From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model

Sam Tsemberis, PhD
Sara Asmussen, PhD

SUMMARY. This paper describes essential elements of the Consumer Preference Supported Housing (CPSH) Model of homelessness prevention in use at Pathways to Housing, Inc. in New York City. This intervention prevents homelessness by engaging and housing homeless substance abusers with psychiatric disabilities whom other programs have rejected as "treatment resistant" or "not housing ready." The CPSH model is built on the belief that housing is a basic right for all people. As opposed to the housing continuum model, housing is based on consumer choice and is not connected to compliance or treatment. Housing is provided immediately, and there are separate criteria for housing and treatment needs. Support services are aimed at integration of mental health and substance abuse services.

In a randomized controlled study, individuals who are currently homeless and have psychiatric disabilities and/or substance abuse problems are randomly assigned to either the CSPH intervention or an intervention using the linear continuum model. Participants will be followed for a period of one year and the study will provide feedback

Sam Tsemberis is Executive Director and Sara Asmussen is Project Coordinator, both at Pathway to Housing, New York, NY.

Address correspondence to: Sam Tsemberis, Pathways to Housing, Inc., West 23rd Street, New York, NY 10011-2426.

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regarding the effectiveness of the CSPH model. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworthpressinc.com]*

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INTRODUCTION

The homelessness prevention program presented in this chapter, the Consumer Preference Supported Housing Model (CPSH), was developed by Pathways to Housing, Inc., a private non-profit social services organization in New York City. Pathways to Housing, Inc. was founded in 1992 to serve the most visible and underserved segment of New York's homeless population–persons with psychiatric disabilities and co-occurring substance use disorders who live on the streets, parks, subway tunnels, and other uninhabitable public places. The agency concentrates on individuals rejected by other housing programs due to refusal to participate in psychiatric treatment, active substance abuse, histories of violence or incarceration, and other behavioral personality disorders.

Pathways' CPSH program is the only one in the U.S. to offer homeless street dwelling individuals with dual diagnoses immediate access to independent apartments. The cornerstone of this intervention is the belief that housing is a basic right for all people. Unlike traditional housing programs, Pathways regards housing and treatment as two distinct domains with separate criteria for evaluation. Thus housing is not connected to compliance or treatment; however, every individual in the program receives support services or treatment from Pathways' Assertive Community Treatment (ACT) teams. The ACT teams are modeled after the original Stein and Test (1980) community based treatment teams and meet the majority of current program criteria for fidelity to ACT (Teague, Bond, & Drake, 1998), with some modifications to reflect the special needs of the agency's target population. This includes a significant number of peer counselors on the team and a nurse practitioner to tend to the numerous medical problems of this population. Consistent with many other aspects of the ACT model, the teams provide services to tenants in their new homes and communities, 24 hours a day, 7 days a week.

The CPSH program prevents homelessness by successfully engaging and housing a segment of the population that has resisted or been rejected by all other housing programs. This segment of the homeless population is often

described as "treatment resistant" or not "housing ready" by other housing programs. In addition, the program prevents the cycle of recurring homelessness by achieving long-term housing stability through the provision of client centered, home/community based support services that are relevant to the tenants needs, such as rapid crisis intervention to avert unwanted hospitalizations, client-determined service plans, and a harm reduction approach to alcohol and substance use. The majority of clinical interventions are provided in the context of a radical acceptance of the point of view of the tenant.

This paper describes the essential ingredients of the CPSH model including the program's conceptual framework and logic model; a description of the concept mapping process that was used to obtain stakeholder perceptions; the logic model which resulted; a discussion of program effectiveness; and the lessons learned from the past five years of operation.

Foundation of the CPSH Model

To date, there have been no well-controlled randomized studies comparing different housing models to one another (Goldfinger et al., 1997); therefore, the CPSH program was developed based on findings from related studies, supported housing and psychiatric rehabilitation theoretical models, and years of clinical practice based on respect for individual's empowerment, and faith that tenants who had no previous experience can maintain independent apartments when provided with the right support. The model was developed by the first author after years of directing the Homeless Emergency Liaison Project (Project HELP), a large city-wide outreach psychiatric emergency team for street dwelling individuals with severe psychiatric disabilities (Katz, Sabatini, & Codd, 1993). In spite of Project HELP's best efforts to find housing for their clients, innumerable individuals continued to live on the streets (Tsemberis, Cohen, & Jones, 1993). A careful review of the mental health housing literature provides ample evidence that there are problems with the continuum of care housing model, the most widely used housing approach in the U.S.; problems with the fragmentation of mental health and substance abuse services; and very few programs where any attention is paid to consumer choice. The following is a brief synopsis of the existing literature in these areas.

HOMELESSNESS IN NEW YORK CITY

Homelessness in New York City has reached an all-time high. It is estimated that there are 100,000 to 120,000 homeless individuals in New York

City–approximately 50,000 to 80,000 homeless individuals are served by various social agencies during a one-year period with an additional 30,000 people on the street who receive no services (Barrow et al., 1989). Of the single adult homeless population, 25% to 37% exhibit serious mental disorders or have a history of psychiatric illness (Plapinger et al., 1988; Struening, 1987; Susser et al., 1988). These numbers clearly indicate that the existing system of care is simply ineffective for a large number of individuals who remain homeless and mentally ill.

HOUSING FOR INDIVIDUALS WITH PSYCHIATRIC DISABILITIES

Most mental health systems have responded to the crisis of homelessness among individuals with mental illness by developing residential treatment programs. The prevailing treatment/housing model in the US is the linear continuum of care model. While the ultimate goal of this model is independent living, the environment fosters dependence. Residents have little choice or freedom concerning treatment or housing options and the move to independent housing may take years. Typically, a client is first placed in a residential treatment facility, such as a community residence, where he or she lives with others with similar levels of impairment or function, and by satisfying treatment goals set by staff may "graduate" to higher" levels in the continuum. Supervision and treatment is reduced along each step of this gradient, and programs are less structured and less restrictive (Bassuk & Lamb, 1986; Telson & Couco, 1993). It may take anywhere from one to five years to obtain independent housing through this model compared to days to several weeks in the CPSH model. Given that the continuum of care model has had a low success rate among the target population, CPSH was designed to resolve the barriers to housing for dually diagnosed individuals living on the streets.

Overall, consumers and researchers have attributed the model's low success rate to the following factors: (1) constant changes required by the continuum are very stressful for clients, demanding that clients abandon existing relationships formed in one setting only to start anew in another; (2) paradoxically, the changes along the continuum coincide with a decrease in staff support and treatment, in many cases it has proven unrealistic to expect people with psychiatric disabilities to fit into this highly structured linear progression; (3) skills learned for successful functioning for a structured congregate setting are not necessarily transferable to an independent living situation (Anthony & Blanch, 1989); (4) clients lack choices and freedoms, residential treatments offer standardized levels of care to which clients must adapt (Ridgway & Zipple, 1990); and (5) clients are placed into a level of

supervised housing based on the decision of clinical staff and clients are afforded little privacy or control (Grunberg & Eagle, 1990).

Studies indicate that most consumers prefer to live independently (Owen et al., 1996; Shutt & Goldfinger, 1996). Many individuals prefer the relative independence of the streets to the structure of residential facilities (Howie the Harp, 1990). When consumers have a choice in housing options, this correlates with greater housing satisfaction, housing stability, and psychological well-being (Srebnik et al., 1995). In fact, numerous surveys indicate that consumers identify lack of income, not mental disability, as the main barrier to stable housing (Tanzman, 1993). In the CPSH model, the needs of the clients, from apartment and neighborhood selection to comprehensive service plans, are determined by the clients. There has been a national and state policy shift towards developing more of this type of supported housing (Carling, 1993); however, the CPSH program is one of the only operational models.

FRAGMENTATION OF SERVICES

There are systems variables which create an environment which may further foster homelessness. Fragmentation and lack of coordination between mental health, addiction, and housing services contribute to recurring homelessness (Oakley & Dennis, 1996). Mental health providers often assume that substance abuse providers are responsible for dually diagnosed individuals and vice versa. Housing programs are usually not even involved in this treatment process since the entire premise of the continuum of care model is that the person must first seek treatment to be "housing ready." Programs characterized by low demand and consumer driven approaches have not been widely used by traditional housing providers (Asmussen et al., 1994; Osher & Drake, 1996; Tsemberis, 1996; U.S. Dept. of HHS, 1994). Overall, research has shown that with adequate support services, even severely mentally ill persons can maintain stable housing (Brown et al., 1991; Livingston et al., 1992), even if they are substance abusers (Goldfinger, 1994). Other studies have shown that individuals are more willing to participate in and complete treatment for substance abuse if housed (Erickson et al., 1995).

Based on the barriers and weaknesses as described in the literature, the CPSH Model was developed on the following tenets: (1) homeless individuals with psychiatric disabilities can maintain independent housing of their choice with the right supports; (2) the consumer selects his/her own housing (apartment); (3) apartments are rented from landlords in the community and the landlord does not provide the support services; (4) clinical crises such as relapse to substance abuse or psychotic episodes, do not place the tenant at risk for losing his/her housing; (5) services are offered by an ACT team, in

vivo, in the community, 24 hours a day; (6) type, frequency, and sequence of services is determined by the tenant; and (7) sobriety, medication compliance, or any other form of treatment is not a requirement, the staff use a harm reduction model for drug and alcohol abuse.

RELEVANT STUDIES

As stated earlier, there is a lack of controlled research in the field of housing which makes it difficult to assess the effectiveness of any model of housing. In an older analysis of the literature, continuum of care programs showed relatively little success in realizing the long-term goals of housing tenure and independent living. In a review of 109 studies on residential treatment facilities, no clear evidence for reducing symptoms, improving economic self-sufficiency, or community functioning were found (Cometa, Morrison & Ziskoven, 1979).

In a study conducted in Boston which assessed the effectiveness of the support systems used by two different supported housing programs, Goldfinger et al. (1997) randomly assigned and tracked 109 homeless individuals selected from the Department of Mental Health's shelter system to one of the two supported housing programs. At month 16, there was an 81% retention rate between the two groups, with 59% (n = 65) remaining in their original housing.

In another study of supported housing which examined the effectiveness of different case management models, Hough et al. (1997) randomly assigned 362 individuals from the San Diego area into one of four housing/case management groups. Across all four groups, at 18 months, 60% (n = 217) were still housed in independent living situations.

In an initial analysis of the existing data, over the past five years, the Pathways CPSH program has maintained 85% of all tenants who entered the program. In contrast, the continuum of care model in New York City that carefully selects out the very clients Pathways seeks to serve, reports the housing retention rate over the past 2 years at 60% (Tsemberis, 1996).

CONCEPT MAPPING

Representing the Views of the Program's Shareholders

In writing the manual that describes the CPSH program, it was essential to include the perspective of those who played an integral role in establishing and operating the program. This includes tenants, staff, and the board of directors. The concept mapping methodology developed by Trochin (1989) was adapted for the collection and analysis of data from these three groups. By examining the program descriptions offered by each of the groups, concept mapping allows for a representation of the key elements of agreement among the groups and the essential ingredients of the program can be identified and included in the manual and the logic model.

Different groups met individually to brainstorm assumptions, experiences, and approaches which operationally defined the topics as they related to the CPSH Model. Ideas were combined into lists resulting in 97 statements about the environment, 113 about supports, 30 about philosophy, and 72 conceptualizations about outcomes.

The groups then held an additional meeting where the ideas generated by all three groups were sorted and classified within each of the four domains. Each individual rated each statement as to its level of importance, accuracy or relativeness to the CPSH model. Data were entered into the Concept System8 computer software program. A total of 63 individuals consisting of staff, tenants, and board members participated in at least one of six meetings that served to drive the Concept Mapping process. By the end, 35 conceptual categories had been developed.

Logic Model

The Logic Model for the CPSH program was taken from the Concept Mapping exercise and is exhibited in Figure 1. The following is an explanation of the model.

Logic Model Inputs: Population and Environment

The tenants currently in the program will be described in the Program Description section below. Resources available to tenants consist of benefit or entitlement systems from Federal, State, and City governments. Benefits/entitlements are often difficult to obtain and may be discontinued arbitrarily.

Logic Model Basis: Theory and Assumptions

One of the basic assumptions of this model is that the tenants in this program consist of individuals who, although able to survive on the streets for long periods of time, are highly vulnerable to other stressors. Clients need access to housing and support services that do not make demands that compromise the individual's dignity or increase stigma. This group of individuals

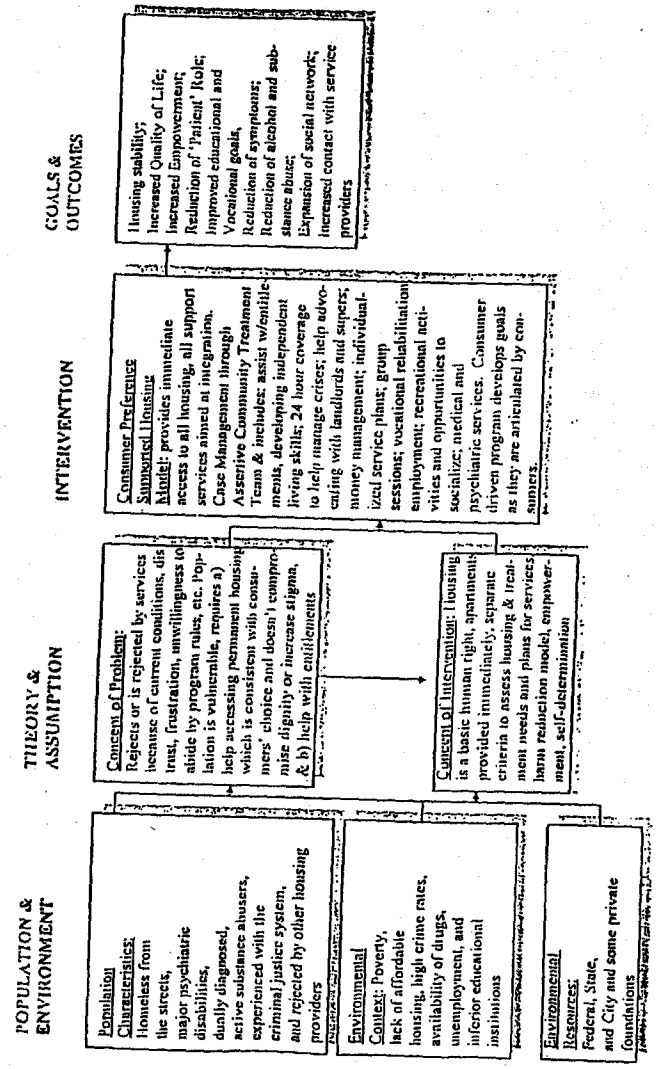

FIGURE 1. Pathways to Housing, Inc.

is somewhat distrustful and, as a whole, becomes easily frustrated by "rules and regulations." Many times, they simply leave situations in which they have housing, or they will lose their benefits, rather than deal with the frustration of dealing with a funding source.

Logic Model Thruput: Intervention

More important than the specific interventions is the feeling and intention with which services are provided. The CPSH program interventions are comprised of numerous supported housing and ACT team services, comprising a conceptual framework that is an amalgamate of psychiatric rehabilitation, harm reduction, self-psychology, advocacy, and crisis intervention, among others, provided in an atmosphere that fosters the expression of love and respect and the creation of new possibilities. The specific services are listed in Figure 1.

Logic Model Output: Goals and Outcomes

First and foremost is housing stability: to retain housing and prevent relapse into homelessness. Other outcomes can be sought such as increases in quality of life, empowerment, and obtaining needed services; reduction in the "patient" role, symptoms, alcohol and substance use; improvements in educational and vocational goals; and expansion of the social network. The outcomes for each tenant are individualized, based on the needs expressed by that person.

DESCRIPTION OF THE HOMELESSNESS PREVENTION INTERVENTION

Program Structure

A flexible program structure is central to the success of the CPSH program. The administration of the program, including the Board of Directors, fiscal operations, and clinical staff, are committed to the values of the program that emphasize consumer preference. Program staff have access to a flexible accounting system such that money is immediately available for emergencies without unnecessary paperwork. Program staff have flexibly scheduled hours and rotate the responsibility of on-call coverage. Funding sources must be informed about the program so that they are flexible regarding what expenses are reimbursable.

Eligibility Criteria for Admission to/Participation in the Program

Eligibility criteria for admission to Pathways' CPSH program are very simple. the individual must be homeless, must have a psychiatric disability that compromises their ability to function (active symptoms or history of hospitalization, primarily described by a DSM IV Axis I diagnosis), and during the first year of tenancy must be willing to meet with a service coordinator twice a month and participate in the money management program. There are no requirements for participation in psychiatric or substance use treatment, or in sobriety programs. A history of violence or prison time does not disqualify the applicant from entering the program.

CPSH Client Characteristics

In the CPSH program, all tenants are homeless and have psychiatric disabilities. Of the 218 current tenants, 79 are women (36%) and 139 are men (64%) with an age range of 18 to 51+ years. Of this group, 85 individuals (39%) have children, all of whom are in foster care or living elsewhere. Only 7% (n = 15) are married, 65% (n = 142) are single, 20% are divorced or widowed, and data are not available for 8% (n = 17) of the group. These numbers are suggestive of a disabled group and the 85% who are single or divorced closely matches the percentage found in other groups of people diagnosed with major mental illness. Thirty-six percent of the tenants (n = 79) were raised by someone other than their parents; 38 (17%) reported being sexually abused as children, and 55 (25%) reported being physically abused. Thirteen percent (n = 29) refused to answer these questions, so the numbers could be higher. Of those responding, 102 (47%) reported having been arrested and 82 (38%) reported being a victim of a crime.

The last place the person lived prior to entering the program was as follows: 65% living on the streets or using drop-in centers, 18% in shelters, 7% in treatment facilities, with the remainder in transitional hotels, the Y, or with friends. Levels of education and employment histories are consistent with other studies of psychiatrically disabled urban populations. Figures indicate a fairly disabled group with 77% receiving Medicaid and 67% receiving SSI.

Of the current tenants, 73% (n = 160) report past psychiatric hospitalizations. The diagnosis for this group are as follows: schizophrenia 52% (n = 113), mood disorders 27% (n = 59), other psychotic disorders 9% (n = 20), and other disorders including Axis II 13% (n = 28).

Finally, the most difficult numbers to obtain are those having to do with substance and alcohol abuse. Based on self-report, 36% (n = 78) of the tenants reported having actually received treatment for substance or alcohol abuse in the past, 9% (n = 33) reported that they currently abused substances, including alcohol. Staff, on the other hand, observed that 17% (n = 38) were currently actively using and overall, 60% of the tenants (n = 131) had been abusing drugs or alcohol within the past year. The high percentage of dually diagnosed tenants is consistent with estimates of dual diagnoses obtained from other samples of this population (U.S. Dept of HHS, 1994).

Staffing Selection and Staff Training

One of the most important aspects of staff recruitment is the establishment of cohesive teams of culturally diverse individuals who are creative, compassionate, and flexible and who have a willingness to put the needs of the tenants ahead of all other considerations. The most highly-rated staff characteristics in the Concept Mapping process was a "staff that is able to work inter-racially and inter-ethnically."

Gender composition of the 33 current staff at Pathways is 48% male and 52% female. Forty-two percent are African-American, 27% Caucasian, 24% Latino, 3% Asian-American, and 3% other. A total of five languages is spoken. Fifty percent of the staff are people in recovery, either from homelessness, substance abuse, or psychiatric disability.

Staff must be capable of understanding the need to attend to the spoken and unspoken needs of tenants. They must be able to separate societal and personal beliefs concerning mental illness and learn to listen to the needs of the individual with whom they are working. It is essential that the tenant be allowed to make his or her own mistakes. This was supported during Concept Mapping with the statement, "The program allows for every crisis to be an opportunity for growth," receiving a very high rating.

The harm reduction philosophy is one of the more controversial program practices and it is important for all staff to embrace this approach if it is to succeed. The CPSH harm reduction model offers an effective alternative to the prevailing 12-step program approach which may create problems for those individuals who are accustomed to enforcing strict behavior rules and sobriety. The statement, "The program does not require medication or sobriety compliance," was rating among the highest during Concept Mapping. The tenant who is actively using drugs or alcohol is offered a series of harm reduction objectives to reduce the harm that drug use causes in a manner that is supportive and empowering.

The staff characteristics which were rated quite high were, "a staff that can relate to people," "a staff that can work hands-on with people," and "a staff that is flexible." In part this is accomplished by careful selection of staff. Training is an ongoing process. Monthly in-service sessions encompass a variety of subjects including advocacy, managing benefits, domestic violence, preventing violence, legal issues, stress reduction, cultural sensitivity, and many others as well as presentations from Pathways' staff and tenants.

Training sessions range from traditional lecture presentations to on-site workshops offered by other agencies with compatible program approaches.

Other effective ways to increase staff effectiveness in the clinical application of the CPSH model are to provide staff support, ample and careful supervision, and staff retreats where work-related issues are discussed. Another support is the use of staff mutual support group session for staff to discuss work-related feelings and concerns. The support meeting is confidential and the team leader is not present.

Administrative Structure

Agency administration and leadership is always a challenge, especially when one is operating a service that challenges the prevailing views. The governance and decision-making process is a combination of hierarchical and collaborative. The Executive Director (ED), who reports to the Board of Directors, is also the agency's founder. He collaborates closely with the Board. The ED also meets with two management teams: the clinical management team comprised of the ACT Team Leaders and the Director of Programs and the Operations Team comprised of the Comptroller, Housing Director, Continuous Quality Improvement Director, and other relevant administrative staff.

Cost of Operating the Program

There has not been a formal cost analysis of the CPSH program. An estimate of program services during the 1997-1998 fiscal year was computed by dividing the total agency budget by the total number of funded apartments (including the current vacancies). The result is an estimated annual cost of $15,000 for the agency's share of the rent and support services for each apartment. To provide a context for this figure, the annual cost for a cot in a municipal shelter is $18,500 and the annual costs of congregate living supported housing ranges from $35,000 to $50,000. Though rudimentary, these figures strongly suggest that this supported housing program is a very reasonably priced intervention.

ACT Team Services

The Pathways ACT teams embody the philosophy and values of the organization's mission. Each tenant is assigned a case manager, but the entire team is involved in the planning and delivery of services. The primary case manager is responsible for charting and ensuring coordination of services, including referrals to other agencies. The team composition includes case

managers who are often peer counselors or former consumers, a nurse, a psychiatrist, vocational rehabilitation counselor, social worker, drug counselor, and an administrative assistant. The team leader carries a small caseload, but the nurse, psychiatrist, and vocational rehabilitation counselor offer their services to all tenants referred by staff. When the team cannot provide the services directly, tenants are referred and escorted to the relevant programs including vocational training, psychosocial clubs, court appearances, job interviews, and medical and dental clinics. The type, frequency, and sequence of services is determined by the tenants. This flexibility is an essential ingredient to operate a program truly based on clients' preferences.

Housing

The goal is to obtain an apartment for the client as soon as possible. The three-person housing department keeps logs of all new acquisitions from brokers or landlords, lists new vacancies, and works closely with service coordinators to negotiate new tenant leases, complete Section 8 applications, and coordinate apartment repairs.

The agency leases two transitional apartments which can support two or three tenants at any one time and are always supervised by Pathways staff. The immediate access to these apartments is available for clients who have been accepted into the program, but have yet to find an apartment of their own. The other option for such temporary housing is using the local YMCA. In either case, tenants move out of transitional housing and into apartments of their own as an apartment is found. The average length of stay in a transitional apartment is 15 days for the small percentage of clients who cannot move directly into apartments of their own.

Money Management

Money management is part of the service coordinator's function. Money management is one of the two requirements for becoming a tenant of the Pathways CPSH program. This usually means that the tenant will make the agency a representative payee. This requirement is introduced at different points in time for individual tenants.

There are two major reasons for this requirement: (1) Pathways has the responsibility for paying the tenant's rent, including 30% of the tenant's income. Having a centralized banking system is much more efficient when such a large number of rents must be paid at the beginning of each month, and (2) money management ensures that tenants' utilities, food, and other essentials are provided for and, in instances of dually-diagnosed tenants, this service limits their expenditures for alcohol or drugs. The money manage-

ment service is a central ingredient for effective homelessness prevention procedures with this tenant population.

After the rent is paid, a monthly budget is developed by the tenant and the service coordinator which meets the requirements set for Representative Payee responsibilities. Some tenants receive the entire balance of their funds while others may have weekly or biweekly budgets. Tenants receive monthly banking statements showing their deposits, credits, and balance for the month. The goal is for all tenants to eventually manage their own money after learning appropriate money management skills.

Comprehensive Service Plan (CSP)

The housing component is the first of ten domains addressed by the CSP. The remaining goal domains are education, vocation, mental health, physical health, alcoholism and substance abuse treatment, finances, self-care, social and family network/support, and other needs. The tenant selects the domains to be addressed, defines the objectives for each goal, and determines the rate of progress for each goal. After a period of time, not more than three months, the service coordinator and the tenant discuss the progress toward the goals and update the plan.

Exceptions to adhering to the plan occur in rare cases such as: (1) staff deems that the tenant is at risk to self or others; (2) legal constraints such as mandated services, including probation and conditional discharges are in place for the tenants; (3) rent or utility bills are not being paid by the tenant; (4) instances of violence; and (5) instances of child abuse.

Service Coordinators

The second program requirement is that the tenant agrees to meet with the service coordinator at least twice per month in the first year. The service coordinator is a member of the ACT team and shares the responsibility for the rotating on-call schedule. The purpose of the 24-hour, 7 days per week schedule is so that tenants will know they can obtain help whenever they need it. Another goal of the service coordinator is to provide and coordinate a comprehensive array of services determined by the tenant. These linkages are central to the success of the CPSH Model and there are many linkages already in place including individual providers and the numerous clinics and hospitals in the New York City area. The program places a strong emphasis on developing vocational opportunities and operates a tenant worker program. If a tenant enters long-term treatment, a psychiatric hospital, or jail, the service coordinator will continue to follow-up. The length of the intervention is as long as the tenant wishes it to be.

Evaluation

Finally, to assess the effectiveness of the Pathways CPSH Model as compared to other models of housing, a randomized, controlled study has been funded by SAMHSA and is currently underway. In this study, individuals who are currently homeless and have psychiatric disabilities and/or substance abuse addictions are randomly assigned to either the CPSH intervention or an intervention using the linear continuum model. The participants will be followed for a period of at least one year and the study will provide feedback regarding the effectiveness of the CPSH model, as well as for whom the model is most effective.

LESSONS LEARNED AND RECOMMENDATIONS

The lessons learned and recommendations made after operating the program for the past five years are presented separately for the areas of program/clinical issues, housing, and financial.

Program/Clinical Issues

1. The most important and exciting discovery of operating the Pathways CPSH program is that individuals who are homeless, living on the streets, in parks and other public places, who have severe psychiatric disabilities and/or substance abuse problems can be successfully housed in independent apartments with support services. However, it should not be assumed that because some people have successfully survived the hardships of life on the streets, those same people will not need assistance managing their new household.
2. The relationship between psychopathology, substance abuse, and level of functioning is not as strong as assumed by most clinicians and housing providers. People with a host of psychiatric symptomatology, as well as alcohol and drug addictions, can handily demonstrate the skills necessary for living in an apartment.
3. Treatment participation and housing tenure are achieved more effectively when the tenant determines the conditions under which to participate. Tenants should have a right to treatment and a right to refuse treatment.
4. The Assertive Community Treatment (ACT) team model serves as an excellent clinical support for the CPSH program.
5. Staff composition should include approximately 50% consumer representation (peer counselors, people in recovery, etc.) to serve as role

models and embody the empowerment model espoused by the program.

6. Vocational rehabilitation is an essential program component, if independence and community integration are the long-term goals. Immediately after moving into an apartment, tenants are more likely to seek paid employment rather than treatment.
7. Harm reduction and other substance treatment models that allow for prevention are effective treatment strategies for dually diagnosed individuals.

Housing

1. Housing and treatment must be regarded as separate domains.
2. It is useful to have several transitional apartments (or the local YMCA) in order to provide immediate access to safe and comfortable housing for eligible tenants while they await a place of their own.
3. The scattered-site model has several important advantages: (a) landlords are surprisingly welcoming of program tenants because they are assured of regular rent payments; (b) there is no required bureaucracy, that is, no community board approval, zoning, Not in My Back Yard (NIMBY), etc.; and (c) it is most effective at community integration when no more than 15% of the units in any building are rented by program tenants.

Financial

1. The program accounting department must be flexibly structured in order to be able to issue checks for emergency housing and other urgent client needs as necessary.
2. The money management component should operate like a bank, including providing tenants with monthly statements.

In summary, the Pathways program has provided a unique opportunity for tenants and staff to participate in an exciting and courageous program with results that demonstrate that when we look beyond psychopathology and focus on person remarkable accomplishments are possible.

> They took me around and showed me some apartments. It was wonderful coming out of the jungle and into success. This is a successful program. They do want to help people get their lives together. They turned me around and made me see there is somebody that cares about another individual.
>
> *R. G., East Harlem ACT Team tenant*

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