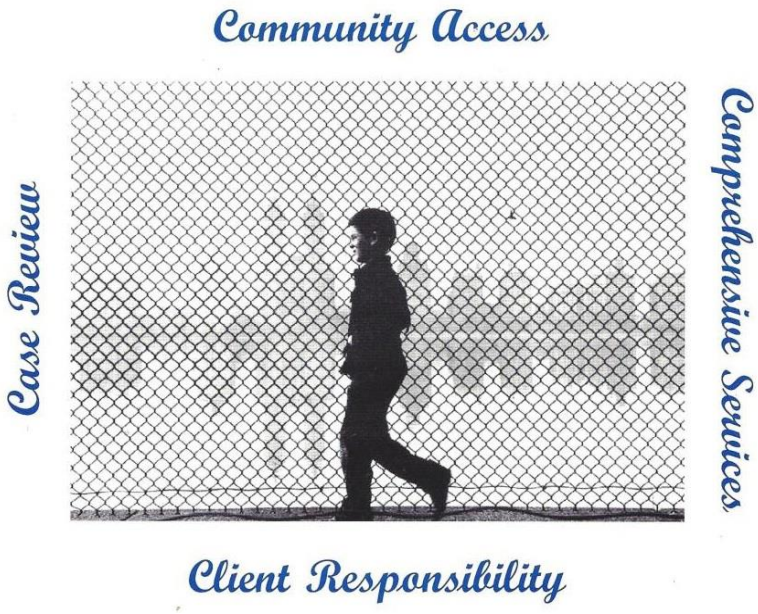
Few Sheep, Little Corn:

Preventing Homelessness & Stabilizing Communities



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Chapter 1: Introduction

In November, 1995 the Hartford, Connecticut City Council voted to prohibit for a nine-month period the opening of any new shelters for the homeless, rehabilitation homes or centers for "welfare and charitable purposes." Elected officials publicly expressed the community's distress over the perceived negative effects of large numbers of homeless and poor people on the city's economy, its budget and its quality of life. They felt social service agencies located in the city were attracting people in need from other towns that lacked services, and limiting services in Hartford would distribute the poor population more equitably.[1]

Social service providers and advocates for the poor had a different interpretation. Poor people come to the city for the same reasons they always have, because that is where the opportunities--jobs, housing, transportation--are. They said their statistics indicate most of the poor they serve are Hartford residents anyway. The non-profits are just trying to maintain the safety net, they argued, and with government programs being eliminated, to restrict their services would be a formula for disaster.[2]

The frustration on both sides of the debate is palpable.

Governments fund social services to help the poor into the mainstream, yet the problem and the cost keep growing, good times or bad. In Massachusetts, from 1983 to 1985, state spending on emergency shelter for the homeless grew over 300% from $2.4 million to $10.5 million, and then another 300% to $45.9 million by 1990.[3] During the winter of 1995-96, the Greater Boston area sheltered over 2,600 people per night, requiring over 12 beds per night per 10,000 population.[4] Many cities, including Washington, D.C., Cleveland and Dayton, Ohio, St. Paul, Minnesota, Albany, New York, Allentown, Pennsylvania, Bridgeport, Middletown and Stamford, Connecticut, Providence, Rhode Island, and Huntsville, Alabama have implemented or are considering restrictions, usually through zoning laws, on the growth of social services. Several New York City community boards are seeking moratoriums on group homes or shelters.[5]

Social service agencies complain about increasing case loads and declining resources. Dedicated counselors and case managers fight the good fight daily to eke out small victories in what seems to be a losing war. They express frustration about systems that inadvertently or carelessly reward irresponsible or self-destructive client behavior, but that make it almost impossible to provide appropriate or adequate support and resources for motivated clients. Burnout is endemic to the profession. Many yearn for a system in which they can do their best work and achieve success consistently, rather than occasionally and then only with luck or extraordinary effort.

In the middle, as always, are the poor and the homeless. They are always with us because they <u>are</u> us. Many of us who are now successful

were once poor, although we may have used the resources of supportive family and friends in emergencies. Most of the poor and many of the homeless are on their way to not being poor. It's a developmental process which, for some, has been delayed, sometimes chronically, by trauma, abuse, neglect, discrimination, addiction, disease, accident, genetics and other factors. The chronically poor wander, act out or hide out in a complex society where even the social services have become so specialized that they are inaccessible without a guide. Enough of us have overcome poverty and other obstacles to achieve success, however, so that we know it is possible.

This book is about how to make success a probability, instead of just a possibility, for more people at less cost. It describes a program model that prevents homelessness before it occurs and that, in the process, produces tremendous dividends for the whole community. This book is a "how to" manual for human service professionals and community leaders who want to make homelessness and chronic social distress things of the past by designing and implementing a preventive counseling program that:

--Reduces the community's emergency shelter requirements to just one bed per night per 10,000 population;

--Improves housing conditions and stabilizes neighborhoods;

--Increases the economic self-sufficiency of low-income households;

--Redirects community resources from crisis management to education and economic development;

--Creates a more efficient, effective social service delivery system;
--Stabilizes student populations so schools can focus on education;

--Prepares communities for welfare reform without increased homelessness; and

--Teaches clients to advocate for themselves and take responsibility for solving problems.

This prevention model can satisfy the interests of all three groups of stakeholders--government and the taxpayers it represents, human service providers and advocates, and the poor and homeless--and release them from their "danse macabre" in Hartford and other cities. It does this by stabilizing large numbers of people in their homes and neighborhoods--over 2% of the community is served annually--at the low annual per capita cost of $2. Most communities can finance preventive counseling without raising new money simply by reallocating existing resources.

As the community stabilizes, frustrations are relieved. Government can focus on education, infrastructure and economic development projects that support the whole community. Human service workers experience increased job satisfaction as they see real progress among their clients and they observe the impact of their work on the community. And, most importantly, more poor people find

productive, satisfying roles and become valued members of the community.

The title of this book contains terms that it might be useful to define. Although few people remain who measure wealth in livestock or grain, Few Sheep, Little Corn serves as a poetic metaphor for wealth in the United States. The word "poor" is derived from the Indo-European root, *pau-*, meaning few, little.[6] Sheep and corn are North American staples that occur in almost all geographical areas, cultural groups and historical periods. The ideas, prescriptions and model described in this study apply to communities in the United States, which is culturally diverse enough in itself to probably require some modification to the model by practitioners in their own communities. Although these ideas may have applications in other countries and cultures, their usefulness would be largely serendipitous.

We define people as homeless if they have no permanent place to live; if they live in a place not ordinarily used for human habitation; if they live in a shelter or hotel/motel paid for with vouchers for the homeless; or if they live in someone else's home but do not have a regular arrangement allowing them to stay there at least five days per week.[7] We define "family" broadly to encompass all household compositions including families with children, single individuals and households containing members unrelated by birth or marriage.

Homelessness is the most desperate and dangerous manifestation of poverty. It disturbs us not only because it displays publicly the hopelessness and extreme insecurity of the individual, but also because it

is symptomatic of a distressed and unstable community. A low incidence of homelessness is an indicator of a healthy, productive, stable community; and preventing homelessness, using the program model described in this book, contributes to and creates the conditions for regenerating healthy, productive, stable communities from distressed, destabilized communities.

By prevention we mean primary prevention--to use a term from the public health field--or intervention before homelessness occurs.[8] Therefore, the primary target population for our program to solve homelessness is people who are not homeless. We will address secondary prevention--facilitating the recovery of a stable home for the already homeless--as a necessary intervention that becomes less needed as primary prevention takes effect in the community. We consider tertiary prevention--ameliorating the ill effects of homelessness through emergency services such as soup kitchens--to be counterproductive to achieving health for the individual or the community because it enables people to remain homeless.

We are concerned with geographical communities represented by one or more political divisions, usually a small or medium city and surrounding towns or a neighborhood or district within a large city. A single prevention program office can serve a community of 25,000 to 250,000 people, with optimal size being 50,000 to 150,000. We will discuss why serving smaller populations is not cost-effective and why serving larger populations from one office is not case management-efficient. Communities with emergency shelter requirements exceeding three beds per night per 10,000 population will benefit most from a

homelessness prevention and community stabilization program.

Stable communities retain people long enough to establish diverse and supportive relationships and networks. Most residents and businesses choose to remain and make plans right there rather than moving away in search of opportunity. A stable community can absorb newcomers and can support a reasonable number of transients. The diverse, plentiful opportunities available in a stable, healthy community allow people to remain and contribute even as their incomes and interests change. In The Death and Life of Great American Cities, Jane Jacobs wrote:

> Cities need not "bring back" a middle class and carefully protect it like an artificial growth. Cities grow the middle class. But to keep it as it grows, to keep it as a stabilizing force, means considering the city's people valuable and worth retaining, right where they are, before they become middle class.[9]

The homelessness prevention and community stabilization program described in this book helps mostly poor families and individuals avoid homelessness and achieve their goals and aspirations. By serving large numbers of households efficiently and organizing diverse and complex resources effectively, it has a profound and rapid effect on the whole community. Homelessness disappears as a chronic, visible problem as emergency shelter requirements are reduced to just one bed per night per 10,000 population. Housing conditions improve as tenants are better able to pay their rents and responsible landlords maintain their buildings. Economic activity increases as businesses locate in safer, more attractive streets and neighborhoods. Unemployment declines, schools improve as

students move less frequently, and more voluntary and neighborhood associations form. Government resources can be redirected from crisis management to higher value-added investments like education, infrastructure and economic development. Urban communities become what cities have always been at their best--incubators of the middle class.

There is some empirical evidence that this homelessness prevention and community stabilization model works. Since 1990, it has been fully operational in North Adams, Massachusetts, serving a community of 40,000 people, under the name Family Life Support Center. During the 1980s, the North Adams area experienced severe economic dislocation due to factory closings and the departure of its largest employer. It is estimated that by the end of the decade, the emergency shelter requirements of the community had risen to over four beds per night per 10,000. Housing conditions had deteriorated dramatically and the community had among the highest unemployment, teen pregnancy, child abuse, alcoholism and suicide rates in Massachusetts.

Within five years, the Family Life Support Center assisted the North Adams community to achieve a 50% decrease in homelessness and a 75% decrease in emergency shelter placements. Emergency shelter requirements for the community are currently below one bed per night per 10,000. By stabilizing many hundreds of low-income families and individuals, the Family Life Support Center has contributed to the current economic and cultural rebirth of the community.

Although success in one relatively small community may not constitute compelling evidence that this homelessness prevention and

community stabilization model can have a far-reaching impact, it does suggest that success is possible elsewhere. During the 1990s, the nearby city of Pittsfield, with an effective population (city plus adjacent towns) of 75,000, experienced a similar economic dislocation when its largest employer downsized radically. Emergency shelter requirements reached six beds per night per 10,000. An influx of homeless households from Pittsfield to North Adams motivated the Family Life Support Center to establish an office in Pittsfield in late 1995. While it is too early to measure positive outcomes definitively, low-income households have responded well to outreach efforts and emergency shelter placements have declined for at least one shelter.

Solving homelessness is a problem of organized complexity. It requires dealing simultaneously with numerous factors and systems which are interrelated in an organic whole. It is not a problem of simplicity involving just two factors in a cause and effect relationship, nor is it a problem of chaos or disorganized complexity to which statistical methods hold the key. Individuals, families and communities each are comprised of complex, intersecting systems. Therefore, as systems break down they affect many other systems, creating negative feedback loops and sometimes destabilizing whole communities. But, conversely, as people stabilize and gain control of their lives, the impact goes beyond themselves and their families. They create the conditions in the community for others to achieve stability in the same way that trees holding and adding to the soil in a forest create the conditions for other trees to grow.

This is why the homelessness prevention and community

stabilization model presented here can contribute to regenerating any community. The pronoun "we" has been used throughout this manual to reflect the fact that the model has been developed, tested and refined by the dedicated case managers at the Family Life Support Center, stabilizing many hundreds of poor and homeless families and individuals. As the first director of the Center, my earlier work in New York City at Covenant House in the Times Square area and at Stanley Isaacs Center in the Yorkville/East Harlem area provided some components of the model and showed the need for a comprehensive, integrated, holistic and preventive approach to homelessness. Finally, an extraordinarily supportive, caring and visionary community in northern Berkshire County, Massachusetts provided a home and a laboratory for homelessness prevention and community stabilization.

This manual consists of seven chapters. The second chapter discusses the organizing principles of a successful homelessness prevention and community stabilization program. It makes two basic assertions that distinguish this prevention model from other, dominant approaches to the problem of homelessness. Then it outlines four operating principles that provide the essential structure and framework for this model.

The third chapter details the client services that a homelessness prevention and community stabilization program must offer. It shows where to find resources for staff and how to organize resources so they are useful. Chapter four shows how the program is structured so that the client services are integrated and effective. It describes client outreach, intake and assessment; it discusses how to leverage client responsibility

and how that relates to the art of counseling; it discusses the importance of a regular, frequent and formal case review and how to facilitate that process; it shows how to gather and analyze program statistics as part of the counseling and case management process; and it calculates the staffing requirements and program costs for communities of all sizes.

Chapter five addresses the role of the homelessness prevention and community stabilization program within the context of the whole community and specifically the social service community. It offers some ways to define the community's homeless problem, to describe the community in geographic, political, economic and demographic terms, and to map the relevant community resources. It discusses the prevention program's potentially competitive, cooperative and collaborative relationships with other stakeholders and it outlines some possible funding strategies.

The sixth chapter presents twelve cases that include a wide variety of factors and outcomes to illustrate the program principles and components described in preceding chapters.

Although this prevention model is derived primarily from many years of experience providing services to poor and homeless people, several writers and researchers have provided insights and paradigms that help explain and give context to our method. We have not referenced these books in this manual except when directly quoted, therefore, we want to acknowledge and recommend them here:

--Jane Jacobs, The Death and Life of Great American Cities (1961),

The Economy of Cities (1969), and Cities and the Wealth of Nations (1984). Provides an understanding of how cities work physically, socially and economically.

--Stephanie Coontz, The Way We Never Were (1992). A history of the American family that documents how households have always been interdependent and needed community supports.

--Lisbeth Schorr, Within Our Reach (1988). Illustrates the importance of comprehensive, flexible interventions that coordinate diverse resources for low-income, at-risk families.

--Mickey Kaus, The End of Equality (1992). Makes the case for work as the unifying, most generally accepted community value.

--Ronald Heifetz, Leadership Without Easy Answers (1994). A theory of leadership that views crisis and distress as opportunities for adaptive change; relevant for both counselor-client and prevention program-community relationships.

--Marvin Olasky, The Tragedy of American Compassion (1992). A history of American philanthropy and social services that emphasizes client responsibility and obligation as essential for positive change.

--Jacob Needleman, Money and the Meaning of Life (1991). Discusses money as a measure of the health of our relationship to family and community and as a mediator between our physical and spiritual lives.

--Christopher Jencks, The Homeless (1994). An analysis of research on and public policy affecting homelessness.

This homelessness prevention and community stabilization model makes the connection between individual responsibility and community resources. It can generate visible, measurable improvements in any community. To paraphrase Christopher Jencks, no program can ensure that everyone is happy and healthy at all times. But we can make sure that everyone who wants it has a home and a productive role in a healthy community. Because we can, we should.[10] Here's how.

Chapter 2: Organizing Principles

Many people think of homelessness as an intractable, unsolvable problem they have learned to live with uncomfortably. Some consider it an inevitable by-product of a free market economy that chooses winners and losers and encourages gross inequities among people. Others view it as one more manifestation of a permanent "underclass" that has resulted from poorly designed social welfare policies. This homelessness prevention and community stabilization model uses the vast resources of the free market economy and the social welfare system combined to help poor people avoid homelessness, take responsibility for achieving their goals and aspirations, and contribute to their communities.

In this chapter, we make two basic assertions that distinguish this model from other, currently dominant approaches to homelessness. We assert homelessness is not the problem, it is just the result of other, usually multiple problems in the household that have remained unaddressed. Therefore, to solve homelessness we must address these contributing problems before homelessness occurs, in households that are not homeless and may never become homeless. We also assert that the resources to accomplish this exist today, and homelessness can be solved now, in every community in the United States. We discuss four operating principles that provide the essential structure and framework for a successful homelessness prevention and community stabilization program: community access, comprehensive services, client responsibility, and case review.

Basic Assertions

1. Homelessness is not the problem.

Homelessness is not the problem, it is simply the result or symptom of the real problems. The root causes of homelessness are the multiple, unaddressed problems of a household before it ever becomes homeless. These problems include unemployment and underemployment, inadequate income, mental and physical disabilities, substance abuse, domestic violence, and poor life skills including budgeting, money management, parenting, homemaking, problem-solving and conflict resolution. Life skills deficiencies may precipitate events leading to homelessness such as utility terminations, family breakups, landlord-tenant disputes, excessive consumer spending, non-payment of rent, voluntary relocation or discharge from an institution without adequate resources, and other situations. Occasionally homelessness results from events beyond the control of the household such as fire, natural or industrial disaster, or acts of war or civil unrest but these are rare.

Some programs treat the symptom rather than the causes of homelessness. They offer tertiary prevention in the form of emergency food and shelter to relieve the hardships of homelessness and poverty, but do not address the root causes in terms of both the individual's life style and behavior and his access to the community's support system and resources. In recent years, many more programs have acknowledged and addressed the complex causes of homelessness by pulling together comprehensive supportive services for homeless households. They recognize shelter and housing are necessary but not sufficient to

permanently stabilize a household. However, they offer only secondary prevention because they provide services only to households that have already become homeless instead of to households before they become homeless.

The Stewart B. McKinney Act of 1987 is the federal legislation that enables much of the funding for programs for the homeless. The Department of Housing and Urban Development (HUD) administers the lion's share of these appropriations and also serves as lead agency for the Interagency Council on Homelessness (ICH), a collaboration of federal agencies administering homeless programs. The ICH report, Priority Home: The Federal Plan to Break the Cycle of Homelessness (1993), provides clues to why tertiary and secondary prevention still dominate homeless policy.

Most of Priority Home is devoted to the causes and demographics of homelessness and to a strategy for addressing homelessness that has come to be known as the "continuum of care." It offers communities a series of interventions from outreach through emergency shelter, transitional housing and permanent housing to move the homeless back into the community. To its credit, the plan recognizes the complex causes of homelessness and the need for comprehensive supportive services. However, while ranking prevention as a high priority, it admits to not yet knowing how to actually do prevention:

> As long as there are constant entries and reentries into homelessness, the size of the problem cannot be significantly reduced. The constant replenishment of the homeless population wipes out any

> evidence of program success. Better prevention would avert significant costs accrued in treating the consequences of homelessness. But a better understanding is needed of the efficacy of prevention measures, whom they serve, and under what circumstances they operate best.[11]

This book will provide a better understanding of the effectiveness, costs, clients and operations of primary prevention--intervention before homelessness occurs. In addition to reducing homelessness at a low annual cost, prevention effectively stabilizes communities by improving housing conditions, increasing economic activity and coordinating social services. Investing in primary prevention would make HUD's narrow goal of ending homelessness better serve its broader mission of supporting community development. However, this will require government to get over its reflexive need to segment the community and target narrow populations, like the homeless, for services. It will require recognizing homelessness was never the problem--the real work is helping all poor people remove personal and systemic obstacles to success so they can contribute to building healthy, stable communities.

2. Homelessness is resolvable now, with the resources available today in or near every community.

Much of the policy analysis and research on homelessness takes a deficit-based view of the problem, concluding that the combination of an inadequate supply of affordable housing and the declining purchasing power of low wages and income supports creates homelessness and makes it impossible to resolve. The search for housing and employment has become a game of musical chairs, a zero-sum game, in which *n* households

chase *n-1* resources and the weakest, most vulnerable, least adaptable people lose. Until housing and a minimum income become a right, it is often argued, homelessness can only grow.

The program model described in this book takes an asset-oriented view of homelessness prevention and community stabilization.[12] Communities vary in the resources available to them but virtually all communities that experience significant homelessness have the necessary ingredients in or near them to solve the problem: affordable housing, access to jobs and income supports, and supportive services including health, mental health and substance abuse services, elder and disability services, schools and educational programs, child care and child protection services, domestic violence and women's services, parenting and family planning services, youth programs, legal and financial services, religious and neighborhood organizations, and transportation and communication systems. Stephanie Coontz, discussing the historical importance of community supports, has written:

> The stereotypical solitary Western family, isolated from its neighbors and constantly on the move, did exist, but it was also generally a failure. Economic success in nineteenth century America, on the frontier as well as in the urban centers, was more frequently linked to persistence and involvement in a community than to family self-reliance or the restless "pioneering spirit." Mutuality and suppression of self-centered behavior, not rugged individualism or even the carving out of a familial oasis, were what created successful settlements as America moved West, while the bottom line of westward expansion was federal funding of exploration, development, transportation and communication systems.[13]

Many communities offer abundant resources to poor households but access to them is a complex research and administrative task most poor people, in fact most citizens and even many human service professionals, cannot master. These communities are like countries that grow food abundantly but where people starve anyway because of an inadequate or corrupt distribution system. Once poor households obtain consistent access to resources, they begin to stabilize in significant numbers and a positive feedback effect begins. As poor households stabilize, their presence in the community expands the very resources analysts of national statistics believe are so lacking. As rents are more consistently paid, affordable housing becomes more abundant. As people initially go outside the community for jobs, the money they bring back creates new jobs within the community.

This homelessness prevention and community stabilization model views poverty as a developmental stage in many people's lives that cannot be transcended simply or primarily by distributing cash assistance. This model helps poor people achieve the ultimately non-economic goal of dignified lives and believes this process builds healthy communities. Mickey Kaus has written:

> At some point, it will be obvious that [we] cannot succeed in reversing the inegalitarian economic trends. [We] will then either continue to tell Americans that their place on the income distribution tables is vitally important....Or [we] will tell the voters that money is ultimately not the most important thing about America, in which case [we] will learn to live with income differences while preserving the possibility of a more profound equality.[14]

This program model uses the combined private and public resources of the community, and of adjacent communities as well if necessary, to stabilize low-income households. It also recognizes poor people, in aggregate, are a powerful economic force in their communities. The program maximizes the choices available to clients by collecting and organizing information and resources and it expands and improves the available resources by helping clients select, through housing, budget and employment counseling and through social service and treatment referrals, the resources most beneficial and useful to them. As poor households select the products and services that contribute to their stability, the health and economic diversity of the community grows.

Operating Principles

An effective homelessness prevention and community stabilization program should apply four basic operating principles: 1) No eligibility requirements, allowing everyone in the community to receive services; 2) Comprehensive services that allow for "one-stop shopping" to solve any problem or combination of problems; 3) An emphasis on client responsibility for making positive life style changes; and 4) A commitment to high quality services and intensive, ongoing staff training through case review. Many programs incorporate one or more of these principles; but, it requires the dynamic interaction of all four to prevent homelessness efficiently and effectively and to maintain a stable, productive community.

1. Community Access

The goal of primary prevention is to stabilize households before homelessness occurs. Since it is not possible to accurately predict whose problems will lead to homelessness in the future, an effective homelessness prevention and community stabilization program must be prepared to provide services to everyone in the community without regard to homeless or housing status, income, family composition, length of residency or other factors. It should establish no eligibility requirements or barriers for service.

Most programs target their services to limited, specific segments of the community such as the already homeless--making them secondary prevention programs at best--or only families with children, single individuals, low income households, families with housing subsidies, families receiving public assistance, the unemployed, the mentally ill, substance abusers, veterans, battered women, etc. Such programs may be essential components of the community's total resources--what we call "specialty providers"--to which the homelessness prevention and community stabilization program will make referrals and from which it will receive referrals. However, without a prevention program open to all members of the community clients must navigate a complex array of programs and eligibility requirements on their own. They may become discouraged and not seek out services until their problems reach crisis proportions--until they become homeless. Lisbeth Schorr has written:

> Many services have been reduced as a result of budget cuts, but their weaknesses go deeper than budgets. The kind of schools, preschools, day

> care, health clinics, and social services that might help are, with a few stellar exceptions, simply not reaching those who need them most. Cost constraints, market pressures, and bureaucratic rigidities operate to make services too narrow, too fragmented, too hard to obtain, and out of synch with the needs of traumatized families.[15]

It is also more cost-efficient to make prevention available to the whole community rather than to target segments of the population. Populations that have been denied resources and services due to eligibility restrictions will survive by becoming dependent on, sometimes preying on, members of groups that are eligible for services. For instance, when single women with children are targeted for services but single men are not eligible, some men will survive by preying on women who have access to resources. This destabilizes the very households on which so many resources and services were expended. In contrast, when the needs of all members of the community are addressed, each additional stable household contributes to creating the conditions for other households to achieve stability.

Every household in the community, regardless of its special circumstances, has the same basic needs--housing and an income. When we target special populations to address basic needs, we create programs that duplicate efforts and we require people to figure out for themselves where in this complex system their basic needs can be met.

It is also important to achieve maximum accessibility to compensate for the fact that many clients will perceive this program model as unresponsive when it requires them to take personal responsibility for resolving problems and making positive life style

changes as discussed below under "client responsibility." Clients are routinely required, or "leveraged", to reduce unnecessary spending, actively seek employment, repay accumulated debts, continue their educations, attend counseling and treatment programs, and participate in community activities in return for the services provided by the program.

Eligibility requirements sometimes have the perverse effect of motivating people to create the crisis or conditions that will make services available to them. There is some evidence, for instance, that some families have let themselves become temporarily homeless in order to access housing subsidies. Welfare reform has been partly motivated by the perception, accurate or not, that eligibility for public assistance benefits may be a factor for some people in the decision to have children. This program model uses community resources to encourage positive life style changes and begins that process by making services completely accessible to all groups within the community.

Many programs devote significant resources to determining eligibility. A prevention workshop participant who is a nurse offered this image: this program model is like an inverted funnel with a narrow opening where few resources are expended on determining eligibility--if you're alive and breathing in the community, you're eligible--and with a wide exit from which emerges a cornucopia of services. Many programs are like a traditional funnel where enormous resources are expended at the front end separating the eligible from the ineligible and out comes a little pellet of service.

Community access is affected by three factors in addition to

eligibility: location, outreach and responsiveness. Each is discussed in detail later. A successful homelessness prevention and community stabilization program must be physically accessible to potential clients by locating in the commercial and transportation hub of the community. Desperate clients who are homeless or nearly homeless may be willing to walk a mile or more or take two buses or trains to reach a program. However, our goal is to attract clients before their problems become desperate. Outreach through fliers and brochures should be ongoing and targeted to places poor people go rather than depending only on referrals from other agencies, and staff need to respond quickly to requests for services by setting appointments within one to three business days.

2. Comprehensive Services

Since primary prevention programs address the root causes of homelessness, they must be prepared to respond to a wide array of problems and to individually tailor and organize services for each unique household. To be comprehensive, prevention programs should offer:

a. *Housing Services*
   --Housing search assistance
   --Landlord-tenant and utilities mediation
   --Financial assistance

b. *Income Services*
   --Employment counseling
   --Benefits advocacy
   --Budget counseling

c. *Specialized Services*

--Referrals for specialized services

--Life skills counseling

--Emergency shelter

Solving homelessness and stabilizing households is a problem of organized complexity which requires dealing simultaneously with numerous factors and systems that are interrelated in an organic whole. Individuals and families are comprised of complex, intersecting systems. As systems break down they affect other systems and destabilize the household. Just as the most efficient way to stabilize the community is to make services available to all groups instead of targeting only select groups, the most efficient way to stabilize a household is to address all the interdependent systems or components of the household. Otherwise, the work done with a household in one area, such as housing, is undone by neglecting another area, such as employment. Lisbeth Schorr gives an example of this common dynamic:

> Striving for efficiency by deploying personnel to focus on sharply defined, single problems, bureaucracies fragment services into absurd slivers. In 1986, New York City's Office of Family Services had twenty-two full-time employees working exclusively as "utility disconnect caseworkers," whose task it was to assess a family's utility situation and arrange, in hardship cases, for restoration of gas and electricity, canceled for failure to pay. The workers' mandate did not include responding to any family needs except those associated with the inability to pay utility bills. As a result, these cases tended to reappear in the agency's offices with their utilities again disconnected or with other

serious problems.[16]

Obviously, a program to solve homelessness must address housing. This program helps clients find affordable and appropriate housing rapidly and helps clients keep their housing by mediating with landlords and utility companies. However, it is not enough to find housing. Clients must have incomes adequate to pay for their housing in the long term. This program helps clients to obtain an income through employment or benefits and teaches clients to budget for their needs and manage their money effectively. Most clients come to the program with personal and systemic obstacles to obtaining an income and securing housing. These may include mental illness, substance abuse, physical disabilities, learning disabilities or many other factors which must be resolved or stabilized through case management.

If the prevention program tried to address all these issues by itself it would need a staff of hundreds including doctors, lawyers, psychiatrists and other specialists. Instead, it is able to offer comprehensive services efficiently--using just one counselor per 25,000 population--through a combination of direct counseling (organizing the client's personal resources) and case management (organizing the community's resources for the client through referrals and by coordinating the work of other agencies). The next chapter discusses each service--housing, income and specialized services--in detail and shows where to find resources and how to organize them so they are useful.

This prevention model finds a solution for any problem or crisis presented by a client. If the program cannot solve the problem directly, it

finds the solution in the community. And if it cannot find the solution, it creates the solution. The prevention program's tenacity in working for clients can be humorously described by paraphrasing a character's description of the Terminator, a machine from the future that hunts and kills human beings, from the science fiction film of the same name: "That prevention program is out there. It can't be bargained with; it can't be reasoned with. It doesn't feel pity or remorse or fear. And it absolutely will not stop, ever, until your problem is solved." More seriously, a prevention counselor needs to be a little like the protagonist of Kurosawa's film, 'Ikiru", who politely but relentlessly persists against all odds and bureaucratic indifference until a playground has been built in a poor neighborhood. Providing comprehensive services to the whole community is natural for a homelessness prevention and community stabilization program since it addresses the most basic needs--housing and income--which are shared by every person, rich or poor, in the community.

3. Client Responsibility

This prevention model views the crises experienced by homeless and at-risk households less as problems requiring immediate solution than as opportunities to leverage positive life style and behavior changes that will make future crises less likely. The program uses the client's distress to keep the client focused on the real work of finding permanent solutions to the root causes of the crisis. People are more likely to consider adaptive solutions that challenge their established behaviors if they feel the sense of urgency brought on by crisis. However, clients must first be both leveraged and supported to overcome the tendency to

avoid change and seek easy, short-term solutions to problems. Ronald Heifetz has written:

> People fail to adapt because of the distress provoked by the problem and the changes it demands. They resist the pain, anxiety, or conflict that accompanies a sustained interaction with the situation. Holding onto past assumptions, blaming authority, scapegoating, externalizing the enemy, denying the problem, jumping to conclusions, or finding a distracting issue may restore stability and feel less stressful than taking responsibility for a complex challenge. These patterns of response to disequilibrium are called work avoidance mechanisms in this study....[17]

People often initially perceive the program as an authority with sufficient resources to solve their problems painlessly, without any investment from them. Few, if any, programs have the resources to do this for the entire community. It is extremely important to maximize the use of personal, family, neighborhood and community resources to prevent homelessness and re-establish homeless households in the community. It is equally important to motivate clients by leveraging them to change their behaviors, adopt generally accepted community values and norms, and make effective and responsible use of available resources.

Programs that offer resources and services free of obligation or responsibility for change on the part of the recipient are worse than ineffective--they are counter-productive or iatrogenic. They perpetuate long-term dependency and actively contribute to household and community destabilization. Christopher Jencks has written:

> By the late 1980s America had created a network of shelter and soup kitchens that serviced between 200,000 and 300,000 people a day. These institutions tried to improve the lives of the homeless, and they apparently succeeded. When the cost of something falls, demand usually rises. That truism holds regardless of whether the costs are monetary, emotional or physical. When the expected cost of crime or adultery falls, more people engage in them. When homelessness becomes less painful, people are less willing to sacrifice their pride, their self-respect, or their cocaine fix to avoid it.
>
> Those who see the homeless as passive victims of circumstances beyond their control often react to this argument with a mixture of fury and disbelief. To say that people choose to become homeless seems indecent. But the homeless are not just passive victims. They make choices, like everyone else. The choices open to the homeless are far worse than those open to most Americans, but they are still choices.[18]

Programs that view homelessness from an emergency services perspective often assume the homeless are passive victims of acts of God or nature, or that they are hopelessly deficient and needy people. They offer tertiary prevention in the form of emergency food and shelter to relieve the hardships of homelessness and poverty, but they do not address the root causes. This results in anomalies such as increasing demand for emergency food and shelter even in years of economic health and low unemployment.

Advocates who view benefits and subsidies as ends in themselves measure success by how much wealth can be redistributed from the haves to the have-nots through advocacy, legal action and legislation. They may assume the poor are passive victims of a society unable or

unwilling to provide for all of its members. This approach can result in outcomes that violate community norms, such as advising a parent not to require her adult son to find a job because the additional income may disqualify them for a housing subsidy.

This prevention model places the responsibility for resolving homelessness squarely on the client. Overcoming poverty is a developmental process that involves changing personal behaviors and adopting community values as well as using abundant public and private resources effectively. The program has four basic commodities to exchange for responsible behavior and positive life style changes: information, counseling, advocacy and intervention. Each requires a higher level of performance and commitment from the client.

To obtain information which includes access to employment, housing and financial resources simply requires non-threatening behavior from the client. For information to be useful, however, most clients will need a counseling relationship to select, interpret, organize and apply the information effectively. Client responsibility is fostered in every interaction with the prevention program. For example, to maintain the counseling relationship the client must arrive on time for appointments. For counselors to advocate for clients by using their influence and relationships with service providers, landlords, employers, utility companies, and other members of the community, clients must successfully complete specific tasks as part of a service plan such as submitting job applications, completing a resume, viewing apartments, attending treatment appointments, implementing a budget plan, volunteering in the community, etc. Interventions such as emergency

shelter, money management and financial assistance may require clients to temporarily forfeit their ability to make some life style choices until the crisis is resolved.

The services provided by prevention programs cannot be offered as entitlements--the program must be willing and able to withhold resources and services from clients who refuse to follow through responsibly on a service plan. An often used saying among program staff is: "If all your clients are happy, you're not doing your job." This does not mean, however, clients are rejected by the program. In compliance with the community access requirement, the door is always open to clients who want to negotiate their service plans. The art of counseling involves motivating each client to do the maximum possible work toward implementing permanent solutions to problems without overwhelming clients beyond their abilities to function or enabling them to avoid substantive change by doing too much for them or protecting them from the consequences of their choices.

Each service plan is individually tailored to the needs, aspirations and abilities of the client. Whereas a high-functioning client might be expected to conduct an intensive job search while at the same time participate in substance abuse counseling, a chronically or acutely mentally ill client might initially be expected to simply take his daily medication in return for services. The emphasis on client responsibility does not at all diminish, and actually facilitates, warm and supportive counselor-client partnerships that advance the sometimes unavoidably painful work of making positive, permanent life style changes. Many clients exit the program with the self-knowledge and self-confidence that

come from achieving their goals through their own efforts and commitment.

4. Case Review

Using the vast public and private resources of the community to increase the capacity of clients to prevent and solve their own problems is the core competency and dynamic of this prevention model. It requires extensive knowledge of the community's economy, housing stock and social service infrastructure. It also requires a repertoire of counseling techniques and strategies to manage the distress of clients in crisis and overcome their work avoidance mechanisms. The training and support to develop these skills and resources is provided for and by staff in the weekly case review.

Case review is a meeting of prevention counselors and program managers during which information and service plans of client households are presented, reviewed and modified using up-to-date case notes and statistics. Case review brings the full experience and creativity of the staff to bear on each case so options and opportunities are maximized for each client. It also provides intensive, ongoing support and training for staff while reducing the need for isolated decision-making by individual case managers.

This prevention model uses a holistic, rather than an assembly line, approach to case management. Each counselor is a generalist instead of a specialist, trained to provide the full array of counseling and case management services. This reduces the duplication of effort that occurs

when housing, income and case management services are divided among specialists since, for instance, good housing counseling requires an understanding of a household's income and budget. It also ensures the case management for a household is the responsibility of one identifiable and accountable counselor, and it reduces staff turnover by keeping their jobs varied and interesting.

Case review is the quality control mechanism of this prevention model. Decisions to provide or withhold resources and services may have life-threatening outcomes in a program that addresses basic needs like food and shelter. Many programs have handled this danger by making food and shelter entitlements without a concomitant obligation from the client to change the behaviors that led to the crisis. This prevention model applies the ideas and experience of several counselors to these decisions through case review to reduce the chances of tragic outcomes. The same process results in constant sharing and cross-fertilization of ideas and resources between counselors to find safe and effective ways for clients to take responsibility for their own lives. This prevention model is not a perpetual motion machine; it requires constant inputs of energy through the weekly case review to train counselors and develop effective service plans and extensive resources.

By applying the four operating principles--community access, comprehensive services, client responsibility and case review--homelessness prevention and community stabilization programs can be extremely cost-effective and can produce benefits for the community far exceeding reduced homelessness, including improved housing and increased economic activity. A single prevention counselor can serve

200-250 households annually and stabilize a population of approximately 25,000. Our experience suggests that the program can eliminate street homelessness in any community within two years and, in communities where emergency shelter placements are made exclusively through the prevention program, reduce emergency shelter requirements by 20%-25% annually until they reach just one bed per night per 10,000 population. The cost of homelessness prevention and community stabilization is approximately $2 per capita annually, and it can reduce the annual cost of emergency shelter for the community to less than $2 per capita as well.

Chapter 3: Client Services

This homelessness prevention and community stabilization model provides services using a combination of direct counseling--organizing the client's personal resources--and case management--organizing the community's resources for the client through referrals and advocacy. It collects and makes available all the public and private resources of the community including employment and housing opportunities, benefits and subsidies, and health, educational and other human services. It trades access to these resources for life style and behavior changes from clients that will make future crises less likely. Client services may be divided into three general areas: housing, income and specialized services. In almost all cases, clients will need assistance in more than one area to resolve problems and stabilize in the community.

1. Housing Services

The purpose of housing services is to help clients find adequate, affordable housing rapidly and prevent clients from losing their current housing. There are three components to housing services: housing search assistance, landlord-tenant and utilities mediation, and direct financial assistance.

HOUSING SEARCH ASSISTANCE

To find housing as rapidly as possible, clients need access to comprehensive information about available rental units. A successful

housing search is, in large part, a matter of probabilities, a numbers game--the more housing one knows about and views, the more quickly one will find satisfactory housing. This prevention model uses two primary sources of housing information: 1) rental listings from the classified sections of local newspapers, and 2) cold-calling landlords from lists created from the property ownership and tax records of cities and towns. Clients are, of course, encouraged to use their networks of personal contacts, also.

The weekly apartment list (as it has come to be called by staff and clients) is created from the Sunday and Monday local newspapers and then updated two or three times during the week from daily and weekly newspapers. Classified ads for apartments that are affordable for the general client population are clipped from newspapers and taped in columns to a blank sheet of paper. The original is then photocopied for use by staff and clients in the search for housing. The apartment list has several benefits--it keeps staff constantly updated about the local housing market; it focuses clients on affordable apartments and makes the classifieds easier to read and analyze; it gathers information from many sources, including obscure but important neighborhood weeklies, into one comprehensive, inexpensive, easily accessible document and saves clients the cost of purchasing many newspapers.

The landlord list consists of the names and phone numbers of many hundreds of owners of multiple unit properties within and near the community served by the prevention program. This list includes all the housing authorities and subsidized housing projects in or near the community as well. It is researched and updated bi-annually from the

property ownership and tax records of cities and towns. These records typically include owners' home or business addresses but not their phone numbers, so these must be obtained from telephone books or the Internet. Researching the landlord list is a time-consuming project, often best done by volunteers, however one list can usually serve more than one prevention program in adjacent communities or in neighborhoods within the same city.

Together, the apartment list and the landlord list are powerful tools for maximizing the options of poor people in the housing market. Helping large numbers of poor households find adequate and affordable housing removes housing problems as an obstacle for many people so they can begin addressing higher value-added issues such as employment and education. It also shapes the local housing market as responsible landlords are rewarded with referrals, and potential tenants are directed away from slumlords. Programs that do not adequately research the housing market often work with just a few large landlords with many properties. This gives landlords a market advantage, in effect artificially decreasing supply, and sometimes consigns poor households to doing business with predatory landlords.

Some programs and advocates for the poor have given up on the private market as a source of affordable housing. They depend entirely on publicly subsidized housing, resulting in long delays in finding housing and long stays in emergency shelter. It is true that affordable private housing is a scarce or negligible resource in some neighborhoods and communities, and accessing subsidized housing should be part of any housing strategy for poor households. However, we have found that affordable, unsubsidized private housing can be located with careful

research, in adjacent or nearby neighborhoods or communities if necessary. Christopher Jencks has written:

> Vacancy rates were slightly higher in unsubsidized low-rent units than in more expensive units throughout the late 1980s. This pattern recurs when we focus on the East and West Coasts, where homelessness was most common. It also recurs when we look at metropolitan areas with more than a million residents....How are we to explain the fact that vacancy rates in low-rent housing remained high at a time when rent was rising faster than income? The simplest explanation is that rents rose because tenants no longer wanted to live in the kind of housing private landlords could provide for under $250 a month. Dissatisfied with what they could find at the price, tenants chose to pay more rent, even though that left them with less for everything else. Such a change in priorities could have had at least two sources: rising expectations about the physical quality of housing and growing aversion to bad neighborhoods.[19]

Although some clients will successfully find housing once provided with information from the lists, many clients will need counseling to use the information effectively. Most housing search assistance is conducted with budget counseling, described later, to ensure that clients rent apartments they can afford. Many clients need help understanding their rights and responsibilities as tenants and the federal, state and local laws that address non-discrimination, eviction procedures, health and building codes, etc. Some clients need assistance organizing their housing search including scheduling viewing appointments, finding streets and neighborhoods and arranging transportation, presenting their housing histories and financial situations in the best light, completing applications, obtaining receipts for deposits, and even improving their initial telephone presentation and keeping a

record of their contacts. Clients often need help thinking through the qualities of a good apartment, building or neighborhood and the particular housing needs of their household.

The prevention program will sometimes help clients negotiate a more affordable rent before taking an apartment. When this is done for hundreds of households over several years, it drives rents down by making landlords compete with each other and educates landlords about what poor people can afford, resulting in more affordable housing for the community as a whole. Counselors will also need to advocate with landlords to consider taking as tenants some clients, especially those with histories of eviction for non-payment or other violations of rental agreements. This is an opportunity to change the habits and behaviors of clients that lead to housing crises by trading advocacy for commitments from clients to participate in budget counseling, substance abuse treatment, employment counseling or other relevant activities. Many landlords are willing to rent to high-risk tenants if the prevention program can show the client is committed to making changes. They are also interested in maintaining a good relationship with a prevention program that can be a referral source for potential tenants and that can resolve problems with current tenants. There is even a role for a small number of landlords who do not maintain their properties well and who are not selective about tenants as the housing of last resort for clients who often violate tenancy agreements and are not ready to adopt values that would give them access to better housing.

LANDLORD-TENANT AND UTILITIES MEDIATION

Resolving problems between landlords and tenants before they result in eviction or the tenant vacating the housing is a cost-effective way to prevent homelessness. Landlord-tenant mediation most often addresses a rental arrears or other dispute that may have resulted from inadequate income, poor budgeting skills, a temporary financial setback or emergency, property damage, disputes between neighbors, or purposeful nonpayment due to alleged or actual housing code violations by the landlord.

Often the prevention counselor, based on knowledge about the client's budget and housing needs from a thorough intake and assessment, will coach the client in negotiating with a landlord or directly negotiate a repayment plan for rental arrears or damage that is within the client's budget capabilities but that satisfies the landlord's needs sufficiently to retain the tenant. Sometimes there will be additional conditions, required by the landlord or, more often, by the prevention program as a condition for advocacy, such as participation in counseling, treatment or education to address the root causes of the housing crisis. The same process applies to negotiating repayment plans or rescheduling mortgage payments for clients who own their homes.

When a tenant has complaints about a landlord's housing code or rental agreement compliance, the prevention counselor's first step is to coach the client in negotiating or directly negotiate compliance from the landlord. If necessary, the prevention counselor helps the client use the housing and health code enforcement mechanisms of the locality and document violations and communications. This may also involve helping the client to establish an escrow account for withheld rent.

All landlord-tenant mediation begins with the prevention counselor helping the client assess whether the current housing is affordable and whether it is preferable to find alternative housing rather than make the effort to repair relations with the current landlord or, in the case of homeowners, keep the house. A program with comprehensive resources for a rapid housing search gives the client this option. In cases where the prevention counselor and client cannot negotiate a resolution with a landlord but the client wants to remain in the apartment or obtain restitution, a settlement will need to be reached through the court system. Some communities offer formal landlord-tenant mediation using a trained mediator or attorney as an objective third party to negotiate a settlement that is entered as a judgement in district or housing court. If mediation is either not an option or unsuccessful, the client will need legal counsel, often through legal services or a pro bono attorney, to which the prevention program should be able to make a referral.

To be habitable, housing requires heat, electricity and water. Utilities mediation involves negotiating repayment plans for arrears with utility companies so that services are not interrupted or terminated and ensuring clients are accurately billed and services are adequate. It also involves helping clients and sometimes landlords achieve savings by changing usage patterns and making physical modifications to the housing.

The process for negotiating repayment plans for utilities is the same as for rent or mortgages. The prevention counselor needs a

complete understanding of the client's income and expenses to know why the arrears occurred and what is affordable for the client. The mediation process is an opportunity to leverage the client to change behaviors and participate in counseling, treatment or education to address the root problems and prevent future crises. The prevention counselor also teaches clients simple ways to reduce the cost of utilities, and refers clients and landlords to energy conservation programs to install energy-saving devices.

The prevention program provides a housing information package for clients called "Finding and Keeping an Apartment". It addresses housing search techniques, tenant rights and responsibilities and some homemaking tips, and it includes the state housing code in checklist form. The prevention program can also offer direct financial assistance for first month's rent and security deposits or to avert evictions by helping to pay rental or utilities arrears, as well as provide free furnishings, housewares, food and other materials donated by the community.

FINANCIAL ASSISTANCE

This prevention model views financial assistance as an investment in a household's future ability to live independent of the social service system and make a productive contribution to the community. Financial assistance is not an entitlement and, as an intervention, it is a last resort--after information, counseling and advocacy--in resolving a housing crisis. Financial assistance is offered as a no-interest loan with a repayment schedule that is within the client's budget capabilities and,

therefore, may be long-term with payments as low as a dollar a month. Financial assistance is almost always combined with a cash contribution from the client and a repayment plan or partial forgiveness from the landlord or utility. This spreads the burden among several stakeholders, including the client to emphasize responsibility for resolving problems, and minimizes the prevention program's expenditures.

Like any lender or investor, the prevention program needs to see a plan ensuring the money will achieve the intended results. This is known as a "service plan" in this prevention model and it details the steps the client will take to prevent future crises. The service plan is designed by the prevention counselor and the client and they work together to successfully implement it. The plan usually consists of four broad components: 1) a housing plan to find or maintain an adequate, affordable place to live; 2) a budget plan to balance income and expenses and manage money effectively; 3) an employment and education plan to find a productive role in the community; and 4) a counseling and treatment plan to address a wide range of life skills and health issues.

Many programs provide financial and material assistance as an immediate response to crisis to reduce the client's distress and protect the client from the pain of his situation. It is also the easiest, fastest response when available and it requires the least knowledge about the community's resources and systems or effort by the provider. However, when applied reflexively, it creates dependency and misses the opportunity for the client to learn from the crisis and consider and implement permanent life style and behavior changes that would make

future crises less likely. Several writers with very different perspectives arrive at the conclusion that financial and material assistance is most effective when it involves a relationship of mutual obligation. Stephanie Coontz, in discussing welfare, has noted:

> Psychological studies show that aid...which allows [the recipient] opportunities to reciprocate [has] positive rather than negative effects upon the recipient--among them subsequent attempts at self-help on his part. (Goodin, 1985)[20]

Marvin Olasky, reviewing the history of American charity, has written:

> The New Orleans Charity Organization Society emphasized "personal investigation of every case, not alone to prevent imposture, but to learn the necessities of every case and how to meet them" and printed on its annual reports statements like, "Intelligent giving and intelligent withholding are alike true charity." Only discernment on the part of charity workers who knew their aid-seekers intimately could prevent fraud. Baltimore charity manager Mary Richmond wrote that her hardest task was training volunteers. Volunteers had to learn that "well-meant interference, unaccompanied by personal knowledge of all the circumstances, often does more harm than good and becomes a temptation rather than a help." Discernment by volunteers and organizational barriers against fraud were important not only to prevent waste but to preserve morale among those who were working hard to remain independent.[21]

Jacob Needleman, discussing the role of money in connecting the material and the spiritual, has written:

> Money was invented to allow contact and exchange between fundamental aspects of human life, the material, external life and the internal life, in the sense of man's relationship to God within and above....But used wrongly, money prevents relationship, prevents exchange between certain essential elements of the whole life. As a drug, money can simply substitute an external reconciliation for an internal confrontation of forces. It can solve problems where what is needed is the experiencing of questions....Money fixes things, but not every difficulty in life should be fixed. There are some difficulties that need to be lived with and experienced more and more consciously.[22]

2. Income Services

It is not enough to find housing, clients must have incomes adequate to pay for their housing and other needs in the long term. This prevention model helps clients to obtain an income through employment or benefits and teaches clients to budget for their needs and manage their money effectively.

EMPLOYMENT COUNSELING

This prevention model projects the value that work is better than welfare. A service plan largely consists of counseling and case management that positions the client to make a contribution to the community and achieve independent living and economic self-sufficiency through employment. We believe "value-neutral" counseling is not possible or desirable, therefore, the program consciously and deliberately projects generally accepted community values. The most important and universal of these is that work is the basis for full, adult participation in a

democratic community. Mickey Kaus has written:

> We're looking for a value, shared by rich and poor alike, on which to build an egalitarian life. It seems to me that there is only one real candidate: work....The work ethic poses a test that anyone, rich or poor, smart or stolid, can pass....
>
> When Jesse Jackson wants to move a national audience, he doesn't talk about race or poverty or "kids" or the "middle-class squeeze"....He talks about maids and janitors who "work everyday." The values of work and social equality are not, need I add, unrelated. Ask most Americans why they feel they're as good as anyone else and the answer will be that their family works to pay the bills. This ethic isn't abstract. It is how the vast majority of voters themselves survive and try to prosper.[23]

Helping people to find employment, like housing, begins with extensive, up-to-date information. The prevention program produces a weekly "job list" consisting of classified employment ads from Sunday and Monday newspapers photocopied and updated from daily and weekly newspapers published throughout the week. The job list gathers employment information from many sources, mainly newspapers, into one easily accessible, free document for clients. It is an important tool for teaching and learning about the local economy and job market and helping clients compare and match their skills and aspirations with reality.

The job list is supplemented by cold-calling employers from yellow pages listings relevant to the client's interests. The yellow pages of the telephone book give another important overview of and access

point to the local economy. We sometimes jokingly say to job-seekers: "The yellow pages is the bible of a capitalist economy. You live in a capitalist economy. Read your bible everyday." Cold-calling from the yellow pages may, of course, be further supplemented by applying at businesses door-to-door in commercial districts and by the client's personal network of contacts through friends and family. Clients are also referred to state and private employment agencies to access their data bases and job development services.

The program prepares a resume for each client who is conducting an employment search. The prevention counselor helps the client reconstruct her employment history and educational background and articulate her skills, hobbies and interests. The client usually prepares a handwritten draft of the resume that is then typed and photocopied by the counselor. The program uses a standard resume format that is part of the employment information package given to clients called "How to Find a Job".

Counselors help clients develop effective interviewing skills that highlight their strengths and obtain useful information about the employer and the job. They develop strategies for handling difficult questions about issues such as criminal records, job terminations, incomplete education, etc. Clients learn about appropriate appearance and hygiene for interviews as well as basic information about interviewing such as not bringing friends or children to interviews, not smoking or chewing gum, and how to sense when the interview is over. Clients are debriefed following their interviews to further refine their skills and counselors help them develop a schedule for contacting

employers following interviews and applications. Counselors also address a wide range of employment retention skills with clients including problem-solving and conflict resolution, employer expectations and business decorum.

Clients may use telephones in the prevention office to call employers and set up interview appointments, as well as to call landlords for housing and to make other calls relevant to advancing their service plans. Therefore, the prevention program should have one or more telephones not assigned to counselors and available for client use. This gives counselors an opportunity to help clients refine their telephone skills and presentations and overcome clients' anxiety about conducting business on the telephone. A prevention program should also have the ability to overcome logistical obstacles to successful employment searches. Street maps and public transportation schedules should be available in the office. Clients may need clothing or temporary child care for interviews and may need transportation money. The program helps clients organize their personal resources to solve these problems and may also provide assistance directly or through referrals to agencies that specialize in these services.

Some clients may want or need additional education or training to achieve their goals or be competitive in the job market. Prevention counselors help clients develop employment and education plans that not only satisfy the immediate need for income but position clients to find productive, fulfilling, meaningful work if possible. Prevention counselors make referrals to high schools, colleges, high school equivalency programs and job training programs. Using many of the

same resources and techniques as for employment counseling, they also help clients who receive benefits find volunteer and community service placements with both non-profit and for-profit businesses. Through community service clients can obtain work experience and get training in specific skills, develop contacts with employers that can lead to paid employment, and make a productive contribution to the community.

Job development, in which employers agree to list job openings with the program and the program screens and recommends applicants, is a form of advocacy. A prevention program could provide this service directly or refer clients to a program or agency that specializes in job development, depending on the availability and quality of that service in the community.

Theoretically, the prevention program could refer clients out for the entire employment counseling component and, for that matter, budget counseling and even all the housing services if they were available from specialty providers in the community. However, this would leave little or no concrete, direct services with which to build a counseling relationship sufficient to leverage positive changes in client life styles and behaviors that will prevent future crises. The program would be primarily an information and referral service, unlikely to attract enough clients to impact the rate of homelessness in the community. The task of tracking client performance and progress in the key areas of housing and income would require complex inter-agency coordination. Specialty providers do not often address problems outside their specialty even if they become obstacles to providing their service, leaving clients to navigate a complex system of service providers on

their own. The core housing and income services described in this chapter are, in our experience, the optimal mix of direct services to prevent homelessness and stabilize communities.

BENEFITS ADVOCACY

Annually, about half of prevention program clients have temporary or permanent disabilities or caretaker responsibilities that make them eligible for cash benefits. These income supports are available through the federal Social Security Administration and Veterans Administration and through public assistance programs administered by the states. In addition, non-cash or voucher benefits may include food stamps, housing subsidies, fuel assistance, medical insurance, child care, tuition, clothing and transportation. The purpose of benefits advocacy is to ensure that clients obtain the benefits for which they are eligible. This involves making information available and assisting clients with the various application and appeals processes.

The Social Security Administration manages three major income support programs: Social Security Disability (SSD) for people who are disabled but who have previously worked and contributed to social security through payroll deductions; Supplemental Security Income (SSI) for people who are disabled and have not made sufficient payroll contributions to social security; and Old Age and Survivors Disability Insurance (OASDI) for people who have retired from the work force due to age or for the dependent survivors of workers who have died. The Veterans Administration provides income supports for veterans with service-related disabilities.

The federal government has recently redesigned its public assistance program, formerly known as Aid to Families with Dependent Children (AFDC), now called Temporary Assistance to Needy Families (TANF). Formerly, AFDC was a program with rules set by the federal government and followed by all states. Under TANF, it is a block grant with a few broad guidelines within which each state can design its own program. Therefore, eligibility, amount of assistance, length of time on assistance, and activities required of participants vary from state to state. In addition, each state has a different program for temporary aid for adults without children.

The social security and veterans programs provide permanent benefits to disabled individuals. The state public assistance programs provide temporary benefits to families and individuals who are unable to work for a number of reasons including temporary disability and caretaker responsibilities. This prevention model collects information directly from the federal and state agencies operating the benefits programs and makes it available to clients. Prevention counselors stay up to date with changes in the benefits programs. Many state and local legal services offices have prepared accurate summaries of the changing benefits programs which are an excellent source of current information.

Prevention counselors help clients complete the application processes for benefits which may include collecting medical records, wage histories and other documents as well as writing the application. For example, recently the Social Security Administration eliminated chronic substance abuse as an eligible disability for SSI. It has been

very important to assist clients affected by this change to document their eligibility under other disabilities when they exist and to compile a thorough and compelling application. In almost all cases, our counselors have actually written the application for clients to minimize the number of rejections. The eligibility rules governing benefits programs can be complex and it is not uncommon for clients to be mistakenly denied benefits. Without advocacy by a knowledgeable prevention counselor, many clients will accept these determinations and experience unnecessary hardships such as homelessness.

This prevention model views publicly funded benefits as it does direct financial assistance to clients by the program--as an investment in the client's future ability to make a productive contribution to the community. The program is supportive of new federal and state legislation setting time limits on and work requirements for public assistance benefits. Prevention counselors are proactive about determining the benefits remaining to clients and helping them use their time effectively to obtain education, training and employment. Even for clients with permanent disabilities who receive SSI, prevention counselors encourage and, in the case of those receiving money management services described below under "budget counseling", require clients to find productive roles and obtain work experience by volunteering in the community or finding part-time employment.

BUDGET COUNSELING

It is not enough to obtain housing and an income. Clients must be able to manage their money effectively or they will continue to

experience the crises that lead to homelessness. Budget counseling is not a service consistently offered to low-income households in most communities. Yet, money management is an essential life skill for clients to master if they are to successfully stabilize in the community and achieve their goals. Budget counseling is also an important diagnostic tool for prevention counselors, providing a window to understanding a household's strengths and needs. In his dialogue exploring the origins and meaning of money, Jacob Needleman has written:

> She explained that when she had some years before decided to become a CPA, she had assumed it would only be a matter of arithmetic, mathematics, rules and regulations. She had coldly and calmly chosen that because, after years of fighting a losing battle as an artist, she had no choice but to make herself "marketable." She had assumed her work would be more or less mechanical from that point on...."But I had no idea of the people element in this profession. I'm not dealing with forms and figures. I'm dealing with people. I'm dealing with lives. I'm dealing with hearts. Maybe even with souls?" I knew exactly what she meant. Time was, in our society, when it was the clergyman, the physician, or the psychiatrist who was most privy to people's secret lives, their fears, desires, anxieties, their shame and misdeeds, their private sorrows, all their psychic "beauties." But now this role is occupied more and more by the accountant and tax preparer.[24]

Through budget counseling, this prevention model projects the generally accepted community value that people should live within their means and honor their financial commitments. Much economic activity depends upon people fulfilling their commitments to each other to pay for services received and deliver services for which payment has been

made. Money symbolizes the respectful, supportive giving and taking among individuals which gives people the feeling of having emotional roots in their community. When these economic relationships break down, communities experience social and physical distress. We have already discussed how housing conditions can improve when rents are paid, enabling responsible landlords to maintain their properties.

Budget counseling consists of balancing a household's finances by increasing income and reducing expenses. The first step in budget counseling is to understand the amount and sources of the household's income and the amount and types of monthly expenses. This prevention model uses the intake form described in the next chapter to organize the client's financial information. Potential non-benefits sources of income include employment, child support, pensions, investments, loans and gifts. Sources of cash benefits include social security programs, veterans benefits and public assistance. Non-cash benefits include housing subsidies, food stamps, child care subsidies, clothing, transportation and tuition vouchers. Expenses are divided into numerous categories including rent/mortgage, utilities, telephone, food, transportation, medical, education, entertainment, etc. For each expense the actual monthly cost, the current arrears, if any, and a new budgeted amount is noted.

Many clients are unable to give an accurate estimate of their monthly expenses. This prevention model has developed an "envelope accounting system" to help even the most innumerate clients account for their spending. Clients obtain receipts for every purchase during a month and save the receipts in envelopes corresponding to the expense categories listed above. At the end of this period the prevention

counselor can review the receipts to get an accurate picture of the household's expenses. The envelope accounting system may be used by some clients to track their expenses on an ongoing basis as well. This accounting system as well as other budgeting information is made available to clients in the handout "Budgeting Your Money".

The prevention counselor's analysis of the household budget will generate recommendations for increasing income and reducing expenses. These suggestions may be simple, such as subscribing to basic cable instead of pay-per-view television or replacing rent-to-own furniture with second-hand furniture, or they may involve far-reaching life style changes such as reducing smoking, renting a more affordable apartment, obtaining alcoholism treatment, finding a job, etc. These recommendations are formalized in the service plan, discussed in the next chapter, which is the road map or blueprint of activities that will prevent homelessness and stabilize the household in the community.

Clients may be resistant to implementing some or all of the prevention counselor's suggestions, especially when they involve painful life style adaptations. Counselors develop partnerships with clients by identifying options whenever possible from which clients can choose, and by teaching clients life skills relevant to the problems that are being resolved. The program's emphasis on client responsibility requires clients to conduct their own housing and employment searches, apply for benefits, and account for their spending under the guidance of the prevention counselor. Through the process of resolving current problems clients learn the life skills to prevent the same problems in the future. When counselors advocate for clients, for example by

negotiating affordable repayment plans, or when the program offers direct financial assistance, clients will be required to make the necessary life style changes in return for the advocacy or assistance.

This prevention model offers money management as an intervention for clients who are temporarily or permanently unable to manage their own finances. Under money management the prevention program takes over bill-paying responsibilities and check-writing privileges from the client, using the client's income, to ensure that the client's basic housing, nutrition and health needs are met. The prevention program opens a joint checking account with the client and all checks require a counselor's signature. The prevention counselor provides the client with a cash allowance from the client's income for incidentals. Money management is most commonly implemented for SSI recipients who are mandated by the Social Security Administration to have a representative payee, however, occasionally other clients voluntarily choose this option temporarily while they learn budgeting and money management skills from the prevention counselor. This prevention model requires clients in money management to select a community service or educational placement to learn job skills and make a productive contribution to the community. Money management is offered only when no other solution is viable, and the prevention program first seeks responsible friends or family members of the client who can provide this service.

3. Specialized Services

REFERRALS FOR SPECIALIZED SERVICES

Most clients experience personal obstacles to maintaining stable housing and obtaining an income. A homelessness prevention program must address issues such as mental illness, substance abuse, physical disabilities and health problems, learning disabilities and illiteracy, legal problems, family planning, etc. in route to stabilizing households in the community. To address these directly the prevention program would need a staff of dozens of professionals and counselors from many fields, making it prohibitively expensive. This prevention model coordinates and networks with existing organizations and agencies in or near the community, called "specialty providers" in this book, by referring clients for specialized services.

Prevention counselors make clients aware of the specialized services available to them and may leverage resistant clients into participating in programs and accepting services by trading resources such as housing and benefits advocacy, financial assistance and shelter, for the client's commitment to address root problems. Prevention counselors also help clients negotiate the complex maze of application and eligibility procedures.

Referrals involve detailed communication between the prevention program and specialty providers to ensure the client's goals and needs are understood and quality services are provided. These consultations, sharing information usually by telephone, are made only with the client's knowledge and written permission. Because the prevention program works with large numbers of households, serving over 2% of the total population of the community annually, it becomes an important

referral source for specialty providers. It improves the efficiency of the social service delivery system by getting clients to the right providers quickly, by sharing relevant background information and by making sure providers are working toward the same goals.

A major role of the prevention program is to coordinate and manage the care specialty providers offer to homeless and at-risk clients. To use a medical analogy, the prevention program serves as the primary care physician, diagnosing problems and organizing specialists for the patient. To use a business analogy, the prevention program orders from suppliers (specialty providers) the parts necessary to make the product which in this case is productive, self-sufficient families and individuals. This product, in turn, is used to produce an even more complex product--healthy, stable communities.

LIFE SKILLS COUNSELING

This prevention model with its aggressive, comprehensive counseling and case management often results in strong working relationships between prevention counselors and clients. It is inevitable that referrals for specialized services will be supplemented by direct life skills and crisis counseling addressing some of these specialties. Therefore, prevention counselors will find themselves offering support and advice regarding substance abuse, mental health, parenting, family planning, health and nutrition, education, etc. As implied by the term "life skills", the background for this counseling largely comes from common sense and life experience. However, it is important to identify in-service training needs through the case review process and offer

training for prevention counselors by staff from specialty providers.

EMERGENCY SHELTER

The most measurable objective of this prevention model is to reduce the emergency shelter requirements of the community to just one bed per night per 10,000 population while eliminating street homelessness. Prevention will minimize emergency shelter and transitional housing as components of the community's social service system, however, there will still remain some need for shelter. Shelter can be provided in a residential facility with its own counselors and case managers, or it may be provided in scattered sites throughout the community such as motels, apartments, and single room occupancy (SRO) units. It is sometimes offered for periods as short as overnight without a counseling and case management component or it may be offered for periods of as much as three months or longer with many supportive services. The prevention program may provide shelter directly or it may refer homeless clients to programs that specialize in emergency shelter or transitional housing.

We will discuss in chapter four the ideal relationship between prevention programs and shelters to maximize the impact of prevention and minimize homelessness and shelter use. Here we will review the prevention principles most applicable to shelter operations which will result in shorter shelter stays and less recidivism.

Three of the operating principles described for prevention programs are relevant for shelter programs. The comprehensive services

needed to stabilize a household in order to prevent homelessness are the same services needed to re-establish a homeless household in the community: housing, income and specialized services. Shelter programs should emphasize client responsibility for resolving homelessness by leveraging clients to change their behaviors, adopt generally accepted community values and norms, and make effective use of available resources. Therefore, shelter should be provided in exchange for the client's commitment to follow through on a service plan. Shelter staff, as well as prevention staff managing clients being sheltered in scattered sites, need a regular case review for training and support to pool their knowledge of the community's resources and develop counseling techniques to manage their clients' distress and overcome their work avoidance mechanisms. The only principle not applicable is community access since shelter programs clearly target a sub-population within the community--homeless families and individuals.

We cannot recommend to a community a tertiary prevention measure such as providing emergency shelter without a service plan that requires client responsibility. Marvin Olasky relates this anecdote:

> In 1989 and 1990 homeless shelters were busy, most believing that they should provide a spot to all who came, whenever space allowed. In New York, a shelter administrator was reprimanded after he wrote a memo proposing that residents of a men's shelter not be allowed to wear dresses, high heel shoes, and wigs. Reid Cramer, assistant director of the Coalition for the Homeless in New York City, pointed out the administrator's error: "The memo is evidence of a real misconception of what the shelters are all about. Trying to curtail freedom of expression,

trying to shape the behavior of clients is completely inappropriate."[25]

Actually, shaping behavior is exactly what shelter programs are about. And behavior is often shaped by curtailing freedoms. In any institution--schools, halfway houses, hospitals, the military--freedoms that people take for granted in their own homes are abridged to accomplish specific goals. The goal of homeless shelters is to return people to the community as soon as possible with the life skills and resources necessary to avoid homelessness in the future. Although their choices are usually extremely limited, people still enter the homeless shelter voluntarily, which is a choice to accept the restrictions and benefits of shelter life. One freedom that is never denied is the freedom to leave the program.

Shelter rules and expectations may vary from program to program but should be designed to advance the service plans of residents as efficiently as possible and teach life skills through participation in the operation of the residence. In the shelter program model we advocate, the daily schedule parallels that of many working people. Residents are awake by 6:00 a.m. on weekdays and must be bathed and breakfasted with their rooms cleaned by 8:00 a.m. From 8:00 to 4:00 residents are actively working on their service plans which may include going to work or looking for work, looking for housing, going to school, volunteering in the community, and attending counseling and treatment appointments. There is no television until after 4:00. Household chores are done by the residents including preparation of a communal evening meal on a rotating basis. Each adult resident must submit a written schedule for the following day and there is a curfew and bedtime for residents of all

ages. Alcohol use is not permitted and residents are required to save most of their income in accounts to which they have access only with staff authorization.

Shelter residents are debriefed and counseled daily regarding their day's activities and plans for the following day. For programs that shelter the homeless in unsupervised scattered sites, counseling is provided and service plan performance is monitored through daily appointments at the prevention office. Aggressive case management, supportive counseling and intensive life skills training shortens the average length of shelter stay and, combined with aftercare through the prevention program, reduces recidivism, thereby contributing to lower overall emergency shelter requirements for the community.

Food pantries and free meal programs have also become ubiquitous features of the social service landscape in most communities. Although hunger, like homelessness, is a condition that must be relieved before other services can be successfully provided, it is primarily a symptom or result of more basic problems. Food pantries and meal programs are ideal opportunities to support and leverage clients to address their root problems. To make this prevention model as effective as possible, it is recommended that the community food pantry be located at the homelessness prevention program to link food distribution to counseling and case management leading to self-sufficiency. Alternatively, hunger programs could refer clients to the prevention program and make future distributions contingent upon the client following through on prevention appointments. Many food distribution programs, however, will be unable or unwilling to give up autonomy or require clients to accept

other services in return for hunger relief. This homelessness prevention and community stabilization model can still be highly effective in communities where hunger programs continue to operate independently.

Chapter 4: Program Structure

Client services are not random, independent interventions. They must be connected dynamically so that providing one service leverages the client to accept another, and resolving one problem motivates the client to work on others. To augment each other and become a powerful, efficient prevention and stabilization tool, client services must be organized within the context of a program structure.

This homelessness prevention and community stabilization model is structured around six basic elements: 1) Outreach introduces clients into the program; 2) Intake and assessment enables prevention counselors to understand clients' needs, assets and goals; 3) Service plans define the type and chronology of counseling and case management, performance benchmarks and time lines for completion; 4) Case review is the process by which prevention counselors are trained and service plans are modified and improved; 5) Program statistics provide an understanding and a record of client demographics, community needs, program services and outcomes; and 6) Staff and funding provide the means by which all the elements become a functioning program.

1. Outreach

Posting fliers in the places poor people go is the most effective way to make potential clients aware of the program. Some of the best

locations include supermarkets and grocery stores, fast food restaurants, laundromats, bars and liquor stores, banks and check-cashing outlets, discount and department stores, post offices, and even lamp posts and telephone poles in neighborhoods and commercial districts. Fliers and brochures are distributed to social service organizations, churches, police and fire departments, building inspectors, welfare offices, hospitals and psychiatric facilities, schools, district courts and probation offices, and other institutions and organizations that may come in contact with people in distress. It is a good sign when fliers are removed, but staff must go into the community and replace them regularly.

The outreach flier directly addresses people's fears of losing their housing or having insufficient money to pay their bills. It lists many of the program services that may result in solutions, including the availability of limited financial assistance. It conveys the sense that anyone is welcome at the program's offices, even if they just want information.

We have found 40%-50% of new clients are self-referrals who learn about the program by seeing a flier or from friends or family members, and 50%-60% are referred by a wide array of organizations. The quality of the program's services--its effectiveness in solving problems and organizing resources for clients--is the most important outreach factor. As the program matures, the percentage of new clients who first learn about the program from a flier may decline from perhaps 25% in the first year to as low as 5% in later years. As word about the prevention program gets out on the streets and into neighborhoods, referrals by friends and family--usually former or current clients--

increase, as do referrals from community organizations and institutions. The prevention program encourages other programs--especially in-patient and residential programs such as hospitals, psychiatric facilities, detox facilities, halfway houses, jails and prisons, and shelters--to refer clients early in their residencies or well before discharge for homelessness prevention services rather than waiting until discharge to address homelessness.

We have discussed the importance of community access as an operating principle in preventing homelessness and stabilizing communities. In order to conserve limited resources, some programs may be tempted to deny services to people from outside the community. However, these individuals will not always understand or communicate the reasons they were ineligible when they speak to friends and family members from the local community. When they speak of their difficulties obtaining services and their disappointment, their listeners may assume they too would be ineligible and therefore not seek timely services from the program. The problems of local people will become more complex and critical as they are neglected, and the end result overall is less efficiency in reducing homelessness and stabilizing the community. To manage the cost of cross-border access, the prevention program can identify the distressed communities from which clients are coming by collecting accurate statistics, as discussed later in this chapter, and can develop prevention strategies for and with those communities, as discussed in the next chapter.

A successful homelessness prevention and community stabilization program must be physically accessible to potential clients by locating in

the commercial and transportation hub of the community. Desperate clients who are homeless or nearly homeless may be willing to walk a mile or more or take two buses or trains to reach a program. However, an objective of outreach is to attract clients before their problems become desperate and result in homelessness. Therefore, the program should be located no more than one-half mile from the commercial center of the community, where the most bus and train routes converge and where there is a concentration of stores and businesses.

Some programs may locate further than one-half mile from the commercial center to be more accessible for a particular neighborhood with a concentration of distressed households. While this is not a bad instinct, unless the program is serving a neighborhood of at least 25,000, in which case there is usually an identifiable commercial center, it is probably not cost-efficient. Some programs may be located outside the commercial center for reasons that meet the organization's needs better than the clients' needs such as to occupy a building in which the agency has invested or to provide parking or other conveniences for staff. In communities where homelessness is a significant enough problem to justify a prevention program, it will almost always be possible to find affordable office space in the commercial district.

Staff need to respond quickly to requests for services, both to intervene early enough to make a difference and because many clients are easily discouraged by any obstacle or delay. This prevention model offers intake appointments within one business day to clients who declare themselves homeless, and within three business days to all other clients who have not previously missed an appointment without advance

cancellation. Clients who have missed appointments without prior notification and are not currently homeless are given appointments as soon as the schedule permits. The program arranges overnight accommodations in a shelter, motel or SRO for homeless clients who must wait through a weekend or holiday for an appointment. If staff become unable to meet these benchmarks, it may indicate that the community is distressed enough to require additional prevention counselors.

Most requests for services are made initially by telephone. Staff are instructed to offer appointments to virtually everyone who asks, even when the problem as presented on the telephone may not seem immediately relevant to the program's purpose. Usually the presenting problem is embedded in a complex of problems that can be addressed through the prevention program's combination of counseling and case management. If not, no harm is done and a simple referral can be made.

This prevention model does not attempt to diagnose problems or prescribe solutions through telephone interviews. It is too easy to offer prescriptions based on an incomplete or inaccurate understanding of the situation and contribute to worsening the problem or enable the client to continue in counterproductive or self-destructive behavior. Sometimes staff conduct intakes at clients' homes or an institution when clients are unable to come to the prevention office, and intakes may even be conducted on the streets for homeless clients unwilling or afraid to go to an office. In other words, everyone who asks can get an intake appointment and, with few exceptions, all intakes are conducted in person.

2. Intake and Assessment

Prevention counselors learn about the problems and resources of a client household through the intake interview. The intake or client assessment form collects information about household composition, housing history, financial circumstances, employment and educational background, and social service involvements. An intake begins with the client describing the problem and her assessment of the causes. The prevention counselor may work outward from this description, asking relevant questions, and complete the intake form as the information appears in the client's narrative. Other counselors prefer to follow the prompts on the intake form in order after the client's initial presentation of the problem. In either case, the intake form is a worksheet, a note pad with prompts, for getting a complete picture of the client's current situation and the events leading up to it.

The intake form begins with the intake date, counselor name, referral source and the client's stated request. Then it addresses household composition starting with each adult's name, age, date of birth, social security number, pregnancy status, birthplace and marital status. For each child it lists name, age, date of birth, social security number, name of mother and father, current school or workplace, and involvement with early intervention or child protection services. The housing history lists each address, going back as far as necessary to reveal relocation patterns and identify periods of stability, and lists occupancy dates, rent or mortgage amounts and landlord names.

The financial background lists the sources of income for household members, pay or benefit check frequency and gross and net amounts. It lists bank accounts and sources and amounts of non-cash or emergency income such as food stamps and fuel assistance. In response to recent welfare reform legislation, it determines the time remaining for the household to receive public assistance benefits so clients and counselors can plan ahead to replace this income. The financial background portion of the intake form details the household's current expenses and debts, and leaves space for a new budget plan.

There is an employment background section for each adult in the household. It lists current employment, education and vocational training, skills and licenses, military experience, hobbies, volunteer work and memberships, and current and long-term goals. For each past employer it provides address, job title and duties, dates of employment and reasons for leaving. This section of the intake also assesses the client's strengths and assets as the client sees them. It asks what three things out of the client's skills and experience she does best, which skills are good enough for people to want to hire her, and which skills could she teach to others. It asks if the client is currently self-employed or has considered self-employment and what obstacles to self-employment she may have experienced.

The intake reviews the educational background of each adult and child in the household. For adults it notes the highest grade completed and current educational goals. It lists each school attended, usually secondary and post-secondary schools but earlier education as well if necessary, courses and dates of study, diplomas and reasons for leaving.

For children, it lists the school, primary teacher or counselor, tracking or special needs, and most recent grades in language/writing and math/science. It asks the parent or guardian the homework procedures for their children and the method and frequency of parent-teacher communication.

Medical, legal and social service providers currently involved with the household are listed with a brief notation describing the service or treatment. The intake asks about orders of protection, visitation rights and child support arrangements, court dates, warrants and probation, health insurance and medication, physical and mental disabilities, alcohol or drug abuse, domestic violence or child abuse, recreational activities and memberships, and interest in family planning. It concludes with the prevention counselor's assessment and summary of the problems, needs and assets of the household and a service plan.

The intake form is designed with internal redundancies. Information from one part of the intake will lead an experienced counselor to look for corresponding information in another part. For instance, a housing history of frequent, short-term rentals might lead a counselor to look for rental arrears from previous evictions or raise concerns about the client's status with utility companies which could affect his ability to rent some apartments. An erratic employment history might lead a counselor to explore the possibility of substance abuse or a learning disability, which in turn could affect options and decisions about alternate income sources and, of course, education and treatment. A teen or young adult with a history of many schools might have been in foster care which could be an indicator of a limited

personal network of supports or trauma in early life. The question about medication will alert the counselor to health or mental health concerns if that has not already been learned by listing social service providers.

There is really no substitute for a thorough intake and assessment. Counselors have a saying in our program: "You should be able to tell your client's story almost as well as your own." Two of this prevention model's operating principles--comprehensive services and client responsibility--are dependent on the intake and assessment. Without complete information about the history and systems of a household, we cannot select appropriate services and may overlook important services. Without understanding the client's assets and capabilities, we cannot accurately assign responsibility for tasks or demand adaptive behavior. Instead, we will frequently overburden fragile or distressed clients beyond their abilities to cope, or enable clients to continue irresponsible, unproductive or self-destructive behavior by doing too much for them and protecting them from the consequences of their choices. A comprehensive intake and assessment makes an effective service plan possible.

3. Service Plans

The service plan describes the counseling and case management activities to be accomplished, and sets performance benchmarks for the prevention counselor and the client. It consists of four broad components: 1) a housing plan to find or maintain an adequate, affordable place to live; 2) a budget plan to balance income and expenses and manage money effectively; 3) an employment and

education plan to find a productive role in the community; and 4) a counseling and treatment plan to address a wide range of life skills and health issues.

This homelessness prevention and community stabilization model trades comprehensive services--information, counseling, advocacy and intervention--for client responsibility--the client's commitment to complete tasks and make life style and behavior changes. Therefore, developing the service plan is a business negotiation between the prevention counselor and the client, and the service plan is an informal contract. As tasks are accomplished, problems are resolved, and needs and goals change, the service plan may be modified through discussion and negotiation during counseling appointments.

Many clients are looking for a short-term, "technical" solutions to problems, such as cash to pay for a rental or utility arrears, or somebody to "give" them a job. This prevention model leverages clients to make "adaptive" changes in their life styles and behaviors which will prevent crises like homelessness from occurring in the future. Clients will often resist the expectation for adaptive change with a range of "work avoidance mechanisms." Ronald Heifetz has written:

> ...[The] final cause of adaptive failure--the tendency to avoid distress--holds the key to setting strategy. It frequently provides the ultimate impediment to adaptive change because the learning associated with identifying blind spots and options..., or strengthening...problem-solving capacity, will generate conflict and distress. Thus, a key question...becomes: How can one counteract the expected work avoidance and help people learn despite resistance?[26]

It is through the counseling relationship and by offering the services of the program that we manage the client's distress and overcome the tendency to avoid the work necessary to make adaptive changes. The balance between giving resources to the client to reduce pain and distress and expecting the client to learn new skills and habits in order to resolve problems for himself is individually tailored and articulated for each household in the service plan. The counseling relationship provides a "holding environment" that both supports and challenges the client, creating a partnership that requires effort from both parties and that avoids the anonymity of a bureaucracy. Heifetz explains:

> A holding environment consists of any relationship in which one party has the power to hold the attention of another party and facilitate adaptive work. The holding environment can generate adaptive work because it contains and regulates the stresses that work generates. The holding environment of the doctor-patient relationship consists primarily of bonds of trust, but in other authority relationships it includes bonds of fear, mutual need, and brute force or its threat. The point of the holding environment is not to eliminate stress but to regulate and contain stress so that it does not overwhelm. People cannot learn new ways when they are overwhelmed. But eliminating the stress altogether eliminates the impetus for adaptive work. The strategic task is to maintain a level of tension that mobilizes people.[27]

A relatively simple, hypothetical case may illustrate service plan development. A 30 year old single male requests that the program pay three months of back rent because he is being evicted from his apartment for non-payment. The intake interview reveals that he stopped paying

his rent because he lost his job, and he lost his job because he missed too much work, and he missed work because he started drinking again, and he started drinking again when he broke up with his girlfriend. This is not a homeless problem primarily; this is a drinking problem and, perhaps, a mental health problem.

The prevention program can offer a number of services to respond to the client's request. The prevention counselor will call the landlord to try to negotiate a stay of the eviction, indicating that the program is working with the client to obtain an income sufficient to pay current and back rent over a period of time. The prevention counselor will advocate for the client with the state agency that administers public assistance to obtain temporary general relief benefits based on a substance abuse or mental health disability. This will require helping the client to obtain and organize documentation of the disability through substance abuse and mental health providers. The program will also provide assistance with an employment search or perhaps access job training for the client.

One thing the prevention counselor will not do is pay the whole three months rent because then there is less incentive for the client to follow through on his part of the service plan. This includes coming to the office several times per week neatly dressed to conduct an intensive employment search. It includes attending daily Alcoholics Anonymous meetings and accepting counseling at the local substance abuse agency or facility. It may require a week of detoxification. The service plan may include obtaining mental health counseling to address the depression resulting from the break up with the girlfriend.

As the service plan is implemented the prevention counselor may need to improvise some modifications. For instance, the landlord may demand some rent money up front to agree to keep the client as a tenant. The prevention counselor would negotiate a reasonable amount and the program may advance that money as a loan to the client with the expectation in a signed agreement that the money would be paid back in specific monthly payments once an income is in place. The landlord may be unwilling to retain the tenant under any circumstances, in which case the prevention counselor will ensure that legal eviction procedures are adhered to which, in most cases, will buy the client one to two months to secure an income through employment or benefits and locate new housing.

The client may refuse to conduct an employment search or accept substance abuse or mental health counseling. The prevention program may then let the eviction process run its course so the client understands the consequences of his choices. The program will always leave the door open for the client to renegotiate his service plan. He may choose to forego the substance abuse counseling but conduct the employment search, calculating that he can find work quickly enough to salvage his housing situation. The program could then choose to help with the employment search but not advocate with the landlord.

The client may experience difficulty obtaining timely or appropriate services from the public assistance, substance abuse or mental health agencies. The prevention counselor advocates for the client with these agencies, sharing information with the client's permission, and if necessary, working her way up the chain of command

within these agencies until she obtains the services for which the client is eligible. This process, however, may modify the service plan if the arguments of the other service providers convince the prevention counselor that her initial assessment may have been inaccurate. For instance, the other service providers may assess the client as ready for employment now and not in need of benefits. After sharing information and perspectives, the prevention counselor may choose not to continue advocating for benefits and focus instead on employment.

Usually there are enough combinations of services and responsibility available to the prevention counselor and the client to find some working agreement, a service plan, acceptable to each. Occasionally a client refuses to accept any responsibility for completing tasks and making adaptive changes. This may be because the client has other resources--friends or family, assets or savings--that he has not revealed and he is simply attempting to offset the personal costs of resolving the situation using the program's resources instead. The program will allow the eviction to proceed and may not hear from the client again because he has applied his personal resources to resolving the problem. Since a goal of the program is to maximize self-sufficiency and reduce dependency, this is an acceptable outcome.

There are some clients who have no personal resources yet still refuse or are unable to take responsibility for part of their service plan. These clients may expose themselves to severe hardships such as homelessness if the prevention program has not accurately assessed the root causes of the problem. Chronic or acute mental illness will often be a factor. In these cases, shelter is usually provided with minimal

expectations for client participation in a service plan. Performance benchmarks for the client are set low enough to achieve successes from which a productive counselor-client relationship can be established and more complex performance benchmarks can be built. A careful intake and assessment combined with case review and staff consultation in constructing a realistic service plan should almost eliminate the chances of consigning a client without resources to the streets.

The service plan for a chronically or acutely mentally ill client may subsequently call for obtaining temporary benefits through public assistance, followed by permanent benefits through supplemental security income. The prevention counselor will collect and prepare the necessary documents and facilitate the process by advocating for the client. She may strongly recommend a representative payee for the permanent benefits to ensure that the client's basic needs are always met. She may need to help the client follow through on mental and physical health appointments and arrange for community supports to make independent living possible.

A service plan summary is completed and updated as needed by the prevention counselor. The summary lists each step within each component of the plan--housing, income, employment/education and counseling/treatment--and is stapled into the front of the case file. A completion date is noted for each step and space is provided for a brief outcome description and comments. The service plan summary is designed so counselors can get a quick overview of the work accomplished and still to be accomplished with the client. It also provides data as part of the reporting and evaluation system of the

program as described in the section on program statistics later in this chapter.

In addition to the client assessment form and the service plan summary, each case file contains at least two other documents. Prevention counselors write a narrative for each counseling session using the client planning form. Each narrative is preceded by the date of the counseling session and the counselor's initials. The client planning form is a detailed record, not only from day to day but from year to year, of the prevention program's work with the client. It allows any prevention counselor to pick up the file and continue the work begun by another counselor, uninterrupted by vacations or staff turnover.

A consent for release of confidential information, on agency letterhead, is signed by the client for each specialty provider or other organization or individual with whom the prevention counselor may need to communicate regarding the case. The client, of course, has the option not to give consent and the program has the option to withhold services that are dependent on such information. For instance, the program would be unlikely to pay rental arrears for a client who refused to allow the prevention counselor to speak with the landlord. Even in states where client confidentiality is not protected by law, this homelessness prevention and community stabilization model requires consent so the client is always aware of and invested in the service plan and so the program cannot make decisions that are rightfully the client's or expose the client to services or individuals in which he has expressed no interest.

4. Case Review

Case review is a weekly meeting of prevention counselors and program managers during which information and service plans of client households are presented, reviewed and modified using up-to-date case notes and statistics. Case review brings the full experience and creativity of the staff to bear on each case so that options and opportunities are maximized for each client. It provides intensive, ongoing support and training for staff and serves as the quality control mechanism of this prevention model.

At case review, each prevention counselor verbally presents the intake information and service plan of each case for which there has been a counseling session since the previous case review. For new intakes (clients who have never received services from the program in a previous month) and recidivists (clients who have used the program previously but have not received services in the immediately preceding month), the prevention counselor presents the case while referring to the information on the intake form. He describes the problem and request as presented by the client, the household composition, the housing history, the financial background, the employment and educational background and the medical, legal and social service involvements. The prevention counselor gives his assessment of the needs and assets of the client household and summarizes the service plan and the counseling and case management provided to date to implement it. For follow-up clients (clients who have received services during the previous month) the prevention counselor simply provides an update of the counseling and case management completed and any changes to the service plan.

During each case presentation, the other prevention counselors may ask questions, request clarification and make suggestions. They may question gaps in the housing history or financial background. They may want to know more about the purpose of a medication or the counseling or treatment being received from a specialty provider. Prevention counselors may suggest referrals or other resources of which the presenting counselor may be unaware. The team may have suggestions about how to successfully leverage and motivate the client to follow through on her part of the service plan. These suggestions may include scheduling counseling appointments more frequently for closer monitoring and additional support, delaying or withholding certain advocacy services or interventions until the client has completed specific tasks, or setting clearer benchmarks and expectations for the client such as a specific number of job applications per day or apartment viewings per week.

Case review is usually facilitated by a program manager or senior counselor. A consensus style may be used to maximize staff participation and discussion. However, due to the volume and complexity of the cases, the facilitator will need to assertively keep the discussion on task, and may need to truncate discussion of some cases to prescribe service plan modifications and direct counselors to implement specific counseling and case management activities. We have found that a three- to four-hour weekly case review can accommodate a maximum of six prevention counselors and to stay within these time limits sometimes only new intakes and recidivists are reviewed. Follow-up clients may be reviewed only during case reviews when there are

relatively few new intakes and recidivists or when a prevention counselor indicates the need to present a difficult case and get the team's advice.

Using the vast public and private resources of the community to increase the capacity of clients to prevent and solve their own problems is the core competency and dynamic of this prevention model. It requires extensive knowledge of the community's economy, housing stock and social service infrastructure, and it requires a repertoire of counseling techniques and strategies to manage the distress of clients in crisis and overcome their work avoidance mechanisms. Case review provides the training and support to develop these skills and resources.

It is the job of the case review facilitator to overcome the work avoidance mechanisms of prevention counselors. Prevention counselors have the very difficult task of motivating clients to engage in painful adaptive work. It is often much easier to make financial assistance available to clients than to ask them to live within their means by making life style changes. It is sometimes easier to make familiar referrals than to research and develop new sources of support and services for clients. It can be easier to send clients out unprepared on a random employment search than to construct a resume, find transportation and child care solutions, teach interviewing skills and target employers in the client's field of interest.

The facilitator, as well as counselors listening to cases, must be alert to opportunities to teach new skills to staff and improve the quality of the program's services. This requires an atmosphere in which

comments and suggestions for improvement are expected and acceptable and it requires acknowledging the difficulties, frustrations and stressfulness of working with homeless and at-risk households. The creative innovations, counseling insights and discovered resources of prevention counselors should be valued, praised and shared. Case review can sometimes have a "hospital humor" quality as counselors release tension and stress by joking about the situations, attitudes and choices of their clients. This should be tolerated and even encouraged to the extent that it does not impede substantive case work.

While information, counseling and advocacy are provided to clients at the prevention counselor's discretion within the context of the service plan, interventions such as financial assistance, emergency shelter and money management require case review authorization. When such decisions must be made before the next case review, they require consultation between at least two staff. Interventions can be extremely enabling (i.e., help clients to continue dysfunctional, unproductive or self-destructive behavior) if they are not carefully targeted and constructed, while some situations can be life-threatening if an intervention is unadvisedly withheld. Case review and consultation reduce the need for isolated decision-making by case managers.

5. Program Statistics and Evaluation

This homelessness prevention and community stabilization model collects extensive program statistics to understand client demographics, needs, service patterns and outcomes. By analyzing statistics, the program can identify gaps in its own outreach and services as well as

community needs. Statistics help management make program modifications and select areas for staff training, and they help funding sources evaluate the effectiveness of the program. The program produces quarterly and annual statistical reports.

Prevention counselors collect statistics as an integral part of their case work. A statistical record or "stat line" is maintained on a "stat sheet" for each client served during a quarter. The stat line is updated after each counseling session. It contains the name of the head of household, the age and ethnicity of each household member, last address, homeless status, and reasons for homelessness or risk of homelessness. It records the client's intake status (new intake, recidivist or follow-up), the referral source for new intakes, and the dates of counseling sessions during the quarter. The prevention counselor records the current or starting status and any changes in housing, income, source of income and education. For clients who have lived in their current town or district for less than one year, the prevention counselor notes the previous address. The counseling services the client has received from the program, any referrals to other agencies and organizations, and amounts of direct financial assistance are noted. The stat sheet records the client's previous involvement with other programs that address homelessness within the community. At the end of the quarter the prevention counselor selects an outcome category, defined below, for each client.

This volume of information would be unwieldy without a shorthand or code to condense it. This shorthand is contained in the "key to statistics" which each counselor learns quickly through constant

use. As a result, recording statistics is not as time-consuming or distracting as it may seem. This system for collecting statistics can be easily modified as the program or its funding sources identify the need for new types of information. Yet it can satisfy the information requirements of multiple funding sources without designing a unique system for each one. This system is adaptable to almost any agency's overall information system including those that are still entirely paper-based, those that use a combination of paper and personal computers, and those that have computer networks.

Data from individual counselors must be combined to produce quarterly and annual statistical reports for the program. The statistical report counts each household once for an unduplicated number. It then categorizes these households by intake status--new intakes, recidivists and follow-up clients. It further divides recidivists by time elapsed since last counseling session--less than one year, one year or more, and three years or more. It calculates a rate of recidivism by dividing total recidivists by total households. It counts chronic recidivists (recidivists who have returned to the program more than once in the previous three years) and calculates a rate of chronic recidivism by dividing chronic recidivists by total households.

These figures tell us at what percent of capacity the program is operating if, as we will discuss in the next section, we accept that 100% capacity is 200 households per year per counselor. Operating at below 75% of capacity may lead us to review our outreach systems, question whether homelessness and poverty are significant community problems, or determine whether another agency is providing the same services and

whether the quality of our services is competitive or if there are opportunities for collaboration to reduce duplication and increase cost-efficiency. Operating at above 125% of capacity may indicate we are understaffed for the size of the population, the distress of the community as indicated by rates of homelessness and poverty is much higher than average or the program does not emphasize client responsibility sufficiently and is instead trying to solve problems with cash or material handouts.

Rates of recidivism help us determine if clients are satisfied with services and comfortable returning to the program when new problems occur in their lives. However, very high recidivism rates may indicate the program is not effectively teaching clients life skills or accomplishing its goal of stabilizing the community. Although our experience is still limited, we think recidivism rates should stabilize at about 35% and chronic recidivism rates at 10%-15% for a program achieving full community access and comprehensive services. Measuring chronic recidivism can add to our understanding of the community's distress level and the program's success rate, as well as identify specific households experiencing recurring homelessness and severe distress. Analyzing the factors contributing to these households' distress may identify gaps in the community's support systems or community problems that need extra attention.

The statistics count total clients--men, women and children within all households, and total client contacts--all counseling sessions for all households. Total clients divided by total households tells us the average size of client households which may also be reflected later in the

report under breakdown by head of household--families with children and without children, headed by a single female, single male or two adults--which tells us about household compositions. It may reflect whether poor families or poor individuals, men or women, are in more distress in the community and lead us to examine the relative access of these groups to resources.

Client contacts is another measure of the program's capacity for which our 100% benchmark is 800 client contacts per counselor annually. This should generate a slightly different program utilization measurement than total households. If the difference is substantial, however, it might lead us to examine whether many client households are exploring the program briefly during one visit and not following through on additional appointments--perhaps because the program is not offering high-quality comprehensive services, the program is new, there is competition from another program, or the distress level of client households is relatively low. Many appointments per client household may be reflected in increased money management services or indicate higher client distress levels.

Our prevention program has averaged between three and four contacts per household per year, however, this reflects wide variations among clients including about 5% of total client households receiving money management services with weekly appointments. At the other extreme, about 20% of client households investigate the program through one intake appointment and never return, perhaps realizing they have adequate personal resources to resolve their situations, having obtained information sufficient to solve their problems on their own, or

choosing not to do the work involved in a service plan.

The number of homeless households is reported in the statistics and described as a percent of total households. We define people as homeless if they have no permanent place to live; if they live in a place not ordinarily used for human habitation; if they live in a shelter or hotel/motel paid for with vouchers for the homeless; or if they live in someone else's home but do not have a regular arrangement allowing them to stay there at least five days per week. All other clients are defined as "at-risk." In the early years of a prevention program we expect homeless households to be 40%-50% of total households using the program, and that number to drop to 20%-30% as the community stabilizes. Emergency shelter requirements decline even more dramatically as homelessness is resolved more quickly and people use the resources of stable friends and family during a crisis.

Source of income at the start and end of services is reported to understand the financial resources of the client population, the role of disability, unemployment and other factors in risk of homelessness, and the extent to which the program has ensured all clients have an income. Categories of income include no cash income, AFDC (or TANF), child support, SSI, other social security, employment, general relief, and veterans benefits. A prevention program goal is to document a decline in households with no cash income and an increase in households obtaining income through employment.

The statistics report number and percent of households classified as having low and moderate incomes as defined by federal guidelines for

the locality. Although this prevention model applies no income eligibility guidelines to ensure maximum community access, we find the number of higher income households requesting services is negligible--less than one percent. Clearly higher income households normally have little difficulty providing for their own basic needs, but the program's emphasis on client responsibility--using the client's resources before the community's--further reduces casual or opportunistic use of the program. A section for health, educational and child protection status documents number and percent of households that have no health insurance at start of services, in which a head of household is a high school graduate or an adult non-reader, and that are involved with a child protection agency.

While the breakdown by head of household will report the number of households with and without children and show the incidence of single parenthood, the breakdown by age and ethnicity will report the number of individuals within several age and racial groups. The age breakdown can be further analyzed to determine the age groups with the largest concentrations of clients by dividing the total number of clients within each age group by the number of years making up that age group. This may show that young families preponderate among client households if infants and one-to-five year olds as well as eighteen-to-twenty-five year olds show the heaviest concentrations. It may indicate major employment shifts if forty-one-to-fifty-nine year olds are heavily represented, or that services to elders are disorganized if sixty-plus year olds are frequent clients. Ethnic breakdowns combined with the geographic breakdown may reflect possible discrimination patterns or changing community demographics. Ethnicity statistics are kept

primarily, however, to demonstrate compliance with federal and state non-discrimination requirements in providing services.

The geographic breakdown reports the distribution of the client population by city and town or, in the case of large cities, by district using zip codes. It can also report the previous towns or districts of clients who have lived in their current communities less than a year. The program will attract clients from towns or districts outside the primary community it serves. We have discussed why it is important not to deny services to these clients. They may be referred to another prevention program in their own community, however, many communities will not have a homelessness prevention and community stabilization program. The geographic breakdown will identify communities in distress when their share of total households using the program exceeds 10%. Then the program may want to expand into that community to provide services directly or assist organizations within the community to develop an effective homelessness prevention and community stabilization program.

The statistical report lists the referral sources of new intakes which can help the program refine and improve its outreach strategies. It will show the number of clients who learn about the program by word of mouth from friends or family members, which is a good indicator of the program's reputation among consumers. Combined with information later in the report about referrals made to other agencies and organizations by the prevention program, it offers a detailed map of the community's services for low-income households. Analyzing the referrals section may identify gaps in the prevention counselors'

knowledge of the community's social service infrastructure and provide further understanding of the problems and needs of the client population.

Prevention counselors select from a list of seventeen factors all those contributing to each client's homelessness or risk of homelessness which is then collated in the statistical report to show the percentage of clients experiencing each factor. The factors include inadequate income; non-payment of rent; eviction by primary tenant; code violations/building condemnation; fire/disaster; building sale/conversion; overcrowding; unemployment; voluntary relocation; discharge from institution; abuse/domestic violence; utilities arrears; alcohol/drug abuse; physical disability; mental disability; life skills deficiencies; parenting skills deficiencies. This section of the report can indicate the major distress factors in the community.

The percentage of clients using each of the program's direct services is recorded as well as financial assistance provided to households. Prevention counselors select from four types of housing results: permanent housing; homelessness averted; left service area; casework incomplete. They also select an outcome status for each household: 1) Crisis Intervention: immediate intervention needed to address homelessness, risk of homelessness, child abuse and neglect, or domestic violence; 2) Case Management: no risk of homelessness or child abuse, but client needs continuing case management toward permanent stabilization; 3) Independent Living: lives independently without ongoing case management, but uses income supports through benefits systems; or 4) Economic Self-sufficiency: has achieved independent living and has income source above poverty line through

employment or other non-benefits source.

Program statistics alone cannot provide a complete picture of the prevention program's effect on clients and the community. This homelessness prevention and community stabilization model solicits an outcome or client satisfaction survey from each client who has attended six counseling sessions during the quarter and who has not completed an outcome survey within the previous year. For each of nine services--housing search assistance, landlord-tenant mediation, utilities mediation, employment counseling, benefits advocacy, budget counseling, community involvement, referrals for specialized services, and material or financial assistance--the survey asks why the service was needed, what the program did that was most and least useful, and what changes resulted. The client also responds to seven general questions about the program's impact on his situation and provides a numeric evaluation of the program staff and services. The outcome survey uses the client's own words only, written by the client or recorded verbatim by staff.

This homelessness prevention and community stabilization model contracts with an independent auditor every three years to conduct an outside evaluation of the program by reviewing the program statistics, outcome surveys and client files, and by interviewing clients, staff, personnel from other agencies and community leaders. The evaluator produces a report that evaluates the program's impact on clients and the community, reviews the accuracy and usefulness of program statistics, client files and other program documents, and makes recommendations for change and improvement.

6. Staff and Program Costs

The number of prevention counselors needed in a community can be estimated based on the population of the community. Based on our experience with this homelessness prevention and community stabilization model, we calculate that a prevention program will need one counselor per 25,000 population. In communities where shelters agree to accept referrals only through the prevention program and where shelter and prevention staff conduct joint case reviews, we anticipate that this staffing configuration can reduce emergency shelter requirements by 20%-25% per year until they stabilize at one bed per night per 10,000 population. In communities where shelters continue to operate independently, we believe this prevention model can reduce homelessness by 10% annually until stabilizing at one bed per night per 10,000. To estimate the time required to achieve this goal it is necessary to establish a baseline of emergency shelter usage for the community by analyzing shelter statistics.

A fully staffed prevention program will serve approximately 2% of the total population annually. For a community of 100,000 the program will serve 2,000 individuals and therefore, assuming an average of 2.5 men, women and children per household, 800 households annually. With four counselors, each counselor will work with 200 client households per year. If households average four appointments per year each at two hours per appointment (including counseling, case management and case notes), each counselor will log approximately 1,600 hours of case work at 35 hours per week for 46 weeks per year (four weeks vacation, 2 weeks holidays).

The job description for prevention counselors includes both case management and administrative responsibilities. Prevention counselors may be high school graduates with significant experience working with low-income households, or college graduates with some experience. All counselors need good writing, mathematics and verbal communication skills. Other valuable attributes include flexibility and creativity in finding solutions to new problems as they arise; knowledge of the community's business, social service and government infrastructure; ability to empathize and establish good working relationships with clients without an excessive need to be liked or needed; ability to negotiate and facilitate mutually advantageous arrangements and relationships with service providers, employers, landlords and other members of the community. A sense of humor helps, as well as the understanding that we cannot be the definitive positive influence in every life, or even most lives, with which we come in contact. Counselors in our program have a saying: "We do not take credit for our clients' successes, or accept blame for their failures."

Since prevention counselors are the most valuable and expensive component of the program, once the size of the community and the number of counselors is known we can estimate the cost of the program. To estimate costs we assume salaries of $25,000 per counselor, benefits and taxes at 30% of salaries, non-personnel costs at 25% of personnel costs (salaries and benefits), and management and general at 20% of personnel and non-personnel costs. The following tables calculate estimated program costs for communities of varying sizes using two slightly different methods:

Table 1: Annual Program Costs Per Capita

Cost Per Capita	Salaries	Benefits/Tax	Non-Personnel	Mgmt & General
$ 2.00	$ 1.00	$ .30	$ .35	$ .35
100%	50%	15%	17.5%	17.5%

Table 2: Annual Program Costs by Population

Population	Salaries	Benefits/ Taxes	Non-Personnel	Mgmt & General	TOTAL
50,000	$ 50,000	$ 15,000	$ 16,250	$ 16,250	$ 97,500
100,000	100,000	30,000	32,500	32,500	195,000
150,000	150,000	45,000	48,750	48,750	292,500
200,000	200,000	60,000	65,000	65,000	390,000
250,000	250,000	75,000	81,250	81,250	487,500
300,000	300,000	90,000	97,500	97,500	585,000

We believe this homelessness prevention and community stabilization model can effectively serve any community at an annual cost of about $2 per capita. If we assume the cost of emergency shelter and transitional housing to be $10,000 to $20,000 per year per bed, then the cost of shelter for stabilized communities will be $1 to $2 per capita, making the total annual cost to address homelessness $3 to $4 per capita. We anticipate that communities with higher poverty rates will start with

higher rates of homelessness and emergency shelter requirements. The following table estimates the number of years needed to stabilize at one bed per night per 10,000 population for communities starting with different rates of homelessness as measured by emergency shelter requirements:

Table 3: Years to Stabilization from Baseline Emergency Shelter Requirements

Baseline beds/night/10,000	Years to Stabilization 1 bed/night/10,000	Baseline beds/night/10,000	Years to Stabilization 1 bed/night/10,000
4	5-6	15	9-12
6	6-8	20	10-13
10	8-10	30	11-15
12	8-11	50	13-17

The North Adams community achieved a 75% reduction in emergency shelter requirements within five years using this homelessness prevention and community stabilization model. We believe a city of 600,000 that currently shelters 600 homeless people per night (10 beds/night/10,000) could save $25 million to $35 million over 10 years using this prevention model. As shelter beds were eliminated, the community would break even on its investment in prevention in the first or second year, depending on whether the community was receptive or hostile to the prevention program as described in the next chapter. Emergency shelter requirements would stabilize at one bed per night per

10,000 population (60 beds per night for the city) within ten years in the receptive scenario, and within 22 years in the hostile scenario.

Communities that invest more than $2 per capita and deploy more prevention counselors for a higher ratio of counselors to population may shorten the time needed to achieve stabilization as measured by emergency shelter requirements. Our experience suggests that many other benefits that are less easily measured will accrue to communities using this homelessness prevention and community stabilization model including improved housing conditions; increased economic self-sufficiency for low-income households; community resources redirected from crisis management to education and economic development; improved schools as children move less frequently; a more efficient, effective social service delivery system; and welfare reform implementation without increased homelessness.

Chapter 5: Community Relationships

This homelessness prevention and community stabilization model exists in the context of its relationships with groups and organizations in the community--clients, contributors, human service agencies, government agencies, elected officials, funding organizations, clergy, business leaders, employers, landlords, neighborhood groups, etc.--and the relationships between these groups. While few would argue preventing homelessness is not an intrinsically worthwhile goal, other agendas and priorities--cost-effectiveness, organizational survival, preserving people's jobs, existing funding commitments, other human service and economic development activities--may affect the community's commitment to prevention. It is important to define the community's homelessness problem and describe the community in political, geographic, economic and demographic terms. It is also necessary to map the community's resources for solving homelessness and understand the prevention program's potentially competitive, cooperative and collaborative relationships with other stakeholders.

1. Defining the Problem

Homelessness may be perceived as a community problem in any number of ways: police intervening with homeless people on the streets; businesses complaining about the impact on sales; a food pantry whose clients not only have no food but have no homes; a mental health agency unable to begin therapy with clients who are without food and shelter; a

hospital or psychiatric facility discharging patients to the street; a district court or sheriff ordering and enforcing more evictions; a building inspector condemning many apartments and buildings; elected officials frustrated by the increasing cost of shelter and crisis management; shelters consistently running out of beds for the growing number of homeless; a community experiencing an influx of homeless families and individuals from a neighboring community.

These impressions and experiences can be quantified by estimating the average number of emergency shelter beds filled per night plus the number of people sleeping outdoors and in places inappropriate for human habitation. This will be a rough estimate because many shelters serving more than one community do not keep records of the geographic origins of residents, and it is difficult to accurately count the unsheltered homeless. Dividing this estimate by the population of the community divided by 10,000 gives the community's emergency shelter requirements in beds per night per 10,000 population. If the number is three or greater, we believe this homelessness prevention and community stabilization model can make a significant contribution to reducing homelessness in the community.

2. Describing the Community

The community can be described geographically and politically as a particular city or town, two or more cities and towns that are adjacent or in close proximity, or one or more districts within a city. The community can be further described in terms of population and economic demographics using census data.

This homelessness prevention and community stabilization model is designed to ideally serve communities from prevention offices employing two to six counselors working with populations of 50,000 to 150,000. Establishing prevention offices for populations of less than 25,000 may result in one full-time or part-time counselor working alone, making training and a team case review difficult unless it is combined with that of a nearby program. Even with this disadvantage the model can be applied successfully to communities of 25,000 or less although we believe that stabilizing urban areas, including small cities, will have a stabilizing effect on nearby rural and suburban areas.

The upper population limit for a single prevention office is probably 250,000, requiring ten counselors, with the ideal upper limit being 150,000, served by six counselors. Attempting to address homelessness for a large city from a single, centralized location fails to satisfy any of the four operating principles of this model--community access and case review for logistical reasons, and comprehensive services and client responsibility due to the volume of clients. This prevention model is designed to stabilize poor people in the context of their relationships to their families, neighbors and daily business contacts. Jane Jacobs has written:

> Statistical people are a fiction for many reasons, one of which is that they are treated as if infinitely interchangeable. Real people are unique, they invest years of their lives in significant relationships with other unique people, and are not interchangeable in the least. Severed from their relationships, they are destroyed as effective social beings--sometimes for a little while, sometimes forever....[28]

She also writes:

> The constant departures leave...more than housing vacancies to be filled. They leave a community in a perpetually embryonic stage, or perpetually regressing to helpless infancy....In this sense, a perpetual slum is always going backward instead of forward, a circumstance that reinforces most of its other troubles. In some drastic cases of wholesale turnover, it seems that what is getting a start again is hardly a community but a jungle. This happens when the new people flooding in have little in common to begin with, and those who are most ruthless and bitter begin to set what tone there is. Anyone who does not like that jungle--which is evidently nearly everyone, for turnover is tremendous in such places--either gets out as fast as he can or dreams of getting out. Even in such seemingly irreparable milieus, however, if the population can be held, a slow improvement starts.[29]

Marvin Olasky has written:

> [Thomas] Chalmers [rector of St. John's Parish in Glasgow, Scotland from 1819 to 1823] explained that dividing up his parish into what he called "manageable portions of civic territory" was crucial, for "there is a very great difference in respect to its practical influence between a task that is indefinite and a task that is clearly seen to be overtakable." The need to provide relief to a large city "has the effect to paralyze." But personal knowledge of those who needed help in one small area of the city tended to "quicken exertion."[30]

Once the community has been defined, we can identify and map the resources available within and near the community to prevent homelessness. To locate the crisis management and basic needs services

of the community we can ask, Where do you go for help if you are:

-- homeless;
-- hungry, but have no food;
-- not homeless, but have an eviction notice;
-- not homeless, but have a utility termination notice;
-- not homeless or being evicted, but want help finding an apartment;
-- looking for a job;
-- not homeless, but having trouble making ends meet and paying the bills?

These services currently may be provided by many agencies or may be concentrated with one or two organizations. Our goal is to identify one agency or collaboration of agencies in a single office with which to locate these services using the homelessness prevention and community stabilization model described in this book.

To map the community's resources, public and private, non-profit and for-profit organizations providing services in the following areas can be listed, including geographic location and primary funding source where applicable:

Emergency shelter/transitional housing
Food pantries
Meal programs
Utility/fuel assistance

Mental health
Substance abuse
Physically disabled
Developmentally disabled

Domestic violence/women's services
Child protection services
Adoption/foster care
Parenting/family services

Public/subsidized housing
Private housing (major landlords)

Newspapers
Public transportation

Employment agencies
Major employers
Job training/subsidized employment

Income supports
Budget/consumer credit counseling

Public schools
Post-secondary education
GED/Adult education

Child/day care

Head Start/pre-school
Hospitals/clinics
Psychiatric facilities
Family planning
Home health agencies

Legal aid
Courts
Police/fire departments
Jails/prisons
Housing/health code enforcement

Churches/religious groups
Neighborhood/tenant organizations
Civic organizations
Recreational associations
Volunteer groups

Housing development
Economic development

United Ways
Human service coalitions/directories
Chambers of commerce
Elected officials
Talented individuals

This process provides a complete picture of the resources in the

community available to prevent homelessness and stabilize low-income households. It can also begin to identify how and where to establish a prevention program.

3. Establishing Prevention Programs

Communities may or may not be receptive to the establishment of a homelessness prevention and community stabilization program. A receptive community will: 1) identify one prevention program or collaborative to provide the services for homeless and at-risk families and individuals described in this book and eliminate duplicative and competing programs; 2) refer homeless families and individuals into shelter through the prevention program only; and 3) conduct a joint weekly case review for prevention and shelter staff.

Normally, this homelessness prevention and community stabilization model will be implemented by an agency or organization that already has a presence in the community. The clearest route may be for an agency that operates a shelter or food pantry to re-deploy its existing staff and resources to include primary prevention. Community action agencies, established through federal legislation during the 1960s to organize and advocate for poor people and funded through Community Service Block Grants administered by the Department of Health and Human Services, are often a natural choice to operate this prevention model since the client populations are very similar. In New York City and some other large cities settlement houses and neighborhood centers may be excellent locations for this prevention model. However, in many communities other private and even

government agencies take the lead in addressing homelessness. In communities supportive of this model, one agency or a single collaborative consisting of more than one agency is identified to implement the program.

Communities that are receptive to this homelessness prevention and community stabilization model will identify the program as the resource for people who are homeless or who are experiencing problems that may lead to homelessness. Specialty providers, churches and other organizations will voluntarily agree not to provide shelter, cash or other interventions and instead refer distressed households to the prevention program. This ensures clients cannot avoid their responsibility to make adaptive life style changes by finding another program that will provide material assistance repeatedly without counseling and case management.

In the ideal community, shelter providers will agree not to accept residents directly, either through client self-referral or from specialty providers and other organizations, but will accept referrals only through the prevention program. This reduces the casual use of shelter, maximizes the use of clients' own resources, and maintains case management continuity which results in an accurate service history, flexible response to changing needs and efficient use of resources eventually leading to independence and self-sufficiency. If shelter staff combine their case review with prevention counselors, it facilitates staff training and transitions between shelter and the community for clients. Also, ideally, the community's food pantry will be placed with the prevention program so food distribution can be linked to counseling and case management resulting in less dependency.

Communities that are not receptive to this prevention model may be hostile, disorganized or indifferent. The prevention program may compete with some programs for clients and funding, cooperate with others through referrals and information-sharing, and collaborate with one or more by combining staff and resources to operate the program. Shelters may continue to accept referrals and provide case management independently of the prevention program.

Sometimes a community does not see the need for primary prevention because it is satisfied with secondary and tertiary prevention as a response to homelessness or it is dissatisfied with the homeless situation but believes there is no innovative or effective response available. It may view homelessness as an unavoidable condition for some people given the economy and other factors. However, the community's homeless problem may affect neighboring communities by causing an influx of homeless or distressed families and individuals seeking services. This may motivate an agency from a nearby community to establish a homelessness prevention and community stabilization program in the distressed community.

Some communities or organizations within communities may be hostile to the establishment of this homelessness prevention and community stabilization model. This may be especially true of shelter, meal program and food pantry providers. They may misunderstand primary prevention, viewing it as a duplication of their services to essentially the same client population. Or they may correctly perceive that this prevention model positions itself "upstream" in the continuum

of services, reaching clients before they need emergency food and shelter and reducing demand for their services.

Opposition may arise from the resulting competition for clients or "market share" and for scarce funding resources. One strategy mentioned earlier for minimizing competition and opposition is to place the prevention program with an emergency food or shelter provider willing to adopt the model and reallocate staff and resources to primary prevention. This may require training for management and staff from a provider experienced with this model. Resources can be further maximized when more than one agency combine staff and funding forming a collaboration to operate the prevention program. Local food and shelter providers could be encouraged to collaborate and reallocate resources to prevention by requiring a local match for state, federal and foundation prevention grants.

In communities where providers of services to homeless and at-risk households need to preserve their autonomy, it is still possible to create a system that links providers and tracks clients. We have adapted the internal data collection system for statistical reports, described in chapter four, to community-wide systems of providers. Each provider, using a key to statistics similar to the one described in the previous chapter, completes a "stat page" for each homeless household it has served during a quarter. Confidentiality is preserved by identifying clients with a four-letter code derived from the first two letters of the head of household's first and last name. The "stat pages" from each agency are submitted quarterly to an individual or group that enters the data to a spread sheet. By collating and analyzing this information, the

community has a powerful tool for understanding client demographics, patterns of homelessness, relationships among service providers, outcomes for clients and other factors that can help the community improve its service systems.

Occasionally, no existing homeless or hunger services provider will reorganize to offer primary prevention and these agencies may oppose any other agency implementing the model as well. Opposition may also initially come from other important sectors of the community such as specialty providers, local government or local funding organizations. Yet a concerned agency from inside or outside the community may feel compelled to offer primary homelessness prevention anyway. Can this homelessness prevention and community stabilization model be effective in communities where some institutional stakeholders are initially hostile?

Our experience shows primary prevention is so attractive to clients in communities where it has not been previously available that poor households respond in large numbers quickly to a relatively low-profile outreach strategy consisting of posting fliers in poor neighborhoods. The combination of no eligibility restrictions, easy access and one-stop shopping for comprehensive services gives the program rapid market share through client self-referral. Many clients also like the emphasis on client responsibility because it trains and empowers them to control their own lives. As prevention counselors make referrals to specialty providers for services and specialty providers begin to depend on the prevention program to stabilize households so their own case work can be accomplished, dozens of agencies become referral sources for the

program and cooperative relationships multiply.

Just as the crisis of homelessness or impending homelessness can motivate clients when services are traded for positive life style changes, agencies may respond to the distress of competition from a primary prevention program by eventually adopting some or all of this model. Ronald Heifetz has written:

> Just as individuals resist the pain and dislocation that comes with changing their attitudes and habits of behavior, societies resist learning as well. For a social system to learn, old patterns of relationship--balances of power, customary operating procedures, distributions of wealth--may be threatened. Old skills may be rendered useless. Beliefs, identity, and orienting values--images of justice, community and responsibility--may be called into question.[31]

It may take time for this homelessness prevention and community stabilization model to be accepted by other stakeholders in the community. Exploring a diverse array of funding sources can increase the chances that the prevention program will survive long enough to catalyze permanent changes in the community's approach to homelessness.

4. Funding Strategies

Although primary prevention as described in this book is not yet recognized as the solution to homelessness and a necessary activity to stabilize communities, there are some federal, state and local funding sources that may be used to support prevention. The Emergency Shelter

Grants Program, a McKinney Act program designed primarily to fund shelters, allows 30% of its allocation to each state to support prevention programs. States are not required to apply the entire 30% to prevention and may not exceed the 30% limit, but this allows programs that serve clients who are not homeless to receive funding to prevent homelessness from occurring. States apply to the Department of Housing and Urban Development for this funding and distribute it, usually through a competitive application process, to local programs and agencies.

Currently the Supportive Housing Program, another McKinney Act program administered by HUD and distributed through the annual Continuum of Care application process, provides funding only for services for homeless people. However, we believe that this funding could support the activities of this homelessness prevention and community stabilization model directed toward the homeless, including outreach, intake and assessment of homeless households prior to entering shelter, and stabilization services for up to six months after leaving shelter for formerly homeless households transitioning from shelter into the community. Formerly homeless people who are disabled, including those whose sole disability is substance abuse, may receive stabilization services under this funding beyond six months for the term of the grant. Since as much as 30% to 40% of the client population of a prevention program may be homeless or recently homeless, this funding source could support many prevention activities.

The Federal Emergency Management Agency provides funding to communities to address homelessness and hunger. It supports limited payment of rental, mortgage and utility arrears, shelter costs including

food and supplies, meal programs and food distribution. Funds are allocated by the national board to local boards consisting of representatives from community organizations based on the population and unemployment rate of the community. The local board distributes funds to organizations providing eligible services. FEMA funds can support the prevention program's direct financial assistance for rent and utilities, food distribution and some emergency shelter for clients, but not staff salaries, administration, or other program costs.

We have noted Community Service Block Grants (CSBG) which support community action agencies could support this homelessness prevention and community stabilization model when the community's prevention program is operated by an authorized community action agency. Community Development Block Grants (CDBG), administered by HUD and distributed through a competitive bid process by local cities and towns, support social services as well as other development activities that benefit low and moderate income households. Many cities and towns support human service activities through their own tax revenues as well.

This homelessness prevention and community stabilization model may also be supported through United Way funds when operated by a United Way member agency. United Ways raise funds locally for member agencies providing a wide array of human services in the community. Fund-raising and distribution is conducted by volunteers from the community who solicit contributions from businesses and their employees and from other organizations and individuals. An agency implementing this homelessness prevention and community stabilization

model may also want to raise funds locally through its own annual campaign. A constituency of contributors can be a strong source of support in leveraging public funds and gaining broader community acceptance as well. A prevention program can build this constituency through direct mail or fund-raising events and can start a mailing list using the public donor lists of related organizations such as hospitals, other social service agencies, United Ways, and even museums and other cultural institutions. Churches, which often offer ad hoc homeless and hunger services, may be interested in supporting this prevention model especially when it can relieve the clergy of the responsibility and expense of providing emergency services and do the job more effectively and consistently. Foundations, especially community foundations, and corporations can also be a source of support for homelessness prevention and community stabilization

Collaborations, sub-contracts and cooperative agreements with other programs and agencies may be a source of funding support for homelessness prevention and community stabilization. Programs that provide specialty services may need to offer stabilization services, which could be provided by the prevention program, for clients to successfully use the specialty service. For instance, our homelessness prevention and community stabilization program is part of a family literacy collaborative funded through the Even Start program of the Department of Education. High-risk families using the adult, parenting and early childhood education services of the Even Start program may periodically need housing and income stabilization services to avoid dropping out of the educational program. The homelessness prevention and community stabilization program receives some funding through Even Start to

provide these services. However, it would violate the community access principle of this model to deny services to any household or sub-population due to lack of a funding agreement.

Chapter 6: Case Studies

The following case studies are selected from the files of Family Life Support Center, Inc. to illustrate the principles and services of this homelessness prevention and community stabilization model. Client names have been changed to protect confidentiality. The events of each case are presented chronologically to give the reader a sense of the time spans and rhythms of counselor-client relationships. Although the case studies focus on factual chronologies and outcomes, each counselor-client relationship is full of warmth and disagreement, anger and cooperation, and periods of hopefulness, frustration, boredom, crisis and exciting progress that it would take a much better writer to fully convey.

1. Greg - Street Homelessness

Greg was a 47 year old man referred to the prevention program in October, 1993 by the welfare department. He had been homeless on the streets of the community for several days or weeks, and prior to that had been homeless on the streets of Detroit and Boston for many years. He had no income and little work history. At the intake he was soft-spoken, articulate, quiet. He said he wanted to find a niche, settle down and fit in. He was referred to the emergency shelter. The initial service plan included contacting the welfare department in Cambridge, Massachusetts to obtain Greg's birth certificate and obtaining income through general relief. A medical examination, arranged for general relief documentation, revealed a possible hernia, dog bite and rash.

Greg resided at the shelter from October 27 to November 29, 1993. Staff observed he usually spoke only when spoken to, was reluctant to eat dinner with other residents and preferred to eat standing up in the kitchen only after the communal meal was over. He could sometimes be found standing motionless, alone, in the middle of a room with the lights out. During one conversation he said of a typical day on the streets of Boston for the homeless: "You have to keep moving."

An assessment appointment at the mental health agency was arranged. It confirmed Greg had been thinking of settling down somewhere for the past five years. His parents died within a short time of each other when he was 28. No other relatives wanted him, so after a period living between friends he began living on the streets. The mental health agency diagnosed him as disabled for 30-60 days which made him eligible for general relief. The shelter staff requested and received a 60-90 day disability to provide time to work on socialization skills. An appointment at the welfare department to obtain Medicaid benefits and an appointment at the state disability commission for an employment and training assessment were arranged.

At a November case review the service plan instructed counselors to engage in conversation to establish bonds, debrief Greg in the morning and evening regarding his day's activities, arrange for a community service placement and encourage him to eat his evening meal with the other residents. It was learned Greg had previously applied for SSI benefits and had filed for a social security card. By mid-November Greg had begun leaving the shelter early each morning to avoid speaking with daytime staff, was refusing to do household chores

and had largely stopped responding to conversation. He did not want to cook and was feeling pressured and uncomfortable as the shelter census increased.

On November 16th Greg had his hernia operation and the shelter staff obtained post-operative instructions directly from hospital staff. He recuperated during the next two days, but on November 19th he had angry outbursts and staff felt physically threatened. He was discharged to a motel for the weekend and was readmitted to the shelter the next Monday. At the following case review it was decided to start community service, start a housing search as soon as income was secured, continue to initiate conversations with Greg, and deny access to the kitchen for snacks after dinner to motivate him to participate in evening meals.

Greg responded to the case management plan by refusing to do chores and avoiding conversation. On November 29th his first general relief check arrived and that evening he left the shelter for the streets. Staff reserved a room for him in a local rooming house and found Greg on the street. He agreed to accept the room for December 1st. A prevention counselor took him to the rooming house and provided him with furnishings from the shelter. Direct deposit was arranged for his general relief check, a fuel assistance application was completed at the community action agency, and a follow-up medical appointment for his hernia operation was arranged.

During December a dental appointment was arranged for Greg, the prevention counselor suggested that Greg read the daily newspaper to

learn more about his new community, and a volunteer placement interview was arranged at the public library. He started volunteering at the library in January, 1994 and continued in counseling at the mental health agency.

During prevention counseling appointments in January medical care for Greg's foot was arranged, a disability determination appointment for SSI was set, and Greg indicated he liked volunteering at the library. It was observed he was communicating more easily and responding to humor. At counseling appointments in March, Greg was encouraged to apply for a one-bedroom apartment which he moved into on April 1st. The disability commission set up an eye examination and an ear examination.

In May Greg's SSI hearing was arranged and preparations were made with legal services. In June, Greg was still volunteering at the library and the mental health agency elected to move Greg from individual to group counseling. In July the library offered Greg a part-time job for 5-6 hours per week which Greg declined because he was concerned about his hernia. The disability commission enrolled Greg in remedial math classes at the community college in preparation for a health studies curriculum. In August Greg obtained his driver's license.

In September Greg began receiving SSI but was required to have a representative payee. The prevention program was asked to perform this service by the social security office. Greg was not happy about this but a system was arranged so Greg had significant control over his money. In October Greg was attending community college twice per week for

English and math classes and state college twice per week for GED preparation. In November Greg and the prevention program opened a joint checking account.

In January, 1995 Greg requested that the prevention program investigate the best interest-bearing account for his money and over the next six months he saved enough to pay his own tuition and go on vacation. In September the prevention program advocated with social security to discontinue representative payee status for Greg but was denied. After a summer vacation Greg returned to college, studying environmental science during the fall, 1995 and spring, 1996 semesters. He traveled again during summer, 1996. In October, 1996 Greg obtained dental and medical care for himself and arranged bill payment. In November, 1996 he made the Dean's List. As of April, 1997 Greg is completing the spring semester at college and preparing for his usual summer travel vacation.

In Greg's case, the prevention program coordinated its efforts with the mental health agency and the disability commission and helped Greg keep his appointments and follow through on his plan. The prevention counselor coordinated Greg's medical care until he took over that responsibility for himself. The residential and prevention counselors were essential in helping Greg obtain an income, first through general relief and later through SSI, by gathering documents and preparing applications. During his shelter residency, attempts to leverage Greg to interact with other residents at mealtimes by limiting evening access to the kitchen were unsuccessful. However, efforts to engage Greg in conversation, debrief him daily and coordinate his medical care were

instrumental first steps in creating a bond with Greg that made his later success possible.

2. Marilyn - Dual Diagnosis

Marilyn was a 43 year old woman with a history of alcoholism and substance abuse, referred in April, 1991 by a mental health consumer advocacy group because she had received an electricity termination notice. She had been a client of the mental health agency since 1988, accepting clinical services but refusing the community support program. She had been hospitalized several times in the previous four months in a psychiatric facility. The prevention program contacted the electric company who required $60 plus a repayment plan to stay termination. A telephone disconnection was averted when Marilyn's mother paid the arrears. The prevention program required Marilyn to accept representative payee services to manage her income from SSI and pay her bills in return for arranging to advance Marilyn $60 to avert the electricity termination.

Although Marilyn claimed to have been sober for six months prior to her intake at the prevention program, she arrived intoxicated for an appointment in May. She had spent her entire SSI check for that month and had not paid her rent. The landlord initiated eviction proceedings and a furniture rental company reclaimed Marilyn's furniture for non-payment. According to the mental health agency, Marilyn frequently forgot to take her medication or overdosed. She was illiterate. In return for negotiating with the landlord to stay the eviction and replacing Marilyn's furniture with donated furniture, the prevention program

required Marilyn to keep an appointment with a substance abuse counselor. A joint checking account was set up for the prevention program and Marilyn. In June, the community action agency paid a gas arrears for Marilyn.

In October Marilyn's son, recently released from jail, began living with her intermittently, she became involved with a boyfriend much younger than herself, and groups of young men began spending time at her apartment. Throughout 1992 her situation destabilized, she claimed to have been beaten by her boyfriend, the mental health agency discontinued home visits due to safety issues, she consistently ran out of food, and she was hospitalized for a cocaine overdose. The prevention program began working with her to locate new housing and in February, 1993 she moved into subsidized housing.

In April Marilyn claimed the prevention program was mismanaging her money, however, the social security office continued to retain the prevention program as payee. The prevention program reviewed finances and records with Marilyn and her mother and Marilyn remained relatively stable until May, 1994 when her mental health again deteriorated and eviction proceedings were begun due to ongoing disturbances. The prevention program helped Marilyn locate a new apartment in August. In December Marilyn received a large court settlement for an earlier accident which she immediately spent resulting in a reduction in her SSI income which the prevention program negotiated to a sustainable level.

In March, 1995 Marilyn moved again and the prevention program

negotiated an affordable rent. Marilyn was convicted for theft from her mother for which she paid restitution from her income and was convicted for check fraud in November. The court mandated mental health counseling and monitoring of medication. Marilyn was again evicted in December due to ongoing disturbances and the prevention program located a new apartment for her. She replaced the prevention program with a new payee in December, but in February, 1996 requested to return to the prevention program. This was made contingent upon following through on her mental health appointments. The prevention program next heard from Marilyn in December, 1996 when Marilyn moved again and the prevention program provided donated furniture. She had been sober for six months, a police officer was her representative payee and she was attending GED classes and going to Alcoholics Anonymous and mental health counseling regularly.

In Marilyn's case, the prevention program's primary contribution was to maintain housing and an income for Marilyn and avert homelessness during several years of severe destabilization. The prevention counselor provided for Marilyn's basic needs but helped her understand the consequences of her actions by paying her arrears and fines from her discretionary income. Although this led to Marilyn severing her relationship with the prevention program, it leveraged her to re-establish her relationship with the mental health agency to address her substance abuse and mental health problems and may have prepared the way for her current period of relative stability.

3. Elaine - Single Working Mother

Elaine was a 36 year old single woman with a six year old daughter and four year old twin sons, self-referred in April, 1996 when she saw a program flier. She had returned to the area from Alaska when a relationship ended and had been living with a friend and the friend's family. The father of Elaine's children lives in Alaska and although ordered to pay child support had not done so. Elaine has an associate's degree in early childhood education and a bachelor's degree in child development. She worked part-time for a temporary employment service in a variety of placements doing office work. She requested assistance with finding housing and child care.

The prevention program referred Elaine to the YMCA for child care and a scholarship voucher. The prevention counselor helped Elaine locate apartments and prepare housing applications. The counselor also helped Elaine apply for full-time employment. In June Elaine returned to the prevention office to report that she had found full-time employment at a bank through the temporary employment service and that her children were enrolled in the child care program at the YMCA. She was still looking for permanent housing. The prevention counselor continued to assist with and advocate for housing.

In August Elaine reported that she had found permanent housing, was still working full-time at the bank, and her children were still enrolled at the YMCA children's program. The prevention counselor referred her to the community action agency for fuel assistance and the energy conservation program. A referral was made to the public welfare department and a local health advocacy organization for children's health insurance. The prevention counselor provided Elaine with

budgeting information.

The prevention program helped Elaine to find child care which probably made it possible for her to accept full-time employment. Full-time employment, in turn, made it possible for Elaine to find housing and move out of an overcrowded situation. Fuel assistance and health insurance for her children should further stabilize Elaine.

4. Rita - Voluntary Relocation

Rita was a 62 year old single foster parent who was self-referred in April, 1996 when she saw an article about the program in the newspaper. She had moved to the area less than two months earlier from Georgia to be near her son's family. She and her four year old pre-adoptive foster child, Bradley, were living in an overcrowded apartment with her son's family. Rita had worked as a certified nursing assistant for over 30 years in Georgia. She is a severe diabetic and is insulin-dependent. Bradley was born crack-addicted and has congenital syphilis, severe asthma and attention deficit disorder. Rita received $740/month in income through a pension and a pre-adoptive parent stipend but $479 was automatically deducted for loan repayments. Rita was approved to be a foster parent in Massachusetts but needed an apartment to begin caring for children.

The prevention program assisted with a housing search and advocated vigorously with several landlords and housing projects. Rita was referred to Head Start and WIC for Bradley, and to the welfare department to obtain children's health insurance. An SSI application for Bradley had been denied in Georgia but the prevention counselor

referred Rita to the social security office to start a new application. Rita applied for emergency shelter in case she was unsuccessful finding housing, however, Rita successfully found subsidized housing and moved in by mid-May.

The prevention program was able to help Rita find housing rapidly and make emergency shelter unnecessary. By finding affordable, adequate housing Rita will be able to increase her income by being a foster parent. The prevention program also obtained health care and other supports for Bradley.

5. Danielle - Chronic Recidivist

Danielle was a 27 year old single woman with a four year old son, Kevin, when she was referred by the welfare department in January, 1992 for a housing search. She had been evicted by a friend in New Jersey and then stayed in her mother's and step-father's overcrowded apartment. She had received public assistance in New Jersey, had six years experience as a cashier but had not worked since Kevin's birth, did not know Kevin's father's name or location, was a high school graduate but unable to read, and was interested in family planning because she had no birth control. The prevention program referred Danielle for public assistance and medical insurance, a family planning appointment, WIC, a medical appointment for follow-up on recent eye surgery for Kevin, and assisted her with a housing search.

Danielle moved into a subsidized apartment in February with donated furnishings from the prevention program, provided in return for

keeping her family planning and doctor's appointments. Her budget was reviewed and a referral to a family literacy program for adult and parenting education was made. Danielle returned in November because she was being evicted for non-payment of rent and lease violations. Although her income was adequate to meet her expenses she was unable to explain how she accumulated rental and utility arrears. The housing authority was unwilling to retain her as a tenant even if she accepted money management services from the prevention program.

She missed her next several appointments and returned in September, 1993 with termination notices for all utilities from the private market apartment she had been renting for 11 months. She had recently evicted her abusive boyfriend and attempted suicide. The prevention program advocated for new housing for Danielle that would include her utilities in her rent and forestalled utilities terminations in return for accepting mental health counseling. In October she found another apartment which she arranged to rent with her brother, combining their incomes from public assistance and general relief. The prevention program arranged for the welfare department to place all rent and utilities on protective payments (directly paid from benefits checks). Danielle enrolled in an adult literacy program at the library and attended weekly mental health counseling appointments. A new budget was prepared.

Danielle missed her November appointments and was next seen at the prevention program in October, 1994. Her brother had moved out of her apartment and a new boyfriend had moved in. Danielle again had rent and utilities arrears and had tried to use false names to reinstate utility services. The prevention program negotiated repayment plans for

utilities and had service and protective payments reinstated in return for cooperation from Danielle and her boyfriend, John, in working with the prevention counselor to develop a budget, reduce expenses and share responsibilities. Danielle was again referred to the family literacy program for adult basic education.

Danielle missed appointments in November, 1994 and in March, 1995 and next returned to the prevention program in February, 1996. She had been living with John and her son Kevin, now eight years old, in an apartment for the past ten months and again had utilities and rental arrears. Her public assistance had been reduced due to new welfare rules requiring recipients to identify the other biological parent of children, which Danielle was unable to do. However, her public assistance and food stamps and John's unemployment benefits were sufficient to develop a budget and maintain services. They had withheld rent due to alleged code violations and the prevention program coached Danielle in calling the board of health to verify violations and mandate repairs. It was learned the disability commission was working on an SSI application for Danielle. In return for assisting with a housing search to find a less expensive apartment, the prevention program required John to conduct an employment search and assisted him with a resume and interview preparation, and helped Danielle locate a community service placement to satisfy new welfare regulations.

In April Danielle and John moved into a new apartment with all utilities included in the rent and rent paid through voluntary protective payments. Danielle satisfied her community service by volunteering at a meal program and was again enrolled at the family literacy program for

adult literacy and community service. Her public assistance was restored to full benefits when the welfare department was court-ordered not to penalize recipients who are unable to identify the fathers of their children. Danielle missed follow up appointments in April and June.

Danielle has a pattern of returning to the prevention program with a housing and utilities crisis every one to two years. The prevention program has been able to respond by finding housing and restoring utilities each time, avoiding homelessness and placement in emergency shelter. Danielle is probably not employable and will qualify for SSI benefits, at which point the disability commission and the prevention program should advocate for representative payee status in order to permanently stabilize her finances and housing. We anticipate her patterns will continue and she will return with arrears in mid- to late 1997. The prevention program will continue make services contingent upon participation in budget counseling, educational programs, mental health counseling and community service.

6. Jane - Medical Advocacy

Jane was a 51 year old single woman referred by the psychiatric hospital in May, 1995 for assistance obtaining an income and medical insurance. She had two grown children in New Jersey one of whom she lived with for seven years until moving to this area one year ago to live with her mother. She had worked as a secretary all her life for an accounting firm, public schools and manufacturers and had been living on unemployment insurance and a pension since being laid off in December, 1994. Her health insurance expired in January, 1995. She

suffers from diabetes insipidus and her medication for this and other conditions costs $750 per month.

The prevention program pursued benefits for Jane through two sources: general relief, food stamps and Medicaid through the welfare department and social security disability through the social security office. The prevention program coordinated the collection of documents from medical personnel and assisted Jane with preparing applications. In June it was learned that her assets including savings and an automobile exceeded the eligibility limits for general relief. Jane elected not to sell her automobile. The prevention program continued to pursue Medicaid to cover medical and prescription costs. By late June neither Medicaid or SSD had been approved, Jane's savings were nearly depleted and she was distraught. The prevention program aggressively advocated with agencies and facilitated document collection. In July Medicaid coverage was approved and a medical appointment was arranged for Jane.

In late July SSD was denied and the prevention program referred Jane to a disability advocacy group and the disability commission to initiate an appeal. Jane was hospitalized for one week in August for psychiatric treatment resulting from the stress of her situation. In September Jane was approved for SSD. The prevention program worked with her to develop a budget and she elected to continue living with her mother.

The prevention program was instrumental in advocating for Jane with the benefits systems when her disease without treatment and

medication could have been fatal. The prevention program was able to coordinate and accelerate the work of government agencies and medical personnel, assist Jane with the application process and document collection, and provide emotional support during a highly stressful period. In her assessment of prevention program services, Jane wrote that her life situation was "desperate" when she arrived at the prevention program and that now "I finally have hope again." The prevention program will assist Jean to obtain job training and employment if she returns for additional services.

7. Steve - Abused Elderly

Steve was a 66 year old man referred by elder services in July, 1996 for housing assistance. He had moved from New York State in November, 1995 and was renting a room from a friend in a house in which the utilities had been terminated for non-payment although the friend had collected rent and utilities money from Steve. Steve was distressed and unable to maintain his hygiene. The prevention program helped Steve contact several housing authorities for subsidized housing, however, Steve indicated at a September appointment that he did not want to move.

In October the gas heat was put in Steve's name by his roommate so service would be restored, however, Steve thought the substantial arrears from the old bill had been transferred to his name as well. He indicated to the prevention counselor that he was being taken advantage of and wanted to move. Applications were submitted to several housing authorities for subsidized housing. The prevention program advocated

vigorously by writing letters to housing authorities explaining Steve's situation and collecting documents to complete applications. The housing authority was unable to contact past landlords to obtain references for Steve and indicated willingness to rent to Steve if the prevention program would be his representative payee for his SSI to ensure rental payments. The prevention program and Steve agreed and Steve was able to move into a one-bedroom apartment in December. The prevention program contacted movers and elder services provided financial assistance for the move. The housing authority waived limits on pets so Steve could keep his dog and cat. Steve was referred to the community action agency for fuel assistance.

Since December the prevention program has managed Steve's income and prevented his acquaintances from coercing money from him. Steve looks better and his personal hygiene has improved. He noted in his assessment of the prevention program services: "I feel like someone cares about what is happening in my life." The prevention program encouraged Steve to continue attending elder services activities and meal programs to meet people. The gas company continued to dun Steve long after his name was removed from bills and the prevention program successfully stopped the dunning by writing and advocating.

8. Maria - Limited English Proficiency

Maria was a 30 year old separated woman with two daughters, 13 and 11 years old, and a 9 year old son, referred by the welfare department in September, 1992. She had been living for several days in her sister's overcrowded apartment in violation of the lease after moving

to the area from Puerto Rico where she had lived with her parents for a year after being deserted by her husband in Miami. Maria had a ninth grade education and wanted to obtain her GED, her two youngest children were enrolled in special education programs and her oldest child attended middle school.

Maria and her family were admitted to the emergency shelter and resided there from September 9th through October 14th. During that time the residential staff assisted her to locate and rent a subsidized apartment near her sister that also allowed her children to remain in their schools. Residential counselors assisted with public assistance and housing documents and applications, advocated with the landlord and housing authority, coordinated inspections and protective payments, and provided donated furniture and housewares. The children attended school while in the shelter and staff helped Maria and the children with homework, transportation arrangements and advocating with school personnel. Shelter staff helped the family learn English through dinner conversation, counseling sessions and by obtaining an English tutor for Maria through the public library. All members of the family obtained medical, dental and eye check-ups and care for a number of conditions. In September Maria returned to Puerto Rico for four days to visit with her dying father and staff assisted with travel arrangements. Staff helped Maria register to vote and contact legal services to prepare a will.

After moving into her new apartment in October, Maria received follow-up counseling through the prevention program. In November, the prevention counselor facilitated a lease, inspection and protective payments which had not been completed by the welfare department, the

landlord and the housing authority earlier. Maria was carrying large sums of cash on her person and the prevention counselor went with her to a bank to open a savings account. Maria and the prevention counselor worked out a budget for the family.

During December Maria complained that she often ran out of food. The prevention counselor worked with her to develop a grocery budget and menu plan for the family and helped Maria monitor her spending by collecting and reviewing together grocery receipts for several months. During 1993 Maria continued English tutoring at the library and later the tutor came to her home. She priced and purchased used furniture and resolved several telephone and utility bill inaccuracies with the prevention counselor's advice and advocacy. Maria and her children continued to need medical attention for which the prevention program advocated. Her son experienced behavior problems in school and the prevention program coached Maria in how to advocate with teachers and other school personnel. She obtained additional reading, English and spelling tutoring for her son as well as mental health counseling for him. She also successfully advocated for his promotion to the next grade level at the end of the school year. In September, 1993 she took the GED test in Spanish and passed.

Until September, 1993 the prevention program helped Maria to budget her money, advocate for her children's educational and medical needs and achieve her own educational goals. Maria initially had weekly appointments at the prevention program that eventually became monthly. Maria said she liked to "check-in" although everything was going well in her life. In September the prevention counselor suggested

that Maria could succeed without regularly scheduled appointments and gave her a card in case she had problems or an emergency. Maria has not needed the program since then.

9. Nancy - Social Security Recertification

Nancy was a divorced woman referred by a friend in September, 1996 because she had recently rented an apartment and was extremely unhappy living in it. She suffered from a number of mental and physical health problems including ovarian tumors, tinnitus, migraines, insomnia disorder, post-traumatic stress disorder and substance abuse. Her source of income was SSI but she had received a termination of benefits notice effective January, 1997 due to the change in federal social security regulations that discontinued substance abuse as an eligible disability. She was in emotional crisis regarding her housing situation.

The prevention counselor assisted Nancy with a housing search, referring her to private landlords and public housing authorities. Recognizing Nancy's more serious long-term income problem, the prevention counselor referred her to legal services for assistance in preparing an SSI determination appeal. Nancy quickly found subsidized housing and moved into her new apartment in October. However, she did not follow through with her SSI appeal and lost her SSI benefits in January. Although she became eligible for general relief through the welfare department, benefits were much reduced and she soon was in rental and utilities arrears. By late January her electricity service had been discontinued.

The prevention counselor helped Nancy negotiate an affordable utility payment plan and electrical service was restored. Rent was lowered on Nancy's subsidized apartment by submitting income documentation. The prevention counselor also managed the SSI appeals process, contacting Nancy's doctors and other service providers for letters that detailed her medical and mental health history and clearly stated that she was unable to support herself through employment. In return for advocacy and in order to reintegrate Nancy into the community, the prevention counselor required her to try out community service and helped her arrange a volunteer placement as a receptionist for a women's services agency.

A May hearing was scheduled and the prevention counselor worked closely with Nancy in the interim on a budget to maintain her housing and basic needs. The prevention counselor prepared Nancy for the hearing and attended the hearing with her for support. SSI benefits were restored in June. The prevention program anticipates continuing to assist Nancy with budgeting and encouraging her to continue in her volunteer placement as preparation for eventual employment.

10. Laurie and James: Two-Parent Family

Laurie and James were a married couple, each 28 years old with a four year old son, Paul. James worked as an auto detailer at a car dealership earning $6 per hour and had been there 14 months. Laurie did not work. They had been evicted from their apartment for non-payment of rent and were referred by their home visiting caseworker in May, 1996. They were being temporarily sheltered in a motel by the

Red Cross. The prevention program conducted an intensive housing search with Laurie and James, helping them apply to private and public housing, and assisted them to obtain insurance and health care for the family. The couple participated in family and individual counseling at a family services agency.

Although many housing applications were submitted, it was necessary to shelter the family in a more appropriate setting while housing was secured. The family was admitted to the emergency shelter where they lived from June 10th to June 29th. At the shelter James continued to work and conducted an employment search to improve his employment situation, subsidized day care was located for Paul, and Laurie was required to begin an employment search. The residential staff prepared resumes and helped the family implement a budget and resolve past utilities arrears. It was learned that James was subject to seizures when under stress.

The prevention program continued to work with the family after they found permanent housing by developing a budget with James and Laurie and continuing their employment searches. James became increasingly impatient and unhappy with his job. During appointments with the prevention counselor in July James was not appropriately dressed for a job search and Laurie forgot the family's bills and pay stubs for budget counseling. In August Laurie learned that James had not paid the rent. The home visitor observed James hitting Paul forcefully and filed a report with the state child protection agency. James was ordered by the child protection agency to leave the home if Laurie was to keep custody of Paul.

The prevention counselor worked with Laurie to establish an independent income and household. She applied for public assistance and the subsidized rent was lowered to reflect the household's reduced income. Laurie and the prevention counselor negotiated a payment plan with the landlord to avoid an eviction. Laurie experienced some problems with neighbors and was able to set limits and resolve problems with coaching from the prevention counselor. She continued counseling at the family services agency and set clear expectations for James to open a bank account and obtain counseling before ending their separation. In September Paul was enrolled in kindergarten and Laurie started a job working with developmentally disabled people.

In December James came to the prevention program for counseling. The prevention counselor helped him to prepare a new resume and start an employment search. He was living with his parents and wanted to find his own apartment. He had improved his appearance and was more open to suggestions. The prevention counselor helped him apply for job training, and he signed up at temporary employment agencies and with the state employment service. He was enrolled in a medical assistant training program. In January he had an accident that left him unable to work. The prevention program assisted him with obtaining temporary general relief benefits. He continues to attend his job training program and has supervised visitations with Paul.

The prevention program provided housing search assistance that quickly resulted in housing for the family and minimized the time they needed to be in emergency shelter. After moving into permanent

housing, Laurie used the prevention program to establish her own independent household after her separation from James, avoid eviction, and find a job. James also returned to the prevention program after the separation to enroll in a job training program and obtain a temporary income.

11. Diane: Severe Mental and Physical Deterioration

Diane was a 35 year old divorced woman referred by the welfare department in April, 1992 because her electric service had been terminated. She also had telephone and gas arrears but she had borrowed from friends to pay her cable television bill. She could not remember her housing or employment history. She had an adult son living on his own outside the area. Diane had no income but received food stamps and fuel assistance. The prevention counselor observed that Diane was glassy-eyed at intake with difficulty concentrating and remembering her past. The prevention program offered to assist with an employment search to obtain an income and negotiated with the electric company to restore service. Diane did not return for subsequent appointments.

Diane returned to the program in November homeless, having been evicted from her apartment. She had stayed with various friends and family over the preceding three months and may have been hospitalized for some of that time. She was admitted to the emergency shelter where she resided from November 25th to December 9th when she left the shelter and did not return for two days. When she returned she was extremely agitated and disoriented and was referred and admitted to the

psychiatric hospital. The prevention counselor advocated for an extended stay and evaluation. She was diagnosed as a substance abuser and discharged after two weeks. The prevention program located a rooming house for Diane and paid the initial rent while obtaining income through general relief. She did not follow through with substance abuse or mental health counseling appointments and did not attend Alcoholics Anonymous. She was evicted in January, 1993 from the rooming house because she was unable to maintain her room which was strewn with garbage and feces.

Diane had been evaluated by mental health professionals as a substance abuser without a mental health diagnosis so she was referred upon eviction to a detoxification program. It was clear to that staff, as it had been to the shelter staff, that Diane should be treated as a dual diagnosis. An inter-agency review involving the prevention program, shelter staff, the mental health and substance abuse agencies and the state disability commission recommended a neuro-psychological evaluation but no health insurance was in place to pay for it. Diane was housed during February at a mental health crisis intervention facility but when she became belligerent and uncooperative she was discharged and readmitted to the emergency shelter.

Diane resided at the shelter from March 8th to May 18th. Shelter staff secured permanent housing for Diane with rent and all utilities on protective payments. She obtained temporary income through general relief based on a substance abuse diagnosis and an SSI application was initiated. She was referred to doctors for several medical and dental problems and attended Alcoholics Anonymous and substance abuse

counseling daily and volunteered intermittently in the community.

It was observed that Diane could not or would not follow a daily service plan, conform to shelter rules including informing staff when she left the facility or participating in household chores, and her conversation was disjointed and incoherent and her memory was poor. She often left appliances unattended, burning food and clothing and creating fire hazards and she was occasionally incontinent. A mental health assessment indicated possible organic damage and again recommended a neurological evaluation. However, mental health and medical professionals from several agencies assessed Diane as competent and shelter staff proceeded to place her in permanent housing in the community.

In July, 1993 Diane was approved for SSI and the prevention program was designated representative payee. The prevention counselor met with Diane twice weekly to pay bills and budget and to offer life skills counseling. After SSI was secured, Diane's son made a predatory attempt to become her payee, however, the prevention program successfully advised Diane against it. A homemaker was employed to clean Diane's apartment, plan meals and do laundry, however, Diane's apartment soon degenerated with garbage, feces and decomposing food. Over the next two years the prevention counselor made frequent home visits and hired a series of homemakers and professional cleaners to maintain Diane's apartment. Diane often had urine and feces on her person, rarely bathed, and sometimes went outdoors and into stores partially naked. As her mental and physical condition deteriorated her living conditions became more untenable. In September, 1994 the board

of health threatened to condemn her apartment.

Immediately after Diane was placed in permanent housing, the prevention program began to aggressively seek the medical and neuro-psychological evaluations necessary to correctly diagnose Diane's illness. A local physician referred Diane for testing at a nearby university hospital, however, the testing revealed no physical causes for her incontinence and fiber therapy and exercise was recommended. Mental health providers continued to maintain that Diane did not have a mental illness.

In September, 1994 the prevention program was able to find a local doctor to authorize a home health aide for Diane. A referral was made for a visiting nurse and the combination of a health aide on a daily basis and a weekly homemaker stabilized Diane for six months. The prevention program continued to pursue placement in a nursing home facility, however, Diane was either too young or too incontinent or refused to accept placement. The prevention program explored the guardianship process through elder services and evaluations of capacity to consent through the psychiatric hospital and mental health agency without success. The visiting nurse was discontinued in March, 1995 when Diane's condition again deteriorated and she refused to bathe or cooperate with home health aides. In March the prevention program was able to refer Diane for a neuro-psychological evaluation that suggested either frontal lobe deterioration or drug-induced dementia. A CATSCAN confirmed frontal lobe deterioration.

Diane was court-ordered to the psychiatric hospital during which

time it was learned that her brother had also been diagnosed with frontal lobe deterioration. In May a research hospital in Boston accepted both Diane and her brother for treatment where Diane remained for six months. She was transferred to a rehabilitation facility in January, 1996. The prevention program closed its SSI payee account for Diane in March, 1996.

For three years Diane lived in the cracks between the target populations and missions of many agencies. She was not accepted as a mental health patient or as a person with a clear physical disability. As her condition deteriorated, the prevention program struggled to support her in the community and provide for her basic needs. Aggressive advocacy by the prevention program and other agencies and medical insurance through SSI finally resulted in a correct diagnosis and treatment. Diane might have died on the streets or in her apartment without the case management provided by the prevention program.

12. George and Karen: Unemployed and Debt-Burdened

George, age 47, and Karen, age 42, were a married couple with two children, Miranda, age 17 and Charles, age 12. They were referred by the gas company in November, 1993 due to a $400 gas arrears. They owed over $500 in additional rent and utility arrears and over $1,000 in medical bills. They had a car loan and personal loan. George and Karen were each high school graduates; Karen worked as a home health aide and George had recently been laid off during a period of downsizing after 23 years with a large manufacturer. George's unemployment insurance would run out in one week.

The prevention counselor developed a service plan with them that included finding affordable housing, intensive budget counseling, employment search for George, applying for food stamps and Medicaid, exploring veteran's benefits for George who had two years active and six years reserve military background, and a referral for George to the state disability commission for job training. The family obtained an emergency food pantry from the community action agency.

By January, 1994 George and Karen had implemented a new budget and started repaying debts. In March George obtained employment that lasted six months, and soon after found another job lasting eight months. However, in February, 1996 they returned to the prevention program because George was again unemployed and the family was in arrears on most bills. The prevention counselor developed a weekly budget for the family and met with George and Karen monthly to review their spending and refine the budget. At this time Miranda was also working and was asked to contribute financially to the household by paying room and board. The prevention program facilitated veteran's insurance and medication for George, health insurance through a local health advocacy agency for the rest of the family, fuel assistance through community action, food assistance through a food pantry, and an SSI application for Charles who was diagnosed with attention deficit disorder. The family was referred to H&R Block for tax preparation and to negotiate payment of back taxes with the IRS. The prevention program prepared a letter for court describing its budget plan resulting in an affordable credit repayment on a loan from a credit union.

In May George successfully obtained a full-time job, however, the family needed ongoing, intensive budget counseling to keep them on track paying bills and repaying debts. As of June, 1997 the family had adequate income through George's and Karen's employment but needed ongoing assistance with budgeting and money management. The prevention program had successfully maintained the family by organizing a wide range of community and income supports over a four year period and helped George to organize his employment search and land a job. Through additional budget counseling the prevention program may be able to help the family remain stable.

Chapter 7: Conclusion

We have started with the assertion that homelessness is not the problem; it is simply the result or symptom of the real problems. The root causes of homelessness are the multiple, unaddressed problems of a household before it ever becomes homeless. Therefore, the primary target population of our program to solve homelessness is people who are not homeless.

For the community, also, homelessness is not the problem. The problem is to stabilize and retain sufficient numbers of poor people long enough to establish diverse and supportive relationships and networks. This means considering the community's people valuable and worth retaining, right where they are, before they become middle class.

This homelessness prevention and community stabilization model views poverty as a developmental stage in many people's lives that cannot be transcended simply or primarily by distributing cash assistance. It involves changing personal behaviors and adopting community values as well as using abundant public and private resources effectively. This model helps poor people achieve the ultimately non-economic goal of dignified lives and we believe this process builds healthy communities.

We have also asserted that homelessness is resolvable now, with the resources available today in or near every community. The program model uses the vast resources of the free market economy and the social

welfare system combined to help poor people avoid homelessness, take responsibility for achieving their goals and aspirations, and contribute to their communities. It makes the connection between individual responsibility and community resources.

This homelessness prevention and community stabilization program applies four basic operating principles: 1) No eligibility requirements or barriers for service, allowing community access so that everyone can obtain services; 2) Comprehensive services that allow for "one-stop shopping" to solve any problem or combination of problems; 3) An emphasis on client responsibility for making positive life style changes; and 4) A commitment to high quality services and intensive, ongoing staff training through the weekly case review.

Using the public and private resources of the community to increase the capacity of clients to prevent and solve their own problems is the core competency and dynamic of this prevention model. It requires extensive knowledge of the community's economy, housing stock and social service infrastructure. It also requires a repertoire of counseling techniques and strategies to manage the distress of clients in crisis and overcome their work avoidance mechanisms.

This prevention model views the crises experienced by homeless and at-risk households less as problems requiring immediate solution than as opportunities to leverage positive life style and behavior changes that will make future crises less likely. People are more likely to consider adaptive solutions that challenge their established behaviors if they feel the sense of urgency brought on by crisis. The program uses

the client's distress to keep the client focused on the real work of finding permanent solutions to the root causes of the crisis.

The art of counseling involves motivating each client to do the maximum possible work toward implementing permanent solutions to problems without overwhelming clients beyond their abilities to function or enabling them to avoid substantive change by doing too much for them or protecting them from the consequences of their choices. Clients are routinely required to reduce unnecessary spending, repay accumulated debts, continue their educations, seek employment, attend counseling and treatment programs, and participate in community activities in return for services provided by the program.

The emphasis on client responsibility does not at all diminish, and actually facilitates, warm and supportive counselor-client partnerships that advance the sometimes unavoidably painful work of making positive, permanent life style changes. Many clients exit the program with the self-knowledge and self-confidence that come from achieving their goals through their own efforts and commitment.

This homelessness prevention and community stabilization model provides services using a combination of direct counseling--organizing the client's personal resources--and case management--organizing the community's resources for the client through referrals and advocacy. Client services may be divided into three general areas: 1) Housing services, including housing search assistance, landlord-tenant and utilities mediation, and financial assistance; 2) Income services, including employment counseling, benefits advocacy, and budget

counseling; and 3) Specialized services, including referrals for specialized services, life skills counseling, and emergency shelter. The program has four basic commodities to exchange for responsible behavior and positive life style changes: information, counseling, advocacy and intervention.

Three elements of the program structure are essential to successful counseling and case management: the intake and assessment, the service plan, and case review. There is no substitute for a thorough intake and assessment. Without complete information about the history and systems of a household, we cannot select appropriate services and may overlook important services. Without understanding the client's assets and capabilities, we cannot accurately assign responsibility for tasks or demand adaptive behavior. Instead, we will frequently overburden fragile or distressed clients beyond their abilities to cope, or enable clients to continue irresponsible, unproductive or self-destructive behavior by doing too much for them and protecting them from the consequences of their choices.

A comprehensive intake and assessment makes an effective service plan possible. The service plan describes the counseling and case management activities to be accomplished, and sets performance benchmarks for the prevention counselor and client. It consists of four broad components: 1) a housing plan to find or maintain an adequate, affordable place to live; 2) a budget plan to balance income and expenses and manage money effectively; 3) an employment and education plan to find a productive role in the community; and 4) a counseling and treatment plan to address a wide range of life skills and

health issues.

Case review is a weekly meeting of prevention counselors and program managers during which information and service plans of client households are presented, reviewed and modified using up-to-date case notes and statistics. Case review brings the full experience and creativity of the staff to bear on each case so that options and opportunities are maximized for each client. It provides intensive, ongoing support and training for staff and serves as the quality control mechanism of this prevention model.

This homelessness prevention and community stabilization program can effectively serve any community at an annual cost of about $2 per capita. Based on our experience with this model, we calculate that a prevention program will need one counselor per 25,000 population. We believe that this staffing configuration can reduce emergency shelter requirements by as much as 25% per year until they stabilize at one bed per night per 10,000 population and homelessness disappears as a chronic, visible problem. It can reduce by over 60% the community's overall cost of addressing homelessness.

Although the following additional outcomes have not been measured and, therefore, remain somewhat speculative, our experience suggests this homelessness prevention and community stabilization model results in many other benefits for communities, including:

--Improves housing conditions and stabilizes neighborhoods, as tenants are better able to pay their rents and responsible landlords

maintain their buildings, as landlords compete for tenants and low-income households negotiate affordable rents, and as more neighborhood and voluntary associations form.

--Increases the economic self-sufficiency of households, as incomes increase through employment and benefits, and as expenses and debts are reduced through budget counseling; economic activity increases as businesses locate in safer, more attractive streets and neighborhoods.

--Redirects community resources from crisis management to education and economic development, as public and private funds formerly spent on shelter and other emergency services for the homeless can be allocated toward higher value-added activities such as business loans, infrastructure improvement and educational programs.

--Creates a more efficient, effective social service delivery system, as service providers communicate more frequently and clients are referred earlier and are better prepared to take advantage of services.

--Stabilizes student populations so schools can focus on education, as families move less frequently, and parents learn to advocate more effectively for their children and participate in setting educational goals for themselves and their children.

--Prepares communities for welfare reform without increased homelessness, as welfare recipients experience fewer housing and financial crises so they can focus on achieving educational and employment goals before time limits expire.

--Teaches clients to advocate for themselves and take

responsibility for solving problems, by not just solving problems for clients but also showing clients how to prevent and solve problems for themselves, their families and their neighbors.

The poor and the homeless are always with us because they are us. We have always had the resources--and this book has offered a way to organize those resources--to make sure everyone who wants it has a home and a productive role in a healthy community. Urban communities can be what cities have always been at their best--incubators of a diverse and stable middle class.

NOTES

Cover photograph: "Boy Passing by Reservoir" by Ruth Orkin, Copyright 1981 Ruth Orkin Photograph

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Appendices

A. Outreach Flier
B. Intake and Assessment Form
C. Service Plan Summary
D. Client Planning Form
E. Stat Sheet
F. Key to Statistics
G. Statistical Report
H. Client Satisfaction Survey
I. Apartment List
J. Job List
K. Consent for Release of Confidential Information
L. Shelter Rules and Expectations
M. Emergency Shelter Requirements, 1989-1997, North Adams Area

Appendix A

ARE YOU HAVING TROUBLE MAKING ENDS MEET & KEEPING UP WITH THE RENT?? ARE YOU AFRAID YOU MIGHT LOSE YOUR APARTMENT OR HOME??

Get help at:
THE FAMILY LIFE SUPPORT CENTER
74 North Street, Room 412, Pittsfield
443-6580
Monday-Friday, 8:00-4:00

We offer:

I. EMPLOYMENT AND BUDGET COUNSELING

--Develop a budget you can live with
--Learn how to manage your money more effectively
--Find a job: set up interviews and prepare a resume
--Obtain food stamps, rent subsidies and other benefits
--Arrange affordable repayment plans for rent, utilities and other arrears.
--Get information about job training and education programs
--Get help finding a job or community service placement to satisfy welfare requirements

II. HOUSING ASSISTANCE

--Find an affordable, decent apartment
--Tenant advocacy and eviction prevention
--Learn how to inspect an apartment before moving in
--Know your rights and responsibilities as a tenant
--Limited financial assistance & loans for security deposits, rent & utilities

III. REFERRALS AND COUNSELING

--Find child care and recreation programs for your children
--Referrals for medical care, legal aid and other services
--Help for alcohol and drug dependency
--Resolve problems and plan for the future
--Information about homemaking, nutrition and parenting

Client Assessment Form

Date: _____ Counselor: _____

Referred by: _____ Request: _____

Name: _____ Age: _____ DOB: _____ SSN: _____

Name: _____ Age: _____ DOB: _____ SSN: _____

Name: _____ Age: _____ DOB: _____ SSN: _____
Work or EI M:_____
School: _____ HS _____ DSS _____ Parents F: _____
Name: _____ Age: _____ DOB: _____ SSN: _____
Work or EI M:_____
School: _____ HS _____ DSS _____ Parents F: _____
Name: _____ Age: _____ DOB: _____ SSN: _____
Work or EI M:_____
School: _____ HS _____ DSS _____ Parents F: _____
Name: _____ Age: _____ DOB: _____ SSN: _____
Work or EI M:_____
School: _____ HS _____ DSS _____ Parents F: _____

HOUSING HISTORY

Current Tel #

Address	Primary/Other	Dates	Rent/Util	Landlord

Have you ever owned a home?

FINANCIAL BACKGROUND

Income Bank: _____ Checking_____ Savings _____

Name Source (Benefit or Earned) Pay Dates _ __Net____ Gross

_____

_____

_____

_____

EA Eligible? _____ Date last used _____ Food Stamps: _____ Fuel Assist: _____
Public Assistance time remaining: _____ TOTAL INCOME: _____

Expenses

Expense Amt/Mo Arrears New Budget Plan

Rent/Mrtg _____
Electricity _____
Gas/Oil _____
Telephone _____
Cable/TV _____
Food _____
Transportation _____
Medical _____
Cigarettes _____
Entertainment _____
Credit/Debt _____
_____
_____
Other Exp _____
_____
_____
TOTALS _____
Financial Plan/Notes: _____
_____
_____
_____
Order consumer credit report?

EMPLOYMENT BACKGROUND

Name _____ Current Employer _____FT___PT___

Education, Voc Training _____

Skills, Licenses, Military _____

Hobbies, Volunteer, Memberships _____

Current & Long-term Goals _____

Employer/Address Job Title/Duties Dates/Reason Left

When you think about your skills and experience from employment, education, volunteering and hobbies, what three things do you think you do best?

1.
2.
3.

Which of all your skills are good enough that other people would hire you to do them?

1.
2.
3.

Which of your skills would you be able to teach to others?

1.
2.
3.

Have you ever considered starting a business? What kind of business?

What obstacles prevented you from starting or continuing the business?

Do you currently earn money on your own through the sale of services or products? What services or products do you sell? Who are your customers and how do you find customers?

EMPLOYMENT BACKGROUND

Name _____ Current Employer _____FT___PT___

Education, Voc Training _____

Skills, Licenses, Military _____

Hobbies, Volunteer, Memberships _____

Current & Long-term Goals _____

Employer/Address Job Title/Duties Dates/Reason Left

When you think about your skills and experience from employment, education, volunteering and hobbies, what three things do you think you do best?

1.
2.
3.

Which of all your skills are good enough that other people would hire you to do them?

1.
2.
3.

Which of your skills would you be able to teach to others?

1.
2.
3.

Have you ever considered starting a business? What kind of business?

What obstacles prevented you from starting or continuing the business?

Do you currently earn money on your own through the sale of services or products? What services or products do you sell? Who are your customers and how do you find customers?

B-5

EDUCATIONAL BACKGROUND

Adults

Highest

Name _____ Grade Completed _____

Current Educational Goals: _____

Schools Attended Courses/Major Dates/Degree/Reasons Left

Highest
Name _____ Grade Completed _____

Current Educational Goals: _____

Schools Attended Courses/Major Dates/Degree/Reasons Left

Name	School	Children Teacher Phone #	Most Recent Grade In: Read/Write	Math/Science

Where and when do children study at home:

Methods and frequency of parent-teacher communication:

B-6

MEDICAL/LEGAL/SOCIAL SERVICES

Service Provider Caseworker/Phone # Service/Treatment

_____

_____

_____

_____

_____

_____

Orders of protection/visitation rights/child support:

Court dates/warrants/probation:

Health insurance:

Medication/Prescriptions:

Physical/Mental Disabilities:

Alcohol/Drug abuse:

Spouse/Child abuse:

Family recreational activities/memberships:

Interest in family planning services:

Counselor's plan/assessment/referrals: _____
_____
_____
_____
_____

Appendix C

Service Plan Summary

Client Name: _____ Counselor: _____ Service Dates: _____

Discharged to: _____ Tel # _____

Subsidy?

Source of Income _____ Amount _____ FLSC debt _____ Rent _____ Util?

Reasons homeless/risk of: _____

Service Plan Component	Date Complete	Outcome/Comments

HOUSING (search; L/T; util)

_____
_____
_____
_____
_____

INCOME (benefits; budgeting; money mgmt; financial asst)

_____
_____
_____
_____
_____

EMPLOYMENT/EDUCATION (employment; education; community service)

_____
_____
_____
_____
_____

COUNSELING & REFERRALS (life skills; med/legal; food/furn/trans; misc. referrals)

_____
_____
_____
_____
_____

Client Planning Form

Date	Initials	Counseling Report (Services, Appointments, Follow-up, Comments)

Counselor _____ Monthly Statistics Months: _____

Heads of Household	Family Composition	Last Address	Homeless Status	Reasons Homeless	Intake Satus	Referral Source	Client Contacts	Housing Status	Income	Source of Income	Previous Address	Services	Referrals	Fin Asst	Results

Key to Statistics

1) Heads of Household ‘ name(s) of adult(s)

2) Family Composition ‘ Age/sex of household members
example: 35/M; 31/F/P (P’pregnant); 13/F; 10/M
Ethnicity: W ‘ white; B ‘ black; H ‘ Hispanic; A ‘ Asian; NA ‘ Native American
Put family members not residing in household in parentheses

3) Last (or current) Address: If Berkshire County, name of Town
All other locations, list state or country
Note number of years living in town: <1, >1 or >3
Note address of new intakes and change of address for recidivist and follow up clients

4) Homeless status (at top of box): 1 ‘ Homeless; 2 ‘ At risk
DSS status (at bottom of box): 0 ‘ no DSS 3 ‘ Foster care
1 ‘ DSS involved 4 ‘ Permanent planning
2 ‘ C&P (care & protection)

5) Reasons for Homelessness/Risk factors (list all risk factors that apply):
1 ‘ Eviction (inadequate income)
2 ‘ Non-payment of rent/lease violations
3 ‘ Evicted by primary tenant
4 ‘ Violations/condemned
5 ‘ Fire/Disaster
6 ‘ Condo conversion/house sold
7 ‘ Overcrowding
8 ‘ Unemployment
8a ‘ Underemployment
9 ‘ Voluntary relocation
10 ‘ Discharge from institution
11 ‘ Abuse/Domestic violence
11a ‘ Battered woman
11b ‘ Child abuse
12 ‘ Utilities arrears
13 ‘ Alcohol abuse only
13a ‘ Drug abuse only
13b ‘ Alcohol & Drug abuse
13c ‘ Dual diagnosis (substance abuse & mental illness
14 ‘ Physical disability
14a ‘ Chronic health problem
14b ‘ HIV or AIDS
15 ‘ Mental disability
15a ‘ Developmentally disabled
15b ‘ Chronic or severe mental illness
16 ‘ Life skills deficiencies
16a ‘ Household management
16b ‘ Money management
16c ‘ Dysfunctional relationships
17 ‘ Parenting skills deficiencies
17a ‘ Child neglect
17b ‘Lack child development knowledge
17c ‘ Poor limit/boundary setting
17d ‘ Lack educational involvement
17e ‘ Lack communication skills

6) Intake status: 1 ‘ New intake
2 ‘ Recidivist (include mo/yr of last visit)
3 ‘ Follow up (carry over from previous month)

7) Referral source: Friend/family, landlord, clergy, agency, etc.

8) Client contacts: Record month/day each time client is seen

9) Housing status

1 ‘ Street/vehicle/woods
2 ‘ Emergency shelter
2a ‘ SRO (temp)
3 ‘ Louison House
3a ‘ Group home/nursing home
4 ‘ Psychiatric facility
5 ‘ Substance abuse/detox facility
6 ‘ Jail/prison
7 ‘ Hospital
8 ‘ Living with relatives
9 ‘ Living with friends
10 ‘ Rental housing (unsubsdized)
10a ‘ Public housing
10b ‘ Section 8
10c ‘ SRO (perm)
11 ‘ Own home
12 ‘ Utilities terminated
13 ‘ Other

10) Income

	Monthly	Annual		Monthly	Annual
0 ‘	0	0	4 ‘	1,001 – 1,500	12,001 – 18,000
1 ‘	1 – 250	12 – 3,000	5 ‘	1,501 – 2,000	18,001 – 24,000
2 ‘	251 – 500	3,000 – 6,000	6 ‘	2,001 – 2,500	24,001 – 30,000
3 ‘	501 – 1,000	6,001 – 12,000	7 ‘	2,501+	30,001+

11) Income/Education: Note source of income and educational status at start of month in top of box and at end of month in bottom of box if changed. Select all that apply; <u>circle</u> primary source of income (items 1-7 only)

0 ‘ No cash income
1 ‘ AFDC
2 ‘ Child Support
2a ‘ Alimony
3 ‘ SSI (Supplemental Security Income)
4 ‘ SSD (Social Security Disability)
4a ‘ SSA (Social Security Retirement)
4b ‘ OASDI (Old Age & Survivors)
4c ‘ Private pension
5 ‘ Employment (full time)
5a ‘ Part time employment
5b ‘ Unemployment insurance
13 ‘ HSG or GED
13+ ‘ Post secondary degree
14 ‘ Non-reader
15 ‘ Enrolled in educational program
15a ‘ Adult lit/basic ed/GED program
15b ‘ High school
15c ‘ College
15d ‘ Job training program
15e ‘ Community service/volunteer
16 ‘ Unable to work
16a ‘ Permanently disabled
16b ‘ Temporarily disabled

5c ‘ Worker’s compensation 16c ‘ Retired
5d ‘ Rental income
6 ‘ EAEDC 7 ‘ Veteran’s benefits

12) Previous address: If lived in current town less than one year, note previous town

13) Service: List all counseling and services directly provided to client

Housing	‘ helped client find apartment	Life skills ‘ counseling
LT	‘ landlord-tenant negotiation	1 ‘ Homemaking
Income	‘ assist obtaining benefits	2 ‘ Health/hygiene
Employment	‘ employment/career counseling	3 ‘ Parenting
Budget	‘ budget counseling	4 ‘ Conflict resolution/ Adult relationships
Money Mgmt	‘ check writing and payee services	
Utilities	‘ utilities arrears negotiation	5 ‘ Crisis counseling/ Mental health
Transportation	‘ provided transportation	
Furnishings	‘ provided furniture/appliances	6 ‘ Substance abuse
Food	‘ provided food or food money	
Medical	‘ documents for medical services	
Legal	‘ documents for legal services	
CS	‘ community service placement	

14) Referrals: List <u>all</u> referrals to outside agencies/organizations

15) Financial Assistance: List amount and purpose

16) Results (select one from column I <u>and</u> one from column II)

<u>Column I</u>

P/H ‘ Permanent housing LSA ‘ Left service area
H/A ‘ Homelessness averted I/C ‘ Incomplete casework

<u>Column II</u>

C/I ‘ Crisis intervention: Immediate intervention needed to address homelessness, risk of homelessness, child abuse and neglect, or domestic violence

C/M ‘ Case Management: No risk of homelessness or child abuse, however, client needs continuing case management toward permanent stabilization

I/L ‘ Independent Living: Lives independently without ongoing case management, but uses income supports through benefits system

E/S ‘ Economic Self-Sufficiency: Has achieved independent living <u>and</u> has income source above poverty line through employment or other non-benefits source

Family Life Support Center – North Adams (6th yr of program)
STATISTICS : October, 1995 – September, 1996

Number of households (unduplicated): 383

New intakes:		207	
Recidivists:		139	
-1 yr:	37		
1+ yr:	64		
3+ yrs:	38		
Rate of recidivism:			36%
Chronic recidivists:		55	14%
Follow up:		37	

Total number of clients: 882
Total number of client contacts: 1,540

Homeless status:

Homeless:	108	28%
At risk:	275	72%

Breakdown by head of household: clients)

With children:		177	(46%)
Single female:	83		
Single male:	9		
2 adults:	85		
Without children:		206	(54%)
Single female:	55		
Single male:	115		
2 adults:	36		

Geographic breakdown:

Berkshire County:		346	(90%)
North Adams:	228		
Adams:	67		
Williamstown:	19		
Pittsfield:	18		
Florida:	4		
Cheshire:	3		
Clarksburg:	3		
Windsor:	2		
Other (1X)	2		
Massachusetts:		12	(6%)
Out of state:		25	(7%)
Vermont:	9		
New York:	4		
California:	2		
New Hampshire:	2		
Other (1X):	8		

Source of income:	Start	End
No cash income	117	68
AFDC:	80	78
Child support:	6	0
SSI:	88	84
Other SS:	20	16
Employment:	58	115
EAEDC:	12	20
Vet Benefits:	2	2

Low/Mod Income: 378 (99%)

Health/Educational/DSS status:

No health insurance:	139	(36%)
HS Grad/GED:	206	(54%)
Adult non-reader:	20	(5%)
DSS involved:	53	(14%)

Breakdown by age/ethnicity(total

Pregnancies:	14	18-25:	138
Infants:	20	26-40:	228
1 – 5:	138	41-59:	118
6 –12:	127	60+:	30
13-17:	69		
White:	822	Asian:	4
Black:	38	Nat Am:	0
Hispanic:	17	Bi-Racial:	1

Referral source (new intakes):

Friend/Family:	64	DET:	2
Comm Action:	25	DSS:	2
Flier/Media:	16	HAs:	2
DTA:	15	Landlords:	2
Utilities:	9	Schools:	2
Grey Pav:	8	Other (1X):	14
Salv Army:	7		
Mass Rehab:	6		
Parent's Place:	6		
Red Cross:	6		
WSC:	5		
Police:	4		
BCAA:	3		
Clergy:	3		
SSA:	3		
Turner House:	3		

Family Life Support Center – North Adams
STATISTICS : October, 1995 – September, 1996

Reasons for homelessness/risk of homelessness (as a factor in % of households):

Inadequate income:	14%	Discharge from institution:	10%
Non-payment of rent:	14%	Abuse/Domestic violence:	18%
Evicted by primary tenant:	11%	Utilities arrears:	52%
Violations/condemned:	6%	Alcohol/Drug abuse:	31%
Fire/disaster:	4%	Physical disability:	22%
Condo conversion/house sold:	2%	Mental disability:	37%
Overcrowding:	7%	Life skills deficiencies:	75%
Un-/under employment:	59%	Parenting skills deficiencies:	17%
Voluntaray relocation:	24%		

Counseling services (% of households receiving service):

Housing assistance:	49%	Education advocacy:	6%
Landlord-tenant advocacy:	10%	Community service:	6%
Utilities mediation:	31%	Life skills counseling:	11%
Employment counseling:	43%	Medical/Legal advocacy:	5%
Income advocacy:	29%	Transportation:	5%
Budget counseling:	53%	Food:	6%
Money management:	7%	Furnishings:	6%

Referrals (number of households referred to each agency):

AA:	2	DTA:	60	Red Cross:	4
Ad Lib:	4	EcuCare:	4	Salv Army:	3
BCAA:	8	HousingAuth:	43	Share:	28
BMC:	3	Louison Hse:	22	SSA:	18
BTEP:	5	Mass Rehab:	18	VA:	4
Comm Action:	30	MHSB:	12	WIC:	9
DET:	18	NARH:	2	With Child:	3
Dist Ct:	8	NASC:	2	YMCA:	2
DSS:	2	Parents Pl:	9	Other (1X):	7

Financial Assistance ($):

Rent:	1,673.93
Utilities:	342.80
Transportation:	562.17
Medication:	30.77
Education:	0.00
Other:	109.00
TOTAL:	2,718.67

Results (by household)

Permanent housing:	55
Homelessness averted:	149
Left service area:	21
Casework incomplete:	158

Outcome Status (by household)

Crisis Intervention:	167
Case Management:	169
Independent Living:	34
Economic Self-Sufficiency:	13

Family Life Support Center – Pittsfield (1st year of program)
STATISTICS : October, 1995 – September, 1996

Number of households (unduplicated): 258

	End
New intakes:	235
Recidivists:	21
-1 yr: 9	
1+ yr: 6	
3+ yrs: 6	
Rate of recidivism:	8%
Chronic recidivists:	0 0%
Follow up:	2

Total number of clients: 568
Total number of client contacts: 754

Homeless status:

Homeless:	98	38%
At risk:	160	62%

Breakdown by head of household: clients)

With children:		124	(48%)
Single female:	79		
Single male:	4		
2 adults:	41		
Without children:		134	(52%)
Single female:	46		
Single male:	66		
2 adults:	22		

Geographic breakdown:

Berkshire County:		227	(88%)
Pittsfield:	180		
North Adams:	7		
Dalton:	6		
Lanesboro:	6		
Adams:	5		
Lee:	5		
Becket:	4		
Lenox:	4		
Cheshire:	3		
Gt Barrington:	2		
Other (1X):	5		
Massachusetts:		14	(5%)
Out of state:		17	(7%)
New York:	5		
Connecticut:	4		
California:	2		
Other (1X):	6		

Source of income:	Start	End
No cash income	78	44
AFDC:	44	36
Child support:	10	0
SSI:	36	38
Other SS:	30	32
Employment:	56	94
EAEDC:	4	14
Vet Benefits:	0	0

Low/Mod Income: 254 (98%)

Health/Educational/DSS status:

No health insurance:	114	(44%)
HS Grad/GED:	150	(58%)
Adult non-reader:	5	(2%)
DSS involved:	38	(15%)

Breakdown by age/ethnicity(total

Pregnancies:	17	18-25:	86
Infants:	8	26-40:	161
1 – 5:	93	41-59:	68
6 –12:	85	60+:	14
13-17:	36		
White:	411	Asian:	0
Black:	112	Nat Am:	0
Hispanic:	39	Bi-Racial:	6

Referral source (new intakes):

Flier/Media:	60	VA:	2
Friend/Family:	59	Other (1X):	21
WSC:	16		
McGee:	12		
DSS:	10		
Mass Rehab:	10		
BCAA:	5		
Christ Ctr:	5		
BCFC:	4		
Housing Auths:	4		
Red Cross:	4		
BCHoC:	3		
Jones:	3		
OFH:	3		
BMC:	2		
Quarry Hill:	2		
VA:	2		
Other (1X):	21		

Family Life Support Center – North Adams
STATISTICS : October, 1995 – September, 1996

Reasons for homelessness/risk of homelessness (as a factor in % of households):

Inadequate income:	16%	Discharge from institution:	19%
Non-payment of rent:	20%	Abuse/Domestic violence:	32%
Evicted by primary tenant:	11%	Utilities arrears:	27%
Violations/condemned:	5%	Alcohol/Drug abuse:	37%
Fire/disaster:	0%	Physical disability:	17%
Condo conversion/house sold:	0%	Mental disability:	33%
Overcrowding:	16%	Life skills deficiencies:	77%
Un-/under employment:	66%	Parenting skills deficiencies:	15%
Voluntaray relocation:	17%		

Counseling services (% of households receiving service):

Housing assistance:	68%	Education advocacy:	14%
Landlord-tenant advocacy:	15%	Community service:	5%
Utilities mediation:	12%	Life skills counseling:	25%
Employment counseling:	43%	Medical/Legal advocacy:	13%
Income advocacy:	33%	Transportation:	2%
Budget counseling:	47%	Food:	9%
Money management:	2%	Furnishings:	2%

Referrals (number of households referred to each agency):

AA:	28	DET:	47	Red Cross:	19
Ad Lib:	5	Dist Ct:	20	Share:	7
ALC:	9	DSS:	11	SSA:	26
BCAA:	35	DTA:	73	VA:	5
BCC:	7	HousingAuth:	55	WIC:	10
BCFC:	7	Louison Hse:	29	WSC:	13
BMC:	25	Mass Rehab:	24	YMCA:	2
BTEP:	13	MHSB:	27	Other (1X):	7
Comm Action:	37	OFH:	3		

Financial Assistance ($):

Rent:	275.00
Utilities:	124.00
Transportation:	295.45
Medication:	41.39
Education:	0.00
Other:	158.00
TOTAL:	893.84

Results (by household)

Permanent housing:	63
Homelessness averted:	70
Left service area:	27
Casework incomplete:	98

Outcome Status (by household)

Crisis Intervention:	59
Case Management:	157
Independent Living:	40
Economic Self-Sufficiency:	2

Client Assessment of Family Life Support Center

1. Did you need help in finding a house or apartment: Yes / No
   Why did you want or need this service?

   _____
   _____
   _____

   What did we do for you that was most useful? Least useful?

   _____
   _____
   _____

   What changes in your situation resulted from these services?

   _____
   _____
   _____

2. Did you need help negotiating with your landlord: Yes / No
   Why did you want or need this service?

   _____
   _____
   _____

   What did we do for you that was most useful? Least useful?

   _____
   _____
   _____

   What changes in your situation resulted from these services?

   _____
   _____
   _____

3. Did you need help negotiating past-due utility bills: Yes / No
   Why did you want or need this service?

   _____
   _____
   _____

   What did we do for you that was most useful? Least useful?

   _____
   _____
   _____

   What changes in your situation resulted from these services?

   _____
   _____

4. Did you need help finding a job: Yes / No
   Why did you want or need this service?

   _____
   _____
   _____

   What did we do for you that was most useful? Least useful?

   _____
   _____
   _____

   What changes in your situation resulted from these services?

   _____
   _____
   _____

5. Did you need help getting benefits: Yes / No
   Why did you want or need this service?

   _____
   _____
   _____

   What did we do for you that was most useful? Least useful?

   _____
   _____
   _____

   What changes in your situation resulted from these services?

   _____
   _____
   _____

6. Did you need help budgeting your money: Yes / No
   Why did you want or need this service?

   _____
   _____
   _____

   What did we do for you that was most useful? Least useful?

   _____
   _____
   _____

   What changes in your situation resulted from these services?

   _____
   _____
   _____

7. Did you want to become more involved in you community and neighborhood: Yes / No
   Why did you want or need this service?

_____
_____
_____

What did we do for you that was most useful? Least useful?

_____
_____
_____

What changes in your situation resulted from these services?

_____
_____
_____

8. Did you need referrals to other programs or services: Yes / No
   Why did you want or need this service?

_____
_____
_____

What did we do for you that was most useful? Least useful?

_____
_____
_____

What changes in your situation resulted from these services?

_____
_____
_____

9. Did you need help getting furniture, transportation, food and or a money loan: Yes / No
   Why did you want or need this service?

_____
_____
_____

What did we do for you that was most useful? Least useful?

_____
_____
_____

What changes in your situation resulted from these services?

_____
_____
_____

10. What was your life situation when you came to the Family Life Support Center?

_____
_____
_____
_____

11. What is your life situation now?

_____
_____
_____
_____

12. What is the best thing about the way Family Life Support services are given?

_____
_____
_____
_____

13. In what ways could there be improvement in the way these services are given?

_____
_____
_____
_____

14. What changes occurred in your life after receiving Family Life Support Center services?

_____
_____
_____
_____

15. How will you continue to improve your life in the future, and what did you learn from Family Life Support Center to enable you to make changes and achieve your goals?

_____
_____
_____
_____

16. In one sentence describe your experience with Family Life Support Center and its staff.

_____
_____
_____

Family Life Support Center - Client Assessment

Client Name _____ First Client Service Date _____
Assessment Date _____ Most Recent Client Service Date _____

		Poor		Fair		Excel
1. Help me find a house/apartment						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
2. Negotiating with my landlord						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
3. Negotiating past-due utility bills						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
4. Helping me find a job						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
5. Helping me to get benefits						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
6. Helping me budget my money						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
7. Becoming more involved in the community/neighborhood						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
8. Referring me to other programs or services						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
9. Helping me get furniture, transportation, food or a money loan						
Did you need this service?	Yes/No					
Did you actually get housing?	Yes/No					
Rate the way FLSC helped you:		_____	_____	_____	_____	_____
10. Overall I rate the services I received at Family Life Support Center as:		_____	_____	_____	_____	_____
11. Overall I rate the Family Life Support Center Staff who provided me these services as:		_____	_____	_____	_____	_____

TRANSCRIPT 8-11-97 APTS K-1

Apartment Rentals 200

PITTSFIELD. 3, 1 bedroom apartments for rent. Secure building, off street parking. [illegible] special — rent before [illegible] of the month, pay no [illegible] until the 1st of Sep[illegible]. Includes heat and hot [illegible] $190 per month. 1 800 [illegible] or 860 253 9020, ask for [illegible].

[illegible]FIELD. 4 room apart[illegible] with heat. $500 per [illegible]th. No pets. Call 445 7354.

PITTSFIELD. 4 room $460 +, 7 room $585 +. Yard & parking. 442 0036, leave message.

PITTSFIELD. 5½ room. No utilities. $475. 442 4746

PITTSFIELD. 6 room spacious duplex. Appliances, carpet, parking. $600. 448 8015.

PITTSFIELD 7 North St. 1 bedroom, modern, full service lease includes basic cable TV, heat, air conditioning, washer & dryer in unit, microwave & dishwasher. $695 Call Scarfoni Realty 1 800 664 4539.

PITTSFIELD. Allengate area. 3 modern rooms, coin laundry, parking, no pets. $475 with heat & hot water. 443 0309.

PITTSFIELD. A beautiful, elegant, immaculate, new 1 bedroom. Parking, appliances, carpeting, curtains, laundry and more. Furnished (or unfurnished). Non smoking. $395 $475 plus utilities. References. 443 0933. No pets.

PITTSFIELD. A bright, 1 bedroom, heat included, wood floors. Diane 442 6077.

PITTSFIELD. A quiet 2 bedroom apartment with front porch enclosed. Modern [illegible]en & bathroom. Near bus [illegible], within walking dis[illegible]e of BMC. No pets. $450/month. Security required. No utilities 443 1820.

PITTSFIELD, Briggs Ave. Small 2 bedroom, 1st floor. Thursday Sunday before 2pm, otherwise after 4. 413 243 1457

PITTSFIELD. DALTON AVE. 1 bedroom, stove, refrigerator. $350 + 698 2113.

PITTSFIELD: DUPLEX. Sunny 3 bedroom, 1 bath; full attic; garage; appliances included. Lovely residential neighborhood. $625 per month. Available 9/1. 442 9005.

PITTSFIELD. Draper Ave. Duplex, side by side. 3 Bedroom. Applications being taken for 9/1. Year lease. $650 + utilities. Deposits required. No pets. References 442 9982.

PITTSFIELD: Ground floor, 2 bedroom, modern apartment. Walking distance to downtown. Parking & appliances. $825 per month. 743 0941.

PITTSFIELD. Modern deleaded apartment. 2 bedroom $425. Call 442 8503.

PITTSFIELD. Merriam Street. 2 bedroom, first floor, spacious yard, garage, appliances. $550 plus utilities. Call Tracy at 443 7211 from 9—3.

PITTSFIELD: No stairs. No lead 2 bedroom. Big kitchen. Spring St. $485 + 684 3950.

PITTSFIELD. Off Elm Street. 2—3 bedrooms, first floor. Stove and refrigerator, nice yard. Available September 1st. $575 plus utilities. Call Tracy at 443 7211 from 9—3.

PITTSFIELD. Quiet, heat, hot water, stove, refrigerator, laundry hookups. No pets. Freshly painted. Updated kitchen and bath. $550. 443 0314.

PITTSFIELD. Spacious 3 bedrooms, off South St. Section 8 welcome. $600 447 9056

PITTSFIELD. Spacious 1 and 2 bedroom unit in country setting. Laundry facilities, parking and on site maintenance. Shown by appointment. Dalton Apartments, 447 9809. EHO. Sorry no dogs.

PITTSFIELD. Southeast 3 bedroom. Laundry hookup, garage. $625 +. 443 8201.

STOCKBRIDGE. Large 1 bedroom. Hardwood floors. Beautiful views. Non smokers only. $575 + utilities. 298 4495.

WEST STOCKBRIDGE, village center. 2 bedroom, 2 bath apartment. Covered balcony. Laundry on premises. Skylights. 2nd floor. Secured parking. $1250/month. Available 9/1. 232 8596.

WEST STOCKBRIDGE, 1 bedroom. Air, laundry, covered balcony, full kitchen, large living room. Available 9/1. $850. 232 8596.

WEST STOCKBRIDGE - STATELINE. 1 bedroom apartments. Secluded, skylight no pets. $375 includes hot water. Call for details Meyer's Realty 518 781-4899.

WILLIAMSTOWN Arnold St., 1st floor. Renovated. Central heat. $400 plus utilities. Year lease. 458 4739.

WILLIAMSTOWN, 3 bedrooms, $550; 3 bedrooms with heat, $575; also 2 bedrooms with heat, $525. 458 8571.

1 BEDROOM, quiet. Heat & hot water included. Available immediately. 442 6004.

Apartment for Rent 201

A BEAUTIFUL, sunny 2 bedroom, first floor, recently refurbished, (off West Street) available immediately. No dogs. 442 6873.

A BEAUTIFULLY APPOINTED 2 BEDROOM. South Street area. Fireplace, appliances, $400 includes hot water. 443 7674.

A NICE 2 Bedroom. Private. Springside. Porch. No pets. References. $450 + . 499-3216.

Sharing Quarters 215

NICE QUIET residential home/garage. Female, professional, references. $390 includes utilities. 448 2645.

ROOMATE to share house. Non smoker. $350 includes rent & utilities 664 9203.

COUNTRY HOME with traveling professional. Must like pets. $450 inclusive. 238 5355.

OFF ELM. Share home, furnished, cable in room. 445 5251.

Apartment for Rent 201

A QUIET, 5 ROOM updated apartment. $495. 499-1711.

A VERY NICE; QUIET 4 room 2nd floor with appliances, off South. $425. 447-7844.

TO OUR READERS: Please note Apartment for Rent ads are listed under two classifications, # 200 and # 201. # 200 Apartments for Rent contain all apartment listings that are key worded by location (city or town). # 201 Apartments for Rent contain all apartment listings that are not key worded.

APPLETON AVE. 2 bedroom, no utilities, parking. $425. 442-6675.

AVAILABLE SEPTEMBER 15. Large duplex, business zoned. No pets. $600 + . 499 1702

"BEVY OF APARTMENTS, Condos, Houses" $350 $1000. Call 442-1291. BEVERLY ANN Property Management.

BRIGHT, CLEAN & freshly painted 1, 2 & 3 bedroom apartments available now. Most include heat, hot water & appliances! Act now! Call 443-2307 for appointment.

CENTRAL 2 bedrooms, bath, eat-in kitchen with appliances, large living room. 442-2274, 442-7588, 442-1428.

CLEAN *QUIET *SECURE Livingston/Greylone Apartments. Centrally located. Studios, one & two bedrooms available. Appliances, heat & hot water included. No pets. $325-$525. 448 8665.

DOWLING BLOCK. North Adams. One bedroom and studio apartments. From $195 to $325 per month includes all utilities. 413 664 4539. Parking available.

ELEGANT PENTHOUSE. 4 rooms, large bath with jacuzzi, security system, stove, refrigerator, parking. No pets. $375 month. Liberty Realty, 442 8957.

ELM ST. 2 bedrooms, off-street parking. $500 + utilities. Ask for Tom, 499-0991.

ELM ST. 4 modern rooms. Appliances, yard, garage. $550 includes all. References. 443-6304.

GLENWOOD AVENUE: Clean, quiet 3 bedrooms, 2 baths with heat. Garage. $575. 442-3478, 494-7251.

NICE 3 ROOM, 1 bedroom apartment. Martha Thompson Realtors, 684 2006 or 684 1007.

Furnished Rooms 220

AFFORDABLE ROOM. Near Williamstown, In Pownal, VT. Bath & cleaning (802) 823-5136.

CHESHIRE: Route 8. Room for rent. Excellent affordable living. 743-1998 evenings or leave message.

CLEAN, QUIET, near buses. Shared kitchen and bath. $70 per week. 443 3067.

AVAILABLE Immediately. Clean, quiet rooms. No pets. Kitchen privileges. $65/weekly. 499 0550.

Apartment for Rent 201

NICE, well kept two bedroom apartments available on Dalton Avenue, Dartmouth Street and Fourth Streets. $400.00/$410.00/$525.00 a month. Security deposit required. No pets. Nice neighborhoods. Showings on Wednesday and Friday afternoons. Call for an appointment. Leave your name and telephone number. 413-499-4838.

VERY NICE southeast 2 bedroom, 2nd floor, hardwood floors and attic. $575 plus security and utilities. 443-1766.

WALKING DISTANCE TO downtown Pittsfield. 2 room apartment, bath, parking, appliances and electric included. $385 per month. 743 0941

WOODLAWN AVE.: 5 room apartment. For further information call 442-1923 after 5p.m.

1 bedroom efficiency. 49 Bartlett. $350 includes utilities. Security. No pets. 623 5958.

2 bedroom, 131 Linden. $350 plus utilities. Security & references. No pets. 623 5958.

2 & 3 BEDROOMS available now. Wahconah, Bradford & Grove Sts. Ranges from $300 to $595 +. References & security. No pets. 443 3530.

4 bedroom. 92 John St. $550 plus utilities. Security & references. No pets. 623 5958.

5 ROOMS, 2 bedrooms, like new condition. New carpeting. Lead free. Upper Lincoln St. 499 3919.

Furnished Apts. 205

LENOX. September June. Unique 1 bedrooms, on 2 cleared country acres. Easy access. Heat & utilities included. From $500. 637 8167.

LENOX. Sept-June. 2 bedrooms, 1½ baths, heat, hot water, $700 month. 637-1513.

PITTSFIELD, 1 bedroom, 1st floor. Heat & appliances included. No pets. $345/month. 684 0391.

STOCKBRIDGE. Walking distance to Red Lion. 1 bedroom. Newly renovated. Short or long term. 413 298 0130

WILLIAMSTOWN, 4 rooms, unusually well furnished, parking. Available September— June. $500. 413-458-8280.

FULLY FURNISHED quality homes, condos, apartments available. Short or long term. Everything provided. Pittsfield, Stockbridge, Lenox, Adams. BC Realty, 445 6311.

ADAMS: 1 bedroom apartment with appliances. $205 month plus security. No utilities. No pets. 743-3142.

ADAMS: 2 bedrooms. Inlown. Modern. Parking. Trash removal. $400. Call 458-0285.

ADAMS. 3 ROOMS. Recently renovated. 743-9695.

ADAMS: 4 rooms, 2nd floor. Heat, hot water, parking. Bob 743-5397, 743-4921.

ADAMS. Apartment. Appliances. Large sunny kitchen. No pets. Deleaded. 743-2242.

ADAMS. Small 2 bedroom, 1st floor. New paint. $300 + security. References. 743-2378.

CHESHIRE. Clean, quiet 1 bedroom. Call 413-743-2789.

Apartment Rentals 200

DALTON. 2 bedrooms. Newly renovated. Appliances. No pets. $550. + . 684 0598.

DALTON. Available now. 3 bedrooms, carpet, reference and security. $465 a month plus utilities. 655-8292.

HINSDALE. 2 bedroom country apartment. Heat, hot water included. $475. No pets. 637-8259.

JASON ST. Modern 2 bedroom deleaded apartment. No utilities. No dogs. $500. 442-8503.

LEE: 1 bedroom efficiency. Appliances, walking distance to stores. $350 with no utilities. No pets. Security deposit. 243-1968 or 243-1983.

LEE, 2 bedroom, 1½ baths, appliances, on bus route. No pets. Security deposit, references. $700 month with electric. Write Eagle Drawer 17D, PO Box 1171, Pittsfield, MA 01202.

LENOX. 1+ & 3+ bedrooms, new kitchen, dishwasher, washer/dryer, fireplace, porch, parking. Walk to village. NO PETS. Quiet setting. $650, $850 + utilities. 637-2054.

LENOX VILLAGE. Church St. Available now. Sunny studio, all appliances, laundry on premises, all utilities included. $535. 637-4388, 298-4070.

LENOX VILLAGE. Church St. Available now. Efficiency with separate kitchen, all appliances, large bath, good closets, laundry on premises. All utilities included. $475. 637-4388, 298-4070.

NEAR BMC. 1 Bedroom, carpeted, appliances, heat, hot water, parking. $500. 443-7500.

NEW LEBANON: 1 bedroom, 2 bath Cottage apartment with garage. $450. 518-432-0849.

NEW LEBANON. $400 efficiency apartment. Heat included. No pets. Lease. 518-477-6222.

NORTH ADAMS Deleaded 5 room. Hot water, parking, no pets. Section 8 welcomed $400 664-4354 or 663-3752.

NORTH ADAMS A prestigious place to live, Franklin Court. 1 or 2 bedroom apartments in modern brick buildings. Large living room and eat in kitchen. Each apartment has own garage. Laundry and swimming pool on premises. From $485 includes heat and hot water. No pets. Franklin Court, 663-8566.

NORTH ADAMS. Free cable & telephone hookup. Our one & four bedroom apartments have lots of closet space, sliding glass doors leading out to a private patio/porch. Full sized appliances. Heat, hot water, trash removal and parking are included in your rent. Rent starting at $358 per month. Professionally managed. 663 3645 from 9 to 4 weekdays, night and weekend by appointment. Equal Housing Opportunity.

Apartment Rentals 200

NORTH ADAMS: 2,3,4 rooms. Some furnishings. From $150 month. 663 7456.

NORTH ADAMS 125 State St. 2,3 or 4 bedroom; 1 end free. Section 8 accepted. 663 9928.

NORTH ADAMS. Quiet tenants for pristine 2-3 bedroom apartment near local bus lines. No pets. $400. 664 7730.

NORTH ADAMS. 1 bedroom apartments. Heated, parking, lease. No pets. 802 823 5604.

NORTH ADAMS. Lovely 1 and 2 bedrooms. Next to Library in professional building. Includes heat, washer/dryer, parking, trash, ideal for quiet people. References. No smoking. $400-$500. 664 9588.

NORTH ADAMS Clean 4 room. Appliances. Washer/dryer hook-up. Parking. 663 7962.

NORTH ADAMS. Clean, deleaded 2 bedrooms. Lakeview, fireplace, $450. 664 4163.

NORTH ADAMS. 1 and 2 bedroom with appliances, hardwood floors. 1st floor. References. 663 9119.

NORTH ADAMS small 5 room. Quiet area. Yard. Parking. References, deposit. 663 3933.

NORTH ADAMS 2 bedroom, 2nd floor, quiet building. Washer/dryer hookup. $350 + utilities, security 413 637 2659

NORTH ADAMS, 3 bedrooms, 2 baths, $350; 2 bedrooms, all new, $400; 2 bedrooms, heat/hot water/electric, $450; 1 bedroom, some $350. 458 8571.

NORTH ADAMS: 2 bedroom, heat included. Washer/dryer hookup. $500 month. 663 8732.

NORTH ADAMS: 3 & 4 bedrooms, deleaded, parking, appliances, newly renovated. No dogs. 413 663 6951.

NORTH ADAMS 2 or 3 bedroom. Nice location. Yard. Parking. 663 9448.

NORTH POWNAL quiet country farm apartment. 3 large bedrooms, family room. $600/month plus utilities. First months rent and security. No pets. 518 663 5699.

Pittsfield. 2/3 bedroom, 2nd floor. Freshly painted. $550. + utilities. 445-7468 mornings.

PITTSFIELD. 2 single bedroom apartments, all utilities included. No pets. Orchard Street. 655-8311

PITTSFIELD. 2 bedroom, $525 includes garage & all utilities. 445-7541.

PITTSFIELD. 3 rooms overlooking Onota Lake. Carpet, appliances. No pets. 442-9724.

PITTSFIELD. 3 bedroom, 2 bath, 1/2 duplex. Off street parking, washer/dryer hookup $550 + utilities. 442 1412.

PITTSFIELD. 3 Bedroom Hall place, remodeled. $595 + utilities. Security & references. No pets. 445-4569 after 5pm.

Furnished Rooms 220

NICE, remodeled rooms. Laundry, parking. Quiet. Near downtown. Weekly $65-70. Monthly $245-275. 623 5958.

LARGE. Washer, dryer, cable, Parking. Share 2 kitchen/4 baths. No pets. 442 4185.

Unfurnished Rooms 225

DALTON. Available now. Includes utilities, cable, laundry. $375. month. 684 5051.

WILLIAMSTOWN $700. month. Heat, electric included. Call 458 3704.

Help Wanted 310

HOST/HOSTESSES

The Dakota Restaurant is now hiring for year round employment.

- Top earnings in the Berkshires
- Full or part time
- Employee Stock Option Plan
- Paid vacation, full time only
- Flexible hours.

Apply in person, 1035 South Street, Pittsfield.

HOTEL. Operated by one of the nation's premier hotel management companies, our award winning, franchised hotel seeks a FRONT OFFICE MANAGER. Qualified candidates will have related experience in hotel reservations process as well as excellent human resources and communication skills. We offer a salary commensurate with experience and a comprehensive benefits package including health coverage, vacation time, 401(k), tuition assistance and more! Excellent opportunity for growth and advancement. Please send resume detailing work and salary history to: Eagle Drawer 18D, PO Box 1171, Pittsfield, MA 01202. EOE, M/F/D/V.

HOUSEKEEPER. Flexible hours and duties. The Village Inn, 16 Church St., Lenox. 637-0020.

HOUSEKEEPER needed for small residential school. Must be hardworking, honest and extremely reliable. Call Linda 413-298-3776.

HOUSEKEEPERS: For part-time work weekdays and weekends. Experience preferred but not required. Apply in person 9:30 a.m. to 2 p.m. at the Williams Inn, Main Street, Williamstown, MA 458-9371.

FOOD COURT ATTENDANT

Horizon Group seeks a dependable person for both full time and part time positions. Must have a valid drivers license and a dependable source of transportation. This position requires the ability to work flexible hours and weekends. Attention to detail and a proven track record for thorough work, a must. Only individuals who desire to work as part of a team should apply. Interested candidates, please call The Berkshire Outlet Village Management Office, 413-243-8186, and ask for Len.

E.O.E.

FOOD SERVICES

Several positions open immediately at Kripalu Center, a holistic health and yoga center. Full-Time Cook: experience in all aspects of a smooth running vegetarian kitchen required. Kitchen Support Staff: Weekend and evening hours required; duties include washing pots and pans and cleaning dining room. Part-time Veggie Prep: Preparation of raw veggies for cooking. Please come to Kripalu, Route 183 in Lenox for an application, or send resume to Kripalu Center, Human Resources, P.O. Box 793, Lenox, MA 01240. FAX 448-3384.

Help Wanted 310

HOUSEKEEPERS AND LAUNDRY WORKERS needed for Country House Hotel. Full time preferred, weekends required, now until mid November. Must be hard working, neat and caring. Apply in person 9-12am, Blantyre, 16 Blantyre Rd., Lenox.

CUSTOMER SERVICE REP Needed for fast paced office. Full time. Pleasant phone manner, good communication skills, and ability to work in a team environment a must. Duties to include answering multi-line phone system, taking phone orders and processing daily paper work. Triumph Auto Glass, 123 East St., Pittsfield. Leave message or fax resume to: (860) 645-7670.

CUSTOMER SERVICE REPRESENTIVE. Individual to work in our Personal Lines customer service department. Duties include assisting clients for all aspects of account activity. Prior experience and license desired. We offer a competitive salary, benefit package and pleasant work environment. Send resume information to: Gallup & Casey Insurance Services, Inc., P.O. Box 748, North Adams, MA 01247.

INNKEEPER for 18 room inn. Berkshire foothills. Resumes to Box 479, Stockbridge, MA 01262 or FAX 413-298-4416.

PRETZEL TIME in the Berkshire Mall is now hiring Shift Supervisors and General Sales Help. Days and evenings needed. Must be available weekends.

RETAIL SALESPERSON for local carpet store. Flexible hours. Some weekends. 499-5405.

SINGLE COPY STORE AND VENDOR COLLECTIONS

Part time

Our circulation department has a part time position open which involves working with and collecting from the stores who sell our paper. Position is part time days, Monday through Wednesday, 8a.m. to mid-afternoon. Flexibility needed for some Thursday and Friday hours.

You need to possess good analytical skills, strong organizational skills and have the ability to perform multiple tasks. Lifting required.

If interested please see our receptionist for an application or send your resume to:

The Berkshire Eagle
75 South Church Street
Pittsfield, MA 01201

SMALL HORSE boarding farm needs experienced horse care person(s) to caretake during winters. Nice house plus salary/one free stall. 443-2393.

COOK, LINE COOK/Assistant Chef needed. Please call (518)781-4933.

CREW LEADER POSITIONS

Must have full availability. Prior supervisory and restaurant background helpful. Fax resume to 499-5799.

Help Wanted 310

INTERIOR LANDSCAPING, part time position to maintain tropical plants in local mall. Early morning or late evening. Experience required. 800-345-4488.

THE BUSY 1896 House is in need of professional waitstaff, banquet staff, prep & line cooks & baker. 458-1896.

THE ORCHARDS HOTEL

The Berkshire's only 4-Diamond hotel has the following positions available:

- Bartender
- Housekeepers
- Line Cooks
- Waitstaff

Friendly, outgoing personality to work with our enthusiastic team. Pleasant working environment. Excellent opportunity for advancement.

Please apply at:
The Orchards
222 Adams Rd.
Williamstown
(413)458-9611

THE RED LION INN has immediate full and part time positions available for service oriented individuals who are looking for a career in the hospitality industry (A.M. and P.M. shifts available).

- Front Desk Supervisor
- Front Desk Clerks
- Room Reservations Clerks
- Room Attendants
- Early Morning Cleaner
- Hosts & Hostesses
- Custodians
- Laundry Staff
- Line Cooks
- Wait Staff
- Lion's Den Wait Staff

Excellent benefits. Apply in person at The Red Lion Inn Front Desk, Main Street, Stockbridge. (Line Cooks, please ask for Chef Douglas)

UNEMPLOYED? Solve it with Career Training. Call 442-0333. Mildred Elley ... The School For Careers.

WANTED- FOR new South County Restaurant- professionally minded & efficient: hostess/host- wait persons- kitchen stewards- compulsive cleaners- cooks. Reply to-...P.O. Box 69, Glendale, MA 01229...All inquiries replied to.

FRONT DESK CLERK 3-11pm, approximately weekend & holidays a must. Experience preferred. Must posess good people & telephone skills. Strong math & computer skills. Fax resume to 243-2339, or apply in person Pilgrim Motel, Rte 20, Lee.

EAGLE
8-11-97
JOBS

Help Wanted 310

SERVERS

The Dakota Restaurant is now hiring for year round employment.

- Top earnings in the Berkshires
- Full or part time
- Uniforms Provided
- Employee Stock Option Plan
- Paid vacation, full time only
- Flexible hours.

Apply in person, 1035 South Street, Pittsfield, plan available, In-

FULL AND PART TIME RETAIL SALES CLERKS

McClelland Drug Store is seeking responsible, organized individuals with excellent communication skills to join our retail pharmacy team. We are committed to the needs of our customers and community and we desire employees who will further promote the philosophy.

PART TIME PHARMACY TECHNICIAN

McClelland Drug Store has an opening for a part time evening position among our staff of pharmacy technicians. Previous experience is not necessary- we will provide complete training for the right candidate.

PART TIME COLLECTIONS

McClelland's is seeking to add a part time accounts receivable collection position to its business office team. If you understand customer service, are self-motivated and have the ability to work independently, we would like you to join our team. Previous collection experience is helpful, however we will train the right candidate. McClelland Drug Store and Health Systems offers very competitive wages, flexible schedules, and a complete benefits package (pro-rated for part time positions), including a 401(k) plan. Please forward a resume or stop by to apply in person.

McClelland
Health Systems
43 Main Street
Lee, MA 01238

DINING ROOM WAITERS & Waitresses. Year round employment. Housekeepers. Secretary to managers, computer skills important. Apply in person or phone 243-3500. Oak N' Spruce Resort, Meadow St., South Lee.

DISHWASHER AND HOUSEKEEPERS. Busy restaurant and inn has full time and part time positions available. Afternoon, evening and weekend hours. Reliability essential. Apply to Old Chatham Sheepherding Company Inn, 99 Shaker Museum Road, Old Chatham N.Y. 518-794-9774.

Help Wanted 310

SERVERS, BARTENDERS & HOST/HOSTESS Positions. Full & part time available. Great benefits and advancement opportunities. Apply in person Monday & Tuesday 2-4p.m.

RED LOBSTER
607 Merrill Rd.
Pittsfield

HOUSECLEANER. No experience necessary. Growing, local company will train you to be a residential home cleaner. Good hours, pleasant working environment. Call before 9p.m. 442-9028.

HOUSEKEEPER: Williamstown motel. Responsible person with own transportation. Must be available A.M. hours including weekends. 458-3950.

HOUSEKEEPER, year round. Call 458-4351 after 12:00 noon.

Help Wanted 310

COOK/HOUSEKEEPER. Secure home and generous wage for reliable, experienced homemaker to provide for elderly lady in Fairfield, CT. Year round or with summers off. Gracious home on Long Island Sound. Please send qualifications & references to Miss Susan, Box 455, Sheffield, MA 01257.

COUNTER POSITION. Afternoons, Monday-Friday, 3:30-7:30 plus some Saturdays. Apply in person Superior Cleaners, Coltsville.

DISHWASHER WANTED. Full time, nights. Start immediately. La Bruschetta, West Stockbridge, 232-4263, 232-7141.

DISHWASHERS NEEDED for Country House Hotel. Full or part time positions, evenings and weekends, now through Mid November. Call Chef Michael Roller at Blantyre, 413-637-3150.

DISHWASHERS needed for small residential high school. Reliability and flexibility a must. Call "Chef" at 413-298-3776.

DRIVER NEEDED for local deliveries. Must have 2 year accident free commercial driving experience with class "B" CDL and HAZMAT endorsement and high school degree. Must be self motivated and able to work without direct supervision with ability to lift up to 85 lbs. Competitive pay with full benefits. Apply by stopping at the Merriam-Graves Corp. office at 563 Dalton Ave., Pittsfield, MA between 8:00 A.M. and 5:00 P.M. and complete an application.

NIGHT AWAKE COUNSELO needed in residential trea ment center for adolescen Full time position, 4-10 ho shifts of 11pm to 9am shif Must be 21 + and be commit to meeting the special needs our population. Good sala and benefits. Call 802-447-15 Monday-Friday, 8-4 for int view.

Night Monitor

Part time- 16 hours per we for Long Term Care Su stance Abuse Facility locat in Sharon, CT. The night m itor is responsible for ov seeing the facility between hours of Saturday and Sund from 12:00 A.M. to 8:00 A. Please call 203-792-4515, for Director, Human R sources.

EOE

NOW Hiring cashiers, coo waitstaff at Racing Cafe, minutes off Exit 83, I-90 naan, NY. Friendly atm phere, above average inco potential, flexible schedu weekday & weekends. Ap or call Tom, 518-781-3333.

RESIDENT MANAGE wanted for elderly housin apartment complex in Wi liamstown, MA. The qualifi individual or couple would responsible for daily recor keeping, grounds maint nance, coordinating or assi ing in vacant apartmen preparation and inspection and dealing with vendor Some supervisory experien and ability to relate to eld tenants is desired. This po tion offers a salary, rent-fr housing, health insuranc and retirement benefits. Ide for retired individual or co ple. Send resume to Eag Drawer 16D, PO Box 117 Pittsfield, MA 01202. EOE.

RESIDENT MANAGEMEN COUPLE needed to fill pos tion of security, maintenanc and office at our self storag facility. For further inform tion, please call 445-5181 fro 9am-4pm. No smoking, no pe

RESIDENTIAL STAFI

Needed. Full time/part ti and relief in programs for dividuals with disabiliti Previous experiences nec sary. Comprehensive ben package available, inclu life insurance, short and l term disability income, s pay, etc. Hourly rates fr $6.25 to $7.52 per hour. S resume or apply in perso BCARC, 395 South Stre Pittsfield, MA 01201. AA/E

RESTAURANT- PANTR Prep/Dish positions for bu casual bistro. Full time- f hours. Creative attitude, m tivation, hustle & good taste music more important th experience. Apply Zampano's, Rt. 7, Lenox.

DRIVER/GUARD. Full part time position availat Clean driving and crimi record required. Must h pistol permit. Call 10am-2 Monday-Friday, (413) 4843.

Appendix K

Consent for Release of Confidential Information

I, _____, authorize

_____

(Agency and/or Individual)

to receive and/or disclose such information as may be deemed necessary by my counselor,

_____ , and/or his/her designee, to Family Life

(Name)

Support Center, Inc. (Family Life Support Center, Louison House, The Parent's Place).

I understand that this permission is given pursuant to Section 2 of Chapter 66A of Massachusetts General Law, the Fair Information Practices Act. This consent automatically expires one year from the date of signing or as follows (enter date, event or condition upon which consent expires):

_____

_____

_____

Client Signature Date

Family Life Support Center, Inc.

Welcome to Louison House!

Our goal is to offer a safe, clean and peaceful, temporary place for those who are homeless. We have developed the following set of rules to protect you and the peace and safety of our house. IF YOU VIOLATE THESE RULES, YOU SHOULD EXPECT TO BE ASKED TO LEAVE THE SHELTER. Please initial each rule as it is read to you.

RULES

_____ 1. All potential Louison House residents are required to give counselors written permission to conduct a police background check and/or contact personal references prior to admission to the shelter.

_____ 2. Evening curfew is 9:00 p.m. every night except Friday and Saturday. Friday and Saturday curfew is 11:00 p.m. unless you have staff permission to stay out overnight on Saturday only. Saturday overnight is a privilege granted at staff discretion, not a right; individuals under age 18 and recovering alcoholics and drug dependents are not eligible for Saturday overnights. Curfew for families with children is one hour before children's bedtime every evening (see #36).

_____ 3. No alcohol, drugs or weapons are allowed in the shelter or on shelter property. If a staff person suspects you are using drugs or alcohol, you may expect to lose your space at the shelter. No one who is under the influence of drugs or alcohol will be permitted to enter the shelter at any time. Staff reserve the right to require residents to undergo alcohol or drug testing.

_____ 4. Violent or abusive behavior is not allowed in the shelter. Behavior which may frighten othe residents is absolutely not allowed. This includes threats, name calling, discrimination, swearing, sexually explicit language, and disrespectful language.

_____ 5. Single men may not be on the second and third floors without a staff member.

_____ 6. Friendships may develop at the shelter, but no part of the shelter or its property may be used for intimate sexual relationships. Residents are permitted to sleep in their own rooms only.

_____ 7. Everyone is expected to be at evening meal Monday-Friday at 5:30 p.m. All residents must attend weekly house meetings on Tuesday at 7:00 p.m. No resident may leave the shelter in the morning without checking with a counselor first.

_____ 8. Residents will pay 20% of income up to a maximum of $200 per month to Louison House for rent.

_____ 9. Residents are required to open a savings account and deposit 60%-90% of

income after rent in the account. The passbook will be held by the Louison House staff and returned when permanent housing has been found or upon discharge. Any loans received will be deducted from your savings upon discharge.

_____ 10. Residents must meet with staff as scheduled and follow through on housing search and all other elements of their service plans, including community service and volunteer assignments. Residents will prepare a daily activity schedule each evening for the following day, to be submitted to staff before bedtime. Failure to actively pursue independent living or follow through on the service plan is grounds for discharge from the shelter. Upon discharge from the shelter, all clients will receive a follow-up appointment with counselors at the Family Life Support Center.

EXPECTATIONS

House

_____ 11. Residents should be awake, dressed and have had breakfast no later than 8:00 a.m. All residents are expected to bathe or shower on a daily basis.

_____ 12. Residents must be in their own rooms by 12:00 midnight.

_____ 13. No one should be in the first floor common areas in pajamas or robes or not fully dressed. You must wear footwear downstairs.

_____ 14. The television and stereo in the living room and playroom may be turned on at 4:00 p.m. during the week, except during workshops or other scheduled activities, and must be turned off by 11:30 p.m. Television is o.k. during the day on weekends.

_____ 15. You are responsible for keeping your room in order and doing the chores you are assigned each day. Daily room inspections are held, and staff reserves the right to make more frequent checks in case of emergency or other need.

_____ 16. Physical damage to the house and rooms is unacceptable. Treat the house with care and respect! You may be required to pay for any damage you or your family members cause.

_____ 17. All residents will be expected to participate in housekeeping, kitchen and child care chores as scheduled at weekly house meetings. This includes men as well as women!

_____ 18. All residents will be expected to participate in maintenance, groundskeeping, donation pick-ups, and other chores as directed. This includes women as well as men!

_____ 19. All residents must participate in Saturday morning house and grounds maintenance and clean-up before beginning other weekend activities.

_____ 20. Residents are responsible for doing their personal laundry as well as any linens

and towels issued to them by the shelter staff. Linens, towels and laundry baskets must be returned to staff upon discharge from the shelter before rent money will be returned.

_____ 21. Music, television or radios should not be played so loud that they can be heard outside the room in which they are played. Residents may not make or receive telephone calls after 10 p.m. Mon.-Thurs., or after 11 p.m. Fri.-Sat.

Safety

_____ 22. No incense or candles may be burned at the shelter.

_____ 23. Smoking is allowed ONLY outdoors. Smoking is NOT allowed anywhere in the shelter.

_____ 24. Fire drills are held periodically. When the fire alarm sounds leave the building using the nearest exit and to the the yard in front of the house.

_____ 25. Visiting hours are 11:00 a.m. to 8:30 p.m. All visitors must be pre-approved by staff. You are responsible for the behavior of your guests when they visit. Unacceptable behavior may jeopardize your stay at the shelter. Guests may not be on the second or third floors or in the men's dormitory. Acceptable visiting areas are the living room, kitchen, dining room, playroom, porch and yard.

_____ 26. The conference room may be used for business activities only, including housing search, employment search, meetings and counseling activities. Recreational activities are permitted in the living room, play room and dining room.

_____ 27. Doors will be answered by the person on duty, staff or volunteer. Residents are not to answer the door for safety reasons. All doors are locked at 7:00 p.m.

_____ 28. All vehicles parked on shelter property must be properly registered and inspected.

_____ 29. All drugs, prescription and non-prescription, are kept by staff in lock-up. Staff and residents must sign the medication log when drugs are taken.

_____ 30. Stealing: a 24-hour period will be given to allow for the return of the missing item(s). After that, the police will be called in to do an investigation.

_____ 31. Valuables may be checked with staff for safe-keeping. Louison House is not responsible for residents' articles or possessions, and all possessions are brought to and stored at Louison House at the resident's own risk.

Children

_____ 32. Physical punishment of children is not acceptable. Excessive screaming and yelling, including the use of profanity, is also not permitted. We can work on other ways to discipline children.

_____ 33. Parents are responsible for their children at all times. Children age 5 and under must be supervised by an adult at all times. Supervision requirements for children over age 5 will be established through your service plan. Parents are responsible for damage done by their children.

_____ 34. All school age children living in the shelter must register for school. All

school age children must attend school unless they are sick.

_____ 35. Children may use the playroom with a parent, staff person or volunteer. Children may not use the playroom without proper supervision.

_____ 36. Bedtime for children under 12 years old on school nights is 8:30 p.m. For weekend and summer nights it is 9:30 p.m. Children 12 and over must be in their rooms by 10:00 p.m. on school nights and by 11:00 p.m. on weekend and summer nights.

Food

_____ 37. Evening meals are served at 5:30 p.m., Monday through Friday. Everyone is expected to be there. Meal preparation and cleanup are tasks you will be asked to do. The kitchen will close at 4:00 p.m. to allow the cook of the day to prepare the dinner meal.

_____ 38. You are responsible for preparing your own breakfast, lunch and Saturday and Sunday meals. This includes washing your dishes for these meals and for any snacks you may have.

_____ 39. The pantry will be closed after evening meal cleanup. Snack foods are items in the kitchen cabinets and refrigerators that do not require cooking. Baking may be done in the evening if planned ahead at the weekly house meeting. The kitchen is closed for any food preparation or snacks at 10:00 p.m. Beverages are o.k.

_____ 40. Residents are not allowed to bring up food from the basement or bring food into the house. Children under 12 are not allowed to open refrigerators without adult supervision.

_____ 41. Food is permitted only in the kitchen and dining room.

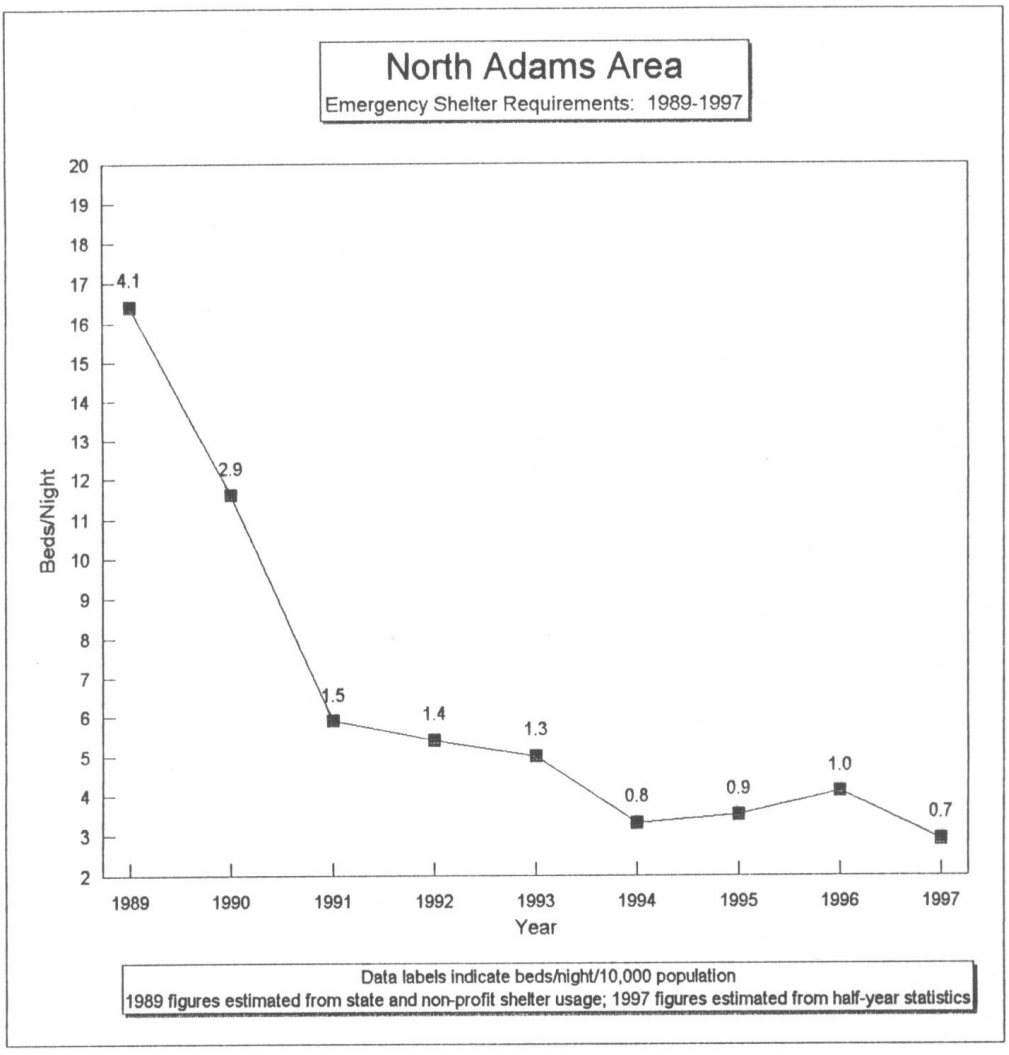
_____ 42. Breast-feeding must be done in the privacy of your room.

IF YOU VIOLATE THESE RULES OR ARE UNABLE TO COOPERATE WITH THESE EXPECTATIONS, YOU SHOULD EXPECT TO BE ASKED TO LEAVE THE SHELTER.

I understand these rules and will cooperate with them while living at Louison House.

Signature _____ Date _____

M-1


North Adams Area
Emergency Shelter Requirements: 1989-1997
Beds/Night
Year
4.1
2.9
1.5
1.4
1.3
0.8
0.9
1.0
0.7
1989
1990
1991
1992
1993
1994
1995
1996
1997
Data labels indicate beds/night/10,000 population
1989 figures estimated from state and non-profit shelter usage; 1997 figures estimated from half-year statistics