and substance abuse. Disentangling these disorders can be a challenge because in some cases mental illness can predate substance use and, in others, alcohol or drug use may have occurred first. Achieving a clear understanding of a mental illness that is co-occurring with chemical dependency is often not possible. Significant cognitive impairments, for instance, can be caused by long-term alcohol and substance use; on the other hand, when an alcohol or chemically dependent person achieves sobriety, it may be discovered that the substance use has been masking a mental illness such as depression.

Mental health and substance-use issues need to be addressed simultaneously through an integrated treatment approach since changes in one condition can often cause changes in the other. Program structures should ensure that staff from all organizations involved in an individual's treatment communicate regularly and coordinate interventions. Responsibility for coordinating communication among these agencies often falls on supportive housing staff. (See chapter 6, Substance Use Services, for more on this subject.)

Working Toward Recovery

It is still not widely understood that complete or near recovery from a serious mental illness, including schizophrenia, is possible. The general public remains largely misinformed about the nature of mental illness and the success rate of modern treatments. In practice, however, many people recover from mental illness, returning to work and independently carrying out all routines of daily living.

Recovery from a serious mental illness requires a supportive environment. People who have mental illness are much more likely to improve if their relationships with family, friends, and the mental health community are positive and genuinely supportive. It is difficult for a mentally ill individual to remain motivated if those around him/her are not. A prolonged focus on "day treatment" or "maintenance," for instance, can stagnate the recovery process and reflect a limited perspective about the individual's capabilities. Similarly, individuals who have histories in institutional settings such as hospitals, prisons, and shelters often need help to shed adapted behaviors and set higher expectations.

Rehabilitation and Recovery from Mental Illness

In the 1950s, Yale University researchers began following 269 chronic schizophrenics at Vermont State Hospital.[1] Some had been languishing in the back wards of the hospital for years. The patients, most of whom were poorly educated and had little social support, participated in a comprehensive psychiatric rehabilitation program.

Participants in the study were linked to vocational counseling, jobs, family, and friends. The program emphasized peer support, rehabilitation, self-sufficiency and community integration. In a twenty-year longitudinal study, the researchers found that, in comparison to a group that received traditional treatment, the Vermont subjects were significantly more productive, had fewer symptoms, and exhibited better community adjustment and overall functioning. Over 25% of the study participants recovered completely from their symptoms. Approximately 50% of participants exhibited no signs of schizophrenia, although most of the people in this group showed some other problems in functioning.[2]

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1. Editors' Note: Diagnostic criteria for schizophrenia were less refined during this era, and some patients in this study would probably be diagnosed today as having bipolar disorder, psychotic depression, borderline personality disorder, or some other mental illness. Nonetheless, the patients included in the study were all seriously mentally ill and institutionalized, and the reported recovery rates are unchanged for those who participated.

2 DeSisto, M. J., et al. "The Maine and Vermont Three-Decade Studies of Serious Mental Illness." The British Journal of Psychiatry 167, (1995): 331-342.

Some people who have experienced serious mental illness identify themselves as "survivors", indicating that they have made it through the ravages of illness as well as environments that were often unkind and unjust to them. In other words, people not only have to deal with trying to overcome mental illness but also must contend with various social consequences including rejection, isolation, and unemployment. Frequently, the staff can assist tenants by helping them resume contact with family and friends, return to school or work, and have a satisfying social life. These efforts can happen simultaneously while providing assistance with money management, medication, and other basic activities of daily living.

There is no doubt, however, that some mental illnesses can cause very significant impairments, and recovery may occur very slowly. The negative symptoms of schizophrenia or depression, for instance, can make it difficult for some individuals to express thoughts, set long-term goals, and independently complete all of the tasks necessary for daily living. Similarly, the physical and cognitive effects of long-term mental illness and its treatment can often be noted in the demeanor of people who have been prescribed high doses of psychotropic medications for many years. Still, even in the most difficult cases, improvement happens, and most individuals can function at higher levels than expected. Working from a recovery perspective is important, as it helps foster upbeat and progressive environments that are motivational and productive.

Psychiatric Medication

Psychiatric drugs or "psychotropics" can substantially diminish many of the most disruptive symptoms of major mental illnesses, and they are often key to helping people live stable lives in the community. Initially developed in the 1950s, these medications spurred the release of hundreds of thousands of mentally ill people from state-operated psychiatric facilities across the nation. Since then, medication has improved, and the number and type of psychiatric medications have grown tremendously.

Psychiatric medications work on various chemical processes in the brain to reduce or eliminate psychiatric symptoms such as hallucinations, delusions, anxiety, and depression. Medications can substantially improve mood and levels of functioning, helping people to focus and achieve their goals. Medications also reduce the need for psychiatric hospitalization.

Specific medications and optimal dosages vary with each individual. A person may do well on one drug for a certain period of time but need different medication at another point in his/her life. Often people will be prescribed more than one drug and will usually take doses orally. Since psychiatric medications will not cure mental illness, they are a lifetime necessity for many people who have serious and persistent disorders.

Psychiatric medications also have downsides. Side effects vary from person to person and may include lethargy, weight gain, tremors, gastrointestinal disturbances, sleeping problems, and sexual dysfunction. Some side effects can be very serious and may even be life threatening. Where applicable, medication may also be prescribed to help diminish these side effects. Some medications require ongoing blood tests to ensure that the medication level is not toxic. (See Appendix III, Overview of Psychiatric Medications.)

Using a Rehabilitation Approach

The development of the psychiatric rehabilitation model began in the late 1970s in response to the deinstitutionalization of mentally ill people from state psychiatric centers. Unlike earlier custodial approaches, rehabilitation services consider each individual relative to his/her environment with the goal of increasing successful, independent functioning in living, social, learning, and work settings. Rehabilitation refers to a treatment philosophy and to assessment and intervention techniques designed to reduce disability, focus on strengths, and maximize self-sufficiency and adaptation to the environment.

> "In contrast to the de-institutionalization initiative, with its focus on emptying buildings, rehabilitation, with its focus on people outcomes, is a field in which one can become excited and enthusiastic. De-institutionalization opened the doors of the hospital and gave people a prescription for their medicine when they left. Rehabilitation tries to open the doors of the community and help people develop a prescription for their lives." [3]

Through the rehabilitation process, people with psychiatric disabilities recover a new sense of self and purpose. A fundamental principle of psychiatric rehabilitation is the involvement of the individual, engaging his/her active communication of values, experiences, feelings, ideas, and goals. The process of rehabilitation is characterized by a sense of hopefulness and an orientation toward the future. "A paradox of recovery is that in accepting what one cannot do or be, one begins to discover who one can be and what one can do." [4]

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3 Anthony, W. Rehabilitation Programs in the 1980's: Laying the Groundwork for the 1990's. Paper presented at the Twelfth Mary Switzer Memorial Seminar, 1988.

4 Deegan, P. "Recovery: The Lived Experience of Rehabilitation." Psychososocial Rehabilitation Journal 11, no. 4 (1988): 11–19.

Rehabilitation services have three phases: the diagnostic phase, which includes cognitive and functional assessments; the planning phase, which includes the identification of goals, objectives, and skills as well as environmental supports or modifications necessary to function successfully; and the teaching phase, which includes the use of resources, technologies, and supports to enable the individual to acquire new skills. The need for skills training can be wide ranging and include medication and symptom management, household management, advocacy skills, and interpersonal and problem-solving skills. Access to vocational training and employment opportunities for interested individuals is central to the rehabilitation approach.

Core Program Components

In addition to the core program components identified in chapter 2, Developing a Supportive Services Program, there are additional considerations when developing supportive housing programs that serve individuals who have mental illness. These areas include assistance to meet the obligations of tenancy, comprehensive assessment, coordination with psychiatric services, medication management, crisis intervention, and staff training.

Meeting the Obligations of Tenancy: The nature of mental illness is that it can negatively impact skill levels, behavior, and judgment. These consequences can sometimes diminish an individual's ability to meet the obligations of tenancy. As evidenced in the disproportionate number of homeless individuals who are mentally ill, ensuring housing stability for individuals who have serious mental illness is particularly important.

Failure to pay rent and other lease violations can jeopardize tenancy and are areas that usually need to be addressed by both property management and supportive services staff. In cases of nonpayment of rent, the service staff may assist by addressing income and benefits issues and/or intervening in money management and budgeting. Getting involved in lease infractions will often require that service staff also address related problems that are at the source of disruption, such as debts, substance use, or noncompliance with prescribed medications.

Problems might occur, for instance, with maintaining a living unit or apartment at a minimum standard of cleanliness. Some people lack the skills or interest to meet basic health and safety standards, and this can be compounded when people hoard food or have growing collections of newspapers or other materials. It is preferable to confront these issues early and not wait for circumstances to reach a crisis level. Optimally, the staff should be able to combine short-term strategies to address problematic behaviors with long-term interventions that address the root causes of problems that could ultimately lead to eviction.

Depending upon an individual's background, the nature of the mental illness, and the age of onset, a tenant may also need instruction and/or hands-on assistance to perform basic activities of daily living. It is necessary to have a thorough understanding of individual skill levels to determine the type of support that is required to effectively work with tenants who require extra assistance to maintain housing stability. (For an example of a tool used to assess community living skills, see Appendix V, Housing Skills and Supports Checklist, in chapter 2, Developing a Supportive Services Program.)

Tenants, building management, and service staff can usually work together to develop a plan that results in continued tenancy, even in the most difficult cases. When this is not possible, there should be clear guidelines for addressing situations that seem destined for eviction. If a tenant must leave the housing, the service staff should help the individual to locate an alternative housing setting. Although there are usually clear distinctions between the responsibilities of building management and service support staff, everyone must work together to address the specific behaviors that place an individual at risk of losing his/her housing. Sometimes, the potential risk of eviction may motivate the tenant to change problem behaviors and/or engage in treatment.

Housing Eligibility

Eligibility for housing based upon mental illness is often limited to those who have an Axis I psychiatric disorder and have difficulty functioning as a result. Functional difficulties include emotional, cognitive, social, and/or occupational problems. States and localities vary in their criteria for determining eligibility for local assistance and access to mental health housing opportunities and sometimes establish local priorities, such as a history of psychiatric hospitalizations or homelessness. Usually, however, a substance abuse disorder alone will not translate into eligibility for mental health housing. (Some of the more common housing options and models for people with mental illness are described in Appendix IV, Residential Options Serving People with Mental Illness.)

Comprehensive Assessment: An accurate psychiatric diagnosis is a core component of a mental health assessment. The diagnosis provides a framework for understanding specific illnesses, symptoms, and behaviors. The diagnosis also guides treatment and the prescription of medication. Effective interventions depend on thorough assessments and accurate diagnoses.

Beyond the psychiatric diagnosis, assessment is also a process of understanding the individual's strengths, abilities, fears, goals, interests, significant relationships and social supports. Assessments should also include an understanding of impulse control, memory, judgment, thought processes, and feelings about mental health treatment. It is important to learn about the extent and level of hallucinations, delusions, depression, anxiety, and substance use. In sum, staff have to be attentive to a broad range of information.

Assessments occur over time, and the nature of some mental illnesses may lengthen the process. Mental illness may, for example, cause an individual to be paranoid, distrustful, or disorganized. Similarly, disorganized thinking or delusions can make it difficult for some individuals to stay focused on goals. Ongoing assessment and monitoring of functioning levels are important aspects of support, as changes in behavior patterns can signal a need for staff intervention. When an assessment reveals changes, a review and update of the treatment plan may be indicated.

Case Study: The Importance of Accurate and Ongoing Assessment

Ms. P is a 50-year-old single woman who has worked on and off for the U.S. Postal Service for the past twenty years and has had several leaves of absence due to mental illness. Living in supportive housing for seven years and in recovery from alcoholism for almost three and a half years, Ms. P was seeing a psychiatrist at a local mental health clinic. She was diagnosed as having paranoid schizophrenia and alcohol abuse in full, sustained remission. She was taking 12 milligrams of Haldol daily.

Ms. P's interaction with others, including the support staff, was always friendly though somewhat limited in depth. Ms. P's case manager worked to maintain a relationship with her and made it a point to stay in contact. During the course of one visit, however, Ms. P told the case manager that he was telephoning too much and shortly thereafter accused him of calling during the night. Over the next month, her involvement with the case manager and others in the building became more strained, and fellow tenants began to avoid her because she was irritable and argumentative.

The case manager noted that Ms. P had increasingly rapid mood swings and an increased level of hostility, and he suggested that changes in Ms. P's behavior coincided with a change in her work schedule from twenty to forty hours per week. Following a case conference, staff decided to address Ms. P's deteriorating condition with her treating psychiatrist and also arranged for a consultation to occur between Ms. P's psychiatrist and another psychiatrist working with the supportive services program. Following this consultation, Ms. P was re-evaluated.

Ms. P's more pronounced symptoms ultimately resulted in a change in her diagnosis from paranoid schizophrenia to schizoaffective disorder, bipolar type. A mood stabilizer and an atypical antipsychotic were added to her medication regimen, and the dosage of Haldol was decreased. Ms. P was able to regain psychiatric stability and to remain employed full-time at the postal service. It was concluded that, in the past, Ms. P's alcohol use had been masking an underlying mood disorder that ultimately emerged after a long period of sobriety and the stress of the increase in work hours.

Coordination with Psychiatric Services: Psychiatric services should be provided in coordination with rehabilitation services and other supports. In some settings, psychiatrists are on the staff of the supportive housing program, and their notes are included in the program's charts or records, ensuring access to information for those who need it. Preferably, in all cases, treating psychiatrists are coordinating with supportive service staff, adjusting treatment and support as required.

Regular communication between the treating psychiatrist and supportive service staff is essential. Case managers and other frontline program staff are in regular contact with tenants and are able to observe changes in behavior that may indicate increased instability or a need to adjust the psychiatric medication regimen and other aspects of the treatment plan. A psychiatrist who is seeing a tenant only once or twice a month usually benefits from information provided by others who have more contact. Additionally, helping tenants to recognize changes and discuss them with their respective psychiatrists is key to increasing their sense of control and reducing their feelings of powerlessness.

Assistance with Medication Management: Psychiatric medication is a critical component of the treatment of mental illness, and there are various ways to assist tenants with medication management issues. (See Appendix V, Ten General Principles for the Use of Psychiatric Medications.)

In most states, "dispensing" medication means having a nurse or other licensed health professional handle the prescribed medication, hand it to the individual, and watch him/her ingest it. Since this level of supervision is not always necessary and the financial cost associated with it can be prohibitive, supportive housing programs have also incorporated a range of other options that do not translate into dispensing but do assist with medication management and compliance. The following practices and supports can be offered individually or in combination.

- **Central Storage of Medication** Medication kept by the housing program is stored in a secure central location, such as a medication lockbox. Tenants are expected to come to the program area to take medication as prescribed and dispense the medication to themselves. Designated staff people log the date, time, and dosage taken. (Pre-packaged individual doses can make this process substantially easier, and some providers have made arrangements with local pharmacies to provide this service.)
- **Record Keeping/Pill Counts** Tenants take responsibility for obtaining, storing, and taking medication independently. Staff members collaborate with tenants to ensure that prescriptions get filled and medications are being taken correctly. The staff keep records of prescription dates, dosages, pill counts, and any related issues.
- **Reminders** Medication is not strictly monitored, but inquiries about medication are part of individual counseling and case management services.

In some cases, it takes time and several adjustments of drugs and dosages for a psychiatrist to determine an individual's optimal medication regimen. This can be frustrating because psychotropic drugs can take weeks to have an effect and then do not always work. Additionally, people can experience negative side effects in the interim. Some individuals give up trying, particularly if they were ambivalent about taking medication in the first place. Supportive housing staff can play a critical role with tenants who stop taking or want to stop taking medication. Ongoing psychoeducational information about mental illness and medication can make a critical difference in improving long-term compliance. Educational supports should review what the prescribed drugs can and cannot accomplish as well as potential side effects.

In general, taking medication is not a goal; rather, medication is a tool that enables people to manage their symptoms in order to achieve their goals. Helping people to see this connection is often a motivator for compliance. Additionally, once an individual is taking medication, he/she may not be able to see the improvements that have been achieved or may not connect the improvements to the medication. Direct

service staff are especially well positioned to help individuals see these connections and to remain motivated to take medication.

Where applicable, staff should explore an individual's unwillingness to take psychiatric medication (e.g., bad experiences in the past, serious side effects) and try to address these concerns if possible. (For instance, many of the earlier medications had extremely unpleasant side effects, and many of the newer drugs do not.) In some cases, people may agree to take medication for a trial period only. Since mental illness is one of the most stigmatized illnesses one can have, taking psychiatric medication is an acknowledgment of having a mental illness, which can be very hard to accept. The staff should not underestimate the difficulties that the social stigma brings and may need to help tenants manage painful feelings.

Staff must take complaints about side effects seriously and help people advocate with their physicians as needed. They can also be helpful in working with tenants to see that the benefits of medication can outweigh the side effects. By serving as allies who are willing to discuss the issue fairly and openly, staff can play a major role in helping people with this difficult and important part of their treatment.

Crisis Intervention: Unfortunately, many people with mental illness experience crises, and programs should have guidelines for responding to decompensation, suicidal behavior, and other psychiatric crises. When a person is a danger to self or others, staff should contact the police and local emergency medical units. This guide provides a more complete discussion of managing crisis, including psychiatric crisis and hospitalization, in chapter 7, Crisis and Conflict.

Connections to Community-based Services: There are many types of community-based treatment and rehabilitation programs that have been designed for individuals who have mental illness. To be most effective, supportive housing staff must develop relationships within their local network of health care and human services organizations. A basic understanding of different programs that are available in the community as well as the roles of different departments and personnel in local hospitals and psychiatric facilities are essential.

Programs that might be used to assist a mentally ill individual include continuing day treatment programs, community mental health clinics, outpatient programs targeting substance and alcohol use, specialized outreach programs, case management and assertive community treatment (ACT) teams, clubhouses, specialized employment programs, hospital-based programs, and peer support programs. Services within other systems may also be needed, such as legal services, educational programs, family supportive services, and entitlements programs. Localities vary widely in the types and range of referral sources available. (See Appendix II, Overview of Community-based Mental Health Services.)

Clubhouses

A clubhouse is a rehabilitative program for adults with psychiatric disabilities. Members work alongside staff people in planning and operating the clubhouse and engage in mutually planned vocational, educational, and social activities that develop skills and promote rehabilitation. A central goal of the clubhouse is to promote recovery and improve the quality of life for its members.

The founders of Fountain House, a nationally acclaimed mental health organization, developed the clubhouse model in the 1950s in New York City. The original members, a group of formerly institutionalized mentally ill individuals, organized a club to help each other adjust to life in the community. They helped each other with issues such as finding work, locating housing, and dealing with the stress of mental illness. Since then, the clubhouse movement has spread around the globe and includes thousands of programs.

A major emphasis of the clubhouse model is employment. Members often work for the club or are gainfully employed in the community. The opportunity to work is a central principle of the rehabilitation process and promotes self-reliance and independence. Membership in the clubhouse leads to continued growth, improved self-esteem and increased confidence. (See chapter 3, Employment Services, for a discussion of employment for persons who have mental illness.)

Staff Training: Although the roles and responsibilities of staff members vary with the type of program, ensuring psychiatric and housing stability is central to most supportive services programs, and staff training and supervision should address these two major areas. Mental health practitioners require ongoing training. Similarly, professional supervision should be provided on an individual basis. Case conferencing or discussing the service plan of individual tenants with the entire service team can also be an effective learning tool. If possible, the staff should have opportunities to attend conferences and training workshops so that they can remain current about advances in treatment and services.

To be most effective, supportive services staff members should receive training and supervision as needed in the following areas: the major psychiatric disorders and associated symptoms and behaviors, the use and management of psychiatric medications, principles of psychiatric rehabilitation, substance-use services, outreach and engagement, case management, counseling skills, and crisis intervention techniques.

Appendix I

Resources and Additional Readings

American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision*. Washington, D.C.: American Psychiatric Press, 2000.

This text revision of the DSM IV updates and lists all current mental disorders and their general characteristics. Specifically, new information on associated features, including associated laboratory and physical findings, has been added for many of the disorders. Sections on prevalence, gender/age/culture, course, and familial pattern have also been revised.

Anthony, W. *Rehabilitation Programs in the 1980's: Laying the Groundwork for the 1990's*. Paper presented at the Twelfth Mary Switzer Memorial Seminar, 1988.

The author emphasizes that the era of deinstitutionalization is past and focuses on the conceptual and empirical foundations of the new era of rehabilitation. The paper examines the development of now established concepts such as spectrum of services, improvement of quality of life, case management, and strengthening social/environmental support for psychiatric consumers. Early empirical support for rehabilitation programs is also discussed.

Bachrach, L. L. "What We Know about Homelessness among Mentally Ill Persons: An Analytical Review and Commentary." *Hospital and Community Psychiatry* 43 (1992): 453–464.

The author analyzes and comments on the current literature on the homeless mentally ill population by using the following questions as points of departure: (1) How much of the homeless population suffers from chronic mental illness? (2) Has deinstitutionalization precipitated an increase in homelessness among mentally ill persons? (3) What kinds of programs and what specific services should homeless mentally ill individuals be offered?

Baxter, E., and K. Hopper. *The Homeless Mentally Ill: A Task Force Report*. Washington, D.C.: American Psychiatric Association, 1984.

A review of the nature and value of developing databases on homelessness and an analysis of official positions and policies about the problem. The authors discuss the goals, standards, and strategies of advocacy, with and on behalf of homeless people.

Carling, P. J. "Housing and Supports for Persons with Mental Illness: Emerging Approaches to Research and Practice." Hospital and Community Psychiatry 44 (1993): 439–449.

Supported housing, based on principles of consumer choice, integrated community housing, and flexible services, is replacing residential treatment facilities for persons with psychiatric disabilities. To improve understanding of this approach, its evolution, and issues involved in its implementation, this paper reviews studies of the effectiveness of traditional housing programs and early reports of the development of supported housing programs.

Cournos, F. "The Impact of Environmental Factors on Outcomes in Residential Programs." *Hospital and Community Psychiatry* 38 (1987): 848–852.

A review of the literature on the impact of the residential environment on the course of serious mental illness. In most studies, environmental variables were better predictors of outcome than were patient variables. There is a growing body of evidence to suggest that the course of serious mental illness can be favorably modified by providing a low-stress environment that neither overwhelms nor underestimates the patient.

Deegan, P. "Recovery: The Lived Experience of Rehabilitation." *Psychosocial Rehabilitation Journal* 11 (1988): 11–19.

Reflecting on her personal experience with psychiatric illness, the author illustrates the important distinction between rehabilitation and recovery. Her insights yield recommendations that rehabilitative programs should consider if those programs are to encompass the process of recovery as well. Emphasis is placed on the need for nurturing support, flexibility, and innovation, peer support, and less dichotomization between staff and consumers.

Ford, J., et al. "Needs Assessment for Persons with Severe Mental Illness: What Services Are Needed for Successful Community Living?" *Community Mental Health Journal* 28 no. 6 (1992): 491–503.

This article presents the results of a survey of ninety community mental health agency case managers in Ohio. They were asked to assess the community support and residential needs of more than 1,400 people with serious mental illness. The survey was conducted to determine what services in addition to traditional case management are most needed to sustain a good quality of life in the community. Medication monitoring, psychosocial services, vocational activities, and therapy were rated as priority needs.

I'm Still Here: The Truth about Schizophrenia. Wheeler Communications Group, 1996.

In this hour-long documentary video, individuals who have schizophrenia describe their lives and researchers discuss their challenges. Wheeler Communications Group has an entire series of nonfiction film productions on the topic of schizophrenia.

Katz, S. E., D. Nardacci, and A. Sabatini. *Intensive Treatment of the Homeless Mentally Ill*. Washington, D.C.: American Psychiatric Press, 1993.

This book describes the clinical strategies and research findings of the innovative New York City Homeless Emergency Liaison Project (Project HELP), a comprehensive program developed specifically for the evaluation, treatment, and rehabilitation of seriously impaired homeless mentally ill individuals. This work offers insight to working with homeless mentally ill people. The findings reveal that it is possible to develop highly specific therapeutic interventions for this population.

Lamb, H. R., L. L. Bachrach, and F. I. Kass, eds. *Treating the Homeless Mentally Ill: A Task Force Report of the American Psychiatric Association.* Washington, D.C.: American Psychiatric Association, 1992.

Researchers have documented the range of needs and devised new methods for increasing our understanding of homeless individuals with serious mental illness. In this work, the progress-to-date in research, the evolution of new service approaches, and the development of federal, state, and local policies to meet the needs of homeless individuals with mental illness are reviewed. The many challenges that remain are also considered.

Lipton, F. R., with Siegal, C., Hannigan A.E., Samuels, J.A., and S. Baker. "Tenure in Supportive Housing for Homeless Persons with Serious Mental Illness." *Psychiatric Services 51*, no. 4 (2000): 479–486.

This study examines the long-term effectiveness of approaches to housing persons with serious mental illness. The results showed that long-term residential stability can be enhanced by providing access to safe and affordable supportive housing.

Marsa, L. "The Schizophrenia Myth: Actually Three-Quarter Recover, Lead Full Lives." *Los Angeles Times*, 24 June 2000.

Linda Marsa, a Los Angeles Times staff writer, counters the myth that persons living with schizophrenia are hopelessly incurable. She illustrates this point by noting a Yale University Study that followed the lives of 269 chronic schizophrenics at Vermont State Hospital for more than twenty-five years and found a significant number had recovered and had jobs, families, and friends.

Medical Economics. *Physicians' Desk Reference 2001*, vol. 55. Montvale, N.J.: Medical Economics, 2000.

Physicians' Desk Reference is the Food and Drug Administration–approved prescription drug data source on more than 4,000 drugs with the latest available findings on side effects and interactions. This publication includes color photos and three indexes for fast retrieval of all drug information.

Metraux, S., S. Marcus, and D. P. Culhane. "Assessing the Impact of the New York/New York Supported Housing Initiative for Homeless Persons with Severe Mental Illness on Public Shelter Use in New York City." *Psychiatric Services*, (in press).

This report examines the assumption that providing housing with supportive services to persons with histories of homelessness and mental illness reduces the need for acute care services such as inpatient hospitalizations. The authors assess the impact of the New York/New York (NY/NY) supportive housing initiative on the use of psychiatric hospitals administered by the New York State Office of Mental Health.

Neugeboren, J. *Transforming Madness: New Lives for People Living with Mental Illness.* New York: Morrow, 1999.

Neugeboren explores the world of people living with severe mental illness and the transformations in their lives as they cross over from difficulty in managing mental illness to lives filled with promise. The author offers a message of hope and recovery for people living with mental illness.

Srebnik, D., et al. "Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness." *Community Mental Health Journal* 31 (1995): 139–152.

Consumer choice is a central principle of psychosocial rehabilitation and supported housing approaches. This study assessed the level of housing choice and the relationship of this choice to community success in supported housing demonstration projects in five states. The relationship of choice to community success over time demonstrated that choice was positively related to housing satisfaction, residential stability, and psychological well-being. Discussion focuses on implications of the findings for mental health services and public policies.

Stein, L. I., and A. B. Santos. *Assertive Community Treatment of Persons with Severe Mental Illness.* New York: W. W. Norton and Company, 1998.

This book addresses policy issues associated with the dissemination of ACT services. Specifically discussed are key modifications and adaptations necessary to implement effective ACT programs in rural settings for homeless populations to maximize employment opportunities and to minimize the use of illicit drugs.

Torrey, E. F. *Surviving Schizophrenia: A Manual for Families, Consumers and Providers.* New York: Harper Collins, 1995.

Families and mental health professionals need to know about one of the most widespread and misunderstood illnesses. The book includes detailed information regarding symptoms, medications, treatment, and prognosis of schizophrenia.

Tsemberis, S., and S. Asmussen. "From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model." *Alcohol Treatment Quarterly*, 17, no. 2 (1999): 113–131.

This article describes essential elements of the Consumer Preference Supported Housing (CPSH) model of homelessness prevention in use at Pathways to Housing in New York City. This intervention prevents homelessness by engaging and housing homeless substance abusers with psychiatric disabilities that other programs have rejected as "treatment resistant" or "not housing ready."

Wheeler Communication Group, Inc. *I'm Still Here: The Truth about Schizophrenia.* Honeoye, NY: Wheeler Communications Group, 1996.

In this hour long documentary video, individuals who have schizophrenia describe their lives and researchers discuss their challenges. Wheeler Communications Group has an entire series of non-fiction film productions on the topic of Schizophrenia.

Internet Sites

The American Psychiatric Association

http://www.psych.org

The American Psychiatric Association is a medical specialty society recognized worldwide. Its 40,500 U.S. and international physicians specialize in the diagnosis and treatment of mental and emotional illnesses and substance-use disorders. Site visitors may view an electronic Diagnostic and Statistical Manual of Mental Disorders and other publications.

Internet Mental Health

http://www.mentalhealth.com

This site is a free encyclopedia of mental health information, promoting improved understanding, diagnosis, and treatment of mental illness. Information available includes descriptions of the fifty most common psychiatric disorders, information on psychiatric medications and side effects, research information on diagnoses, and links to related sites.

Mental Health Matters

http://www.mental-health-matters.com

Mental Health Matters was founded to provide articles, information, and resources on mental health and mental illness, psychological symptoms, traditional and alternative treatments, and medications for psychiatric disorders to mental health consumers, professionals, students, and supporters.

National Alliance for the Mentally Ill

http://www.nami.org

This web site is dedicated to improving the lives of people with severe mental illness and their family and friends. The National Alliance for the Mentally Ill provides up-to-date information on a variety of mental illnesses, including schizophrenia, mood disorders, and personality disorders. Information includes recommended books and readings, a help line, information on membership, statistics, and links to other relevant Internet resources.

National Resource Center on Homelessness and Mental Illness

http://www.prainc.com/nrc

The National Resource Center on Homelessness and Mental Illness provides technical assistance, identifies and synthesizes knowledge, and disseminates information. Users can be linked to findings from federal demonstration and Knowledge Development and Application projects, research on homelessness and mental illness, and information on federal projects.

New York University School of Medicine–Psychiatry

http://www.med.nyu.edu/Psych/public.html

The NYU School of Medicine–Psychiatry provides the public with a wealth of information on mental illnesses, diagnoses, treatment alternatives, self-help and advocacy groups, and information for family members, as well as numerous articles and booklets about mental illness.

Psych Central: Dr. John Grohol's Mental Health Page

http://psychcentral.com

This site is an annotated and regularly updated guide to useful web sites, newsgroups, and mailing lists online in mental health, psychology, social work, and psychiatry.

Appendix II

Overview of Community-Based Mental Health Services

Assertive community treatment (ACT) teams are designed to provide support and decrease the need for hospitalization for individuals with mental illness who would not usually get involved in treatment programs. The programs are based on an assertive outreach approach, with hands-on assistance provided to individuals in their homes and neighborhoods. Services are provided by multidisciplinary teams and include crisis intervention, medication monitoring, social supports, assistance with everyday living needs, access to medical care, psychoeducational supports to families, and employment assistance.

Case management services are provided by community-based or public agencies and vary in level of intensity. The purpose of case management is to provide any assistance the consumer needs to remain psychiatrically stable and live as independently as possible. Case management services include escorting programs or appointments; teaching daily living skills such as personal hygiene, cleaning, cooking, shopping, budgeting, communication, and health maintenance; and providing support in achieving/maintaining sobriety, taking medication as prescribed, and keeping appointments. Case management services can be tailored to assist a person maintain stability and/or provide rehabilitation services (i.e., teaching various skills) so that the individual can function at a more independent level. These services can be mobile or sited within a mental health clinic or other treatment program.

Clubhouse programs are consumer-oriented rehabilitative programs for adult individuals with a psychiatric disability (in some cases with a history of substance abuse), whose members work alongside staff in planning and operating the clubhouse program. Members engage in mutually planned vocational, educational, and social activities that develop skills and promote rehabilitation. A major component of the clubhouse is employment, either working in and for the club or becoming gainfully employed in the community. Common areas of concentration within the clubhouse include learning about food service, clerical work, maintenance, horticulture, and so on. The opportunity to achieve gainful employment is the central principle of the rehabilitation process, which promotes self-reliance and independence. Membership leads to continued growth, increased self-esteem, and a sense of empowerment for members.

Continuing day treatment provides a social setting in which individuals recovering from mental illness learn social skills and daily living skills in order to increase independent functioning. Structured therapeutic groups meet and discuss such topics as communication skills, problem solving, vocational exploration, and symptom management. Social and recreational groups are also offered. Some programs have groups addressing substance use and some provide medication management. Many provide case management and referral services as well. Individuals usually attend three to five days a week, and there is usually no time limit to participation.

MICA continuing day treatment program is a rehabilitative program offering day treatment activities and case management for adults with chronic mental illness in combination with chemical abuse problems.

Mobile crisis teams provide psychiatric crisis intervention services directly in the community to individuals in need and to their families. In addition, staff members are available to provide interim supportive services to individuals who have been in crisis and are awaiting formal entry into an outpatient or residential psychiatric treatment program. Mobile Crisis Teams are usually linked to large hospitals and respond to crises in their catchment area.

Outpatient clinics/programs provide treatment designed to reduce symptoms, improve functioning, and provide ongoing support. Services include assessment, health screening and referral, counseling, medication therapy, medication education, symptom management, and psychiatric rehabilitation-readiness determination and referral.

Outreach teams provide services to homeless individuals living in public spaces. These teams work to engage and build trust with individuals over an extended period. They often distribute food and make a variety of referrals, including linking individuals to drop-in centers or shelters.

Partial hospitalization programs provide active treatment designed to stabilize and reduce acute symptoms, to serve as an alternative to inpatient hospitalization, or to reduce the length of a hospital stay within a medically supervised program. Eligibility for admission to a partial hospitalization program is based on a designated mental illness diagnosis that has resulted in dysfunction due to acute symptomatology and requires medically supervised intervention to achieve stabilization (and which, without a partial hospitalization program, would necessitate admission to or continued stay in an inpatient hospital.) Services include assessment, health screening and referral, symptom management, medication therapy, medication education, verbal therapy, case management, crisis intervention services, activity therapy, and clinical support services.

Appendix III

Overview of Psychiatric Medications[5]

Major Classes of Medications

1. Antipsychotics
2. Mood Stabilizers
3. Antidepressants
4. Anxiolytics/Hypnotics
5. Miscellaneous Agents

1. Antipsychotics

Used to treat the following:

- Schizophrenia
- Schizoaffective disorder
- Mania/bipolar disorder type I (with mood stabilizers)
- Psychotic depression (with antidepressants)
- Dementia
- Psychosis second to medical conditions
- Tourette's disorder
- Severe personality disorders (borderline and schizotypal)
- Obsessive-compulsive disorder (with antidepressants)
- Autism

The treatment of schizophrenia requires the targeting of four primary categories:

Positive symptoms: Auditory hallucinations, delusional thinking, thought disorder, motor agitation.

Negative symptoms: Social withdrawal, blunted affect, passive behavior, impoverished thinking.

Cognitive dysfunction: Decreased attention span, impaired memory, impaired executive functioning. Cognitive functions influence successful community functioning in people who have schizophrenia, even more than positive symptoms do.

Mood symptoms: Affective liability, depressed mood.

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5 Nardacci, D.E.: "Overview of Psychiatric Medications." New York: CUCS In-Service Training, 2001.

Antipsychotics can be divided into two classes:

Atypical antipsychotics are the newer medications like Risperidal, Zyprexa, Seroquel, Clozaril, and Zeldoc.

These medications are more likely to benefit all the targeted categories of schizophrenia: positive symptoms, negative symptoms, cognitive dysfunction, and mood symptoms. Atypicals are less likely to cause unwanted motor side effects like stiffness, akathisia, acute dystonias, and tardive dyskinesia.

Conventional antipsychotics are the older medications like Haldol, Prolixin, Thorazine, Mellaril, Navane, Stelazine, Trilafon, Loxitane, and Moban.

These medications are primarily beneficial in reducing the positive symptoms of schizophrenia and also work on mood symptoms to a limited extent. They are not really helpful for treating negative symptoms and can actually worsen cognitive functioning. They are generally more likely to cause unwanted motor side effects.

2. Mood Stabilizers

Used to treat the following:

- Mania/bipolar disorder type I (often with antipsychotics)
- Hypomania/bipolar disorder type II
- Schizoaffective disorder (with antipsychotics)
- Cyclothymia
- Aggression second to brain injury
- Borderline personality disorder
- Post-traumatic stress disorder
- Depression (to boost antidepressants)

Mood stabilizers include Lithium and a number of medications originally marked for the treatment of epilepsy, the anticonvulsants, such as Depakote, Tegretol, Neurontin, Lamictal, Topomax, and others. Antipsychotic medications such as those listed in the previous section also have mood stabilizing properties but do not work as well as the first line mood stabilizers like Depakote and Lithium.

Mood stabilizers are primarily used to control symptoms such as affective liability, irritability, expansiveness, motor agitation, grandiosity, and pressure of speech. However they are also useful in decreasing the frequency and severity of "swings" between mania, depression, and "mixed states" and reducing aggression. They are less effective at treating the depressive phase of bipolar illness.

3. Antidepressants

Used to treat the following:

- Major depression
- Dysthymia
- Panic disorder
- Obsessive-compulsive disorder
- Bulimia nervosa
- Schizoaffective disorder (with antipsychotics)
- Generalized anxiety disorder
- Social phobia (and avoidant personality)
- Attention deficit disorder (ADD, ADHD)
- Smoking cessation
- Post-traumatic stress disorder
- Premenstrual dysphoria
- Body dysmorphic disorder
- Chronic pain syndrome
- Impulsive aggression/agitation
- Hypochondriasis
- Borderline personality disorder
- Premature ejaculation
- Autism
- Trichotillomania
- Sexual compulsivity
- Compulsive gambling
- Kleptomania

Antidepressants can be divided into several different classes based on mechanism of action and pharmacodynamic properties. The principle classes of antidepressants are the following:

Selective Serotonin Reuptake Inhibitors (SSRIs). This is the most commonly prescribed group of antidepressants and includes Prozac (fluoxitine), Zoloft (sertraline), Paxil (paroxitene), Luvox (fluvoxamine), and Celexa (citalopram). These drugs have only modest differences from one another in efficacy and side effect profiles but differ substantially in their drug-drug interactions. SSRIs are effective over a wide range of diagnoses and are generally very well tolerated and compatible with an active lifestyle, have little sedation effect, and cause relatively less weight gain. They may, however, impair sexual functioning.

Serotonin Antagonist Reuptake Inhibitors (SARIs). SARIs include the newer antidepressants, Serzone (nefazodone) and Desyrel (trazodone), and have a narrower range of efficacy than the SSRIs but are also safe and relatively well tolerated. They tend to be more sedating but do not impair sexual functioning. Serzone does have significant drug interactions with a number of other medications. Trazodone is often used as a sleeping pill with other antidepressants.

Serotonin/Norepinephrine Reuptake Inhibitors. Effexor (venlafaxine) is the only currently marketed member of this group. Some people, who do not respond to the other categories of antidepressants, are helped by this drug. Side effects may include slight nausea, impairment in sexual functioning, and increase in blood pressure.

Norepinephrine/Dopamine Reuptake Blocker. Wellbutrin (bupropion) is the only agent in this group. It is pharmacologically very distinct from the other agents, is structurally related to amphetamine, and works for attention deficit disorder (although it is not addictive). It is also marketed as Zyban and used in smoking cessation. Like the SSRIs, it is very safe and nonsedating and has few drug interactions. It is relatively safe for bipolar depression although it may exacerbate psychosis in susceptible patients. Because it has a distinct mechanism of action, it is often used in combination with other antidepressants to boost their effectiveness in people whose mental illnesses are unresponsive to medication.

Tricyclic (Heterocyclic) Antidepressants (TCAs). Prior to the arrival of Prozac and the other SSRIs, these were the most commonly used antidepressants, but their use has dwindled substantially because of numerous safety issues.

The most commonly used tricyclics include Elavil (amytriptyline), Pamelor (nortripyline), Anafranil(clomipramine), Tofranil (imipramine), Norpramin (desipramine), Sinequan (doxepine), Surmontil (trimipramine), and Vivactil (protripyline), and the related drugs Ludiomil (marprotiline) and Ascendin (amoxapine). Tricyclics are available in very cheap generic forms (still a favorite for use in correctional facilities) but are very dangerous in overdose.

Monoamine Oxidease Inhibitors (MAOIs). MAOIs include Nardil (phenelzine), Parante (tranylcypromine), and Marplan (isocarboxazid). This is another older seldom-used class of antidepressants that actually have a very broad range of efficacy and are often effective in treatment of cases that are unresponsive to other psychiatric medication. The drawback is that they require significant dietary restrictions and are incompatible with many other medications. When taken with aged foods (cheeses, meats, overly ripe produce, etc.) and certain other medications (stimulants and many over-the-counter cold preparations), they can cause a fatal hypertensive crisis and death. They are also dangerous in combination with most other antidepressants. They are primarily used as medications of last resort in highly reliable patients able to follow all necessary restrictions.

4. Anxiolytics/Sedative Hypnotics

Used to treat the following:

- Insomnia
- Generalized anxiety disorder
- Panic disorder
- Situational anxiety/phobias (fear of flying, fear of dental work, etc.)
- Acute agitation in emergency settings
- Psychosis (for rapid control of symptoms before antipsychotics and/or mood stabilizers have begun to work)
- Alcohol and sedative detoxification
- Social phobia
- Catatonia/diagnostic interviewing

Benzodiazepines

The largest most important group of sedative agents include the anxiolytics, Valium (diazepam), Ativan (lorazepam), Klonopin (clonazepam), Librium (chlordiazepoxide), Xanax (alprazolam), and others. Benzodiazepines also include the popular hypnotics (sleeping pills), Restoril (temazepam), Halcion (triazolam), and Dalmane (flurazepam). These drugs differ from one another mainly in terms of their rapidity of onset and half lives (how long they remain in the body). Generally shorter-acting agents like Xanax and Ativan have the highest abuse risk. Barbiturates like Seconal, Amytal, and Tuinal are older tranquilizing agents with severe abuse potential that are extremely lethal in overdose. Phenobarbital, a less addictive member of the barbiturate family, is commonly used in the treatment of epilepsy.

Buspar (Buspirone)

This is a unique anxiolytic without any risk for addiction that is sometimes used as an alternative to the benzodiazepines. It has a much narrower spectrum of action and does not work for panic or sleep, but it is useful for generalized anxiety disorder and potentiating antidepressants. It probably has a mild antidepressant effect on its own. Unlike benzodiazepines, it has a delayed onset of action and generally takes several weeks to work.

5. Miscellaneous Agents

The miscellaneous agents are the following:

- Medications commonly used to treat side effects
- Psychostimulants
- Cognitive enhancers
- Thyroid medications

The medications commonly used to treat side effects include Cogentin (benzotropine), Artane (trihexphenidyl), Benadryl (diphenhydramine), Symmetrel (Amantadine), Inderal (propranolol), and Benzodiazepines. Not all side effects of psychotropic medication can be treated. These medications treat side effects related to increased anxiety, body tics, and tremors.

Stimulants are used to treat the following:

- Attention deficit disorder
- Narcolepsy
- Depression augmentation
- Depression in the medically compromised (elderly, AIDS patients, cancer patients, etc.)

The most commonly used stimulants are Ritalin (Methylphenidate), Amphetamines (Dexedrine and Adderall), and Cylert (Pemoline).

Cognitive Enhancers: The agents are used in the treatment of patients with Alzheimer's disease and dementia.

Thyroid Hormone: Thyroid hormones are important in regulating the body's baseline metabolic rate. Thyroid hormones are being used increasingly in psychiatry with antidepressants and to reverse lithium-induced thyroid dysfunction and cognitive impairment.

Appendix IV

Residential Options Serving People with Mental Illness

Many different housing and program models have been developed along the continuum of residential options for individuals who have psychiatric disabilities. At one end of the continuum is lease-based permanent housing, which is often operated in conjunction with supportive services; at the other end are residential programs that have more intensified treatment requirements and are intended to have limited lengths of stay. In recent years, "supportive housing" has become a popular term, referring to all housing approaches linked to some form of support services regardless of configuration. For mentally ill individuals, this includes supported housing in a single-site setting, scatter-site apartments, supervised community residences and group homes, and safe havens.

Nationally there is a wide range of housing programs that have been developed for people who have mental illness, although not all options are available in most communities. Housing models differ fundamentally regarding the following:

- Goals and philosophies
- Length of stay
- Staffing levels
- Program participation requirements
- Rules
- Rents
- Resident mix (including people with mental illness with other population groups)
- Legal rights to tenancy
- Level of functioning requirements
- Level of supervision provided
- Autonomy of the residents to act independently

Since the 1970s, there has been a much greater emphasis on the importance of providing individuals with psychiatric disabilities a range of community-based housing options. In more recent years, there has also been recognition of the importance of offering permanent housing with supportive services. In these settings, services are usually geared to support housing stability and to help tenants achieve maximum independence and personal growth. Independence, which refers to an individual's autonomy, includes decisions about use of income, management of medication, privacy, and daily routines.

Following are examples of housing and program models that provide various levels of support for people with mental illness.

Permanent supportive housing in a single-site setting usually offers a single room with a private bath and kitchenette, though some buildings have shared bathrooms and kitchens. These settings are designed for individuals who are able to live independently with modest support, which is usually provided on-site in varying configurations. Tenants are not required to use the supportive services as a condition of tenancy, although a relationship between the service program and tenant is preferred. Many housing sites serve a mixed tenancy that includes formerly homeless and mentally ill individuals, people living with AIDS, and low-income working people. Tenants usually have a lease and pay 30 percent of their income for rent. In some locales and research projects, this model is called permanent supported housing.

Scatter-site apartments in the community may be individual units or shared arrangements of one to four adults. Housing may be permanent or transitional, clustered in one area or throughout several neighborhoods, in multiunit dwellings or single-family homes. A range of mental health and supportive services are made available through mobile services, outreach and case management programs, and neighborhood clinics. In some localities scatter-site housing programs are supported by ACT teams, which combine psychiatric, nursing, and social work services. The rental lease is either held directly by the tenant or in the name of a sponsoring nonprofit organization. In most instances, residents pay 30 percent of their income for rent.

Supervised community residences and group homes are congregate care facilities that house approximately eight to twenty-four residents and are usually considered transitional, as their goal is to move individuals to less supportive levels of care. Residents often share bedrooms, and meals are served in a community dining room. Participation in mental health treatment, if not required, is expected. Most programs are staffed around the clock. Services may be provided on-site or in a community-based setting, and daily participation is the norm. Rents are typically set at an enhanced SSI reimbursement rate, depending upon the level of supervision and certification requirements.

Safe Havens offer housing to people with mental illness who have been unwilling or unable to participate in other housing and services. While the initial goal of the Safe Haven is to engage individuals in services, the ultimate goal is to facilitate access to the next stage of housing and, if possible, into permanent housing. The length of stay is determined by the time it takes to access housing, and there is usually no predetermined, standard time frame. These settings may have any combination of shared and private facilities, although most programs provide all meals. Residents do not usually pay rent or program fees.

Appendix V

Ten General Principles for the Use of Psychiatric Medications[6]

Psychiatric medication can make a substantial difference in quality of life for an individual with mental illness by:

- Decreasing the need for hospitalization
- Enhancing community adaptation
- Reducing hallucinations, delusional thinking, anxiety, depression, and other specific symptoms of mental illness
- Improving work/vocational functioning
- Improving socialization

The ideal medication would work on all the target symptoms without causing unwanted side effects; unfortunately, truly ideal medications do not exist.

Side effects of medication vary in seriousness and severity.

- Many side effects are uncomfortable and/or annoying but not acutely dangerous (dry mouth, constipation, dizziness, sedation, weight gain, tremor, rigidity, restlessness, etc.)
- Other side affects are potentially very serious, even life threatening (agranulocytosis with Clozaril, acute Lithium toxicity, or neuroleptic malignant syndrome)

Choosing medications involves carefully weighing the potential risks against the potential benefits and striking the optimal balance between the two.

Medication choices are made on the basis of multiple factors:

- Diagnosis
- Targeted symptoms
- Potential side effects/tolerance
- Medical condition
- Other current medications
- Past medication experience
- Drug-abuse history
- Patient preference

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6 Nardacci, D. E. "Overview of Psychiatric Medications." New York: CUCS In-Service Training, 2001.

Treatment must be individualized for the following reasons:

- Certain medications work better for certain people
- Different people need different doses of medication to get the best response
- People get different side effects from the same medications and vary in their ability to tolerate them
- People may respond differently to the same medication at different times depending on the natural course of their illness, psychosocial stresses in their lives, or interactions with other medications they may be taking
- Optimal treatment response sometimes requires the use of multiple medications simultaneously

Medication management is an ongoing process that benefits from focused observation by all members of the service team as well as front desk, maintenance, and other housing staff. Staff should be able to:

- Determine whether the desired clinical response is occurring
- Describe the nature of the person's response to the medication accurately and in detail
- Monitor for unwanted side effects and signs of medication toxicity

People benefit from direct positive feedback about changes in their behavior and day-to-day functioning observed by staff.

Focused psychoeducation for people taking psychiatric medication is imperative to achieve optimal results and improve long-term compliance.

- Individuals need to have realistic expectations about what medications can and cannot do
- Individuals need to learn about potential side effects in a manner that will not stir up unnecessary anxiety and foster noncompliance
- Individuals need to understand how the medications are likely to help them with their own lives, in practical and constructive terms
- Individuals need help dealing with the stigma of having mental illness and taking psychiatric medications
- Individuals should be encouraged and assisted (if necessary) to talk with their doctors about the positive and negative effects of medication

Medication noncompliance is a serious issue that impacts treatment outcome and community adjustment. Active ongoing intervention by staff members is necessary to reinforce compliance. Communication between the treating psychiatrist and service staff is critical for the following reasons:

- Some individuals will want to stop taking medications, even if they have been doing well
- Denial of mental illness is the most common reason for noncompliance
- Unpleasant side effects can also impact compliance
- Enhancing an individual's acceptance of his/her mental illness and awareness of the positive benefits of medications are effective in promoting further compliance
- Staff support, encouragement, and supervision are necessary to assure the compliance of individuals who do not easily accept that they need psychiatric medications

HIV Services

The first supportive housing projects serving people with HIV (Human Immunodeficiency Virus) were developed in the mid to late 1980s, a time when life expectancy following an AIDS (Acquired Immune Deficiency Syndrome) diagnosis was extremely short. Since then, a better understanding of HIV and the development of more sophisticated diagnostic and treatment protocols have decreased mortality rates and the prevalence of opportunistic infections. In general, people can take full advantage of these new treatments if they have access to quality medical care and adequate supports.

AIDS has taken well over half a million lives in the United States since the disease was first discovered. In the United States, intravenous drug users and men who have sex with men have been at the greatest risk for HIV infection, although this is currently shifting because of dramatic increases in the transmission of the disease among heterosexuals, especially women. A significant increase in the incidence of HIV has also occurred among people living in poverty, particularly among African American men. Recent medical research has focused on controlling HIV with an emphasis on preventing the progression of the disease and reducing the risk of transmission.

Supportive housing serving people with HIV should provide a stable environment with the opportunity to access quality medical care and necessary psychosocial supports. Even supportive housing programs that do not have a focus on HIV should be prepared to work with people living with the illness due to the likelihood that the tenancy will include individuals with HIV disease. This chapter provides an overview of HIV and the core program components and support services to be developed to help tenants manage the disease.

HIV Disease

"HIV disease" refers to the entire continuum of illness from the point of infection with the human immunodeficiency virus through the duration of an AIDS diagnosis. Untreated, HIV is relentlessly progressive and diminishes the capacity of the immune system to protect against a wide range of infections, some of which are fatal. These are known as opportunistic infections.

The Current State of HIV Treatment

Recent advances in HIV research have dramatically expanded the medication and treatment protocols that are available. New combination regimens of anti-HIV drugs have demonstrated surprising effectiveness in preventing and treating opportunistic infections. Increasingly, the medical community views HIV as a chronic, treatable, and potentially curable disease, rather than one that is relentlessly aggressive and always fatal.

Current medical treatment for HIV disease includes prevention against opportunistic infections and antiretroviral therapy.

- **Prevention against opportunistic infections:** Routine prescription of antimicrobial medications that suppress or prevent various opportunistic infections such as pneumocystis pneumonia (PCP), herpes, fungal and bacterial infections, and tuberculosis.
- **Antiretroviral therapy:** Highly active antiretroviral therapy (HAART) refers to prescribed combinations of medications that inhibit the virus' ability to replicate itself and thus decrease the amount of HIV in the body.

People who respond well to HAART show increased appetite and energy levels, as well as general improvement in appearance, health, and sense of well-being. However, since 1987, when the first approved antiretroviral drug became widely available, expectations of drug therapies have been tempered. While many people with HIV are now living longer, there are numerous barriers to the success many believed could be achieved. There is still no cure for HIV disease, and not everyone responds well to available treatments.

Although HAART can result in an increase in CD4 and T-cell counts, which are signs of the immune system being restored, the ultimate public health goal is the development of a vaccine that would effectively prevent HIV infection. Vaccine research is ongoing.

Successful outcomes from antiretroviral therapy currently require an indefinite commitment to adhere to complex medication regimens that have associated risks. HAART requires individuals to take medication at precise intervals throughout the day. Resistance and cross-resistance to medication can occur even with successful adherence to the regimen. Many of the medications can also cause severe side effects in some people. To obtain the full advantages of treatment, an individual must be able to manage the medication regimen and have access to medical services, health education, support services, a healthy diet, and a suitable place to live. (See Appendixes II and III for a list of antiretrovirals and other commonly prescribed HIV medications. Also see Appendix I, which lists web sites that provide updated treatment information.)

HIV Transmission

HIV can spread by any activity that allows the blood, semen, ejaculatory fluids, vaginal secretions, or breast milk of a person with HIV to gain entry into the body and bloodstream of another person. These activities include:

- Unprotected anal, vaginal, or oral sex
- Sharing sex toys
- Sharing needles for injecting drugs, tattooing, or body piercing
- Sharing razors and tooth brushes (potential presence of blood)
- Pregnancy
- Breast-feeding
- Receiving blood products (e.g., transfusions) that contain HIV (The risk of transmission in this manner in the U.S. is small since all blood products are supposed to be screened for HIV.)

HIV Transmission (cont'd)

HIV is not transmitted through casual contact. HIV is not passed through the air or by any of the following:

- Holding hands or hugging a person with HIV
- Eating food prepared by a person with HIV
- Sharing dishes or food with a person with HIV
- Sneezing or coughing
- Sharing toilet seats
- Sharing a household with a person with HIV
- Contact with saliva, tears, sweat, urine or feces (unless they contain blood)
- Mosquitoes

Core Program Components

The health status and service needs of people living with HIV can vary tremendously and change repeatedly. A supportive services program should have the flexibility to reach out to those who are living independently, while accommodating individuals who require extensive support.

In scatter-site programs, staff members visit with tenants in their apartments or homes, although many services are provided in neighboring hospitals, clinics, day treatment programs, AIDS service organizations, and other off-site locations. Although there are multiunit, single-site supportive housing projects exclusively for people with HIV, an increasing number of single-site housing initiatives are mixing people living with HIV with other tenant groups, creating more integrated settings. (For more discussion on single-site versus scatter-site issues, see chapter 2, Developing a Supportive Services Program.)

In any housing setting, it is the responsibility of all staff members to create a supportive environment that helps tenants make the adjustments that are part of living with HIV disease. Access to counseling, educational programs, support groups, health care, and HIV drugs are essential. Similarly, due to compromised immune systems, tenants are often particularly concerned with food safety and handling, housekeeping, and personal hygiene. During periods of serious illness, some tenants may also need more extensive medical supports and services.

In addition to the core program components identified in chapter 2, there are specific considerations in developing supportive housing programs that serve individuals who have HIV/AIDS. Providing supportive housing for people with HIV requires the capacity to assist individuals who will have wide ranging medical and psychosocial needs. The remaining sections of this chapter discuss key strategies and core program components for developing a supportive services program for individuals living with HIV.

Medical Assessment and Supports

Tenant Selection/Intake: Sponsors need to assess their ability to arrange for or provide services and determine what, if any, health-related criteria impact eligibility for tenancy. It is advisable to consult an attorney for final approval of selection criteria since the Fair Housing Act and the Americans with Disabilities Act may apply. Supportive housing programs should have standardized assessments to determine the services the individual is receiving and the level of need.

In addition to information provided directly by prospective tenants, health care providers are usually able to provide information about current health status, as well as any support that may be required for the housing applicant. Release of confidential information requires individuals to sign consent forms allowing for the exchange of information between other organizations and housing staff. Generally, per legal guidelines, no information that might identify a person as having HIV disease and related illnesses can be shared without specific up-to-date authorization.

Ongoing Assessment: People with HIV disease may experience long periods of good health, although the nature of the illness may result in a decline in health and a need for additional short- or long-term assistance. Some tenants will initiate a dialogue with staff about requiring more help, while others will not.

Depending upon the circumstances and program protocols, staff members can maintain consistent communication with tenants through both casual conversations and meetings in which they assess and document the need for services. In some instances, staff may identify cognitive, emotional, or medical issues that the tenant is unaware of. Some service programs develop formal disease-management plans with each tenant to identify the range of needs that an individual living with HIV may have, such as medication and medical services, nutrition counseling, mental health and substance use services, legal counseling (e.g., wills and health care proxies), and alternative therapies.

Some individuals experience debilitating health conditions that may not be temporary, and services or arrangements must be in place to support the individual in his/her home or in a medically supported facility. During periods of extended absence (e.g., hospitalization), sponsors also need guidelines that address the status, security, and personal contents of housing units that remain vacant for extended periods.

Access to Health Care: A principal component of any supportive housing program serving people with HIV is assistance in the management of health care and medication regimens. This usually involves collaborative relationships with medical providers. Frequently, supportive housing projects establish relationships with one or two primary health care providers who have expertise in HIV treatment. Some projects arrange for health care providers to deliver routine services on-site. In some states, health aides may be available to come into the home and assist with personal care and housekeeping. Linkages with pharmacies, visiting nurse services, specialized medication clinics, day treatment programs, and other support services are usually essential.

In general, program staff should make it a priority to help tenants obtain health services. This includes addressing barriers to care, such as communicating health concerns to physicians, providing escort assistance and/or subsidies for transportation, and helping people obtain public benefits and entitlements, including health insurance. Program staff should routinely assist tenants with issues regarding their medications and closely track those who are having difficulties. Additionally, to avoid potentially dangerous interactions, it is important to help tenants keep the primary care physician and other health care providers informed of medication adherence issues, illicit drug use, and over-the-counter medications.

Summary of Universal Precautions Guidelines

The Centers for Disease Control and Prevention (CDC) developed universal precautions to minimize the transmission of illnesses such as HIV and hepatitis B and C. The guidelines (available at www.cdc.gov) are designed to prevent people from having direct contact with blood and other fluids, including semen, vaginal fluid, breast milk, and amniotic fluid. Anyone handling other body fluids (e.g., feces and urine) should also use appropriate infection-control practices. As it is impossible to know what pathogens may be present, body fluid spills from all individuals should be treated with the same degree of caution.

Recommended Barrier Precautions:

- Use gloves when there is a risk of contact with body fluids.
- Wash hands with hot soapy water after removing gloves.
- Use masks and protective eyewear when splatter of body fluids may be possible.
- Use gowns or other protective garments when clothing may get soiled.

Disinfecting Body Fluid Spills:

- Clean up spills before disinfecting surfaces.
- A solution of one part bleach to ten parts water is an effective germicide.
- Do not premix water and bleach solution, since it will lose its potency.

Handling Sharps or Needles:

- Never attempt to re-cap a needle.
- Dispose of used needles in a "sharps container" immediately.
- Keep sharps containers readily available and do not overfill.

Access to Antiretroviral Therapy: The use of antiretroviral medications for the treatment of HIV should begin when an individual is able and prepared to strictly adhere to a multidrug regimen. A physician can best determine this state of readiness, although the staff can help ensure that there is sufficient discussion regarding the significance and commitment of choosing antiretroviral therapy. Though substance use does not necessarily rule out antiretroviral therapy, full disclosure of drug use is important to avoid potentially dangerous interactions.

The possibility of serious side effects can have a significant impact upon a person's willingness and ability to start antiretroviral therapy. Similarly, illness from the side effects of the medications can undermine adherence.

Some of the side effects of HIV medications include:

- Anemia
- Bone marrow toxicity
- Hypersensitivity reaction
- Insomnia
- Kidney stones
- Kidney toxicity
- Liver toxicity
- Mouth ulcers
- Headaches
- Heart disease
- Nausea
- Nightmares
- Osteoporosis
- Pancreatitis
- Rashes
- Vomiting
- Muscle aches
- Chills
- Diabetes
- Diarrhea
- Dizziness
- Fatigue
- Fever

Whether or not a person experiences side effects, everyone who uses these medications does so in the absence of scientific data regarding the potential health implications of prolonged use. The risks of treatment are issues that each person confronts when choosing to undergo antiretroviral therapy. Prior to beginning treatment, individuals should inform their physicians of any life circumstance that may cause one regimen of medication (and dosing requirements) to be difficult, if not impossible, to maintain.

Specific help that staff can offer tenants to overcome logistical barriers for initiating and adhering to antiretroviral therapy include:

- Dosing prompts and reminders
- Referrals to programs that pay for medication
- Availability of meals and snacks
- Provision of appropriate storage for medication (For more on medication management systems, see chapter 4, Mental Health Services.)

Sample Antiretroviral Drug Regimens

For an individual with few HIV complications, a fairly "simple" regimen:

- Combivir, one tablet twice daily (combines 150 milligrams of Lamivudine [3TC], with 300 mg of Zidovudine [AZT])
- Nelfinavir, five 250 mg tablets twice daily

For an individual with advanced HIV infection, the following regimen:

- Lamivudine (3TC), one 150 mg tablet twice a day
- Stavudine (D4T), one 40 mg tablet twice a day
- Indinavir, two 400 mg capsules every 12 hours
- Ritonavir, two 100 mg capsules taken every 12 hours

Drinking approximately one half-gallon of fluids per day is required with this regimen

Additional drugs:

Both regimens are likely to include medication to prevent infections that strike people with HIV and to check the side effects that HIV medicines bring. The three drugs listed below might be prescribed for such purposes.

- Bactrim, one double-strength tablet once a day to prevent pneumonia
- Azithromycin powder, 1,000 mg dissolved in water and taken once weekly to prevent mycobacterium avium infection
- Pravastatin, one 20 mg tablet at bedtime to treat increased cholesterol that can be induced by HIV medications

Source: Dr. Harold Jaffe, Centers for Disease Control and Prevention

In 2001, the U.S. Department of Health and Human Services changed the *Guidelines for the Use of Antiretroviral Agents in HIV Infected Adults and Adolescents* to suggest that treatment be delayed in asymptomatic patients. This was based, in part, upon the recognition that once therapy is initiated it is supposed to be forever, yet some patients cut therapy short in the face of severe side effects or in response to toxicities that can be caused by long-term use of medications. Similarly, resistance to medication sometimes occurs when medication is taken over an extended period of time. Therefore, beginning treatment too early may result in fewer therapeutic options in the future. Nonetheless, the decision to start therapy early must be balanced against data suggesting that delaying therapy until someone is severely immuno-compromised increases the risk of death.

Severe Side Effects

The side effects of antiretroviral therapy as well as medications used to prevent and treat opportunistic infections can sometimes be as debilitating as HIV disease. It is not uncommon to encounter situations in which individuals have made clinical improvements (such as a decreased viral load or an increased CD4 count) but feel significantly worse than they did prior to treatment. A frequent consequence of HIV medication is severe and persistent gastrointestinal distress that can compromise overall health by causing such problems as dehydration and electrolyte imbalance, poor nutritional intake, and an inability to tolerate medications.

Metabolic changes can also occur as a result of drug therapies and can possibly result in diabetes, heart disease, diminished bone mass, and disfiguring redistribution of body fat. Liver, kidney, and pancreas toxicities have caused severe illness and death. In addition, an overwhelming fatigue brought about by medication and/or the emotional and physical consequences of living with severe side effects can be devastating.

Since switching drugs may not eliminate negative symptoms, people are sometimes left to choose between stopping antiretroviral therapy and dealing with debilitating side effects. It can be especially difficult for people in this situation to cope in light of the promise that the drugs held when therapy was first initiated, particularly if these individuals are witnessing clinical and quality of life improvements among their peers.

Staff members who have an understanding of HIV disease and treatment will be better prepared to participate in dialogues about embarking on a lifelong commitment to antiretroviral therapy. While some people may be eager to start, others may approach it with apprehension; indeed, despite the advice of physicians and health care providers, some individuals will refuse to engage in medication-based therapy. Finally, there are those who seek treatment for HIV outside the realm of traditional western medicine or combine the use of antiretroviral medications with alternative treatments. These treatments include the use of vitamins, marijuana, herbs, acupuncture, meditation, individualized nutrition and exercise programs, and various forms of bodywork.

While taking HIV medication often provides a greater level of control over the disease, some see it as a glaring reminder of their diagnosis. A person's ability to cope emotionally with the transition to treatment is a factor that should be evaluated prior to beginning treatment. Assisting individuals to acquire the support needed to make these decisions and to live with the results is an important responsibility. Program staff should recognize that being bound to a complicated regimen of medications and the risk of serious side effects is not a route that everyone will take.

Not surprisingly, those who experience prolonged adverse reactions to HIV medications are prone to feelings of despair, anger, and frustration. Similarly, there are people who do not respond to treatment and can do little to stop or slow the progression of their illness. In cases where years of treatment result in drug resistance, some find that they have exhausted all medication options including those still in clinical trials.

Staff should be particularly supportive during times of significant distress and observant of signs of depression, relapses to alcohol and substance use, and suicidal ideation.

Program staff should encourage tenants to inform their treating physicians about medication side effects, changes in mood and symptoms, and health problems as well as the positive benefits of the drugs. In some instances this may include coaching or assisting an individual to generate a list to bring to an appointment or have ready for a phone call. If necessary, supportive services staff can also offer valuable information to health care providers, although communication on behalf of tenants must be done with written consent.

Hepatitis C

Complicating HIV treatment even further is coinfection with hepatitis C virus (HCV). It is estimated that as many as 90 percent of people with HIV disease who have histories of injecting heroin and other drugs are also living with HCV. HCV can result in fatal liver disease and may progress more rapidly in those who are also infected with HIV. Currently, therapeutic options for HCV are quite limited. Additionally, the majority of people in the United States who are living with HCV have a strain of the virus that is less responsive to available treatments than are other types of HCV. At this time there is limited data on HCV treatment efficacy for people who are also infected with HIV.

Physicians should carefully monitor patients who have HCV for evidence of liver toxicity caused by antiretroviral or other medications used to treat HIV disease. Prior to the newer therapies, most people with coinfection were not expected to live long enough to experience the most severe consequences of their liver disease. However, those who have HCV and respond well to HIV therapy now face the additional medical and emotional burden of attempting to manage another potentially debilitating, life threatening illness.

HIV Education and Resource Networks

If individuals living with HIV disease are to actively participate in their own care, they should have an understanding of the continuum of HIV disease, special issues posed by the infection, and available interventions. An informed consumer is in the best position to make decisions about medication, nutrition, substance use, alternative therapies, exercise, and stress management. In addition, learning about the illness can reduce feelings of powerlessness and increase self-reliance, advocacy skills, and investment in decision-making.

Supportive services programs should include staff members who are versed in the area of HIV and are able to serve as basic educators and make referrals as needed. Programs should also make available to tenants and staff up-to-date materials and information about health issues specific to HIV and the range of topics to be addressed in a comprehensive disease management plan, including:

- Information about HIV and hepatitis A, B, and C
- Treatment and medication guidelines and specific information about antiretrovirals and medications used in the prevention and treatment of opportunistic infections
- Information about reinfection issues
- Impact of substance use (including tobacco and alcohol)
- Safe sex
- Hygiene
- Exercise
- Nutrition
- Use of alternative therapies

In supportive housing that also serves individuals who do not have HIV disease, HIV prevention and testing information should be made available to all tenants. In general, all tenants benefit from HIV education and from information about safe sex practices and negotiating safer sex. Programs may also need to consider providing education on safer substance use practices, including referrals to harm reduction and needle exchange programs. Education can occur through access to written materials and the media, engaging in informed conversations, and attending seminars and workshops.

The Internet is also an invaluable source of information that is often provided in various languages. Providing tenants and staff with computer access and an Internet connection can foster independent research and even provide connections to physicians, dietitians, and others who can provide current information about disease management in an interactive format. (See Appendix I for a list of HIV-related web sites.)

The services necessary to adequately support people with HIV are extensive, and a single organization will probably not provide all needed services. Supportive services programs should maintain an up-to-date listing of community resources that may be needed by tenants with HIV. Some providers have also developed collaboratives, consortia, and partnerships to help ensure access to a range of services including housing, health care, case management, food/nutrition, assistance with activities of daily living, legal assistance, substance use services, support groups, psychiatric treatment, employment/job training, and education. These efforts allow for more support and can include services that accommodate the healthy and the ill. The inclusion of non-HIV-specific services also encourages integration into the community at large, reducing the marginalization of people with HIV.

Individual Counseling and Support

For a person living with HIV, individual counseling can be especially helpful in adapting to the life changes brought about by the illness. Counseling can also be helpful in response to critical events that occur throughout the course of the disease. (See Appendix IV for a discussion of the issues that arise when a person first tests positive for HIV.) Counseling can assist individuals to cope with their diagnosis, change in health status, and modifications in lifestyle. It can also be central in the treatment of depression, which occurs frequently in people who have HIV. Treating depression is critical because the condition adds to an individual's pain, can weaken the immune system, and compromises the person's ability to assist in the management of HIV. Not surprisingly, a higher mortality rate occurs among those who have HIV and chronic depression.

Individuals who respond well to treatment and are not seriously compromised by health barriers to employment, education, or other goals may nonetheless experience a reluctance to switch into a healthier mode. Some may relapse or return to self-destructive behaviors that had previously ended only because they were too ill to participate. In other words, some individuals never made a conscious decision to choose a healthier lifestyle and instead were forced into it through illness. For tenants experiencing these situations, individual counseling can help overcome obstacles to continued growth and independence. Support services that focus on substance use and mental health support services are key components of work in the area of HIV, and this guide contains chapters devoted to each of these topics.

To experience a significant decline in health or to be dying of AIDS-related conditions can cause a level of anguish that did not exist during earlier stages of illness. Fear, anger, and frustration may also occur for people who continue to fail on medication that originally held promise, particularly when others achieve better outcomes. Counseling can offer those experiencing such feelings a safe place to voice resentment, an environment in which to address feelings of despair, and a means to reconcile these feelings in a constructive manner.

Peer Support and Volunteers

The support, knowledge, and shared experiences of others living with HIV can be a lifeline, particularly for those who are newly diagnosed or are dealing with transitions in their disease. There are many roles that staff members can play to facilitate peer support and the development of volunteer programs within supportive housing.

A volunteer mentor/buddy program links the individual who is newly diagnosed or dealing with a transition in the disease with another individual who has HIV. From the peer perspective, the mentor can talk about the illness, answer questions, and give advice on how and where to get help. Additionally, the mentor may be able to serve as a bridge to an existing network of informal and formal supports and educational opportunities. Most important, perhaps, is that the mentor can be a powerful catalyst for diminishing anxiety, reducing isolation, and motivating a person to actively manage the disease.

It is both unrealistic and unnecessary to expect a volunteer to commit him/herself indefinitely. A match made between a mentor and a tenant is usually intended to assist an individual through a crisis, particularly when the individual is newly diagnosed. The goal is to help the individual develop his/her own support and service network. Of course some people still maintain a friendship when the mentorship has formally ended.

Having a diagnosis of HIV is not a sufficient criterion to be a volunteer mentor/buddy. That is, those who provide support need to be reliable, good listeners, and have a grasp of the fundamentals of HIV disease management. Some people may have difficulty maintaining appropriate boundaries and not imposing their own values and beliefs. Mentors must also understand and be able to respect confidentiality. Training for volunteers is a crucial component of a successful mentoring program. In many localities, there are AIDS services organizations that train volunteers (those with and without HIV disease) to do mentoring and support work.

Mentoring/buddy arrangements and other peer support programs for individuals living with HIV provide important assistance. Hopefully, they are complements to an overall environment that is free of discrimination and hostility toward individuals with HIV. Staff members or trained volunteers can also facilitate peer support groups or activities that are less formal, such as community meals or outings. The staff should recognize that supportive relationships frequently occur among tenants without program and staff intervention. (For additional information on building community and relationships among residents, see chapter 8, Community Building.)

Volunteers

A volunteer program requires an investment of staff time to train, supervise, and support the volunteers. Written policies and procedures provide clarity and structure for volunteer involvement and help avoid problems. Agencies utilizing volunteers should also seek legal counsel regarding liability issues.

The use of volunteers requires the development of a protocol to process requests for help as well as a system for recruiting, assigning, and supporting volunteers. At a minimum, volunteers must have a basic understanding of the treatment of HIV disease and know the basics of transmission and universal precautions. Preferably, training should also include fundamental information pertaining to counseling and support, substance use and recovery, and responding to crisis and conflict.

Supporting Improvement and Stability

Many people with HIV disease experience a stabilization or improvement in immune system functions through the use of antiretroviral medication. People often live longer than expected and have futures that may not have seemed possible when initially diagnosed. However, the good news of health stabilization and improvement can also present a new set of stressors.

Ironically, contracting HIV sometimes enables people to access stable housing, adequate nutrition, medical care, substance use counseling, and mental health services for the first time in their lives. These individuals often respond with enthusiasm about going to work and school and pursuing an improved lifestyle. On the other hand, some people will relapse into substance use and/or unsafe sexual behavior as their health improves. This may be an individual's way of reintegrating into the community or responding to the demands or feelings of being well again, even though these behaviors can undermine the improvements in health that the person has achieved.

A return to drug use can expose the person with HIV to multiple complications, including interference with prescribed medications and taxing the liver and immune system. Shared needles and straws and unsafe sex are also modes of transmission for hepatitis C and introduce the risk of reinfection with drug-resistant HIV or other sexually transmitted diseases that can further harm an individual's health.

Staff must carefully monitor medication compliance as an individual's health improves. A more active lifestyle can make it more difficult to follow dosing requirements. In addition, new situations that require discretion about disclosure of one's HIV status can make a rigorous medication regimen inconvenient.

Safe Sex

Most people who know they are HIV-positive would not want to pass the virus to others; however, many who have HIV are not aware of it. Awareness of being HIV positive and engaging in unsafe sex cannot be condoned and can result in criminal prosecution. Fortunately, people can reduce the risk of transmitting HIV by always practicing safe sex.

People who are sexually active can reduce the risk of infection or reinfection by using latex condoms during vaginal, anal, and oral sex. Other latex products, such as dental dams, finger cots, and gloves, also help to prevent contact with body fluids, thereby reducing transmission risks. Some kinds of sexual activity, including erotic massage, licking or kissing intact skin, masturbation, and stimulation with unshared sex toys do not involve contact with potentially infected body fluids, thereby eliminating risk of transmission.

Vocational and Employment Services

Going to work will be a possibility for tenants whose health has stabilized. Some people, especially those with good work histories, may return on their own with little or no assistance. Other tenants may want to upgrade their skills prior to entering or re-entering the workforce. Since some people will not enter the workforce, volunteer work or classes for personal enrichment can also offer fulfillment, enhance quality of life, and decrease feelings of isolation. Tenants returning to work should speak to a benefits/entitlement specialist who can discuss the impact of earned income on medical and financial benefits. (See chapter 3, Employment Services.)

Managing Medical Decline and Death

To experience a serious decline in health or to be dying of AIDS-related conditions can bring on a heightened level of need and significant distress. During periods of declining health, an individual may have to contend with multiple hospitalizations for the treatment of opportunistic infections and various conditions related to HIV and/or side effects of medication. Physical deterioration can occur, resulting in changes in appearance and motor and cognitive abilities. People at this stage of the disease will also experience a series of losses such as decreased independence and privacy. If the supportive housing project does not have the capacity to provide needed services, the individual could face losing his/her home and an integral part of his/her support system.

Pain, limited energy, time-consuming care, and restricted movement will contribute to decreasing opportunities to spend time with others. Additionally, changes in appearance and depression can contribute to self-imposed isolation. Peers and fellow tenants who may have offered supportive relationships may not be as comfortable remaining close to someone who is dying. As the quality of life declines, it is not uncommon for a person to think about terminating his/her life. The possibility of suicide allows some individuals to maintain a perspective of having ultimate control over their lives, even though they may never choose to exercise it. Others will take action toward ending their lives by either terminating treatment or actively engaging in behavior that is destructive. Of course, all staff should be advised that it is illegal under any circumstances to assist an individual to terminate his/her life. (See chapter 7, Crisis and Conflict for more information regarding suicide.)

When a tenant becomes increasingly incapacitated by illness, program staff must give priority to the safety and essential service needs of the individual. Whenever possible, the individual should participate in this planning. Preferably, an individual can remain at home for as long as possible by arranging for a visiting nurse, personal care, hospice services, and the assistance of family, friends, and volunteers. If illness requires placement in another setting, staff can remain involved by maintaining as much of the support system as possible, including making visits, making phone calls, and sending letters.

The final stages of illness are very hard for everyone involved. As a practical matter, staff may need to assist in burial arrangements and memorial services. The way the community handles and memorializes a person's death is often a concern to other tenants and staff, particularly those who are living with HIV disease. Memorial services and life celebrations give people the opportunity to honor the life of the individual, to say good-bye, and to share their grief.

Death is a great hardship not only for family and friends, but also for staff. Both tenants and staff may need support when dealing with death, and it is important that sponsoring agencies provide opportunities to address these feelings.

Staffing and Training

Program staff should have at least a basic knowledge of and access to current information about HIV disease. Sources for HIV information include conferences, training workshops, newsletters, journals, the media, and the Internet. Formal and informal mechanisms that enable employees to seek information and support from supervisors, fellow staff, and colleagues are of tremendous value.

Even though individuals may share the commonality of being HIV positive, differences in ethnicity, language, sexual orientation, gender, alcohol and drug use, and mental health status are important to anticipate. Staff should be sensitive to these differences and reflect that awareness in programming. Sponsors should provide sensitivity training for staff, as needed, and staff members should be models of respectful

behavior. Enforcement of antibias and harassment policies is important. Sponsors should also ensure that all staff are aware of the risks that their own behaviors may pose for people with compromised immune systems. This includes personal hygiene (especially washing their hands regularly) and the handling, preparation, and storage of food.

Myths and fears concerning the transmission of HIV persist among individuals of all educational and professional backgrounds. Creating a safe, harmonious environment in which there is no reluctance to interact and provide services to tenants with HIV disease requires ongoing training at all levels. Training should include information about modes of HIV transmission and guidelines for universal precautions. Staff should be able to ask questions, have opportunities to express their doubts and fears, and be able to assess the risks of transmission in any situation they may encounter in the workplace.

Appendix I

Resources and Additional Readings

AIDS Housing of Washington. *Breaking New Ground: Developing Innovative Care Residences*. Seattle: AIDS Housing of Washington, 1993.

A guide for individuals and agencies, architects, planners, and developers interested in building or renovating HIV/AIDS housing. Major topics covered include: community-based planning, building effective partnerships, creating an HIV/AIDS housing continuum, program planning and design, project management, community notification and siting, licensure, financing and fundraising, predevelopment, construction, start-up, operations, and maintenance. The guide includes information collected from site visits to over eighty HIV/AIDS care residences across the U.S. and Puerto Rico.

AIDS Housing of Washington. *Financing AIDS Housing. Seattle: AIDS Housing of Washington*, 1998.

This guide provides sources of funding and technical assistance to develop and operate supportive housing for people living with HIV/AIDS, including all federal and other available AIDS housing finance tools. Written as a reference for use during the planning and development phase of AIDS housing projects, this book has information about funding sources, application instructions, selection criteria, and tips from AIDS housing developers.

AIDS Housing of Washington. *Health Resources and Services Administration: Housing Is Health Care.* Seattle: Health Resources and Services Administration, AIDS Housing of Washington, 2001.

This guide explains the flexibility of HAB Policy 99-02 (Use of CARE Act Funds for Housing Referral Services and Short-term or Emergency Housing Needs). It outlines three implementation areas: housing categories to use in allocations and applications, record keeping and documentation, and funding/program changes. Case studies on integrating housing funds under the CARE Act and HOPWA (Housing Opportunities for Persons with AIDS) are also featured.

Blackwell, P. "Holistic Counseling for the Minority AIDS." Abstract no. 166, presented at the National HIV Prevention Conference, 1999.

The mental health issues surrounding minorities impacted with HIV/AIDS are multifaceted. Due to socioeconomic issues, various exposure category issues, physical and mental health issues, and sexuality issues, traditional counseling approaches must be adjusted. To properly address issues with these populations, a holistic approach to counseling is advised.

Blackwell, P. "Multicultural Counseling and HIV/AIDS." Abstract no. 167, presented at the National HIV Prevention Conference, 1999.

Counseling approaches with respect to HIV/AIDS are historically based on theories and techniques derived from working with white gay male clients. With the increasing presence of HIV/AIDS in the minority communities, counseling and therapeutic approaches must become culturally sensitive and culturally appropriate.

Chavez, R., et al. *Guide to Developing Supportive Housing Programs: The Scatter Site Model.* New York: Bailey House Inc., 1998.

This manual provides detailed guidelines and tools for the creation and administration of scatter-site housing programs for people living with HIV/AIDS. Topics addressed include program design and start-up, staffing patterns, job descriptions, training issues, operations, intake, case management services, health care coordination, activities, and program evaluation. It also contains sample forms.

Clegg and Associates. *Tools for Outcome Based Evaluation of HOPWA Funded Programs.* Seattle: AIDS Housing of Washington, 2001.

The materials contained in this guide are intended to assist HOPWA-funded HIV/AIDS housing agencies in implementing outcome-based program evaluation. These materials include key terms in outcomes measurement; a program outcomes and indicators digest; sample program logic models and evaluation plans; sample data collection tools; and an evaluation resource guide.

Enterprise Foundation. *Beyond Housing: Profiles of Low-Income, Service-Enriched Housing for Special Needs Populations and Property Management Programs, 2d ed.* Columbia, Md.: Enterprise Foundation, 1997.

Provides profiles of low-income supportive housing programs that have successfully integrated social services and housing as well as model property management programs. Includes transitional and permanent housing programs for families and individuals affected by substance use, HIV/AIDS, mental illness, and domestic violence.

Kawata, P., J. Kaye, and J. Masaoka. *Compass Point: Nonprofit Services: Collaboration Continuum*. Washington, D.C.: National Minority AIDS Council, 1996.

This manual is designed to provide AIDS service organizations with the tools necessary for planning, choosing, and negotiating collaborations. It also presents fundamental principles of collaboration with practical guidelines to support specific initiatives.

Mid-America Institute on Poverty, Heartland Alliance for Human Needs and Human Rights. *Opening Doors: Adapting Housing and Substance Abuse Services to Meet the Needs of HIV/AIDS Impacted Persons.* Chicago: Heartland Alliance, 2000.

This conference report shares practice and knowledge about the intersection between substance abuse services, housing, and HIV/AIDS services. Also included are briefings about emerging trends, implications for existing models and systems, and the need for adaptation and change, as well as innovative models and funding sources.

Putnam, M., et al. *Rural AIDS Housing: Issues and Opportunities*. Seattle: AIDS Housing of Washington, 1998.

This report targets small communities and the local organizations that are working to meet the housing needs of people living with HIV/AIDS. It includes an extensive listing of government contacts for each state, a survey of the state of HIV/AIDS and housing in the rural United States, an examination of the unique barriers to the provision of housing and supportive services to rural residents, case studies of successful rural housing and services programs, and profiles of the reality of living with HIV/AIDS in rural and nonmetropolitan parts of the United States.

Takahashi, L. M. "The Socio-Spatial Stigmatization of Homelessness and HIV/AIDS: Toward an Explanation of the NIMBY Syndrome." *Social Science and Medicine* 45, no. 6 (1997): 903–914.

This paper develops a conceptual framework for understanding the role of stigma in community rejection of human services, particularly those associated with homelessness and HIV/AIDS. Three facets of stigma concerning homelessness and HIV/AIDS (nonproductivity, dangerousness, and personal culpability) are offered as a way of understanding the rising tide of community rejection toward human service facilities.

Internet Sites

Note: Not all web sites have the capacity to immediately post new material or to delete what is no longer accurate. Some maintain a large archive of information that will include items that are no longer up to date, while they simultaneously provide regular postings of the latest materials available. It is important for the reader to check the dates of all materials and verify information elsewhere, as needed.

AIDS Education Global Information System

http://www.aegis.com

The AIDS Education Global Information System (AEGIS) site offers an HIV-related multi-issue database, with numerous links and daily updates.

AIDS Housing of Washington

http://www.aidshousing.org

This web site offers a variety of resources, including information about AIDS housing development, funding sources, technical assistance, and advocacy issues, and an on-line searchable resource library.

AIDSLINE

http://igm.nlm.nih.gov

AIDSLINE is the National Library of Medicine's on-line database containing references to published literature on AIDS and HIV. The scope of AIDSLINE includes biomedical, epidemiological, health care administration, oncological, clinical, and social and behavioral sciences.

AIDS Treatment News

http://www.aids.org/immunet/atn.nsf/page

This treatment newsletter contains information for people living with HIV/AIDS who are looking for news regarding HIV therapies.

Centers for Disease Control

http://www.cdc.gov/hiv

This federal agency's web site provides health and prevention information as well as epidemiological data.

Direct Access Alternative Information Resources

http://www.daair.org

This nonprofit buyer's club provides online ordering and treatment information for people with HIV and other chronic health conditions.

HIV Education Prison Project

http://www.hivcorrections.org

Sponsored by the Brown Medical School Office of Continuing Medical Education and the Brown University AIDS Program, this site targets correctional administrators and HIV and hepatitis service providers and offers information regarding HIV and hepatitis care in the correctional environment.

HIV/AIDS Treatment Information Service

http://www.hivatis.org

This web site provides treatment information, including regularly updated treatment guidelines.

HIV and Hepatitis

http://www.hivandhepatits.com

This web site offers information about HIV, hepatitis, and coinfection issues. It also provides daily updates, with access to free interactive teleconferences that coincide with major national and international scientific meetings and conferences.

Johns Hopkins University AIDS Service

http://www.hopkins-aids.edu

This site is a resource for health care professionals and consumers interested in the treatment of people with HIV/AIDS.

New Mexico AIDS Project

http://www.aidsinfonet.org

This web site provides fact sheets on numerous HIV-related topics, including medication, opportunistic infections, and lab work.

Project Inform

http://www.projectinform.org

This national nonprofit organization provides on line information about the diagnosis and treatment of HIV disease.

University of California at San Francisco

http://www.hivinsite.ucsf.edu

This University of California at San Francisco–sponsored web site has in-depth HIV-related information on topics including, treatment, prevention, policy, and international issues. It also contains an on-line HIV textbook, The HIV InSite Knowledge Base.

Appendix II

Approved Antiretroviral Medications for the Treatment of HIV

The medications listed on this page have been approved by the U.S. Food and Drug Administration (FDA) for treating HIV Infection as of May 2003

Nucleoside/Nucleotide Reverse Transcriptase Inhibitors (NNRTI'S):

NNRTI's inhibit the reverse transcriptase enzyme used by the HIV virus to transform its own genetic material (RNA) into DNA. The viral genetic material must be transcribed into DNA in order for the virus to exploit the host cell for its own replication. NRTI's interfere with this process because they get taken up as substitutes for biologically active nucleosides in the newly manufactured viral DNA. DNA incorporating NRTI's is unable to elongate correctly and never becomes viable. Without a viable DNA copy of itself, the virus is unable to replicate.

Abacavir (Ziagen)
Abacavir+Lamivudine+Zidovudine (Trizivir)
Didanosine (Videx, ddl)
Lamivudine (Epivir, 3TC)
Lamivudine+Zidovudine (Combivir)
Stavudine (Zerit, d4T)
Tenofovir DF (Viread)
Zalcitabine (HIVID, ddC)
Zidovudine (Retrovir, AZT, ZDV)

Protease Inhibitors (PI'S):

PI's inhibit the HIV protease enzyme. HIV protease enzymes are used to carve up large precursor proteins into smaller functional units that enable the virus to attach itself to a host cell. Without these smaller units attached, the virus becomes non-infectious.

Amprenavir (Agenerase)
Indinavir (Crixivan)
Lopinavir+Retonavir (Kaletra)
Nelfinavir (Viracept)
Ritonavir (Norvir)
Saquinavir (Fortovase, Invirase)

Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTI'S):

NNRTI's bind HIV reverse trancriptase directly. They modify the configuration of the enzyme's catalytic site and render it biologically inactive. Without active reverse transcriptase the virus is not able to generate viable DNA and is unable to use the host cell to replicate itself.

Nevirapine (Viramune)
Delavirdine (Rescriptor)
Efavirenz (Sustiva)

Fusion Inhibitors

Fusion inhibitors work by blocking the HIV virus from entering human cells. Enfuvirtide interferes with the entry of HIV-1 into cells by inhibiting fusion of viral and cellular membranes.

Enfuvirtide (Fuzeon, T-20)

Appendix III

Commonly Used Medications for the Treatment and Prevention of HIV-Related Conditions

Infection/Condition	Medication
Pneumocystis carinii pneumonia (PCP)	TMP/SMX (Trimethoprim and Sulfamethoxazole, Bactrim, Septra), Dapsone, Pentamidine, Atovaquone (Mepron)
Cytomegalovirus (CMV)	Ganciclovir (Cytovene): oral Ganciclovir: intravenous, eye implant, injection into eye Valganciclovir (Valcyte): oral Foscarnet: injection into eye, intravenous Cidofovir (Vistide): intravenous Fomivirsen (Vitravene): injection into eye
Candidiasis (thrush)	Clotrimazole (Lotrimin, Mycelex), Ketoconazole (Nizoral), Nystatin, Miconazole (Monistat), Terconazole (Terazol), Butoconazole (Femstat), Amphotericin
Herpes simplex virus (HSV)	Acyclovir
Karposi's sarcoma (KS)	Paclitaxel (Taxol), Doxorubicin (Doxil), Daunorubicin (DaunoXome), Adriamycin, Bleomycin, and Vincristin, liquid nitrogen, radiation
Mycobacterium avium complex (MAC)/ Mycobacterium avium intracellulare (MAI)	Amikacin (Amkin), Azithromycin (Zithromax), Ciprofloxacin (Cipro or Ciloxan), Clarithromycin (Biaxin), Clofazimine (Lamprene), Ethambutol (Myambuto), Rifabutin (Mycobutin)
Non-Hodgkin's lymphoma (NHL)	Cyclophosphamide, Hydroxydaunomycin, Oncovin, Prednisone, radiation
Herpes varicella zoster (shingles)	Acyclovir, Famciclovir and Valacyclovir
Toxoplasmosis	Pyrimethamine, Sulfadiazine, Clindamycin (Cleocin), Bactrim, Septra
Wasting syndrome	Megace, Marinol, cannabis, Human Growth Hormone, Thalidomide, nutritional supplements (Advera, Ensure, etc.)
Tuberculosis (TB)	Rifampin, Rifabutin, Isoniazid (INH), Pyrazinamide (PZA), Ethambutol, Streptomycin
Cryptococcal meningitis	Amphotericin B, Fluconazole, and Flucytosine
Hepatitis B (HBV)*	Interferon Alfa-2b (Intron A), 3TC (Epivir), vaccine (3 part)
Hepatitis C (HCV)*	Interferon, Ribavirin, Pegylated Interferon

*The occurrence of HBV and/or HCV is not dependent upon the presence of HIV. However, as their modes of transmission are similar to those of HIV, many people with HIV also have HBV and/or HCV.

Appendix IV

Testing HIV Positive: Reactions and Responses

Most people who receive a positive HIV test result are likely to be very distressed and often overwhelmed, although individuals who believed that infection was inevitable may express relief that the wait is over. People who are aware of advances in treatment and improved prognosis in recent years may not be as fearful as those who have limited familiarity with HIV disease.

Newly diagnosed people may experience feelings of powerlessness, fear, guilt, and/or shame. A positive test result may be viewed as a death sentence. Some people may also experience distress about possibly having passed the virus to someone else. Cultural or religious beliefs that HIV is a punishment for immorality can increase the anguish.

Individuals may withhold the news of their HIV status from their loved ones out of fear of causing them worry or of being rejected. This disclosure often involves revealing intimate parts of one's self and life that had previously been undisclosed, such as sexual orientation. Some people may grieve for what they perceive will be lost opportunities (e.g., intimate relationships, having children, educational/career plans). Other concerns include uncertainty about the future and the ability to care for oneself financially and physically, how to gain access to appropriate treatment, and how to maintain housing. Parents with dependent children have the additional anxiety of confronting the possibility of being unable to care for them or dying before they are grown.

No matter how a person responds to a positive test result, some type of support is often essential. The role of the staff at this point is to offer support, information, and assistance with the entry into services. Staff should be mindful and respectful of the person's ability to process the information. Substance use, mental illness, overwhelming feelings, and language and literacy barriers are all factors that can impact an individual's ability to process information.

Staff must be attentive to the impact of the information they provide to tenants. What may cause one tenant to be empowered may cause another to feel overwhelmed. In addition, the manner in which people learn and adapt will be different. Those who will be educating and supporting tenants will find that their efforts are more effective when they are responsive to these differences.

It is usually best for staff members to confront some of the myths about HIV disease as soon as possible. This will include challenging the notion that HIV is a death sentence and making sure that the tenant is aware that having hope about her/his prognosis is reasonable. Staff should quickly offer basic education about the continuum of HIV disease, medical management, and the potential for HIV to be a chronic but manageable illness.

Some people receive a positive HIV test result and a diagnosis of AIDS at the same. While some may experience a significant improvement in health due to treatment, others may not, and some may die. Whether the tenant is diagnosed in an early or a more advanced stage of disease, it is important that staff's desire to offer reassurance and support does not result in what may be false promises about treatment outcomes.

Additional intervention including nutrition, exercise, and stress management should be discussed for the purpose of demonstrating the many aspects of control an individual can have and to help provide a context for living with HIV. By offering information about what type of services are available (medical, financial, legal) as well as how to access them, the staff can further ease anxiety. Tenants in recovery can be very vulnerable to relapse when they learn that they are HIV positive. Staff members should not hesitate to initiate discussions about this, including what additional supports may be needed in order to remain sober.

People who receive an HIV/AIDS diagnosis frequently experience shifts in their self-perceptions. Some have described this shift as becoming "HIV personified." Others describe feelings of being contaminated or poisonous. Staff can play a major role in assisting a newly diagnosed tenant to make the transition from "being HIV" to "having HIV." Staff members can discuss the tenant's future in a manner that conveys the expectation, as appropriate, that the diagnosis does not necessarily replace responsibilities and pleasures in the tenant's life. An introduction to another person living with HIV disease who has adjusted to his/her diagnosis can help to reduce some of the initial anxiety and fear.

Substance Use Services

Every supportive housing sponsor will find it necessary to address issues of alcohol and possibly illegal drug use among the tenancy. Although alcohol and substance use can cause difficult and complicated challenges, supportive housing provides opportunities for innovative approaches for working with people who have substance use problems. This chapter discusses various approaches and strategies for addressing substance use issues in supportive housing.

Addiction and Recovery

People use mind- and mood-altering substances (drugs and/or alcohol) for a variety of reasons. Substances are taken, for example, to heighten good times and to manage boredom and stress. Though they may realize substance use is problematic and unhealthy, people often have difficulty exercising control over drug use and drinking. For some, substances become a way of life. Feeling that they are unable to live without alcohol and/or drugs, substance users often feel trapped and, in many cases, remain actively addicted for years.

The development of a dependency on substances is a process that occurs in stages over time. It progresses from social or recreational drug use, to increased use, to extended and uncontrollable use, which frequently leads to problems in social, occupational, and/or interpersonal functioning. The effects and consequences of substance use are different for each person, and an individual may fluctuate in levels of use regardless of whether he/she receives treatment. Determining distinctions between use and dependency are generally based on the amounts used, the amount of control over use, and the severity of impairments that occur. (See Appendix II, DSM IV Diagnostic Criteria for Substance Abuse and Substance Dependence.)

Recovery from substance dependence also occurs in stages. Adapting to a life without substances usually requires filling vast amounts of time, altering daily routines, and finding new social groups and activities. Resisting the temptation to use substances is a struggle that requires substantial energy and commitment. During the initial period of abstinence, feelings of great loss can override any sense of freedom from addiction. The experience is often compared to losing a best friend.

Many who are in recovery see themselves as constantly vulnerable and at risk of relapse. People often remain involved for decades in Alcoholics Anonymous (AA), for example. Some people still have dreams about drinking or drugging after many years of abstinence. Helping people deal with their addictions to substances is a major challenge, posing the possibilities for both enormous reward and great frustration for tenants and staff.

Approaches to Substance Use in Supportive Housing

Traditionally, substance use treatment is made available to people once they have made the decision to stop. In recent years, however, the development of alternative interventions has helped to expand the range of available options. Substance use issues and addictions are increasingly viewed as chronic, relapsing

problems that require long-term intervention. One model, the Stages of Change, identifies interventions that can be effective in helping individuals reach the decision to reduce or stop use as well as to address relapse. Other approaches emphasize "harm reduction" and focus on helping individuals reduce the consequences of substance use and better manage their lives and health (e.g., working, paying rent, meeting family obligations, and avoiding illness).

Supportive housing presents a unique opportunity to help people with substance use problems. Staff members are in the position to provide support over an extended period of time and work with people where they live. In other settings, individuals who need help with a substance problem must find support and services outside of their living environment; in other words, help is not likely to come to them. In fact, if substance use becomes a danger or threat to other tenants, the supportive services program usually has to intervene.

In recent years, there has been an expansion of the range of housing options available to people who are at various stages of use, dependency, and recovery. Supportive housing projects that are not specifically designed as substance treatment programs have become integral components in the continuum of available options, blending various approaches and models of service delivery. (See Appendix III, Models of Substance Use, Addiction, and Recovery.) Following are discussions and examples of various types of housing and approaches to addressing substance use. In many instances, the goals and features of the housing types overlap.

Sober/"Dry" housing

Dry housing offers a sober/drug free-living environment and focuses on working with people who have stopped using. Nationally, this category represents the majority of residential alcohol and substance use treatment programs. Some of the features of dry housing are:

Goals

- To maintain sobriety and support recovery
- To foster sobriety through peer support
- To teach the skills of relapse prevention

Assumptions

- People should have the option to live in a safe drug- and alcohol-free environment
- Achieving and maintaining sobriety is the primary goal of substance use treatment
- People in the early stages of recovery should be separated from people who are actively using
- It is effective for people to work on their drug- and alcohol-related issues with others who are doing the same. Supportive services should focus on promoting self-help among participants to reinforce recovery efforts
- Drug and alcohol use endangers the supportive community. The community should instill the value of sobriety, and alcohol and drug use should not be tolerated on the premises

Characteristics

- Usually designed as transitional housing
- Abstinence is usually a condition of entry
- Structured daily schedules are common
- Abstinence from alcohol and substances may be monitored through urine screenings
- Often sponsored by organizations already providing other drug and alcohol treatment services
- May or may not be equipped to handle special needs and disabilities, such as mental illness
- Residents are often involved in the enforcement of house rules
- The staff frequently includes people who are in recovery themselves
- Usually requires residents to work or seek employment
- Relapse sometimes results in a reduction of responsibilities and/or privileges and, in some programs, discharge or eviction

Advantages

- Provides a structured environment that completely supports sobriety
- Presents an opportunity to focus on sobriety and is particularly effective for those in the early and middle stages of recovery
- Meets the needs of individuals who would have difficulty staying sober in an environment where people are using
- Makes recovery a central part of everyday life

Possible disadvantages

- Can limit eligibility compared to other types of housing
- Can create secrecy and shame around use, particularly if people face eviction for relapse
- Can place staff and residents in a monitoring and policing role
- Can be difficult to detect use with certainty without using measures such as urine testing

Illustration of SOBER/DRY SUPPORTIVE Housing

JERICHO HOUSE, New York, New York

About the housing: Jericho House opened in 1991 to provide housing with a full range of services for single men and women in recovery. Jericho House stresses the importance of life skills and the belief that sobriety alone is not enough to be successful.

Number and type of units of housing: Jericho House consists of 56 units fashioned after the SRO model, with shared kitchens and bathrooms. Although the housing is considered permanent, Jericho House emphasizes the importance of transitioning into the community and assists in guiding tenants to graduate into independent housing over a two-year period.

Project sponsor: Jericho House is sponsored by the Jericho Project, which was responsible for the acquisition and renovation of the building and the development of the support services. The Jericho Project was founded in 1983 on the Upper West Side of Manhattan in response to the alarming epidemic of homelessness.

Goals and philosophy: Jericho House offers sober housing with a philosophy of building a community to support individuals in their recovery. People in recovery simultaneously working on sobriety and life skills create a culture of motivation and accountability. The program emphasizes socialization and living skills as well as the importance of employment, which is understood to greatly enhance the ability to remain sober and to participate in society.

Tenancy profile: Tenants of Jericho House are formerly homeless individuals in recovery. The ratio of men to women is about equal, and the median age is approximately 40. Motivation and three to six months of sobriety are required for entry into the program. About two-thirds of the tenants are from the New York City shelter system, and the remaining third is "housing needy." Tenants are expected to take an active role in their community and to invest in keeping Jericho House a positive place to live.

Physical description of the housing: Jericho House is a four-story elevator building located in central Harlem. All units are fully furnished. Each floor has a community kitchen and two and a half bathrooms. A large community room is available on the first floor with an adjoining kitchen and laundry room located in the basement. The offices of on-site support services staff are easily accessible and situated on the first floor.

Services description: Some service staff members are on-site twenty-four hours a day, seven days a week. The staff consists of a director, an assistant director, a substance-abuse counselor, two case manager aides, a vocational/education specialist, and a reunification/aftercare specialist.

Jericho House combines affordable safe housing with a four-phase support services program. The first phase is "Addiction Recovery." All Jericho House tenants must be enrolled in an outpatient drug treatment program upon intake. Intensive case management and crisis counseling are provided. Peer support plays a key role in each individual's recovery, and there are weekly support groups. In the event of relapse, the tenant is expected to enter detoxification and return to Jericho House. Relapse is normalized and used as an opportunity for learning.

The second phase of the service program is "Socialization and Living Skills," which offers activities that assist tenants in re-entering mainstream society. Aside from many social activities, living skills classes are offered to assist with the development of the basic skills of daily living.

The third phase is "Educational and Vocational Training," which offers assistance with pursuing careers in areas as diverse as social work, truck driving, and nursing. This comprehensive program provides job training referrals, tutoring, vocational training, and educational and job retention activities. Jericho House also has a computer learning center, which trains and employs tenants and operates as a nonprofit business serving central Harlem. As part of orientation, tenants are required to attend four classes and are able to access the computer learning center on an ongoing basis if desired.

The last phase is "Aftercare." Upon entry to Jericho House, individuals are prepared for eventual graduation and reuniting with their families and communities. A Mother & Child Reunification Program is available to help assess and facilitate custody issues. Aftercare continues for two years and includes home visits and follow-up help, ensuring successful transition to independent living.

Eligibility criteria/lease and occupancy agreement/rent: Upon entry into Jericho House, rent is usually paid by public assistance. When individuals enter the vocational phase of the program, they begin to pay rent out of their earnings. There is no formal lease, but tenants are required to sign an agreement to the house rules. Although Jericho House is a permanent housing program, there is an emphasis on the importance of transitioning into the community and assistance in guiding tenants to graduate into independent housing. The average length of stay is two years.

Harm Reduction/"Wet" Housing

Wet housing is less prevalent than other types, and its development often sparks debate. Wet housing is usually targeted to specific groups in a community or locale, such as individuals living with AIDS or chronic inebriates.

Wet housing is a form of harm reduction, which emerged in the 1980s in response to the AIDS crisis and initially focused on interventions to prevent the spread of HIV. Examples of harm reduction efforts intended to prevent the spread of HIV include condom distribution and needle exchange programs. Over the years, harm reduction approaches have been expanded to include substance use. For some individuals who are unable or unwilling to achieve sobriety, harm reduction strategies have helped them to get and stay housed, connect with family, and go back to work. Some of the features of wet housing are:

Goals

- To provide a safe and secure environment for people who are not ready or able to stop using substances
- To reduce the negative impacts and consequences of substance use
- To help individuals meet the obligations of tenancy and maintain housing stability
- To provide ongoing opportunities for each individual to address substance use problems
- To help people achieve abstinence; in others cases, the goal may be addiction management or reduced use

Assumptions

- People deserve safe, affordable housing regardless of addictions
- In helping people reduce the harm caused by their substance use, self-awareness about the impact of substance use is increased. This awareness can often be a motivator to reduce or stop use
- The quality of life of substance users can be improved even though they are still using drugs or alcohol
- People can have substance use problems and still function and meet life obligations
- In helping people achieve goals they set for themselves, a trusting relationship with staff is established, which is key to a process of change for many individuals

Characteristics

- Services focus on helping tenants stay housed by assisting with the management of problems that interfere with meeting tenancy obligations, such as nonpayment of rent and disruptive behavior
- Services include case management, health education, medical care, nutrition, personal safety, risk reduction, supportive counseling, and self-help groups
- Offers an environment where tenants can openly admit and talk about alcohol or drug use without fear of losing their housing
- Staff can arrange access to substance use treatment, if applicable
- Supportive services arrangements anticipate that there may be issues of dual and multiple diagnoses, such as mental illness and HIV/AIDS
- Tenants must be able to follow basic rules of conduct and comply with lease obligations
- Illegal substances are generally not allowed on the premises, and alcohol is usually not permitted in public spaces
- Behavior that is threatening to other tenants and the larger community is not tolerated
- Participation in supportive services is not a condition of tenancy

Advantages

- Provides active substance users with housing
- Enables substance users to have an improved quality of life
- Gives individuals the opportunity to explore substance use issues in an open and nonjudgmental atmosphere, where they can freely contemplate the costs and benefits of continued use
- Reduces the risks associated with using substances
- Supportive services are available on an unconditional basis

Possible disadvantages

- Can be very difficult to gain public and community support
- Staff must be vigilant about monitoring disruptive behavior
- Can be viewed as enabling individuals to continue substance use
- Increased risk of illegal and disruptive activities associated with substance use
- Is outside the funding guidelines of some localities

Illustration of HARM REDUCTION/Wet Supportive Housing

ANISHINABE WAKIAGUN, Minneapolis, Minnesota

About the housing: Anishinabe Wakiagun provides safe, affordable service-supported housing for homeless people with chronic alcohol addiction through a harm reduction, permanent housing model. It has been in operation since September 1996.

Number and type of units of housing: There are 40 SRO units in a single building on the edge of downtown Minneapolis.

Project sponsors: Two agencies partnered in the development of Anishinabe Wakiagun. American Indian Housing and Community Development Corporation (AIHCDC) is an outgrowth of the American Indian Task Force on Housing and Homelessness, which formed in 1991 to identify the housing needs of the homeless Native American population in Minneapolis. Its primary mission is to identify and provide safe, affordable housing for American Indians. Project for Pride in Living (PPL) was founded in 1972 by a group of volunteers who worked in two neighborhoods to fix up rundown houses. Today it offers affordable housing and support services to 800 people and manages more than 350 units of housing.

Goals and philosophy: The goal of Anishinabe Wakiagun is to provide housing and stability for homeless chronic inebriates in a low-demand environment. Anishinabe Wakiagun is considered to be housing of last resort for this population. Staff are diligent in trying to locate other options for applicants who are homeless but not chronic inebriates, including people who are addicted to drugs other than alcohol. Tenants do not need to be sober, but it is encouraged. The project tries to allow people to make their own choices. It is based on the philosophy that even if a person cannot be sober, they can still contribute to the community and to society.

Tenancy profile: Tenants are single adults. Thirty units are for males and ten are for females. All tenants are formerly homeless, mostly from the streets and detox. All are chronic alcoholics. The housing is designed primarily to serve homeless Native Americans who are late-stage chronic inebriates. Very few, if any, of the tenants use drugs other than alcohol. Almost all are unemployed, and about 10 percent receive SSI/SSDI or other benefits. Tenants do not have to be engaged in services prior to entry into the housing, nor do they have to meet a sobriety requirement. Most are not engaged in treatment programs. More than 50 percent of the tenants have never

held a permanent job, and more than 50 percent have never before had permanent housing. Applicants are rejected if references indicate they are currently violent or dangerous.

Physical description of the housing: Anishinabe Wakiagun is a three-story structure with rooms that are 142 square feet each. Tenants share common bathrooms on each floor. There are no kitchen facilities for use by tenants. A congregate dining facility with a commercial kitchen provides daily meals. There is an on-site common room, an arts and crafts room, and a supervised entry. Video cameras monitor halls, the entryway, and common spaces. The building also includes a common laundry, social services and management offices.

Services description: The project has one program coordinator/case manager. It originally had two staff members, but experience indicated that the kinds of case management services that tenants want are fairly limited. The focus is largely on health and medical issues. In addition to case management, on-site services include new tenant orientation, daily living skills assistance, entitlement programs assistance/benefits counseling, peer-to-peer mentoring and support, and crisis intervention. There are also recreational/socialization opportunities such as movies, powwows, arts and crafts, and a community garden. Tenants must be sober when participating in events. Tenants are encouraged to participate in activities, keep their rooms clean, and keep in contact with family members. Participation in services is not a condition of tenancy. Services are available for as long as is needed. All meals are provided.

Eligibility criteria/lease and occupancy agreement/rent: The units are permanent and tenants have leases, with no length-of-stay limitation. Tenants sign a month-to-month lease upon entry. The lease includes an assignment of the individual's General Assistance/SSI/SSDI benefits except for a personal needs stipend. The lease provides that a unit can be considered abandoned if the tenant does not occupy it for a certain number of days. While sobriety is not required, no alcohol is allowed in the building's public spaces or on the property outside the building. Illegal substances are not allowed on-site.

"Damp" Housing

Damp housing usually includes tenants who fall within a continuum from "never touch alcohol or drugs" to "can't stay away from them." Alcohol use is generally discouraged, though it is not prohibited except in public spaces. Illegal substances are usually prohibited. While alcohol and substance use treatment are not typically central features of damp housing, supportive services programs in these settings are usually designed to provide assistance to tenants who have alcohol or substance use issues. Some of the features of damp housing are:

Goals

- To provide a safe and stable housing environment for all tenants
- To enable individuals to meet the obligations of tenancy and maintain housing stability
- To link people who have disabilities and/or special needs to appropriate supportive services
- To provide ongoing opportunities for each individual to address substance use problems

Assumptions

- People who have substance use issues can usually meet the basic obligations of tenancy
- Staff must work to build relationships with tenants, particularly individuals who have disabilities or special needs, including alcohol and substance use problems
- Supportive services are user-friendly and driven by the needs and goals of the tenants
- Relapse is a part of the recovery process and individuals can benefit from relevant services at all stages of the use and recovery continuum (See Appendix IV, Stages of Change and Recovery)

Characteristics

- Recovery is promoted but not required, and abstinence is not a condition of tenancy
- Substance dependency is understood to be a chronic health problem with symptoms that vary in severity over time. Consequences for substance use are related to behaviors that violate or break lease obligations
- Substance use services are offered unconditionally and in the same way that other services (mental health, medical, etc.) are offered
- Support services focus on assisting tenants to meet the obligations of tenancy, such as paying rent and remaining in compliance with lease obligations
- Staff can arrange access to substance use treatment, if applicable
- Applicants may be expected to be substance free at intake into the housing, although policies vary. Supportive service designs anticipate relapse and active use issues
- Supportive service designs anticipate that there may be issues of dual and multiple diagnoses, such as mental illness and HIV/AIDS

Advantages

- Housing is made available to a wide range of individuals, including those at various stages of use and recovery
- The program approach is flexible, can be adapted to meet a wide range of needs, and is particularly suitable to working within a permanent housing setting
- Individuals in this housing tend to maintain housing stability for extended periods of time
- The focus is on behaviors relative to maintaining housing rather than trying to detect use, which helps to reduce secrecy and encourages tenants to seek services

Possible disadvantages

- Some tenants in recovery may find it intolerable to be in an environment with active users
- Alcohol and substance use can cause problems that pose threats to the stability and safety of the housing environment
- Alcohol and substance use problems can be very difficult to manage

ILLUSTRATION OF DAMP SUPPORTIVE HOUSING

THE RIO, New York, New York

About the housing: The Rio, located in northern Manhattan, is a permanent, supportive housing project developed in 1991. It provides affordable housing with supportive services to a diverse population, including formerly homeless single adults, low-income working people, families, and people living with mental illness, substance use issues, HIV/AIDS, and other special needs. The Rio was created through a partnership between a nonprofit housing development organization and a social service agency.

Number and type of units of housing: There are 82 units, including 75 efficiency studios for single adults and 7 two-bedroom units for families.

Project sponsors: The Rio is a collaborative effort between Broadway Housing Communities (BHC) and the Center for Urban Community Services (CUCS). BHC acquired and developed the Rio. Originally founded in 1983, BHC sponsors six supportive housing programs in the Washington Heights and Harlem areas of New York

City and employs a significant number of tenants to operate the buildings' front desk services. CUCS, a provider of mental health and social services, is partner to BHC at all six of its housing sites.

Goals and philosophy: The Rio offers permanent, affordable housing with on-site support services. A strong emphasis on self-sufficiency is supported by numerous employment opportunities and a focus on self-help approaches.

Tenancy profile: Seventy-five single individuals and seven families reside at the Rio. Tenants range in age from infants to the elderly. All of the tenants were formerly homeless or marginally housed. Approximately 35 percent of the units are reserved for individuals with a serious mental illness.

Physical description: The Rio is a five-floor elevator building, and each studio unit has a private bath and kitchenette. The two-bedroom apartments each have a full kitchen, bath, and living room. A laundry room is located within the building, and common spaces include an entry lounge, a garden roof deck, a penthouse with offices, a public meeting space, and an art gallery.

Services description: On-site supportive services are available to all tenants and are intended to be flexible and based on individual need. Accepting services is not required as a condition of tenancy. Services include case management, education and employment assistance, relapse prevention services, psychiatric and health care services, assistance with activities of daily living, crisis intervention, parenting groups, cultural awareness programs, and recreational groups. The Rio, located in a neighborhood plagued by high drug activity, has on-site recovery support groups and AA and NA meetings. The use of alcohol is discouraged, although it is not prohibited except in public spaces. Use of illegal substances is prohibited on-site. Education is provided to all tenants regarding substance use, mental illness, and HIV disease.

The Rio staff includes three case managers with supervision provided by a master's level social worker. Staff are on-site during the day, Monday through Friday. During nonbusiness hours, supportive services staff are on call.

Eligibility criteria/lease and occupancy agreement/rent: All tenants sign a one-year renewable lease and pay 30 percent of their income for rent, which is often subsidized by Section 8. Abstinence is not a condition of eligibility.

Core Program Components

In addition to the core program components identified in chapter 2, Developing a Supportive Services Program, there are specific considerations for working with individuals who have substance use issues. These include establishing expectations for behavior, using interventions that help people to change, ensuring coordination and continuity between on-site and community-based services, promoting community-building and peer support strategies, offering relapse prevention services, addressing issues of dual-diagnoses, and supervisory and staff training issues.

Establishing Expectations for Behavior

Policies, procedures, and rules provide direction to staff and tenants and clarify expectations for behavior. To be effective, policies and rules must be clearly understood and enforceable. (See Appendix V, Substance Use Policy and Program Development Guide.)

Rules about Use of Alcohol and Substances On-Site: Housing sponsors should be aware of relevant legal issues prior to determining rules about alcohol and substance use on-site. Where tenants hold statutory leases, for instance, alcohol use cannot usually be prohibited, and eviction of tenants for using illegal substances may require court approval. Prohibition of the use of alcohol or any other substance in common spaces, however, is widely practiced among supportive housing sponsors.

In housing intended to be "dry," sponsors should establish that they can legally ban alcohol in private units. Transitional housing programs generally have more latitude. If house rules restrict or forbid use, it should be determined how use will be detected, who will detect it, and how infractions will be handled. Sponsors should also ensure that policies can and will be consistently and equitably enforced.

Expectations for Behavior: Clearly, substance abuse can result in very disruptive behaviors. Although use of illegal drugs or other criminal activity is usually prohibited in the lease or occupancy agreement, it is common to specifically identify related behaviors that are not acceptable (e.g., yelling, violence, destruction of property, stealing, etc.). Additionally, if allowable under local law, policies regarding visitors can specify that tenants are responsible for their visitors and the circumstances in which visitors may be barred from the building (e.g., if they are intoxicated).

In short, many supportive housing projects have found it effective to concentrate on behaviors rather than focus on detecting alcohol and substance use. It is important to establish which behaviors will not be tolerated and what the consequences for violations will be. Once expectations are established, tenants should be held responsible for their behaviors.

Focusing on Behavior

One supportive housing site described a tenant who was screaming obscenities late at night in the hallways and waking neighbors. The supportive services staff were unsure if this was a symptom of mental illness or substance use, and they spent the large part of two staff meetings disagreeing with property management staff about the root cause of the disruptions.

Meanwhile, tenants organized and called a meeting to complain about the noise. They insisted that the staff address the situation. It became clear that the immediate priority was to respond to the noise problem and disturbance to neighbors, regardless of the cause. Consequently, staff concentrated on stopping the noise, and it ultimately turned out that the tenant was in need of assistance with both mental health and substance use issues.

Relapse: Relapse can take many forms and may involve an isolated incident of use or repeated use accompanied by difficulty regaining sobriety. Frequently, tenants benefit most from services during relapse or troubled times, and withholding services and support when the tenant most needs help serves little purpose.

Ideally, relapse should be viewed as an opportunity for the individual to learn more about his/her recovery and how to live without using. Interventions that result in tenants feeling bad can have the adverse effect of increasing use to manage the negative feelings, particularly when there are other real consequences, such as loss of job, housing, friends, or family support.

When a recovering person begins using again, a natural starting point for intervention is to identify and discuss what triggered the relapse, develop a plan to regain abstinence, and manage the trigger in the future.

Rule Violations: Once policies and guidelines have been established, responses to drinking and/or drug use should be consistent. Responses to violations of house rules often include a written notice from property management regarding the violation. The role of support service staff in these cases is to ensure that the tenant understands the reason for the violation and to help plan how to avoid additional violations. Coordination between supportive services and property management staffs is critical in this process. Sometimes, for example, the threat of eviction will cause individuals to seek treatment.

Sometimes, repeat violations due to drug use and/or drug dealing can be so severe and disruptive that eviction must be pursued. The decision to pursue eviction must be considered in the context of local landlord-tenant law. For example, New York City and Chicago require substantial documentation to meet the legal requirements for eviction. In Arizona, on the other hand, state law permits rapid eviction with minimal evidence that the tenant has violated the Drug-Free Housing Agreement attached to his/her lease.

Drug Dealing

Providers must be vigilant about monitoring drug dealing because of its impact on the housing community and the potentially disruptive problems that can occur. Typical problems resulting from drug dealing include visitors who steal and instigate relapse among people in recovery. Similarly, drug dealing engenders loan-sharking, violence, prostitution, and an overall decrease in tenant morale and commitment to the goals of the larger community.

The Stages of Change

Prochaska, DiClemente, and Norcross identified a series of predictable stages that people pass through before they actually achieve sobriety.[1] Their work resulted in the Stages of Change model, which describes the experiences that individuals using substances undergo before achieving sobriety. The Stages of Change suggest ways of working with individuals at each point in the process. Sometimes, the frustration experienced by staff working with substance users is due to a mismatch between a substance user's actual stage of change and the specific interventions being applied by staff.

The Stages of Change model emphasizes that change takes time, movement can be back and forth, and interventions must be tailored to an individual's particular place in the five-stage process. The stages are:

Precontemplation: An individual is "in denial" and unaware that a problem exists. Precontemplation is the stage of unawareness or underawareness of problems related to drinking and/or drug use. There is no intention to change behavior in the foreseeable future. Many defensive behaviors are evidenced, including denial, externalization, and minimizing. ("I don't have a problem...it's your problem.") At this stage, the staff focuses on engaging the person and working to learn more about the individual's interests, concerns, and goals. The issue of substance use is raised as it affects the individual's ability to address these concerns and goals.

Contemplation: Contemplation is the stage in which the person is aware that a substance use problem exists and begins to think seriously about overcoming it. However, a commitment to take action has not yet been made. It is sometimes called the "yes, but..." stage. Helping people to clearly examine how drug use is creating negative consequences and interfering with personal goals is important. People usually weigh the positive effects of substance use and getting high against the considerable effort, discomfort, and loss of not using. In the contemplation stage, the staff can help the individual envision how to replace old counterproductive behaviors with behaviors that support independence, stability, and health.

Preparation: An individual is thinking about the steps to be taken to make change. Preparation is a decision-making stage and combines intent with a real plan. ("This is what I will and will not do.") Some reductions in problem behaviors may have been made—such as no longer drinking in the mornings—but the desired outcome, such as abstinence, has not yet been reached. At this stage, a tenant may say he/she does not want to drink at all. Staff should help tenants develop plans for the action phase.

1. Prochaska J. O., C. C. DiClemente, and J. C. Norcross. "In Search of How People Change: Applications to Addictive Behaviors." American Psychologist 47, no. 9 (1992): 1102–1114.

Action: An individual is now changing his/her behavior and/or environment to address use issues. Abstinence requires a considerable commitment of time and energy. Moving into action following relapse is difficult, but the reminder that it has been accomplished in the past is encouraging. Prior relapses are used as an opportunity for learning about triggers for use and how to live without using. The staff assists tenants in the action phase by helping them talk about and plan how they will remain abstinent, avoid triggers, and deal with urges.

Maintenance: An individual has maintained the change in behavior for six months or longer. Maintenance is the stage in which people work to prevent relapse and consolidate the gains attained during action. For most people, maintenance lasts a lifetime, and ongoing relapse prevention is critical.

The Stages of Change model recognizes that many people have false starts and that relapse is a part of the recovery process. Relapse occurs if the person resumes the problem behavior and returns to one of the first three stages. In theory, an individual could go through detoxification and join AA (action), quit drinking for ten years (maintenance), start drinking again for three years (relapse), and begin to think about stopping again (contemplation). A person could cycle through all or part of the process numerous times.

The Stages of Change approach has been incorporated into programs where abstinence is a goal and where it is not. In the latter, action is not necessarily defined as sobriety but a change in behavior, such as not drinking during the week. The Stages of Change can also be used in conjunction with other models of addiction and recovery. (See Appendix III, Models of Substance Abuse, Addiction, and Recovery.)

Individual Counseling and Support

Supportive housing provides a unique opportunity for staff to establish one-on-one relationships with tenants. The one-on-one relationship between a worker and tenant is often a key factor in promoting or maintaining change when substance use issues exist. Having faith in the individual's ability to improve his/her life and providing support through missteps and setbacks are very important, regardless of other variables. High levels of trust, acceptance, empathy, and a nonjudgmental stance characterize these relationships.

Maintaining good relationships with chronic substance users can be difficult and complicated. Repeated alcohol and/or substance use without real change can be very frustrating, and strong negative reactions in response to the consequences of use can also occur, particularly when harm to others is involved. In this regard, the staff need forums and supervision to discuss their own feelings and frustrations as well as guidance about maintaining these relationships and remaining helpful. Counseling should not become the support that "enables" a tenant to continue to use but rather enables the individual to honestly evaluate the impacts of substance use.

Specifically, staff members can work with tenants to discuss and evaluate any of the following:

- Current needs and goals
- How substance use fits into one's life
- Where a person is at in the "stages of change"
- The pros and cons of changing substance use patterns
- The costs and benefits of change (reducing or stopping use)

Some of the primary goals for staff include:

- To listen and understand the relevance of substance use for the individual
- To understand individual readiness or efforts to change and to match interventions accordingly (see Appendix IV, Stages of Change and Recovery)
- To help identify meaningful reasons for stopping or reducing use
- To raise awareness by pointing out instances where use interferes with the individual's ability to achieve self-identified goals

Sometimes, staff members approach substance use issues by encouraging and pressuring tenants to stop using. Unfortunately, this usually sets up push-pull scenarios, with tenants trying to avoid staff and staff looking to "land the tenant." In some cases, individuals may want to stop using but cannot sustain sobriety and may find the staff to be just another hassle. Even though it may seem obvious that substance use is a primary cause of problems for some tenants, "hitting them on the head" with it is usually ineffective. Similarly, some people may not know "why" they drink or use substances, and it is not necessarily helpful or practical to focus on this. Instead, in an effort to build motivation for change, it is important to focus on the discrepancies between what a person wants and what that person has.

Since substance use can interfere with functioning in a variety of ways, it is often helpful to address substance use as it impacts an individual's goals such as employment, reunification with family, or staying housed. The reasons to reduce or stop use may begin to outweigh the reasons to continue. The fact is, however, that substance users ultimately face giving up something that provides them with comfort in exchange for the pain of withdrawal and the loss of a familiar lifestyle. When working with people who are preparing to change, staff should help in planning to manage these losses and to avoid triggers that can lead to relapse.

Individualized recovery plans are important. A recovery plan delineates the strategies an individual has decided to use to maintain abstinence as well as plans to manage urges and anticipated triggers. The plan addresses matters such as friends and support, routines and rituals, filling time, and managing feelings. This process can also be conceptualized as a "use reduction plan" for those still actively using, focusing on reducing some of the consequences of use such as disruptive behavior and poor health.

Combining On-site Services with Community Linkages

Supportive housing programs have to evaluate which services will be provided on-site and which will be provided through community linkages. The usefulness of community-based services is dependent upon the quality of services available and the fit with tenants' needs. Preferably, supportive housing staff are able to coordinate their efforts with a community-based support program that specializes in substance use services.

Housing programs should determine the range and type of services that are available in the community; optimally, there are detoxification programs and outpatient substance use counseling services. Meetings between the staff of supportive housing and community-based programs can lead to better coordination and enhance the quality of service being provided. Even with extensive community-based supports, however, supportive housing service programs should be prepared to get involved directly with substance use issues because some tenants may not get engaged in treatment or may create substance-related problems in the housing.

Recovery Planning and Relapse Prevention Services

Once a person has made a decision to commit to abstinence or reduced use, there are a variety of interventions that supportive housing programs can provide to assist in recovery planning and relapse prevention. Following are examples of supports that can be offered individually or in groups.

Education: Teaching about managing the withdrawal process, urges, cravings, addiction patterns, and hurdles to recovery. This can occur via presentations, discussion groups, reading materials, and the Internet.

Exploring positive and meaningful alternatives for spending time: Looking at how to manage time when substance use is not the organizing force by engaging in new activities, such as education and other pursuits.

Developing new relationships and a support network: Making new friends and learning how to live without substances. Attending AA, NA, and other self-help meetings. Identifying a sponsor and/or others in recovery who can provide support and guidance.

Identifying triggers: Looking at people, places, and things associated with addictive behavior. One group activity, "the clock," identifies times of the day most associated with use. Another, "treasure hunt," identifies and examines triggers in the neighborhood.

Developing coping strategies for high-risk situations: Using rehearsals, role plays, and discussion to prepare for difficult encounters such as; meeting the "active" friend, telling family about recovery needs, or attending a social function. Learning stress and anger management techniques is also important.

Recording thoughts, emotions, and behaviors: Using a personal journal to record situations that provoke thoughts and emotions and how these can lead to relapse or continued sobriety.

Documenting solutions and rewarding success: Reviewing high-risk situations and identifying coping strategies that were particularly useful. Integrating successful strategies into future recovery planning efforts, identifying rewards for success, and celebrating accomplishments.

Learning from relapses: Normalizing the experience by listing the circumstances that preceded the last relapse. Identifying the changes in thinking, behavior, and emotion that precipitated the act of "picking up." Helping the person to identify his/her own particular warning signs and making connections between use and the consequences of use.

Employment and vocational supports: Engaging in employment and vocational services can be key. Not only does work fill time, it can provide meaning and life-changing opportunities. In models using harm reduction approaches, work may be a motivator and strategy to use less substances.

Common Relapse Triggers

Though relapse triggers can be profoundly different for each person, the following ten triggers are common.

- Being exposed to alcohol and other drugs, active substance users, and places where the individual used to buy or use substances
- Boredom, feelings of emptiness
- Negative feelings including anger, sadness, envy, loneliness, guilt, and shame
- Positive feelings that are associated with celebrating
- Having a taste, such as having a drink or feeling high from prescription drugs

- Experiencing a loss, setback, or grief reaction
- Attempting to test the ability to use only on a "recreational" basis
- Physical pain
- Suddenly having a lot of cash
- Romanticizing getting high

Fostering a Supportive Community, Leadership, and Self-Help Strategies

A hallmark of supportive housing is a focus on fostering community among people who live in the housing, promoting connections to the community outside the housing, and otherwise assisting in the development of tenants' support networks. Efforts that bring people together and promote socialization and healthy living help to build community and provide alternatives to using substances. Providers can engage in a variety of interventions with tenants, including educational and support groups, recreational activities, socialization opportunities, and classes to learn new skills and information. Celebrations of holidays, anniversaries (such as sobriety periods), and other gatherings can offer people opportunities to socialize without substances. Educational sessions on a wide variety of subjects from anger management strategies to job searches to yoga can engage people in new pursuits and teach new coping strategies.

Cultivating leadership among tenants who have histories of recovery can be helpful to those who are still struggling with substance use problems. These individuals can become role models and mentors for others and take on proactive roles within the housing. Some, as part of Alcoholics Anonymous or Narcotics Anonymous, may become official "sponsors". These individuals can be particularly helpful when working with people who may be more responsive to peers than staff members.

AA (Alcoholics Anonymous) and NA (Narcotics Anonymous)

Many supportive housing projects host AA and/or NA meetings. The motivation for starting on-site meetings often comes from the tenants as part of their recovery processes. AA and NA are extremely effective in promoting and supporting sobriety, and providers routinely rely on these and other self-help groups as part of their supportive services program plan. The vast majority of groups are started and run by members, and listings of local meetings are readily available.

On-site AA or NA meetings that are open to the public are a way to provide a service to the tenants and the community at large. On the other hand, many decide to attend AA and NA meetings off-site because they feel more comfortable discussing personal matters outside the housing setting. Some housing sites offer meetings on-site and publicize meetings in the community as well. One distinct advantage of on-site meetings is that they are convenient, and some people may attend who otherwise might not make the effort.

Creating Services for People with Dual Diagnoses

Many supportive housing programs serve people who are dually diagnosed with mental illness and chemical addiction (MICA). Addressing mental health and addiction problems simultaneously is the preferred approach. Substance use can increase psychiatric symptoms (e.g., hallucinations, severe anxiety, depression) and can also mute these same symptoms. When people stop using or reduce consumption of alcohol and other substances, symptoms can increase or decrease.

There is evidence that treating both severe and moderate mental disorders with appropriate medications, such as anti-depressants, can reduce substance use. In these cases, staff should monitor symptoms and side effects and coordinate closely with the psychiatrist prescribing medication. Matching interventions to the individual's "stage of change" is particularly important for dually diagnosed people, since confrontational strategies can be more stressful and disorganizing for those with fragile defenses.

Some supportive housing projects offer Double Trouble groups for tenants who are mentally ill and chemically addicted. (Double Trouble groups use an adaptation of the AA/NA twelve-step model that is particularly sensitive to mental health issues.) One advantage to having these groups is that people can share their experiences with others who have similar backgrounds. Ideally, tenants should have access to Double Trouble groups as well as other substance use and relapse prevention groups. (See chapter 4, Mental Health Services, for more information on this subject.)

Staff Expertise, Expectations, and Training

Staff who work in supportive housing frequently report that dealing with substance use issues is the most difficult part of their work. It can help to hire staff who have prior experience working with substance users, although those who have worked in treatment or transitional settings sometimes find permanent housing to be very different due to a lack of leverage in requiring sobriety. Some programs hire people in recovery because of the natural alliance that they are able to build with other people working to remain clean.

Staff burnout increases when there are unrealistic expectations regarding the outcomes of their work. It can be very frustrating to put out a great deal of effort and time and feel like nothing is working. Similarly, it can be difficult to maintain a clear perspective within the one-on-one relationship, where the steps may be small and substantial change can feel completely out of reach. A staff person can also feel undue responsibility for an individual's inability to change, particularly if the person's behavior is causing problems for other tenants. The supervisor's role is to help staff members set reasonable expectations for their work and provide support and guidance. Additionally, staff need maximum clarity regarding the program goals, philosophy, and rules regarding substance use.

Some supportive housing programs have substance abuse specialists. Specialists can be effective in planning intervention strategies for particularly difficult cases and providing extra support to them. These positions can also be particularly helpful in gathering and sharing resource information about service options and conducting training for staff. In most cases, however, it is important that the specialist not be viewed or defined as the sole person responsible for working with substance users, which can cause other staff members to become detached once the specialist gets involved. For obvious reasons, the design of the service program should avoid setting up the specialist to be the end of the line for tenants who have substance use problems. Therefore, many programs weave substance use services into overall staff responsibilities. In designing a staffing pattern, it is important to delineate roles and responsibilities for addressing substance use issues to ensure that mechanisms are in place for coordination between different staff functions.

Staff members should have the necessary skills to deliver the services that are expected. Preferably, they should have training in the following areas: counseling techniques and motivational interviewing; commonly used street drugs and their effects; the symptoms of overdose and withdrawal; and a primer in addiction and recovery, the stages of change model, and relapse prevention.

Appendix I

Resources and Additional Readings

Baumohl, J., ed. Homelessness in America. Westport, Conn.: Oryx Press, 1996.

The authors explain why homeless people with alcohol, drug, and/or mental disorders are often excluded from programs that assist homeless people. Service and policy implications are examined, including the following: the importance of outreach and engagement, using case management to negotiate systems of care, offering a range of supportive housing options, responding to consumer preferences, providing mental health and substance abuse treatment, the need for harm reduction approaches to substance abuse, the importance of meaningful daily activity, providing culturally competent care, and putting the need for involuntary treatment in perspective.

Corporation for Supportive Housing. Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing (National edition). New York: Corporation for Supportive Housing, 2002.

This manual offers basic information about the laws that pertain to supportive housing and approaches to resolving common dilemmas.

Gorski, T. The Staying Sober Workbook: Exercise and Instruction Manuals. Independence, Mo.: Herald House/Independence Press, 1988.

These two companion manuals teach relapse prevention skills in the form of exercises, with one workbook for the client and a separate educational manual for the worker.

Heymann, P., and W. Brownsberger. Drug Addiction and Drug Policy: The Struggle to Control Dependence. Cambridge, Mass.: Harvard University Press, 2001.

This book is the culmination of five years of conversations among distinguished scholars in law, public policy, medicine, and psychology about the most difficult questions in drug policy and the study of addictions. Challenging conventional wisdom, the authors discuss how coercion and support can be used together to steer addicts toward productive lives.

Marlatt, A. Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors. New York: Guilford Publications, 1998.

This text examines a wide range of applications from needle exchange and methadone maintenance programs to alternative alcohol interventions and AIDS prevention campaigns. This volume explains the model's rationale and examines a range of strategies in diverse communities.

Miller, W. Treatment Improvement Protocol (TIP) 35: Enhancing Motivation for Change in Substance Abuse Treatment. Washington, D.C.: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 1999.

This TIP shows how substance-abuse treatment staff can influence change by developing a therapeutic relationship that respects and builds on the client's autonomy and, at the same time, makes the treatment clinician a partner in the change process.

Miller, W., and S. Rollnick. Motivational Interviewing: Preparing People to Change Addictive Behavior. New York: Guilford Press, 1991.

This book describes a nonauthoritarian approach to helping people struggling with addictive behaviors overcome their ambivalence and get "unstuck." The authors review the conceptual and research background of motivational interviewing, provide practical introductions to using the approach, and bring together contributions from international experts describing their use of the model with a broad range of populations.

Minkoff, K., and R. Drake. Dual Diagnosis of Major Mental Illness and Substance Disorder. Indianapolis, Ind.: Jossey-Bass, 1991.

Significant advances have been made in both the conceptualization and the development of innovative models providing integrated assessment and treatment for people with dual diagnoses. The purpose of this volume is to provide information about the current theories and clinical interventions and to describe innovative treatment programs.

Prochaska, J. O., C. C. DiClemente, and J. C. Norcross. "In Search of How People Change: Applications to Addictive Behaviors." American Psychologist 47, no. 9 (1992): 1102–1114.

This seminal article describes the transtheoretical model of change (Stages of Change), an idea that describes how people change or modify addictive behaviors. The authors describe five stages in the process: precontemplation, contemplation, preparation, action, and maintenance.

Robbins, R., A. Tafe, and M. Argeriou. Alcohol and Drug Free Housing Guide. Alcoholism and Drug Abuse Association and Stabilization Services Project, 2000.

This guide is intended to assist individuals in recovery to achieve their goal of sobriety. The authors suggest that adequate preparation for securing alcohol- and drug-free housing increases the likelihood of success. This manual provides information and advice to those seeking sober housing and serves as a teaching tool for substance abuse workers.

Roberts, L., and T. Eckman. Overcoming Addictions: Skills Training for People with Schizophrenia. New York: W. W. Norton and Company, 1999.

This book helps staff members teach groups of individuals with schizophrenia how to avoid drugs and alcohol, recognize signs of relapse, and build healthy habits and pleasures into their daily routines. The book emphasizes an attitude of acceptance, tolerance, and optimism toward clients. Each chapter includes suggested scripts for use in each training session. Includes a glossary, numerous forms, and other materials for use in the program.

Stevens, P., and R. Smith. Substance Abuse Counseling: Theory and Practice. Upper Saddle River, N.J.: Merrill Prentice Hall, 2001.

A good resource for substance-abuse counselors seeking information on the stages of counseling—from assessment and diagnosis through relapse prevention.

Tims, F., J. Platt, and C. Leukefeld. Relapse and Recovery in Addictions. New Haven, Conn.: Yale University Press, 2001.

This important volume brings together the major perspectives on addiction, treatment, and recovery, along with current research findings. The contributors explore a wide range of topics, including craving and emotional factors in relapse, pharmacotherapies, adolescent treatment, outcome research, clients in the criminal justice system, the self-help movement, and health services issues such as managed care and linkages to other systems.

Internet Sites

Harm Reduction Coalition Education Services

http://www.harmreduction.org

This website provides information about harm reduction training, conferences, and literature.

Lindesmith Center of the Open Society

www.lindesmith.org

This organization is devoted to policy reform and considering nontraditional approaches to drug problems. The web site has a chat room and many resources that can be downloaded.

The National Center on Addiction and Substance Abuse at Columbia University

http://www.casacolumbia.org

This organization provides up-to-date information on substance abuse research and policy in the areas of prevention, treatment, and general and mental health.

National Institute on Drug Abuse

http://www.nida.nih.gov

Part of the National Institute of Health, the mission of the National Institute on Drug Abuse (NIDA) is to lead the nation in bringing the power of science to bear on drug abuse and addiction. NIDA has two major components: research and disseminating the results of research to improve drug abuse prevention, treatment, and policy.

National Resource Center on Homeless and Mental Illness/Policy Research Associates, Inc.

http://www.prainc.com

This site includes information related to homelessness, mental illness, and substance abuse, and it features an extensive database of publications on related subjects.

Substance Abuse and Mental Health Services Administration

http://www.samhsa.gov

This federal agency is charged with improving the quality and availability of resources, treatment, and rehabilitation services in order to reduce illness, death, disability, and costs to society resulting from substance abuse and mental illness.

Appendix II

DSM IV Diagnostic Criteria for Substance Abuse and Substance Dependence[2]

Criteria for Substance Abuse

A. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve-month period.

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance; absences, suspensions, or expulsions from school; neglect of children or household)
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
3. Recurrent substance-related legal problems (e.g., arrests for disorderly conduct)
4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with significant other about consequences of intoxication, physical fights)

B. The symptoms have never met the criteria for substance dependence for this class of substance.

Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least three of the following, occurring at any time in the same twelve-month period.

1. Tolerance, as defined by either of the following:
   - a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   - markedly diminished effect with continued use of the same amount of the substance
2. Withdrawal, as manifested by either of the following:
   - the characteristic withdrawal syndrome for the substance
   - the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
6. Important social, occupational, or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., cocaine use despite cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

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2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th ed.. Washington, D.C.: American Psychiatric Press, 2000.

Appendix III

Models of Substance Use, Addiction, and Recovery

These models have been culled from a variety of sources and are meant to highlight some of their key features and principles. Most programs do not apply only one theory but rather blend elements of various models. Assistance in developing these brief sketches was provided by Meredith Hansen, Ph.D. (For more specific information on these models see Appendix I, Resources and Additional Readings.)

Genetic/Disease Model

Addictions are caused by pre-existing, perhaps genetic, physiological conditions that result in a "loss of control" over drug use. Loss of control means the addict cannot control the amount they will consume during an episode of substance use, nor can they predict when it will stop.

Goal: Lifelong abstinence from all drug use.

Strategies: Detoxification or maintenance on substitute drugs such as methadone. Addicts are educated about the adverse consequences of addiction and helped in overcoming psychological defenses, such as denial, that prevent abstinence. Relapse prevention planning is key.

Self-Help Model

Alcoholics Anonymous and Narcotics Anonymous are two well-known self-help groups. These groups believe that addicts are powerless over their use and must accept this fact and commit to a life of sobriety. In self-help groups, people in recovery share their experiences and support each other in the hopes of maintaining their own sobriety and promoting the sobriety of others. Except for institutional-based groups, self-help groups do not employ a professional staff.

Goal: To achieve sobriety and maintain recovery.

Strategies: Use of the Blue Book, working the "Twelve Steps," and upholding the "Twelve Traditions." Extensive use of meetings where members speak publicly about their struggles and work on the twelve steps. People with stable recoveries "sponsor" others who are newly recovering, offering them support and guidance.

Self-Medication Model

People use/abuse substances to soothe unpleasant mood states and feelings such as anxiety, emptiness, hyperactivity, and depression in an attempt to gain emotional equilibrium. This is particularly relevant to mentally ill people who may self-medicate in an effort to control their thoughts and behaviors.

Goal: To treat the underlying emotional problems and reduce subjective distress.

Strategies: Use of biofeedback, acupuncture, stress reduction, and various medications, including methadone, psychotropic, antidepressant, and antianxiety drugs.

Learning Model

Addictions are learned behaviors that are acquired and shaped by positive and negative reinforcements resulting from one's own behavior and/or observing the behaviors of others. For instance, one may learn to reduce tension by taking drugs.

Goal: To interrupt drug use behavior patterns and develop alternative behaviors for coping with stimuli.

Strategies: To discover the stimuli that cause drug use, the events that shape that stimuli, and the effects that maintain it. For instance, one may argue with the boss (event), feel anxious about a job (stimuli), and use drugs to alleviate the tension (effect). In this case, the treatment objective would be to help the person become aware of this pattern and find alternative ways to deal with stimuli without the use of drugs.

Social Model

Addiction is caused by social arrangements in which an addict is embedded. It is thought that social conditions that produce alienation, frustration, and despair lead to drug use. Addictive behavior is seen as being supported by subcultures in which drug use is accepted as normal.

Goal: Change society so that conditions favoring drug use, such as poverty and racism, do not exist.

Strategies: Vocational training and job development programs designed to give people with addictions access to mainstream opportunities and culture. Relocate people from subcultures that are seen as supporting/legitimizing use. Pursue economic and community development in substance-infested communities that are reliant on the drug economy to survive.

Symptom Model

Addiction is a result of underlying emotional disturbance. Psychodynamic theorists see addiction as a symptom that is shaped by underlying emotional conflicts, low self-esteem, or other intrapsychic events.

Goal: Resolution of the underlying conflict that gives rise to drug use.

Strategies: Psychotherapy that is aimed at gaining insight into the causes of the addicted person's behavior and restructuring his/her personality.

Biopsychosocial Model

The biopsychosocial model incorporates all aspects of a person's life and is a holistic approach to viewing addiction. Addiction is influenced by many conditions and factors. As the addiction process unfolds, biological, psychological, physiological, and sociocultural factors interact to influence not only the emergence of addiction but also its maintenance and interruption.

Goal: To help the person identify factors that affect his/her addiction and recovery and mitigate the impact of these influences.

Strategies: To intervene with the person on a number of levels including the biological, social, learning, and psychological.

Appendix IV

Stages of Change and Recovery: The Course of Change and Worker Tasks[3]

As people change problem behaviors such as substance abuse, they go through a series of predictable stages. The following combines the Stages of Change and the Stages of Recovery. Every person on the road to change will find they are, for the most part, in one of these stages. The worker's role during the change process includes:

- Assessing what stage a person is at
- Choosing and making stage-appropriate interventions
- Putting personal opinions/biases aside and remaining nonjudgmental

The worker's role adjusts to the person's stage of change and keeps the helping process connected to "where the tenant is at". The focus of the work is on helping individuals identify their current stage of change and prepare for, then progress from one stage to the next. The following are suggested interventions for each stage of the change process.

Stage 1: Precontemplation

Person is unaware that a problem exists. This is often referred to as "denial."

Tasks

- Raise the person's awareness about how substances are affecting his or her life by listening to their opinions about the pros and cons of use.
- Denial is a defense. Telling the person the consequences of their substance use often increases their denial as they try to convince you that you are wrong.
- Ask the person to tell his/her story and listen for the role substance use plays in his/her life.
- See the "whole person" and not just the substance use issues.
- Have frank discussions about substance use, such as type of substance(s), frequency, and so on.
- Work on mutual goal(s). These may not be related to substance use, but substance use will often come up in the context of achieving other goals.

Stage 2: Contemplation

Person is aware of a problem and begins to consider whether a change is needed.

Tasks

- Elicit pros and cons of substance use from the person.
- Help build awareness of negative consequences of substance use. Keep in mind that what we identify as negative consequences may not be meaningful to the individual.
- Give credence to the person's perceived sense of how substance use is helpful.
- Continue to work on mutual goal(s), for example, look for a vocational program.
- Help to examine the pros and cons of changing behavior, for example, reducing or stopping use.

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3. Adapted from Prochaska, DiClemente, and Norcross

Stage 3: Preparation

Person is aware that a problem exists and begins to think about change or takes some tentative steps toward change. Once reaching this stage, many people remain at this point in the process for an extended period of time.

Tasks

- Help the person continue to assess the need for change and the tools and supports needed to make the change.
- Explore strategies to address the problem and develop a plan of action.
- Reinforce the positive results of using less.
- Talk about feelings like anger at having to stop and normalize the recovery process.

Stage 4: Action/Early Recovery (approximately the first six months of sobriety)

The person is now changing their behavior and/or environment to address the problem. They have stopped using substances, even if for only one day, and are experiencing the physical and psychological effects of withdrawal.

Depending upon the substance used, frequency and duration of use, some of these withdrawal effects include:

- Agitation
- Bone pain
- Drug dreams
- Exacerbation of mental illness
- Gastric distress
- Insomnia
- Lack of energy
- Loss of libido
- Mood swings
- Physical aches and pains
- Severe cravings
- Trouble sleeping

Other more serious symptoms of withdrawal, which may indicate the need for a medically supervised detoxification, include hyper- or hypotension, delirium tremens, psychosis, thoughts of suicide, confusion, disorientation, fever, chills, and/or dehydration.

The person in the action phase has developed and is using a recovery plan. He/she is learning new ways to cope with cravings and to interact socially without chemicals.

Tasks

- Help the person understand and avoid "triggers" to use (people, places, things).
- Expect and encourage expression of the person's sense of loss.
- Recognize, support, and reinforce positive behavior changes.
- Assist in the ongoing management of a recovery plan that includes how the person will cope with triggers and stress.
- Provide recovery resources such as lists of AA, NA, or CA meetings or substance abuse programs. If necessary, help the person make the needed connections to these services.

Stage 5: Middle Recovery (approximately six months to two years of sobriety)

The person is continuing to develop the internal and external resources to achieve a balanced lifestyle without drugs or alcohol.

Tasks

- Expect the person to hit "the wall" after the initial positive experience of recovery subsides.
- Guide the person toward new stress-management techniques to replace reliance on substances.
- Help the person begin to rebuild his/her life—hobbies, friends, work, and so on.
- Participate in goal planning and assist in identifying steps to achieve identified goals.
- Provide access to support services such as AA, NA, and CA meetings and outpatient counseling.
- Recognize and encourage emerging interests.
- Help the person plan for reparation of past.

Stage 6: Maintenance (approximately two years of sobriety and on)

The person is now focused on self-actualization and setting and meeting goals of personal importance. People may want to reinforce their commitment to sobriety through helping others with their addictions.

Tasks

- Reinforce relapse prevention skills and strategies.
- Connect person with a wider support network.
- Enhance person's decision-making skills.
- Help the person increase their ability and capacity to give self-praise.
- Explore cravings and/or drug dreams, which can continue for years after stopping use.
- Help to develop ongoing plans to deal with triggers.

Relapse

Relapse is a normal, expected, and usually unpleasant part of the change process. It can happen at any point after a person has stopped using. After a relapse, the individual may return to any of the preaction phases or recommit to sobriety.

Tasks

- Explore the events, thoughts, and feelings that led to the relapse.
- Affirm that relapse is a normal occurrence in the process of change.
- Present relapse as an opportunity for learning.
- Help to avoid demoralization, shame, and further relapse.
- Develop plans to regain sobriety and avoid triggers in the future.

Appendix V

Substance Use Policy and Program Development Guide

This questionnaire was created to guide in the development of substance use policies for supportive housing and other residential settings. The questionnaire is intended to help programs develop written policies that specify (1) what behaviors are allowed and not allowed, (2) the consequences of breaking these rules, (3) who monitors and enforces the rules of behavior, and (4) what services are provided to help people with substance use problems.

What are the goals of your housing program?

What are the goals for tenants who have chemical dependency issues? For example, total abstinence, harm reduction, housing stability, and so on.

What are the rules around substance use? How are they communicated to staff and tenants? For example, drug- and alcohol-free environment, no drinking in common areas, and so on.

What behaviors are unacceptable at the housing site? For example, violence, destroying property, knocking on doors to borrow money at night, and so on.

What are the consequences for violation of rules around substance use and unacceptable behaviors?

Who is responsible for enforcing the rules and the consequences?

What is the policy for addressing relapse at your program? Are there consequences for relapse?

What are the criteria for eviction from the housing?

In light of your project's goals and rules, what percentage of tenants do you expect to be in each of the following stages? What supportive services or interventions will be offered to people at specific stages?

Active substance use/Denial of problem

Active use/Some motivation to change behavior

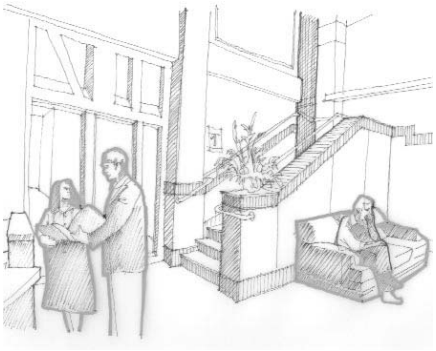
Active use/Preparing to make change

Early recovery/First six months of sobriety

Middle recovery/Six months to two years of sobriety

Maintenance/Two years or more of sobriety

Crisis and Conflict



Crises and conflicts cannot always be avoided, but much can be done to prevent them and reduce their negative effects. Severe and frequent crises can cause the supportive housing environment to feel out of control and unsafe. Strategies that anticipate and prevent conflicts and crises are essential, as are effective interventions to manage them.

A crisis is an intense and difficult situation that can either deteriorate or improve. Often, staff can reduce the intensity of crisis situations through advanced planning and by intervening at crucial points. Interpersonal conflicts can also lead to crises and sometimes occur among tenants or between staff and tenants. When conflicts erupt into heated disputes, threatening behavior, or a disregard for rules and norms, they should be promptly addressed, particularly if they have the potential to escalate.

This chapter provides information for preventing and managing crisis and conflict in supportive housing.

Prevention Strategies

Communication is the common denominator for preventing, managing and resolving conflicts and crises. "Nobody told me" or "I didn't know" reflect poor communication and are common responses after something has gone wrong. When staff identify the need for "better communication", it is often an expression of needing more guidance and information to function effectively.

The housing community benefits when there are both multiple avenues for relaying information and responsible individuals to make communication happen. Structures should be in place to ensure that communication flows among those who need it, and the information being communicated should be clear and current. There are many tools for communication including policy and procedure manuals, staff trainings, staff supervision, team meetings, tenant meetings, log books, incident reports, case conferences, individual counseling, bulletin boards, and casual gatherings and conversations among staff and tenants.

In supportive housing, front desk managers, security personnel, maintenance workers and other frontline staff may be first to notice that a potentially problematic situation is brewing. Open communication among all levels of staff should be encouraged, as working together is central to averting crisis and maintaining a safe environment. Since communication is a process that evolves, mistakes are sometimes made despite best efforts. In the aftermath of a crisis, it is important for participants to review what could have been done differently.

Early intervention is also important in preventing conflict and crisis. Some crises are single events, while others result from a series of events. In the absence of precautions, supportive housing projects may experience a disproportionate number of crises and conflict situations. Staff can help reduce the potential for these situations by doing the following:

- Identifying tension centers. Tension centers vary from site to site but often include common areas or shared facilities such as recreation rooms, kitchens, laundry rooms, and bathrooms.
- Identifying and anticipating stressors. There are times that are predictably more stressful, such as the end of the month when tenant funds can run low. Staff being on vacation, holidays, and anniversary dates of sad occasions can also be sources of stress.
- Paying attention to changes in behavior. Maintaining connections between staff and tenants and being aware of shifts in behaviors and conditions are important.
- Providing extra support around transitions. Transitions are often accompanied by stress. Moving into a building, moving out, quitting drinking, or leaving a job can all cause stress and require additional support.
- Intervening sooner rather than later. In general, early intervention increases the potential for positive outcomes and decreases the severity of the conflict or crisis situation.
- Training to de-escalate conflicts and crises. An informed and skilled staff is better prepared to respond effectively.
- Learning from experience. The aftermath of a crisis should include an assessment of why it occurred, identification of any warning signs that may have been present, a review of interventions that worked effectively and those that did not, and a plan for the next time similar situations arise.

Guidelines for Managing Crises

Clear policies and procedures should be established and communicated to guide program operations and to set expectations for behavior. At a minimum, guidelines should address crisis prevention, safety, and how to respond to medical, psychiatric, and substance-abuse emergencies. (See Appendixes II, IV, VI, and VII for sample policies and procedures.)

Safety

Safety is a primary concern of tenants and staff. Policies and operating guidelines should be in place to protect the safety of everyone in the housing community. Sponsors can help ensure safety and prevent crisis by addressing basic security and safety needs such as front desk coverage, security lighting and cameras, intercom systems, fire safety and evacuation plans, on-call/backup staff availability, and visitor policies. Safety precautions can also be extended to office and program areas, such as locking up all sharp instruments and situating staff desks to face entrances.

All supportive housing sites should have written procedures for communicating with staff during off-hours and for contacting emergency medical services, the police, and mobile crisis units. Establishing relationships with the local police and relevant emergency units in advance can be useful. Not knowing who to call, what to do, or how to handle a situation increases anxiety among staff and tenants and results in confusion and less effective interventions.

Incidents should be documented in tenant records, staff communication logs, and incident reports. Communication logs can be particularly important in transferring information between shifts, as it allows all staff members on duty to have current information. Incident reviews should include recommendations for changes that may be needed in program policies or procedures to avoid similar occurrences. Policies should include the consequences for violations of rules, particularly those that have safety implications. If consequences are not consistently enforced, rules to protect the safety of staff and tenants may be interpreted as flexible, negotiable, and unenforceable.

Medical Issues

Medical emergencies may occur instantly and anywhere. Some medical crises have no warning signs while others give more advanced notice. Programs should have written procedures for reporting medical conditions and responding to medical crises, although basic action usually involves calling for emergency medical services and transportation to a hospital.

Staff should be aware of individual health and medical histories and potential issues such as heart problems, diabetes, seizure disorders, asthma, and substance and alcohol use. This information can help staff members identify potential medical emergencies before they occur. Training in cardiopulmonary resuscitation (CPR), universal precautions, and first aid provide staff members with basic skills to respond to medical emergencies. Similarly, being able to identify warning signs of distress, such as impaired motor abilities or slurred speech, or being responsive to a sudden change in the course of an acute disease can save lives and give everyone greater ease and comfort. Programs should ensure the availability of standard supplies necessary for staff to follow universal precautions, such as gloves, shields for mouth-to-mouth resuscitation, and bleach. (See chapter 5, HIV Services, for a discussion of universal precautions.)

In the event of a medical emergency, the staff should assist medical personnel to locate the tenant and provide any applicable medical information. Staff members on all shifts should be able to access basic medical information and emergency contact information. (See Appendix II, Sample Policy and Procedure: Medical Emergencies.)

Alcohol- and Substance-Induced Incidents

There are instances when substance use can induce a crisis. People use substances for different reasons and are affected by them in different ways, although reduced inhibitions and impaired judgment are most common. When a person enters the housing or program area in an intoxicated state, the chances of an incident occurring increase because the behavior of someone who is "high" is unreliable and unpredictable. Some individuals can become belligerent and more prone to conflict when they are high, while others may go from happy to sad. These situations can also result in overdoses, which are medical emergencies and should be handled accordingly. Indications that an intoxicated person needs medical attention or hospitalization include, but are not limited to, difficulty breathing, seizures, excessive vomiting, and loss of consciousness.

If an intoxicated individual is posing a threat, staff should act to ensure the safety of other staff members, tenants, and the individual. If a situation is becoming unsafe, the police or 911 should be called per site emergency protocols. If the individual does not pose a threat and the police or emergency response unit is not needed, staff members should try to separate the individual from other tenants to avoid potential conflicts. Staff should not work alone when in the company of an individual who is intoxicated and should avoid conflict or confrontation.

Supportive housing programs should have guidelines for responding to excessive substance and alcohol use and guidelines for addressing and following up on substance-induced crises and emergencies. (For more on this topic, see Appendix III, Comparison of Signs and Symptoms across Categories of Substances, and chapter 6, Substance Use Services.)

Psychiatric Decompensation

Tenants who have mental illness can "decompensate" psychiatrically. A person decompensates when his/her ability to control behavior is diminished, resulting in a deterioration of functioning. In most situations, an individual who is decompensating psychiatrically can avoid a crisis if the condition is immediately evaluated, addressed, and monitored. The staff should be alert to potential cues and pay particular attention to changes in behavior so as to offer support and psychiatric follow-up. Signs that may indicate early stages of decompensation can be emotional and/or behavioral, including:

- Shifts in sleeping and eating patterns
- Deterioration in personal hygiene activities or other daily living skills
- Medication noncompliance
- Increased isolation
- Increased agitation
- Increased paranoia
- Depression or mania
- Psychosis (hallucinations or delusions)

Many things can contribute to or cause a person to decompensate. If an individual's usual coping mechanisms are ineffective, for whatever reason, the potential for decompensation increases. Some common risk factors include:

- Loss of usual support (e.g., loss or death of a friend or family member)
- Medication changes
- Substance and alcohol use
- Severe or prolonged stress
- Physical illness
- Conflicts
- Sleeplessness

Significant changes in behavior should alert staff and trigger a supervisory review. Intervention is usually required, and service staff should work with the tenant to slow or reverse decompensation (e.g., increase staff contacts, obtain a psychiatric evaluation, seek adjustment of medication prescriptions). If necessary, the individual should be continually assessed for potential harm to oneself or others. Program staff members should be made aware of significant changes in mental health status. If functioning continues to deteriorate or the individual is assessed to be a danger to self or others, inpatient hospitalization should be considered. Careful documentation is important to track and identify changes in behavior patterns. Ensuring the safety of the tenant and those around him/her at all times is critical.

People who are psychotic sometimes isolate themselves and thereby limit the likelihood of getting treatment. It is usually helpful to counter the pull toward isolation by encouraging participation in whatever ways are possible. This may aid in achieving an agreement to seek psychiatric treatment. In the interim, the staff should be working with a psychiatrist while simultaneously trying to serve as a bridge to psychiatric treatment.

There should be an action plan in place to involuntarily hospitalize an individual who becomes a danger to self or others, and the program should provide the staff with any resources necessary to address and support individuals who are at risk and destabilized. Line staff usually require additional supervisory support with cases requiring involuntary hospitalization. Staff support and involvement throughout the hospitalization process usually ensures better outcomes. (See Appendix IV, Sample Policy and Procedure: Psychiatric Hospitalization.)

Suicide

Suicidal ideation falls along a continuum, from people who experience passive thoughts of suicide to people who are in an active crisis state and require protection. In all cases, it is important to assess whether an individual has a plan to commit suicide and if there is immediate danger. Supportive housing programs should have guidelines for responding to suicidal ideation and attempts. As a general rule, all threats should be taken seriously, and supervisory staff should be notified. Staff should be aware of any history of suicidal ideation or attempts. Individuals with these histories are more likely to attempt and succeed at suicide. Suicide prevention and intervention require a team effort directed at protecting the individual and ensuring adequate psychiatric treatment, including involuntary hospitalization if necessary. (See Appendix V, Assessing for Suicide.)

There are an infinite number of risk factors that contribute to suicidal ideation and attempts. Following are more common factors.

- History of past attempts
- Familial history of suicide
- History of trauma
- Unresolved or untreated mental illness
- Command hallucinations (such as voices that tell a person to kill himself/herself)
- Recent significant loss
- Severe stress
- Major illness or extreme pain
- Substance abuse

Individuals may exhibit overt signs of suicidal behavior while others may show no apparent signs. Generally, however, most people who have suicidal thoughts reveal them in various ways, and signs of suicidal behavior can be subtle or blatant. One person may indicate ideation by giving away personal items or tying up loose ends. Others may begin stockpiling medications, become socially isolated or withdrawn, or show increased symptoms of depression. Helping these individuals avoid isolation and get psychiatric help is important.

Suicidal Ideation among People with Mental Illness

Schizophrenia: Suicide is a primary cause of death among people living with schizophrenia. The risk is highest in the first ten years after diagnosis, and suicide is generally more likely in men. Inadequate treatment and command hallucinations are powerful determinants. A major cause of suicide in persons living with schizophrenia is severe depression that can occur as part of the disease.

Depression and mood disorders: People who are seriously depressed are usually treated with medication. It often takes time for medication to work, and individuals may need reassurance that the medication will eventually help. Some antidepressant medications may take from two to four weeks before the most severe symptoms of depression decrease; therefore, people with depression are still at risk of suicide even as they begin to feel better.

Ironically, as a person begins to feel better, he/she may also acquire the energy and resolve to actually plan and carry out a suicide. Similarly, a person who is depressed may seem to be improving and feeling some relief when, in fact, he/she has made a resolution to commit suicide. Staff must carefully monitor and provide extended support to individuals who are overcoming serious depression.

Borderline Personality Disorder: Although frequent for some individuals, threats of suicide should always be taken seriously. Individuals with borderline personality disorder often lack impulse control, may also suffer from depression or a history of trauma, and may be chronically suicidal. Similarly, there are those who only intend to make suicidal gestures but succeed anyway.

Psychiatric Hospitalization

In most instances, programs should ensure that they have exhausted other alternatives before deciding to pursue psychiatric hospitalization. When discussing hospitalization with a tenant who needs inpatient care but is opposed to it, staff can emphasize the opportunity to get help, feel better, and take a break. Ideally, if the need for hospitalization is anticipated, discussions about hospitalization should occur before the condition becomes critical. It can be helpful to emphasize how hospitalization will relieve the individual's pain and discomfort. Staff should also try to understand and address the feelings behind reluctance, which might be fears of hospitalization, abandonment, loss of control, or previous negative experiences in hospital settings.

If possible, a staff person should accompany the tenant to the hospital to answer questions and advocate for the individual as necessary. Effective advocacy can make the difference in whether an individual is hospitalized. A copy of relevant medical or psychiatric information should be available for emergency room staff.

If the person does not agree to be hospitalized, then involuntary hospitalization should be considered; in most states, the law requires that the individual pose a danger to self or others, such as violent behavior, suicidal or homicidal ideation, or extreme self-neglect. Staff should follow emergency protocols and be prepared to provide evidence that the tenant is a threat. Emergency units (911) should be called and alerted to the type of emergency. Tenants should be cleared from the area. In instances when the tenant may become violent or flee, staff should not disclose to the tenant that emergency units have been called.

In many localities, the police usually arrive first in cases of psychiatric emergency calls. If possible, staff members should discuss concerns in private with the police before engaging the tenant. Once the police and emergency medical personnel arrive, they usually assume control of the situation. Staff should be prepared to provide basic identifying information and explain the circumstances in clear and exact terms.

In psychiatric emergencies, involuntary transports to the hospital will be reviewed by the emergency room attending physician to determine if the individual should be admitted. Staff can consult with the attending physician and advocate for admission if necessary. Staff should remain at the hospital until the tenant is

either admitted or released, and program supervisory staff should remain in communication throughout the process. If the tenant is not admitted, a member of the program staff can ask for a written statement from the hospital clarifying the reasons for not admitting and should also consider documenting concerns about the admission decision in writing to the hospital. This documentation can prompt the hospital to reconsider the decision and be helpful in future interactions.

In any event, program staff should contact the tenant's psychiatrist and/or primary care physician to advise them of the individual's status. If possible, a staff member should encourage the tenant's psychiatrist and/or primary care physician to consult with the attending physician prior to an admission decision. If the individual has been hospitalized, staff members should establish contact with the physician and social worker of the unit. Visiting the individual in the hospital is essential. The staff should also be advised of the hospital's treatment plan. Supportive housing staff should participate in discharge planning and assist the tenant with returning home by helping him/her to adhere to the specifics of the treatment plan, such as medication compliance and follow-up with psychiatric or medical appointments. (See Appendix IV, Sample Policy and Procedure: Psychiatric Hospitalization.)

Passive or "Slow-Brewing" Psychiatric Crises

Passive or "slow-brewing" crises are defined by difficult situations that emerge slowly and continue to worsen over time. These often include the following:

- Deteriorating personal hygiene
- Medication noncompliance
- Collecting materials such as newspapers, trash, or other items that create fire or health hazards
- Refusal of some or all medical or psychiatric services
- Symptoms of decompensation such as hallucinations and delusions that are not causing imminent danger

Passive crises can pose prolonged periods of difficulty and inconvenience for other tenants and the staff. The staff should have guidelines for working with tenants in nonpunitive ways while helping to enforce house rules and behavioral norms that support the safety and comfort of everyone. Depending on the circumstances, a tenant who is in a passive crisis may need to be placed on a "911 watch" in the event that the crisis escalates and requires hospital evaluation. Planning and communication, especially with the building maintenance and front desk staff, helps to ensure that the staff is sufficiently informed and prepared to coordinate information and respond to the situation appropriately.

Guidelines for Managing Conflict

Anatomy of a Conflict

Conflict can occur for as many different reasons as there are people. Although conflict can lead to change—sometimes positive—it is not a preferable mode of interaction, as it creates stress and tension in the environment. The role of the staff is to assist in the resolution of conflicts and to prevent them from escalating. Staff members and tenants can be trained in mediation skills, giving them greater capability to resolve conflict situations.

Trying to understand how someone communicates is important for managing conflict. "That's just the way he talks" may be the advice of a seasoned staff person who is pointing out that the way a person is communicating should not interfere with the message. Sometimes, for instance, people demonstrate aggressive, hostile, or combative behaviors that were adaptive to the street and/or to previous environments such as shelters, prisons, or institutions. These behaviors were a means of survival, but they can be out of place in housing. Other times, people are simply in bad moods or have other problems that are putting them on edge. An appreciation of the circumstances affecting communication can be instrumental in preventing and resolving conflict. In this regard, it is important to develop staff competencies in cultural awareness, mental illness, and substance use disorders.

Conflicts often occur in response to conditions a person perceives he/she cannot do without, including privacy, space, respect, resources, and peace and quiet. Conflicts are sometimes the result of incompatible needs between people that have to be negotiated. Sometimes conflicts are the result of a misinterpretation that requires clarification. Some tenants find it difficult to express their views and are passive in their communications; others are so intent on having their own needs met that they use aggressive tactics. By observing how individuals communicate, the staff will become more skillful at reading situations and helping to avoid and resolve conflicts. In the end, people can have very different and hardened positions and might have to agree to disagree.

In the aftermath of a conflict, the warning signs and points of escalation become clearer in hindsight. To the extent possible, however, the service staff should try to identify the signs of escalating tensions before a conflict occurs. Similarly, the staff should consider environmental stressors and tension centers within housing that contribute to potential conflicts, such as common areas, TV and recreation rooms, laundry facilities, and public phones. Simple rules regarding use of these facilities, developed with input from the tenants, can help reduce conflict in these areas.

Communication Aids

- "Open-ended" questions establish an atmosphere of acceptance and trust by encouraging a person to talk. For example, asking "What do you think the problem is?" invites information and begins to explore the tenant's perspective without guiding or limiting his/her response.
- "I" statements guide the expression of one's own feelings and ideas and can help avoid "you" statements that can lead to blaming and verbally attacking the other person. Taking ownership of one's feelings and opinions and allowing others to express theirs are important elements of good communication. Examples are "I am upset" or "I don't feel good about that." Keeping the dialogue focused on what each person is feeling can avoid arguments and focus energy on what needs to be addressed.
- "Reflective listening" requires one to focus attention on the substance of what another is saying. To listen reflectively, one must stay focused on the speaker and his/her feelings. The listener confirms his/her understanding of what is being said with the speaker and tries to understand the problem from the other person's perspective. This technique provides useful information and can be particularly helpful when interviewing individuals who are agitated.
- "Assertive communication" incorporates open-ended questions, "I" statements, and reflective listening. Assertive communication focuses on problems and goals while respecting the rights of others. This technique is useful in negotiating conflicting needs and disagreements.

Mediating Conflicts

Staff intervention in conflicts can often reduce the possibility of escalation and avert crises. Mediating conflicts can also help to mend relationships, reinforce norms and rules, and support the cohesiveness of the community. On the other hand, staff interventions that are meddling or micromanaging can have negative outcomes because they are invasive and do not allow tenants to solve problems on their own. Conflicts among tenants are not uncommon, and staff will want to exercise judgment about becoming involved, particularly if the conflict is not affecting other tenants. Conflict mediation can also be complicated and time-consuming. Circumstances that may require staff intervention are when a tenant is at odds with the program or staff or is interfering with the well-being of other tenants. Examples of these conflicts are:

- Breaking house rules
- Threatening the safety of others
- Antagonistic behaviors
- Criminal behavior

When the staff does become involved, talking with all parties separately, even though there is no clear resolution, can help to relieve tensions. Some programs take conflict mediation to a higher level by sponsoring tenant mediation programs or involving an outside mediator. The role and responsibilities of the staff person/facilitator should be made clear and be accepted by the participants. Mediation requires skill. The mediator must remain balanced, be perceived as neutral, and avoid viewing a conflict as having right and wrong dimensions or that good and bad people are involved.

Seven Steps to Resolving Conflict

The goal of conflict meditation is to facilitate a discussion and understanding of the reasons for a conflict and arrive at a mutually acceptable plan for resolution. A facilitator works with the parties who are involved, meeting independently and as a group. Ideally, the parties involved agree to a process. The role of the facilitator is to guide those involved in a conflict toward an agreement, if possible. This section reviews seven basic steps to mediating a conflict. Completing all seven steps will usually require more than one meeting, and getting stuck at a particular point may indicate a need to go back to an earlier step in the process.

1. Introduce the resolution process and set the tone and guidelines for the process.

At the beginning of a conflict resolution process, the facilitator should review the purpose and guidelines for meeting. Some effective guidelines to use during the resolution process include:

- One person speaking at a time
- Talk from one's own experiences and feelings (e.g., "I" statements)
- Agree to participate in a non-hostile manner
- Use positive communication
- Manage anger

2. Ask clarifying questions, elicit information, and listen.

This process begins a discussion about perceptions. The facilitator helps tenants explore the conflict in further detail and focus on hearing the opposing view. An agreement to hear one another must be established here. The facilitator, at this time, tries to help the tenants ask each other clarifying questions and help them listen to one another.

3. Focus on the interests behind the conflict.

This step is intended to clarify further the different perspectives about the causes of the conflict. Each individual explores perceptions and feelings and defines needs and interests. Values and beliefs are often introduced, allowing each participant to explain views and perspectives about the conflict. The facilitator and participants work to identify and isolate the causes of the problem.

4. Arrive at a mutually agreed upon definition of the problem.

Achieving agreement among all participants about the definition of the problem is the first formal step to resolving a conflict. The facilitator should sum up each participant's definition of the problem and confirm agreement with all parties. If an agreement cannot be reached, then previous steps need to be revisited.

5. Brainstorm solutions.

Once there is agreement about the problem definition, the tenants and facilitator explore possible solutions, and the participants and the facilitator propose different possibilities.

6. Evaluate options.

The facilitator helps participants discuss the pros and cons of each solution that has been identified.

7. Create an agreement.

Participants agree on one or more of the solutions and establish time frames for implementation and review. It is essential that participants commit to working toward solutions for a period of time that is long enough to determine its effectiveness. Depending upon the circumstances, the agreement may be written down.

Managing Conflict in the Assault Cycle

Following are intervention strategies for responding to tenants who are en route to becoming abusive or violent. The characteristics of escalating behavior and corresponding suggestions for effective responses are described in the phases of the assault cycle identified by Kaplan and Wheeler[1]. Although there are no definitive interventions that work with every person, being able to identify phases of behavior is useful in deciding how to intervene.

Trigger Phase: The trigger phase is a stress-producing event that alters the feelings and behavior of an individual. People who have a history of poor impulse control or are experiencing frustration, anger, fear, dementia, or psychosis are at greater risk of being triggered. Effective responses at this point in a situation can have substantial impact. A staff person has many options that depend, in part, on how well he/she knows the individual. During this phase, one should use the least confrontational interventions available to address the situation.

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1. Kaplan, S., Wheeler, E. "Survival Skills for Working with Potentially Violent Clients." Social Casework 64 (1983): 339-346.

Interventions during the trigger phase may include redirecting or engaging a tenant in an alternative activity, removing the stimuli (such as the other person or people in the conflict), or removing the tenant from the stimuli. The staff should allow the individual sufficient space and structure to vent feelings and help him/her move toward calm. It can be helpful to assist the person to look at the potential consequences of his/her actions in a nonthreatening and empathic manner. Intervening with the tenant during the trigger phase does not guarantee that the person will calm down, but it is a critical point for intervention. Longer-term prevention measures may also be necessary, such as psychiatric evaluation in cases of repeated behavior.

Escalation Phase: During this phase the individual continues to escalate, as evidenced by increased agitation, verbalized anger, raised voice, irrational acts, and negative body language. Physiological changes also occur, usually consisting of rapid breathing, sweating, increased heart rate/blood pressure, muscle tension, and an adrenaline buildup.

During escalation, staff should attempt to control his/her own stress response. Each incident is unique to the circumstances and people involved. If a staff person overhears a disruption that seems to be escalating, he/she should notify other staff and enter the area to provide support. When talking with the escalated individual, staff should speak calmly, evenly, and in a simple and direct manner, allowing for flexibility and spontaneity.

Awareness of one's own body language is advised when approaching an individual who is agitated. Additionally, the individual's physical space should not be violated. Staff members should avoid entering the "intimate zone" (within 18 inches) and the "social zone" (18 to 36 inches) of individuals who are very agitated. Staff members and tenants should also avoid blocking the exit from the room, if applicable.

During the escalation phase, humor should be avoided as it can backfire by sending the message that the situation is not being taken seriously. Instead, reflect concerns back to the individual and try to provide options for resolving the problem without engaging in a power struggle. Staff should be supportive as well as assertive in urging calm.

It may not be possible to curb the escalation of an angry individual. Staff should be ready to back off or back out of a dialogue with an agitated tenant, particularly if he/she feels that the conversation is veering out of control. Each scenario is different, and the person intervening will need to use his/her best judgment to determine how to respond effectively.

Crisis Phase: A situation has reached this point when an individual is out of control and jeopardizing his/her own safety or the safety of others. When someone loses control, it is frightening and potentially dangerous. Most tenants have sufficient coping and problem-solving skills to avoid this point or to regain control quickly. However, some individuals may experience extreme emotional turmoil, disorganized thinking, confusion, loss of contact with reality, and physical outbursts. Protocols for emergencies and contacting the police should be followed, and staff members who have the strongest relationship with the individual can be most helpful in assisting him/her to regain control.

During a crisis or emergency, the staff should be working as a team and be familiar with the site's emergency protocols and roles and responsibilities of each staff member. Staff should be careful not to fuel anger and should not attempt to physically disarm a tenant who has a weapon. An individual who is out of control often expresses fear, pain, and powerlessness through anger, and staff should be careful not to exacerbate these feelings. Essential tasks include remaining attentive to the agitated person(s), calling for emergency assistance, and removing other tenants from the area. (See Appendix VI, Sample Policy and Procedure: Intervening in Potentially Violent Situations.)

Recovery Phase: When the tenant appears to have calmed down, staff should remain with the individual for at least an hour or more while his/her adrenaline is still elevated. Staff members should not attempt to have the individual reflect back on the situation during this phase. During the recovery phase, the goal is to support the tenant's return to his/her emotional baseline. Staff should continue to maintain a safe distance and assist the individual to let go of the anger.

Post Crisis Depression Phase: Once a crisis has ended, the tenant may be remorseful, less angry, tearful, or even embarrassed. The person may also exhibit none of these emotions and remain aloof, often to avoid showing damaged pride or embarrassment. This phase gives the individual an opportunity to work through the experience, as he/she may be more willing to listen to ideas and input from staff people. This is a good time to introduce the importance of improving anger management skills and to discuss a plan for next steps and preventing future occurrences. Depending upon the incident, staff should determine if follow-up is necessary with other tenants involved.

Anger Management Techniques

When people get angry they may blame others and lash out. In the past, therapists sometimes encouraged their clients to express their anger by yelling or punching pillows. However, newer research indicates that extreme venting can make a person angrier because he/she solidifies the sense of being victimized.

Anger management strategies can be integrated into individualized service plans. These strategies include identifying triggers to anger and personal warning signs, developing alternative plans to respond to triggers, being conscious of mood swings, and learning deep breathing, positive affirmations, self-talk, and relaxation techniques and exercises.

Debriefing and Incident Review

After a conflict or crisis, the staff and tenants should debrief. The supportive services program should provide opportunities for all involved or concerned to process and come to terms with what happened. It is important that these meetings be structured to avoid a venting session that risks causing further argument or tension. If a conflict occurs between two tenants, discussing it with each person independently can help work through any lingering tensions. It is also an opportune time to identify areas that should be integrated into each individual's service plan, if applicable.

If a dispute included numerous tenants, then additional outreach and debriefing may be necessary. In the aftermath of an involuntary hospitalization, for instance, the tenant who was involved may feel confused and angry. Other tenants who witnessed the event may also require help managing feelings they have about the incident. Without support and discussion following a crisis, groups and communities can sometimes split against themselves or against staff, as individuals are left to draw independent interpretations and conclusions about what happened.

Debriefing should include an assessment of why the incident occurred and identification of warning signs that may have been present but overlooked. The staff should review which interventions worked effectively and which did not. Many programs also have incident review committees or similar review processes, including policies on how and when to complete an incident report, procedures for investigating a reported incident, and follow-up procedures. Senior supervisory staff members should review these reports. Incident review processes should include discussions about changes needed in program policies and procedures to avoid similar occurrences in the future. (See Appendix VII, Sample Policy and Procedure: Incident Review.)

Appendix I

Resources and Additional Readings

Callahan, J. "A Specific Therapeutic Approach to Suicide Risk in Borderline Clients." Clinical Social Work Journal 24 (1996): 443–459.

The author reviews the various types of suicidal behavior exhibited by people with borderline personality diagnoses, including self-destructive behavior and overt suicide attempts. Frameworks are offered for understanding and managing both kinds of behavior.

Gilliland, B., and R. James. *Crisis Intervention Strategies*, 4th ed. Pacific Grove, Calif.: Brooks/Cole Publishing Company, 2001.

A six-step model gives students and practitioners a systematic way of dealing with people in crisis: defining the problem, ensuring client safety, providing support, examining alternatives, making plans, and obtaining commitment. Throughout the book, this model is applied to many different crisis situations, such as suicide, domestic loss, sexual assault, addiction, posttraumatic stress disorder, and school violence.

Goleman, D. *Emotional Intelligence: Why It Can Matter More Than IQ*. New York: Bantam Books, 1995.

Drawing on groundbreaking brain and behavioral research, Goleman discusses the biopsychosocial roots of emotions. Findings on trauma, temperament, and social adaptation can be used to help persons learn how to identify and work with emotions.

Griffin, W. V. "Social Worker and Agency Safety." In Encyclopedia of Social Work, 19th ed., edited by R. L. Edwards. Washington, D.C.: NASW Press, 1995.

This is an overview of safety considerations and strategies for social workers in various professional settings.

Kaplan, S., and E. Wheeler. "Survival Skills for Working with Potentially Violent Clients." Social Casework 64 (1983): 339–346.

This article discusses the roots of violence, predictors of violence, the concept of the assault cycle, violence prevention, and intervention. Modalities such as assertiveness training, transactional analysis, and anxiety management training are briefly reviewed.

Kleespies, P. *Emergencies in Mental Health Practice.* New York: Guilford Press, 2000.

This resource helps clinicians evaluate and manage a wide range of mental health emergencies. The focus is on acute clinical situations in which there is imminent risk of serious harm or death to self or others.

Marlatt, G. A. *Harm Reduction: Pragmatic Strategies for Managing High-Risk Behaviors.* New York: Guilford Press, 1988.

Rather than defining drug use as a disease or a moral failing, harm reduction proponents stake out a humane and practical alternative—meeting clients "where they are at" to help them understand the risks involved in their behaviors and make appropriate decisions about their own treatment goals.

Mathews, L. "Effects of Staff Debriefing on Posttraumatic Stress Symptoms after Assaults by Community Housing Residents." Psychiatric Services 49, no. 2 (1998): 207–212.

This study examined the efficacy of critical incident stress debriefing in ameliorating the impact of posttraumatic stress on direct care psychiatric workers after a traumatic event at work.

McKay, M., P. R. Rogers, and J. McKay. *When Anger Hurts.* Oakland, Calif.: New Harbinger Publications, 1989.

This book discusses theories about anger and anger management. It provides specific exercises and interventions for use with individuals and groups.

Messing, J. "Mediation: An Intervention Strategy for Counselors." Journal of Counseling and Development 72, no. 1 (1993): 67–73.

This article presents an overview of conflict mediation and resolution concepts and compares these with therapeutic counseling interventions. Applications for family mediation, community disputes, mediation in public schools, and counseling are reviewed.

Miller, W., and S. Rollnick. Motivational Interviewing: Preparing People to Change Addictive Behaviors. New York: Guilford Press, 1991.

This book discusses skills for motivating people to change problem behavior and provides concrete information on reflective listening, motivational interviewing, and other counseling skills.

Murdach, A. "Working with Potentially Assaultive Clients." Health and Social Work 18, no. 4 (1993): 307–312.

This article discusses a variety of reasons why violence occurs, how clinicians and other social service professionals can recognize clues to impending danger, and various clinical approaches for intervening.

Rooney, R. Strategies for Work with Involuntary Clients. New York: Columbia University Press, 1992.

This book discusses techniques to engage clients and help them become participants in the treatment process.

Trezza, R., and S. R. Papp. "The Evaluation and Management of Alcohol and Drug-Related Crises." In Emergencies in Mental Health Practice. New York: Guilford Press, 2000.

This chapter provides information for clinicians on evaluating and managing life-threatening behavior in the context of alcohol- and drug-related crises. Includes signs and symptoms of withdrawal and overdose for various substances.

Yeates, C., J. Cholette, and P. Duberstein. "Suicide and Schizophrenia: Identifying Risk Factors and Preventative Strategies." Medscape Mental Health 3, no. 3 (1998).

This article discusses the prevalence of suicide and suicide attempts among different groups of people diagnosed with schizophrenia and outlines risk factors and implications for preventive strategies.

Internet Sites

Center for Mental Health Services Knowledge Exchange Network

www.mentalhealth.org

The Knowledge Exchange Network (KEN) web site offers a variety of information, including publications, consumer survivor information, and services locator. Visitors are able to read information on psychiatric decompensation, suicide prevention, and managing violence.

Conflict Dispute Resolution Associates Services

www.mediate.org

Conflict Dispute Resolution (CDR) Associates provides mediation and facilitation services for a variety of clients, including private corporations, government agencies, nonprofit organizations, and families. This web site provides information about mediation, facilitated decision making, consulting and dispute systems design, and training in conflict management skills.

National Alliance for the Mentally Ill

www.nami.org

The National Alliance for the Mentally Ill (NAMI) is a nonprofit, grassroots, self-help, support, and advocacy organization of consumers, families, and friends of people with severe mental illness. This web site offers educational information on a number of mental health topics on crisis prevention and recommended support for people with mental illness in crisis.

National Mental Health Association

www.nmha.org/index.cfm

The National Mental Health Association (NMHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. With more than 340 affiliates nationwide, NMHA works to improve the mental health of all Americans. This website offers resources on various mental health issues, including decompensation, crisis prevention, and intervention.

National Security Institute

www.nsi.org/homeframe.html

This web site is used by security professionals and features an extensive virtual security library. Visitors can download various guidelines and procedures for the prevention of workplace violence.

The Network of Violence Prevention Practitioners

www.2edc.org/nnvpp

The Network of Violence Prevention Practitioners is a membership organization with a base of practitioners drawn from such diverse groups as community coalitions, educational agencies, law enforcement, courts, hospitals, and public health agencies. This site offers tools and articles on managing conflict as well as research-based strategies for violence prevention.

Training Institute for Suicide and Clinical Interviewing

www.suicideassessment.com

This web site offers visitors information and tips on suicide prevention and clinical interviewing for mental health professionals and articles on suicide assessment techniques.

Appendix II

Sample Policy and Procedure: Medical Emergencies

The following represents an example of a protocol. Policies and procedures for an individual program must be consistent with local laws and regulations and should take into account staffing levels and other conditions specific to that program.

Medical emergencies are defined as situations in which a person complains or has symptoms of acute or serious distress (e.g., persistent chest pains, loss of consciousness, seizures, lack of pulse, severe bleeding) or is debilitated or incapacitated.

- Only if it will not cause a dangerous delay, the staff should determine with the program supervisor if a call for emergency services is warranted. Once this is determined, make the call immediately.
- Indicate to the emergency service operator that this is a medical emergency. The operator will connect the staff to Emergency Medical Services (EMS).
- The operator will first ask if the person is breathing and what the specific nature of the emergency is. The operator will ask questions about age, gender, medical history, and any information related to the incident. For example, if the tenant is complaining of chest pains, they may ask if there is a history of heart disease.
- The operator will ask for the name of the caller, telephone number, and location.
- At this point, immediately notify the front desk staff that emergency services has been called. Instruct the staff where to direct the service personnel and provide the location of the tenant.
- For medical emergencies, the police may or may not respond. Emergency services personnel will request basic identifying information for their records including age, gender, current medications, and medical history. Staff members should escort emergency service personnel to the tenant. They will take vital signs and assess if the tenant needs to be transported to the hospital. If the tenant refuses to go to the hospital, emergency services will contact a supervisor. The supervisor may ask to speak to the tenant directly on the phone. The supervisor can overrule the tenant's wishes and authorize that the tenant be taken involuntarily.
- A staff member should accompany the tenant to the emergency room when possible.
- If a staff member does accompany the tenant to the emergency room, he/she should act as advocate and offer support to the tenant during the waiting process.
- After emergency services personnel have left, staff members should communicate and appropriately document the event. Contact the appropriate staff members and provide follow-up details, record the incident in the logbook, and write an incident report.

Appendix III

Comparison of Signs and Symptoms Across Categories of Substances[2]

	Withdrawal				Overdose						
Signs and Symptoms	Alcohol	Stimulants	Depressants	Opiates	Alcohol	Stimulants	Depressants	Opiates	Hallucinogens	Phencyclidine (PCP)	
Abdominal cramps			■	■					■		
Aches, Muscle	■			■							
Affect, Labile											
Analgesia (pinprick)					■	■	■	■		■	
Angina (chest pain)						■					
Anxiety	■		■	■		■			■	■	
Arrhythmia						■					
Chest pain						■					
Chills				■							
Circulatory collapse			■					■	■		
Coma					■		■	■		■	
Comprehension, Slow	■	■			■		■	■		■	
Convulsions	■	■				■					
Delirium	■		■		■	■	■	■	■		
Depressed mood	■	■									
Diarrhea				■		■					
Dizziness									■		
Facial grimacing						■					
Fatigue	■	■									
Flushing	■		■			■			■		
Hallucinations	■		■			■			■	■	
Headaches			■			■					
Hypertension				■		■			■	■	

2. New York State Office of Mental Health. Mental Illness and Chemical Abuse: A Resource Manual. New York: New York State Office of Mental Health.

Signs and Symptoms	Withdrawal					Overdose						
	Alcohol	Stimulants	Depressants	Opiates		Alcohol	Stimulants	Depressants	Opiates	Hallucinogens	Phencyclidine PCP)	
Hyperthermia							■			■		
Irritability	■		■	■			■	■		■		
Lack of appetite	■		■	■			■			■		
Memory, poor	■											
Motor seizures	■		■				■			■	■	
Mouth dry							■			■		
Muscle spasms (rigidity)				■							■	
Nausea			■	■			■			■	■	
Piloerection				■								
Psychosis	■		■				■			■	■	
Pupils, dilated				■			■			■		
Pupils, pinpoint									■			
Reflexes, hyperactive	■		■				■			■		
Respiration, shallow						■		■	■			
Restlessness	■			■								
Rhinorrhea (mucous)		■		■								
Skin picking							■					
Sleep disturbances	■	■	■	■			■					
Sleepiness		■					■					
Stare, blank											■	
Suspiciousness							■			■	■	
Sweating	■			■			■					
Tachycardia	■		■	■		■	■			■	■	
Talkative							■					
Tremors	■		■				■			■		
Violence											■	
Vomiting	■			■			■			■		
Yawning				■								

Appendix IV

Sample Policy and Procedure: Psychiatric Hospitalization

The following represents an example of a protocol. Policies and procedures for an individual program must be consistent with local laws and regulations and should take into account staffing levels and other conditions specific to that program.

Psychiatric emergencies are defined as situations in which a person is experiencing acute psychiatric distress or a psychiatric episode (e.g., marked changes in behavior, thought, mood). Some emergencies may include a person expressing homicidal or suicidal ideation, verbal threats of a serious nature, assault or threat of assault, displaying a weapon, and floridly psychotic or bizarre behavior such as disrobing in public or uncontrollable yelling. Psychiatric emergencies may result in either voluntary or involuntary hospitalization. Involuntary hospitalizations are necessary when it has been assessed that a person is in danger to self or others and will not voluntarily seek hospitalization.

While assessing the need to call emergency services, the issue of hospitalization should be raised with the person if possible. For hospitalizations that are voluntary, admissions can be arranged beforehand with the hospital or the managed care/insurance plan. If you suspect that such a discussion could result in violence, flight or overt resistance, the tenant should not be informed of the hospitalization until after emergency services have arrived.

- Move the person to a private space, or if necessary, ask others to stay clear of the area. Keep the tenant supervised and calm in a private space away from other tenants. Two staff members should remain with a tenant in psychiatric crisis, whenever possible.

- Notify all appropriate staff of the incident, including security, administrative staff, and building management staff. Assign roles and coordinate plan for intervention.

- Determine with the supervisor if an emergency services call is warranted. Designate a signal for staff communications around when to make the call.

- If emergency services are called, an operator will ask the nature of the emergency. Indicate this is an emotionally disturbed person (EDP) emergency. The operator will connect you to Emergency Medical Services (EMS).

- When the person is identified as an EDP, the operator will ask the following questions: Do they have a weapon? Are they violent? Do they have a psychiatric history? Are they using substances? Additionally, they will ask general identifying information such as age and gender. It is important that the staff person making the call has this information about the tenant. Also be prepared to quickly and succinctly describe the reason for the call.

- Gather relevant tenant data that will be required by emergency service personnel and/or hospital staff. This information will include the tenant's name, date of birth, social security number, insurance identification, current medications, description and duration of symptoms and behavior, reasons behaviors are dangerous to self or others, history of psychiatric hospitalizations, and name and contact information for primary mental health provider.

- When emergency services personnel arrive, calmly and quickly describe the reason for the call and provide basic identifying and medical and psychiatric information.

- At this point, the person who authorizes transport will want to meet with the tenant and make his/her own assessment. This person has the authority to cancel transport and may decide at this point that the tenant is not a danger to self or others. If staff does not agree with this determination, advocate that the decision be re-evaluated. Highlight important facts from the tenants' psychiatric history or repeat the details of the incident.

- If the authorizing official determines that the person should be transported to the hospital, emergency services will attempt to convince the tenant to go voluntarily. If the tenant does not agree to go voluntarily, he/she may be physically restrained and possibly handcuffed.

- It is generally recommend that a staff person accompany the tenant to the emergency room. Accompany the resident to the hospital in the ambulance, if possible.

- If possible, notify a contact at the emergency room of the person's impending arrival. It is helpful to develop a good working relationship with the local hospital and emergency room staff.

- Upon arrival, present admitting staff with appropriate documentation and request to speak with the attending physician or psychiatrist and the social worker on duty.

- Remain in the emergency room, if possible, until the tenant is admitted. In some cases, the tenant may not have a bed immediately assigned, but will be admitted.

- If the tenant is not going to be admitted, the worker can ask to speak with the attending physician again and advocate for admittance. The staff person can ask for a written statement from the hospital with reasons for not admitting the tenant. Programs can also document their concerns and ask to put a copy in the hospital medical chart.

- Exchange names and numbers with emergency room staff or the floor staff if the tenant is assigned to a bed at that time.

- Reassure the tenant that members of the staff will be in close contact and make sure the resident knows how to reach the service team. Be sure to follow through with maintaining close contact.

- Update the supervisor and appropriate staff members upon returning to the program. Call the tenant's outpatient psychiatrist and inform them of the hospitalization.

- Document the event in the tenant chart and incident report. Be sure to include all salient information, including contact names and phone numbers.

Appendix V

Assessing for Suicide

Suicidal ideation falls along a continuum, from people who experience chronic but passive thoughts of suicide to people who are in an active crisis state and require protection. All threats should be taken seriously and assessment should include supervisory staff.

Warning signs

- Depression (the number one cause of suicide): Hopelessness, isolation, sleeping/eating changes, feeling overwhelmed, tearfulness, recent loss, irritability, command hallucinations.
- Tying up loose ends: Giving away possessions, sudden improvement in mood (signaling resolution).
- Talking about death and/or threatening suicide.

To assess how a person is feeling and coping with a crisis, ask the person:

- "You seem sad/upset/are going through a tough time, how are you managing?"
- "How is your sleep, energy level, and appetite?"
- "Are you feeling hopeless, helpless, like there you cannot imagine a positive future in sight?"

To assess if a person has suicidal ideation, ask the person:

- "When people are depressed/very angry/feeling overwhelmed, they sometimes think about dying. Have you ever had thoughts like that?"
- "Are there times you wished you wouldn't wake up?"
- "Have you ever felt life isn't worth living? Have you felt that way recently/now?"

To assess if a person has a plan for hurting himself/herself, ask the person:

- "Have you recently made any plans to hurt/kill yourself?"
- "Have you thought about how/where/when you might kill yourself?"
- "Have you thought about how easy or difficult it would be to kill yourself?"

To assess if a person has the means to achieve the plan, ask the person:

- "How would you kill yourself?"
- "You said you feel like shooting yourself. Do you have access to a gun?"
- "You said you feel like taking an overdose. How many pills do you have?/Have you been saving your pills?/Can you get enough pills to do that?"

Appendix VI

Sample Policy and Procedure
Intervening in Potentially Violent Situations

The following represents an example of a protocol. Policies and procedures for an individual program must be consistent with local laws and regulations and should take into account staffing levels and other conditions specific to that program.

If a tenant is exhibiting threatening or homicidal behavior towards other(s), this information must be communicated to the supervisor and the rest of the team immediately. This should be done both verbally and in writing (in a logbook or progress notes). The reporting staff should attempt to gather as much information from the tenant as possible in order to determine the urgency of the situation and accurately share information with the rest of the team.

- Before entering room, the worker should notify other staff in case he/she needs back up. The worker must always notify his/her supervisor and coworkers of his/her whereabouts in the building during a crisis.
- Establish who will intervene with the tenant(s), who will call the police or 911, and who will perform crowd control with the rest of the community before entering the situation. If a situation is violent, a staff person should call the police immediately.
- Try to stay as calm as possible and not show fear or agitation. Avoid conveying impatience or annoyance with the tenant and try to remain neutral.
- When approaching an agitated tenant, staff members should be aware of his/her body language and remain a minimum of a leg's distance away. The worker should respect the tenant's physical space, avoid positioning him/herself between the tenant and the door, and be conscious of and positioned near the exit if possible.
- Clear the area of potential weapons such as sharp instruments or household/office items that could be used as weapons.
- Do not intervene with a tenant who is clearly drunk or high except to curtail disruptive behavior. If a person is not posing an immediate threat by engaging in disruptive behavior, allow him/her to sleep off the effects of the drugs or alcohol. Check for signs of overdose or withdrawal. If a tenant is disruptive, the police or 911 should be called.
- Avoid using humor or sarcasm, which could be misunderstood.
- Do not engage in power struggles; instead reflect the tenant's concerns.
- Attempt to offer appropriate options. Most people respond negatively when they experience someone attempting to limit their personal freedoms and dictate or demand certain behavior. On the other hand, too many choices, particularly when a person is disorganized or agitated, can be confusing.
- Adopt a supportive yet firm stance, as an alliance is crucial when working with an agitated person. Try to approach the situation as a problem that can be solved together.

Appendix VII

Sample Policy and Procedure: Incident Review

The following represents an example of a protocol. Policies and procedures for an individual program must be consistent with local laws and regulations and should take into account staffing levels and other conditions specific to that program.

All events that jeopardize or may jeopardize tenant or staff safety, including allegations of tenant or child abuse and/or neglect must be reported, investigated, and reviewed by senior program and administrative staff in a timely manner. Such incidents must be reported to the site director within twenty-four hours and a preliminary investigation by senior management must be conducted within seventy-two hours. The agency has an incident review committee that regularly reviews all incident reports and assures appropriate follow-up or resolution.

When to file an incident report

A staff person should immediately make known any of the circumstances listed below to his/her supervisor and an associate director, who will require the completion of a written incident report.

- Death of a tenant.
- When a tenant's whereabouts have been unknown for more than seventy-two hours.
- When a tenant assaults or injures another person or is assaulted or injured.
- When a tenant attempts or commits suicide.
- When there is a complaint or evidence of tenant abuse.
- When there is an allegation or suspicion of child abuse.
- When a tenant behaves in a manner that directly impairs his/her well-being, care, or safety or of another tenant(s) or substantially interferes with the orderly operation of the program.
- When a tenant is involved in an accident that results in medical attention or services.
- When the tenant experiences a serious drug reaction.
- When a staff person is injured while at work.
- When it appears a crime has been committed (e.g. theft, vandalism). In such circumstances, a police report must also be completed.

Procedure for investigating a reported incident

Upon being informed of an incident, the program director (or designate) shall immediately investigate the allegation by interviewing the informant, the victim, witnesses to the incident, and any alleged perpetrators and gather all relevant information.

- The investigation interviews will be conducted within seventy-two hours of learning of the incident, the speed of which will match the seriousness of the incident.
- Investigation interviews will be summarized and all reports filed with the appropriate city and state agencies as required.

- An incident report will be completed for each incident reported, and a copy of the form will be sent to the agency Incident Review Committee.
- A copy of the incident report form is filed in the case record of all tenants involved in the incident.
- Whenever a law enforcement officer arrives in response to a call, the staff member handling the incident should take the badge number of the officer and include this information in the incident report.
- Any incident that involves Emergency Medical Service (EMS) should be documented and include names, telephone numbers, or other identifying information of EMS staff or emergency room personnel, including phone contacts.

After the incident report is complete

After reporting the incident, the staff member and or program director (or designate) should file, in consultation with an administrative supervisor, a written incident or accident report form.

- The original is filed with the office of the executive director.
- Copies are sent to the respective associate director. The executive assistant should forward copies to the members of the incident review committee prior to the next incident review meeting.
- A copy should be placed in the tenant's individual record (in case of staff injury, in the staff person's personnel file).
- A copy should be placed in a chronological incident report file.

Incident Review Committee

The Incident Review Committee shall meet regularly to review and evaluate all incidents and make recommendations to the executive director regarding policy and practices to prevent future incidents.

- The Incident Review Committee shall meet quarterly.
- Additional meetings may be scheduled when necessary or requested by an administrator.
- The Committee will evaluate all untoward incidents having occurred in the preceding three months.
- Members of the Incident Review Committee directly involved in a particular incident will exclude themselves from deliberation regarding that incident.

Community Building

When tenants and staff feel pride and responsibility for the supportive housing community, they become partners in the creation of a comfortable and safe environment. Efforts to foster community can be wide ranging and usually begin with activities that give tenants and staff opportunities to get to know one another, but they can also evolve into efforts that promote connections to the surrounding neighborhood and broader environment. This chapter discusses various strategies for guiding community-building efforts.

What Is a Community?

A community is a group of people who have common interests. Characteristics of a strong community include:

- A friendly environment
- Concern for each other's safety and property
- Mutual support and respect
- Shared goals

Promoting Participation

Fostering Relationships: Fostering relationships with and among tenants enhances the overall stability of a supportive housing project. This can occur through informal conversations, one-on-one outreach efforts, workshops, group activities, and special events. Monitoring outreach efforts and patterns of attendance at group functions is important for tracking tenant involvement as well as the popularity and target audiences of group events.

Activities that allow for casual interaction such as coffee hours and entertainment are effective for bringing people together. Similarly, staff can invite guest speakers and organize groups and workshops that focus on topics of common interest such as career advancement, financial planning, men's/women's issues, health, and current events. For new tenants and staff, a welcome committee may be organized. Many supportive housing projects have handbooks and/or orientation packets that include information about the housing project, the service program, important policies and procedures, neighborhood resources and telephone numbers.

Involving Tenants: Tenant involvement and input are investments in the supportive housing community. When project sponsors seek and respond to tenant input, tenants are given ownership in the community. Forums that allow tenants and staff to discuss each other's ideas help to promote mutual understanding and maximize cooperation.

Community meetings and tenant advisory groups and councils are useful mechanisms for involvement. Programs can also use tenant surveys to gather opinions about the perceived usefulness, quality and relevance of the services being offered and incorporate this information into ongoing planning efforts. Similarly, getting input through surveys and conversations can help to ensure that activities and special events will be appealing to a cross section of interests.

Involving tenants in decision-making is an effective way to develop trust and encourage shared responsibility, although engaging their input must also translate into a willingness to hear criticism, to share some authority for decision-making, and to be open to change. Sharing power can be challenging, particularly when the input is critical of the supportive housing project, such as disagreements over house rules or complaints about staff. However, failing to respond to tenants' ideas and concerns can be a source of mistrust and can damage relationships.

Prior to seeking tenant input, project sponsors should be clear about which decisions they are willing to negotiate and those that are not negotiable due to program philosophy, resources, or restrictions from funding sources. To avoid raising false expectations, it is important that the boundaries are clear and basic questions are answered. How are tenants' ideas to be incorporated into the decision-making process? Who makes the final decisions? What is the process for evaluating and revisiting decisions in the future?

Another vehicle for involving tenants is to hire them as staff. Having tenants on staff helps to prevent "we/them" divisions, and seeing fellow tenants working is a visible reminder that everyone is an integral and valued part of the operation. Similarly, involving tenants in interviews of prospective staff can add valuable perspectives.

Community Meetings

Regularly scheduled "community meetings" that are open to all staff and tenants are a feature of many supportive housing projects. Occurring on a regularly scheduled basis, the meetings serve as a forum to make announcements and to express viewpoints and suggestions. Community meetings help to trouble-shoot issues, dispel rumors, sing praises, and share information. With an outlet to express concerns, staff and tenants can identify and solve problems and work toward common goals.

Involving Staff: Collaborative efforts between tenants and staff are usually required to make community-building efforts successful, although the experience of working as a group toward common goals may be new. In fact, everyone may be more accustomed to the staff "doing for" tenants (e.g., making building repairs or making a referral for health services), and it may feel different to "do things with" tenants (e.g., attending a conference or rally). Sometimes, it can be difficult for staff members to switch roles from service provider or property manager to "partner." In more effective community-building efforts, staff members are able to move beyond the concept of "client" as the primary frame of reference for tenants. Similarly, tenants may have to shift how they relate to staff.

Since direct service staff members are likely to have had more training or experience in the delivery of counseling and supportive services than in community organizing, they are sometimes less interested in community-building tasks than other areas of work. Consequently, community-building efforts can land

on the back burner. In this regard, programs should consider the interests, experience, and training needs among staff when hiring or assigning responsibilities for community-building efforts. Staff members who have experience in group work often have skills that are transferable. In-service training sessions that emphasize community-organizing techniques, negotiation, conflict resolution, and the facilitation of task-oriented groups are useful. While some staff members may be specifically assigned to work on community-building activities, all staff should have a role in creating the supportive housing community and, preferably, are able to integrate these efforts into day-to-day work.

To be successful, staff members that have responsibility for community-building efforts should have:

- Clear goals and objectives
- Commitment of resources from project sponsors
- Time to invest
- Commitment to the issues
- Enthusiasm about the work
- Willingness to share authority with tenants
- Ability to hear and respond to criticism
- Ability to work well with management, other staff members, tenants, and neighborhood and community groups, if applicable

Guiding Group Norms: "Norms" or informal rules for behavior have a substantial impact on the housing environment. Although leases and occupancy agreements establish the formal requirements of tenancy, the culture within supportive housing projects is very much determined by the everyday behaviors and traditions of tenants and staff. Norms can be effective to control noise and littering, maintain cleanliness, and guide the use of shared facilities such as kitchens, hallways, elevators, recreation rooms, and bathrooms. A building that is kept clean and in good repair by management, for instance, encourages tenants and staff to have pride and respect for the building as well.

Some norms may also contribute to negative patterns within the community, such as an unspoken understanding that it is better to give in to the demands of a particularly bossy tenant than to risk confrontation. It is useful to identify behaviors that conflict with the expectations of the supportive housing community and to determine how they will be addressed. In instances where individuals exhibit undesirable behaviors, it is sometimes necessary for tenants and staff to join together to reinforce positive norms and challenge negative behaviors. Tenant and community meetings are sometimes used as forums to address these issues.

Discouraging Negative Patterns of Behavior

Allowing negative behaviors to go unchecked can be harmful and lower the morale of the housing community. For example, not addressing sexist, racist, or homophobic remarks could result in an environment in which some members feel vulnerable, unsafe, and disrespected. Engaging discussions at community meetings or other forums about how people feel about such comments can help reinforce group confidence, positive attitudes, and mutual respect. Working together, staff and tenants can brainstorm possible solutions.

Developing Tenant Leadership: Although the staff usually initiates community-building activities, transferring leadership responsibilities from the staff to tenants is sometimes a logical and natural progression of these efforts. Particularly when regarding self-help groups and tenant associations, it is clear that tenants, not staff, should take the lead.

Working with individuals to become fully empowered as a group or organization is an exciting prospect and, in some cases, the ultimate goal of community-organizing efforts. To the extent that developing more autonomous group structures is within the staff's scope of work, the quality of the effort that takes place in the early phases of the process is an important predictor of ongoing stability and success. Engaging tenants and effectively involving them in decision-making are critical steps in the development of independence and self-reliance.

Creating autonomous group structures requires complex tasks and responsibilities, however, and there are many variables to consider. For example, a successful transition from staff to tenant leadership requires an accurate assessment of tenant leaders' skills and commitment to the group. Similarly, group dynamics and the respective forces at play can make the choice of tenant leaders very complicated. While establishing group autonomy is a desirable goal, the premature withdrawal of staff leaders can leave a major void if tenant leadership has not sufficiently developed.

A common error among inexperienced staff members is to make premature judgments and move too quickly to establish formal tenant leadership without providing the necessary level of support and training. Much of the literature regarding group development and community organizing point out the problems of creating "democratic" structures without the required organizational sanctions and group stability. Misjudging important group development processes can cause unwanted conflicts among the staff and tenants. These efforts can end in disarray. Staff people interested in working in this area should see Appendix I, Resources and Additional Readings, for materials about group development, tenants associations, and community organizing.

Tips for Guiding Community-Building Efforts

Progress from simple to complex activities. Confidence, skills, and ability grow with experience.

Establish reasonable priorities. Successful outcomes are empowering and enhance future prospects for success.

Focus on both process and outcome. Community-building efforts are most effective when there are concrete goals and an appreciation for group process, such as building relationships, identifying leadership, and being inclusive.

Connecting to the Neighborhood and Broader Environment: From any angle, connecting with neighborhood residents and working together on local community issues create win-win scenarios. Getting involved in improving the local quality of life helps neighbors see the supportive housing project as an asset, and being a good neighbor helps connect tenants and staff to the neighborhood. There are many ways that staff and tenants can become involved in the community, and supportive housing projects sometimes adapt and expand their staffing and resources to work in the neighborhood and broader community. Following are examples of these efforts:

- Getting involved in local block associations, crime watch groups, and civic associations
- Participating in neighborhood cleanup and block parties
- Supporting community gardens by donating materials and volunteering time
- Providing homework help and tutoring for neighborhood children and youth
- Providing information to local residents
- Circulating a petition or advocating with local officials for specific improvements, such as increased police protection in the neighborhood
- Joining community advisory boards
- Working with advocacy groups and coalitions for social change
- Volunteering at neighborhood senior centers, nursing homes, and soup kitchens
- Making meeting space available to neighborhood groups

Sponsoring Community Art Galleries

By using community rooms and other open spaces, some supportive housing projects create art galleries for local artists. Similar to most art galleries, sponsors host "openings" and post announcements for new shows. Some organizations have secured private funding to hire consulting curators and to cover additional costs and expenses. Galleries can gather a wide interest and following from the neighborhood and artist community.

One way to promote a good-neighbor policy is to allow neighborhood residents and organizations to use space within the supportive housing project. By hosting the meetings of block associations and other community groups, housing sponsors fill a neighborhood need while encouraging tenants and staff to participate as well. Providing organizations such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), or the National Alliance for the Mentally Ill (NAMI) with public meeting space can also be of mutual benefit to tenants and the community at large.

Service providers typically have linkages to networks of provider organizations, self-help groups, coalitions, and advocacy groups that are of interest to tenants and staff. A designated area for posting flyers and notices announcing activities that are being sponsored by outside organizations is a basic communication tool. In some supportive housing projects, staff and tenants identify issues and concerns that are of importance to them—such as homelessness, crime, AIDS, or mental illness and work together in the interest of promoting change (e.g., attending rallies, participating in letter writing campaigns, and meeting with elected officials).

Preparing a Plan for Community-Building Efforts: The quality and success of community-building initiatives frequently depend upon the leadership and commitment of the supportive housing sponsors. The long-term success of community-building efforts requires careful planning and ongoing evaluation. This section provides a checklist of basic considerations for developing a community-building action plan. The following series of questions was adapted from *Community Building: What Makes It Work.*[1] These questions are intended to guide planning, resource allocation, and evaluation during community-building efforts.

Organizational Sanction and Purpose

- What are the goals/purposes of community-building efforts?
- How does the proposed effort fit with the organizational mission?
- Are tenants, community members, staff, and project sponsors likely to agree on priorities?
- How relevant is community building from each perspective (i.e., tenants, community members, etc.)?
- What resources are available to bring to the effort in terms of staff time, funding, and training resources?
- What are the possible risks to the project sponsors?
- At what levels in the organization will the community-building plan require review?
- Who has responsibility for monitoring and supervising implementation?
- What were the results of any previous community-building efforts? Have there been failures and/or successes? What was learned?

Connections Among Community Members

- How well do tenants know one another?
- Do tenants and staff have experience working together in a group towards a common goal?
- Have past efforts caused damaged to any relationships? What was learned?

Awareness of Issues and Motivation

- Is there interest among staff and tenants to work together to address issues?
- How will issues be selected and prioritized?
- Are the goals of sufficient interest to a significant number of tenants?

Participation

- Do mechanisms exist to help new staff and tenants feel accepted and part of the process?
- Is adequate effort going into outreach to those who are not involved?
- Do the tenants participating in the process truly represent the views of the larger community?
- Are there groups of tenants who are not represented? If so, is this acceptable?
- Are all participants clear about the purpose of the effort?
- Are there a substantial number of tenants who are not participating? If so, why?

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1 Mattessich P., B. Monsey, and C. Roy. *Community Building: What Makes It Work: A Review of Factors Influencing Successful Community Building.* St. Paul, Minn.: Amherst H. Wilder Foundation, 1997.

Leadership

- How will the group make decisions? Is the process clear and acceptable to all?
- What type of leadership is needed to implement the community-building efforts being considered?
- Are tenants and/or staff assuming leadership positions? If so, is this viewed positively by everyone?
- Does the leadership reflect the diversity of participants in terms of gender, race, cultural backgrounds, and orientations?
- What would it take to involve and train people who have not taken on leadership positions in the past?

Training Requirements

- Are the community-building activities reasonable and matched to the skills and abilities of participants?
- What training is needed for participants?
- How can training promote and support the participation of people who haven't previously been involved?

Communication Systems

- Do all members of the community get the information they need to get or stay involved?
- Are there existing communication structures that can be used to support community-building efforts (e.g., staff or community meetings, new tenant/staff orientations, bulletin boards, e-mail, fax, and mailing lists)?
- Does the community-building effort employ a variety of techniques and strategies to reach as many people as possible?

External Relations

- Do tenants and staff have links to useful contacts in the larger community? If not, how can these be developed?
- Are the efforts having an impact on relationships with neighbors, neighborhood organizations, funders, and government?

Appendix I

Resources and Additional Readings

Berman-Rossi, T. "Empowering Groups through Understanding Stages of Group Development." *Social Work in Groups* 15, no. 2/3 (1992): 239–255.

This article presents stages of group development and, using the preaffiliation stage as an example, discusses ways a worker can apply knowledge of the group system and member behavior to determine worker skills and tasks corresponding to a group's stage of development.

Berman-Rossi, T., and M. Cohen. "Group Development and Shared Decision Making Working with Homeless Mentally Ill Women." *Social Work with Groups* 11, no. 4 (1989): 63–78.

An on-site community support system team in an SRO hotel worked with homeless mentally ill residents toward rehabilitation through empowerment. The issue of power in the group process over five years is described and analyzed.

Brager, G., and H. Specht. *Community Organizing*. New York: Columbia University Press, 1997.

The authors discuss methods of practice and issues in community organizing. "This is a book about how individuals, groups and organizations develop the means to deal with problems in their interaction with institutions."

Breton, M. "On the Meaning of Empowerment and Empowerment-Oriented Social Work Practice." *Social Work with Groups* 17. no. 3 (1994): 23–37.

This article outlines five conditions necessary for clients to experience empowerment: social action, political awareness, the right to say and to "have say," recognizing oneself and being recognized as competent, and the use of power. Describes two major requisites for empowerment-oriented social work practice: the principle of collegiality, which includes abandoning the expert role, engaging clients in authentic dialogue, and utilizing collaborative strategies, and group and community work, which includes work at the personal, interpersonal, and sociopolitical levels.

Center for Community Change. *Community Organizing for You!* Washington, D.C.: Center for Community Change, 2000.

This set of three workbooks contains the tools and materials needed to conduct a training series on community organizing. Materials are especially helpful for training people who work in settings in which organizing is not currently a primary method of addressing community change.

Ewalt, P., E. Freeman, and D. Poole, eds. *Community Building: Renewal, Well-Being, and Shared Responsibility*. Washington, D.C.: NASW Press, 1998.

This book is a compilation of National Association of Social Workers (NASW) journal articles organized around ideas of community. The chapter on community building in housing settings examines the properties of community. Readers will learn about structures and processes that enable disadvantaged citizens to more effectively define and advance the changes they desire in their lives.

Cox, E. O. "The Critical Role of Social Action in Empowerment Oriented Groups." *Social Work with Groups* 14, no. 3/4 (1991): 77–90.

The author examines the role of groups as a vehicle for empowerment, describes the necessity of a social action component for empowerment-based group work, and presents examples of a welfare self-help group for women and work with elderly residents of an SRO hotel.

Freese, L. "Consumer Empowerment in Congregate Housing Programs." *Innovations and Research* 2, no. 3 (1993): 63–65.

Describes a housing program that incorporates consumers performing vital management tasks, such as staff hiring, choosing new tenants, and developing house rules. Supports provided are flexible and change as each individual's need changes. The author asserts that congregate living programs need not operate like the more traditional group homes.

Gutiérrez, L. "Working with Women of Color: An Empowerment Perspective." *Social Work* 35 (1990): 149–154.

Gutiérrez describes four changes associated with moving from apathy and despair to action: increasing self-efficacy, developing group consciousness, reducing self-blame, and assuming personal responsibility for change. Describes techniques that support empowerment-based practice: "accepting the client's definition of the problem," "identifying and building upon existing strengths," "teaching specific skills," and "mobilizing resources and advocating for clients."

Gutiérrez, L., and R. Ortega. "The Organizational Context of Empowerment Practice: Implications for Social Work Administration." *Social Work* 40 (1995): 249–258.

Relating the results of their research, the authors describe organizational barriers to empowerment, including expectations of funders, interactions with agencies not subscribing to an empowerment orientation, workers' overinvolvement in directing outcomes, and dilemmas associated with clients' autonomous decision-making. They also describe organizational supports such as opportunities for staff training, emphasis on collaborative partnerships, and administrative leadership and support for empowerment-based practice.

Kahn, S. *Organizing: A Guide for Grassroots Leaders*. Washington, D.C.: NASW Press, 1991.

This book is a practical guide on how to unite people for change and help people work together to get things done. It offers a solid introduction to topics such as identifying and developing leaders, choosing issues, holding effective meetings, and deciding on strategies and tactics. The author presents step-by-step guidelines and provides a framework for multiracial organizing.

Lord, J., and P. Hutchinson. "Empowerment, Disability and the Community Context." *Rehabilitation Digest* 27, no. 2 1997): 13–15.

The authors draw on interviews with persons with disabilities to describe an experience of moving from powerlessness, to gaining awareness, to receiving support from others, to initiating and participating, and then to contributing to the community. The paper underscores the "importance of participation and relationships within the context of community."

Mattessich, P., B. Monsey, and C. Roy. *Community Building: What Makes it Work: A Review of Factors Influencing Successful Community Building*. St. Paul, Minn.: Amherst H. Wilder Foundation, 1997.

This book is the result of nationwide research to find what leads to successful community building. Researchers discuss how residents develop and sustain relationships, increase group decision-making skills, and improve their ability to collaborate effectively to get things done. The result is a user-friendly synthesis of research about community-building strategies with helpful tools for people who wish to develop or improve their communities.

Ridgeway, P., et al. "Home Making and Community Building: Notes on Empowerment and Place." *The Journal of Mental Health Administration* 21, no. 4 (1994): 407–418.

The authors contends that some supportive housing developments are creating a new generation of quasi-institutional settings. They focus on consumer involvement in building and program design and propose strategies for "co-creating" environments and social settings that can result in empowerment-oriented supportive housing programs.

Rog, D., and C. Holupka. *Reconnecting Homeless Individuals and Families to the Community*. Presented at the National Symposium of Homeless Research, 1998.

This paper summarizes what we know about reconnecting homeless people and individuals to the community, including improving their residential stability and employability and reuniting them with family and friends. The success of comprehensive programs that concentrate on the range of needs of individuals suggests the need for increased efforts integrating housing, support services, job training, and social opportunities.

Shapiro, J. H. *Communities of the Alone*. Washington, D.C.: Association Press, 1971.

The author invites the reader to observe community life among SRO residents within the building and with the world outside the residence and discusses the complex social community that exists within the building and a lack of connection to the outside world. While some of the language and observations are dated, many of the insights offered are relevant today.

Internet Sites

Center for Community Change: Advocacy 101

www.communitychange.org/advocacy

This site includes a comprehensive introduction to public policy advocacy. "How and Why to Influence Public Policy: An Action Guide for Community Organizations" introduces practical organizing and advocacy themes, including obstacles to advocacy and practical solutions, selecting issues, registering and educating voters, influencing administrative agencies, conducting a power analysis, and federal lobbying by nonprofits. Also available at this site is "How to Run a Good Meeting: A Guide for New Leaders."

Citizen's Handbook: A Guide to Building Community in Vancouver

www.vcn.bc.ca/citizens-handbook

This handbook is a comprehensive guide to grassroots organizing. The Vancouver-specific information is isolated, and most of the information is useful no matter where you live. The community organizing section includes practical advice on leadership, meetings, recruiting and keeping participants, facilitation, group structure, and more. The site also features a large list of community-building activities.

COMM-ORG: The On-Line Conference on Community Organizing and Development

http://comm-org.utoledo.edu

This site's mission is to help connect and provide information to people engaged in community organizing. Resources available on this site include links to readings about community organizing and community development, policy resources, funders of community organizing, and groups engaged in community organizing and community development in your area.

Community Tool Box: Bringing Solutions to Light

http://ctb.lsi.ukans.edu

This site is full of practical, easy-to-read guidance for improving communities. There are more than 3,000 pages of specific, skill-building information that can be downloaded for free. The community troubleshooting guide lists typical community-building obstacles and offers strategies for overcoming them. The guide to conducting effective meetings has useful tips on planning, setting up, and running meetings.

Management Assistance Program for Non-Profits' Free Management Library

www.mapnp.org/library

MAP for Non-Profits is a consulting firm that works primarily with nonprofits in the Minneapolis/St. Paul area. The online library is easy to use and includes a wealth of resources organized into 72 categories. The group skills category includes topics like icebreakers and warm-up activities, group dynamics, and group-based problem solving and decision-making. The site also has information on community organizing.

National Housing Institute: Shelterforce On-Line

www.nhi.org/online/issues

This site includes information about national affordable housing and community development issues. The article entitled "Building Communities from the Inside Out" is a solid introduction to community building from a strengths perspective, and it includes a model for using asset maps and capacity inventories to discover individual, organizational, and institutional resources available in your neighborhood. This site also contains information about building effective partnerships. The Leadership Training Directory and more general Training Directory offer a wealth of resources for agencies interested in pursuing organizing and leadership development training opportunities for staff or clients.

Glossary

Acetylcholine: A neurotransmitter at all autonomic nerve endings that helps control muscle tone, learning, and primitive drives and emotions.

Activities of daily living skills (ADLS): Basic skills required to take care of one's personal needs, such as grooming, housekeeping, budgeting, and using transportation.

Agranulocytosis: A disease in which the production of granulated white blood cells by the bone marrow is impaired. Although the disease may occur spontaneously, it is usually induced by exposure to antithyroid drugs, sulfonamides, phenothiazines, chemotherapy, and radiation therapies.

AIDS (**Acquired Immunodeficiency Syndrome):** The advanced stage of HIV disease is characterized by a severely compromised immune system that increases vulnerability to life-threatening opportunistic infections. The criteria established for diagnosis includes HIV infection with a CD4 count below 200, a CD4 lymphocyte percentage of total lymphocytes of less than 14, or a clinical condition listed by the Center for Disease Control (CDC) as AIDS defining.

Akathisia: Describes the pattern of intense inner restlessness often associated with neuroleptic and antidepressant medications.

Americans with Disabilities Act (ADA): Federal legislation that defines the rights of access to and use of public accommodations, commercial facilities, and the workplace for people with disabilities. Also provides mechanisms for enforcement of rights of disabled persons against private persons, other entities (such as employers), and state and local governments.

Anemia: Inability of the blood to carry sufficient oxygen through the body.

Antiretrovirals: Medication specifically the virus targeting HIV.

Anxiolytic: A sedative or minor tranquilizer used primarily to treat episodes of anxiety.

Assertive community treatment (ACT) teams: Multidisciplinary teams that provide case management, crisis intervention, medication monitoring, social support, assistance with everyday living needs, access to medical care, and employment assistance for people with mental illness. The programs are based on an assertive outreach approach with hands-on assistance provided to individuals in their homes and neighborhoods.

Asymptomatic: Without symptoms.

Blunted affect: Refers to a milder variant of flat affect; someone who is only able to express a limited range of feeling in response to current circumstances, or when describing emotionally charged events from the past, fails to show the expected degree of responsiveness.

Borderline personality disorder: Personality disorder characterized by instability of interpersonal relationships, self-image and affects, and significant impulsivity, believed to stem from desperate efforts to avoid abandonment (actual or imagined).

Buy-in: The level to which an individual or member of a community is involved with and supports the ideas, concepts, processes, and projects that are advanced by the leadership.

Case management: The overall coordination of an individual's use of services, which may include medical and mental health services, substance-abuse services, and vocational training and employment. Although the definition of case management varies with local requirements and staff roles, a case manager often assumes responsibilities for outreach, advocacy, and referral on behalf of individual clients.

CD4 count: A test that measures the number of CD4 cells in a blood sample. CD4 cells are white blood cells that coordinate the immune system's response to infection. Normal CD4 counts in adults range from 500 to 1,200 cells per cubic millimeter (mm3) of volume.

Cholinergic: Refers to the parasympathetic nervous system, which produces the neurotransmitter, acetylcholine, a chemical the brain needs to process information and to function normally.

Cholinergic syndrome: The clinical syndrome that results from excessive stimulation of acetycholine receptors. It is characterized by mental status changes, muscle weakness, and excessive secretory activity.

Clinical: Pertaining to standardized evaluation (through direct observation and assessment) and conducted with the intent to offer intervention/treatment.

CMV (**Cytomeglavirus):** A virus that may become active in people with AIDS, resulting in serious, possibly life-threatening illnesses, including blindness and disease of the colon or nervous system.

Cognitive: Relating to intellectual activity, such as thinking, reasoning, and remembering.

Collateral providers: The various organizations involved in the provision of services to an individual.

Community building: Efforts intended to accomplish any of the following: develop and sustain strong relationships among individuals, develop and sustain involvement in neighborhood and community-based organizations and institutions, and develop group capacity to collaboratively identify and accomplish common goals

Community organizing: The process of bringing people together to identify common interests and work collaboratively to accomplish common goals.

Consumers: Recipients of health, mental health, and/or social services.

Contraindication: A situation in which a particular medical intervention is inadvisable.

Damp supportive housing: Housing that discourages but does not prohibit alcohol use on premises.

Day treatment: Provides therapeutic, recreational, and social services to individuals who have chemical dependencies or emotional, psychological, developmental, physical, or behavioral needs.

Debriefing: A process that allows people to discuss thoughts, feelings, and opinions regarding a recent experience.

Decompensation: Movement away from functioning at baseline level toward a reduced level of functioning and stability; psychological imbalance.

Delirium tremens (DTs): Mental disturbance characterized by confusion, disordered speech, hallucinations, and tremors that is induced by excessive and prolonged use of alcohol.

Delusion: A serious disturbance in thought content; belief systems that are not based in reality

Depression: A mood disorder that is characterized by anhedonia (the inability to experience pleasure), hopelessness, and loss of mood reactivity (the ability to feel a mood uplift in response to something positive).

Detoxification: The process of ridding the body of addictive substances via a gradual or complete decrease of substances, intended to result in the cessation of use.

Dosage: Amount of prescribed medication.

DSM IV (Diagnostic and Statistical Manual of Mental Disorders): A publication of the American Psychiatric Association that describes mental disorders and the criteria for diagnosis.

Dually-diagnosed: Term used to describe individuals who are diagnosed with two different disorders, such as mental illness and chemical addiction.

Dystonia: A neurological movement disorder characterized by involuntary muscle contractions that force certain parts of the body into abnormal, sometimes painful, movements or postures. It can affect any part of the body including the arms, legs, trunk, neck, eyelids, face, or vocal cords.

Efficacy: Capacity or power to produce a desired effect.

Entitlements: Publicly funded financial and medical benefits available to individuals who meet criteria usually based upon income or disability measures.

Expansiveness: Open and communicative; overly talkative or effusive.

Fair housing: Refers to federal laws designed to protect access to housing regardless of race, color, national origin, sex, familial status, or disability.

Gastrointestinal distress: Symptoms of the gastrointestinal system (stomach and intestine), such as severe abdominal pain, diarrhea, and gas.

GED (**general education diploma):** High school equivalency diploma, which can be attained without enrollment in a formal high school setting.

Group development: The stages through which groups naturally progress: orientation and exploration, power and control, growth and working, maturation and performance, and termination. Groups may move back and forth between developmental stages depending upon changes in the group membership, conflicts that emerge, and shifts in the group focus.

Halfway house: Transitional residential program focusing on reintegration of participants into the community, such as substance abusers or ex-offenders.

Hallucination: A false or distorted perception of objects or events, including sensations of sight (visual), sound (auditory), taste (gustatory), smell (olfactory), or touch (tactile).

Harm reduction: A model of substance use intervention that focuses on helping people who use substances to better manage their use and reduce the harmful consequences to themselves and others.

Harm reduction or wet supportive housing: A housing model that allows individuals with chronic substance abuse problems who are unable to achieve sobriety to get and stay housed in spite of active use.

Herpes simplex virus: A virus whose varying types cause painful cold sores or genital/rectal lesions.

Highly active anti-retroviral therapy (HAART): A combination of at least three antiretroviral medications used in an effort to manage HIV disease.

HIV disease: The entire continuum of infection with the human immunodeficiency virus (HIV), from the point of infection through AIDS.

Hospice care: End of life assistance focused on caregiving and emotionally supportive services rather than aggressive treatment.

Hypersensitivity reaction: A severe negative and potentially life-threatening immune response to a medication or other agent.

Hypertension: High blood pressure.

Hypotension: Low blood pressure.

Immune compromised: An individual whose immune system functions below normal capacity.

Impulse control: A term used to describe someone's ability to control his/her urges.

Indigenous leadership: Members of any community who, without any outside intervention, are guiding or directing a group towards the accomplishment of common goals or who have the skills and capacity to do so.

In-house employment: Job opportunities within an organization that are available to the users of its services.

Intake: The process for determining or assessing eligibility of applicants for services.

Intervention: The action taken to address a situation or problem.

Job development: Creating or connecting to job opportunities.

Karposi's sarcoma (KS): An AIDS-defining illness manifested by external or internal lesions.

Kidney toxicity: Some level of poisoning to the kidneys.

Late-stage chronic inebriate: Long-term chronic alcohol abuser usually suffering from related medical conditions.

Life skills: See Activities of daily living skills (ADLS).

Lipodystrophy: Abnormal production and distribution of fat, resulting in thinning of the face, legs and arms and the accumulation of fat in the abdomen and upper back, and in women the enlargement of breasts.

Liver toxicity: Some level of poisoning to the liver.

Living wage: Income provided through employment that is at an adequate level to afford necessities such as housing, food, and medical services.

Low-demand environment: A low threshold program that emphasizes ease of entry and ongoing access to services with minimal requirements.

Mania: Mood disturbance characterized by grandiosity, pressured speech, excessive energy and activity, and an inflated sense of self-worth.

Mediation: A process by which a neutral facilitator assists disputing parties to resolve conflicts and reach a settlement.

Medicaid buy-in: Federally approved expansion of the Medicaid program giving states the option to permit employees with disabilities to purchase health-care coverage through the Medicaid program. Income requirements and sliding-scale premiums are determined by participating states.

Medicare: A federal program that provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities.

MICA: Designates the coexistence of mental illness and chemical abuse/addiction.

Mood disorders: A cluster of mental disorders characterized by depression, anxiety, and/or mania.

Mutual aid: Peer support.

Negative symptoms: Those aspects of mental illness that manifest as deficits in functioning (e.g., inability to engage with other people, passive behavior, blunted affect, and poverty of speech and/or thought).

Neuroleptic malignant syndrome: A life-threatening idiosyncratic side effect of medication characterized by muscle rigidity and hyperthermia.

Neuropathy: Conditions involving damage to the nerves, causing symptoms ranging from tingling or numbness to severe, debilitating pain.

Opportunistic infections: Infections that take advantage of a weakened immune system and become active. Frequently refers to AIDS-defining conditions and illnesses.

Osteoporosis: Loss of bone density.

Pancreatitis: Potentially life-threatening inflammation of the pancreas causing severe abdominal pain.

Pathogens: Microorganisms that cause disease.

Perinatal: Referring to the period of time near birth.

Personality disorder: A cluster of personality traits and behaviors that deviate markedly from the expectations of an individual's culture and are inflexible, pervasive, maladaptive, and/or cause subjective distress.

Picking up: A return to alcohol or drug use after a period of abstinence; also called relapse.

Pneumocystis carinii pneumonia: An AIDS-defining lung infection and historically a leading cause of death among people with AIDS.

Prophylaxis: Treatment used to prevent the occurrence of illness.

Protease inhibitor: A class of antiretroviral drugs used in combination with other antiretrovirals to treat HIV disease.

Psychosis: An extreme break with reality, characterized by disturbances in thinking (delusions), perception (hallucinations), mood, and/or behavior, generally resulting in functional impairments.

Psychotropics: Psychiatric medications that reduce the symptoms of mental illness.

Reasonable accommodations: A key provision of the ADA, which requires that alterations in the work environment (including scheduling and physical modifications) be made by employers (with more than 15 employees) who are aware of the limitations of a qualified individual with a disability, thus enabling the employee to perform his or her job functions.

Rehabilitation: A treatment approach that involves assessing a person's skills and needs, and teaching skills to reduce a person's disability and maximize a person's functioning in the community.

Relapse: A return to addictive behavior after a period of abstinence. It may take the form of an isolated incident of use or repeated use. Also known as *picking up*.

Relapse prevention: A variety of supports and tools, including group and individual work intended to assist individuals who have made a commitment to abstinence.

Release of information forms: Documents signed by residents that allow staff to share confidential information (e.g., mental health and substance use treatment, HIV information) with other service providers as necessary.

Rent up: The process by which a newly developed property fills vacant units.

Representative payee: Refers to instances when a person's SSI, SSD, or public assistance check is payable to someone other than the recipient (e.g., a family member, an agency).

Scatter-site housing: Dwelling units in apartments or homes spread throughout a neighborhood or community that are designated for specific populations, usually accompanied by supportive services.

Schizophrenia: A biochemical disturbance that causes and is accompanied by social withdrawal, disorganized thinking, and other maladaptive behavior.

Self-disclosure: The sharing of personal information about oneself with others.

Self-help: An individual helps himself/herself or peers to acquire the skills needed to achieve personal goals.

Self-medicate: The use of unprescribed or misuse of prescribed substances to alleviate symptoms of mental illness, physical pain, and other discomforts.

Shingles: Extremely painful blisters that follow the path of individual nerves caused by a reactivation of the virus causing chicken pox.

Single room occupancy (SRO) Building: A type of building that offers residents a single, furnished room, usually with shared bathroom and kitchen facilities.

Single-site housing: A housing program in which all living units are located in a single building or complex.

Sober or Dry supportive housing: Housing that emphasizes abstinence and prohibits alcohol and the use of illegal psychoactive substances.

Social entrepreneurial venture: A for-profit business that benefits a nonprofit or other mission-driven organization.

Sponsor: An organization that pays for or plans and carries out a project or activity

SSDI (Social Security Disability Income): Cash benefits for people with disabilities who have made payroll contributions to the federal social security program while they were employed.

SSI (Supplemental Security Income): Federal cash benefits for people aged 65 and over, the blind or disabled. Benefits are based upon income and living arrangement.

Stages of change: A model of addiction and recovery that identifies phases of readiness to alter addictive behavior. Related interventions are based upon the individual's state of awareness and desire to change behavior at a given point in time.

Stakeholders: Individuals who have a vested interest in the outcomes or the process of a particular endeavor.

Stigma: Misperception that results in bias towards an individual or group.

Suicidal gesture: An action taken intentionally that may threaten one's own life.

Suicidal ideation: Thoughts of suicide that include plans for killing oneself; also a wish for one's own death not accompanied by a plan for killing oneself.

Supported employment: Employment in an integrated setting with ongoing support provided by an agency with expertise in providing vocational services to people with disabilities.

Supportive housing: Combines and links permanent, affordable housing with flexible, voluntary support services designed to help the tenants stay housed and build the necessary skills to live as independently as possible.

Tardive dyskinesia: A syndrome involving dysfunctional, involuntary movements caused by the long-term use of antipsychotic drugs.

Tenancy obligations: Minimum requirements to be a tenant in good standing, such as payment of rent, following house rules, maintaining a healthy and safe living unit, and meeting other lease requirements.

Tension centers: Predictable locations or instances in housing in which conflicts are most likely to develop, such as shared kitchens and TV lounges.

Therapeutic communities: Highly structured, residential treatment programs for substance abusers.

Thrush: Yeast infection occurring in the mouth.

Transitional employment: Temporary employment focused on helping individuals to develop the skills to achieve permanent, competitive employment.

Transitional housing: Housing meant to help homeless people access permanent housing, usually within two years.

Triggers: People, places, and things associated with precipitating an untoward event such as violence or drug use.

Tuberculosis (TB): A bacterial infection, which is AIDS-defining when it affects the lungs (where it most often occurs).

Twelve-step model: An alcohol and substance abuse recovery model characterized by its peer-run approach, anonymous meetings, peer sponsorship, and a series of twelve steps that members must work through as part of the recovery process. Examples of such programs are Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA).

Universal precautions: Workplace guidelines developed by the Centers for Disease Control (CDC) to minimize exposure to pathogens, such as HIV and hepatitis.

Vocational assessment: Evaluation to assist consumers to identify skills, goals/interests, areas of expertise, and needed skills development

Withdrawal: The period of time following cessation of an addictive substance, characterized by symptoms that may cause discomfort, severe pain, and in some instances death.

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.

Developing the "Support" in Supportive Housing
Written by Tony Hannigan and Suzanne Wagner. 2003: 206 pages.
Price: $15 or download for FREE at www.csh.org
A guide to providing services in housing. This manual addresses core housing tenancy and service delivery issues, with details on employment, mental health, HIV/AIDS and substance use services, as well as chapters on community building and facing crisis and conflict.

The Monmouth County Supportive Housing Collaboration
Two-Year Evaluation Written by Tony Proscio. 2002; 72 pages.
Price: $5 or download for FREE at www.csh.org.
This report concentrates on the process of improving interagency and intergovernmental cooperation for the purpose of creating long-term solutions to the housing and human service needs of residents with special needs in Monmouth County, New Jersey.

Connecticut Supportive Housing Demonstration Program-2001 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. 2001; 142 pages. **Price: $5**
The second annual evaluation of the Statewide Connecticut Demonstration Program that 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.

Family Matters: A Guide to Developing Family Supportive Housing *Written by Ellen Hart Shegos. 2001; 346 pages.*
Price: $15 or download PDF files for FREE at www.csh.org.
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.

A History of The New York/New York Agreement to House Homeless Mentally Ill Individuals
Written by Ted Houghton. 2001
Price: $5 or download PDF file for FREE at www.csh.org.
This document provides a description and history of the New York/ New York Agreement to House Homeless Mentally Ill Individuals, signed in 1990 by the City and State of New York.

The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals *Written by Kay E. Sherwood. 2001*
Price: $5 or download PDF file for FREE at www.csh.org.
A Summary of: *The Impact of Supportive Housing for Homeless Persons with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York/New York Initiative*. Written by Dennis P. Culhane, Stephen Metraux and Trevor Hadley Center for Mental Health Policy and Services Research, University of Pennsylvania. This document summarizes the cost analysis of the New York/New York Agreement.

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 & Lipman. 2001; 226 pages.
Price: $15 or download PDF files 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 resolving common dilemmas.

Keeping the Door Open to People with Drug Problems — Volumes I, II and III *Written by Wendy Fleischer, Juliane Dressner, Nina Herzog and Alison Hong. 2001; 180 pages.*
Price: $5 Each or download PDF files for FREE at www.csh.org.
This three-part guide offers employment program managers and staff encouragement, strategies and tips for serving people with drug problems. The guide is divided into three volumes to make it easy to read for busy practitioners. Volume I is written with managers in mind. It focuses on the systems needed to train, manage and support staff in a program serving people with drug problems. Volume II is targeted to employment program staff. It covers basic information about drug addiction and treatment, and offers tips for working with people, including sample dialogues and forms. Volume III is focused on employment programs operating in public housing. It discusses the related housing policies and regulations, and some of the challenges and opportunities provided by the public housing context.

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir. 2000; 191 pages.* **Price: $5 or download PDF file for FREE at www.csh.org**
This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving health, housing and integrated services tenants where they live.

Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel *Written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez. 2000; 65 pages.*
Price: $5 or download PDF file for FREE at www.csh.org
Evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engaging 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.

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

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 PDF file 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 PDF file 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.

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 & Lipman. 2000; 217 pages.
Price: $15 or download PDF files 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 resolving common dilemmas.

Supportive Housing and Its Impact on the Public Health Crisis of Homelessness *Written by Tony Proscio. 2000; 40 pages.*
Price: $5 or download PDF file for FREE at www.csh.org
This publication announces the results of research done between 1996 and 2000 on more than 200 people who have lived at the Canon Kip Community House and the Lyric Hotel in California. It also looks at pre-occupancy and post-occupancy use of emergency rooms and inpatient care.

Vocationalizing the Home Front: Promising Practices in Place-Based Employment
Written by Paul Parkhill. 2000; 79 pages.
Price: $5 or download PDF file 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.

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 and community impact—both economic and aesthetic—property values and use of services once tenants were stably housed.

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.

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 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.

Next Door: A Concept Paper for Place-Based Employment Initiatives *Written by Juliane 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."

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.

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.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults *Commissioned by CSH, written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez 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.

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, DC, Chicago and Minneapolis/St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

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.**

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Our Mission

CSH helps communities create permanent housing with services to prevent and end homelessness.

CORPORATION *for* SUPPORTIVE HOUSING

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