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Homelessness Prevention TC for Addicted Mothers

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The homelessness prevention program described in this manual was developed by Gaudenzia in the late 1980’s as a response to the urgent problem of homelessness in Philadelphia, and is a program for homeless substance abusing mothers and their children. The program uses therapeutic community (TC) principles and methods as the foundation for recovery and the structure within which the homelessness prevention interventions unfold. There are two program settings: New Image in Philadelphia; and Kindred House in West Chester. In the course of the program, mothers progress through program stages and move from residential to transitional to permanent housing. The specific homelessness prevention interventions begin early in the residential phase, increase in frequency and intensity (especially in the latter part of the residential program), and continue at somewhat reduced frequency upon re-entry into the community. While other standard TC programs may include some homelessness prevention elements, this program differs in its singular concern with preventing homelessness and in the richness of services designed to achieve this goal. The program has undergone refinements over time and, in the process of development of this manual, continuity between residential and non-residential programming was increased and several homelessness prevention interventions were intensified.

Conceptual Framework

The Individual. The perspective of the individual is used to define the nature of the problem. The disorder is considered as that of the whole person; the person is viewed as having multiple deficits with multidimensional needs and problems. Recovery is viewed as a developmental process in which change continues to take place over time. The concept of “right living” (prosocial change) highlights the need to address attitudes and values as well as behavior. The disaffiliation of the individual from the community is fundamental, and benefits from the use of the community as the healing agent (“community-as-method”) to achieve reintegration with mainstream society.

The Mother-Child Dyad. The perspective of the present project on homelessness prevention also includes the mother-child dyad. Homeless substance abusing mothers must learn to manage their own lives and to provide proper care, guidance, and a secure environment for their children. The developmental, social, emotional, and familial needs of the children must be addressed. The mother-child relationship requires special attention in order to strengthen, and in some cases to forge, the bonds between mothers and children, many of whom have lived apart. In addition, the perspective also includes the social context of poverty, economic dependence, family deterioration and alienation with which these women must contend. Successful homelessness prevention interventions must provide tools and supports to help the mother break this cycle for herself and for her children.
Background & Review of the Literature

**Homelessness.** Homelessness represents one of our most pressing and complex social problems. It is imperative to address the multi-dimensional needs of the homeless, including housing, health care, use of mainstream programs and support services, job training and placement, and treatment for mental illness and substance abuse. Effective programs must confront the disaffiliation of homeless people and facilitate a return to functioning within the mainstream by providing skills, strengthening values, and reinforcing (or establishing) a positive social network or community.

**Addicted Mothers.** Homelessness prevention programs for homeless, substance abusing women and their children must simultaneously contend with the needs of the mothers and the children. Services for mothers must address: the social isolation of the homeless parent; the need to establish a healthy support network with shared family goals; the means to emerge from poverty through educational and vocational advancement; the ability to provide effective parenting; and the capacity to attain and sustain recovery from substance abuse.

**Children.** Specific services are needed for children at risk, including child care and other specialized interventions: to promote self-esteem and reduce stigma; to provide specialized educational and developmental enrichment; to permit access to adult role models; to ensure access to treatment designed to help cope with the history and memory of living with a substance abusing parent; to build special personal relationships for stable interpersonal skills; and to forge firm bonds with mothers and the extended family for family preservation.

History, Setting & Environmental Context for the Interventions

**Gaudenzia.** The homelessness prevention TC program was developed by Gaudenzia, with the support of the City of Philadelphia Department of Health, in response to the increasing numbers of homeless addicted mothers and families entering the Philadelphia shelter system, and the lack of program resources to help those families extract themselves from the cycle of poverty, substance abuse, and homelessness. The program provides a continuum of homelessness prevention interventions in residential and non-residential settings.

**Convergent Developments.** Several convergent developments led to the adaptation of TC principles and methods to the problem of homelessness prevention. These included: increased prevalence of homelessness; development of a recovery perspective and codification of the TC model; evolution of TC methods toward homelessness and prevention; and field experience in refining, documenting and evaluating TC programs.

**Collaboration/Principles of Program Implementation.** Gaudenzia and The Center for Therapeutic Community Research (CTCR) at National Development and Research Institutes, Inc. (NDRI) formed a collaborative relationship and assigned a project team to refine the program interventions and to document the program in manual form. The team followed six principles in refining and implementing the program elements: i) work within the guidelines of agency and system; ii) involve stakeholders in the project; iii) use a strategic program planning approach and involve all key staff in program planning and refinement; iv) employ active training and technical assistance during the refinement and implementation of new elements; v) review program fidelity periodically; and vi) develop ownership and a firm collaborative relationship among service, training, and evaluation staff. The success of this project in developing the manual is based on expertise, mutual trust, and a strong collaboration between service, training and evaluation staff.
Description of the Client Population.

The program serves homeless, substance abusing women and their dependent children. The women are primarily single parents, minority members, in their mid-30’s, and unemployed. The needs of the family unit are multidimensional; the needs of the mother and child(ren) are interrelated. As described in the review of the literature, these needs can be broadly categorized as related to: impaired functioning and disaffiliation of the mother; family reunification and the mother-child relationship; developmental and social deficits of the child; prosocial reintegration of the family with mainstream society; and stabilization of housing.

Description of the Homelessness Prevention Interventions

Program Structure

Essential to the homelessness prevention TC specifically, and to positive behavior change generally, are: a defined daily regimen; staff members who serve as role models and guides; peers who provide support and mentoring; and the use of the community as the healing agent. Gaudenzia furnishes the necessary organizational support and administrative structure.

Goals. The short term program goals, which establish a foundation for recovery, are stabilization of the mother and child, affiliation with the TC community, and increasing assumption of personal responsibility. The homelessness prevention short-term goals concentrate on: preservation of the family (by improving child development, parenting and the mother-child relationship); employment (through learning work readiness skills, locating work, and sustaining job performance); housing stabilization (by obtaining and maintaining housing); building a supportive community (initiated by affiliation with the residential TC community and extended to defining a support network in the community at large); and societal reintegration (developing positive attitudes, incorporating prosocial values and fostering lifestyle change).

The homelessness prevention longer term goals reflect stabilized, independent living in the community. The goals of societal/organizational change involve breaking the cycle of poverty, substance abuse, homelessness and family deterioration, in concert with generalizing self-help methods and building supportive communities.

Logic Model. The logic model depicts the relationship between the population/environment, conceptual framework, interventions, and expected outcomes in this project, focusing on the homelessness prevention specific interventions of the program. The description of the client population includes both profiles and needs. The conceptual framework briefly lists the basic theoretical assumptions for the TC-oriented program before focusing on the conceptual framework of the current homelessness prevention program. The interventions briefly list the core activities of the TC program before focusing on the full array of homelessness prevention specific interventions.

Process: Stages

The process is defined in terms of the stages of the program. A developmental perspective of change (for the mother and for the mother-child dyad) and the interrelationship of TC methods and homelessness prevention activities is reflected. The program model incorporates five stages: Stage 1, Foundation for Recovery; Stage 2, Planning for Prevention; Stage 3, Live-In Re-Entry; Stage 4, Live-Out Re-Entry; and Stage 5, Independent Living. Homelessness prevention initiatives begin in Stage 1 and intensify in later stages, in conjunction with clients’ increasing capacity to take responsibility for themselves, their children, and their community.

The goals of Stage 1 are affiliation with the peer community, stabilization of the family, assumption of personal responsibility, and commitment to recovery from substance abuse. The goal of Stage 2 is to begin the planning for homelessness prevention, includ-
The model provides homelessness interventions in a TC environment... reducing substance abuse. 

The model provides homelessness interventions in a TC environment...
Introduction

The homelessness prevention program described in this manual was developed by Gaudenzia in the late 1980’s as a response to the urgent problem of homelessness in Philadelphia. The goal of the program is to prevent homelessness for homeless, substance abusing women and their children. The program addresses homelessness by focusing on several broad and interrelated goals: recovery from substance abuse as a foundation for homelessness prevention; improving parenting and the mother-child relationship; reunification of the family; sustaining gainful employment; stabilization of housing; building a healing and supportive community; and reintegration with mainstream society. During the course of the program, mothers progress through program stages and move from residential to transitional and/or permanent housing. The specific homelessness prevention interventions begin early in the residential phase, increase in frequency and intensity (especially in the latter part of the residential program), and continue at somewhat reduced frequency upon entry into transitional and permanent housing.

The program uses therapeutic community (TC) principles and methods as the foundation for recovery and the structure within which the homelessness prevention interventions occur. The evolution of a concentration on the mothers and their children coupled with the recognition that concrete activities were needed to prevent future homelessness transformed the model from its earliest implementation to a program focused on the prevention of homelessness. This manual describes in detail the homelessness prevention specific activities. Also described, in summary form, are the core TC principles and methods incorporated by this unique program.

The program and program manual have considerable potential to affect the field by identifying a broad array of best practices for homelessness prevention applicable to many settings; hence, the utility of therapeutic community programming for human service initiatives is also increased.

The section that follows describes the conceptual framework of the homelessness prevention program in terms of a perspective and approach. Previous writings of the investigative team are briefly reviewed and extended (see De Leon, 1996; S. Sacks, De Leon, Bernhardt & J. Sacks, 1994).

Perspective

The Individual. The nature of the problem of homelessness is viewed from the perspective of the individual, and encompasses the aspects of: the disorder, the person, recovery, “right-living” (prosocial change), and affiliation. The disorder is perceived as one affecting the whole person; the person is viewed as having multiple deficits accompanied by multidimensional needs and problems. Recovery is viewed as a developmental process in which change continues to take place over time. The view of “right living” (prosocial change) highlights the need to focus on attitudes and values as well as behavior. The disaffiliation of the individual from the community is fundamental, with the process of reintegration with mainstream society being facilitated by the use of community-as-method (i.e., the community as the healing agent).

The Mother-Child Dyad. In the present project on homelessness prevention, the perspective also includes the mother-child dyad. Homeless, substance abusing mothers must learn to manage their own lives, while providing proper care, guidance, and a secure environment for their child(ren). The educational, developmental and social needs of the children must be addressed. The mother-child relationship requires special attention in order to strengthen, and in some cases develop, the bonds between mothers and children, many of whom have lived apart. In addition, the social context of poverty, economic dependence, family deterioration and alienation with which these women must contend is to be considered. Successful homelessness prevention interventions must provide tools and supports to help the mother break this cycle for herself and her children.
Approach

Structure. The structure of the program is defined in terms of the daily regimen, the role of staff, the role of the peer community, and the peer hierarchy. The daily regimen provides a predictable pattern to the day, and a predictable environment within which mother and child(ren) learn and practice consistency, responsibility, and community living skills. The daily schedule is structured and group-oriented, but flexible enough to accommodate mothering tasks and the special needs of the child, determined on an individual basis. As mothers move from residential to transitional and/or permanent housing, the daily regimen becomes more individualized. The staff serve as role models and guides for the mothers, using their own experiences and current behavior to set examples for clients, providing supportive guidance and skills training to facilitate achievement of program goals. The role of the peer is to provide support, leadership and mentoring for other members of the peer hierarchy, building mutual self-help supports, and a peer “safety net” for mothers and their children who have moved into individual apartments in the community.

Process. The process is defined in terms of the stages of the program, reflecting a developmental perspective of change (for the mother and for the mother-child dyad) and the interrelationship of TC methods and homelessness prevention activities. The program model consists of five stages:

Stage 1 – Foundation for Recovery
Stage 2 – Planning for Prevention
Stage 3 – Live-In Re-Entry
Stage 4 – Live-Out Re-Entry
Stage 5 – Independent Living

Homelessness prevention initiatives begin in Stage 1 and intensify in later stages (see Figure 1).

The goals of Stage 1 are affiliation with the peer community, stabilization of the family, assumption of personal responsibility, and commitment to recovery from substance abuse. Homelessness prevention activities (especially those related to family reunification/preservation) are initiated in this stage. The goal of Stage 2 is to begin the individualized planning for homelessness prevention and includes the introduction of basic homelessness prevention activities focused on issues involved in the mother-child relationship, obtaining housing, and assuming work responsibilities. The goal of Stage 3 is to prepare the mother and family for re-entry into the community, and includes a considerable intensification of all homelessness prevention activities as described later in this manual. The goal of Stage 4 is to stabilize the family in the community, and to support and consolidate the self-management of all activities to prevent homelessness. The goal of Stage 5 is to achieve independent living in the community through use of the support community to sustain lifestyle changes for integration with mainstream society.

(See the section on Sequence of interventions & passage through the process, page 51, for an elaboration of the process of the program model.)

Interventions

The homelessness prevention interventions are based on the perspective and approach described in the preceding paragraphs and include:

i) core therapeutic community (TC) elements that facilitate recovery from substance abuse and provide a foundation of readiness for homelessness prevention activities; and

ii) activities specific to homelessness prevention and residential stability, that include family preservation, obtaining work, housing stabilization and building a supportive community.

(See the section on Homelessness prevention activities, page 34, for a full description of the interventions that are the main subject of this manual.)
A TC program is a behavior change system based on uniform theory, principles and methods. The Gaudenzia program delivers homelessness prevention interventions within a TC environment.

The Gaudenzia program takes place in both residential and non-residential locations. There are two programs—New Image in Philadelphia; and Kindred House in West Chester. The non-residential settings include both transitional housing (when available) and permanent housing.

The program is related to a larger effort to use TC principles for service to special populations in a variety of settings—e.g., day treatment, supported housing and a variety of other “aftercare” or ambulatory settings (see S. Sacks, De Leon, Bernhardt & J. Sacks, 1994; Sacks, 1995).

While other standard TC programs may include some homelessness prevention elements, this program differs in its singular concern with preventing homelessness and in the richness of services assembled to achieve this goal.

Figure 1 depicts the relationships among TC structure, homelessness prevention specific interventions, program stage, location and time.

Figure 1 – Illustration of the Homelessness Prevention TC

TC Environment

Social Environment
The Problem of Homelessness

Homelessness represents one of our most pressing and complex social problems. The National Alliance to End Homelessness (1988) estimates that between 1.3 and 2 million people are homeless at least one night during the year, and approximately 730,000 people are homeless on any given night. Despite these alarming statistics, our understanding of the diversity of this population, their service needs and the treatment options available is still being formulated. Homeless people suffer from a variety of associated problems, including those related to health and medical (Institute on Medicine, 1990), HIV (Schutt & Garrett, 1992), criminality (both as victims and participants; Rahav & Link, 1995), alcohol and drug use (Fischer & Breakey, 1987), and mental illness (Rossi, 1990).

Several workers have developed a priori and experiential classification systems (Arce et al., 1985; Fischer & Breakey, 1987; Roth & Bean, 1986); however, these classification systems have not described the relationship of subtype differences among homelessness and treatment effectiveness, nor have they documented effective interventions for homeless individuals. Homelessness is frequently a symptom of one or more underlying problems, such as lack of job skills or education, mental illness, and/or a substance abuse disorder. The interaction of any of these problems with identifiable social and economic factors may result in individuals becoming homeless (NYC Commission on the Homeless, 1992).

The primary individual factor to be identified with homelessness is substance abuse (McCarty, Argeriou, Huebner & Lubran, 1991). Approximately 70% of participants in recent National Institute on Alcohol Abuse and Alcoholism (NIAAA) demonstration projects identified alcohol/drug problems as the primary reason for their homelessness in both the first and most recent episodes (Stevens, et al., 1993; Leaf et al., 1993). About two-thirds of the homeless are estimated to abuse alcohol and 50% to abuse other drugs. Among those in shelters, almost 90% are estimated to have alcohol problems and over 60% to have problems with other drugs (Fisher & Breakey, 1991; Interagency Council on the Homeless, 1992; NYC Commission on the Homeless, 1992).

It is imperative to address the multi-dimensional needs of the homeless, including housing, health care, use of mainstream programs and support services, job training and placement, and treatment for mental illness and substance abuse (S. Sacks, J. Sacks, De Leon, Bernhardt, & Staines, 1997). Effective programs must address the disaffiliation of homeless individuals and facilitate a return to mainstream functioning by providing skills, strengthening values, and reinforcing or establishing a positive social network or community. A common motif of using the community as a vehicle for change was evident in several model programs described at a recent conference on the homeless mentally ill chemical abusers (MICA; Center for Mental Health Services, 1995). TC-based approaches which focus on the whole person and the use of the peer community for healing may be ideally suited to ameliorate the multi-dimensional deficits and disaffiliation of the homeless, substance abusing population.

The Problem of Homeless Women

As Merves (1992) observes, women constitute one of the fastest growing groups of homeless in the US, but their existence, needs and concerns have received little study. Homeless single women, women with children, and homeless single men differ significantly on a number of variables, with implications for both the probable causes of their homelessness and for preventive and remedial efforts (Burt & Cohen, 1989). For example, as compared to homeless men, women have shorter spells of homelessness, are more likely to have a history of psychiatric hospitalization and attempted suicide, and those with children are substantially more likely to be on welfare (see also Calsyn & Morse, 1990). Furthermore, according to Merves (1992), homeless women face more discrimination than homeless men in seeking shelter, food and employment.
A recent finding to emerge from the comparison of the sexes in a study of homeless mentally ill chemical abusers (MICAs) was the particular vulnerability of female clients (Balistreri & McKendrick, 1996). Compared to men, women reported more problematic family backgrounds, much more experience of sexual abuse, more problems with physical health, more pervasive problems with mental illness, more exposure to the dangers of crack, more challenges to their adequacy as parents, and more sexual exposure to the risks of HIV/AIDS. Whereas males tended to commit crimes that had victims, females tended to participate in victimless crimes, especially prostitution, jeopardizing their own health and placing themselves in a position to become the victims of male-initiated crimes (see also Crystal, 1984). These findings reinforce earlier and more general evidence that female drug abusers enter treatment with more deviant psychological profiles and with more social deficits than do their male counterparts (De Leon & Jainchill, 1981).

The needs of homeless women with children include all of those specified in the sections above as well as the following: provisions for child care; services for child developmental, educational, and health care needs; education in child development and parenting; support for sustaining the family unit and avoidance of foster care; skills training in household, finance and resource management; practice in community resource utilization; specialized education and vocational training for stable, open competitive employment; and a support network.

The Problem of Homeless Women and Children

Motherhood. Homeless women with children have constituted the fastest growing subgroup of the homeless population in the United States for the past 10 years; homeless families comprised 33% of the total homeless population in 1987, with the percentage rising to 43% by 1993 (US Conference of Mayors, 1987; 1993). Empirical data from studies conducted across the United States reveal that most urban homeless families are headed by single mothers, most of whom are younger than housed mothers (McChesney, 1995; Knickman, Weitzman, Shinn, & Marcus, 1989). In the context of economic subsistence, lack of education, and inadequate job training, motherhood—especially as a single parent—imperils a woman’s ability to maintain her home (Bassuk, 1993). Extreme poverty, compounded by a reduction of government sponsored social welfare programs for families (including child care), and a diminished supply of low income housing, provides a partial explanation for single motherhood as a risk factor for homelessness.

Social Supports. In addition to the critical factors cited above, the mother’s social support network has been posed as a safety net operating to prevent homelessness and/or assisting families in remaining housed (Bassuk & Rosenberg, 1988); limited social supports have been cited as a significant factor placing the family at risk for homelessness (McChesney, 1992; Wood, Valdez, Hayashi, & Shen, 1990; Weitzman, Knickman & Shinn, 1990). Mothers who can share housing with a relative or friend do not become homeless.

Homeless mothers in Boston, Los Angeles, New York, and Baltimore/Washington, DC, all report perceiving the members of their social support system as unavailable to assist them with housing, finances or child care, suggesting that even those with an identified support network of family and friends may have worn out their welcome by the time they became homeless, or that they are members of social networks whose constituents are only marginally better off (Bassuk & Rosenberg, 1988; Wood et al., 1990; Shinn, Knickman & Weitzman, 1991; Letiecq, Anderson & Koblinsky, 1996). Indeed, homeless mothers receive less actual support from parents, relatives and friends than housed mothers living at the same socioeconomic (poverty) level; increased time homeless, transient homelessness, and maternal substance abuse are each associated with reduced assistance from the social network (Letiecq et al., 1996; Geissler, Bormann, Kwiatkowski, Braucht & Reichardt, 1995). Homeless, head of household mothers perceive, and experience, that when they are in need, few people in their lives can provide...
assistance; the safety net—child care, assistance with food or money, and guidance, usually provided by the extended family—has been lost or exhausted.

The empirical evidence of limited or eroded social supports for homeless mothers with young children, and the role the social support network may play in helping homeless families remain permanently housed, has implications for homelessness prevention for families, especially those who have experienced prolonged periods of transient homelessness. Homelessness prevention programs must address the social isolation of these women, assisting them to build a new, healthy peer support network with shared values and family goals, while also helping them to re-establish positive ties with the extended biological/kinship family. Successful programs, such as the one described in this proposal with its focus on the use of a community as a healing agent, will maximize responsiveness to the issues surrounding the development of new support networks and the extension of those networks into the community-at-large, at the same time that ties to the biological family are re-established.

**Parenting.** As noted above, homeless individuals have been found to have different needs based upon gender; research has also observed that homeless women express different needs depending upon whether they have children with them in the shelter.

Homeless women with children, interviewed within the Maryland shelter system, differed significantly from other homeless women in citing needs for child care, parenting skills training, help with their children, job training, finding work, education, and service coordination (DiBlasio & Belcher, 1995). It would appear that women with children focus their efforts to escape from homelessness on their responsibility to provide proper care for their children. Consideration that the needs of homeless women with children are different from other homeless individuals, and that those needs include the opportunity to perform their parenting responsibilities more effectively, has implications for programming designed to reintegrate homeless families within the community and to prevent future homelessness.

**Homeless Children.** The stress of living in shelters or on the streets is severe for both women and men but is greater for mothers with young children. Beyond the financial burden that the children pose, providing for their education, play and ensuring their rest is difficult. In addition, a growing body of studies of homeless families provides evidence that homelessness profoundly and disproportionately affects the youngest family members, indicating that homeless children are at risk for: severe and chronic health problems; poor and inadequate nutrition; developmental and emotional problems; educational problems; and child abuse (Bassuk & Rosenberg, 1990).

Children in homeless families are more apt to have been called upon to assume child care and emotional supports for their mothers; homeless mothers name their young children more frequently than their own mothers as important social supports in their lives (Bassuk & Rosenberg, 1988; Wood et al., 1990). In studies of homeless families in Massachusetts, Bassuk and her colleagues found that a majority of children were suffering from developmental delays, severe anxiety, depression, and learning difficulties (Bassuk & Cohen, 1991; Bassuk & Rosenberg, 1988; Bassuk, Rubin & Lauriat, 1986). These difficulties occurred in both preschool and school-aged children who also faced risks associated with substance abuse, lack of appropriate role models, stigma, poor self-esteem, family disintegration, housing instability and transience, and unstable personal relationships with family and friends. Homeless mothers, attempting to raise children under conditions of limited economic and social resources, can become overwhelmed and feel ill equipped to provide effective mothering for children in distress or those needing special supports.

**Substance Abuse.** In addition to the issues and needs cited above for homeless women and their children, evidence of increased drug use among homeless women has emerged throughout this decade, with many of these women having children and/or being pregnant (Hausman & Hammen, 1993). Homeless women with dependent children report rates of drug abuse ranging from two to eight times higher than those for housed
women with children (McChesney, 1995; Robertson, 1991; Knickman et al., 1989). Substance abuse constitutes a threat to housing, not only by causing disrupted functioning but by actual evictions as a consequence of national policy for public housing (Cranston-Gonzalez Affordable Housing Act, 1990).

Homelessness and substance abuse also present serious threats to family preservation by virtue of being major factors in the decision to separate children from their mothers for placement in foster care (Allen, 1991; Steinbock, 1995). The implication of this emerging body of information is that homeless women and their young children are at great risk for experiencing family separation and disruption, and this risk is exacerbated by the mother’s substance abuse. Programs to combat homelessness and to promote preservation of families with drug dependent or abusing mothers must address the multi-faceted needs of the family, but cannot ignore that the essential bedrock upon which most other homelessness prevention interventions are built is predicated on the mother’s need for drug treatment. A program based on TC principles and methods and working with the family unit provides an ideal opportunity for the single parent family to develop a drug abstinent foundation, and to address the parenting, economic, home management, and affiliative needs of the family which are crucial to homelessness prevention.

The current project describes a homelessness prevention TC for addicted mothers. The program uses therapeutic community principles and methods as the foundation for recovery and the structure within which the homelessness prevention interventions unfold. These interventions address family preservation, work, housing stability, building a supportive community, and societal reintegration. Although other standard TC programs may often include some specific homelessness prevention elements, the Gaudenzia homelessness prevention program is distinguished by its singular focus on preventing homelessness, and in the richness of services developed to achieve this goal.

**Summary**

Services for mothers must address: the social isolation of the homeless parent and the need to establish a healthy support network; the means to emerge from poverty through educational and vocational advancement; the ability to provide effective parenting; and the capacity to attain and sustain recovery from substance abuse.

In addition to services for mothers, services specifically for children at risk are needed, including child care and other specialized interventions that: promote self-esteem and reduce stigma; provide specialized educational and developmental enrichment; permit access to adult role models; ensure access to treatment to help them cope with the history and memory of living with a substance abusing parent; build special personal relationships for stable interpersonal skills; and forge firm bonds with the mother and the extended family for family preservation. 
Development of the Interventions

**Convergent developments.** Several convergent developments led to the design and implementation of the homelessness prevention TC program. This section describes these interrelated lines of inquiry in conceptualization, research and practice.

**Increased prevalence of homeless families & lack of intervention models.** As noted previously, beginning in the mid-to-late 1980s, homeless shelters in major urban centers nationwide began to document a significant increase in the prevalence of families entering the system; most notably, families headed by single mothers. In a large proportion of these families, the mother’s inability to sustain housing could be attributed to poverty, lack of education and/or employment skills, but was often compounded by pervasive social deficits and substance abuse problems.

At the time, homelessness prevention programs which would permit the family to remain intact, while contending with the complex needs of the entire family unit, were non-existent. Because most programs required separation from their children, homeless, substance abusing mothers resisted entering treatment (Stevens, Arbiter & Glider, 1989). The children, who were often in distress or in need of special supports arising from their experiences of homelessness and inconsistent parenting, faced the further disruption of family separation, foster care placement, and unpredictable services or supports. Consequently, thinking was directed toward the development of programs to meet the complex needs of homeless, substance abusing parents and their children.

**Theoretical Framework of the Therapeutic Community (TC)**

**(1) Recovery Perspective.** The recovery-oriented perspective describes a process of change from drug use to abstinence and a positive lifestyle (De Leon, 1996). The key concepts in the recovery perspective are stages of recovery, and motivation and readiness. In the early stages of recovery, clients experience a gradual shift from denial to admitting that a problem exists. This shift includes: a growing recognition and acceptance of drug use and associated problems; a desire to change that has a greater motivation than external pressure and that includes “inner” reasons; and a readiness for treatment that includes a need for a change in themselves extending beyond the elimination of chemical dependency.

The later recovery stages involve perceptions and behaviors associated with achieving abstinence and maintaining sobriety, increased self-examination, improved self-management, and development of a revised life plan. Motivation refers to client awareness of the need for change; readiness refers to a willingness to undertake the actions necessary for change. Each recovery stage has characteristic emotions, cognitions, and behaviors. Thus, of particular relevance to the current project, the recovery perspective provides a basis for emphasizing change over time and for addressing both substance abuse and related problems.

**(2) Codification of the TC Model.** In a series of papers, De Leon has provided a full description of the TC for the addictions in order to advance research and guide training, practice, and program development (De Leon, 1974; 1976; 1980; 1984; 1989; 1996; De Leon & Jainchill, 1981; 1992; De Leon & Rosenthal, 1989; De Leon, Skodol & Rosenthal, 1973; De Leon, Rosenthal, & Brodney, 1971; De Leon, Wexler, & Jainchill, 1982; De Leon & Ziegenfuss, 1986). This work makes increasingly explicit the perspective, treatment approach, program model, and treatment process of the TC; thereby facilitating the identification of essential elements, comparisons across programs, evaluation of program effectiveness, and testing of some of the implications of the model. More specifically for this project, an essential conceptual framework and core program elements for the development of a homelessness prevention program within a TC environment have been provided.
(1) **The Traditional TC.** Several articles (De Leon, 1989, 1995; De Leon & Rosenthal, 1989; De Leon & Ziegenfuss, 1986) describe the perspective and approach of the traditional TC for recovery from drug abuse. Briefly, drug abuse is a disorder of the whole person reflecting problems in conduct, attitudes, moods, emotional management and values. Many drug abusing individuals have deficits in social, educational and marketable skills. A critical assumption is that stable recovery depends upon an integration of both social and psychological goals. The goals of the TC approach are to promote freedom from alcohol and illicit drug use, to eliminate antisocial behavior, and to affect a global change in lifestyle, including personal attitudes and values.

(2) **Main Findings.** A number of NIDA-funded, multi-site, and program-based evaluations document the effectiveness of TCs (De Leon, 1984; Simpson & Sells, 1982; Hubbard, Rachal, Craddock & Cavanaugh, 1984). Short- and long-term follow-up studies show significant decreases in alcohol and other drug use, reduced criminality, and increases in employment. The demonstrated effectiveness of the TC, in terms of drug use, prosocial behavior, and psychological outcome, provided the rationale for the development of TCs for special populations such as homeless addicted mothers.

(3) **TCs and Homelessness.** TCs have always served drug abusers with histories of homelessness; program administrators classify over 30% of the clients in standard TCs as “undomiciled” at the time of entry into treatment. No differences exist in socio-demographic and psychological profiles between these clients and other substance abusers in TCs; however, as distinct from the clients in shelters, the TC clients do not appear to be a homeless group characterized by psychiatric histories and an embedded lifestyle of homelessness. In part, this difference is expected since standard TCs have generally excluded clients with histories of severe mental illness as part of the admission protocol, although homelessness per se has not been an exclusionary admission criterion. Several studies, though not focused on homelessness prevention, are evaluating the effectiveness of TCs for homeless clients (Leaf *et al.*, 1993; Stevens *et al.*, 1993). The proposed project with the Gaudenzia program will provide the first manual and evaluation of a homelessness prevention program for addicted mothers in a TC environment.

(4) **TCs and Families.** During the same time period, several TC agencies began to address the increased prevalence of young, cocaine-abusing women within their treatment programs, with a special focus on the difficulties of retaining this population in treatment. The most common reason for leaving treatment, reported by program and clinical staff, involved separation from children and problems of child care. The focus on retention led to the development of live-in modified TCs for non-homeless substance abusing mothers along with their children, which were pioneered in New York, Arizona and Florida. Informal information from the field, in each of these circumstances, suggested successful results with regard to retention, increased length of stay, and improved outcomes (Hughes *et al.*, 1995).

(5) **Field Experience.** The staff of the Center for Therapeutic Community Research (CTCR) has developed a modified TC model for several clinical populations and implemented this model in community-based mental health settings (S. Sacks, De Leon, Bernhardt, & J. Sacks, 1995), hospital facilities (Galanter, Franco, Kim, Metzger, & De Leon, 1993), methadone treatment clinics (De Leon, Sacks, & Hilton, 1993), and prisons (S. Sacks & Bernhardt, 1995). The investigative team has also extended this model to day treatment (S. Sacks, Bernhardt, & J. Sacks, 1994) and aftercare supported housing settings (S. Sacks, De Leon, Bernhardt, & J. Sacks, 1994; J. Sacks, 1992).

This field experience has established the clinical feasibility of the model, provided guidelines for its implementation, developed a training and technical assistance capacity, and provided a field laboratory for evaluation research. The current project further extends this work by focusing on a new target problem—homelessness prevention; by refining a program for this problem—homelessness prevention interventions; and by
using the TC principles and methods as the framework and structure within which the interventions unfold—i.e., as a foundation for recovery.

Setting
Agency and Facilities

Gaudenzia is a private, not-for-profit TC-oriented agency, incorporated in 1968, to provide treatment, prevention and other services to people with substance abuse and related problems. Two of Gaudenzia’s 34 programs, New Image and Kindred House, were developed in 1989 at the request of local and state agencies to establish a homelessness prevention program for homeless, substance abusing women who were pregnant and/or who were parenting one or more children.

With the support of the City of Philadelphia Department of Health, the initial project, known as the Family Shelter Project, opened in a wing of the Stenton Shelter for Homeless Families in Philadelphia; this program was called New Image and exists in the same physical location today. The Kindred House program was developed on property owned by Gaudenzia in West Chester, PA, a suburban community near Philadelphia. In addition to sharing a common administrative and treatment structure, both programs serve homeless, substance abusing mothers and their children from Philadelphia and the surrounding communities. Both programs share similar physical design elements, including: bedroom space occupied by two to three mothers and their young children; gender-specific dormitory bedrooms shared by four older children; communal dining and recreational space; infant and pre-school nursery/day care space; group meeting rooms and office space for group and individual programming.

Program Evolution
Initial Program

The basic concept guiding the initiation of the program was that homeless, substance abusing mothers would be more likely to avoid a return to homelessness, to remain in recovery, to attain economic independence, and that the family unit would function more effectively if child care, parenting, health and mental health care, literacy, job readiness services, and children’s services were added to addiction counseling. Initially, the program attempted to use a modified TC residential program for substance abuse, to add support services for homelessness prevention on-site (provided by outside agencies), and to link to community-based services when the mother’s recovery process was stabilized and sufficiently advanced. The refinement of the model over time was influenced by program experience and other developments in the field, leading to the current homelessness prevention program.

Providing Integrated Services

In order to address gaps in services and to provide a comprehensive, integrated prevention program, Gaudenzia staff integrated major components of the supportive service noted above within the basic residential program, while retaining the strongest community-based service elements. The initial model encountered several difficulties in linkages: difficulty coordinating multiple service providers; confusion for residents created by a lack of a common philosophy to guide the individual providers; inadequate communication among providers; significant gaps in services associated with the inability of service providers to provide essential contracted services; and the exposure of women early in the recovery process to drug addicted individuals seeking treatment from local...
community-based providers.

The revised model includes community-based providers of specialized services for children and parents, including early childhood evaluation and intervention, GED, vocational training, as well as adult, child, and family mental health counseling. The residential and post-residential program have integrated child care, parenting education and counseling, pre-vocational training, independent household maintenance, budgeting, and substance abuse prevention for children, within the core foundation of recovery, community affiliation and relapse prevention program elements.

Earlier Introduction of Homelessness Prevention Elements

The goal of preventing homelessness presented Gaudenzia with an initial challenge to adapt the program for the inclusion of homelessness prevention elements specific to the needs of mothers, children, and the family unit early in the course of the program. These prevention elements were based upon information from the shelter system, the mothers, and the literature as available at the time. Included were: child care, in the form of the therapeutic day care program; parenting and counseling interventions for the family unit; educational and vocational interventions for the mother; educational and developmental enhancements for children; and development of a social network with shared values of family and recovery.

Intensification of Homelessness Prevention Elements

In order to furnish support to families during the transition from residential to community-based housing, intensive transitional homelessness prevention services, provided within transitional or permanent housing settings, were added to the traditional outpatient counseling aftercare program. These included: case assistance for housing stabilization; re-entry and work appraisal groups; procedures to monitor self-management of household, family and work activities; and building of a supportive community in aftercare to stabilize change. These activities intensify during the latter part of the residential stay, are predominant on entry into community-based housing, and continue at reduced intensity over time.

Current Program

From the evolution of the program as described in the previous paragraphs, emerged a new homelessness prevention model to provide homelessness prevention interventions within a TC environment. The TC environment provides a foundation for recovery and a structure for change; however, the enriched program elements focused on homelessness prevention constitute the crucial elements of the program. These activities, specific to homelessness prevention and residential stability, occur in several domains: family preservation; sustaining work; housing stabilization; and building a supportive community. In addition, program refinements implemented in the process of development of this manual included intensification of homelessness prevention specific interventions in the latter part of the residential stay (i.e., during Live-In Re-Entry), greater continuity between residential and non-residential programming, and improved monitoring of all later activities (by means of self-management forms and group review).

The New Image and Kindred House programs have remained in operation since 1989, with hundreds of mothers and their children successfully reintegrating with the community, establishing permanent homes, and becoming contributing members of society, thereby breaking the cycle of poverty, homelessness, and family disintegration. This manual describes, and the research plan evaluates, these innovative homelessness prevention elements at New Image and Kindred House.
Agency and Community Context for the Intervention

Gaudenzia

Gaudenzia, the participating agency and program site, is well known and well respected in Pennsylvania for the quality, scope and innovation of its treatment and prevention programs serving a variety of sub-populations of substance abusers. The agency has enjoyed significant growth over more than a quarter of a century, and has adhered to its mission to treat people suffering from chemical dependency and other behavioral disorders; to educate the public as to the cause and prevention of these problems; and to conduct research into the causes, prevention and treatment of dysfunctional behavior patterns. Agency TC programs have been modified to provide residential and outpatient services at different levels of intensity for target groups that include: adults, adolescents and children, homeless adults and families, dually diagnosed mentally ill chemical abusers (MICAs), and people who are HIV/AIDS symptomatic. Central to its mission have been the treatment and prevention of homelessness for various populations of clients.

As noted earlier, the Family Shelter Project was conceptualized during the late 1980’s in response to the increasing numbers of homeless, pregnant women, young mothers, and families who were entering the shelter system in Philadelphia. A large proportion of the mothers within the shelter system were substance abusing and unable to maintain housing and parenting responsibilities: they wanted to keep their families intact; some women were pregnant; they had lost custody, or were in danger of losing custody, of their children; they had no financial or social resources to assist them; they were resistant to entering any program which enforced separation from their children; there were no program resources for substance abusing women which would permit their children to live with them; nor were there programs that would provide resources for the infants and children, many of whom were suffering from the effects of in-utero exposure to drugs and/or the effects of homelessness and a disrupted, or abusive living environment. No programs existed that concentrated on the prevention of future homelessness for these families.

The Center for Therapeutic Community Research

The Center for Therapeutic Community Research (CTCR) is a research center funded by NIDA to advance scientific knowledge concerning TCs, substance abuse and related problems. Staff of the CTCR are responsible for development of the manual and evaluation plan. The staff of CTCR consists of senior TC scientists and TC professionals with several decades of experience launching, directing, documenting, and evaluating programs. The CTCR is an institute of National Development and Research Institutes, Inc. (NDRI), the applicant organization; NDRI is a not-for-profit agency specializing in psychosocial research. The CTCR developed a collaborative relationship with Gaudenzia designed to: refine the homelessness prevention program; provide training and technical assistance to implement the program refinements; develop a manual to codify the program; and design a research plan to evaluate the homelessness prevention elements. The cornerstone of this collaboration was a strategic planning group to ensure a participatory process. This process was developed and refined by the CTCR project team during prior projects (see S. Sacks, De Leon, Bernhardt & J. Sacks, 1994; Sacks, 1997).
Implementation

The remainder of this section describes the structure and methods used to refine and enhance the current project and to ensure a successful outcome. A creative process is depicted, one that engages stakeholders in the joint ownership of an innovative model and the successful implementation of that model’s program elements. Systems issues are confronted. An attempt is made to illuminate the basic question of the practitioner concerning innovative programming: “How do you do it?” And, wherever possible, general principles derived from our immediate experience are provided.

How to Organize

(1) Develop a project leadership team that is skilled, representative, and that has decision-making responsibility. The initial project leadership team consisted of representatives of two agencies: Gaudenzia (Michael Harle, Executive Director) and the Center for Therapeutic Community Research (CTCR; Stanley Sacks, Ph.D.; Allen Bernhardt, MSW; JoAnn Sacks, Ph.D.). These individuals provided expertise in service provision, program design and staff training, and evaluation and project management. The project team eventually expanded to include program directors, program supervisors, and clients.

(2) Develop the project within a field demonstration framework. A field demonstration model provides a sound framework for program refinement, documentation and evaluation. The investigative team develops information for a program narrative, empirical information on client profiles, evaluation of the overall effectiveness, and clarification of client predictors of successful outcome. Even if there is no separate research funding, it is important to implement projects within an empirical framework and to provide the system with program information. This includes information on program design, program implementation, and program outcome. Program outcome information on retention rates, program completion rates, length of stay, client progress in the program, critical incidents, etc., is usually available in agency records and Management Information Systems (MIS).

How to Integrate with the Health Care System, including Managed Care

Two main principles were followed in the successful refinement of a homelessness prevention intervention in the Pennsylvania Health Care System:

(1) The project leadership team refined the program within the policy, guidelines, and constraints of the Pennsylvania health care system, although changes were being implemented in the transition to state-wide managed health care while the project was being refined. Gaudenzia Executive Director (Michael Harle) conveyed the State system compliance requirements during program planning meetings. Interactions within team meetings were forthright and, at times, intense; changes and mutual accommodations ensued and material describing the program was often rewritten. The project team accomplished accommodations without compromising or distorting the model. System guidelines demanded compliance, and these guidelines were often helpful in refining the program.

(2) The project leadership team supported Gaudenzia staff in strengthening its partnership with system representatives. The project team assisted in the development of descriptive materials used to justify the expansion of transitional housing opportunities in Chester County to county officials. The imprimatur of a federal grant and working drafts of the manual enhanced these efforts. In working with the project team, Mr. Harle and Mr. Leake, the Regional Director, provided the administrative leadership necessary to refine the program and, in working with system representatives, their leadership provided appropriate program visibility. Thus, the project team built a strong cadre of stakeholders familiar with the project, at the highest levels within Gaudenzia and the State.
How to Integrate with the Service Agency

(1) Organizational Readiness. The project was initiated in a service organization that had a proven record of developing innovative substance abuse and prevention models for special populations. The criteria of organizational readiness include a well-established identity, existing program philosophy and methods, a demonstrated record of excellent programming, and an administrative structure that supports change, that is capable of communicating to staff, and that provides mechanisms for new program initiatives. Most importantly, organizational readiness is determined by the existence of an aggressive executive leadership that conveys a clear message to staff members—"I want this to happen."

(2) Collaboration. A collaborative relationship was established among the project leadership staff and other staff members of the participating agency. The collaborative relationship was organized around the concept of mutual commitment and shared responsibility. The collaboration was comprehensive, intensive, embraced all considerations in bringing about change, and derived from an intense commitment to the program and to one another. The collaboration of these individuals (and others) was the critical human factor in the success of the project.

How to Refine and Implement Program Elements

As mentioned above, program refinements implemented in the process of development of the manual included the intensification of interventions specific to homelessness prevention in the latter part of the residential stay (i.e., during "Live-In Re-Entry"), enhanced continuity between residential and non-residential programming, and improved monitoring of all family, household, and work activities (by means of self management forms and group review).

Three initiatives were essential to successful program refinement and implementation:

i) developing a strategic planning group involving all key staff;
ii) providing training and technical assistance in the context of implementation; and
iii) ensuring staff and client orientation to all new program elements.

Each of these initiatives will be described below as they were undertaken in organizing this program.

(1) Develop a strategic program planning group involving all key staff

The basis of successful programming is the development of a participatory strategic planning group consisting of key project staff. In the present context, strategic planning refers to an emphasis on overall comprehensive planning for homelessness prevention interventions within the context of a TC environment. The remainder of this section describes the structure, goals, and methods of the strategic planning group.

a) Who are the members of the strategic planning group? The strategic planning group consists of individuals with key roles in designing and implementing the program refinements (see Table 1). The participants have an equal stake in the success of the project and share the responsibility for program design, development, quality assurance, documentation, and evaluation.

b) What are the goals? The group has three agenda goals: i) to refine and enhance the homelessness prevention TC program; ii) to train staff in all new program elements; and iii) to ensure staff input and ownership of the program by follow-up activities that convey developments from the strategic planning group to the entire staff. Table 1 describes the membership and the role of each participant.

c) Client participation. Clients actively participate in the strategic planning process. Firstly, as part of the program, they provide regular feedback to staff on how the program is working and on the need for new elements. Secondly, clients meet with the strategic planning staff as new elements are developed and provide input for both the content of the new elements and the methods for implementation. Thirdly, strategic planning staff review drafts of the manual with the clients who provide comments and
(2) Provide Training and Technical Assistance in the Context of Implementation

Providing training and technical assistance in the context of implementation means that staff training takes place in the field, that this training is direct, hands-on, immediate, and demonstrable. The key point for this section of the manual is that training and technical assistance are provided in the context of implementation; in other words, staff members learned exactly how to carry out program activities by participating in the activities; the consultants participated in the initial implementation activity for new or refined elements and illustrated new techniques.

(3) Ensure Client and Staff Involvement and Orientation to All New Program Elements

A successful launch requires client and staff understanding and involvement. The strategic planning group accomplishes this through a process of gradual and guided implementation. In brief, the new program element was gradually introduced into the community during an implementation phase; each step was planned, discussed, and reviewed by clients and staff; each change was implemented, reviewed, and adjusted to the needs of the community, based on feedback from the peer community. The consultants enter this process through a mechanism of observation, participation, and training with clients and staff; the process takes, on average, four to six weeks.

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<tr>
<th>Name</th>
<th>Title</th>
<th>Agency</th>
<th>Role</th>
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<tr>
<td>Allen I. Bernhardt, MSW</td>
<td>Consultant</td>
<td>CTCR</td>
<td>Refinement of program elements</td>
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<td>JoAnn Y. Sacks, Ph.D.</td>
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<td>Technical assistance</td>
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<td>Training</td>
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<tr>
<td>Stanley Sacks, Ph.D.</td>
<td>Principal Investigator</td>
<td>CTCR</td>
<td>Management of project activities</td>
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<td>Michael Harle, MHS</td>
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<td>Gaudenzia</td>
<td>Administrative link with agency, project and State representatives</td>
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<tr>
<td>James Leake</td>
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<td>Gaudenzia</td>
<td>Development of external resources</td>
</tr>
<tr>
<td>Sandra Murphy-Grover, MHS, CAC</td>
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<td>Gaudenzia</td>
<td>Participate in planning and refinement and development of interventions</td>
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<tr>
<td>Avis Sawyer, AAS, CAC</td>
<td></td>
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<td>Spearhead implementation</td>
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<tr>
<td>Leslie Ziegler, MA</td>
<td>Clinical Supervisor</td>
<td>Gaudenzia</td>
<td>Participate in planning and refining elements</td>
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<tr>
<td>Joan Groves, MA</td>
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Who is Being Served?

Gaudenzia’s New Image and Kindred House residential programs are currently serving a total of 32 homeless, substance abusing women and 41 of their children. An additional 23 mothers and 40 children are being followed in the Transitional and Permanent Housing settings. Referrals to the residential programs come from homeless shelters, out-patient treatment programs, and the correctional system throughout Philadelphia and the surrounding communities; however, because of the agency’s high community visibility, some clients are self-referred.

(1) Demographic Profile. The vast majority of women at New Image and Kindred House (75%) are African-American; 10% are Caucasian, and 15% are Hispanic. Their average age is 30, with a range from 17 to 47. The 32 women currently in the program (evenly divided between New Image and Kindred House) have 98 children (an average of 3.0), 41 of whom are also in the program and 57 of whom are not. All of the women in the program have children or are pregnant; these features are part of the admission criteria. The ages of the children in the program range from newborn (one month) to 12, with an average age of four; the children outside the program average nine years of age. The rationale for inclusion of some, but not all, children is to create a balance between the opportunity for the mother to develop her skills for independent living (including parenting skills) and the need for sustaining the family unit. Children not living with the mother are living with relatives or placed in foster care. The program fosters family reintegration with the remaining children (and other family members) during the move to transitional or independent living.

Of the 32 women in the program, 15 have obtained a high school diploma or GED (some while in the program); the other 17 have completed 10th grade. Although all are mothers and/or (in two cases) pregnant, 22 have never been married. Prior to admission, nearly all were on welfare (29), one was on SSI, four were in prison, three had regular full-time paid employment, three had legitimate part-time jobs, and 23 were unemployed.

(2) Homelessness. All admissions are homeless, or at risk for homelessness, at the time of program entry. The great majority of referrals to New Image and Kindred House have spent from six to twelve months within the shelter system prior to referral; prior to their shelter experience, most have spent about six months on the street.

(3) Substance Abuse. All of the women admitted to the two programs have a substantial history of substance abuse. The profile of substance use for the women at New Image and Kindred House is as follows: roughly 72% abuse crack cocaine; 19% abuse heroin (sniffing and snorting are more common than injecting); and 3% abuse cocaine in forms other than crack. Agency records reveal a significant history of poly-substance abuse including combinations of cocaine, marijuana and alcohol. The majority of women report a prior history of alcohol/drug treatment.

(4) Mental Illness. Two of the women currently in the program have a formal psychiatric diagnosis of Major Depression. In addition, a significant number of women in the programs (approximately 60%) suffer from a variety of psychological problems and psychopathology, including: anxiety, depression, phobia, antisocial personality and other characteristics that are often part of a dual disorder profile.

(5) Qualitative/Clinical Summary. The clients are disaffiliated, dispirited, and impaired. They have been living on the streets, in vacant buildings, and in shelters—and they have, in most instances, brought their children into those settings. They have broken kinship ties with family and friends; those ties that remain are often negative and undermining. Their social contacts are with drug users in a similar situation. They have suffered physical and emotional abuse; they have exposed and subjected their children to abuse. They hustle money, drugs, shelter, and food. They are undereducated, unemployed, and overwhelmed by parenting demands they are ill-equipped to fulfill. Nonetheless, they are functional enough to have retained custody of some of their children, and they care enough to fight for a reunited family. When food is available, they go hungry so their...
children will have more to eat. Contacts with the criminal justice system are primarily due to victimless crimes such as prostitution. Effective interventions for homelessness prevention must address the family unit, not just the mother, and must address the disaffiliation, isolation, and social/emotional deficits of all family members.

**What are Their Needs?**

Client needs are determined by intake assessment and clinical/program data. The needs of the family unit may be classified into six categories:

1. **Basic needs** include health care for mother and child, entitlements (Medicaid, SSI, etc.), child care, temporary housing, legal consultation on personal and family issues. The program attends to basic needs in order to stabilize the family in the program, to begin to establish trust with the mother, and to begin the process of engagement in program.

2. **Needs related to the impaired functioning and social deficits of the mother.** Personal needs related to homelessness prevention are complex and interrelated. The mothers enter the program having broken kinship bonds with family and friends, disaffiliated with other than their drug abusing cohorts, and unable to manage interpersonal relationships. They have difficulty coping with the demands of parenting and are ill-prepared to provide effective guidance for their children; most cannot manage the routine, daily demands of independent living.

First, the mother must gain control of her substance abuse and begin to accept personal responsibility for her actions as a foundation for homelessness prevention. Next, the homelessness prevention interventions address her varied deficit areas by incorporating a comprehensive, integrated focus for personal growth, building skills in target deficit areas but also by attempting to change the attitudes and feelings underlying these deficiencies. Most fundamentally, the interventions focus on the peer self-help community to restore her trust in others and her affiliative spirit, and to establish a proactive kinship group with shared goals of family unity.

3. **Needs related to the developmental and social deficits of the child.** Children enter the programs with a history of homelessness, exposure to drugs and drug use, family disruption, neglect and abuse. Their history has placed them at risk for developmental, social and emotional problems. They require a stable and safe home, developmental assessment and intervention, structured child care and/or enrollment in a stable school setting, age-appropriate prevention activities, and opportunities for positive socialization experiences with peers and with caring adults. The homelessness prevention program provides for all of these needs within the residential setting, and provides continued interventions in the targeted areas through ongoing case assistance, re-entry interventions with the mother, and individual/family counseling once the family moves into the community.
(4) Needs related to the mother-child relationship and family reunification. The mothers entering the program have serious deficits in parenting knowledge and skills, many having never been parented adequately themselves. They need assistance in navigating the child welfare system; they need parenting education and skills training in providing effective guidance for their children; they need assistance in repairing any damage to the parent-child bond and in forging stronger bonds within the family unit. And they need to develop a support network of peers who share values of positive parenting—who can provide support and assistance when they are independent, and alone, in the community. The program provides the opportunity for mother and child, separately and in family groups, to address the personal and interpersonal problems and deficits within the family, along with the underlying attitudes and feelings associated with the family history of homelessness and substance abuse. The impetus for this focus is to promote healing and emotional bonding within the mother-child dyad and to prepare the family for reunification with the other siblings in the community.

(5) Needs related to pro-social, productive reintegration into society. Mothers entering the program are impoverished, undereducated, unemployed and lacking work-related skills. They are disaffiliated and disconnected from the lifestyle and the values of mainstream society. Many represent a second generation trapped in a cycle of poverty, substance abuse, homelessness and family disintegration. It is essential that the problem of substance abuse be addressed as the cornerstone for homelessness prevention; however, breaking the cycle of poverty requires that additional attention be directed to the mother’s ability to enter the world of work and to sustain employment. This means compensating for deficiencies in basic education, vocational skills, and prosocial attitudes and values needed to sustain economic independence as opposed to dependence on the social welfare system. Lifestyle change of this magnitude means that consideration must be given to the attitudes and values surrounding work performance, work in relation to single parenting, and work in relation to recovery and relapse prevention.

Societal reintegration also means establishing a home in the community, helping children to remain in school, forming friendships in the community, and successfully juggling the demands of the family, work, and society while sustaining recovery. This daunting task will require utilization of all the tools the mother has developed in the program, full support from the peer network, and supports from program staff. More intensive staff supports are needed during the transition to community, followed by individualized, graduated supports.

Education and vocational training begin early in the process and are integrated during each stage of the homelessness prevention program; as the mother takes on increased work responsibilities, the program remains focused on work performance and on the attitudes underlying poor performance. Similarly, the family transition into the community and self-management of homelessness prevention activities receive staff and peer supports, beginning with the residential phase and continuing for a minimum of six months once the family re-enters the community; these supports guide the re-entry while promoting a peer supported self-help process.

(6) Needs related to stabilization of housing. The mothers enter the program from the shelter system, the streets, or from a housing situation considered at risk for homelessness by virtue of unsafe construction, temporary nature, or probability of eviction. In the short-term, these mothers need interim shelter, in a safe environment, that will permit their children to live with them. Long-term housing stabilization needs include access to affordable, or rent-subsidized, housing. Early in the program the mothers apply for Section 8 housing; the availability of such housing is the linchpin of housing stabilization. In addition to affordable housing, the women need to develop knowledge, skills, and attitudes which will enable them to maintain a safe, healthy home for themselves and their children, to budget their money, to cope with the daily problems of life in the community, and to develop a safety net of peers who can provide positive support.

Many of the mothers have never lived on their own, maintained their own apartment,
or taken care of shopping and cooking for a family. They have never budgeted money; they have never had a bank account. Successful practice of the “skills of independent living” will mean a lifestyle change and will require education, skills training and the internalization of a new set of values. Ongoing supports within the community will be needed for a period of time to help to integrate the new demands of their environment and to generalize the tools they have learned in the program to these new demands. The homelessness prevention interventions attempt to alter not only the skills deficits, but also the underlying attitudes and feelings which may undermine effective practice of newly learned skills in the community.

In summary, it is essential that the multidimensional needs of the entire family unit be addressed in order to establish an effective homelessness prevention program for homeless substance abusing mothers and their children. The Gaudenzia program meets these psychological and social needs in a program of mutual self-help, community-as-method, and personal responsibility that provides a foundation for, and delivers, specific homelessness prevention activities.

What are the Eligibility Criteria for Admission to the Program?

Program eligibility criteria are inclusionary in four areas: i) clients are women; ii) who have children and/or are pregnant; iii) who exhibit a substance abuse disorder; and iv) who are homeless or at-risk for homelessness. Clients meet the substance abuse criterion if their scores on the Addiction Severity Index (ASI; administered at intake) show chronic substance abuse. Forms are completed on admission and sent to the Office of Services to Homeless Adults (OSHA) of the City of Philadelphia to establish the client’s eligibility for services. To be considered homeless, or at-risk for homelessness, clients must currently meet one of the following criteria:

1. reside in a group shelter, domestic violence safe home, hotel or motel paid for with public or charitable funds, or a mental health, drug or alcohol facility
2. have received verification that their children are to be placed in foster care placement solely because of lack of adequate housing, or children currently in foster care could return to parental care if housing were adequate
3. reside in a doubled-up arrangement on a temporary basis that is in violation of the lessee’s rental agreement
4. reside in a condemned building
5. reside in housing in which the physical plant presents life-threatening conditions; e.g., dangerous structural defects, or lacking heat, plumbing or utilities
6. reside on the streets, in cars, doorways, etc.
7. face eviction
Program Structure

Goals of the prevention intervention

Short-Term Goals.

(1) Stabilization of mother and child(ren). This goal involves establishing a stable, albeit temporary, home for the family in the residential setting, the provision of child care/enrollment in school, reuniting of mother and child(ren), and beginning the homelessness prevention interventions.

(2) Affiliation with community. This goal involves participating in community enhancing groups and activities, connecting with the peer community, talking more openly with peers, giving and receiving feedback, socialization, and learning to rely on the community as the healing agent.

(3) Assumption of personal responsibility. This goal involves accepting personal responsibility for past choices and actions, especially those related to substance abuse, and assuming personal responsibility for change and recovery.

These short-term goals are mainly associated with the early stay in the residential setting and focus on constructing a foundation for recovery by addressing the mother’s substance abuse, and by providing preparation for homelessness prevention. The mother changes her behavior and commits to abstinence, but also learns to recognize, discuss and modify her feelings, thoughts, and behaviors as they relate to substance abuse and all other problem areas of her life. She begins the process of stabilizing the family by working on the parent-child relationship and by improving parenting skills. The mother discovers a peer group committed to recovery and family unity, and learns to substitute affiliation with this community for her isolation. She learns to accept and believe in herself; this provides the inner strength to assume personal responsibility for her actions and her choices. These activities, all part of the core TC, increase the mother’s receptivity to the homelessness prevention interventions, and maximize their potential impact on her life and lifestyle.

Homelessness Prevention—Short-Term Goals.

The homelessness prevention specific goals fall into five discrete areas, each of which has a distinctive impact on homelessness prevention. The homelessness prevention intervention is not based on providing isolated services or elements; rather, it is based on providing a comprehensive, integrated system of homelessness prevention interventions which flourish on a foundation for recovery. All goal areas are interrelated; achievements in one area facilitate achievements in other areas, such that the whole is greater than the sum of the individual interventions. Homelessness prevention results from the interaction of a recovery process and specific homelessness prevention interventions.

(1) Family reunification and preservation. This goal involves reuniting the mother with her children, fortifying the mother-child bond and moving the family into the community. In large part, this is an educational process in which mothers who have never functioned effectively as parents learn how to do so. This is also a healing process for families scarred by homelessness, family disruption, and abandonment. Repair of the mother-child bond, or the formation of bonds between the mother and child that had never existed, is critical to helping families recover from past injury and thrive. These bonds are essential to ensuring that the family can remain together once they are in the community.

(2) Enter the world of work. This goal promotes the mother’s entry into the work force, after having acquired and/or honed work readiness and vocational skills sufficiently to sustain permanent part-time or full-time employment. Skills development for many begins with acquiring a high school equivalency diploma, and includes preparatory skills for job searching (dressing for work, preparing a résumé, interview behavior) as well as vocational skills training. For Gaudenzia mothers, skills development includes under-
standing the connections between work and relapse prevention in relation to substance abuse and homelessness. Entering the world of work is fundamental to ensuring stable housing for the family and, thus, is essential to homelessness prevention.

(3) Housing stabilization. This goal consists of the mother establishing the family in housing located in the community, followed by ensuring that a safe home for the family is maintained. The mother will need to learn and use various skills of independent living in order to manage expenses and household chores surrounding the provision of shelter, food, clothing, sanitation, etc., while helping her child(ren) to become a part of the new neighborhood. Learning how to manage all of the activities of household management in order to establish a stable home is a crucial element in homelessness prevention for the mothers.

(4) Build a supportive community. In accomplishing this goal, the mother moves from a state of isolation from friends, family and mainstream society, to affiliation with a supportive network of peers who share the values of recovery and family unity. For the single mother, the ability to form strong interpersonal relationships with other adults, and to give as well as receive support within this group, provides the “safety net” that helps her to manage her family responsibilities, maintain her employment, sustain her recovery, and bolster her spirits. Affiliation with a fellowship of peers is the force that provides long-term support for the family’s achievements in all other areas of homelessness prevention.

(5) Societal reintegration. The accomplishment of this goal requires that the mother and her child(ren) move into the community and integrate with the life and lifestyle of the community. They must overcome social, emotional, and functional deficits and develop the knowledge, understanding and skills to permit them to maintain a home, form friendships, and join the work force. The attitudes and values supportive of family unity and community integration become an integral part of the mother’s sense of self and well-being, and guide her actions. Societal integration is a composite of the other goals, and is the end result of achievements in all other areas of homelessness prevention coalescing into a whole.

Homelessness Prevention—Long-Term Goals

The longer term goals reflect stabilized, independent living in the community. They are, for the most part, an extension of the homelessness prevention goals over the longer term.

(1) Sustaining abstinence from substance use. The mother refrains from using drugs and develops attitudes, beliefs and behaviors necessary for maintaining abstinence and making a commitment to recovery.

(2) Stabilization/preservation of family in the community. The mother and her children live together in permanent housing and become integrated with the local community.

(3) Affiliation with supportive community/fellowship. The mother maintains and expands her relationship with peers who share the values of recovery and family unity; she and a fellowship of peers provide mutual assistance and emotional support to sustain family and recovery.

(4) Sustain employment. The mother maintains satisfactory (or above) performance in a stable job, and pursues opportunities for advancement.

(5) Maintain permanent independent housing. The mother and child(ren) will live in permanent housing of their choice; the mother will provide for all costs of this housing, and will maintain a safe, pleasant living environment for the family.

(6) Achieve economic independence. The mother is able to earn enough income and manage her money well enough to provide the necessities for herself and her children, as well as saving money to provide for planned and unplanned extra expenses.
Goals of Societal/Organization Change.

(1) Break the cycle of poverty, substance abuse, homelessness, family disintegration. Clinical evidence indicates that many of the mothers in the Gaudenzia homelessness prevention programs are themselves the children of parents (and grandparents) tangled in the web of poverty and family disruption, with an underlying sub-structure of familial substance abuse. Most report a history of dependence on the social welfare system, parental substance abuse and parental separation/divorce. The foundation of recovery and the tools of homelessness prevention provide an infrastructure to support the ability of a family to become self-sufficient, prevent future homelessness, and break the cycle that has trapped the family in the past. The program addresses homelessness for individual families, and for the collective of all program families, and includes principles and methods with the potential to have an impact on the larger problem of poverty, substance abuse, homelessness, and family disintegration.

(2) Generalization of self-help methods. The homelessness prevention interventions use mutual self-help as a guiding approach to addressing the problem of homelessness. The success of the interventions in helping the mothers and families to achieve the goals of the homelessness prevention elements demonstrates the efficacy of extending self-help methods to new populations, to a variety of social problems, and to varied environments. Peer self-help is applicable as a best practice in other program models, and is a methodology capable of being generalized to broader intervention plans for a wider variety of populations and social problems.

(3) Building supportive communities. Affiliation with the peer community helps the mother develop skills for stabilizing her family in permanent housing and guiding her own and her children’s integration within society. The values underlying this affiliation (trust in others, the ability to recognize need and seek help, the willingness to help and support others), become part of a lifestyle that affects the nature of social organization in the community. The establishment of supportive communities is now being implemented for a variety of social problems in addition to that of homelessness in addicted mothers; e.g., criminality (Sacks & Wexler, 1995) and co-occurring disorders (Sacks et al., 1997). The supportive community is a critical element for the broader applicability of the methods of this intervention.

Claire’s story

In 1989 I was 17 years old and had a son who was almost 5. I was an addict. I started using drugs right after my son was born. My sister was 18 and she had a child also. She was an addict. We lived with my mom. She was an addict. We lived in the shelters and we kept bouncing from one to another. We were constantly getting evicted because we spent our rent money on drugs. Then things got really bad . . . we were way in debt . . . we were sharing a room. We were two welfare checks behind – and the loan sharks were after us.

We were in the Germantown shelter and one day we got fed up and we just walked to the Mayor’s office at City Hall. We stopped at a supermarket and took a basket and put the kids in it and we wheeled it to City Hall. They sent us to the office of the head of the homeless sector and they called Gaudenzia. My mom wound up at one program and my sister and I, and our children, went to New Image, two days after the program opened [4/3/89]. We had never been separated from mom – it was very hard for us. Once we showed responsibility, they let us visit our mother, in her program, on Family Visiting Day, when all the other parents had their kids visit.

Where is everyone today?

My mom is doing fine and my sister is too; they have their own apartments.

While I was in the transitional apartment [1990], I began working for Gaudenzia doing clerical work. In three months they hired me as a bookkeeper. I started Community College and I will graduate next year with an Associate’s degree in accounting. I was just promoted to an Accounting Trainee. I have gotten special training in budgeting, establishing credit and paying a mortgage. Gaudenzia has given me help in every area of my life. I’m getting ready to be a homeowner. In June, I am buying the three-bedroom house my son and I have been living in, in Germantown.

By the way, my brother graduated from a Gaudenzia program, too.
Logic model of the intervention

The logic model (Figure 2) depicts the relationship between the population/environment, conceptual framework, interventions and expected outcomes in this project. This logic model focuses on the homelessness prevention specific interventions of the program. Several other points are necessary for understanding the current logic model:

i) the description of the client population includes both profiles and needs;

ii) the conceptual framework is expressed in terms of Perspective and Approach; the approach briefly lists the basic theoretical assumptions for any TC-oriented program before focusing on the conceptual framework of the current homelessness prevention program;

iii) the interventions briefly list the core activities of any TC program before focusing on the full array of homelessness prevention specific interventions; and

iv) the outcomes section adds short-term goals related to foundation, and then focuses on expected homelessness prevention specific short-term goals, long-term goals and social/organizational change.

In all, the logic model presented is for homelessness prevention specific activities and includes sufficient material on TCs for understanding the foundation and structural context within which these interventions occur. (The investigative team developed a treatment-oriented logic model for another TC program for homeless MICAs—see S. Sacks, De Leon, Bernhardt & J. Sacks, 1994.)

Conclusion

The homelessness prevention interventions are designed to provide the mother, and the family unit, with the tools, skills, personal strengths and community supports to become self-sustaining members of the larger society. Homelessness, substance abuse and separation have been a family experience, and the prevention of future homelessness needs to address all aspects of this experience for each family member. Having the mother participate in the homelessness prevention program together with her child(ren) provides a unique opportunity for intervention in the family unit as well as the individual. The integrated approach to homelessness prevention provided by Gaudenzia programs enables the family to undertake change in behavior, attitudes and values. These, in turn, foster lifestyle change for the family, promote societal reintegration, and help the family to break the cycle of poverty, family disruption, substance abuse and homelessness. On a larger scale, a homelessness prevention TC can extend beyond the immediate family situation to provide a model for addressing other social problems within our environment. The extension of self-help methods and community-as-method has the potential to influence policy and planning in the larger human service field.
Figure 2 – Logic Model – Homelessness Prevention TC for Addicted Mothers

**Population & Environment**
- **Individual Characteristics**
  - Profiles:
    - Single mothers
    - Homeless
    - Substance abuse history
    - Unemployed
    - Minorities
  - Needs (related to):
    - Basic needs
    - Impaired functioning & social deficits of the mother
    - Developmental & social deficits of the child
    - Family reunification & preservation
    - Pre-social, productive reintegration into society
    - Stabilization of housing

- **Environmental Resources**
  - Public shelters
  - Prisons
  - Community agencies

**Theory & Assumptions**
- **Perspective**
  - Individual
  - Mother and child relationship

**Interventions**
- **Foundation for Recovery**
  - All core TC elements (e.g. morning meeting, seminars, encounter groups, peer work hierarchy)

**Homelessness Prevention Specific**
- **Family Preservation**
  - Child Focus
    - Structured Childcare/School*
    - Assessment & Early Intervention*
    - Children's Prevention Group*
    - Prevention Group for Visiting Children*
  - Mother & Family Focus
    - Family Focus/Parenting Seminar
    - Parents' Group*
    - Childcare Participation*
    - Family Education Day*
    - Mother-Child Group*
    - Individual/Family Counseling*

- **World of Work**
  - Educational Preparation (e.g. GED)
  - Work Readiness Seminar
  - Job Search/Location Training
  - Recovery & the World of Work*

- **Housing Stabilization**
  - Independent Living Skills
  - Case Assistance*
  - Individual/Group Counseling (OP)
  - Re-Entry Group*
  - Transitional Housing Group*

- **Building Supportive Community**
  - Seminar Leader/Mentor
  - 12-Step Meetings
  - Re-Entry Board*

**Goals & Outcomes**
- **Short-Term**
  - Stabilization of mother and child(ren)
  - Affiliation with community
  - Assumption of personal responsibility

**Homelessness Prevention**
- **Short-Term**
  - Family reunification and preservation
  - Learning successful parenting and child care
  - Re-unification of mother and child(ren)

- **Enter the world of work**
  - Learning work readiness skills
  - Locating work
  - Sustaining job performance

- **Housing stabilization**
  - Locating housing in the community
  - Learning skills necessary to maintain housing (budgeting, etc.)

- **Build a supportive community**
  - Affiliation with community
  - Becoming a mentor / role model
  - Developing support network in the community

- **Societal reintegration**
  - Developing positive attitudes & prosocial values
  - Fostering lifestyle change

**Long-Term**
- Abstinence from substance use / commitment to recovery
- Stabilization/preservation of family in community
- Affiliation with supportive community / fellowship
- Sustain employment
- Maintain permanent independent housing
- Achieve economic independence

**Societal/Organizational Change**
- Break the cycle of poverty, substance abuse, homelessness, family disintegration
- Generalization of self-help methods
- Build supportive communities

* Distinctive Homelessness Prevention Interventions

15 June 1997
Staffing and staff training

Backgrounds and characteristics of the staff

The senior supervisory staff in the program have credentials in substance abuse treatment and have received advanced professional degrees. Gaudenzia provides specialized training, and contributes tuition payments for staff to attend community-based training directed toward receipt of credentials in substance abuse treatment. Almost all staff members employed in the program are graduates of substance abuse treatment programs, including the Gaudenzia programs, and have credentials in that area. This background supports the role of staff as guides and role models for the women who are in treatment. The supervisors of the child care and children’s prevention programs have training and experience in the field of education. Direct care and supervisory staff are female; their ages, ethnic and racial backgrounds reflect those of the residents within the program.

Staff Training

Gaudenzia places special emphasis on the training and development of direct care and supervisory personnel. Most staff are graduates of substance abuse treatment programs but, to insure that each staff member has a basic knowledge base and understanding of treatment and prevention issues, all receive foundation training in the principles and practices of the therapeutic community and its modification for special populations. Staff continue training through a process of individual supervision at the program level as well as attendance at regularly scheduled program-specific and agency-wide in-service training sessions. Gaudenzia also provides formal classes and training for which staff receive credit toward advanced certifications.

The CTCR project team also provided staff training in the course of the development of this manual. This training included a review of TC theory and methods, information and findings from the homelessness prevention literature, results of related studies of the investigative team, and a field-tested methodology for program refinement and quality assurance. Thus, program staff are provided the rigorous training necessary for effective job performance.

Administrative structure

Gaudenzia is a private not-for-profit agency providing treatment, prevention and other services for individuals with substance abuse and related problems. The agency has been in operation for 29 years, during which time it has developed 34 programs throughout Pennsylvania.

The agency Executive Director, Mr. Michael Harle, has had over 25 years experience in the administration and operation of programs for special populations. He is the key administrative link between the agency, City, State and Federal representatives, and the project team. He is active in developing external resources to support program expansion and/or enhancement of program services for all special populations served by Gaudenzia. He provides executive administrative leadership for the agency, insuring that all program operations are consistent with State and local government regulations and congruent with agency philosophy and direction.

Administrative supervision of program operations is divided between two Regional Directors of Programs, one for eastern Pennsylvania and the other for the western portion of the State. This administrative structure was developed to insure quality control and programmatic consistency within all programs despite the geographic expanse of program sites. The Eastern Regional Director of Programs, Mr. James Leake, has over 20 years of experience in operating programs for substance abusing individuals. He provides weekly formal supervision, on-site, for all Program Directors, and is available for daily problem-solving, as needed. He has administrative responsibility for the homelessness
prevention programs at New Image and Kindred House. Mr. Leake insures that agency policies and guidelines are maintained at all program sites and coordinates the development and codification of new policies and procedures. Mr. Leake reports to, and works closely with, Mr. Harle, and functions as his representative at the project’s strategic planning meetings.

The **Program Directors** (Ms. Sandra Murphy-Grover and Ms. Avis Sawyer), have over 10 years experience in the substance abuse field and in TC programs, and have worked extensively with substance abusing mothers and their children; both are certified in addictions counseling. They provide immediate on-site supervision of daily program activities, and insure clinical and programmatic quality and consistency. They review all program developments for their immediate impact on clients and staff, implement program modifications, and provide critical information for program review and refinement. They guide the development of the written protocols and procedures within the program. They report directly to Mr. Leake, and also attend monthly planning meetings with the Executive Director.

Each program has a **Clinical Supervisor** who works closely with the Program Director in implementing the program. The Clinical Supervisors at New Image and Kindred House, Ms. Leslie Ziegler and Ms. Joan Groves, respectively, have graduate degrees in counseling, qualify for or have obtained certification in addictions counseling, and each has close to ten years of experience in operating programs for substance abusing populations. They provide direct clinical oversight to Counselors and House Managers, leadership to key groups and selected activities, and lead new activities during their launch. They also provide crisis intervention and on-call supervision for emergencies, ensuring program stability through immediate attention to all crises and incidents.

**Program Counselors** lead or facilitate groups and activities, provide individual counseling and crisis intervention as needed, assist families in their interface with community-based providers and governmental agencies, and perform other case assistance functions. The Counselors are hired on a promotional ladder determined by experience and attainment of credentials in addictions counseling.

The **Prevention Specialists** have acquired degrees in education and have extensive experience working with children, adolescents, and families. They provide direct supervision to the Child Care Program and staff, leadership to children’s prevention groups and activities, training to individuals and groups in effective parenting, liaison with schools and other child-related providers in the community, facilitating and guiding parental interactions with providers of child-related services. The Prevention Specialists report to, and work closely with, the Program Directors in ensuring integration of children’s and mothers’ services.

**Child Care Workers** lead and expedite all activities in the Child Care Program, providing direction and instruction to those mothers who are daily participants in the program in order to help impart effective skills for child care and parenting. The Child Care Workers are hired on a promotional ladder, as determined by experience (including relevant life experience) and education.

The program is staffed 24-hours/day by **House Managers**, who facilitate group activities, provide immediate individual interventions as needed, make certain that the daily regimen is followed according to program protocols, and insure that the environment is safe for mothers and children. House Managers are placed on a promotional ladder in accord with experience and attainment of educational credentials.

Specialized services are provided by **Other Staff** from community-based agencies. These services include: GED classes; work readiness classes; child assessments and developmental interventions; etc.

In the program, staff members function as role models and “wise guides” for program participants. The broadest use of the “community of peers” is encouraged, rather than total dependence on staff, for input, feedback and direction in making the lifestyle changes suggested in the homelessness prevention program. Most program staff members
are themselves graduates of addiction treatment programs; some are graduates of the New Image and Kindred House homelessness prevention programs. Because of this background, program staff members not only provide positive role models for the clients, but their achievements highlight the levels of personal success that can be attained through completion of the program; they provide hope for those just beginning the long road to family reunification and community reintegration.

Program Staffing

The residential program is staffed 24-hours/day, seven days/week, with a combination of supervisors, counselors, and house managers. Three staff members, including at least one supervisor, are present during peak programming hours (9 a.m. to 9 p.m.); two staff members are present overnight. The Director and Clinical Supervisor are available for consultation on an emergency beeper system when they are not present on-site. The Prevention Specialist provides special parenting skills training groups on weekdays and during the Sunday Family Program, enriching the staffing at those times. The Transitional (Live-Out Re-Entry) program is staffed with one counselor/case manager for approximately 20 individuals.

The Child Care program is staffed by a Prevention Specialist and Child Care Worker. In addition, two to three mothers are assigned to participate in the Child Care program each day as part of their parenting training. The program operates five days/week with an adult:child ratio that varies between 1:4 and 1:6, depending on the age of the child.

In total, 14 staff members are assigned to each program site.

Cost of operating the program

The annual cost of running the homelessness prevention TC residential program was calculated separately for the New Image and Kindred House sites using the formula

\[ \text{Costs} = \frac{\text{Personnel Services Expenses} + \text{Other Than Personnel Services Expenses}}{\text{Service Slots (Bed Capacity for Mothers + Average Child Census)}} \]

The cost for the New Image program is approximately $15,210 per service slot ($547,550 / 16 beds + 20 average child census). The cost for the Kindred House program is approximately $16,822 per service slot ($605,615 / 16 beds + 20 average child census). These cost figures are best understood in the context of the comprehensive nature of the homelessness prevention TC program.

Cultural, ethnic, and gender relevance and sensitivity

In all TC programs, respect for ethnic/racial and gender differences is taught as part of the general lesson of respect for others. The TC model and methods encourage integration of persons differing in age, gender, race/ethnicity, and social class; learning to understand and accept others is essential to self-understanding and self-knowledge. The program uses community to foster cultural integration.

The specific cultural competence of the current program may be stated as follows: the program serves minority (mainly black), female populations; staffing patterns and leadership reflect the demographic profile of the program population; staff selection reflects sensitivity to the client population; the program encourages natural self-expression and the use of idiomatic language and communication (while stressing assimilation to mainstream values); the program respects all traditions and incorporates them into various meals, celebrations, and events; the emphasis on self-help and role models facilitates personal growth that is related to history and background. The program places great emphasis on individual pride in being a black woman, a mother, and on family unity and kinship connections; specifically, the program incorporates African-American art, myths and
family proverbs into the physical environment. In addition, the program also incor-
porates the culture of other minorities (Hispanic, Caribbean) and the celebration of all hol-
idays that form the tradition of the US and other nations represented in the program. In
all cases the program emphasizes pride in one’s self and in one’s heritage.

In summary, this program is a pluralistic, egalitarian micro-society that teaches com-
passion, empathy, and responsible concern. The TC’s central message is one of commu-
nity; a community of “brothers” and “sisters” working together to foster change in them-
selves and others. Cultural, ethnic, and gender relevance and sensitivity is embedded
within the program principles and an integral part of the program activities.

The Homelessness Prevention Intervention Process

Outreach and client recruitment

As described earlier, homeless, drug dependent mothers are referred to the program
from shelters and community service agencies within Philadelphia and surround-
ing communities, through traditional professional channels existing between the
referral sources and Gaudenzia. Gaudenzia has high community visibility and a positive
reputation as an agency that is willing to accept and work with difficult, unmotivated
individuals—those typically rejected by many other agencies. Because of this, some clients
are self-referred or referred by family members. Most frequently, the number of referrals
exceeds the number of available residential vacancies; nevertheless, the program uses
active outreach to inform referral sources and potential clients.

To insure that shelter residents and staff are fully informed about the available pro-
grams, New Image and Kindred House counselors schedule regular visits to shelters; fre-
cently, mothers who are in the re-entry phase of the residential program assist in mak-
ing presentations. Women in the shelter system are much more trusting and responsive
to the peer presentation; few women question the authenticity of a woman standing up
before the group and beginning with: “six months ago I was living in this shelter . . .
now I have my children back and I’m getting ready to move to my own apartment . . .”
Those who have given up hope of regaining custody of their children and making a
home for their family find their hope restored by such presentations.

In addition, the outreach meetings permit the counselor and the upper level peers to
form a personal bond with potential program residents. The personal bond with a key
staff member and/or with a peer committed to the recovery and homelessness preven-
tion process is often an essential element in the decision to enter the program. The ini-
tial outreach contact, and multiple outreach contacts that may follow, can form the ini-
tial step in a process of engagement; in essence, the outreach contact can be considered
the beginning of the program process.
The screening process begins after outreach; initial contact is made when walk-in clients ask for services, when a phone referral is received from a shelter or community agency, or when a written referral arrives at the agency.

**Initial Intake.** The initial task at intake is to collect three items of information from the client: name; social security number; and date of birth. The counselor then establishes medical assistance status by calling the Department of Urban Development ACT 152 office which provides case management services for Pennsylvania. With the introduction of managed care to this process, approval for funding is received directly from the managed care case managers. Whenever possible, Gaudenzia staff assist interested clients with obtaining ACT 152 or managed care qualification.

Referral sources provide the client’s: history of homelessness; psychiatric, substance use/dependence, and medical diagnoses (as known); family history (including children and location of each child); and legal status. This information is frequently sparse or incomplete, often due to the mother’s inability to remember while under the influence of drugs. Completing and verifying information takes place during assessment/interviewing sessions, although this has proven to be an ongoing process as the mother’s memory improves during drug-free time in program.

**Assessment.** The assessment procedure, involving one or more interviews, may start immediately after the initial intake, beginning with the administration of the Addiction Severity Index (ASI), a standardized instrument for determining substance abuse status and history. The ASI also measures such domains as medical status, employment/support status, legal status, family and social relations, family history, and psychiatric status. The Psychosocial History (PH) interview is also administered to supplement the ASI by garnering additional information in such domains as education, health, and employment history. The sum of the information obtained through the ASI, PH, and intake data determines whether the client meets the eligibility criteria as follows: i) parenthood (or pregnancy); ii) history of, or at-risk for, homelessness; and iii) substance abuse diagnosis. Virtually all residents meet DSM-IV criteria for substance abuse/dependency disorder.

**Program Review.** Each referral receives a complete description of the program and a tour of the facility to ensure that both are acceptable to the prospective resident. The review includes a complete description of the program in terms of the level structure, activities, responsibilities and peer self-help philosophy; a tour of the physical facility, including sleeping arrangements and communal space; and introduction to some residents currently enrolled in the program. The tour is frequently conducted by upper level peers, as a means of initiating engagement in the peer self-help process.

**Team Meeting.** After the prospective client has completed these interviews, the complete information packet is reviewed by the staff team, headed by the Program Director, to arrive at a final decision regarding admission to the program. The decision-making, however, is inclusive; if the referral meets the basic criteria for homelessness, substance abuse, and parenthood, and expresses a willingness to enter the program, acceptance is virtually assured. The program rejects only those individuals who do not meet the inclusion criteria. The program acceptance rate is close to 90%.

**Admission.** At the end of the team meeting a date is set for scheduled entry into the program. The formal admission process concludes on the client’s first day in the program with: an intake meeting with an assigned primary counselor; a review of the program orientation manual; assignment of an upper level peer buddy; meeting staff members and touring the facility (once again); and a team interview. The team is typically composed of four clients plus a staff member; the team interview process is supportive and designed to assure realistic expectations, facilitate compatibility, and accelerate engagement in the program and affiliation with the peer community.

**Service Planning.** During the mother’s first week in the program, she meets with the primary counselor to complete and verify information for a psychosocial assessment.
and, jointly, to prepare a goal/service plan. The goal/service plan includes individual short term and long term goals, objectives and methods. Each plan is individualized for the particular mother and contains material relevant only to that mother and her children. The service plan includes goals related to: 1) attaining recovery from substance abuse; 2) education and vocation; 3) family and parenting responsibilities; 4) permanent housing; and 5) building a support network.

I want you to know something . . .

I believe that

my worst day clean

will still be better than

my best day getting high

Homelessness prevention activities

Foundation for Recovery

TC principles and methods provide the structure within which the homelessness prevention interventions occur. Many of the core elements and activities of therapeutic community programs are present, as described in other writings (De Leon, 1996; S. Sacks, De Leon, Bernhardt & J. Sacks, 1994), but have been adapted to provide a foundation for recovery and homelessness prevention. The basic elements of the TC, broadly grouped into four classifications of elements (Community Enhancement, Therapeutic/Educative, Community and Clinical Management, Vocational), are briefly listed in Table 2. These interventions include, for example: i) morning meetings—to establish community affiliation for the future building of a supportive community; ii) encounter groups—to achieve a basic foundation of abstinence upon which the homelessness prevention interventions are built; and iii) peer-work hierarchy—to increase personal responsibility and begin the process of vocational training. In all instances, core TC elements are present, in adapted form, to address the problem of substance abuse, to provide a foundation for a full personal recovery or change, and to furnish an environment within which homelessness prevention interventions occur.
### Core TC Elements

#### Community-Enhancing

1. **Morning Meeting**
   - Designed to increase motivation for the day’s activities and create a positive family atmosphere, this is a structured daily meeting that reviews house business, the concept of the day, information of general interest, etc.

2. **Evening Meeting**
   - Designed to review the events of the day and plan the business and schedule for the next day.

#### Therapeutic

1. **Individual Counseling**
   - Qualified counselors meet once a week with clients on a one-to-one basis to help individuals understand themselves and to develop appropriate coping mechanisms for their problems.

2. **Group Counseling**
   - (Encounter) These sessions, held three times per week, have the multiple purposes of helping clients to understand themselves, others, and their interpersonal interactions; to develop prosocial behavior; and to reinforce prosocial change values and attitudes.

3. **Relapse Prevention**
   - This intervention is a weekly group seminar with a lecture and discussion that seeks to reduce, eliminate, or neutralize situations that have the potential for triggering relapse.

#### Educative

1. **Daily Living Skills**
   - This seminar class, held three times a week, teaches clients skills necessary for daily functioning, addressing and correcting basic living skills deficiencies that often fuel addictive behavior.

2. **Drug & Alcohol Seminar**
   - This seminar class meets once a week and is intended to educate clients about drugs, alcohol, and the cycle of addiction. By understanding their addiction, clients are better able to develop appropriate means of combating that addiction.

#### Community & Clinical Management

1. **Learning Experience**
   - This intervention involves corrective learning experiences (e.g., tasks, written assignments in response to inappropriate behavior).

2. **Level System**
   - This system defines client privileges and responsibilities at various program levels.

#### Work/Vocational

1. **Peer Work Hierarchy**
   - This is a system of job assignments intended to address issues of job performance and work attitudes, involving a rotating assignment of residents to jobs within the facility; jobs are often specifically assigned to address observed deficiencies in performance or attitude. Through this process, clients gain a diversification of work skills and experience; develop productive and appropriate work attitudes; and identify aptitudes for particular work.

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See De Leon, 1995

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Homelessness Prevention Specific Interventions

This section describes the homelessness prevention interventions of the program as summarized in the logic model, presented in four categories: family preservation; world of work; housing stabilization; and building a supportive community. Of the 22 homelessness prevention interventions, 14 are distinctive to the homelessness prevention TC (denoted in the Logic Model by asterisks). The other interventions, although important in combination with the 14 distinctive interventions of the present program, may also be present in standard TCs. These interventions begin on entry to the residential setting, intensify over time, becoming predominant in the re-entry phase, and are the primary focus of the manual and evaluation plan. Table 3 depicts the relationship of homelessness prevention interventions to program stages.

Family Preservation. These interventions address the specific needs of the child(ren), the mother and the family, and are divided into two groups. Those focused on the children include: (1) Structured Child Care/School; (2) Assessment & Early Intervention; (3) Children’s Prevention Group; (4) Prevention Group for Visiting Children. Those focused on the mother and the family unit include: (1) Family Focus/Parenting Seminar; (2) Parent’s Group; (3) Child Care Participation; (4) Family Program/Family Education Day; (5) Mother-Child Group; (6) Individual & Family Counseling. The child-focused activities include elements involving the mother; for example, the mothers participate in the structured Child Care program to promote the mother-child relationship and to enhance the mother’s parenting skills. The mother and family-focused activities have elements that are directed towards the children and their role within the family dynamic.
The Prevention group for children teaches the children to express their feelings. I wasn’t there for them and they need to talk about that, and they need to talk with me. That’s important.

Child Focused

(1) Structured Child Care/School. The daily child care program for infants and toddlers is designed to provide a nurturing environment for pre-school children and to address their identified social, emotional and developmental needs. Composed of varied educational and recreational activities, the child care program is formulated to provide: a consistent structure to the day; a stimulating environment (with opportunity for art, music, large and small motor action, outdoor play, and creative expression); developmentally appropriate learning experiences (including tasks directed toward achieving developmental milestones); socialization with peers; and daily interactions with warm, nurturing adults. The intervention takes the form of an on-site child care program staffed by trained professionals (a prevention specialist and a child care worker) along with mothers who have an assigned job function in the child care program. This program also provides a learning experience for the mother (see Child Care Participation, following).

All school age children attend the local neighborhood public school. The principal of the school and the program administration maintain a strong working relationship to facilitate the child’s integration into the classroom and to create an active information exchange between parent and school, with staff guidance. This ensures that any identified problems are addressed rapidly and in a collaborative manner between parent, school, and program. School age children have access to special educational and psychological assessments and intervention programs through the public education system. The mother participates fully through attendance at all parent-teacher conferences and special planning meetings. Meetings with school personnel receive first priority in the mother’s schedule; she is fully involved in all decisions regarding her child’s education and special needs programming. To insure that this is a positive learning experience for the mother, and that she develops the tools for working with school personnel on her own, she is guided by her counselor and the Prevention Specialist. These same staff supports continue for mothers living in their apartments.

(2) Assessment and Early Intervention. All children entering the program are considered at risk due to their history of exposure to homelessness and substance abuse. They receive a comprehensive assessment from the local school authority within the first month of entering the program. This assessment provides entree into early intervention and/or special needs programming, if indicated, for the children. Children visiting the mother, but not yet reunited with her, are eligible for the same referral, assessment and intervention process if their behavior raises the concern of the mother, family members, or staff. Discussion of the assessment with her counselor and assessment professionals provides an opportunity for the mother to learn more about her child and child development norms, to participate fully in decision-making regarding her child, and to expand her experience in working with the educational system.

(3) Children’s Prevention Group. The goal of the Prevention Group is to engage children in age-appropriate substance abuse prevention activities; to provide a forum for the child to discuss concerns about his/her mother’s past substance abuse, as well as the effects on his/her life. The “BABES World” and the “Here’s Looking at You 2000” materials provide the basic prevention curriculum for age groups from 3-12; these include the use of puppets, games, and discussion activities.

The curriculum for this group makes use of material related to self-esteem, relationships with peers, relationships with parents, decision-making, coping skills, drug and alcohol information, addictions, and getting help. The expected outcomes for this group are primary prevention of substance abuse in the children of addicted mothers. The intervention occurs as a weekly group meeting, with separate sessions held for preschool and for school age children. The weekly prevention group is held simultaneously with the mothers re-entry group, so that children who have left for community living with their mothers are able to return to the familiar residential setting, and to meet with the same peer group and prevention specialist, for continuing prevention activities.
(4) Prevention Group for Visiting Children. An additional group provides prevention activities for visiting children not yet reunited with their mothers. This prevention group uses abbreviated materials from the “BABES World” and the “Here’s Looking at You 2000” curriculum. These visiting children will typically become reunited with their mother when she completes the residential phase of the program and moves into transitional or permanent housing. Beginning the Prevention Group during visits helps to reconfigure the mother-child dyad prior to reunification and facilitates incorporation of the child into the Prevention Group during Live-Out Re-Entry. This group is held during weekend visiting, often coinciding with Sunday Family Program/Family Education Day led by the Prevention Specialist. The expected outcomes for this group are to begin the process of primary prevention of substance abuse in the visiting children.

Mother and Family Focused

(1) Family Focus/Parenting Seminar. The goal of this activity is to teach parenting skills, improve family interaction and family functioning. The Family Focus/Parenting Seminar employs a psychoeducational format that contains educational modules on infant, child and adolescent development, parenting skills and family life. The format includes didactic educational materials (audio tapes, etc.), experiential exercises, and discussion. The classes often begin with a film or lecture that introduces a topic for the mothers, followed by supervised activity with the children to reinforce the topic. The seminar provides an opportunity for the mothers to dispel the myths and misconceptions of parenting while learning effective problem-solving with their individual children. The seminar consists of a 12 week cycle of 2 hour sessions, conducted on a weekly basis, with leadership from the Prevention Specialist (who is an educator).

(2) Parents’ Group. The goal of this group is to improve parenting and strengthen the mother-child relationship. The Parents’ Group provides a forum for mothers to discuss the problems, difficulties and special pleasures of parenting and daily child care, with a focus on self-expression, self-awareness, and problem-solving. This intervention also provides a mechanism for the mother to tackle the underlying feelings and attitudes that led to counterproductive relationships between herself and her child, relationships that undermine her ability to provide a safe, nurturing home environment for herself and her family. Having the children living with the mother while she is in the residential program permits her to address the daily mother-child interactions that cause her stress or distress, which makes this learning experience concrete and practical rather than theoretical.

This group also provides an environment for addressing the guilt many mothers experience in relation to past behaviors with the child, and encourages the formulation of effective problem-solving and healing approaches to resolving those issues. The group uses a variety of formats including didactic, discussion, and therapeutic methods. This intervention results in the acquisition of skills to ensure successful parenting, while promoting utilization of the peer community for guidance and support. In this fashion, the contribution of isolated and inadequate parenting to the cycle of homelessness and family dissolution is interrupted. The group is conducted on a weekly basis, guided by the clinical supervisor with active input from the peer group.
(3) Child Care Participation. The goal of this activity is to improve parenting skills and to reinforce the mother-child relationship. Mothers are assigned, on a rotating basis, to participate in the Child Care Program. They work closely with the staff, who guide their interactions with the children, with much discussion of child care principles. The intervention includes observation of mothers during their interactions with their own and other children, provides role models of positive parenting for the mother/participants, and gives constructive feedback for improvement in parenting. Each mother receives direct and immediate feedback from the staff, opportunity for discussion and information exchange related to parenting, and practice of new approaches to child care. The observations by the staff and the mother’s own awareness of her difficulties with specific children and/or child behaviors, provide information for further discussion at the Parents’ Group (see the preceding section). Ultimately, participation in the Child Care Program augments and enhances the mother’s ability to provide effective parenting for her children. This is a daily activity that is coordinated by the Prevention Specialist and involves the mother for a full morning or afternoon on a weekly basis.

(4) Family Program/Family Education Day. The goal of this intervention is to continue the process of family reunification by fostering relationships between the mother and her extended family, and by improving the relationship between the mother and the children who are not living with her (children not in residence can visit their mother each week and participate in the Family Program/Family Education Day when it occurs). Attendance is solicited from extended family members through written invitation from the mother. Family members who are using illegal drugs or who have an alcoholism problem are not invited to attend in order to help the mother solidify and preserve her commitment to recovery. Family Program/Family Education Day includes family education on subjects relevant to recovery, social and recreational activities for the families, a prevention group for visiting children, and private meeting time for the family unit. The expected outcomes for this intervention are the facilitation of the extended family reunification process. The family program is conducted bi-weekly on Sunday afternoons to maximize family attendance; the various activities are counselor led or supported.

(5) Mother-Child Group. The goals of this intervention are to improve communication between mother and child, to increase the expression of personal feelings (both positive and negative), to reduce stress and improve the relationship between the mother and child, and to improve the child’s ability to interact effectively with the mother and peers. An important activity is the time spent in the Child Care Program, where mothers are taught the importance of being patient and understanding the needs of their child. The Child Care taught me how to be a better mother. Taking care of other mothers’ children taught me patience. You know, you get scared about being a parent and want to give up, but I’ve learned about my patterns that get me into trouble. I don’t want to be homeless again and not be with my children, so I’m learning how to be a responsible mother. The re-entry groups are important for parenting, and parenting classes. It’s a big deal for me and all of us to develop better parenting skills.
itive and negative) between mother and child, and to reduce acting-out or behavioral problems for the children. The group uses an interactive discussion format, meets on a bi-weekly basis, and is led by the clinical supervisor, but emphasizes the importance of peer feedback to strengthen both the mother’s connection to the peer support community and her self-image as a positive role model.

(6) Individual & Family Counseling. The goal of individual and family counseling, in the context of family preservation, is to improve the mother-child relationship and strengthen the family unit. Individual counseling helps the mother to change the family dynamic through increased understanding of herself, her child(ren), and the family unit. Family counseling takes place in the outpatient setting with trained professional staff, and can focus on brief, situational issues or long-term treatment. Weekly individual outpatient counseling is an key element in the mother’s aftercare plan during community re-entry and independent living. Family counseling is individualized to meet the needs of the family members.

Re-Entry Group. The Re-Entry Group is not specific to family issues, but maintains the mother’s focus on self-management of all aspects of homelessness prevention, including those related to family preservation. This intervention is discussed in greater detail under Housing Stabilization.

In summary, the family preservation interventions address the needs of mother, child, and the mother-child dyad. Interventions for the child and the mother are interrelated, with aspects of each serving to fortify the mother-child relationship. Parenting skills can be learned, but mother and child must learn to be mutually responsive and receptive in order for effective parenting to occur. Each mother and child intervention provides a building block in the process of reconstructing a cohesive and unified family.

When I was on drugs I didn't take care of myself or my kids. I got up whenever I felt like it . . . My mother would have to take them. But learning how to dress myself and my child was a big deal. The program really taught me how to be a good mother . . . It's real hard for mothers who are addicts. When I was out there getting high, I don't remember going through my children's teething or anything like that. My mother took care of that stuff You know, you get scared about being a parent and want to give up, but I've learned about my patterns that get me into trouble. I don't want to be homeless again and not be with my children, so I'm learning how to be a responsible mother. The re-entry groups are important for parenting, and parenting classes. It's a big deal for me and all of us to develop better parenting skills. That's why this is a great program and we need more of them.
**World of Work.** These interventions prepare the mother for work. Obtaining and sustaining employment are critical to homelessness prevention. The development of positive work attitudes and work skills are integral to all TC programs. The homelessness prevention program places a distinct emphasis on preparation for work during the residential phase; all mothers are expected to begin work or specialized vocational training during re-entry phases, to prepare for eventual economic self-sufficiency.

(1) **Educational Preparation (e.g., GED).** The goal of this intervention is to attain a basic educational credential as a prerequisite for gainful employment. In order to establish basic competencies and to expand employment opportunities, each client who has not graduated from high school must work toward attaining a high school equivalency degree by attending classes until successful completion of the GED examination. Classes use an instructional format, are held two mornings each week, and are led by a special instructor. Mothers can receive individual tutoring from staff, and are able to take the GED exam at the approved testing center on-site.

(2) **Work Readiness Seminar.** The goal of this intervention is to prepare the mothers to join the work force by teaching work-related skills, including attendance and punctuality, dress, response to supervision, résumé writing, interviewing, etc. These seminars employ an instructional and discussion format in on-site classes conducted weekly by a community-based provider over a 12 week cycle.

(3) **Job Search/Location Training.** The goal of this intervention is to equip clients to conduct a successful job search by finalizing their résumé, polishing their interviewing skills, allocating time and identifying sources of assistance for their newspaper searches, job applications, and practice interviews. The format for this intervention is guided counseling. Consistent with the program philosophy, the job search remains the specific responsibility of the mother, with supports provided by peers and staff. The expected outcome is that all mothers will obtain open competitive employment. This activity is monitored by staff and peers at the weekly Re-Entry Group (described in greater detail in the Housing Stabilization section), with individual guidance available, as needed, from staff.

(4) **Recovery and the World of Work.** The goal of this intervention is to help the mother focus on self-monitoring of her work performance, to establish plans for improved performance and career development, and to sustain heightened awareness of the relationship between work-related issues and recovery. Mothers rate and review their job performance and present any informal or formal work evaluations for discussion. The group concentration on recovery and the world of work is maintained through staff led weekly sessions, held as a part of the Re-Entry Group, using a discussion, monitoring and feedback evaluation format.

**Housing Stabilization.** For most families, housing stabilization involves moving into stable, interim housing during the residential phase of the intervention program, then moving to agency-operated transitional housing apartments (located at a common site) or other subsidized apartments during the transitional, live-out re-entry stage. The expected outcome is for the family to live independently in permanent, subsidized (HUD Section 8) housing. Housing stabilization activities focus on obtaining and sustaining housing, and acquiring the household management skills necessary to maintaining a safe, nurturing environment for the family. Homelessness prevention elements related to housing stabilization are reinforced in the Re-Entry Group, in the regular contacts with the Transitional Counselor, and are practiced in daily living.
Independent Living Skills Class. The goal of this class is to provide information and build skills necessary for sustaining a home and for living in the community. Seminar topics include budgeting, food shopping and preparation, and home maintenance, as well as navigating the complexity of various social service and government systems. These classes primarily employ a psychoeducational format that provides instruction in specific skill areas. In addition, the peer group provides information and support through individuals’ personal experiences. Independent Living Skills Class begins early in the homelessness prevention sequence, and is led, depending on the particular topic, by staff or by peers with staff guidance; the class is held weekly and takes place in the residential setting.

Example: Budgeting Seminar. The goal of this intervention is to teach clients how to manage their money. The intervention is structured as a multi-week class beginning with instruction on how to construct a budget and followed by practical application by each individual. The single parent must manage to meet the needs of her children as well as her own personal needs, juggling two or three different sources of funding (AFDC, SSI/SSA, Medicaid, Home Relief, etc.), coping all the while with one of the strongest triggers for relapse—money. The mother then puts these skills into practice, with monitoring through case assistance and Re-Entry Group.
(2) **Case Assistance.** The goal of this intervention is to provide critical case-specific support for the family’s reintegration into the community, either in a transitional housing apartment or in an independent apartment. This is accomplished by a Transitional Counselor who visits the family regularly: to assess the status of the apartment; to monitor the mother’s home management activities (maintaining sufficient food, cleanliness of apartment, etc.); to provide assistance with immediate problems, as needed; to assess the emotional stability of the mother and the family unit; to determine if evidence of substance abuse exists; and to monitor mother’s compliance with her aftercare plan (including linkage to outpatient services).

The Transitional Counselor employs a case assistance (not case management) approach; *i.e.*, the coordinator places emphasis on “doing with” rather than “doing for” the individual family, and on reinforcing the use of the support community wherever possible. The emphasis on client responsibility, empowerment, and the connection with community, are distinctive features of these homelessness prevention interventions. The expected outcomes of this intervention are support for successful accomplishments, immediate identification of concrete problems, or problems in adapting to community living, and rapid development of revised plans to address any identified issues. The Transitional Counselor visits each apartment bi-weekly at first, with decreasing frequency over time.

(3) **Individual/Group Counseling.** The goal of these sessions is to provide a bridge ensuring continuity of supports for the mother as she moves to different living settings. The sessions have multiple purposes of using the housing stabilization focus to help clients to understand themselves, to develop appropriate coping mechanisms for their problems, and to change their behaviors. Counselors meet weekly with clients on a one-to-one basis, in an outpatient location, and may suggest that the women attend specialized counseling groups as well. The group sessions are staff led, with the expectation that upper level peers will assume an active role and will demonstrate leadership and responsible concern for their peers.

> I never had anyone to teach me about the right foods for my kids. I thought I knew what I was doing, but the nutrition groups taught me a lot, and I found out I had been making lots of mistakes with my kids’ diet.

First is the transitional housing program. They have an apartment in the same complex as the other re-entry women. They help you figure out what you need for the apartment - they give you a list. They help you to find the furniture. The transitional housing counselor helps you get settled.
(4) Re-Entry Group. The goal of this group is to facilitate the family’s successful re-entry into the community at large by assisting the mothers to self-manage all the factors related to homelessness prevention, with special emphasis on peer support. The focus of this group consists of an in-depth, daily review of a 17-point Self-Management Checklist maintained by the mother as a tool to help her focus on the relevant issues related to family preservation, work, housing stabilization, and extension of the support network. The issues range from her child’s attendance at school, to her own attendance at school/work/counseling, and include identification of triggers to relapse. The Self-Management Checklist provides a barometer of family functioning in the community, as well as an early warning signal of impending problems.

The Re-entry Group format also ensures the extension of the peer community into transitional and permanent housing, promotes cooperative and caring attitudes towards others, and facilitates the ongoing growth of the mother’s support network. Membership in the group consists of mothers preparing to move into apartments in the community, along with mothers who have been living in the community for up to 12 months; the latter serve as role models and mentors for the former. The group meets weekly in a structured format, co-led by the Residential Clinical Supervisor and Transitional Counselor. Mothers bring their children who meet with the Prevention specialist while the mother is in her own group.

(5) Transitional Housing Group. The goal of this group is to improve the mother’s ability to sustain housing. The group uses a discussion format and focuses on issues of housing, homemaking and the interrelated matters of community living. Specific topics include Section 8 applications, rental leases, household budgeting and household management. The group also discusses matters of community living in relation to children, school, work, and socialization. This group, attended primarily by people in the re-entry phase, is led by the Transitional Counselor, and meets once a month at the residential site.

I still get frustrated around expecting him to behave like a 16-year old when he is only a six-year-old child. So I talk to my peers about it and use the re-entry groups at Kindred to work this stuff out. I go to 12-step meetings and I’m very close to Nancy who lives in this complex and is a Kindred House peer. I also call other move out peers who don’t live in this complex. So, I’m always reaching out to peers for feedback because I still stuff my feelings and it’s not easy for me to use peers as a support network. I’ve gotten better at it because I learned how to do it in the residential program.

I had just reached Level 3 and went, for the first time, to have dinner at a Level 4 woman’s apartment. It was sooo wonderful!! She was so proud and happy in her apartment. It’s so much motivation for me! And then the other re-entry sisters came over to the apartment to give us [the Level 3 women] support. The women live in apartments in the same complex. We didn’t expect them to come over . . . it wasn’t planned . . . it was a real surprise. They congratulated me for making Level 3. They brought flowers, and someone brought a camera and we all took pictures together.

It was a real celebration for making Level 3 and taking the first steps to joining them in the community. We sat around and laughed and talked. They really made me feel good about my achievement.
Building a Supportive Community. These interventions are designed to facilitate the individual’s assimilation into the community of peers, to strengthen the individual’s perception of community as a nurturing entity, and, thus, to enhance the capacity of the community to teach and to heal. The core TC community-enhancing interventions begin the process. Through these efforts, the mother begins preparation to create a new, positive support network and/or to expand her current social network with those who share similar values related to building a family-oriented lifestyle and sustaining recovery. Each individual uses the community to assist in her personal journey. During re-entry into the community at large, the homelessness prevention interventions promote affiliation with the extended, community-based “family” of mothers, and single individuals, within a recovery fellowship. The Re-Entry Group (explained in detail under Housing Stabilization) is essential to building a support network.

(1) Seminar Leader/Mentor. The goals of this intervention are to enhance connection between members of the peer community, to give individuals the opportunity to “give back” to others what they have learned themselves, and to develop leadership abilities. The activity entails assigning certain clients the responsibility to lead a group seminar and/or to mentor someone preparing to move into the community.

For this intervention, Stage 4 (Live-Out Re-Entry) women return to the residential setting on a regularly scheduled basis to fulfill several distinctive roles. As mentors, their role is to advise, counsel, and assist Stage 3 (Live-In Re-Entry) women in planning their move from residential to transitional or permanent housing. As seminar leaders, the Stage 4 women contribute to the existing community, model future change, and connect...
the residential community to the community that is evolving outside the physical boundaries of the residential program. Through these activities, essential to realizing the goal of building a supportive community, the Stage 4 women elevate their confidence and self-esteem while increasing the affiliation among peers. These are regular activities that occur weekly and are guided by staff.

(2) 12-Step Meetings. The goals of these meetings are to sustain sobriety and establish connections with a broader self-help fellowship. Twelve-step meetings are conducted at the residence; aftercare plans require that the mother identify a 12-step “sponsor” and that she begin attending Narcotics/Alcoholics Anonymous (NA/AA) meetings with a “home group” prior to moving into the community. These groups follow the 12-step methods of individual commitments, group discussion and peer support, and are peer-led by recovering individuals in the community at large. Mothers attend several meetings each week.

(3) Re-Entry Board. The Board has three goals: a) to provide peer review of Live-Out Re-Entry candidates; b) to refine the policies and procedures that govern re-entry; and c) to provide input for program development planning. The group follows a business format with an agenda of items for consideration, including a review of Stage 4 applicants and further refinement of the program. This activity reinforces a supportive community by involving upper level members in the program process. The Re-Entry Board consists of Stage 4 members, graduates, and staff; it is peer led and staff-assisted.

Formulation of intervention plan

Needs and Strengths

As the homeless, substance abusing mothers and their children enter New Image and Kindred House, the needs presented are multifaceted and complex. Reiterating from an earlier section of this manual, the needs fall into the following main categories:

1. basic needs;
2. needs related to impaired functioning and social deficits of the mother;
3. needs related to developmental and social deficits of the child;
4. needs related to reuniting the family and strengthening the mother-child bond;
5. needs related to prosocial, productive reintegration into society;
6. needs related to housing stabilization.

All of these needs must be met if the family is to break the cycle of poverty, homelessness, substance abuse, and family disruption to achieve family preservation and societal reintegration.

The mothers entering Gaudenzia programs with their children, or with the intention of reuniting with their children, demonstrate individual strengths as well as serious deficits. Some have educational or employment skills, some can manage basic apartment living independently, and some have an employment history. Many of the mothers entering the programs have been functional enough to retain custody of their children. In addition, all of the mothers have demonstrated one strength of major significance—each cares enough to fight for reunification of her family. It is this strength that provides motivation to enter the program and to devote months of concerted effort to the daily struggle of changing both her life and lifestyle.

Relationship of the Individual Intervention Plan to Client Needs and Strengths

Addressing the panoply of defined needs requires individualized service planning, incorporating service provisions at both the program and community provider level. The section below relates the individualized intervention plan to client needs, on the one hand, and to program stages and interventions, on the other hand.
Developing the Individualized Service Plan. During the mother’s first week in the program, she meets with her primary counselor to complete and verify her psychosocial assessment and to prepare a goal/service plan. This individualized plan includes short- and long-term goals, objectives and methods related to reuniting with her children, recovery from substance abuse, and homelessness prevention. The homelessness prevention elements are a focus of the program from the moment of entry, but the intensity of the interventions increases as the mother moves through the program stages. The homelessness prevention elements of the individualized service plan focus in the following areas: effective self-management of parenting responsibilities; addressing personal and interpersonal problems; addressing her child(ren)’s educational, developmental, and/or emotional needs; preparation for employment, including completion of basic education; obtaining and sustaining permanent housing; building a supportive network.

Basic Needs. The individualized service plan places immediate emphasis on meeting the mother’s basic needs for safe, interim housing, legal consultation, staff support in reuniting the family, and child care to enable her to focus on her individual needs knowing that her child is in a structured, nurturing environment. Attention to basic needs helps to stabilize the family in the program and begins the process of engagement.

Homelessness Prevention Needs. During the first stage of the program (Month 1), the primary focus of the mother’s individual goal plan is to gain control over her substance abuse and to accept personal responsibility for her actions; these steps form an essential context to increase her receptivity and responsiveness to the homelessness prevention interventions. In addition, she will begin initial homelessness prevention activities. She will begin attending parenting seminars and participating in the child care program to initiate acquisition of the knowledge and skills necessary to effective parenting. Basic education classes are undertaken as a means of increasing her opportunities to be self-supporting in the future. She will join the peer work hierarchy within the residence as part of her work readiness training. She is involved in reviewing the results of her child(ren)’s developmental assessments, also initiated in this stage, and in making decisions about interventions thus indicated.

Review and Revision. As the mother progresses through the program stages, she and her counselor assess her short-term goals and establish new goals within each of the targeted areas. The homelessness prevention interventions increase in frequency and intensity as the mother progresses through the program stages. For example, the mother’s long-term goal is entering the world of work; the mother’s short-term goal during the initial stages of the program may be to complete GED classes; her goal during the Live-In Re-Entry Stage (Stage 3) will be to locate a job. In the earliest stage she will attend GED classes and begin developing work readiness skills; in a later stage she may be participating in all of these interventions simultaneously: attending classes; preparing for the GED exam; attending vocational classes; attending a group on Recovery & the World of Work; learning how to prepare a résumé; conducting a job search; going to interviews.

Movement Through Program Stages. Successful progression through the program stages is dependent on demonstrating attainment of short-term goals and development of the next level of goals which are designed to bring the mother closer to self-management and independent functioning. All clients progress through program stages; however, the rate of progression is dependent on individual needs and strengths. The process incorporates effective use of the peer group, community-as-method. Several interventions each day are designed to facilitate the mother’s connection with the peer self-help community. These activities restore the mother’s trust in others, address her isolation and restore her affiliative spirit, and establish a proactive kinship group with a shared goal of family unity. As she completes each stage in the program, the mother conducts a self-assessment of goal attainment, then presents this assessment to her peers and receives their response. This procedure provides a peer feedback loop that supports the mother’s successes as well as her struggles, and further strengthens her affiliation with the peer support network.
Re-Entry. As she prepares for the final program stages, the mother works with her counselor to develop an aftercare plan that identifies the individualized homelessness prevention goals she will focus upon while living in the community. Essential elements in this plan focus on intensification of her contacts with community-based service providers, continued case assistance supports, mentor activities at the residence, and sustained contact with the self-help community; these insure her continued personal growth, preservation of her family, and housing stability. While living in the community, the mother practices self-management of all homelessness prevention elements with monitoring and support provided by a Transitional Counselor in conjunction with the peer support network. Intensified retraining, monitoring and supports are provided on an individual basis, as needed, to insure housing and family stability.

Linkages with mental health, substance abuse, and other services and supports

Gaudenzia maintains strong relationships with community-based providers of outpatient services for mothers and for children. In some instances, the provider comes to the program to provide services in a group format for all interested clients (e.g., GED classes). In most instances, during their tenure in the residential program, mothers are assisted in establishing linkages with service providers in the local community. Few mothers plan to return to their home communities when they leave the residential program, typically because the home community has not been supportive and may have undermined the her efforts to change a drug addicted lifestyle.

Many mothers move into housing in the local community near the New Image and Kindred House programs and thus, can maintain ongoing relationships with local service providers. If the mother plans to move some distance away, the program staff assist her in forging relationships with providers in her new community several months prior to her leaving the residential program. The providers of outpatient services, if not themselves engaged in mutual self-help efforts, are supportive of such approaches, facilitating integration of services.

Mental Health and Substance Abuse Services

When mothers move into the community after completing the residential phase of the program, they require ongoing support to sustain recovery from substance abuse and to address any psychological issues necessary for continued growth and development. A new “community re-entry” service plan is developed. Since the mothers are particularly vulnerable during this period of time, continuity of outpatient counseling is often elected by the counselor and the mother to help her sustain the gains made in all areas of her life, and to support continued personal growth and development.

Few of the mothers in New Image and Kindred House have a formal psychiatric diagnosis, however, a significant number of the women evidence symptoms of psychological distress indicative of dual diagnosis, including anxiety, phobia, depression, antisocial personality. Many of the women begin to attend community-based individual psychological counseling while they are in the residential program. Frequently, issues that emerge during homelessness prevention interventions in the program are pursued in greater depth during individual counseling. Outpatient counseling is provided by Gaudenzia and other community-based mental health programs.

Gaudenzia operates a large outpatient program in Philadelphia, providing integrated mental health and substance abuse counseling for program members as well as for the local community. This program has the unique feature of providing counseling with a strong recovery perspective as well as an emphasis on mutual self-help. An intensive outpatient counseling program is also offered; participants attend sessions three to five times each week. Clients also attend 12-step meetings as part of their recovery aftercare plan.
As noted earlier, the children in the New Image and Kindred House programs are considered particularly at risk because of their history of homelessness, accompanied by some mix of familial substance abuse, family disruption and separation, exposure to drugs in-utero, and physical and sexual abuse. All children entering the program receive a complete assessment from a community-based child development team funded by local government. The mother is encouraged to use program staff to help her access special services for her children during all program stages to reinforce family preservation. Depending on the age of the child and the nature of the indicated intervention, a variety of service providers may be involved in this process. Access to early intervention and special education programs is provided through the local school authority; local mental health providers supply access to individual child and family counseling services.

The local public school system, and special education programs, become involved with each family on an individual basis, as needed. The school principals and community support personnel actively participate in formal and informal training designed to inform their understanding of the program and of self-help approaches, promoting consistency in messages delivered to the family. To strengthen the family unit and to guide the mother in improving her parenting skills and in taking a leadership role regarding her children’s interests, the counselor and supervisory staff provide assistance to her in attending formal and informal case conferences within the education system. She is also encouraged to look to the peer community for support in these efforts.

In working with the school system and all community providers of services for her children, the mother receives support and skills training from the Prevention Specialist and from her counselor. They ensure that she understands all information being provided, so that she can make informed decisions regarding her children. They encourage and support her assumption of a leadership role in discussing assessments, problems, and recommendations. Similarly, she is encouraged to use the peer community for information, problem-solving and support in all her efforts at positive parenting; affiliation and use of the peer community is an essential element in homelessness prevention, since it is this community of parents she will typically turn to for help and support when she is living in independent housing. In addition, all families are involved in individual and/or family outpatient counseling that focuses on child care, parenting skills, mother-child relationship and family unity.

The homeless, single women with children who complete the residential phase of the program will need subsidized housing in order to establish an independent home in the community. Gaudenzia makes provision for such subsidy in two ways: the agency operates a transitional housing program, funded by the local government, with a limited number of rent-subsidized apartments available in one housing complex; the agency also assists women in filing applications for Federally funded Section 8 vouchers, which provide rent subsidies for independent apartments. In both instances, the mother pays 30% of her income toward the rent and receives a subsidy for the remainder. These mechanisms enable mothers leaving the program to move into affordable, well-maintained housing in neighborhoods that provide a level of safety for their families.

Preparation for employment is considered an essential element in homelessness prevention. The mother cannot break the cycle of poverty and homelessness if she continues to function with a lack of basic reading and math abilities and impoverished vocational skills. For this reason, the homelessness prevention program emphasizes participation in basic education classes and work readiness training from the mother’s
earliest program stages. A community-based educational organization provides GED classes for the mothers at the program site. It is anticipated that all mothers who do not have a high school diploma will pass the GED course while in the residential program. The New Image program has been certified as an approved GED testing site by the State of Pennsylvania. Mothers are encouraged to continue their education at the local community college level, and several have completed Associate and Bachelors degrees after completing the program. Specialized vocational skills training classes are provided in the community by a variety of vendors; Gaudenzia mothers are encouraged to improve their skills, and to expand their career opportunities, through participation in these classes. Several mothers have completed training classes for certification in addiction counseling and have returned to New Image and Kindred House as program counselors.

The Recovery Community

All homelessness prevention elements are built upon a basic foundation of abstinence from illegal drugs and alcohol dependence/abuse. In order to support relapse prevention, all mothers entering community apartments are required to establish a relationship with a 12-step NA or AA sponsor prior to moving. Most individual aftercare plans require regular attendance at 12-step meetings several times per week in order to support relapse prevention from substance abuse. Gaudenzia maintains a strong relationship with Narcotics Anonymous and Alcoholics Anonymous in recognition of their effectiveness in alcoholism and substance abuse relapse prevention for the Gaudenzia populations.

Client relationship with staff, agency, outside providers

Staff. The staff of the program serve as role models and guides for the mothers, using their own experiences and current behavior to set examples for clients, providing supportive guidance and skills training to facilitate achievement of personal goals. The bond between program staff and clients holds particular importance during the initial months of programming for this population, while engagement is a primary focus; however, it is the role of staff to promote self-help and affiliation with the community of peers. Staff function as “wise guides,” providing counseling supports and actively encouraging disclosure and discussion with the peer group. Peers provide support, leadership and mentoring for other members of the peer hierarchy, building mutual self-help supports, and a peer safety net for mothers and their children living independently in the community.

Agency. The client’s relationship with the agency parallels that with the staff; the agency is a source of support and assistance at key junctures in the process of homelessness prevention (i.e., legal consultation to facilitate family reunification with children removed by the child welfare system, access to rent-subsidized housing at the point of community re-entry, etc.), but the client is directed to use self-help and the peer community, rather than to continue to be dependent upon agency/staff supports. And, of course, the clients give back to the agency and the peer community by participating in agency outreach efforts.

Outside Providers. Outside providers are a source of special educational efforts for the mother during the residential phase of the program (i.e., GED classes; vocational courses, etc.), and special interventions for the children. Once the family re-enters the community, outside providers assume an expanded role (including therapeutic interventions), and may be the mother’s major source of personal counseling as well as educational and vocational activities.

The mother’s relationship with some outside providers represents a traditional consumer/provider context for services, in which goals are established and specialized services directed toward the achievement of those goals are provided; however, the recovery-based providers of out-patient counseling for this population are adherents of self-help approaches, and other community-based providers are supportive of self-help approaches. This assures that the mother/family will be receiving consistent messages while receiving
comprehensive services.

Sequence of interventions & passage through the process

Intervention phases

The stages of the program define the client’s passage through the program (see Figure 1), a process that reflects a developmental perspective of change (for the individual and the individual/family) within the interrelationship of TC structure and homelessness prevention activities. The description of the process illustrates the use of therapeutic community principles and methods as the foundation for recovery and the structure within which the homelessness prevention interventions take place. The discussion of the process mentions TC principles and methods as needed, and emphasizes the homelessness prevention specific activities. The program model has five stages: Stage 1, Foundation for Recovery; Stage 2, Planning for Prevention; Stage 3, Live-In Re-Entry; Stage 4, Live-Out Re-Entry; and Stage 5, Independent Living. The relationship of homelessness prevention interventions and program stages is depicted in Table 3.

Stage 1 – Foundation for Recovery. The goals of Stage 1 are affiliation with the peer community, stabilization of the family, assumption of personal responsibility and commitment to recovery from substance abuse, all designed to establish a foundation for homelessness prevention. The specific homelessness prevention activities begin in this stage and include early stage family preservation interventions (structured day care, parenting seminar, etc.), activities that emphasize personal responsibility (e.g., education/GED, the peer-work hierarchy), and core TC approaches for substance abuse (e.g., encounter groups), and enhancing community (morning meetings). Upon completion of this phase, the mothers are abstinent, have established a relationship with their peers, recognize personal responsibility, and their children are settled in day care or school.

Stage 2 – Planning for Prevention. The goals of Stage 2 are abstinence from substance abuse, intensification of parent-child interventions, and the introduction of additional homelessness prevention activities focused on obtaining housing and employment. The methods for this stage include increased intensity of family preservation interventions (e.g., children’s prevention group, parents group and mother-child group), the introduction of housing stabilization activities (e.g., application/follow-up activities for Section 8 housing, independent living skills classes) and interventions for the world of work (e.g., educational readiness classes and work readiness seminar). The mothers who complete this phase are drug free, bonding with their children, learning to manage a household, completing their education and assessing their readiness for work.

Stage 3 – Live-In Re-Entry. The goal of Stage 3 is to prepare the mother and family for movement into the community, and includes intensification of all homelessness prevention activities. The methods of this stage consist of the full array of homelessness prevention interventions described in this manual. These interventions are designed to reach peak intensity in the latter part of the residential phase and to be the focus of Live-Out Re-Entry (Stage 4) in transitional or permanent housing. However, the homelessness prevention interventions occur independently of where the mother is living and, depending on individual considerations of housing availability, may occur primarily in either the residential or non-residential setting. The mother who completes this stage has home management skills, is ready to assume full parental responsibility, has obtained work or is ready for work, and is strongly affiliated with the peer community.
## Core TC Elements

(e.g. morning meeting, evening meeting, seminars, encounter groups, peer work hierarchy)

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## Homelessness Prevention Interventions

### Family Preservation

#### Child Focus

- *Structured child care/school*
- *Assessment & early intervention*
- *Children's prevention group*
- *Prevention group for visiting children*

#### Mother & Family Focus

- Family focus/parenting seminar
- *Parents' group*
- *Child care participation*
- *Family education*
- *Mother-child group*
- *Individual/family counseling*

### World of Work

- Educational preparation
- Work readiness seminar
- Job search/location
- *Recovery and the world of work*

### Housing Stabilization

- Independent living skills class
- *Case assistance*
- Individual & group counseling (OP)
- *Re-entry group*
- *Transitional housing group*

### Building a Supportive Community

- Seminar leader/mentor
- 12-Step meetings
- *Re-entry board*

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OP = Outpatient  
* Distinctive Homelessness Prevention Interventions

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<thead>
<tr>
<th>Intervention</th>
<th>Stage 1 Foundation for Recovery</th>
<th>Stage 2 Planning for Prevention</th>
<th>Stage 3 Live-In Re-Entry</th>
<th>Stage 4 Live-Out Re-Entry</th>
<th>Stage 5 Independent Living</th>
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Stage 4 – Live-Out Re-Entry. The goal of Stage 4 is to stabilize the family in the community and to support and consolidate the self-management of all activities to prevent homelessness. The methods of this stage are the self-monitoring form, the Re-Entry Group, case assistance, children’s prevention group, participation in all needed outpatient services (e.g., individual, group and family counseling, community-based 12-step meetings), and the Re-Entry Board. The mothers in this stage are assuming independent responsibility for home, school and work, and have formed a strong connection with the peer network. At the completion of Stage 4 of the program, the mothers have at least six months experience living in the community in transitional or permanent housing, demonstrating successful self-management of themselves and their children. They have a firm understanding of themselves, their homelessness, and their recovery. They are abstinent, have assumed greater responsibility for work and family, and have become more effective parents. A framework has been constructed for continued advancement, one that is reinforced by the supportive network of the peer community. These women have elevated their self-esteem, have acquired and maintained the skills necessary for effective independent living; they are ready to move to graduate status.

Stage 5 – Independent Living. The goal of Stage 5 is to sustain independent living in the community. The methods of this stage continue many of the methods of Stage 4, usually at decreased frequency, with a continued focus on personal goals important to family unity, including an increased reliance on the supportive community now located in new neighborhoods and environments. At this stage, the mothers and their children are living in their own apartments and are part of the local neighborhood; the support community usually consists of program graduates and new relationships formed in the community. The mothers have developed prosocial values and have made lifestyle changes to permit their integration with mainstream society. They are beginning to “give back,” and to break the cycle of homelessness, substance abuse and family disintegration.
Relapse management/Gaudenzia policy

The Gaudenzia policy regarding responses to relapse is consistent with the philosophy that homelessness and substance abuse are interrelated. The programmatic response to substance abuse relapse should never give rise to homelessness, either through forcing the mother to leave the residential program or to give up her housing.

Relapse is accepted as an essentially unavoidable part of the substance abuse recovery process. As long as the mother’s response to the drug used does not constitute a threat to the safety of her children or the people around her, she will be allowed to remain in the residence or in her apartment, and the relapse event will be incorporated into her goal plan. The issues she will address in that plan include identification of the trigger(s) for this relapse, development of more effective mechanisms for coping with such triggers in the future, recognition and acknowledgment of the impact of the relapse on self as well as the community, and the programmatic impact of the relapse event on the recovering community. In the event that the frequency and/or severity of relapse escalates, assistance may be provided to the mother thorough increased structure and supports; specifically by limiting her access to locations where drugs are available, by readmitting her and her children to the residential program, or by referring her for admission to a more intense treatment setting, such as a detoxification program. If the mother is admitted to detox, her children will be placed in the care of family members or, where no suitable arrangements can be made within the extended family, into temporary foster care. If the mother is living independently at the time of relapse, she will receive assistance in maintaining her rent until she can return to the apartment.

The consistent contact and follow-up provided to the mother during her first year of living independently renders relapse to homelessness highly unlikely. Even in cases where the mother has broken contact with aftercare staff, the peer community can, and does, alert staff to situations of imminent danger for the family; staff members then take steps to intervene. Mothers and children have the program phone numbers, and children have been known to call if they need help and/or if their mother is in jeopardy. If the mother and children do become homeless at any time after moving into the general community, staff help in locating housing can be requested and, if warranted, the family can be readmitted to the residential program temporarily.

Movement among substance abuse and mental health services

The mothers who enter New Image and Kindred House programs are, by admission criteria, current substance abusers. Admission to the program marks their first contact with Gaudenzia substance abuse service systems. The initial stage of the program uses core TC interventions to concentrate on the mother attaining abstinence from substance abuse and acknowledging personal responsibility in her life choices. Homelessness prevention interventions are introduced during this stage of the program, gradually increasing in intensity and number as the mother moves through the residential program steps. The residential substance abuse services continue throughout each stage, but with diminished intensity accompanying a gradual transition to community-based aftercare services.

As noted earlier in this manual, few of the Gaudenzia mothers have a formal psychiatric diagnosis, but many exhibit symptoms associated with prior trauma and/or other psychological symptoms, and benefit from mental health counseling. The Gaudenzia outpatient program, along with other community-based providers, supply mental health services to New Image and Kindred House clients during the residential program and continuing through community re-entry and independent living.
Collaboration and linkages with other community agencies

The program and the community-based providers, including self-help programs, maintain a collaborative working relationship. This relationship is formalized in affiliation agreements between Gaudenzia and the provider agencies in Philadelphia and West Chester, ensuring the provision of health care for mother and child, special developmental/educational services for children, educational and vocational services for mothers, substance abuse out-patient services, and mental health services for all family members. The collaboration is fortified through regular communication between supervisory staff from the agency and affiliated programs.

The mother receives assistance in coordinating and integrating the flow of information regarding problems and progress for herself and her children from the counselor and Prevention Specialist. They also support and assist the mother in addressing any special issues involving community-based service providers. A complete description of the linkages with community providers of services and supports appears earlier (Formulation of intervention plan: Linkages with mental health, substance abuse, and other services and supports, page 48) in this manual.

Intended and anticipated outcomes due to the intervention

Several main outcomes of the interventions are anticipated. The goals are discussed in detail in the previous section, Goals of the Prevention Intervention (page 24), and are listed here in outline form.

1. Reunification of the family (including both child development and improved parenting)
2. Maintaining employment
3. Sustaining permanent housing
4. Affiliation with a supportive community
5. Establishing lifestyle change for integration with mainstream society

Confidentiality of records and protection of participants

Gaudenzia maintains confidentiality protocols for all client records and other client information according to the guidelines of local, State, and Federal oversight agencies. Records are maintained in locked files. Gaudenzia staff receive training in protection of client rights, including confidentiality of client information, and follow accepted agency procedure when receiving requests for client information. The agency procedure includes obtaining client's written consent before any client information is released.

The CTCR project staff have been trained on communication procedures, written and verbal, that protect an individual’s right to confidentiality; these procedures have been used successfully in other projects of the investigative team. All requests by project staff to observe and/or participate in program elements were made with advance notification, enabling program staff to meet privately with clients and obtain their consent. Client statements and case study information that appear in this manual were obtained with full written consent of the participants, using an informed consent form approved by the Joint Institutional Review Board (JIRB) of NDRI as meeting the standard of compliance with established guidelines governing the protection of human subjects and confidentiality.

Follow-up activities

With clients/participants

As the mother prepares to move into her own apartment in the community, she constructs an aftercare plan of activities designed to support recovery and homelessness prevention. This aftercare plan includes participation in individual and group counseling at an outpatient clinic to address the interrelated issues of preventing
relapse to substance abuse, and all aspects of homelessness prevention (work, home, family, etc.). Individual need determines the frequency of individual counseling sessions, as well as the nature and frequency of the counseling groups to be attended by the mother, child(ren), and family. Ongoing communication and special case conference sessions occur between the outpatient/aftercare counselor and the transitional counselor to insure coordination and consistency in follow-up activities and interventions for each family.

Follow-up activities begin as the mother moves into her own apartment in the community, an event which signals that she has entered the final stage of her participation in the program. As described above, participants maintain a daily Self-Management Checklist which serves as a self-monitoring form to highlight all the homelessness prevention activities she must attend to each day and to record the extent to which she completes those activities. The 17 item checklist includes items related to her family (child attends school), work, care of her home (food shopping), maintaining scheduled appointments (including 12-step meetings), contact with peers, and awareness of triggers to relapse. The Self-Management Checklist is reviewed at a weekly Re-Entry Group, a format which provides the opportunity for staff and peer feedback and intervention. A transitional counselor visits each mother at her apartment to provide case assistance, to monitor the family’s progress, and to address any problems. Visits occur bi-weekly for the first three months of apartment living, and then occur monthly for the next several months. The frequency of visits is determined by the family need, and can be increased at any point in time. Mothers in the transitional phase have a group meeting with the transitional counselor on a monthly basis at the residential site to review issues and problems that are common to all. This meeting also serves to reinforce the links to the peer community.

The Re-Entry Group, family case assistance, and transitional housing group provide an intensity of follow-up activities designed to support housing stabilization, family preservation, sustained employment/education, and to reinforce the extension of the peer support network into the community. These follow-up efforts are considered crucial to stabilization of the family in the community and to homelessness prevention, and are provided with gradually diminishing intensity as the mother demonstrates consistency in all self-management functions and in use of the peer support network. The follow-up schedule is flexible to accommodate brief, situational crises in the family.

Mothers reach formal “graduate” status (Stage 5) when they have lived successfully in the community, and maintained abstinence from drugs/alcohol, for one year. Typically, there is little need for case assistance or transitional counselor follow-up during the period from six to twelve months after community entry, but continued follow-up is maintained by the outpatient counselor. The peer community provides ongoing support for mother and family and assists the mother in requesting extra supports from counseling staff if signals of impending family crises are noted. In this fashion, the mutual self-help approach provides an extra layer of long-term follow-up for all participant families. In addition, if the mother and/or family should enter a period of serious crisis, the former Transitional Counselor and supervisory/counseling staff from the residential program can be marshaled to provide more intensive supports until the family re-stabilizes.

Assessment of the intervention (feedback loop/need for program modification)

The TC for homelessness prevention places emphasis on openness, self-disclosure, and mutual self-help as a backdrop for the interventions, and the peer community as the vehicle and guiding force for personal and programmatic feedback. The “community” consists of all residents and staff, and clear, immediate feedback is encouraged among all participants in this community. Thus, the program model itself promotes the concept of client-centered feedback loops for ongoing internal evaluation of the interventions and suggestions for change. Suggestions for program modifications or new interventions are generated by members of the peer/staff community, as well as at the level of program and corporate operations. All program modifications are discussed with the community before implementation, allowing ample opportunity for explanation, dis-
cussion and incorporation of community suggestions into the final version of any new or modified intervention. The process of implementation itself incorporates ongoing assessment from the peer community with resultant modification, as needed. This peer community feedback loop is essential to building a feeling of community within the program and to sustaining genuine “community” in program operations.

**Development of the manual: feedback loops**

In keeping with the program philosophy, program participants and staff were included in all aspects of the development of this manual. Members of the investigative team conducted an introductory meeting with staff and clients to present the purpose and process of manual development, to answer questions and address issues raised by the participants, and to establish a core connection between project staff and the participants. A thorough understanding of the homelessness prevention interventions was developed through a process of direct observation of program activities and follow-up discussions with participants and staff. This methodology entailed frequent visits to each program site by members of the investigative team. During each contact with participants, the purpose and process was discussed to insure that participants understood and felt comfortable with the presence of the project team, and felt empowered to have direct input into the articulation of their program. The clients and staff, in turn, made the investigative team feel welcome in the community.

The project team uses program immersion and active collaboration with agency staff and clients in order to develop a complete understanding of all program elements prior to documentation within the manual. The steps followed in this process provide a mechanism for an ongoing feedback loop between the team and agency, and include:

1. Review of agency resource material;
2. Conducting formal and informal contacts with residents and staff;
3. Observing or participating in program elements and activities;
4. Implementing a strategic planning process for review and refinement of program elements;
5. Providing training and technical assistance regarding program refinement; and
6. Reviewing, discussing and revising drafts of the manual with a collaborative work-group of agency staff and residents.

As part of the feedback loop, the team provided program administrators and staff with brief quality control information regarding fidelity of intervention implementation to articulation in the operations manuals. In addition, findings reported in the professional literature and prior evaluations in similar settings by the research team were discussed with staff and clients during the development of the manual. These discussions stimulated refinement of some program elements during the course of manual development. Finally, drafts of the manual were circulated to staff and clients for review; recommended modifications to content and format were discussed in meetings conducted between project team members, clients and staff. The recommendations were incorporated into the final manual. Multiple copies of the manual will be available at each program site for use by the staff and clients.

**Evaluation of the intervention: feedback loops**

The investigative team has developed a methodology for field demonstration studies that insures ongoing feedback for program staff and participants. That methodology uses the Strategic Program Planning Group (discussed in greater depth in the section on Agency & Community Context for the Intervention: How to integrate with the service agency, page 17) as a vehicle for feedback. As a feedback mechanism the methodology will provide information on the following:

1. Discussion of fidelity of the observed program to the program model;
2. Discussion of client profiles and implications for programming;
3. Discussion of first findings dealing with program retention and client change in program.
In addition, any initial aggregate findings related to critical client variables (e.g., engagement in high risk behaviors), is discussed so as to inform program refinement.

Long term client contact

**The First Year.** During the first year of residence in a community-based apartment, the mother and family maintain contact and are monitored according to the aftercare plan developed by the client and program staff. This plan is assessed regularly, and is changed to reflect goal attainment and emerging client need, but the aftercare plan retains the function of providing a guide to the intensity, frequency and duration of formal staff follow-up activities. During this first year, if the mother begins to miss regularly scheduled contacts with staff, counselor staff will initiate contact, and arrange a home visit with the mother to insure that the family is receiving all needed supports. If phone contact cannot be made within a reasonable period of time, staff will make an unannounced visit to the home to insure that the family is safe and not in crisis.

**Beyond the First Year.** Continued contact beyond the first year is maintained, as noted above, by the individual aftercare counselor, if indicated by need, and by the peer community. The peer community, as noted above, operates as a “safety net” for the mothers and children. The peer support network, and its extension into the community, become the extended family for each mother, and function as the life-long contact point for support and guidance. The peer group, having a shared background and experiences, easily recognizes the signs and symptoms of individual and family destabilization and can help to guide the family toward needed assistance.

**Ongoing Fellowship/Joining the Staff.** The TC homelessness prevention programs, and Gaudenzia as a whole, maintain contact with former clients through a variety of formal and informal mechanisms. The TC for homelessness prevention places emphasis on the extension of the peer community to a larger fellowship of recovering individuals (including the Gaudenzia alumni association) with shared values of societal integration, family unity, and mutual self-help. Many program participants aspire to apply their learning and experiences to help others by developing a career in the helping professions. As part of the program’s mutual self-help philosophy and practice, Gaudenzia encourages graduates to continue their education and training and to join the staff as employees. These staff members function as role models for current program participants and can also serve as pivots for continued contact with members of former program “classes.”

**Graduation/Reunions.** One of the most effective mechanisms through which Gaudenzia maintains long-term client contact promotes the ideal of community/fellowship by inviting graduates to participate in program-wide and agency-wide social/educational events and special celebrations, and to remain active in the alumni association. The main ceremony is the annual “Graduation,” which confers graduate status on current program participants who have qualified, as well as honoring all past graduates and providing special recognition for those who have reached a major anniversary (e.g., 5-year and 10-year pins). These activities maintain an agency-wide focus on long-term client contact and provide a vehicle for each individual to renew connections to the agency and the peer network.
I was living in W. Philadelphia with my father. I had just come out of a program, and everything went downhill from there. I was using heavier than ever. I was using for 11 years. I was in a 28-day program and I came out and went to my father's house and I started using again. I would leave the house and return days later, just to sleep it off. Then I would leave again and go get high. My children were living there too, and my stepmother and father took care of them. I was homeless for months. I made myself homeless. I lived in the park in a box. I thought it was great. I had no responsibility.

I have three children. I have two daughters—16 and 13, and one son—11. The 11 year old and the 13 year old are living with me in my apartment. The 16 year old has her own problems with drugs and she is "out there." They weren't with me before I came to Gaudenzia. First they were living with my father, but he died two years ago. I kept on coming and going when they were living with my father. And then they went to live with their father for over a year before I came to Gaudenzia. It really wasn't the best setting for them. I really missed them, but I wasn't in touch with those feelings at that time.

I never stayed with them for any length of time. The two younger children moved into Gaudenzia with me. My oldest daughter stayed with her father.

I came into the program because of my children. I got tired of taking them from place to place. I wanted to get them a stable environment. The children needed me to go into a program, but they didn't want us to be separated. The children said "Please don't leave us anymore." I wanted to keep my children with me so they could get help too. The first day we were interviewed, they wanted to stay. We had to go and get their belongings and they didn't want to leave the building. They made me promise we would come back and I would go into the program.

Being able to keep my children with me so they could get help too. My daughter resents me because she took care of mom so long. I wasn't really there for them. The children's prevention program helped the kids to be able to talk to me. They learned how to express their feelings more. They learned to understand that it was addiction that caused me to behave the way I did—it wasn't me. It helped our relationship.

The parenting classes and the parents group helped me to understand a lot about my children, and what they were going through. My younger daughter gets sick a lot, and I got to detect all her illnesses here and to get them treated. The encounter group helped a lot too...learning to express my feelings...and listen to other people. And Stage 3, Live-In Re-Entry, was a big help. I was in school and then I got a job and started working. And I kept up with everything else, and learned how to do that...my job, and the groups, and the kids, and their laundry.

Ms. Sandy, the Program Director, helped me a lot. She brought things to my attention...I learned a lot from her. I didn't understand a lot of things about me, but she helped me to see things I never saw about myself. Other people did too...I got a lot from them.
Is being a graduate a big difference from being in the program? The peer group helped a lot . . . they still do. Growing up, I never felt I fit in . . . with my family or anyplace. When I got to New Image and was with people who were doing the same thing I was doing, and who had the same problems I had, I began to feel better. And I learned something in this program—my input means something. What I had to say was important. I never felt like that before. Then, when I moved to the community, I was so scared. I knew I had to get my children to school and go to work. I was terrified. I felt I was going to let myself down. I spoke with the other women constantly. I called my re-entry sisters all the time . . . and I still do. [Jane is in the community four months, at the time of this interview.] We make meals together, go to dances together . . . They’re very important to me. They keep my spirits up. We went through so much together. I always get so much from them.

Can you identify any parts of the program that have helped to prevent you from becoming homeless again? Stage 3 (Live-In Re-Entry) was very important—and the focus on schooling, then working. The program prepared me to move, to get everything I needed for the apartment. My re-entry sisters helped me, reassured me, and gave me lots of support. Things go wrong, but I don’t get overwhelmed. I can talk to people and work things out . . . I realized that my problems were caused by my overall behaviors, attitudes and feelings. Before, “picking up” was my way out. Now I deal with things.

What kind of life would you like your children to have? I was terrified. There was so much responsibility. I went to work and had to get my children to school. I had never done this on my own before. I was afraid I was going to let myself down.

How do you feel now about yourself? Do you have any plans for the future? What do you think your life will be like? The whole program. Having my re-entry sisters to call and to do things with. I felt that I didn’t belong anywhere, now I feel I have something to contribute. I kept my children with me and I helped them too. My children once told me that they used to sit in the bedroom, in the dark, and watch me sleep—just so they could be near me, during the years I was coming and going and never home for them. They can talk to me about that now. We can talk about it. I can talk to people and get along better with them. I used to pick up instead of dealing with things and now I can work on finding solutions to problems and situations. And I have my own apartment for myself and my children. I’m managing my money even though it’s hard. I feel so good putting my own key in my door!

Are you working now? If not, are you planning to work? What are your plans? I was working until two weeks ago, but my boss wouldn’t give me time off to attend my graduation. That was very important to me, so I gave up my job. I’m not overwhelmed. I’m going back to school to complete my GED. I want to work at Gaudenzia. I want to help other women like me.

How do you feel now about yourself? Do you have any plans for the future? What do you think your life will be like? I was shocked when I realized that I made it through a year clean and sober. I just graduated a few weeks ago. Being a graduate isn’t different—it’s one day at a time. But I’m proud of being a graduate.

What kind of life would you like your children to have? There are a lot of struggles in my life, but I know I can make it. I have supports in my life now—from my re-entry sisters, my home group, my outpatient counselor, my baby sister . . . I want to stay clean and sober. I want to live in a house and have a good job . . . I want a job helping people like I got help. I want to remain open.

I would like them not to become addicts. My son likes to play sports—I hope he’ll have a career in sports, because that’s what he wants. My daughter wants to be a lawyer or a pediatrician. I hope they will prosper.
My husband had left me. My daughter went to the hospital with very bad asthma and my husband told them I was using and they took the children [3 girls] away and gave him custody. My apartment was like a crack house, all the pushers were there and everyone was using; it smelled of urine. I stayed out on the street, just walking. I felt helpless. I thought about killing myself. I didn't want to go back to that house. I had nowhere to go. I had no one. My sister let me stay with her, but she said it was just for a few days and I had to find my own apartment.

I had been doing drugs for 20 years (since I was 15). In the end, I was using crack/cocaine and alcohol. I had been in other programs; nothing worked. My husband was using too. He used to hit me and beat me. He hasn't seen the kids for years. He doesn't send any support money. I take care of the kids by myself.

I have three daughters, 15, 10, and 7 [now]. The middle one was very sick, but I didn't realize it until it was nearly too late. I finally took her to the hospital – and then they took the girls away and gave them to their father. I would see them, because he lived only two blocks away. They didn't look right. They didn't look happy, but they didn't let me know what was happening. I just knew they were catching hell from their dad. Once I got to Gaudenzia, I sued for custody and I won. The girls had revealed that they were getting beaten by him . . . The two youngest ones came into the program with me and my oldest daughter went to live with my parents in the South, until I finished the residential program. Then she moved into the Transitional apartment with us.

I was just down so far . . . I wanted me back. I knew I wanted my girls back. They saw me on my runs, and that hurt me too bad. I wanted my girls . . . and I didn't want to go on like this. I went to detox, but I needed more. But I would call places and they would tell me there was a wait list, or I had to wait three days for an intake, and I would say "My welfare check comes tomorrow and you know what I'm going to do with it—I'm going to pick up." But no one responded. Then I got this call from Senator Roxanne Jones and when I told her how I had to wait everywhere -- and I didn't even know how to get to these places--she sent her chauffeur to bring me to her office and she called Gaudenzia and I moved in right away. She came to visit me at New Image. I never found out how she got my name and phone number. It felt like a miracle.

Explain where you were before you came to Gaudenzia.

What was happening with your children?

Why did you come into the program? What was important to you about the program?
The parenting classes and parents group were key for me. I had lots of anger issues, especially with my middle daughter (she looks like her dad). They didn’t deserve any of that anger. I needed to learn a lot about kids, and about my kids. And all the children’s components were so important! They do a lot for the children. People don’t know that the children suffer so much. They need a lot of help, like the moms. The job skills were very important too.

The Transitional Living program really helped me. I was on my own for the first time in my life. I had no confidence in being able to take care of the kids. I went to therapy at the Gaudenzia aftercare program, and I went to [fellowship] meetings and had a sponsor, and I went to Re-Entry Group every week back at New Image. I also went back to be a mentor, to help the other women getting ready to leave and to let them know there’s hope. All those activities were very important. I felt good about myself.

The whole peer group was very important, but I became very close with two women who went through the program with me, and we’re still in constant contact. Before Gaudenzia, I didn’t have any female friends – I didn’t trust them. I still talk to my former counselor and the former director from the program, we always keep in touch. And my sponsor is someone who used to work in the program too. The staff are very special. They really care.

I began working as a part-time receptionist for the Executive Offices while I was going back to school and living in a Transitional apartment [1993]. I went back to college to take a refresher course in computer skills. I completed the course with a 4.0 average. I studied with my kids – I studied and they did. They watched me grow. Now I’m the Purchasing Assistant in the Finance Department at Gaudenzia. I’m the best in my field.

I feel wonderful about my achievements. I’m glad that my kids watched me grow. My kids respect me. They even tell me “I’m proud of you.” My parents are proud of me. I was just appointed to the Office of Mental Health, Substance Abuse Services Advisory Board. I’m very active there. I’m doing RFPs and things like that. I never thought I could do anything like that. I really like it.

I want them to be successful, to complete what they start, to be the best they can be. My middle daughter has always said she wants to be a pediatrician. I hope she achieves that. I want to be an example for them.
How to refine and implement program elements

- work within the guidelines of agency and system
- involve stakeholders in the project
- use a strategic program planning approach and involve all key staff in program planning and refinement
- employ active training and technical assistance during the refinement and implementation of new elements
- review program fidelity periodically
- develop ownership and a firm collaborative relationship among service, training, and evaluation staff.

How to write a Manual

- review of agency and other resource material
- interviews and informal contacts with residents and staff
- participant/observer of program elements and activities
- implementation of Strategic Program Planning process for review and refinement of program elements
- providing active training and technical assistance regarding program refinement
- instituting a collaborative work-group of agency staff and residents to review, discuss and revise manual drafts.

Principles of Good Practice

This section identifies the lessons learned and recommendations from this project in the form of principles of good practice. Included are the issues of the applicability of the homelessness prevention TC in non-TC environments. The principles identified would be appropriate to a variety of settings.

Family Preservation

- Homeless substance abusing mothers regard family unity as a priority in the decision to address their problems. These problems are multiple; most fundamental are their substance abuse problems and their ineffectiveness as parents. Their children have many developmental, social, emotional and familial needs.
Homeless substance abusing mothers are under-educated and under-employed. They often lack positive attitudes toward work, work readiness skills and work experience. They are in need of education, training, guidance and real work opportunities.

Homeless substance-abusing women often have long histories of homelessness and of being at-risk for homelessness. They lack the skills for obtaining and for sustaining housing. Homelessness has become a lifestyle.

Homeless addicted mothers are disaffiliated. They have often worn out their welcome with friends and family. Their social network consists mainly of others in a similar predicament.

**Work**

**recommendations**

- provide work experience in-program
- teach work readiness attitudes & skills
- assist & guide clients to obtain work
- monitor work performance

**Housing Stabilization**

**recommendations**

- assist and guide women in obtaining housing
- provide “same-site” or proximal housing
- teach home management and independent living skills
- regularly monitor successful maintenance of housing in the community

**Building a Supportive Community**

**recommendations**

- apply peer self-help methods
- use the peer community as the healing agent
- build a supportive, ongoing fellowship
In summary, the overarching lesson learned from this project is to provide a comprehensive, integrated program, from residential through community-based housing, to meet the multi-dimensional needs of homeless, substance abusing women and their children. The program should provide critical homelessness prevention interventions in several related areas; namely, family preservation, work, housing stability, and building a supportive community.

Perhaps paramount is the disaffiliation of these women, compounded by homelessness as a part of a larger pattern of poverty, substance abuse and family deterioration. A successful program provides specific interventions in an integrated fashion to facilitate reintegration with mainstream society.

A related lesson is that homeless mothers in recovery will continue to require structured supports and services (at reduced intensity) into an aftercare phase; therefore, model programs should provide continuity between residential and non-residential settings, and combine supported housing with graduated levels of individual and family homelessness prevention supports. One model for such programming is the homelessness prevention TC described in this manual, which provides homelessness prevention interventions in a TC environment.
Cooperative Agreements

Manual Development and Formative Research

SAMSHA should strengthen Phase I of its cooperative agreements by combining manual development and formative research. This approach would establish both program codification and preliminary measures of program fidelity prior to initiating the evaluation phase.

Program theory and practice

SAMSHA should continue its focus on logic models to emphasize the connection between theory and practice. SAMSHA could further advance this feature by providing literature, increasing consultation and developing classification systems that place each program model in an historical, conceptual perspective.

Site visits and technical assistance

SAMSHA should continue to provide technical assistance to the development of the manual and evaluation plan. The site visit protocol could be improved by:

i) developing a list of site-specific questions and concerns by both the project and site visit teams;
ii) earlier selection and fuller participation of consultant staff; and
iii) greater standardization of the implementation of the site visit protocol.

Coordinating Centers

SAMSHA is to be commended for, and encouraged to continue, its focus on cooperative agreements in field studies. These agreements can be improved by the development of a steering committee and a coordinating center, as has already been institutionalized in current SAMSHA initiatives. These mechanisms can facilitate the development of standardized instruments, the establishment of cross-site data sets and data sharing, and the delivery of papers and products.


