

Designing Urban Spaces to Foster Recovery, Housing, and Community

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Central City Concern (CCC) is nationally recognized for success in reducing homelessness and serving people who are difficult to engage in traditional services. A 501(c)(3) nonprofit committed to ending homelessness, CCC's mission is to *provide comprehensive solutions to ending homelessness and creating self-sufficiency*. For 33 years the agency has been working with singles and families with serious addictions, mental illness and/or chronic health conditions who are homeless or at risk of homelessness. CCC has developed a unique, comprehensive service model designed to meet the needs of this fragile and underserved population, helping those served reclaim their lives. To end homelessness and to help individuals in the target population access a higher quality of life and become self-sufficient, CCC's array of services includes primary and mental healthcare, inpatient and outpatient addiction treatment, mentored recovery support, affordable housing (1,560 units of supportive housing, 62 percent of which are drug and alcohol free), intensive case management, and employment services. An estimated 13,000 people access these services each year.

CCC's core programmatic approaches include:

- Direct access to housing which supports lifestyle change.
- Integrated healthcare services that are highly effective in engaging people who are often alienated from mainstream systems.
- The development of peer relationships that nurture and support personal transformation and recovery.
- Attainment of legitimate income through employment or accessing benefits.

Since its formation in 1979, Central City Concern has developed a diversity of supportive housing approaches through constant innovations that are designed to address basic needs in alignment with a client's motivation to make significant life style changes. The result is a multi-dimensional integrated approach dedicated to the mission of ending homelessness through a diversity of housing choices and supportive services.

Low barrier Single Room Occupancy housing

Central City Concern was initially established as the Burnside Consortium in 1979 as a community based agency contracting with the City of Portland and County of Multnomah. The agency was tasked with cleaning up the central city Burnside Street area (Portland's historic nexus of homelessness and services) by getting the homeless off the street and into marginalized Single Room Occupancy (SRO) housing. Portland, like many cities, was struggling with large numbers of late stage chronic alcoholics living on the streets and under bridges in the central city. The original vision for Central City Concern was a community-based organization that facilitated treatment services and repaired and rehabilitated SRO housing. This vision of housing and services predated the concept of supportive housing. The small SRO building and maintenance program funded by the City of Portland was part of the foundation establishing CCC. Repairing older (turn of the century) buildings owned and managed by others was a thankless task. It became obvious that privately owned buildings in which the owners had long ago stopped making investments, in a neighborhood that was in distress, was a vicious cycle of

disinvestment. CCC formed the goal of rehabilitating the whole building before assuming management, and gaining building ownership when possible. In CCC's early years, CCC's mission focused on providing safe, well-managed and well-maintained SRO housing for low income residents. This was low barrier housing with no service supports or sobriety requirements.

Hooper Detoxification Center and Alcohol and Drug Free Community (ADFC) housing:

CCC's second program element was a National Institute on Alcohol Abuse and Alcoholism (NIAAA) grant for services to public inebriates, managed by CCC as the Public Inebriate Project, which subcontracted alcohol and drug services, outreach, shelter, and housing to a range of providers. In 1982, Multnomah County-operated sobering and medical detoxification program, the David P. Hooper Memorial Detoxification Center (named after the last person to die from alcohol withdrawal in the City jail) was spun off to CCC as it became too expensive and too difficult for the County to efficiently operate under prevailing personnel and operational structures. This moved the agency from a service contract entity to a direct service provider. Hooper's sobering and detox programs were first established in 1971 to close the City jail "drunk tank" and replace the police response with a health and substance abuse treatment program. Hooper's Subacute Medical Detoxification program has approximately 2,500 annual admissions; these clients stay 4-8 days as they begin recovery. Hooper's Sobering Program, a safety net service for public inebriates, has approximately 12,000 annual admissions who stay 3-6 hours.

When CCC took over the Hooper Detox Center, two major challenges were clear. First, there was not enough treatment capacity in the community to provide services, even though referrals were being made to any open bed in Oregon and even in Washington State, and most individuals were being returned to the streets for certain relapse. Consequently, the second challenge was the high rate of recidivism in the detox program.

By 1982, CCC was managing several SRO buildings and staff concluded that it would be worth attempting to provide housing to individuals completing the Hooper detox program while they were awaiting a residential treatment bed opening somewhere within the state. The agency was able to draw a minimal budget from its Public Inebriate Project budget to provide facility management of a 16-unit location and include minimal supports to the residents to help prevent them from relapsing. This cobbled-together beginning showed immediate promise. While well over half the residents relapsed within days, many stayed sober. For about a year, this makeshift housing with "case management" kept many residents sober. When they were eventually able to go into residential treatment, most declined and argued, "Why go to residential when I'm staying sober and don't need treatment?"

CCC staff began looking for similar models elsewhere in the country and pooled resources to travel to New York City. There they visited several programs including a midtown social model detox and the Manhattan Bowery Project, a small outpatient program. This visit convinced them that if sober housing within an alcohol and drug free environment was augmented with outpatient treatment, then even late stage alcoholics could stay clean and sober.

Following the NYC site visits, CCC made the commitment to expand the experiment and allocated what was then considered a large block of 54 rooms in the CCC-owned SRO Estate Building to be used as Alcohol and Drug Free Community (ADFC) housing. This turn-of-the-century SRO contained 162 units on the upper three floors with ground floor commercial space. The commercial ground floor tenants included a convenience style neighborhood grocery that

sold alcoholic beverages, mainly fortified wine and malt beverages, the beverages of choice for late stage alcoholics, and was reported to be the largest volume wine sales store in Oregon. This was not a prime location for individuals to begin their recovery. The building was a management challenge and required 24-hour front desk staff, full housekeeping staff, and a nearly full-time maintenance worker. The surrounding neighborhood featured a high concentration of public inebriates, with dozens of people passed out on the sidewalks at any given time.

The Estate ADFC housing component had its own staff present 18 hours a day and was locked off from the rest of the building on its own floor. This island of sobriety was managed and funded separately from the rest of CCC housing, with management provided by clinical staff attached to the Hooper Detox Center. These “case managers” were there to assist residents with information regarding food, clothing, recovery support, housing, and job referral. Staff set communal living standards and performed interventions when residents relapsed or broke other rules. One of the most immediately apparent benefits of the ADFC housing was the greatly reduced number and severity of housing management problems.

Funding for the housing was arranged through a pastiche of sources outside the usual alcoholism treatment services funding mechanisms. Since few, if any, of the individuals coming out of detox were employed or had any other source of income, rent assistance was necessary. To this end, staff marshaled together emergency rent resources, energy assistance funds, and county alcohol treatment dollars.

Residents accepted program “contracts” that required them to be alcohol and drug free on and off the premises, and to participate in ongoing treatment or counseling, or be dropped from housing and services. Zero tolerance was the rule even though the agency’s guiding principle, was, and remains to this day, intervention before eviction. Average length of stay was about ninety days. During the first year, a surprisingly high percentage of the primarily late-stage alcoholic residents were able to move to other more permanent housing clean and sober.

The key lessons from this initial experience led staff to conclude that:

- it was possible to establish a transitional alcohol and drug free community while maintaining residents in a familiar neighborhood;
- peer based support was a natural phenomenon for those who desired sobriety and this permeated the social norms of the small community;
- program-based “contracts” instead of landlord-tenant law contracts were more effective in timely intervention of relapse;
- immediate housing and recovery supports following detox were much more successful in maintaining sobriety than simply returning individuals to the street and hoping they would be able to show up for outpatient care;
- case managers who were themselves in recovery could serve as role models for the residents; and,
- ADFC housing with treatment and linkage to community-based self-help was as effective as hard-to-find residential treatment.

The Estate ADFC was the first project which added the element of housing choice to CCC’s housing services. CCC operated this special type of ADFC housing in parallel with the agency’s other SRO housing that had no restriction on alcohol use. At this time, CCC managed an additional 186 units of SRO housing in several older buildings in Portland’s central core. CCC began by managing these buildings, and over time was able to gain ownership and

rehabilitate them. These buildings were traditional “wet” SRO housing for very low income and homeless residents, subsidized by Section 8 and other sources.

CCC’s initial ADFC housing program highlighted the need for permanent housing and employment support that could not be provided by the partnering agencies. Nonetheless, ADFC housing had proven to be the most effective alternative to unavailable residential care and was embedded firmly within the agency culture. The focus of this housing was not seen by CCC or funders as ending homelessness, but instead as intervening in chronic inebriation and preventing the consequences of untreated late-stage addiction.

Through the 1980s and 1990s, CCC continued to acquire and rehab nearly 500 units of SRO housing in the central city. This was aided by Portland’s Downtown Housing Preservation Partnership to save these and other housing assets. Through this effort, CCC was able to utilize Low Income Housing Tax Credits, local tax increment financing, and various HUD capital and operating grants to acquire and rehab housing. Rent subsidies from Section 8 or service partners, and rent from businesses located in the street level spaces of these buildings, made them affordable to the low income target populations.

As CCC’s array of services (alcohol and drug recovery, mental health, employment, and health care) developed, CCC expanded housing capacity to serve the various populations and growing programs. Starting with CCC’s first ADFC housing model, developed to meet the needs of newly recovering people exiting detox, CCC’s housing has always evolved to reflect the service needs of homeless people with very low incomes and addictions. ADFC housing was the first housing use that demanded specialized housing management.

Later, housing linked to employment, housing for people with mental illness, and housing for people on parole/probation were added to CCC’s housing portfolio. CCC continued to rehab, manage and acquire “wet” SRO housing as well, with no sobriety requirements, continuing the principle of housing choice. All of CCC’s housing was targeted at very low income and/or homeless singles, both those seeking a clean and sober environment and those who were not. The development of permanent and transitional ADFC housing also added an additional element of housing choice, with shorter and longer term housing options for residents choosing to live in an Alcohol and Drug Free Community.

The ADFC housing model pioneered at the Estate had proved successful. The detox revolving door was slowing down. The chronic alcoholic (street drunk) population was getting smaller. From the mid 1980s to the mid 1990s, Hooper Sobering Program annual admissions of chronic inebriates decreased from around 19,000 to the current 12,000 annually. Permanent ADFC housing showed how, in the long term, people stayed sober. While average tenancy increased to over 18 months, over 70% who left went to permanent housing, had a job, and were sober. ADFC housing was showing that its original transitional function also worked for permanent housing.

Starting in the late 1990s, CCC’s ADFC housing model expanded beyond its origins of SRO housing in Portland’s central core. Responding to new resident population needs, and with new funding sources and partners, CCC’s ADFC housing evolved to include a 36-unit rehabbed motel for people living with HIV/AIDS, with studios and SROs, almost 100 units of family housing in 6 different buildings in residential neighborhoods, a new construction project in a suburban/rural area for people with mental illness, and the Richard L. Harris Building, a 12-story, 180-unit new construction building downtown with studios and SROs, with CCC’s healthcare for the homeless clinic on the ground floor

The Harris Building employs the most intensive ADFC model in the CCC housing continuum. The transitional units are supported by several service programs with onsite staff. Most transitional housing residents are in early recovery and are receiving integrated primary healthcare, alcohol and drug treatment, and mental health services from the CCC clinics on the ground floors of the Harris Building or the CCC-owned Mark O. Hatfield building across the street. This building has 106 units of permanent ADFC housing, so between the two buildings, several hundred residents and clients are daily engaging in services and creating a clean and sober community. Residents can transition in place to the Harris Building's permanent ADFC units.

The Harris Building replaced an older building which was demolished by the owner and added 60 new units of permanent housing. With this building, CCC aimed for a new level of architectural and design excellence for affordable housing. ADFC housing places a premium on design that creates opportunities for developing supportive relationships and preventing isolation. Space is designed for intentional interaction – community rooms, kitchen, lobbies, mailbox areas, community meeting rooms (used for 12 step self-help groups like Alcoholics Anonymous [AA], Narcotics Anonymous [NA], and neighborhood meetings).

CCC's experience shows that for chronically homeless people with addictions, the availability of transitional ADFC housing is a critical element of treatment completion, maintaining recovery, and stability in permanent housing. For example, in 2010-2011, from 95 units of CCC's transitional ADFC housing in the Harris Building, exiting residents achieved a 60% (97 out of 163 people exiting) permanent housing placement rate. 74% of these were either employed or receiving federal disability entitlements. One year later, 87% of the people from this housing who completed treatment and moved to permanent housing were still housed and sober. *(Note: This one-year follow-up number is conservative as it only reflects people who CCC was able to contact 12 months after move-out).*

Peer Recovery Mentor Program

In 1999, a peer recovery mentor effort was conceived as a potential intervention in response to mounting evidence of an epidemic of heroin related deaths and low treatment completion rates for heroin addicts in the county. A series of concurrent efforts by the Multnomah County Board of Commissioners, treatment providers, and activists from the Recovery Association Project resulted in the design of the Recovery Mentor Program. Its purpose was to increase the number of heroin clients who engaged in, and successfully completed, outpatient treatment following detoxification.

Operated by CCC, this program hired three Recovery Mentors –recovering heroin addicts, not treatment professionals - to work intensively with heroin addicts exiting the Hooper Detox Center. County funding paid for the Mentor positions and 50 units of transitional ADFC housing. In the Recovery Mentor model, mentees live in transitional CCC housing and receive outpatient alcohol and drug treatment at the CCC Recovery Center. Upon completion of detox, the mentor accompanies the mentee to housing, to treatment appointments, to 12 step meetings, and helps them access food, clothing, and other support. Mentors work with mentees out in the community, actively connecting them with resources. The availability of ADFC housing, with the mentees living in a supportive community, engaging in treatment together, and attending meetings together, is a key aspect of the Mentor Program. The combination of supportive housing and peer/consumer mentors who are not counselors, but people who have experienced

homelessness and addiction like their clients, has proven to be highly effective (Moore, T.L, 2001).

The Recovery Mentor program, as a form of supportive housing based on peer support, was not developed wholly outside of the CCC experience. In fact, CCC had a long history of employing people in recovery from addictions and homelessness, including managers and clinicians. CCC is one of the largest, if not the largest, employer of formerly homeless people and recovering people in Portland. Over 50% of the agency's workforce identifies themselves as in recovery from addiction. Many of them have received CCC services and lived in CCC housing. This has created a unique workforce culture at CCC, with strong dedication to the agency's mission and intimate understanding by staff of CCC's client/resident population.

The success of the Recovery Mentor program has led to its growth and adaptation by other programs at CCC over the years. For example, by 2001, CCC had acquired 90 units of ADFC housing for families, with significant management challenges. High relapse rates resulted in low rent revenues. Considerable destruction of property and criminal activity threatened the credibility of CCC and CCC was preparing to give up on a leased 20 unit property. The last effort to save these properties involved the addition of family Recovery Mentors to work with residents of all 90 units. Within weeks, the problem property was stabilized, and outcomes vastly improved over the next several months. Family Recovery Mentors continue to be an integral piece of CCC's supportive family housing model.

The Recovery Mentor program advanced CCC's understanding of the importance of peer support to long term recovery success, both in and outside of CCC's buildings and programs. Even though sobriety orientation was not new to CCC, the Recovery Mentor program helped the agency to understand that "treatment" is only a phase in sobriety and could not directly result in long term recovery on its own. Recovery is achieved through long-term lifestyle change, based on peer support, a living situation that is supportive of recovery, and acquisition of legal income. This reflects the national movement towards viewing addiction as a chronic relapsing disease, with peer recovery supports – including housing - needed in addition to treatment episodes.

A case study of the Recovery Mentor program found it significantly increased the rate at which heroin clients referred from detoxification engaged in outpatient treatment from 51.6 percent to 85.2 percent. Mentored clients also exhibited significantly higher outpatient treatment completion rates of 45.2 percent compared to a 16.1 percent baseline rate. The average length of treatment program enrollment increased significantly from 27.4 days to 68.2 days (Moore, 2001).

The Recovery Mentor Program, and CCC's ADFC housing, has also proved effective at reducing recidivism among ex-offenders. In 2007, the Regional Research Institute for Human Services at Portland State University conducted a study involving the criminal activity of participants in CCC's Mentor and transitional Alcohol and Drug Free Community housing programs. A few of the most salient findings:

- The annual cost of illegal drugs used by the cohort was estimated at \$6.5 million;
- 93% of the participants were involved in criminal activity before entering the programs;
- 62% were committing crimes on a daily basis;
- Annual income generated from crime other than from drug sales was estimated to be over \$2 million;
- Post treatment participants reported a 95% reduction in the use of illegal drugs and a 93% reduction in criminal activity;

- 87% of participants reconnected with family members post treatment and there was a 29% increase in financial support to children. (Herinckx, 2008)

Permanent Supportive Housing/Housing First paradigm: Expansion of housing models to include wider range of low barrier and scattered site housing.

The Community Engagement Program

By the early 2000s, CCC had established the range of Alcohol and Drug Free Community housing models described above. CCC continued to operate almost 300 units of facility-based SRO low barrier housing with no sobriety requirements. CCC turned its focus, in developing new programs and housing, to the clients who were not succeeding in its existing models. This included people with multiple diagnoses (mental and physical conditions as well as addiction) and chronic homelessness. CCC's Community Engagement Program (CEP) was originally designed in 2001 as an intensive case management team focused on multi-diagnosed high utilizers of the Hooper Detoxification Center. The 30 units of CEP housing were sobriety based but lower barrier than other CCC ADFC housing, with more tolerance of relapse and more chances given to residents who were not remaining sober.

In 2003, CCC was able to greatly expand the CEP program as a lead partner for two successful federal multi-agency Interagency Council on Homelessness (ICH) funding applications for Assertive Community Treatment (ACT) teams. In addition, Multnomah County decided that it wanted to fund an ACT team at CCC. Within a period of a few weeks, CEP grew to include three modified ACT teams, with around 230 permanent housing rent subsidies from HUD Shelter Plus Care, and around 35 staff. The CEP teams are multi-disciplinary, including outreach, crisis management, detoxification, alcohol and drug treatment, mental health services, housing retention, benefits and entitlements counseling, health care, and employment assistance. CEP also employs consumer peers, case managers whose main qualification for the position is their own experience of homelessness, addiction, and mental illness, and their ability to use their experiences to relate to clients. CEP is a client-centered model based on meeting clients where they are.

CEP incorporates both scattered site "Housing First" low barrier housing, and facility-based ADFC housing, with clients having the choice of where they will live. For those who want CCC ADFC housing, transitional or permanent, it is available. For those who want a scattered site location, not part of an identified community, private landlord housing is arranged by CEP housing staff and funded by Shelter Plus Care vouchers. Throughout the course of the CEP effort over the past ten years, individuals have been housed in 27 different zip codes. There are no abstinence requirements, only a willingness to engage in services. Most of the housing is with private landlords and the rental/lease agreements are the same as used for market rental properties. Approximately 20% of clients live in CCC transitional low barrier or ADFC housing while moving toward permanent housing. The permanent housing retention rate is around 90% at one year post move-in and there are approximately 200 formerly homeless people being served at any given time in this program, with over 400 clients housed since program inception.

CEP was recognized in 2003 by the U.S. Department of Health & Human Services as one of six exemplary programs in the country serving mentally ill homeless individuals. In a 2006 cost analysis, an outside evaluation found that CEP generates a savings to the community of over

\$12 million annually in reduced hospitalizations and jail time, or \$15,006 per person per year (Moore, T.L, 2006).

Housing Rapid Response:

In 2005, the Portland Police Bureau, the City housing bureau, and Portland's downtown chamber of commerce funded a new team within CCC's CEP program, the Housing Rapid Response (HRR) program, which focused on recidivism reduction and placed a greater emphasis on access to treatment. These agencies saw a need for a new program to provide outreach, case management, housing and treatment for repeat misdemeanor criminal offenders (mostly crack cocaine addicts arrested for drug related offenses) who have been homeless for long periods of time. The long-term addiction and criminality of HRR clients was negatively affecting the safety and livability of Portland's central core, and other programs were not successful in reaching out to these individuals and helping them change their lives. As in an ACT team model, HRR case managers meet clients where they are and provide the support and housing they need to get off the streets and access alcohol and drug treatment. Data related to police involvement show that 65% of HRR clients have not been re-arrested 12 months after placement into permanent housing.

HRR began with a low barrier housing focus and evolved into a greater range of housing choice through adding ADFC housing and incorporating a "stages of change" model. After two years, the program was successful and the Police Bureau attained funding for a significant expansion of the program. In negotiating the expansion, CCC secured funding for 20 long term transitional ADFC housing units and a Recovery Mentor.

Currently, for HRR clients, CCC reserves 35 units of transitional low barrier housing in one building and 20 units of ADFC housing in another building. In the low barrier housing, residents are not allowed to bring alcohol in the building (most are mandated by their parole officers not to drink). However, CCC does not discharge people who are drinking; HRR case managers work with them to set up limits and expectations. HRR clients can also access some Shelter Plus Care vouchers for permanent housing, and rent assistance to pay initial permanent housing costs. Like the CEP program described above, a major piece of HRR's success is the range of housing options offered to clients. These programs have been an excellent example of the principle practiced by CCC of housing choice. For those who are still active addicts and not ready to contemplate a life of sobriety, or waiting to get into residential treatment, they are still in safe, well managed housing and receiving services.

Healthcare and Housing:

In 2001, CCC assumed management of Old Town Clinic, a homeless primary care clinic. Subsequently, Old Town Clinic was certified by the federal government as a Federally Qualified Health Center. Since then, it has grown to include a mental health clinic (Old Town Recovery Center), now located in a new building adjoining Old Town Clinic, funded in part by the American Recovery and Reinvestment Act (ARRA). In addition to the expanded focus on healthcare, these developments also led to the development of the Recuperative Care Program (RCP).

CCC started RCP in 2005 as a pilot program in partnership with Oregon Health & Science University. RCP includes 25 beds of housing in a CCC-owned downtown building, with

post-hospitalization healthcare services for homeless and low-income patients. The goal is to provide medical support services to stabilize the medical condition and to end the person's homelessness so they become self-sufficient. This program is funded primarily by contracts with most of the major local hospitals and health care systems, which refer patients to the program.

CCC's experience with both the Housing Rapid Response and Recuperative Care Programs shows that housing for very low income people can be funded through non-traditional sources. As any affordable housing provider knows, finding stable ongoing sources of funding for residents with very low or no income is a challenge. In the case of both programs, their success at stabilizing specific sub-populations of homeless people has helped transition initial start-up funding for pilot projects, into longer term funding from the police department (HRR's major funder) and hospitals (RCP's major funder). In both cases, these entities see a direct benefit to their systems and resources and thus are willing to fund supportive housing and services.

Self-sufficiency and housing:

Lack of stable legal income is perhaps the biggest single barrier for individuals engaged in the supportive service and housing system. As CCC has come to realize this systemic problem, the agency has begun to aggressively develop resources to reduce this barrier through the CCC self-sufficiency program. Over the last several years, this effort has become a major paradigm shift for the agency, with significant implications for housing and services outcomes, and the long-term success of clients.

While CCC staff had always been involved with residents and clients in attempting to assist those who were able to find employment, in 1989 the agency was awarded a HUD McKinney Supportive Housing Program grant that was tied to a jobs program for homeless people. The unique concept behind this effort was the idea that individuals who were homeless would experience more success in finding and keeping employment if they were safely housed. This program was based in a 62 unit SRO building and its success eventually led to the establishment of a full-service employment center for homeless and low income people, CCC's Employment Access Center (EAC).

Starting in the late 1990s, with increased federal resources for employment services, CCC's EAC expanded greatly, combining different funding sources in innovative ways to create a comprehensive employment center targeted at homeless people. For almost ten years, this program was a designated Workforce Investment Act-funded "One-Stop," with onsite partners including the State Employment Department and others. Current programs include a Department of Labor funded Homeless Veterans Reintegration Project, a VA-funded Veterans Per Diem program with 50 units of case managed housing, a Department of Justice funded prisoner re-entry initiative, and several City-funded employment programs for homeless people.

The original HUD-funded employment-focused housing project has been the anchor for the EAC, and is now integrated with other employment programs in a "Supported Employment" model. This program uses the SAMHSA recognized evidence based practice supported employment model known as "Individual Placement and Support" in which clients are assisted in finding and keeping jobs. In 2010, the EAC served over 3,600 clients, 56% of whom were homeless, and helped 460 obtain employment. Also in 2010, the Regional Research Institute for Human Services at Portland State University conducted an evaluation of CCC's Supported Employment Program from 2007-2009. This study showed Supported Employment to be an

effective means of helping homeless people with addictions obtain employment. Significant findings included:

- Of the 319 Supported Employment clients included in the study, all were homeless upon entry into CCC programs and had primary addiction disorders;
- 70% had felony convictions;
- 97% were individuals who had chosen to enter into substance use treatment and live in CCC's Alcohol and Drug Free Community Transitional Housing (ADFC), and;
- Despite the barriers posed by their background, 71% of all clients (227) served by the supported employment program achieved employment (Herinckx, 2010).

In 2000, CCC started a Business Enterprises division, creating several social enterprises to employ CCC clients and other homeless people, provide on the job training, generate revenue, and meet the needs of CCC and the community for specific services. These enterprises include:

- Downtown Clean & Safe – a public sanitation and safety service, through a contract with the Portland Business Alliance (the downtown chamber of commerce);
- Central City Janitorial – a professional cleaning service;
- Central City Painting – a certified lead-abatement interior and exterior painting contractor, and;
- Central City Maintenance – repair and room turnover.

Adoption of the self-sufficiency paradigm has, and continues to be, transformative to how CCC operates housing and supportive services. For homeless people with addictions – the majority of CCC's clients – CCC has expanded the agency's conceptualization of recovery to include maximizing potential and increasing self-worth, by becoming an active, contributing member of the community. Since addiction is a chronic, relapsing condition, self-sufficiency is a critical aspect of the long-term recovery management needed to address this condition. **The self-sufficiency focus also changes how the agency views the role of supportive housing. To sustain housing capacity for those who need it most, subsidized supportive housing must function as a limited-term intervention whenever possible for most residents, a launching pad for their transition into housing in the community.** Supportive housing models are less effective, and create less capacity, when residents get "stuck" in subsidized housing beyond the point this housing is helpful to them. The question of "how long is too long" for a homeless individual to engage in supportive services and housing is not easily resolved. The answer will vary depending on the individual's history, needs, and capabilities.

Some of the elements which have proven effective in CCC self-sufficiency strategy, in addition to the employment programs and business enterprises described above include:

- Benefits acquisition: In 2008, CCC formed a Benefits and Entitlements Specialist Team (BEST), to coordinate and expedite SSI/SSDI benefits acquisition. For homeless individuals who are not able to gain employment and who qualify for benefits, targeted benefits assistance is essential to navigate the complex and lengthy benefits process.
- Community Volunteer Corps: In spring 2009, CCC launched a new program to involve clients in volunteer service in the community. CCC is partnering with other nonprofits and government agencies for clients to engage in volunteer activities which give them work experience and allow them to give back to CCC and to the community. Clients who are not yet ready or able to successfully obtain employment receive a stipend and gain on the job experience. After two years, 305 graduates have completed 80 hours of volunteer

work through the Community Volunteer Corps, with a 69% graduation rate. CVC volunteers have given over 28,000 hours to 12 nonprofit community partners.

The self-sufficiency effort will result in residents and clients more quickly achieving emotional and financial independence, becoming contributors to the community, and able to move out of the CCC housing and service system. Moving through ADFC transitional housing in four to five months, or less, instead of seven to eight months, allows the program to serve more people with the same resources. This results from earlier, more successful employment. More people with incomes, who can pay their own rent, allow the rent subsidies to support more people, thus adding to capacity. A core element to being housed is the ability to pay rent.

Focusing on helping residents achieve self-sufficiency is critical to maximizing scarce affordable housing resources. There are some residents who will never be able to work and will always need support services; for these residents, permanent subsidy and services are appropriate. For most, however, subsidized supportive housing is a limited-time intervention until they are able to move on with their lives. With the current national focus on “permanent supportive housing,” less emphasis has been placed on the fact that a relatively small number of homeless people need supportive housing that is truly permanent.

Evaluating the Impact: HEARTH

In 2010, researchers from Portland State University (PSU) and Oregon Health and Sciences University (OHSU) joined CCC leadership, staff, and consumers to form a research consortium. The project, known as HEARTH (Housing, Employment and Recovery Together for Health), received initial funding from the National Institute on Drug Abuse and the Northwest Health Foundation to develop the capacity to conduct community-based participatory research (CBPR) to understand the efficacy of CCC’s services. While some studies and much anecdotal evidence has suggested that CCC’s programs have a positive and beneficial impact on the people it serves, more rigorous studies are needed to impact housing policy on a national level.

Ending homelessness means more than getting people off the streets. To truly end homelessness, and reduce the chance of future homelessness, communities and agencies must focus on successful reintegration into the community. When individuals become self-sufficient, their view of themselves is transformed: from a homeless addict, a user of public resources, a menace to society, to a person with pride and self-worth who is part of something larger than themselves. Through self-sufficiency, people develop relationships, get their kids back, get jobs, pay their own rent, eventually become homeowners, and generally move forward with their lives. The pathway to ending homelessness goes through supportive services and housing and out into the larger community.

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