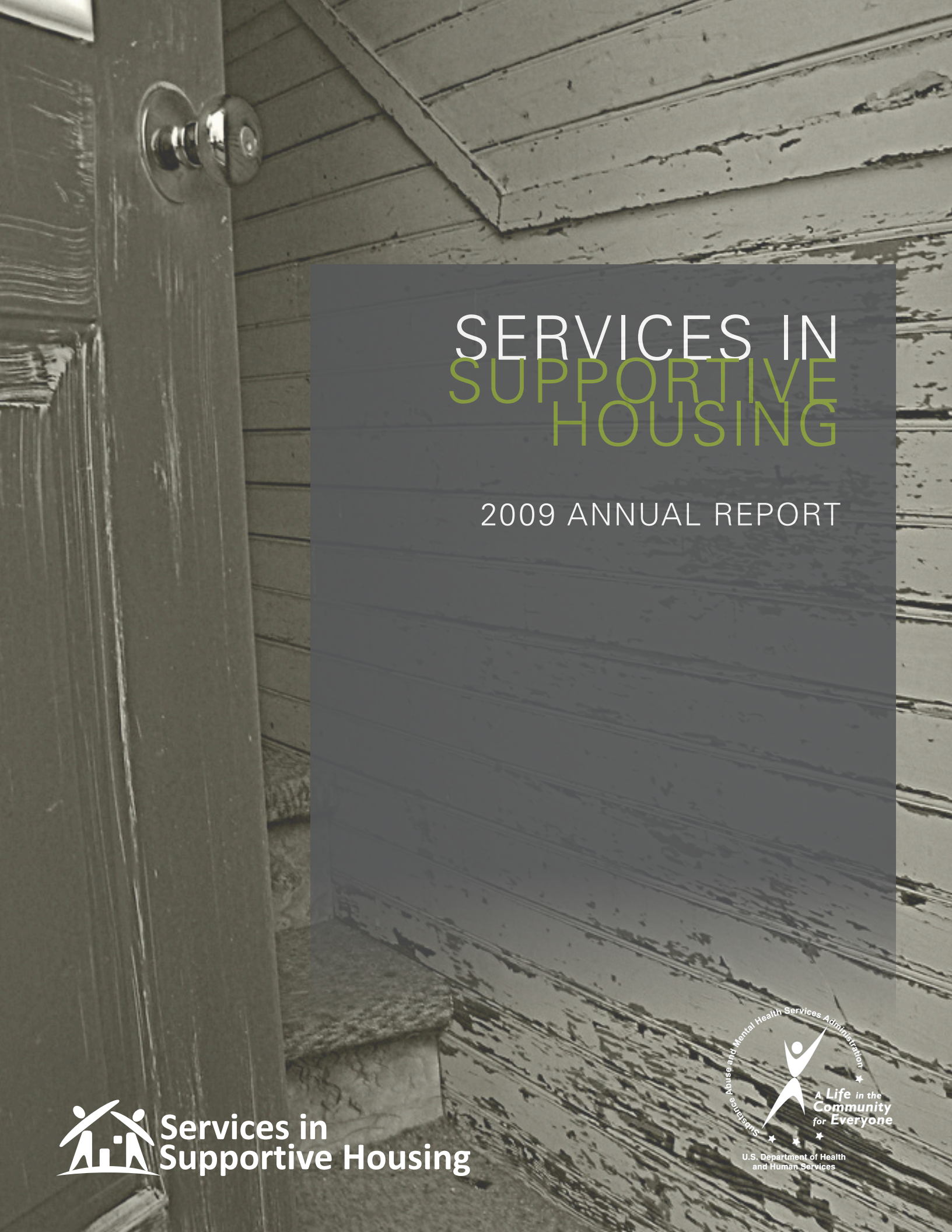

SERVICES IN SUPPORTIVE HOUSING

2009 ANNUAL REPORT

Services in Supportive Housing

Substance Abuse and Mental Health Services Administration

A Life in the Community for Everyone

U.S. Department of Health and Human Services

Acknowledgments

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Disclaimer

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Letter from Nicole Gaskin-Laniyan

It is with pleasure that I submit the Services in Supportive Housing (SSH) Annual Report. The SSH program is a response to the Substance Abuse and Mental Health Services Administration's (SAMHSA) focus on preventing or reducing chronic homelessness. The program is one of SAMHSA's services grant programs, designed to address gaps in substance abuse and mental health services. The Center for Mental Health Services (CMHS) within SAMHSA administers this discretionary grant program. This report describes SSH program outcomes from October 1, 2008 to September 30, 2009 and indicates successful implementation of the program.

The vision of SAMHSA is clear—a life in the community for everyone. "Everyone" includes people like "Linda." When SSH staff first met Linda, she lived in a park, drinking rubbing alcohol and drifting in and out of consciousness. Alcoholism and diabetes severely compromised her health, leading to skyrocketing sugar levels. Admitted to the emergency room twenty-eight times in just six months, staff visited her both there and in the park. Through their efforts, Linda agreed to six months of inpatient treatment then moved into a CMHS-supported SSH program. An American Indian, she now proudly displays the burned wood artwork that is part of her cultural heritage. Sober for almost nine months, Linda enjoys her housing and works productively with her SSH case manager.

The work of SSH grantees to date supports the evidence that permanent supportive housing improves outcomes for people experiencing homelessness, such as Linda, with mental illness and co-occurring disorders (COD). Consumers and grantees also must address the various challenges they encounter. The SSH program looks forward to supporting grantees as they continue to identify and implement solutions to prevent and reduce chronic homelessness.

Sincerely,

LCDR Nicole Gaskin-Laniyan, Ph.D.

Program Director, Services in Supportive Housing

Executive Summary

The Services in Supportive Housing (SSH) Annual Report describes the program and its activities through the end of September 2009. **The objective of the SSH program is to increase housing stability and level of functioning for consumers.** This report provides important preliminary data on effective methods for preventing or reducing chronic homelessness.

Services in Supportive Housing grantees served 1,076 consumers from October 2007 through September 2009. At the end of its second year of operation, SSH program outcomes indicate that providing services to people in permanent housing is an effective strategy for preventing and reducing chronic homelessness. Although the data reflect a limited time period, the promising preliminary outcomes show that a high percentage of consumers:

- remain in housing;
- receive services and supports that mitigate the need for psychiatric inpatient hospitalization; and
- are able to deal effectively with everyday day life circumstances.

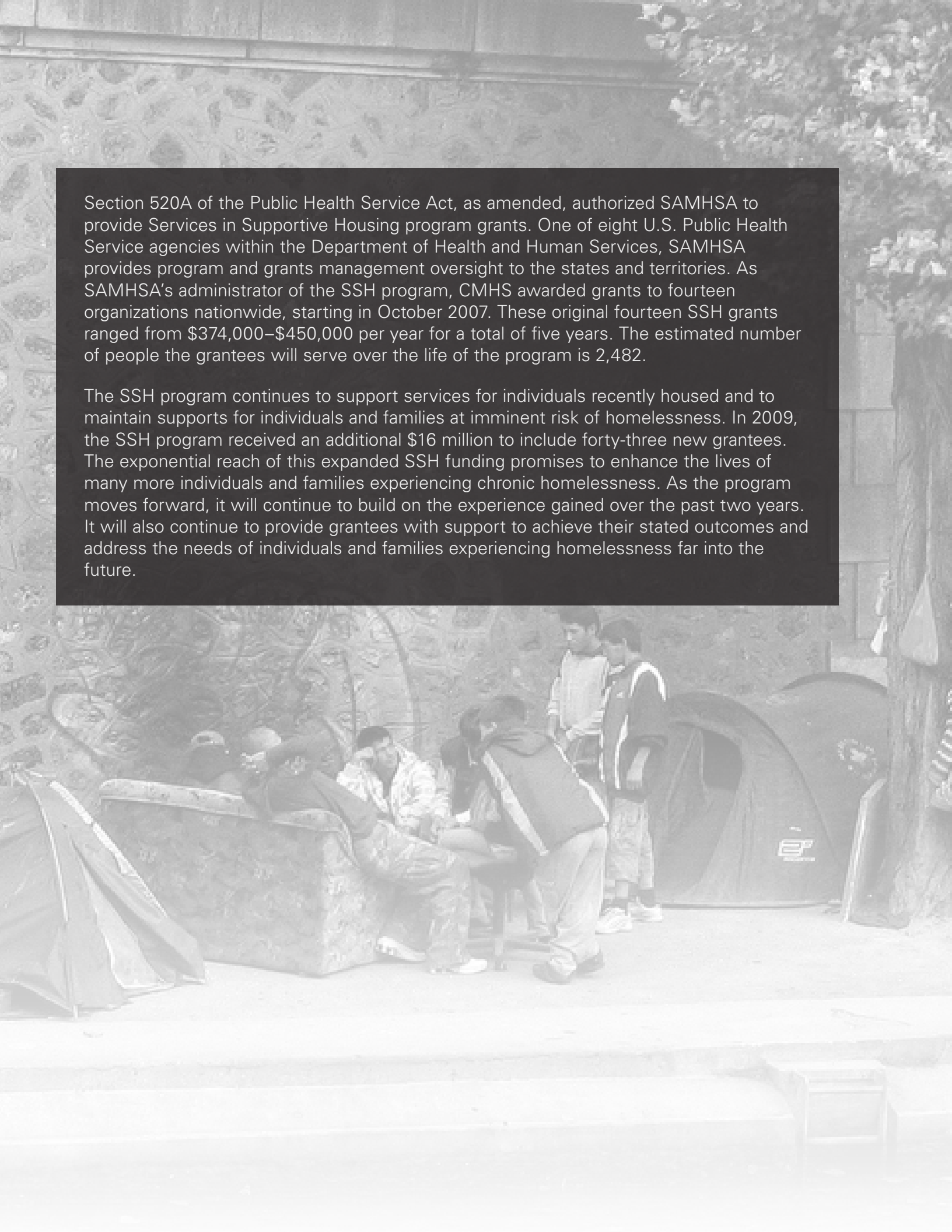
Nine organizations received SSH grants starting October 1, 2007 and five organizations starting May 1, 2008. All of the programs report implementing at least one evidence-based practice (EBP), with nine of the fourteen programs using either Assertive Community Treatment (ACT) or Intensive Case Management (ICM). The preliminary outcomes to date indicate that SAMHSA's requirement that SSH grantees use evidence-base practices is an effective strategy that merits incorporating into future initiatives.

Grantees vary in size, capacity and experience in delivering services in supportive housing. This diversity resulted in a number of challenges for the program overall, but it also resulted in innovations and technologies to share with the field and new SSH grantees. Innovations include tenant councils participating in the interview process of incoming consumers, screening consumers for trauma during the program intake process, and developing culturally competent practices.

Challenges remain. To prevent and reduce chronic homelessness, SSH grantees must continue to develop knowledge of the practices, interventions, staffing configurations, and service intensities that best suit various subpopulations. These groups include families experiencing domestic violence, adult single women, Appalachians, veterans, and Native Alaskans. Technical assistance is available and provided to grantees to address these challenges. The SSH initiative is a five year program with encouraging data to date. It is important to note that further review of outcomes during the three remaining years will yield important information regarding the durability of outcomes.

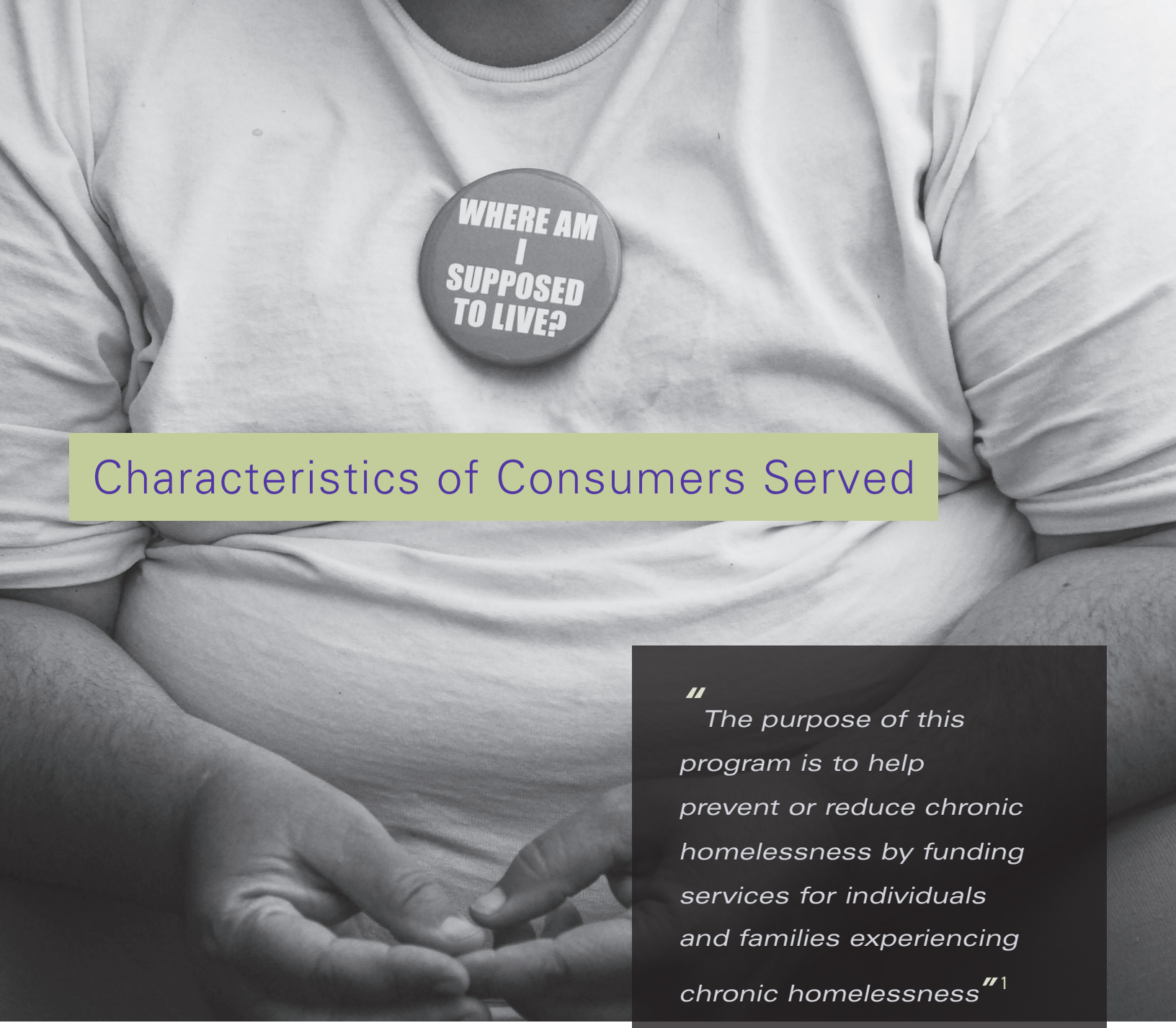
Program History

Secretary Mel Martinez of the U.S. Department of Housing and Urban Development (HUD) first endorsed the goal of ending chronic homelessness in 2000. Beginning in fiscal year 2003, the Collaborative Initiative to Help End Chronic Homelessness (CHI) began with funding from the U.S. Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), and the Department of Veterans Affairs (VA) in coordination with the U.S. Interagency Council on Homelessness (ICH).



Section 520A of the Public Health Service Act, as amended, authorized SAMHSA to provide Services in Supportive Housing program grants. One of eight U.S. Public Health Service agencies within the Department of Health and Human Services, SAMHSA provides program and grants management oversight to the states and territories. As SAMHSA's administrator of the SSH program, CMHS awarded grants to fourteen organizations nationwide, starting in October 2007. These original fourteen SSH grants ranged from $374,000–$450,000 per year for a total of five years. The estimated number of people the grantees will serve over the life of the program is 2,482.

The SSH program continues to support services for individuals recently housed and to maintain supports for individuals and families at imminent risk of homelessness. In 2009, the SSH program received an additional $16 million to include forty-three new grantees. The exponential reach of this expanded SSH funding promises to enhance the lives of many more individuals and families experiencing chronic homelessness. As the program moves forward, it will continue to build on the experience gained over the past two years. It will also continue to provide grantees with support to achieve their stated outcomes and address the needs of individuals and families experiencing homelessness far into the future.



Characteristics of Consumers Served

"The purpose of this program is to help prevent or reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness"[1]

The U.S. Department of Housing and Human Services (HHS), HUD, ICH, the VA, and SAMHSA agree that chronically homeless means: "an unaccompanied homeless individual with a disabling condition who has either a) been continuously homeless for a year or more OR b) has had at least four episodes of homelessness in the past three years."[2] SAMHSA defines a homeless family as "one or more adults, at least one of whom has a serious mental illness or co-occurring disorder, who are caring for their dependent children, and who have been continuously homeless for six months, have had two or more episodes of homelessness in the past two years or have a history of residential instability (i.e., five or more moves over the past two years)."[3]

The 1999 study, "Homelessness: Programs and the People They Serve," estimates that approximately 2.3 to 3.5 million Americans experience homelessness at least once a year.[4] Those working in the field of homelessness divide people experiencing homelessness into three groups: single adults (a subset of whom are referred to as "chronically homeless"); unaccompanied youth; and families with children. In 2007, the National Symposium on Homelessness Research reported that approximately 20 percent of sheltered homeless adults qualify as chronically homeless.[5] The study was likely an underestimate because it did not capture the street population that may not access services. Additionally, those who work in the field of homelessness widely accept that approximately 150,000–200,000 people meet the chronically homeless definition.[6]

In its 2007 Annual Homeless Assessment Report (AHAR) to Congress, HUD stated that the size of the homeless population in the US remained virtually unchanged over the course of the past decade.[7] In 2008, AHAR reported a 9 percent increase in the number of families experiencing homelessness, with the rest of the population remaining stable.[8] These trends reinforce the need for continuing to develop innovative solutions.

Within the fourteen CMHS-funded SSH grantees, lifetime experience of homelessness was sometimes far longer than two years. Resource, Inc. Spectrum Community Mental Health in Minneapolis, MN reported an average of eleven years of lifetime homelessness among SSH consumers.

1 Request for Application, Substance Abuse and Mental Health Services Administration, 2007.

2 Strategic Action Plan on Homelessness, 2007; SAMHSA, Treatment for Homeless Supplement, 2006.

3 Request for Application, Substance Abuse and Mental Health Services Administration, 2007.

4 Burt, M.R., Aron, L.Y., Douglas, T., Valente, J., Edgar, L., Britta, I. (1999). Homelessness: Programs and the People They Serve: Summary Report-Findings of the National Survey of Homeless Assistance Providers and Clients. Washington, DC: The Urban Institute.

5 Office of the Assistant Secretary for Planning and Evaluation, 2007.

6 National Alliance to End Homelessness, Fact Checker: Accurate Statistics on Homelessness, 2007.

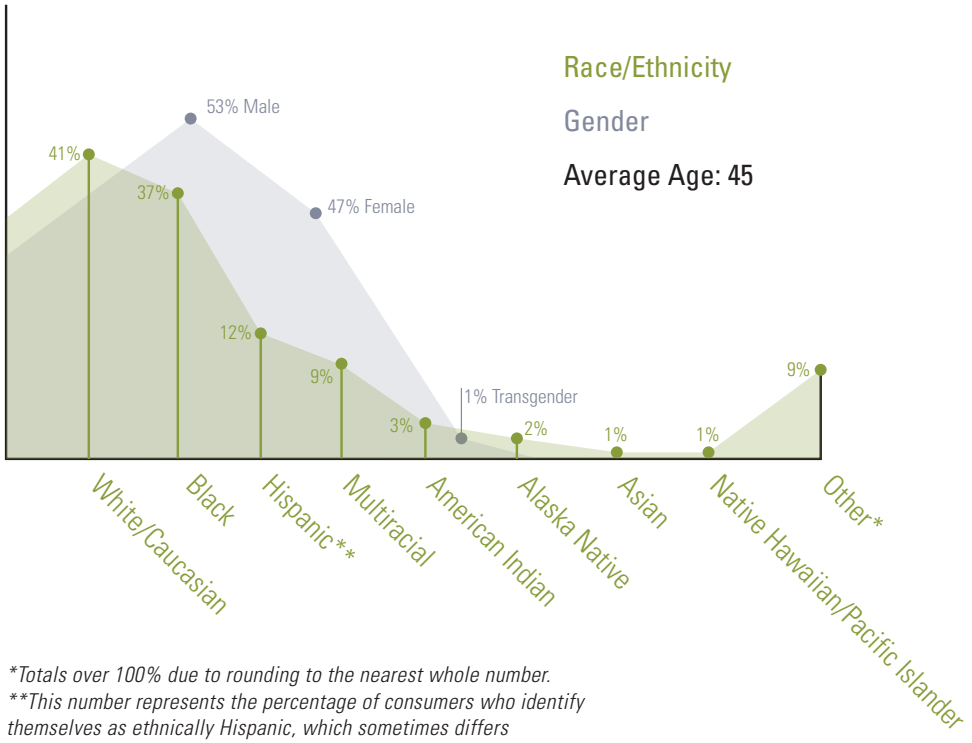
7 Annual Homeless Assessment Report to Congress, HUD, 2007.

8 Annual Homeless Assessment Report to Congress, HUD, 2008.

Consumers experiencing chronic homelessness often face a myriad of challenges including: economic instability; housing instability; substance abuse; mental health symptom relapse; and longstanding relationships involving dysfunctional, dangerous, and drug-using social networks [9]. Virtually all persons experiencing chronic homelessness have a disability. Many have a serious mental illness such as schizophrenia, alcohol and drug addiction, and/or a chronic physical illness. Most individuals who experience chronic homelessness also spent time in treatment programs, sometimes more than a dozen times [10]

Exhibit I: SSH Grantee Consumer Demographics describes grantee consumers, based on 926 consumers as of September 9, 2009. Consumers are typically approximately forty-five years old. Just over half are male and 1 percent are transgender. Just over 40 percent are White; 37 percent are Black; and approximately 12 percent are Hispanic. The remaining consumers identified as Multiracial, American Indian, Alaska Native, Asian, Native Hawaiian/Pacific Islander, or "other." There is a greater number of women among SSH consumers compared to other reports of chronically homeless populations.

Exhibit I: SSH Grantee Consumer Demographics



**Totals over 100% due to rounding to the nearest whole number.*
***This number represents the percentage of consumers who identify themselves as ethnically Hispanic, which sometimes differs from their identification race.*

[9] SSH grantee applications, 2007.

[10] National Alliance to End Homelessness, Chronic Homelessness Brief, March 2007; Burt, M., et al., Helping America's Homeless. Washington, DC: Urban Institute Press, 2001.

Outcomes

Multiple measures assess client outcomes across the fourteen grantee sites. The SAMHSA Transformation Accountability (TRAC) system tracks progress according to several National Outcome Measures (NOMs). This section summarizes selected NOMs across all grantees since the grants began in 2007. Every grantee showed improvement for each of the NOMs. These preliminary data indicate significant accomplishments.

How Are Cases Chosen for NOMs Assessment?

Cases are valid for TRAC when they include a baseline interview and a six-month reassessment. This reassessment interview must occur within thirty calendar days of its due date. Based on these criteria, the number of valid cases for each of the fourteen grantees ranged from 2 to 142. The NOMs reported here represent just over half (53.5 percent) of the total number of 926 consumers interviewed at baseline. Valid cases for individual NOMs vary depending on the number of valid responses.

Number of Consumers Served

The fourteen SSH grantees served a total of 1,076 consumers from October 1, 2007 through September 30, 2009. About 86 percent of consumers served are in housing. The remaining 14 percent received services while in the process of transitioning from homelessness (i.e., entering housing, or receiving in-patient psychiatric or substance use treatment). Nearly all the grantees exceeded the number of unduplicated consumers they expected to serve during this reporting period. This accomplishment illustrates the effectiveness of the grantees' project implementation strategies.

Rate of Change

(see Exhibit II: Consumer Improvement at Six-Month Follow-Up)

The rate of change represents the difference in the percentage of consumers with a positive outcome at baseline and at the first reassessment interview. Although all data elements showed a positive rate of change, several warrant additional discussion.

Stability in housing: Just over three-fifths (61.6 percent) of consumers had a permanent place to live in the community at the baseline interview. This percentage increased to 88.8 percent six months later at the first reassessment (a +44.1 percent rate of change).

Functioning: Half (49.6 percent) of consumers had positive perceptions of their ability to deal with everyday life when they completed the baseline interview. This number increased to two-thirds (65.5 percent) at the time of the first reassessment (a +32.0 percent rate of change).

Psychiatric hospitalization and level of involvement in criminal justice system: A baseline interview is conducted as consumers enroll in SSH that includes questions regarding the use of psychiatric inpatient hospital services in the thirty days prior to the baseline interview. Very few consumers (.2 percent) report using these services immediately prior to enrollment. Additionally, few consumers report arrest during the same period (2.4 percent). The data showing low psychiatric hospitalization mask a broader reality. Among people experiencing chronic homelessness, the rate of lifetime inpatient psychiatric hospitalization is roughly twice the rate of other low-income patients.[11] Among SSH consumers, the rate of change in use of hospital services is nominal at the time of first reassessment. However, it is noteworthy that SSH providers offer services that mitigate the need for hospitalizations once consumers enter their programs—a substantial achievement given this population's greater risks.

[11] Salit, S.A., Kuhn, E.M., Hartz, A.J., Vu, J.M., Mosso, A.L. (1998). Hospitalization Costs Associated with Homelessness in New York City. New England Journal of Medicine. 338:1734-1740.

Exhibit II: Consumer Improvement at Six-Month Follow-Up*

NOMs Data Element**	Number of Valid Cases	% Positive at Baseline	% Positive at First Reassessment	Rate of Change*
Stability in Housing: a permanent place to live in the community	357***	61.60%	88.80%	44.10%
Functioning: ability to deal with everyday life	498	49.60%	65.50%	32.00%
Education: attending school	498	8.20%	10.00%	22.00%
Employment: currently employed	495	13.10%	15.20%	15.40%
Social Connectedness: relationships with others	499	65.50%	75.80%	15.60%
Perception of Care:	499	n/a****	95.40%	n/a****
Crime and Criminal Justice: no involvement with the criminal justice system in prior 30 days	501	97.60%	98.00%	0.40%
Retention: no utilization of psychiatric inpatient hospital beds in prior 30 days	499	99.80%	100.00%	0.20%

*Rate of change calculated as follows:
Positive at First Reassessment-Positive at Baseline/Positive at Baseline.

**See Appendix I: Definition of NOMs Data Elements.

***Due to a coding error, one grantee case omitted from this outcome.

****The vast majority (95.4 percent) of consumers responded positively to a series of statements designed to measure their perception of care when they completed the first reassessment.

Services Provided

The charge of the SSH grantees is to prevent and reduce chronic homelessness. To acheive this objective, grantees employ various interventions and evidence-based practices to support consumers. Currently, there is not enough evidence to suggest that a specific intervention administered at a given level of intensity to a specific subpopulation is consistent with positive outcomes. This section describes selected grantee services, including the evidence-based practices that grantees use or plan to use over the course of the five-year funding period. Collection of the information included in this section is the result of grantee documentation, site visits, technical assistance (TA), and interviews with the fourteen grantees.

The fourteen SSH grantees respond to the complex needs of consumers with a range of services. Multidisciplinary teams or a combination of team-based and brokered services (i.e., community referrals or referrals to other programs within the larger agency) provide these services. For example, the case management model at Pine Street Inn, Boston, MA, includes a formal transition from intensive case management to less intensive support as SSH consumers stabilize in housing. The SSH program provides Intensive case management while other programs within the larger agencies provide the less intensive case management. Formalizing this case management approach allowed staff to provide customized support to consumers during the critical time when they first transition from homelessness to housing. Pine Street Inn shared their greatest accomplishments as "Seeing people coming straight from the street who have been avoiding housing and services for decades coming in and accessing services and enjoying their neighbors in housing" indicating the effectiveness of this approach.

Clinical emphasis varies across grantee programs. Some grantees hired only case managers and others hired only therapists, depending on pre-existing organizational capacity. Three SSH grantees previously received funding from the federal Collaborative Initiative to Help End Chronic Homelessness (CICH). These grantees continue to care for CICH consumers under the SSH grant, while conducting outreach to identify new consumers. Some grantees recruit consumers from internal caseloads (e.g., individuals at risk for eviction), while some focus on street outreach. Programs also vary in their capacity to address co-occurring disorders (COD). Some provide integrated care, while others coordinate services with an external agency. A few have added this capacity using grant funds (e.g., hiring recovery specialists or training staff in COD care).

Services include:

outreach and engagement; case management services; clinical services; income support; housing retention supports; development of independent living skills; supported employment; and peer support.

The previous section on Outcomes highlighted the most significant achievement of the SSH programs thus far: the ability to retain consumers in housing. While all of the SSH programs support housing retention, grantees cited several specific services as particularly helpful in stabilizing consumers in their homes. These include:

- mental health and substance use treatment (e.g., increasing access to mental health and substance use treatment, crisis intervention, and relapse prevention for untreated individuals or intermittently treated prior to housing);
- therapeutic communities (e.g., staff and peers working collectively with consumers);
- advocacy (e.g., working with landlords to address disruptive tenant behaviors and prevent eviction);
- benefits coordination (e.g., hiring benefits coordinators, training staff in Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) acquisition); and
- life skills training (e.g., hiring staff to assist consumers in learning to budget money, maintain a clean home, and how to adjust to "living indoors").

Approaches to Care

The services that SSH grantees provide vary for a number of reasons. These include the size and longevity of the grantee; amount of available resources; experience in serving the target population; ability to train staff; and experience implementing an evidence-based practice. The summaries below illustrate promising approaches to care across SSH grantees.

Mental Health and Substance Use Treatment Services

Most grantees reported that many consumers lost connections to mainstream systems and received little treatment prior to entering the program. In response, a key objective for SSH programs is to provide access to mental health and substance use services. For new consumers, all programs provide mental health and substance abuse assessment and some form of service planning, and a few conduct screening for trauma. The sites that screen for trauma reported that staff received training in trauma-informed care (TIC). Other programs plan to schedule TIC training for staff. One program conducts *Seeking Safety* groups. *Seeking Safety* is a trauma-oriented intervention that assists consumers in early recovery to address both substance use and trauma (see box on next page).[1 2]

Grantees provide access to mental health services in various ways. For example, some SSH programs use grant funds to fund mental health positions. Vocational Instruction Project Community Services, Inc. in New York City, NY hired two bilingual therapists as the main SSH staff. Other programs use therapists from within their organizations to meet this need, and some grantees partner with outside agencies for clinical services.

Grantees link consumers with psychiatric care and medication management services through strategies that fall into four categories:

1. hiring or subcontracting with a psychiatrist to provide a specified number of hours to the team;
2. hiring or subcontracting with a psychiatric nurse practitioner;
3. coordinating care with a psychiatrist from within the grantee agency; and
4. referring out to a community-based psychiatrist.

[1 2] Najavits L.M., Seeking Safety. In: Follette V., and Ruzek J.L. (eds.). Cognitive Behavioral Therapies for Trauma. New York: The Guilford Press, 2006:228-257.

The programs viewed option number three as optimal. Internal access to the psychiatrist or nurse practitioner increased collaboration between clinical and case management personnel. With this arrangement, it is also easier to verify appointments and ensure continuous care—sometimes in nontraditional settings. For example, the psychiatrist for Vocational Instruction Project Community Services, Inc., New York City, NY provides seventeen hours of care per week. Trained both in mental health and substance use disorders, this psychiatrist sees consumers in their homes or in the office. Overall, programs with in-house or within-team mental health staff report few problems coordinating mental health and case management services.

Seeking Safety: An Approach to Addressing Trauma

Project Renewal, Inc. in New York City screens all new consumers for trauma and offers a Seeking Safety group for consumers in early recovery. Over twenty-five sessions, this model helps consumers develop a sense of safety in the context of past and present trauma and substance use. Not all consumers commit to coming every week, and staff and peers accept this. If someone misses a week, the other group members update him or her. Project Renewal adapted the model to meet the needs of formerly homeless consumers, accepting fluctuations in attendance and allowing them to go through the process several times. These accommodations permit consumers to enter the treatment process when they are ready.

Consumer Involvement

The majority of SSH grantees integrate consumers in program activities. This involvement shows that grantees value the importance of the consumer perspective in program development and operation. SSH programs use a range of strategies to involve consumers including:

- hiring consumers as peer support specialists;
- hiring staff who are former consumers;
- implementing service planning processes that emphasize consumer choice and consumer-directed care, such as Wellness Recovery Action Plans (WRAP);[13]
- encouraging consumers to provide input on how to adapt evidence-based practices to meet the needs of persons with histories of long-term homelessness;
- using evidence-based practices promoting consumer involvement, as is the case at Phoenix Programs, Inc. Columbia, MO implementing the Modified Therapeutic Community model;
- developing a peer-run drop-in center; and
- implementing tenant councils and other consumer advisory bodies.

Community Connections, Inc. in Washington, DC works with consumers to develop tenant councils in each residential building. They also solicit feedback on program services through an agency-wide stakeholder group that includes consumers.

Grantees also use the peer support specialist role in various ways. Community Connections, Inc. employs former consumers with mental health and substance use histories formally trained as peer support specialists. These staff provide services, advocacy, and model positive behaviors. Other grantees use peer support specialists as group facilitators or recreational therapists. Prestera Center for Mental Health Service, Inc. in Huntington, WV is in the process of considering peer support specialists as assistants in consumer recovery planning. The peer support specialists in this program completed their own Wellness Recovery Action Plans (WRAP) and advocated for a role in helping SSH consumers through this process. Consumer involvement warrants additional focus as an area to provide assistance to SSH grantees.

[13] Mental health consumers developed the Wellness Recovery Action Plan (WRAP), a self-management and recovery system to incorporate wellness strategies into their lives. This structured system helps consumers monitor uncomfortable and distressing symptoms and modify or eliminate them with planned responses.

Socialization

A common concern among grantees is that newly housed consumers tend to feel isolated and lonely. These individuals often lose former relationships once they move off the streets. They may also feel overwhelmed with the responsibilities of paying rent and maintaining an apartment. Consumers living in housing for a while often look for opportunities to feel socially connected. Grantees responded by creating opportunities to develop new relationships and community contacts. However, this is an area that warrants additional focus as the SSH program matures and grantees learn what works.

In some programs, peer support specialists run activity groups or take consumers on recreational outings as a way to build social connectedness. Project Renewal, Inc., in New York City, NY purchased an apartment that serves as staff offices as well as a meeting place for consumers. Thirty consumers from that program now participate in socialization and skill-building activities, such as cooking, art, and women's issues groups. Because occupational therapy students facilitate these groups, it allows the program to add resources to the team at no cost. Other programs plan to start support groups to enhance socialization. For example, Cook Inlet Housing Authority in Anchorage, AK and Homeless Services Network of Central Florida in Orlando, FL plan to create social support networks out of "natural groups" occurring around clusters of consumers who live close together. Staff will facilitate these natural groups as they bring consumers together for meals and discussions of interest to consumers.

Employment and Income Stabilization

About 15 percent of SSH consumers held employment six months after enrolling in the program. As an example of a successful vocational strategy, two programs created linkages to one-stop employment centers for consumers ready to find a job. While the increase in employment of consumers is positive, grantees also observed barriers to employment such as advanced age, disabilities, and chronic health conditions. For consumers who are elderly and disabled, the programs focus on helping them to achieve income stability through SSI/SSDI. A steady source of income helps consumers maintain housing and Medicaid or Medicare coverage ensures access to health care. Several grantees trained their case management staff in SSI/SSDI and Outreach, Access, and Recovery (SOAR) or hired benefits specialists to assist consumers with benefits acquisition.

Health

Chronic illnesses are very common among the consumers served in all fourteen programs. Some grantees developed integrated models of care to address these needs. These models include the following strategies: the addition of a team nurse; health screening; within-agency linkages to primary care; and strong collaborations with Health Care for the Homeless programs in the community.

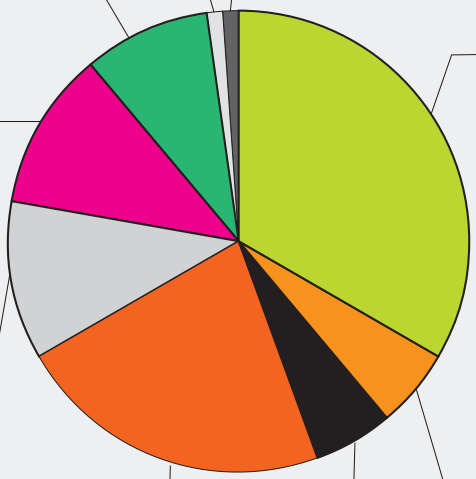
Contra Costa Health Services in Martinez, CA employs a public health nurse (with the support of the local public health department) to screen consumers and link them to a medical "home." This grantee found that health care is central to the well-being of an aging population. Sometimes this treatment includes end of life care in addition to care for chronic conditions. Homeless Services Network of Central Florida in Orlando, FL does not have a nurse on the team. However, staff complete a general health checklist with consumers to identify medical needs. Most recent results revealed diabetes, Hepatitis C, methicillin-resistant Staphylococcus aureus, sexually-transmitted diseases, and cardiac conditions as the most common diagnoses. Project Renewal, Inc., in New York City, NY has both a physician and a psychiatric nurse practitioner on staff. The physician is the medical director for two primary care clinics operating out of two different homeless shelters Project Renewal operates. This physician helps consumers gain access to the clinics and conducts rounds with the SSH program team once a week.

Services for Women and Families

Most SSH programs serve men or unaccompanied women. Resource Inc. Spectrum Community Health, in Minneapolis, MN serves only single women unaccompanied by children. The agency provides services and housing using Housing First as their evidence-based practice of choice. Southern California Alcohol and Drug Programs, in Los Angeles, CA serves families who are formerly homeless with domestic violence histories or women reuniting with their children as they enter permanent housing. Programming to meet the needs of this target population include WRAP groups, non-violent parenting, and *A Window between Worlds*, which uses art as a healing tool for domestic violence survivors.[14]

[14] Available at http://www.awbw.org/awbw/about_us.php.

Exhibit III: Evidence-based and Promising Practices used by SSH Programs



Modified Therapeutic Community
Phoenix Programs, Inc.

Housing First
Resource Inc. Spectrum Community Mental Health

Assertive Community Treatment
Homeless Services Network of Central Florida
Phoenix Programs, Inc.
St. Vincent de Paul Village

Motivational Interviewing
Central City Concern
Contra Costa Health Services
Prestera Center for Mental Health Services, Inc.
Project Renewal
Southern California Alcohol and Drug program, Inc.
St. Vincent de Paul Village
Vocational Instruction Project Community Services, Inc.

Integrated Dual Diagnosis Treatment
Central City Concern
Community Connections, Inc.
Pine Street Inn
Southern California Alcohol and Drug program, Inc.

Supported Employment
Central City Concern
Community Connections, Inc.
Contra Costa Health Services
Cook Inlet Housing Authority
Phoenix Programs, Inc.

Illness Management and Recovery
Community Connections, Inc.
Resource Inc., Spectrum Community Mental Health
Southern California Alcohol and Drug program, Inc.

Intensive Case Management
Central City Concern
Contra Costa Health Services
Pine Street Inn
River Edge Behavioral Health Center
St. Vincent de Paul Village
Vocational Instruction Project Community Services, Inc.

Wellness Recovery Action Planning
Cook Inlet Housing Authority
Prestera Center for Mental Health Services, Inc.
Southern California Alcohol and Drug program, Inc.

Evidence-Based Practices

A primary SAMHSA requirement is that SSH programs use practices known as effective with the target population. Grantees must also describe any changes or adaptations made to these practices in response to the specific needs of individuals served. The SSH grantees use a wide range of evidence-based and promising practices to address mental health, substance use and mental health/co-occurring disorders (COD), and supported employment.

All of the programs report implementing at least one evidence-based practice (EBP). All but one grantee use multidisciplinary teams. Nine of the fourteen programs report using either Assertive Community Treatment (ACT) or Intensive Case Management (ICM). The remaining sites have traditional case managers on their teams or broker case management services from a larger agency. Below are descriptions of the EBPs and promising practices grantees most commonly use. (See *Exhibit III: SSH Programs Evidence-Based Practices* for a summary of the SSH grantee practices implemented as of September 2009.)

Assertive Community Treatment/Case Management Approaches

Four grantees report that they use an ACT model. St. Vincent de Paul Village in San Diego, CA implemented the model for the first time and receives technical assistance (TA) to ensure fidelity. Another grantee, Phoenix Programs, Inc. in Columbia, MO added an ACT team component to its Modified Therapeutic Community (MTC). The ACT team provides intensive support to consumers once they are in permanent housing.

Sites with modified ACT approaches adapted the model to suit consumer needs, with some programs eliminating various components. Examples of adaptations include: seeing consumers in an office instead of in their homes, on the streets, or elsewhere in the community; not including a nurse or psychiatrist on the team; and not convening interdisciplinary team meetings. Two grantees refer to their models as Intensive Case Management (ICM) rather than ACT because of the modifications.

Substance Use and Mental Health

The SSH grantees recognize that COD is highly prevalent among individuals experiencing long-term homelessness. Programs responded with a range of strategies to assist consumers in the recovery process as they transition to permanent supportive housing. Some of these approaches are EBPs, such as MTC, Integrated Dual Disorder Treatment (IDDT), and Motivational Interviewing (MI).

Increasing COD Competence: Successful Strategies

Homeless Services Network of Central Florida in Orlando, FL uses eight strategies to increase its capacity to provide integrated mental health and substance use services:

- hired mental health and substance use specialists;
- placed Addiction Severity Index (ASI) assessment tool on staff laptops to assess all consumers for COD and to ensure that care is integrated;
- initiated regular meetings between mental health and substance abuse counselors to coordinate care and share history;
- conducted cross training/trained all staff in Motivational Enhancement Therapy;
- distributed educational materials to all staff (e.g., TIP 42; psychiatric medications manual);
- provided cross-trained clinician supervision;
- facilitated a team-building retreat; and
- shared common office space.

Four programs include IDDT as part of their services. Three programs offer IDDT through their own teams and one partnered with Health Care for the Homeless. One program, Central City Concern in Portland, OR combined IDDT and ICM to serve its consumers, the majority of whom have COD. Following an internal IDDT fidelity review, the program obtained TA to implement the IDDT fidelity scale. This TA allowed for more accurate fidelity reviews and improved documentation of services.

Aside from EBPs, grantees enhanced their capacity to address COD in the following ways: placing COD specialists on their teams; using the Co-Occurring Center for Excellence's TIPs as a framework for their interventions; and facilitating groups for consumers in early recovery. For example, Project Renewal, Inc. in New York City, NY oriented all staff to TIPS 35 and 42. While not following a specific intervention, a nurse assesses all enrollees for substance use and underlying mental health issues.

Motivational Techniques

A majority of the grantees used MI or variations such as Motivational Enhancement Therapy. Some made MI a priority intervention, investing in ongoing training and consultation. For example, Project Renewal, Inc. in New York City, NY trains its staff in MI twice per year. Two other programs, Vocational Instruction Project Community Services, Inc. in New York City and Saint Vincent de Paul Village in San Diego, CA trained their entire agencies in MI. Several grantees noted in phone interviews that the SSH funding provided them with the opportunity to extend their expertise in EBPs, such as MI, to the larger agency

Modified Therapeutic Community

Phoenix Programs Inc. in Columbia, MO is in the process of implementing the MTC approach for individuals in supportive housing. During their transition from homelessness to permanent housing, consumers live for six months in congregate housing where they begin the MTC intervention. Once they move to permanent, scattered site housing, the MTC continues on an outpatient basis with ACT team support. Program staff view their ability to successfully embed MTC in supportive housing as their greatest accomplishment to date.

Illness/Wellness Management

Multiple grantees implemented Illness Management Recovery (IMR) or Wellness Recovery Action Plans (WRAP) to engage consumers in developing goals for recovery. The primary aim of IMR is to empower consumers with mental illness (or COD) to manage their own illness and recovery. WRAP shares this concept. Three grantees either began to implement IMR or considering doing so. Additionally, three grantees implemented WRAP groups. At Vocational Instruction Project Community Services, Inc., in New York City, NY, consumers develop WRAP plans in a ten-week group. Staff report that consumers "love the classes, help each other, and put a lot of effort into it." At Prestera Center for Mental Health Services, Inc. in Huntington, WV, the case manager or peer support specialist and the consumer develop WRAP plans on an individual basis.

Other Strategies

Less commonly used in SSH are culturally specific interventions, supported employment, and trauma-specific techniques. Consumers at Cook Inlet Housing Authority in Anchorage, AK spontaneously expressed their appreciation of the SSH staff and desire for greater information and education related to their Alaska Native culture, noting that: "Program staff are very supportive . . . helps us get on our feet. If we get on our feet (housing, food, jobs, etc.) then we could (would have the energy to) learn our culture."

To address the needs of consumers actively engaging in substance use, Saint Vincent de Paul Village in San Diego, CA decided to create a group for consumers in the pre-contemplation stage.[15] In order to engage participants, staff offered food and called the group a "rap" group as opposed to a "recovery" group. Consumers come to eat dinner and discuss their daily lives. Once they begin to trust the facilitators and their peers, staff members report that they begin to open up regarding their substance use histories. Staff is not aware of any proven model for such a group, but they found this approach successful in engaging individuals who may not trust formal treatment services. Another grantee, Community Connections, Inc. in Washington, DC, developed "residential recovery communities." These communities represent an approach to recovery that is not yet an EBP, but which shows promise. Residential recovery communities add a supportive context for living in the community to address difficulties in dealing with isolation, loneliness, and destructive personal relationships. The residential recovery communities offer a place for safety, a "surrogate family", and opportunities for skill development and individual growth.

Four grantees adhere to Housing First principles, which promote low-threshold housing and consumer choice in services, while others provide various models along the housing continuum. River Edge Behavioral Health Center in Macon, GA provides a full treatment continuum for consumers experiencing mental health, substance abuse and/or co-occurring disorders prior to entry into SSH housing.

[15] Pre-contemplation is the first of five stages of change according to SAMHSA TIP 35. Consumers in this stage do not consider change and do not intend to change behaviors in the near future.

Challenges

This report highlights the significant accomplishments of the 14 SSH grantees. However, program staff and consumers also face daily challenges. Some are specific to programs or communities. Overall, grantee reported challenges fall into three categories: consumer needs; personnel/staffing; and financial issues. A summary of challenges in these areas follows.

Marc Samsom, 2008

Consumer Needs

- Some grantees currently lack the capacity to address the emerging social needs of consumers. As consumers become more stabilized in permanent housing their need for socialization grows.
- Consumer involvement remains a challenge. Many grantees express an understanding of the value of consumer involvement, but struggle to change their organizational culture to include consumers.
- Consumers sometimes have limited employment and educational opportunities. Reasons given include: prioritizing consumer needs; funding limitations; limited capacity; and age/health conditions of consumers.
- Rural and large geographical service areas pose multiple challenges, including lack of access to mainstream resources and decreased ability to include consumers in treatment/socialization groups.

Personnel/Staffing

- Recruiting and retaining qualified and committed staff is an ongoing challenge for many grantees. Homeless service agencies tend to have lower pay scales. Additionally, the complex needs of many consumers requires professional care and treatment.
- Most grantees depend on external/other systems for psychiatric services rather than hiring a psychiatrist dedicated to their team. This requires a greater ability to coordinate care.
- Many SSH staff enter the profession with little knowledge about homeless services or minimal formal training specific to the needs of the target population. In addition, the use of evidence-based clinical interventions means that additional resources and capacity necessary to train non-professional and professional staff.
- The integration of peer support specialist positions into multidisciplinary teams is an ongoing challenge.

Financial Issues

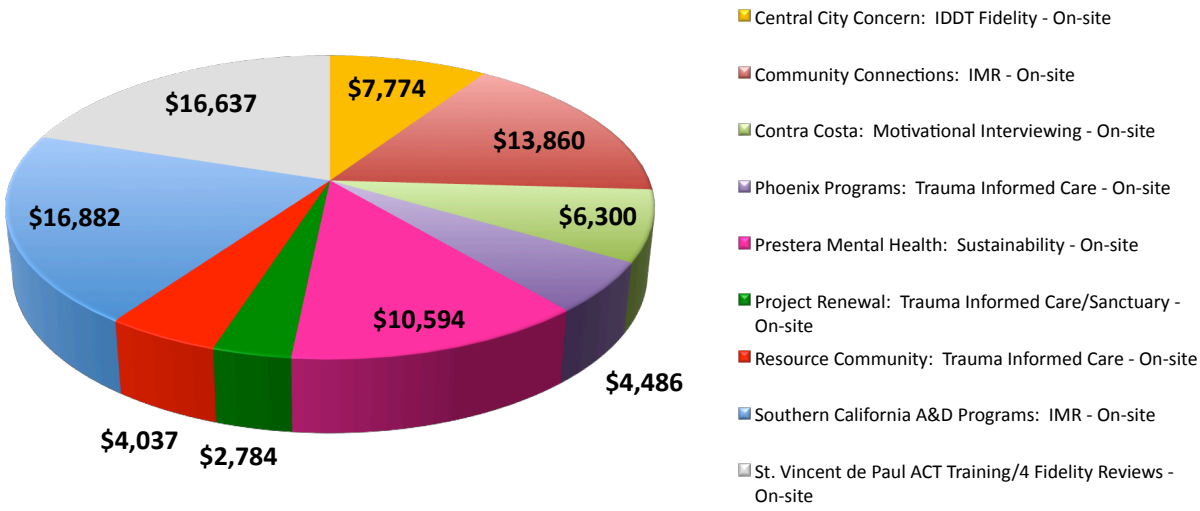
- Many grantees express concern regarding their ability to maintain the long-term viability of their programs and services.
- Hiring practices are dependent not only on consumer needs but also on limited funding, impacting the provision of services.

Technical Assistance

To assist SSH grantees in meeting their projected outcomes, the Center for Social Innovation (C4SI) offers technical assistance (TA). Technical Assistance needs range from in-depth trainings on evidence-based interventions to tips on helping consumers obtain photo identification. The C4SI assists grantees to develop and refine their TA requests and to identify appropriate solutions and resources to address their TA needs (see *Exhibit IV: On-Site Technical Assistance Provided from October 2007 through September 2009*).

Exhibit IV: On-Site Technical Assistance Provided from October 2007 through September 2009

Total Cost: $83, 354*



*TA cost varies depending on type, topic, and duration of TA request.

Satisfaction

In April 2009, as part of regular quality assurance activities, C4SI administered a TA satisfaction survey to a sample of grantees that received on-site TA. Overall, 82 percent responded either "satisfied" or "very satisfied" with the TA received. Eleven percent responded "neutral" and seven percent responded "not applicable." Zero percent responded "disappointed" or "very disappointed." Comments given included:

- "Exceptional compared to other similar services";
- "Excellent, responsive to need, and timely in delivery";
- "Staff is continually working with the information from the training"; and
- "The Homelessness Resource Center is an impressive website."

Impact

The impact of TA is often rapid and dramatic. For example, Saint Vincent de Paul Village in San Diego, CA increased fidelity to the ACT model in just six months. Overall, the team demonstrated a higher degree of implementation fidelity in 2009 when compared to their first fidelity assessment in November 2008.

After training in trauma-informed care (TIC), staff members at Resource Inc. Spectrum Community Health Service in Minneapolis, MN expressed an understanding of trauma-induced behaviors as coping mechanisms and responses to abuse. Staff also identified and applied beneficial as well as contraindicated strategies for working with trauma survivors.

Staff at Contra Costa Health Services in Martinez, CA increased their overall comfort with the language and application of Motivational Interviewing (MI) and stages of change as a result of TA. Gleaned from pre- and post-tests, typical comments from attendees in response to the training were: "I will approach and engage clients in a more confident and positive way" and "This training gave me more ideas about different ways to use MI with a client I have been struggling with." In a thirty-day follow-up TA call, this program's director reported that staff members immediately used the techniques learned.

Although it is premature to assess the long-term impact of TA, the following positive changes occurred:

- increased capacity for use of evidence-based practices;
- improved clinical assessment skills;
- increased confidence in providing services to consumers; and
- increased ability to shape the provision of services and sometimes the development of a new culture/service model throughout the entire agency.

Emerging Topics

Through working with SSH grantees, C4SI identified several emerging TA needs. A list of selected topics is below:

- trauma-informed care;
- sustainability planning;
- COD interventions specific to subpopulations among people who experience chronic homelessness; and
- social connectedness.

Appendix I: Definition of NOMs Data Elements

Five of the eight NOMs result from consumer responses to a single statement, with positive outcomes determined as follows:

- Employment (consumers currently employed full or part-time at the time of the first reassessment);
- Education (consumers enrolled in school or a job training program either full or part-time);
- Crime and Criminal Justice (consumers arrested one or more times during the prior thirty days);
- Stability in Housing (consumers living in an owned or rented home, on a military base, or in a group, nursing, or veteran's home "most of the time" during the prior thirty days); and
- Retention (consumers not living in a psychiatric hospital "most of the time" during the prior thirty days).

Three of the NOMs are mean scores from consumer responses to a series of statements, using a five-point Likert scale ranging from one "strongly disagree" to five "strongly agree." Means are the sum of valid case responses divided by the number of statements with valid responses. Only consumers responding to a minimum of two-thirds of the statements counted in the mean calculation. Means of >3.5 counted as a positive outcome for each of these three NOMs:

- Functioning (eight-item scale based on consumers perception of their ability "to deal with everyday life" during the prior thirty days);
- Social Connectedness (measures consumers responses to four statements regarding relationships with persons other than their mental health provider(s) at the time of the interview); and
- Perception of Care (at the first reassessment, consumers respond to fourteen statements designed to measure their perception of care).

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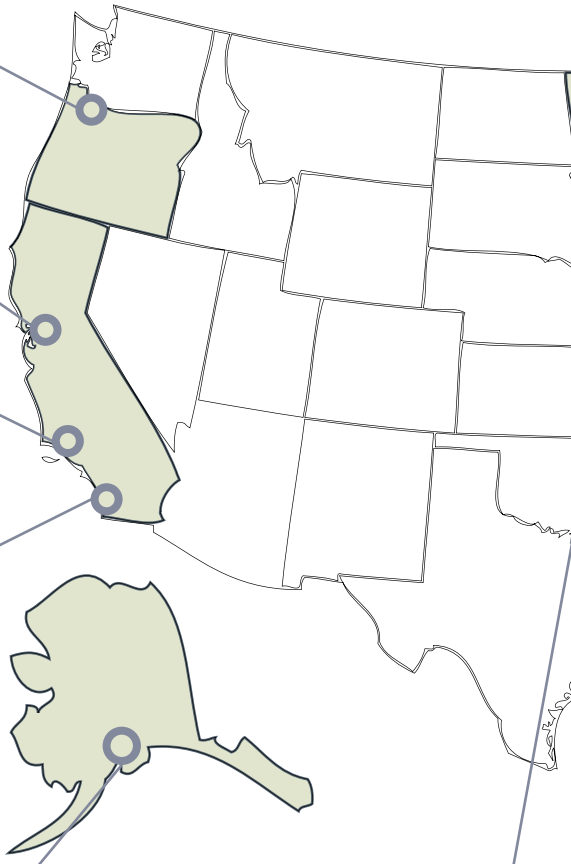

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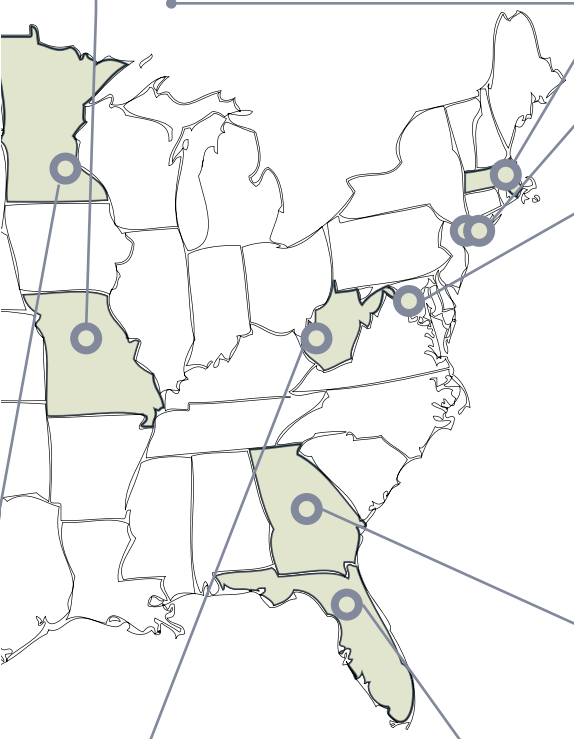
Appendix II: SSH Grantee Contact Information



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A Note about the Logo

The SSH logo was developed in 2008 by a committee of SSH grantees and consumers. The logo symbolizes the reciprocal dynamic between consumers and staff needed to create and maintain housing.

Services in Supportive Housing

Substance Abuse and Mental Health Services Administration

A Life in the Community for Everyone

U.S. Department of Health and Human Services