Services in Supportive Housing Annual Report

# The Power of Community

## Building Connections, Living Recovery

A Life in the Community for Everyone

SAMHSA

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Services in Supportive Housing

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A Life in the Community for Everyone

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# Services in Supportive Housing

# Letter from the Program Director

On behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this Annual Report on our Services in Supportive Housing (SSH) program. Beginning with 14 sites funded in 2007, the program now includes 62 grantees in 25 states and the District of Columbia. These programs offer housing stability and supportive services to people who have been chronically homeless. To date, 3,421 consumers have found homes through the program, reflecting SAMHSA's guiding vision of "a life in the community for everyone."

The SSH initiative squarely addresses one of SAMHSA's eight priorities, "Recovery Support." The agency has articulated the following goal in this critical area: to "provide housing and reduce barriers to accessing effective programs that sustain recovery for individuals with mental and substance use disorders who are homeless." In keeping with this goal, grantees not only provide housing to consumers but strive to offer each consumer the specific services he or she needs and wants to stay housed and in recovery. Recognizing that a majority of participants are trauma survivors, the program also reflects SAMHSA's strategic emphasis on trauma and justice.

Grantees patiently and persistently open the door to recovery for people like "Joe," a person who struggled with homelessness for 30 years prior to accepting services from the SSH program team. Joe has lived in SSH housing for 15 months now, and his substance abuse has decreased from an everyday event to the occasional relapse. His psychiatric symptoms have also dramatically decreased. The SSH program team's engagement approach was to provide Joe with choices: choice of housing and choice regarding what services to accept. A recent visit by SSH program staff found Joe cooking and sharing the following: "You just don't know how nice it is to be able to go to bed when I want, get up when I want, eat what I want, when I want, and right now I want to eat toast. Do you want to sit down with me to have some toast?" Choice is paramount to developing a sense of self-sufficiency and independence, and the SSH program is providing participants with the opportunity for choice.

Grantee outcomes reported to date show that the SSH program is making a difference. SAMHSA continues to hold out hope for all the persons like Joe who live in, but outside, our communities. The program applauds the efforts of grantees and program participants. Government programs officers and our cadre of consults are proud to continue to support their efforts.

Sincerely,

LCDR Nicole Gaskin-Laniyan, Ph.D

Program Director, Services in Supportive Housing

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# Executive Summary

The Substance Abuse and Mental Health Services Administration (SAMHSA) designed the Services in Supportive Housing (SSH) program to help prevent or reduce chronic homelessness. Funded and managed by the Center for Mental Health Services (CMHS), the program's 62 grantees work in 25 states and the District of Columbia. SSH Grantees provide individuals and families who have experienced chronic homelessness the services and treatment they need to stay housed in permanent settings; their efforts help to realize SAMHSA's vision: "a life in the community for everyone."

SSH grantees recognize the value of consumer perspectives, both in choosing their own services and in providing feedback on how to improve the program. In addition, all grantees were required to include consumers in developing their programs. A new Services in Supportive Housing Consumer and Peer-Specialist Network (SSH CPN) has been formed to guide CMHS's SSH program.

Grantees are striving to meet the needs of diverse audiences by understanding the impact of race, ethnicity, gender, age, and other factors in program implementation. Participants' mean age falls in the range of 45-54 years, and many have medical issues or physical disabilities. Forty-one percent of participants are women (a higher percentage than among the chronically homeless population as a whole). Most participants identify themselves as African-American; the second most frequently cited category is White. Multi-racial individuals, American Indians, and other populations are also served.

The majority of program participants have experienced trauma, and program staff are trained to recognize the reverberations of trauma in consumers' wary responses to outreach workers' offers of assistance. In part because of the relative ease with which peers are accepted, two-thirds of grantees provide peer support to their participants, and peer support is gaining rapid recognition as a best practice in supportive housing. Some grantees also offer domestic violence services, survivors of trauma work groups, and other opportunities for consumers to recognize how trauma has affected their life choices. In addition, many grantees train staff to provide trauma-informed care.


Each SSH program is required to implement at least one evidence-based practice (EBP), and many have chosen to implement several. The most frequently used include: the *Housing First* model, in which housing is offered with no preconditions; *Motivational Interviewing*, which enables the counselor to take the consumer's readiness to change into account and to reinforce the consumer's own incentives for change; *Integrated Dual Diagnosis Treatment*, which provides and coordinates treatment for both substance abuse and mental health issues; *Assertive Community Treatment,* which uses a team approach to meet participants' diverse needs; *Illness Management and Recovery,* which enables consumers to manage their own symptoms; and *Supported Employment*, which helps consumers take advantage of appropriate opportunities for mainstream employment. In addition, grantees link participants to such mainstream supports as vocational rehabilitation and to specialized supports such as life skills training and assistance with budgeting. They also help participants benefit fully from the "natural" support that comes through living in a community and connecting with peers, faith groups, and others.

Grantees face challenges in securing sufficient funding to maintain their programs, locating qualified staff, and addressing the distinct needs of diverse consumers. Technical assistance provided by the Services in Supportive Housing Technical Assistance (SSH TA) Center helps grantees address these challenges and enhance their skill in providing housing, services, and support. Assistance may be provided on site, through conference calls or email, or through webinars and other means that reach the overall community of grantees. To date, on-site TA has helped grantees implement evidence-based practices with fidelity, address program start-up issues, and ensure program sustainability.

Available data reinforce evidence that permanent supportive housing with wraparound services is an effective approach for meeting the needs of persons who have been chronically homeless. Housing stability is high, and the use of psychiatric inpatient services is low – two important indicators of success. Through September 10, 2010, 3,421 people who experienced chronic homelessness have found permanent homes and support through the program.


# The SSH Program—"A Life in the Community for Everyone"

SAMHSA initiated its Services in Supportive Housing (SSH) program to end homelessness and to increase the quality of life for individuals who have experienced chronic homelessness. The purpose of the SSH program is to help prevent or reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness in coordination with permanent supportive housing programs and resources.

**This program helps rebuild lives, offers hope, and provides real solutions.**

Services in Supportive Housing provides consumers with long-term, community-based housing options. This housing approach is designed to meet the needs of people with serious psychiatric conditions and those with co-occurring mental health and substance use disorders; to do so, it combines housing assistance and intensive individualized support services. Research indicates that this combination of long-term housing and wraparound services leads to improved residential stability and reduction in psychiatric symptoms.[1] The SSH program offers individuals and families who experience chronic homelessness the appropriate services and treatment they need to stay housed in a permanent setting.

The supportive housing model distinguishes between housing and services. Even if some services are provided on site, there is a functional separation, with the housing elements (rent collection, property maintenance, enforcement of responsibilities of tenancy) carried out by different staff than those providing services, such as case management, mental health treatment, and wraparound services.

By providing safe, stable housing along with the supports and services that people who have experienced homelessness or housing instability want and need, the SSH program aims to make it possible for those served by the program to find a life of their own in their communities.

## Scope of the SSH Program

The SSH program began with the funding of 14 sites in October 2007. In 2009, an additional 43 grantees were funded, followed by an additional five grantees in 2010. SAMHSA has now funded 62 grantees in 25 states, as shown in the Appendix to this document. Each site has received grant funding in amounts ranging from $282,431 to $434,200 per year for 5 years. Approximately 15,000 people are expected to be served through the program.

## Ending Homelessness: The Unique Contribution of SSH

SAMHSA's SSH program has provided many people who experienced chronic homelessness with the opportunity to become productive members of the community. By providing housing *and* supportive services, the SSH program enables participants to grow and thrive in permanent housing.

1. *SSH provides people with what they need to stay in the housing of their choice and helps to end their homelessness.* Rather than emergency shelters or transitional housing that participants know they will soon have to leave, supportive housing is *permanent* housing, geared to individuals' specific needs and preferences. As long as they meet the requirements of tenancy, these participants have the same rights and responsibilities as others who rent their own homes and can stay in their housing.

1 Shern, D., Wilson, N., Coen, D., Patrick, M., Foster, D., Bartsch, D. & Demmler, J. (1994). Client outcomes. II: Longitudinal data from the Colorado Treatment Outcomes study. *Milbank Quarterly*, 72, 123-148.


2. *Staff work with SSH participants to promote long-term stability, recovery, and a sense of themselves as contributing community members.* SSH provides agency staff with the opportunity to make a real and personal difference in the lives of the people they serve and to fulfill their organizational mission. Staff and participants develop a long-term relationship, with staff assisting individuals who were formerly homeless to select and maintain independent housing and determine which services and treatment will improve their lives.

3. *SSH provides communities and system decision-makers with an example of effective policy and program practices that – if applied strategically – can help communities end chronic homelessness.* Communities and policymakers are learning that short-term housing options, while still needed as a stop-gap measure, do not end or prevent homelessness. Helping people connect with the resources they need from their own homes fosters stability and reduces their need for supportive services over time. Ending homelessness by providing long-term housing and flexible supports (supports that can increase or decrease to meet participants' changing needs and preferences) is a sound and financially practical approach.

## Key Concepts and Terms

### *Who the program serves*

SSH programs are designed to meet the need of persons who have experienced "chronic" homelessness.

A **Chronically Homeless** person is defined within the SSH program as "an unaccompanied homeless individual with a serious mental illness or a co-occurring mental and substance abuse disorder who has either been continuously homeless for at least 1 year OR has had at least four episodes of homelessness in the past 3 years." A *homeless family* is defined 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 6 months, have had two or more episodes of homelessness in the past 2 years or have a history of residential instability (i.e., five or more moves over the past 2 years)."[2]

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

## *A Major New Tool: SAMHSA's KIT on Permanent Supportive Housing*

SAMHSA has recognized the effectiveness of permanent supportive housing and is actively promoting this strategy through the recently published an Evidence-Based Practice KIT (Knowledge Informing Transformation) on Permanent Supportive Housing (2010).[1] This KIT provides substantive guidance, practical tips, and examples of how to implement effective programs. The KIT also summarizes the evidence documenting the effectiveness of these interventions.

1 The KIT may be downloaded at no charge from this site: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/housing/

### *What the program offers*

**Permanent Supportive Housing** is decent, safe, and affordable community-based housing that provides residents the rights of tenancy under state and local landlord-tenant laws. The housing is linked to voluntary and flexible support and services designed to meet participants' needs and preferences.

- **Single-site Housing** is housing in which the participants receiving support services live in units in the same building or a group of buildings, with the support services provided either on site or off site.
- **Scattered-site Housing** refers to housing in which participants live in independent apartments throughout the community, in either private or agency-owned housing; depending on the program, staff can deliver some support services on site, or all services may be provided off site.

**Services** in supportive housing are individualized, effective services and supports designed to sustain housing retention for persons who have been chronically homeless. Among the services provided in SSH programs are outreach and engagement, case management, mental health and substance abuse treatment, and assistance in obtaining benefits.

### *How the SSH program works*

**Continuums of Care (CoC)** are planning and implementation oversight groups for activities targeted to homeless persons within a specific geographic area. Participation in the Continuum of Care process is required for programs funded by the Department of Housing and Urban Development (HUD), including emergency shelter and housing programs. Increasingly, all programs in a community – regardless of funding source – participate in the local process. Most SSH programs are active participants in their community's CoC.

**Choice** is a key concept underlying SSH programs. Participants are given options regarding the type of housing they wish to live in and the support services they receive. Staying in one's home is not dependent on accepting services, but rather on meeting the requirements of tenancy. Services are individualized for each person based on the tenant's goals and preferences. SSH programs are designed to increase individuals' ability to choose the way they live and how they use available services and supports to maintain their housing and stability in the community.

**Separation of housing and services** underpins the supportive housing model. Property management functions and support services are handled by separate staff, and often even by different organizations. They coordinate with one another but clearly differentiate the roles of property manager and service provider. This strategy fosters tenant choice and independence, while also recognizing participants' responsibility to fulfill lease requirements, and helps to ensure a safe, secure environment for all participants.

## Keys to Success

### *"Nothing about us, without us": The need for consumer involvement*

SAMHSA supports the meaningful participation of consumers in all aspects of the mental health system including the planning, design, implementation, policy formation, and evaluation of mental health services. Programs are designed to give attention to consumers' choice in their own housing and services and to offer opportunities for consumers to participate actively in program management and direction.

At the April, 2010 Annual SSH Grantee Conference, ten consumers were nominated by their grant sites and attended the conference with scholarship support from SAMHSA. The conference agenda included a consumer

### *Just Launched: The Services in Supportive Housing Consumer and Peer-Specialist Network (SSH CPN)*

The SSH CPN will provide consumer input to the SAMHSA SSH/ Grants for the Benefit of Homeless Individuals (GBHI) programs. Representatives will collaborate with other members to:

- participate in national conferences, such as the annual conference for SSH grantees,
- provide guidance to the SAMHSA SSH program on consumer involvement, and
- provide technical assistance and support to SSH grantees in collaboration with the SSH TA Center.

networking session to help consumers connect with each other and develop a supportive community of peers.

The *Services in Supportive Housing Consumer and Peer-Specialist Network*. The SSH TA Center has worked with SAMHSA and consumer leaders to develop the Services in Supportive Housing Consumer and Peer-Specialist Network (SSH CPN) to ensure consumer input into SSH programs and services. SSH programs nominate consumers who are receiving or have received services from an SSH program to participate in the SSH CPN. The Network schedules regular conference calls and plans to develop a Mission Statement, as well as to provide program guidance on consumer issues.

## *The Importance Of Cultural Competence And Trauma-Informed Care*

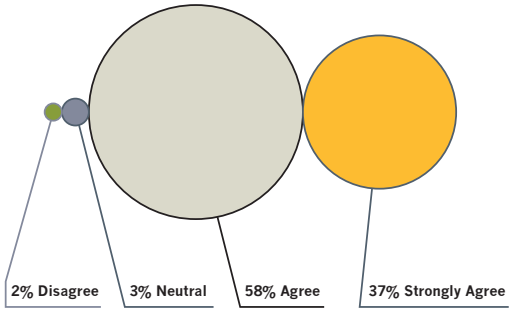
Field experience and research have revealed that two additional features are crucial to program effectiveness. First, services must be provided in a culturally competent and inclusive context. Secondly, trauma and its effects cause complications in the recovery of persons with behavioral health disorders and must be programmatically addressed.

*Services must be provided in a culturally competent and inclusive context.* The people the SSH program is designed to serve are almost by definition marginalized and excluded from their communities and mainstream society. Bringing them into housing and offering meaningful services requires providers to bridge cultural, language, and other barriers. SSH programs are advised to carry out a cultural competence assessment, then develop and carry out ongoing plans to address the areas in which staff need to grow.

Grantees are required to report program data to SAMHSA to gauge the extent to which they are achieving National Outcome Measures (NOMs). One key question related to cultural competence concerns consumers' perception of the care the program has given them. Consumers are instructed to think about the services they have received during the prior 30 days and the people who provided it. As shown in Figure 1.1, the overwhelming majority of consumers in SSH programs either agreed or strongly agreed with the statement, "Staff were sensitive to my cultural background."

### *Figure 1.1 Perception of Cultural Sensitivity Over One Year:*

*"Staff were sensitive to my cultural background"*



*Trauma and its effects cause complications in the recovery of persons with behavioral health disorders and must be programmatically addressed.* Many people with mental illnesses and/or histories of homelessness have experienced violence and trauma as a part of their childhood and in later life. In particular, an extremely high proportion of women with behavioral health disorders have histories of traumatic experiences, violence, and victimization. To be able to engage and help stabilize people who have a history of trauma, SSH programs need to be trauma-informed. This means training all staff who will be working with SSH participants to understand the nature and manifestations of trauma in human life and to ensure that both housing and services are offered in safe, nonthreatening environments.

SSH grant sites are recognizing and responding to these issues, with support from the SSH TA Center. SSH grantees are serving individuals who have been among the most reluctant to seek help – people who have lived on the streets and who have been in and out of emergency rooms, detoxification centers, and jails for years. The SSH program is an important national demonstration of how housing and services can be effectively provided to people who have experienced chronic homelessness and who have multiple needs in ways that respect their dignity, honor choice, and support recovery and community integration.

### *Commitment to Recovery: A Second Chance*

"Steve" is HIV-positive, with a mental health diagnosis and a history of alcohol and drug use. After being in a permanent supportive housing program for about 6 months, he relapsed. He avoided staff and eventually abandoned his apartment. About 1 month later, Steve resurfaced and came to speak with the case manager who visits one of the supportive housing locations. He wanted to see if he could move back into housing.

Staff of Decatur, Georgia's *CaringWorks, Inc.* advocated for a second chance for Steve. Through their relationship with the on-site property manager, they helped Steve make arrangements to pay his previous balance on his previous property so that it would not hinder him from being eligible for tenancy. Steve is now once again a resident of a permanent supportive housing program (since March 2009), where he is stable and considered one of the most reliable residents in the program.

## *Hope for the Future: The Encouraging Experience of the SSH Program*

The SSH program operates in a policy and clinical practice context that has emerged from the field and from more than 20 years of research. Based on the various SAMHSA "Supported Housing" initiatives in the early 1990s, and on the pioneering work of leading programs such as *Direct Access to Housing* in San Francisco and *Pathways to Housing* in New York, the SSH program draws from a rich history of programs and evaluation that support its core concepts.

SAMHSA's slogan, "A Life in the Community for Everyone," is more than just words; it symbolizes a significant commitment to recovery and community integration that is embedded throughout federal policy and programs. SAMHSA's mission statement commits the agency to "Building Resilience and Facilitating Recovery." As defined in the SAMHSA National Consensus Statement on Recovery, this implies "a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential."[3] The SSH program strives to support each tenant on such a healing journey.

3 The National Consensus Statement on Recovery may be found at: http://mentalhealth.samhsa.gov/publications/allpubs/sma05-4129

# Building Connections: Tenants and Their Communities

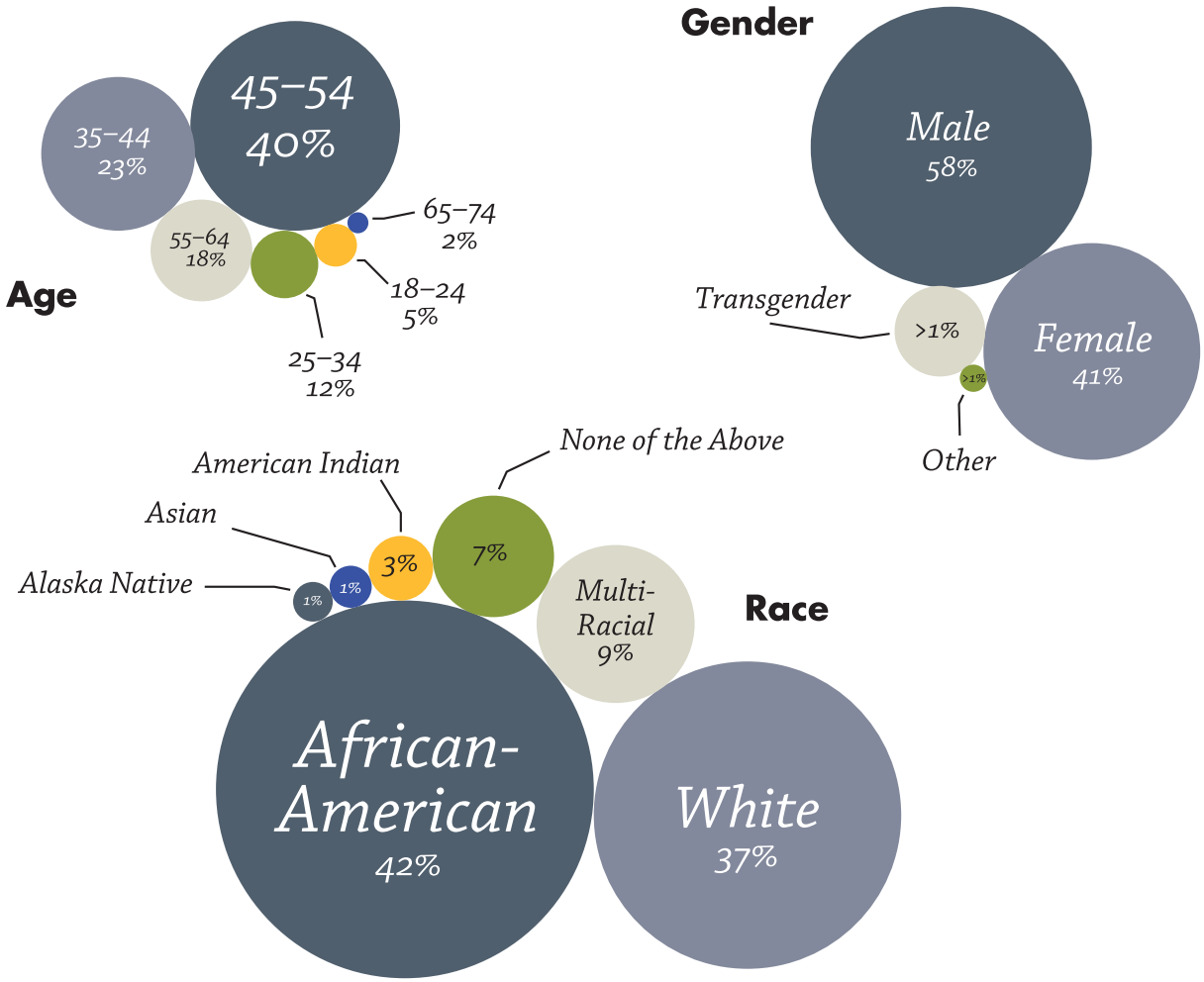
## Who Does the Services in Supportive Housing Program Serve?

Services in Supportive Housing programs must address the diversity and complexity of the chronically homeless population in their communities. Programs have developed creative and effective approaches to adapt services to the specific needs of subpopulations such as veterans and women.

The racial and ethnic diversity of SSH program participants largely reflects the diversity of the homeless population in grantee communities. Figure 2.1 shows the race and age of consumers based on data collected at program entry interviews.

Persons within the target population for SSH programs face difficulties that may include the consequences of trauma or active symptoms of substance abuse or mental illness, as well as practical problems such as where to sleep, eat, and shower until housing is secured. These and other special needs of the population have informed the services provided.

**Figure 2.1**



While most programs target a broad range of eligible people with a variety of needs, several focus on one or more groups with specific characteristics and tailor their approach to respond to their special needs. For example, five programs count among their primary populations those identified with medical issues needing ongoing attention; three include a special focus on individuals with HIV/AIDS; and twelve programs include veterans as one of their primary populations. Grantees meet population-specific needs by reaching out to partners and building strong linkages to relevant services. For example, some grantees that serve veterans include Department of Veterans Affairs social workers in their multi-disciplinary SSH team, while others make referrals to ensure these consumers benefit fully from VA resources for which they qualify.

Several programs report serving an aging homeless population, which often includes many people with chronic health conditions. For example, *Caring Works, Inc*., which serves the greater Atlanta community, reports that 60 percent of its program participants are 40 years or older and that 35 percent of participants have chronic physical disabilities. Philadelphia's *Project H.O.M.E.* is serving a number of older people (late forties and older) with multiple chronic illnesses and disabilities. Among these individuals, diabetes is often a major concern.

## What Does it Take to Open the Door?

People who are chronically homeless and have complex behavioral health disorders typically face numerous challenges. Their poverty has made them economically vulnerable, and they have lived on the edge of homelessness or have been homeless for many years. Their behavioral health issues have long complicated their path out of homelessness and blighted hopes for long-term housing stability.

The SSH programs often find people who are reluctant to accept help, suspicious of promised benefits, and feeling hopeless about their future. Therefore, reaching out and engaging people is a crucial first step in ending their homelessness. SSH grantees have developed a variety of outreach and engagement techniques that bring this severely disenfranchised group into helping relationships and permanent housing settings. The most effective approaches include an attitude of respectful persistence, meeting the person's real and immediate needs, and helping the person address difficulties one step at a time.

As one SSH program director explained, "We serve very difficult, hard-to-reach folks who no one else wants to work with. We provide quality services, don't give up, and continue to work with people as long as it takes."

## Making Connections: Providing Access to Services and Supports

SSH grantees recognize that many among their target population not only have multiple challenges, but they also have long histories of being ill-served by programs that are not set up to respond to the needs of people experiencing chronic homelessness and behavioral health disorders. While supportive housing grantees make a host of services and supports available to consumers, they realize that simply offering access to resources is not sufficient. Grantees adapt the services they provide to accommodate the populations they serve, their service area, and consumers' stages in recovery.

Skilled and flexible case managers most often serve as the bridge between participants and the supports that help them achieve stability and long-term tenancy. Thus, it is not surprising that 93 percent of SSH grantees provide case management. Generally, working as part of a

### *After 30 Years on the Street, Mike is Home*

"Mike" is a consumer served by the *SHAPE* program of the *Prestera Center for Mental Health Services* in Huntington, West Virginia**.** Mike had experienced homelessness for the better part of 30 years. Other providers deemed him difficult, a drug addict with a mental illness, and unpredictable in behavior. No one wanted to provide services to him because he was not receptive to treatment.

The SHAPE program convinced the local housing authority to give him housing, so long as he also agreed to see the SHAPE therapist for 28 days. On the first day, Mike did not make his appointment, so the therapist went to the riverbank and found him. They talked, and the therapist requested that he come for an appointment the next day. He rarely made his appointments, but the therapist talked to him every day for 28 days.

Mike has now been in SHAPE for 15 months. His use of crack has diminished sharply (from every day to twice a month). He keeps his apartment neat and clean, and he is a good neighbor and tenant. Staff continue to work with him to strengthen skills for independent living. Mike is now a "success story," but had it not been for the persistence of SHAPE's staff, he might never have found his way home.

supportive housing team, case managers first build trust, then help participants select and obtain the supports that will work best for them. The majority of grantees offer substance abuse services, mental health services, peer support, medical services, and supportive employment (an EBP).

The key to successful engagement of a severely disenfranchised population is having something worthwhile and real to offer. Because participants arrive at the SSH programs with so many different needs and few linkages to resources, SSH grantees help people engage with a wide variety of services, treatment, and supports. For persons with histories of both chronic homelessness and co-occurring disorders, these services must be easy to access, make sense to the person contemplating a life change, be readily available, and include permanent housing. SSH services and supports that SSH grantees provide directly or arrange for on behalf of participants fall under three broad categories, as follows:

» ***Mainstream Supports*. Examples include income support and entitlements from public benefits programs, health care from hospitals and clinics, and employment help from vocational rehabilitation agencies.**
Some of the most effective SSH grantees consider connecting their participants with community partners to be a vital role. This requires educating those partners regarding best practices with people who have been chronically homeless and have mental health,

substance abuse, and co-occurring disorders issues. A case in point is the Oklahoma grantee program *Tulsa Housing and Recovery (T-HARP).* In addition to fostering close working relationships with public benefits specialists and vocational rehabilitation staff, T-HARP has developed a number of community-based partnerships. Their network includes the University of Oklahoma at Tulsa, which provides on-site medical services; a community health provider that will soon offer dental services and transportation to its dental clinic; an HIV and hepatitis testing program that provides testing through a contract with T-HARP; and on-site services provided by the Department of Veterans Affairs and Goodwill Industries.

» ***Specialized Supports*. Examples of specialized supports that help consumers succeed in accomplishing their goals include life skills training, budgeting, medication management, and behavioral health treatment.**
For some programs, basic supports can have a tremendous impact. In Pennsylvania, the *YWCA of Greater Harrisburg* SSH program, which focuses on supported employment, has found that driving participants to work is a major program asset. This service removes a persistent barrier to finding and keeping jobs, allowing more flexible scheduling, and enables people to take jobs that are not on a bus line. The transportation coordinators who drive employees are helping participants to behave appropriately with one another and build friendships. The employers feel that they have a more direct relationship with the program. Furthermore, the rides have proven to be a program "carrot" and are treated as a privilege.

» ***Natural Supports*. These include connections with peers, family, community, and faith communities.**
Natural supports often do not occur "naturally," but need to be nurtured, especially with individuals who are wary of others and have often lost what social networks they had. *Caring Works, Inc.* in Atlanta has a number of features that promote a sense of community and peer-to-peer support. These range from formal groups (a men's group, a women's group, and a "Double Trouble" group for those with co-occurring substance abuse and mental health disorders) to birthday celebrations. An active alumni association meets regularly, organizes social events, and returns to Caring Works, Inc. to "give back" through volunteer support.

Perhaps the most important part of the SSH program's approach to services is that SSH programs go the extra mile to help participants succeed. Instead of putting the burden of success solely on the person being served, treatment teams adopt a partnership attitude and are willing to step outside the boundaries of conventional services. A case manager in an SSH program might store items while the owner is in jail, secure free veterinarian services for a homeless pet, take diapers and formula out to an encampment, or help someone transport bottles and cans to the recycling center.

## Training and Supporting Staff

One key to effectiveness is providing training and support for staff. SSH staff teams need to understand and embrace the core concepts of permanent supportive housing. This includes having realistic expectations regarding the time it may take for some people to accept services and housing, then to set and work towards their own personal goals for community living. As one program manager put it, "some consumers take two steps forward and one step back, sometimes for years." Linda Coleman of *CaringWorks, Inc.* says, "Be very clear

on the population you are serving and understand that they will not be 'fixed' per se overnight." She emphasizes patience and the importance of staff training to increase program effectiveness.

## Adapting to Culture, Gender, and Other Differences

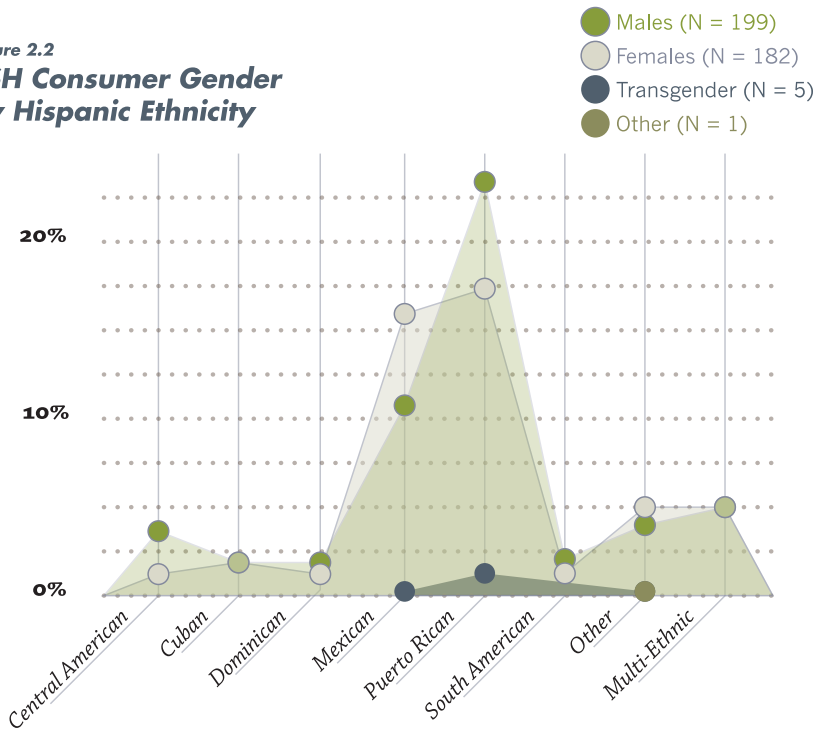
Real engagement is the first step in recovery, and creating a welcoming environment at the front door to services is essential. A key part of a welcoming environment is culturally appropriate services and supports. The SSH programs take this truth very seriously. In order to engage people and provide effective interventions, SSH programs must have intentional and thoughtful approaches that incorporate, but go beyond, language services and trained and alert staff.

Grantees look for guidance to the National Standards on Culturally and Linguistically Appropriate Services (CLAS), developed by the Office of Minority Health.[1] The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3); Language Access Services (Standards 4-7, which Federal law now mandates for all programs receiving Federal funds); and Organizational Supports for Cultural Competence (Standards 8-13).

Many of the people SSH grantees serve have been misunderstood, maligned, and even mistreated based on their differences. In order to build trust, SSH programs are obliged to craft policies and services that lead to culturally competent practices throughout every aspect of the program. This means attending to each of the components of cultural competence and spending the time and training it takes to get them right.

A large percentage (41%) of the consumers served by SSH programs are women. As a result, although the SSH program is now learning about the unique issues of this group, it also recognizes that there is an urgent need to continue to identify more effective strategies for working with the population. One grantee serving victims of domestic violence helps the women access services and resources to assist their children. This need is a major focus of the program, along with identifying and coordinating with legal entities to educate women about their legal rights.

*Figure 2.2*
***SSH Consumer Gender by Hispanic Ethnicity***




1 Department of Health and Human Services, Office of Minority Health (2001). National Standards on Culturally and Linguistically Appropriate Services.

Another grantee serving unaccompanied women over 45 years noted that women who had received some form of treatment for mental illness at some point in their lives prior to entering housing had better housing retention outcomes. This realization led the program to place greater emphasis on mental health assessment during outreach to address the issue as early as possible.

Consumers served include people who are 50 years or older, many of whom have lived on the streets for years. Lack of medical care and treatment during those years mean that many consumers are addressing medical concerns, including chronic and/or severe medical concerns, for the first time when they enter a SSH program. Many grantees, including *Pine Street Inn* in Boston, work closely with the local Health Care for the Homeless program to address medical needs and integrate those services with other behavioral treatment services. Regular meetings and joint delivery of services between Pine Street Inn SSH case managers and Health Care for the Homeless staff in Boston ensure careful coordination of treatment for consumers with critical health care needs.

## *Growing Hope from Cultural Roots*

Two-thirds of consumers at the *Welcome Home Project* are Alaska Natives/American Indians. Cook Inlet Housing Authority, located in Anchorage, Alaska, designed the program to offer individualized services in keeping with participants' cultural identity. Staff also work to develop natural supports within Alaska Native/American Indian community. Services rooted in the culture, such as art, dancing, fishing, story-telling, connection with nature, and support groups, are key to working effectively with program participants. The program incorporates talking circles and other approaches common to the Native System of Care, a promising practice.

Staff are trained to look to the community to ensure that services and supports are consistent with the cultural backgrounds and values of those served. Evaluation staff intentionally included a retrospective pre-test design to assess perceived improvement in key areas. They reported that "this procedure seems to be particularly well suited for Alaska Native/American Indian people, because it measures present performance in context with historical information, using the traditional relational thinking patterns of Native people."

# Going Home: Services And Supports

Current data (as shown in Section 5 of this report) indicate that grantees are overwhelmingly successful in achieving housing stability for program participants. Housing stability allows them to provide the services needed to address the other complex challenges faced by consumers, and thus works to prevent future homelessness. Grantees provide evidence-based practices (EBPs) and additional services tailored to meet the needs and the readiness to change of each tenant, striving to provide culturally competent, trauma-informed care.

## Evidence-Based Practices

All SSH services aim to increase housing stability and consumer level of functioning. To ensure that grantees utilize effective supportive practices, SAMHSA requires all SSH grantees to implement evidence-based or promising practices.

Each of the grantees has implemented at least one EBP or promising practice, and most employ two or more. While some implement the practice according to the defined model, others modify or even combine EBPs. Approximately half of the grantees have made at least some modification to the EBP.

### *Housing First*

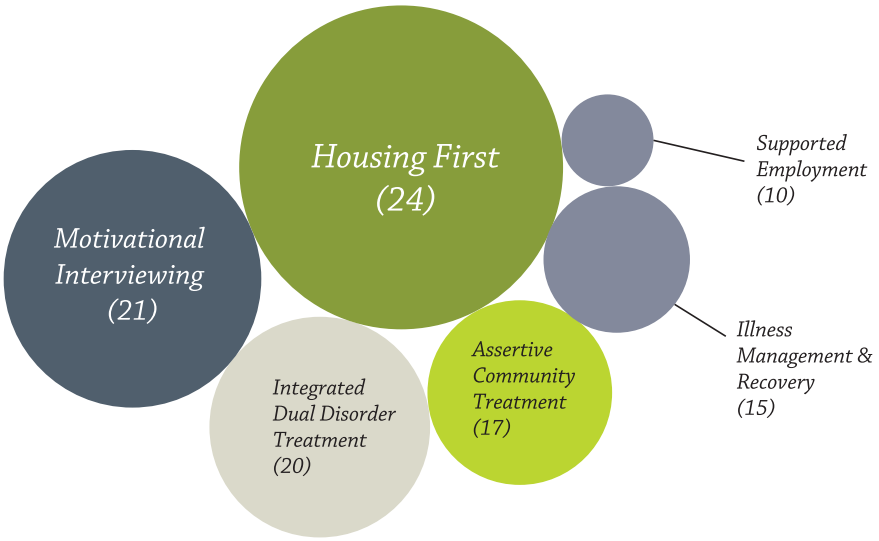
One of the most frequently used EBPs among the grantees is **Housing First,** developed by SSH grantee *Pathways to Housing* in New York. As its name indicates, this model first provides housing, then offers voluntary supportive services. More than one-third of grantees employ this practice.

Some grantees modified their implementation of Housing First to provide treatment services off site. One program deviates from the model by expecting participants to pursue outpatient treatment for substance addiction. Others place consumers in traditional aggregate supportive housing settings or scatter them in a single apartment complex, rather than throughout the community.

Grantees implemented a wide array of EBPs and promising practices (43 in total). The chart to the right shows the six services that reach the largest number of consumers. Some consumers receive services from more than one of the above practices, since many grantees utilize several different practices. A brief description of several of these common practices follows.

***Figure 3.1***

***Six Most Commonly Used Evidenced-Based Practices by Grantees through Sept. 10, 2010***



***What are Evidence-Based Practices?***

Evidence-based practices (EBPs) are practices which, based on research findings and expert or consensus opinion about available evidence, are expected to produce a specific positive clinical outcome.

## Motivational Interviewing

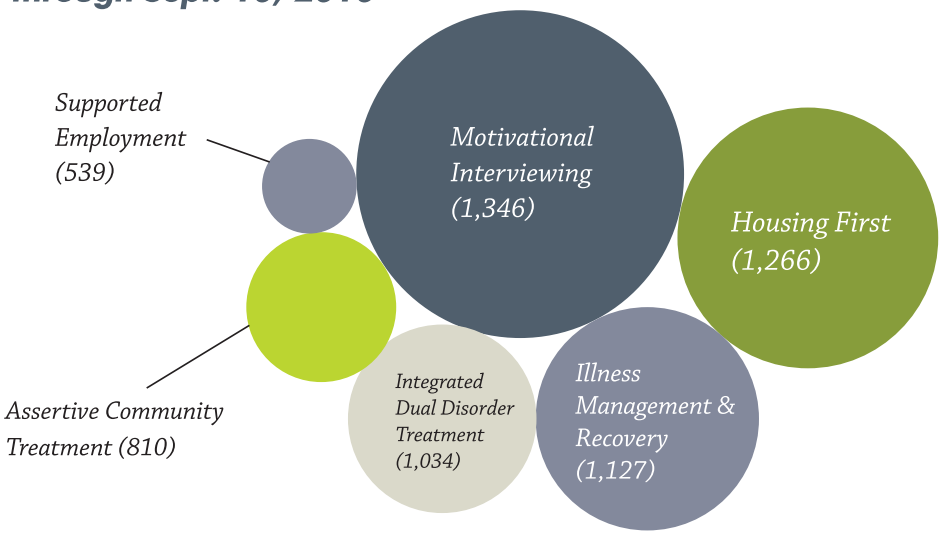
Over one-third of grantees use **Motivational Interviewing (MI)**, a collaborative, person-centered approach for eliciting and strengthening a consumer's motivation to change. *Contra Costa Health Services* developed a universal treatment planning tool for use across its 12-agency SSH collaborative that also reinforces MI and the development of stage-wise interventions. Another grantee reported that program staff currently integrate MI into all facets of their clinical work with consumers who have a history of substance abuse or co-occurring disorders (COD). Their MI skills allow staff to tailor interventions carefully to complement the stage of change of the consumer. To facilitate MI with individuals who have reading difficulties or cognitive impairments, one grantee reports success using a ten-point scale in the form of a "readiness ruler" to assess the consumer's stage of change.

## Integrated Dual Disorders Treatment

More than one-third of grantees practice **Integrated Dual Disorders Treatment (IDDT)** in their work with people experiencing homelessness. This EBP is an approach for people with COD that helps them recover by treating both mental health and substance abuse issues at the same time. Grantees report success with IDDT, which *Central City Concern,* in Portland, Oregon, finds to reduce frustration among staff and

***Figure 3.2***

***Number of Consumers Being Served By a Grantee Utilizing Evidenced-Based Practices through Sept. 10, 2010***



consumers. The implementation of IDDT allows staff to identify consumers at specific stages of their treatment and recognize appropriate actions to take. Staff encounter less resistance from consumers, which ultimately reduces staff burnout and allows the program to become more consumer-centered.

### *Assertive Community Treatment*

Approximately one-third of the grantees use **Assertive Community Treatment (ACT)**, a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious mental illnesses.

Many grantees adapted the staffing/team requirements of the model, either due to funding issues or because they were unable to find qualified staff to fill the positions. On the other side of the spectrum, however, one grantee found that their consumers had a high degree of untreated medical issues and enhanced the recommended staffing pattern by *adding* a .25 FTE physician. Another grantee reports that adapting ACT for use with the Housing First model more fluidly integrates mental health and substance use needs with the unique problems of homelessness.

### *Permanent Supportive Housing*

Grantees provide supportive housing, which combines affordable housing with services. Many are now well prepared to implement the **Permanent Supportive Housing** EBP, released by SAMHSA in April 2010. In fact, many grantees already apply principles of this EBP, which include choice in both housing and services; access to housing; affordability; separation between housing and support service provision; integration; and quality (rights of tenancy, privacy).

### *Other Frequently Implemented Evidence-Based Practices*

Other frequently implemented EBPs include **Illness Management Recovery (IMR)**, **Supported Employment (SE)**, **Integrated Case Management (ICM)**, and **Wellness Recovery Action Plans (WRAP)**. In addition, as grantees advance through the grant period, they sometimes see a need for other EBPs, or they learn about them through the SSH Online Community Network, the Annual Grantee Conference, and other grantee communications. Grantees are able to request technical assistance and thus can add to their "toolbox" of strategies.

## How Do Wraparound Services Support Housing Retention?

Because every population served by the grantees has distinct needs, agencies and programs offer a wide array of recovery-oriented wraparound services. The fact that there is funding available to provide supportive services to stay in housing has a huge impact, as it greatly enhances the capacity of service providers to deal with the complex challenges of the people they serve to help them maintain housing. Examples of benefits of services to consumers include improved health, recovery from mental illness and substance use, housing stability, self-sufficiency, independence, and decision-making abilities.

### *Case management*

All of the grantees are required to provide case management services. Case management is the mechanism for coordination of services to address consumer needs and goals. Although variations occur, most grantees include the development of treatment plans, linkages to resources, an initial sense of connectedness, coordination of resources utilized by consumers, and advocacy.

## *Substance use services*

Another service often made available by most grantees is treatment for substance use disorders. Services include detoxification, outreach and engagement, support groups (e.g., 12-step programs such as Alcoholics Anonymous), treatment plans, service planning, and harm reduction.[1] For example, Cook Inlet Housing Authority's *Welcome Home Project,* in Anchorage, Alaska, strives to help consumers integrate sobriety into their daily lives through activities based on consumer needs and interests (e.g., knitting and crafting). Some programs also work with landlords to keep substance users in housing. Many grantees started out as either substance abuse or mental health treatment programs and provide substantial services in-house or via community programs. The SSH program helps them increase their capacity to address co-occurring disorders.

## *Mental health services*

Mental health services may include assessment, referrals, psychiatric care, COD, behavioral health services, and medication management. One program provides a mobile psychiatric van.

1 Tsemberis, S., Gulcur, L. & Nakae, M. (2004). Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health, 94*(4), 651–656.

### ***Welcome Home: BJM is Sober and Employed***

"BJM" is a 54-year old Tsimshian woman who entered treatment through the Cook Inlet Tribal Council (CITC) after living in homeless camps for approximately 2 years. She reported daily drinking to the point of intoxication for 6 months. She entered residential treatment and upon completion became engaged in the *Welcome Home Project,* a small housing program designed to help individuals transition out of homelessness. She maintained stable housing, received mental health care, and developed skills to cope with anxiety and to encourage sobriety. She completed a vocational training program and successfully maintained employment at a medical clinic. BJM is now a guest speaker in outpatient groups and is active in consumer-run activities. Stable in housing and sober for 2 years, she continues to achieve her goals and set new ones.

Other services include individual and group therapy, counseling, family therapy, psychosocial rehabilitation, and psychiatric evaluation.

Some programs have team members to provide the care; others work with partner providers. For example, Colorado Department of Human Services' *Pike's Peak Mental Health (PPMH)* collaborated with *Colorado Springs Shelter Plus Care Services Enhancement Project* to create an intensive case management team. This "Enhanced Adult Service Team" (EAST) provides integrated, recovery-based mental health care using a drop-in model that enables consumers to access a full range of services.

## *Medical services*

More than half of the grantees offer an array of medical services, reflecting the often serious chronic medical needs of their populations. Services provided include basic health care, emergency and crisis intervention, primary health care, HIV screening and treatment, mobile medical care, dental care, and home visits. Others provide vaccines, routine lab work, and discharge planning. At least one program offers acupuncture as part of the addictions treatment program.

## *Peer support*

Grantees increasingly recognize the importance of integrating consumers onto their teams. Almost two-thirds of the grantees listed peer

### ***Making the Connection: Successful Outreach by a Peer Staff Member***

"Josh" is a consumer served by Philadelphia, Pennsylvania's *Project H.O.M.E.* A veteran who has experienced long-time homelessness, Josh is now stably housed in supportive housing. "Josh" expressed the desire to work helping his peers and is currently learning to do street outreach from employment services staff. On just his second day out, Josh connected with someone whom the professional staff had not been able to reach. Despite long-term and ongoing attempts, this effort was the first time that individual would agree to accept services. The peer outreach worker-in-training is extremely gratified to help, and the outreach team appreciates what peers can bring to the program through their unique ability to reach other consumers.

support as an actual service they provide (reported at the same level as mental health services). Many grantees sent their peer staff members to certification training. Clearly, peer support is rising to the forefront of supportive housing services.

The advantages of peer support include increased empathy and understanding based on shared experiences, a living model of recovery, and helping organizations to be consumer-focused. *Southwest Counseling Solutions* in Detroit, Michigan, noted that peer staff are the members of the team most readily accepted by participants.

Specific exemplary SSH grantee initiatives that use the power of peer support include:

» At *Southern California Alcohol and Drug Program's LIFE* program, frontline staff members are all current or former consumers who have experienced homelessness, domestic violence, substance abuse, mental health disorders, or a combination of these. In addition, all are working mothers. These frontline staff function as role models for success and, given their similar background and knowledge about trauma, are able to develop trusting relationships with the consumers.

» *Resource Inc. Spectrum Community Mental Health* in Minneapolis, Minnesota, includes a peer support specialist to assist with engagement, coordinate activities, and consult with staff. This person leads two weekly activity groups for participants.

» The *Arizona Behavioral Health Corporation* adapted its use of the EBP of Critical Time Intervention (CTI). Its team includes trained peer support specialist staff, who have lived experience in homelessness and mental health services and who work as CTI service coordinators.

» *Southwest Counseling Solutions* incorporated peer support specialists on its housing support teams. Specified roles and responsibilities include assisting participants in their search for housing and providing ongoing supports to improve housing retention.

» At *Project Renewal* in New York, peer support specialists help consumers develop life skills. For example, they recently grew herbs, and then used the herbs in their weekly dinners. Another peer support specialist dedicated herself to providing support and transportation to consumers with more advanced medical needs.

## How Do Grantees Provide Culturally Competent, Trauma-Informed Services?

Overall, grantees recognize the importance of trauma-informed and culturally competent services. Although many grantees realize that further development is necessary in these areas, there are many ongoing positive examples and strategies.

### *Cultural competence*

Each grantee adapts services and supports to the culture and population it serves. For example, *Phoenix Programs, Inc.* in Missouri works with rural homelessness; *Community Connections, Inc.* in Washington, DC works predominantly with African Americans; and *Resource Inc. Spectrum Community Mental Health* in Minnesota primarily assists unaccompanied women. More than two-thirds of SSH grantees have identified formal plans to offer staff training to support cultural competence.

Several grantees report the use of interpreters or translators when necessary, and some provide bilingual written materials. Others read written materials aloud, including consent and authorization forms, to address both language and literacy issues, ensuring consumer

understanding. The *YWCA of Greater Harrisburg* uses the AT&T language line if needed and employs a Bosnian bilingual specialist in its domestic violence services.

Another striking example of cultural competence in action is the *Vocational Instruction Project Community Services' Project Thrive.* This program is fully bilingual and has provided culturally competent addiction services in the Bronx, New York for more than 30 years. At *Prestera Mental Health Services* in West Virginia, both evaluation activities and staff training integrate learning about Appalachian culture. *CaringWorks, Inc.* in Decatur, Georgia expanded their annual cultural competency training to include information on the culture of homelessness, substance abuse, and mental health issues.

## *Trauma-informed services*

Because research indicates that nearly all persons who are chronically homeless have experienced significant trauma at some point in their lives, it is paramount that providers are trauma-informed. In the words of Lori Beyer, Trauma Specialist and Trainer for Washington, DC grantee *Community Connections, Inc.,* "If consumers don't feel safe, nothing else can happen."[2]

Although grantees recognize the importance of trauma in the lives of those they serve, most do not have a formal plan to offer trauma-informed care to consumers. A few implement specific models of trauma-informed care, and one grantee offers trauma-informed care through an outside agency. Specific examples of trauma-informed care by grantees include:

» The *Center for Human Development, Inc.* in West Springfield, Massachusetts, incorporates trauma theory into the delivery of wrap-around services to create a gender responsive outreach and treatment system to help women overcome fear, grief, and shame. This helps consumers see homelessness, substance use, and mental health symptoms as problems they can overcome.

» Contra Costa Health Services' *Project Coming Home,* in San Francisco and *The LifeLink* in Santa Fe received SSH TA in the Seeking Safety model,[3] then incorporated specific trauma-related objectives into the overall goals of their programs. This EBP addresses the fact that most residents in supportive housing have a history of trauma that goes untreated in traditional substance use or mental illness treatment protocols, leaving residents with serious underlying issues that can undermine their treatment.

» The *YWCA of Greater Harrisburg* offers sexual assault and domestic violence services and shelter.

» Many of *Resource Inc. Spectrum Community Mental Health's* consumers in Minneapolis, Minnesota have histories of sexual and physical abuse. Program staff realize that the impact of this trauma is far reaching and influences many decisions that affect participants' ability to remain stably housed. To help participants examine the impact of trauma on life choices, they started a weekly Survivors of Trauma Work Group.

» Staff of the *Pine Street Inn* Housing Supports Program in Boston, Massachusetts realized that consumers who have experienced physical/emotional abuse or trauma are very unwilling to address their mental health issues or substance abuse. Once an atmosphere of trust has been established, it is often problematic and counterproductive to refer the

2 Beyer, L. (2010, June). *Trauma-informed care: Building partnerships and empowerment in supportive housing settings.* Presentation at the Services in Supportive Housing Annual Grantee Conference, Alexandria, VA.

3 See www.seekingsafety.org for further information on the Seeking Safety model.

person to another worker. This situation feeds a sense of abandonment and distrust, and can result in re-traumatization. In recognition of this dilemma, the program is contracting with The National Center on Family Homelessness to provide training, consultation, and organizational assessment for the development of a more trauma-informed system of care.

## Common Challenges Faced by Grantees

Grantees face a range of challenges related to funding, staffing, and addressing the needs of consumers. It is important to understand these challenges to find solutions that will alleviate them in the future. The SSH TA Center is responding to these issues in a number of ways, including customized and regional TA, and the forthcoming development of the "SSH Family of Products," an array of training and technical assistance tools. In June 2010, the SSH Online Community Network was launched to further facilitate communication and resource distribution among grantees.

### *Funding*

The nationwide economic recession contributed to ongoing financial difficulties for providers. Many grantees report that securing basic funding is harder as a result of the economic downturn and experience increased difficulty finding jobs and affordable housing for their consumers. As one grantee reported, the current economic climate placed even more constraints on the rental market in the area. Daunting challenges cited by another grantee included long waiting lists, lack of insurance, complicated paperwork, multiple access portals with varying levels of assistance, restrictive eligibility, and a 2004 state law that restricted eligibility criteria for Medicaid-funded mental health services.

### *Staffing*

Many grantees report significant challenges in the area of personnel and staffing. Burnout, turnover, and pay scales insufficient to attract qualified personnel are prevalent. In addition, although grantees recognize the need for providers who specialize in COD, professionals trained to provide these services are not always easy to find. For example, one program budgeted for a Supportive Housing Coordinator, but had to reallocate the funding to other direct services activities to support consumers because it was not able to fill the position. Another grantee reported that finding qualified therapists with a Master's degree in Social Work (MSW) who can do both mental health and substance abuse treatment was an enormous challenge.

### *Meeting consumer needs*

Beyond funding and staffing challenges, grantees report a number of challenges in meeting the needs of consumers. A common concern is that many members of the target population have poor credit and eviction histories that make landlords reluctant to rent to them. In addition, after many years of homelessness, many do not have adequate housing-related independent living skills, including making timely rent payments, cleaning, and personal

hygiene. To address these barriers, many programs offer housing case management, master-leased units, wraparound services, and other supports through housing and peer specialists. These specialists work with consumers to help them obtain the housing units. Once participants are housed, these staff continue to work with them, teaching needed housing skills and intervening to help resolve problems before they result in eviction.

» *Southern California Alcohol and Drug Programs' LIFE* program noted that a seemingly minor issue, transportation, sometimes hinders achievement of the program's goals: "We're a scattered site program in Los Angeles County, an area characterized by large distances between locations and meager public transportation services... Transportation issues arise frequently in different forms...When public transportation is insufficient (too time consuming, no routes available), transportation is a resource that is out of the direct control of our consumers..."

  As a result, case managers must drive long distances, and participants often depend on persons with cars for rides to appointments. Despite this challenge, case managers stay in close touch with participants, and also keep an open door at the office, maintaining a building environment that is child friendly—even though services are primarily provided in participants' homes. People feel comfortable and safe in the program and can ask for help when they need it.

» The *YWCA of Greater Harrisburg* realized that it needed to increase its transportation budget when it found that jobs located along bus routes were low paying and noncompetitive. Staff worked with consumers in a series of meetings to teach public transportation etiquette and to ensure that they always had transportation to get to their jobs.

» *Bridgeway Center, Inc.* in Fort Walton Beach, Florida, noted that obtaining valid identification for chronically homeless individuals due to the lack of a fixed address was often a challenge, and emphasized intensive outreach to individuals experiencing homelessness as well as to community resources. Another grantee found that initial application fees were a barrier to applying to apartments for participants who have no income or very limited income. In addition, a lack of funds to buy basic household "startup" supplies such as toilet paper, shower curtains, dishes, and bedding was a challenge. Staff sometimes asked for and received donations, or even used their own money to address this deficit. The program noted that this issue is usually only problematic at the beginning, until benefits stabilize and participants find employment.

## Empowering Consumers through Choice

*"You just don't know how nice it is to be able to go to bed when I want, get up when I want, eat what I want, when I want, and right now I want to eat toast. Do you want to sit down with me to have some toast?"*

—Consumer who lived on the streets for 30 years prior to moving into housing *Prestera Center for Mental Health Services*, West Virginia

A key benefit for consumers is choice: choice in both type and location of housing, and choice of services and when to access them. Choice empowers people and promotes independence.

Consumers also choose in other ways. Many programs involve the consumer in the development of his or her own treatment; indeed, the most common practice is for consumers and staff to develop treatment plans cooperatively. For example:

» *CaringWorks, Inc.* in Decatur, Georgia involves members of the target population(s) in the

design, implementation, and evaluation of all new programming, with each consumer actively involved in the assessment and ongoing re-assessment process.

» *Arizona Behavioral Health Corporation* encourages each consumer during the first phase of Critical Time Intervention to complete a Self-Directed Recovery Plan in collaboration with Hope Team staff.

» At Missouri's *Phoenix Programs,* consumers provide input on the delivery and the direction of services via the Peer Hierarchy component of the Modified Therapeutic Community EBP used by this grantee. Three part-time Peer Facilitators assist case managers by coaching consumers in such areas as recovery techniques, job hunting, and other independent living skills.

Other programs use consumer satisfaction surveys and involve consumers in everything from program development to grant applications.

Early data indicate that as consumers stabilize in housing, different needs and priorities may become apparent. For example, social connectedness emerges as a more dominant need for many consumers once other aspects of their lives stabilize. Other individuals turn their attention to ongoing health issues, or begin to seek out educational or employment opportunities. As the SSH program continues, strategies to address this and other needs must be in place to ensure that consumers can continue to benefit from services.

# The SSH Technical Assistance Center: Who We Are and What We Provide

The Services in Supportive Housing Technical Assistance (SSH TA) Center (hereafter, "the Center") plays a key role in ensuring the success of this SAMHSA program. The Center designs and provides technical assistance and resources with two goals in mind:

1. To support grantees in providing high quality, dynamic, and focused services to their consumers, and
2. To work with SAMHSA, grantees and consumers to build a nationwide community of practice that promotes recovery-focused, evidence-based services and systems that place people first.

The SSH TA Center's staff of seasoned leaders and innovators, supplemented by nationally known consultants, offers the full range of expertise needed to help grantees keep the populations they serve stably housed. Advocates for Human Potential, Inc. (AHP), the Center for Social Innovation (C4SI), and ICF International, Inc. comprise the Center.

### *Assessing needs*

The Center works with grantees to determine both individual grantee needs and TA needs shared by a number of grantees. TA needs are determined in a number of ways, grantee requests to the TA Center being the most direct route. Evaluations completed by grantees at the SSH Annual Grantee Conference provide another avenue for the Center to identify TA needs. The Center also identifies needs through Government Project Officer (GPO) requests, during monitoring site visits to grantees, and from TA events.

TA Center staff determines whether a TA request is best fulfilled through targeted on- or off-site assistance to a single grantee, TA to a group of grantees sharing a similar challenge, or TA to the entire community of practice on issues that are relevant to many of the grantees. When a number of grantees indicate a need for training on the same topic, the SSH TA Center may develop a webinar offered to all grantees or upload an electronic product to the SSH Online Community Network (SSHOCN). For example, when site visit teams reported that a number of grantees needed a more thorough grounding in some of the key values and practices of permanent supportive housing, the TA Center followed up with a webinar on "Core Elements in Permanent Supportive Housing."

In addition to providing TA based on identified grantee needs, the Center is charged with conducting monitoring site visits to all grantee sites. Site visit teams comprising two experts in supportive housing implementation issues conduct up to two monitoring site visits per grantee throughout each grantee's 5-year funding period. This ensures that grantees are able to implement their programs fully and meet their goals and objectives. The site visit teams also seek out "pockets of excellence" to share with the SSH community.

## *Types of Technical Assistance Support, Interventions, and Challenges*

The SSH TA Center provides TA through targeted technical assistance and training for specific grantees, both on and off-site, and through TA for the entire grantee community.

### *On-site technical assistance to grantees*

The Center arranges for on-site training by experts to increase the effectiveness of grantee programs, usually in response to direct requests from the grantees. Most training events in the past year have focused on implementation of EBPs. For example, the Center provided two grantees with training on the Seeking Safety model, an EBP utilized for trauma/post-traumatic

stress disorder (PTSD) and substance abuse disorders. The Center also coordinated training on Illness Management and Recovery, an EBP that provides mental health consumers with the knowledge and skills to manage their illness, make informed treatment decisions, and work towards recovery.

When feasible, the Center arranges for more than one grantee to benefit from on-site training requests. A request by one grantee for training on Motivational Interviewing (MI), a therapeutic EBP in use by many SSH grantees, expanded to include training for the three other SSH grantees in the same geographic region.

### *Off-site technical assistance to grantees*

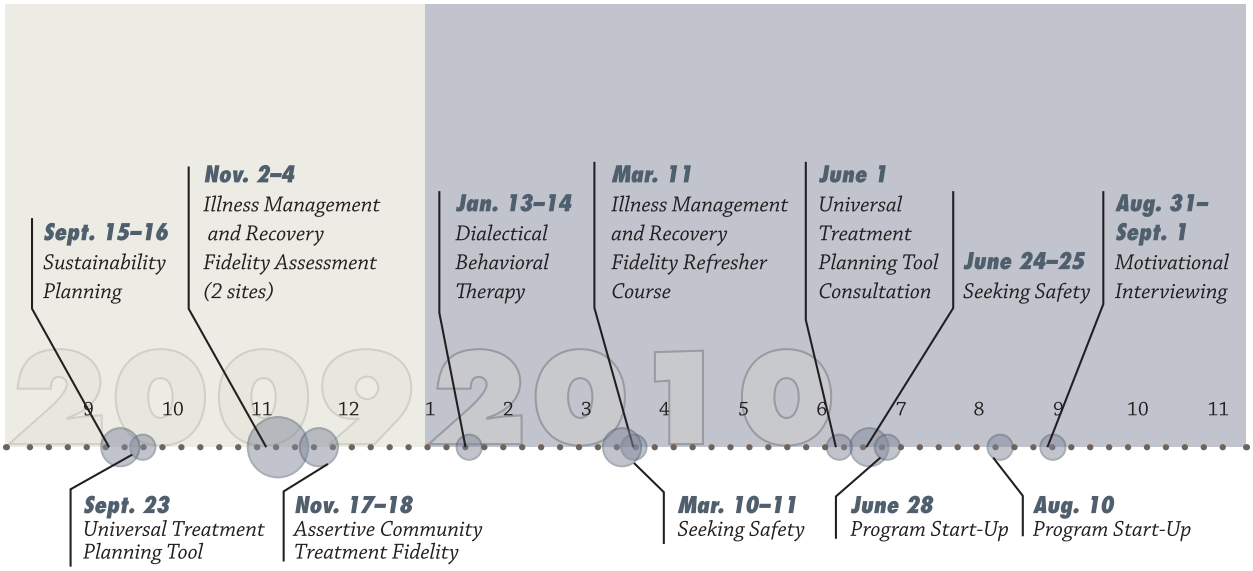
The Center also arranges for grantees to receive ongoing consultation with a TA expert via conference calls. For example, one grantee was in need of consultation and support on program implementation issues. The TA Center has arranged for the grantee's management team to have ongoing calls with Center consultants over a 4-month period. These calls focus on helping the grantee develop policies and procedures for handling fair housing and Americans with Disabilities Act (ADA) requests within the organization. As part of their work with the grantee, the consultants will develop several written products that will be made available to the SSH grantee community, since many other grantees face the same issues.

### *Combination of on-site and off-site technical assistance*

To increase the impact of TA, grantees may receive off-site assistance to reinforce guidance provided on site. For example, a site visit that focuses on implementing a particular EBP within a program may be followed with conference calls over a defined period of time to address challenges staff encounter as they apply the model. One recent example included a 2-day, on-site TA event on Illness Management Recovery followed by 6 months of TA conference calls with the clinical team implementing the model.

***Figure 4.1***

## *SSH Targeted Onsite Technical Assistance*



## *Technical assistance for the SSH grantee community*

The Center directs much of its effort to offering TA and training in formats available to all SSH grantees. The Center prioritizes topics of high interest and need that have been identified through SSH monitoring site visits, formal and informal grantee requests, new developments in the field tracked by the TA Center and other SSH staff, requests made by CMHS staff, and SAMHSA strategic initiatives.[1] The entire community of grantees is invited to receive training and TA through webinars, an online community network, and annual conferences.

*Webinars by national experts on particular practices and content areas.* In this fiscal year, well-attended webinars took place on the following three topics:

- Peer Support in Supportive Housing Settings
- Core Elements of Permanent Supportive Housing
- Housing Choice Vouchers

The webinars featured presentations by nationally respected experts and offered ample opportunities for participants to receive responses to their particular questions from the presenters. All three webinars received high marks from participants for both the quality of the presentations and their direct usefulness to grantees.

*Services in Supportive Housing Online Community Network.* The SSH TA Center regularly sends out online communications to all SSH grantees, providing information on relevant events (e.g., conferences and training opportunities in topics related to supportive housing, mental health, substance abuse disorders, COD, and trauma-informed care), and links to reports and training materials, such as SAMHSA's Permanent Supportive Housing Toolkit.

*Services in Supportive Housing Annual Grantee Conference: The Power of Community: Building Connections, Living Recovery.* The conference took place April 29–30, 2010, in Alexandria, VA. All 57 grantees funded at that point sent teams to the conference, which brought service providers together with consumers, Federal staff, and partner agencies.

The conference agenda purposely included a mix of sessions by Center for Mental Health Services Homeless Programs Branch staff, other Federal staff, expert consultants, consumer leaders, and SSH grantees. Sessions were in a variety of formats and covered program management, as well as clinical, evaluation, and research topics. Through a planning process, the agenda was developed to ensure that all grantees, both incoming and established, would be able to choose sessions that addressed their training and TA needs. Offerings ranged from panel presentations by seasoned SSH providers on challenging aspects of supportive housing, to roundtables providing lively peer-to-peer exchanges through facilitated grantee discussion, to presentations by SAMHSA leaders and Federal partners on the latest developments that had implications for the grantees, and more. The Center received approval from the National Association of Social Workers (NASW) to award Continuing Education Unit (CEU) certificates to 83 attendees.

The conference also provided opportunities for informal networking, strengthening the SSH grantee network. A conference highlight was the introduction of roundtable discussions that fostered informal exchanges among grantees and encouraged them to use each other as resources. Many participants enjoyed getting to know others during a group walk/run organized with the organization *Back on My Feet,* which engages

1 Substance Abuse and Mental Health Services Administration. SAMHSA's 10 Strategic Initiatives. Retrieved from http://www.samhsa.gov/about/strategy.aspx

people who are homeless in running as a way to build confidence, strength, and self-esteem.

A total of 254 participants attended, including 10 consumers who received scholarships. Consumers met as a group during the conference to enable them to connect with and support each other, as well as to help them develop a strong consumer voice. Several sessions were intentionally designed to address consumer issues, such as "Making Your Supportive Housing Program More Recovery-Oriented" and the powerful keynote address by Dr. Pat Deegan, which was based on her personal recovery journey.

Evaluations indicated that grantees overwhelmingly found the 2010 SSH Annual Grantee Conference a valuable learning experience and that they expected to apply much of what they gained to strengthen their SSH programs.

## *Technical assistance challenges*

As shown in the preceding discussion, grantees face a variety of challenges related to meeting the needs of specific groups and implementing EBPs and other services and supports as effectively as possible. Training and TA can greatly assist in negotiating the issues that come with providing housing and a broad array of services to diverse groups with complex needs.

The monitoring site visit teams that spend time with each grantee are an excellent resource for identifying the challenges that warrant TA. The SSH TA Center has simplified the process for grantees to request TA. From reviewing the various sources of grantee information, a picture emerges of the types of TA challenges common to a number of grantees. While not an exhaustive list, the most widespread needs are in the following areas:

- Implementation of planned EBPs with fidelity to the practice;
- Outreach efforts to identify and engage potential program participants;
- Meaningful consumer involvement;
- Housing issues (e.g., separating services from housing, understanding the permanent supportive housing model, partnering with housing providers);
- Incorporating culturally competent, trauma-informed care;
- Evaluation planning and implementation;
- Planning to ensure program sustainability;
- Assisting consumers to obtain employment;
- Developing strategies to help consumers feel part of their communities;
- Addressing the needs of women and families; and
- Increasing COD competence.

The SSH TA Center is dedicated to addressing these issues by providing resources for all grantees and by responding to specific grantees requests for more intensive, on-site expertise. The Center's staff, together with its cadre of consultants – many of whom are themselves self-identified consumers, clinicians, or directors of supportive housing initiatives – have extensive content expertise, a deep understanding of how to work with the people these programs serve, and the breadth of experience to respond to the wide range of needs and unique situations that SSH grantees confront.

# The Story Thus Far: Making An Impact

The mandate of *Opening Doors*, the 2010 Federal Strategic Plan to Prevent and End Homelessness, is clear: finish the job of ending chronic homelessness in 5 years. The 62 SSH grantees continue to work toward achievement of that goal. However, ending chronic homelessness is not just about housing. Once consumers have housing, the process of reintegration into their communities can begin.

The most pressing need is to resolve the consumer's immediate crisis and achieve housing stabilization. The data indicate that grantees are very successful at this first step. As these programs enter the fourth year of the SSH program, they often find that consumers are now ready to address other needs that will help them maintain housing. Thus, the impact of the SSH program goes beyond housing; the services and supports provided by grantees allow consumers to create and sustain a healthy trajectory in their lives.

A total of 62 organizations received Services in Supportive Housing grants. Nine organizations started their programs in October 2007 (Cohort 1), five started in May 2008 (Cohort 2), 43 started in September 2009 (Cohort 3), and five started their programs in 2010, four in April and one in September (Cohort 4).

Because of these different start times, data are available for different amounts of time for different cohorts. Cohort 1 now has 3 years of data, Cohort 2 has 3 years of data, and up to 1 year of data are available for Cohort 3. Data are not yet available for Cohort 4. Due to the different start-up times, some SSH programs enrolled consumers for as long as 3 years, while others are still within their first year. These variations have an impact on the available data.

In addition, enrollment in many of these programs is continuous throughout the life of the grant (i.e., grantees add new consumers on an ongoing basis). Thus, the number of consumers reaching the first 6-month assessment is higher than the number recorded at each concurrent 6-month assessment. Compilation of assessment data uses the aggregate number of consumers reassessed. The main impact that this has on the data is that the sample size diminishes with each successive interval. Currently, there are complete data through four assessment intervals. Only partial data exist for the fifth assessment; thus this report does not include this information.

## Impact of the Funding in the Lives of Program Participants

The SSH program confirms the evidence that permanent supportive housing with wraparound services *works*. The data for this reporting period tell us that grantees reached two of the most important goals of the program: housing stability is high, and the use of psychiatric inpatient services is low.

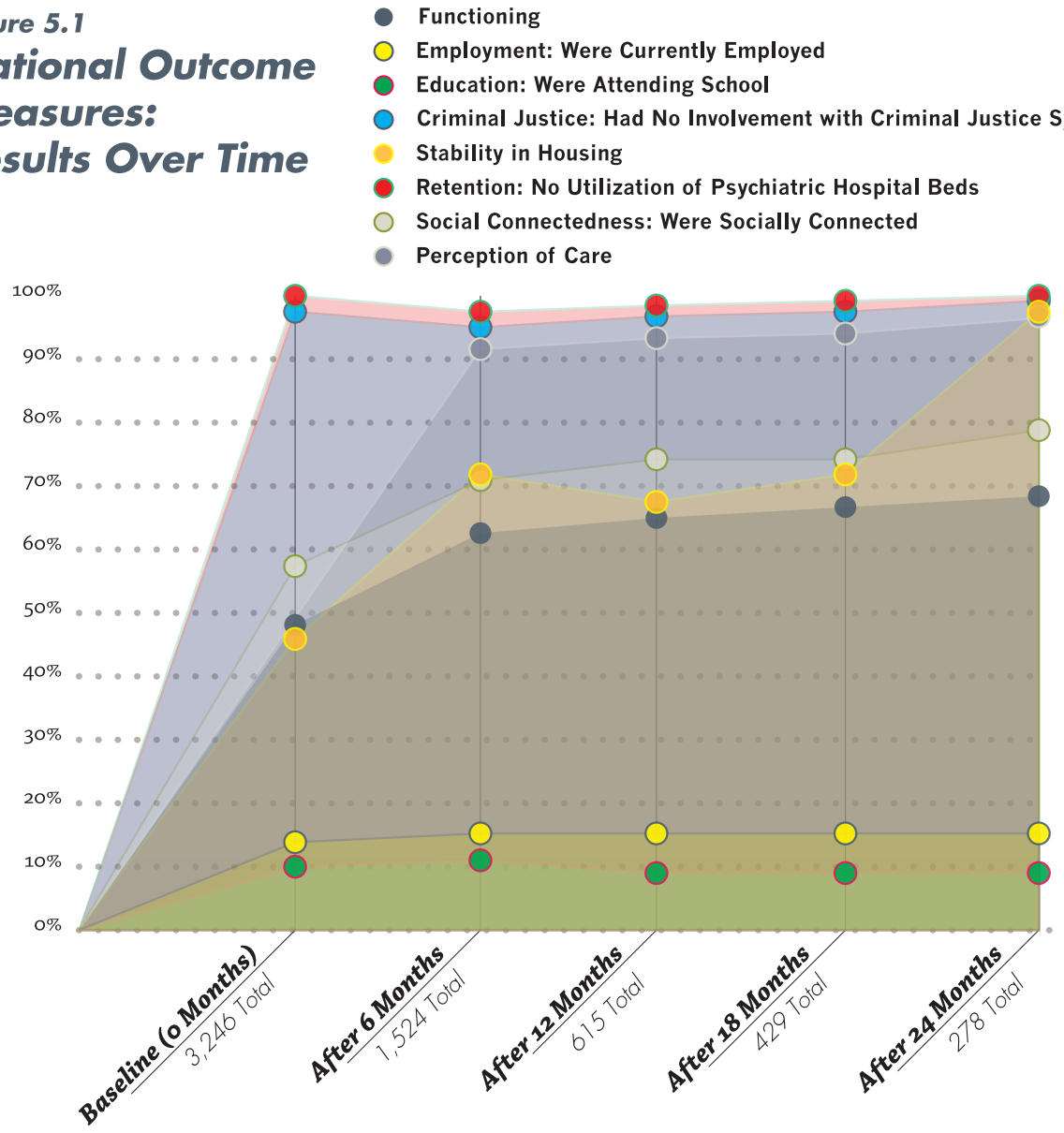
Also significant is the finding that grantees have succeeded in providing services to the number of people they said they would serve. As a result, approximately 3,421 people are no longer chronically homeless. In fact, for several of the SSH programs, some consumers are able to move into unsubsidized, market-rate units (hence "graduating" from supportive housing) because they now have sufficient employment income and connection with community and mainstream services.

## Changes across Grantees

The SAMHSA TRansformation ACcountability (TRAC) system tracks the progress of consumers on several key outcomes. These National Outcome Measures (NOMs) include consumer perception of functioning; employment; education; crime and criminal justice; stability in housing; retention (no utilization of psychiatric hospital beds in prior

*Figure 5.1*

## *National Outcome Measures: Results Over Time*




This table represents the percentage of consumers scoring positive results on each of the National Outcome Measures during each of the data collection points. The data are through September 10, 2010.

### *Finding Employment: It Takes Hope and Resilience*

In an example of success in the area of employment, one consumer enrolled in *Project Renewal,* a grantee program located in the Bronx, New York, has successfully maintained long-term employment at the VA; he takes classes and hopes to receive a promotion. Another tenant lost a job he was able to hold for 3 years. Demonstrating the resilience of many SSH consumers, he is in good spirits and applying for jobs.

30 days); social connectedness; and perception of care. It is a SAMHSA requirement that grantees record TRAC data at 6-month intervals to measure outcome success and allow for the development of creative and effective means to address any areas that remain challenges.

Figure 5.1 presents data compiled using the TRAC system for each of the NOMs on which the grantees collect and record information. The table that follows shows the percentage of consumers scoring positive results on each of the National Outcome Measures during each of the data collection points. The data shown have been collected through September 10, 2010. Note that the number of valid cases varies across each NOM.

## What the National Outcome Measures Tell Us

This section reports the "rate of change" measure for each NOM. The rate of change indicates the overall percentage change in the outcome between baseline and the first reassessment. Cases are only valid for inclusion in TRAC when they include a baseline interview and a 6-month reassessment.

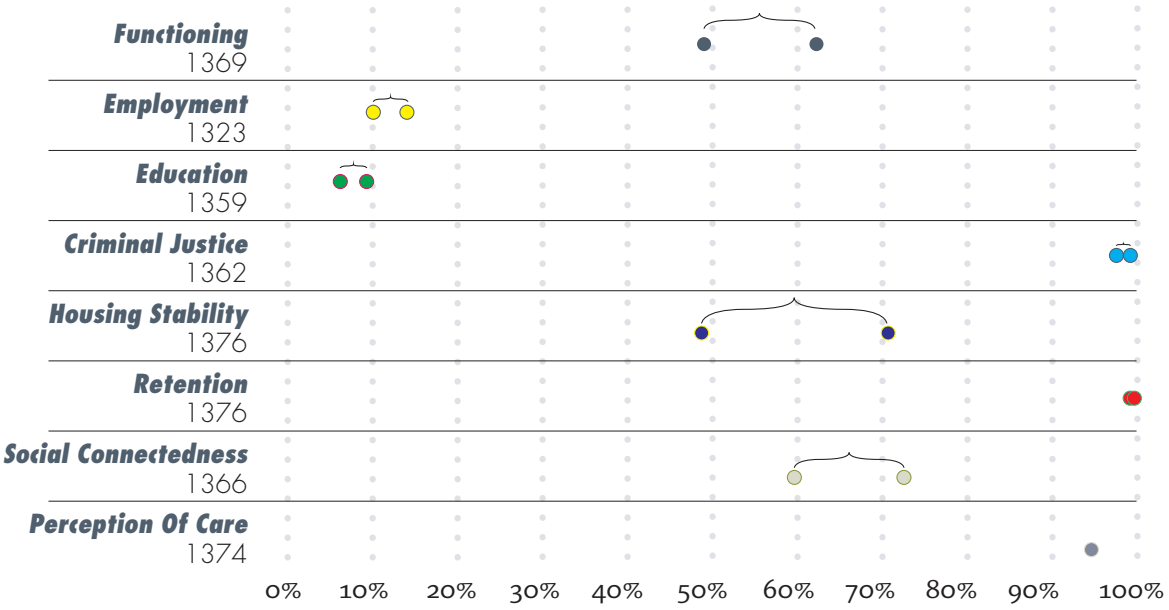
Figure 5.2 represents the rate of change across each NOM for consumers who received both an entry and first follow-up assessment. The formula to calculate the rate of change is the difference between the 6-month assessment and baseline value, divided by the baseline value.

### *Consumer perception of functioning*

In this NOMs domain, the rate of change is 24.7 percent. Perception of functioning depends on the consumers' interpretations of their growth resulting from involvement with the program. This measure assesses whether they have a negative, neutral, or positive perception in areas such as ability to deal with crisis situations, symptom reduction, and general comfort with life. Consumers showed an increase in their level of function from 50.5 percent at baseline to 63.0 percent within 6 months of engagement. After that point, the data reveal a "leveling off" of

*Figure 5.2*

## National Outcome Measures: Rates of Change




This table represents the rate of change across each NOM for consumers who received both an entry and first follow-up assessment. The formula to calculate the rate of change is the difference between the 6-month assessment and baseline value, divided by the baseline value.

the number of consumers who report a positive perception of functioning. One potential reason for this is that as consumers settle into their programs and become more independent, a reduction in the intensity of services occurs. A primary goal behind the SSH initiative is to empower marginalized persons to regain control over their lives. By stepping down the intensity of services, consumers are able to start displaying the independence and life skills gained throughout engagement in the program.

As demonstrated in Figure 5.3, consumers demonstrated the biggest changes in statements such as, "My housing situation is satisfactory," and "I am getting along with my family."

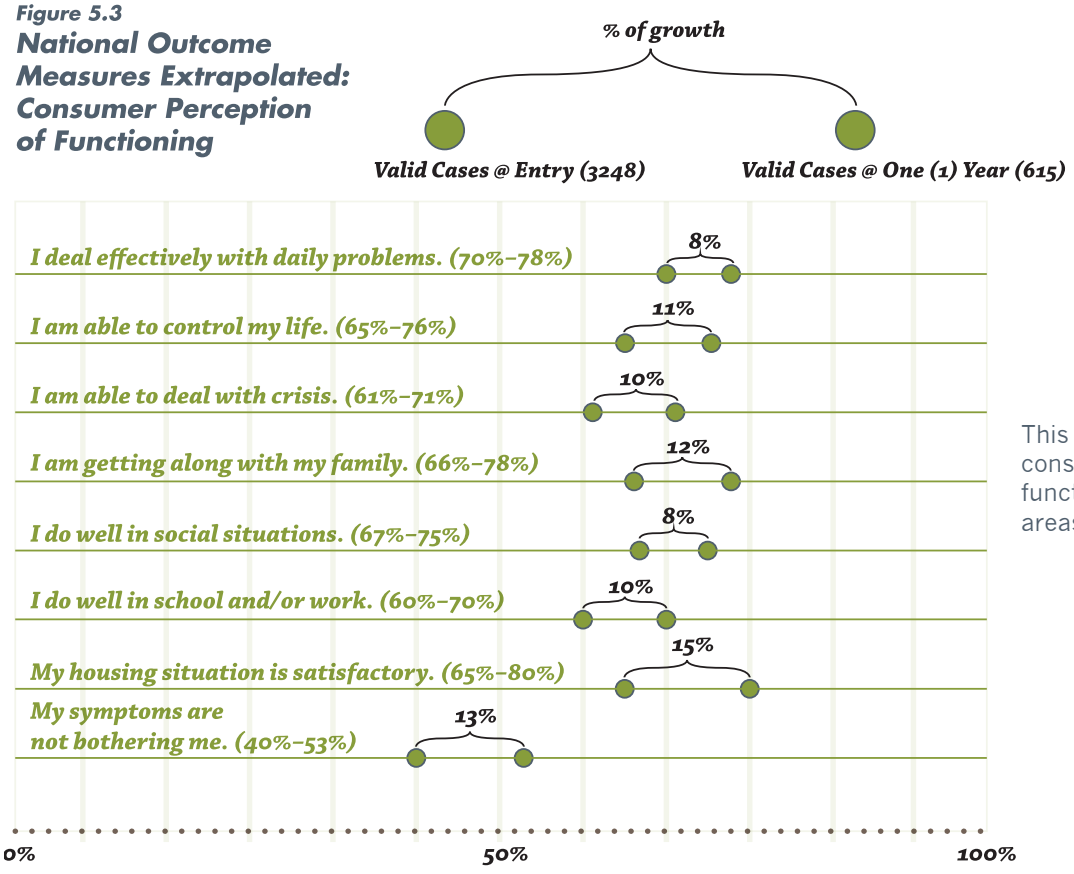
## *Employment and education*

NOMs in the areas of employment and education reflect the challenges faced by persons experiencing chronic homelessness (14.3 percent rate of change for education; 20.0 percent rate of change in employment).

Employment is important for many reasons. It helps people maintain housing and prevents homelessness. However, as John Rio and Gary Shaheen further elaborate, "offering work at the earliest opportunity when people ask for help motivates people who are chronically homeless to seek connections with service providers and address treatment issues."[1]

On the other hand, *Saint Vincent de Paul Village's ACT Project* in San Diego, California, reported difficulty in helping consumers

***Figure 5.3***
***National Outcome Measures Extrapolated: Consumer Perception of Functioning***




This chart demonstrates consumer perception of functioning across different areas.

1 Shaheen, G. & Rio, J. (2007). Recognizing work as a priority in preventing or ending homelessness. *Journal of Primary Prevention*, 28(3–4), 341–359.

### *Rebuilding Relationships*

"Sue" is 49 years old and has a long history of homelessness. She entered housing from the streets through the *Tulsa Housing and Recovery (T-HARP)* program in Tulsa, Oklahoma. Her history of addiction and schizophrenia led to estrangement from all of her family including her children, grandchildren, and sister. When Sue entered housing, she was reluctant to address this painful history. However, she did agree to enroll in the program and soon began to attend Seeking Safety and Double Trouble in Recovery groups, which led her to participate in therapy and group activities.

Today, her life is much different from before the program. Sue remains sober and her mental health has improved. She started volunteering and actively looks for things to do. One of the best outcomes for Sue is that she is engaged in rebuilding her relationships with family members.

understand that they can benefit from employment. *Community Mental Health Affiliates, Inc.* in New Britain, Connecticut, noted that consumers "overwhelmingly want to work or go to school," but "legal histories, medical issues and mandated appointments often preclude work."

As the SSH programs continue to mature, grantees anticipate an increased focus on education and employment. The experience of this program shows that housing is not affordable on Social Security Income (SSI) alone. The only solutions are access to a long-term subsidy to help pay for housing or competitive employment.

## *Crime and criminal justice*

Although the rate of change is low in this area (.2 percent), this number reflects the fact that 97.8 percent of SSH consumers *had no involvement* with the criminal justice system during the reporting period (up from 97.6 percent). Such data may indicate that grantees are succeeding at helping consumers avoid problems in this area.

## *Stability in housing*

*CaringWorks, Inc.,* in Decatur, Georgia, attributes its housing retention rate to allowing consumers to participate in a highly supportive program; staff work individually with consumers to build trust. *Cook Inlet Housing Authority,* in Anchorage, Alaska, works with consumers to establish healthy relationships with landlords from the start of the lease. *Project H.O.M.E.* in Philadelphia, Pennsylvania, notes the benefit of having a variety of different housing models from which consumers can choose, allowing the program to meet individual needs.

## *Retention*

NOMs defines retention as no utilization of psychiatric hospital beds in prior 30 days. The vast majority (99.7 percent) of SSH grantee

consumers did not need to access psychiatric hospital beds during the reporting period. It is not surprising, then, that the rate of change for retention is minimal. Because so many SSH consumers experience mental health issues, these data represent a significant achievement.

### *Social connectedness*

For many consumers, once they move into housing, social connectedness needs begin to emerge. However, in the words of one grantee, consumers' histories of alienation from family members and support systems make community connection an ongoing challenge. The rate of change in the area of social connectedness reflects these challenges, at 20.4 percent. Despite such problems, providers must ensure that consumers are not completely isolated and lacking meaningful activity. They themselves cannot meet this need, however. As Pat Deegan, Ph.D. of Pat Deegan & Associates noted at the 2010 Services in Supportive Housing Annual Grantee Conference, "Those who are paid to work with people with psychiatric diagnoses need to understand their role: They are a bridge into community, not a destination."[2]

There are signs of success in this area. For example, *Cook Inlet Housing Authority* in Anchorage, Alaska, is one of two grantees from the initial group of grantees (along with Missouri's *Phoenix Programs*) with a zero percent rate for "outcome remaining below desired level" in the domain of social connectedness. The program places an emphasis on building a "web of support" within the community so that consumers feel connected.

» *Harbor Homes, Inc.* in Nashua, New Hampshire, has consumer-operated peer support programs that provide recreational activities, socialization, peer support, advocacy, and free nightly meals to people experiencing homelessness who have mental illnesses and/or substance use disorders. They also offer a Social Club Outreach Activities Program, which offers year-round recreational and socialization activities.

### *Perception of care*

As part of the data collection process, grantees ask a series of questions to understand how consumers view the care provided. These questions allow consumers to evaluate their experience of engagement in the program. For example, the questions assess perceptions of their ability to be candid with staff, involvement in determining treatment goals, and satisfaction with services. Consumer perceptions are useful to understand whether practices are well received in correlation to success of the treatment method. Based on the data collected, 94 percent of the consumers report a positive perception of care after engagement in the program for a minimum of 6 months.

## Lessons Learned from the Services in Supportive Housing Program

Throughout the duration of the SSH program, grantees have reported lessons they would like to share with other grantees. Some programs may find these strategies relatively easy to implement; others may require more in-depth expertise. For those grantees, the SSH TA Center is available to provide technical assistance.

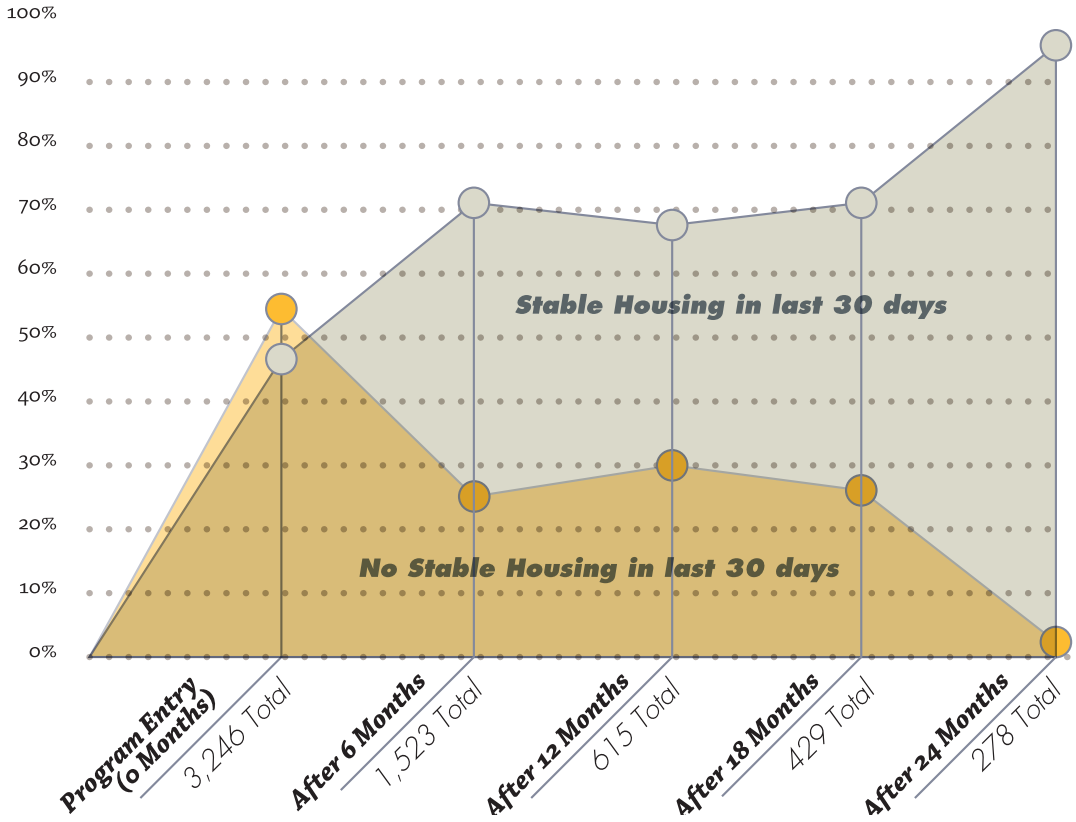
Overall, this "hands-on advice" falls into four categories: *consumer-related needs*, *staffing*, *program characteristics*, and *working with the community*. These lessons learned are presented below to allow other supportive housing providers to benefit from the experiences gleaned by SSH grantees during the first four years of the program.

2 Deegan, P. "The Greening Spring: Reflections on Recovering into Community." Keynote Address at the Services in Supportive Housing Annual Grantee Conference, Alexandria, VA, April 29–30, 2010.

*Figure 5.4*

## Percentage of Consumers Who Had Stable Housing: Enrollment through 24 Months

The rate of change in the area of Stability in Housing ("had a permanent place to live in the community") is high at 44.6 percent. The chart to the right shows the percentage of consumers successfully housed over the duration of 24 months.




### *Consumer-related needs*

Grantees strive to adapt to the needs of individual consumers and constantly work to reconnect them with their communities. Examples of specific effective strategies include:

- Implement a trauma-informed approach. A person cannot experience homelessness without being traumatized.
- Build the program around the consumers served and provide individualized services to each consumer.
- Engage consumers in social activities. Consumers need a community of peers.
- Set realistic expectations. It may take consumers several years to engage in changes.

### *Staffing*

Consumer recovery is predicated on motivated, committed, and professional staff. Grantees found the following personnel strategies to be essential:

- Create a supportive work environment to attract and retain staff.
- Include peer support specialists and recovery support specialists in the program's staffing plan.
- Provide staff with training throughout the program to increase effectiveness.

### *Program characteristics*

Successful programs are dynamic and adapt to the ongoing needs of the people they serve, while remaining true to their missions. Grantees report the following effective approaches:

» Evaluate the program continuously and make adjustments as needed.

» Be flexible with the model.

» Be dedicated to the cause of the program.

» Expect the unexpected.

### *Working with the community*

The very purpose of the SSH program is "a life in the community for everyone." To connect with the community effectively, grantees advise:

» Engage other providers early in the program, as they can be invaluable resources.

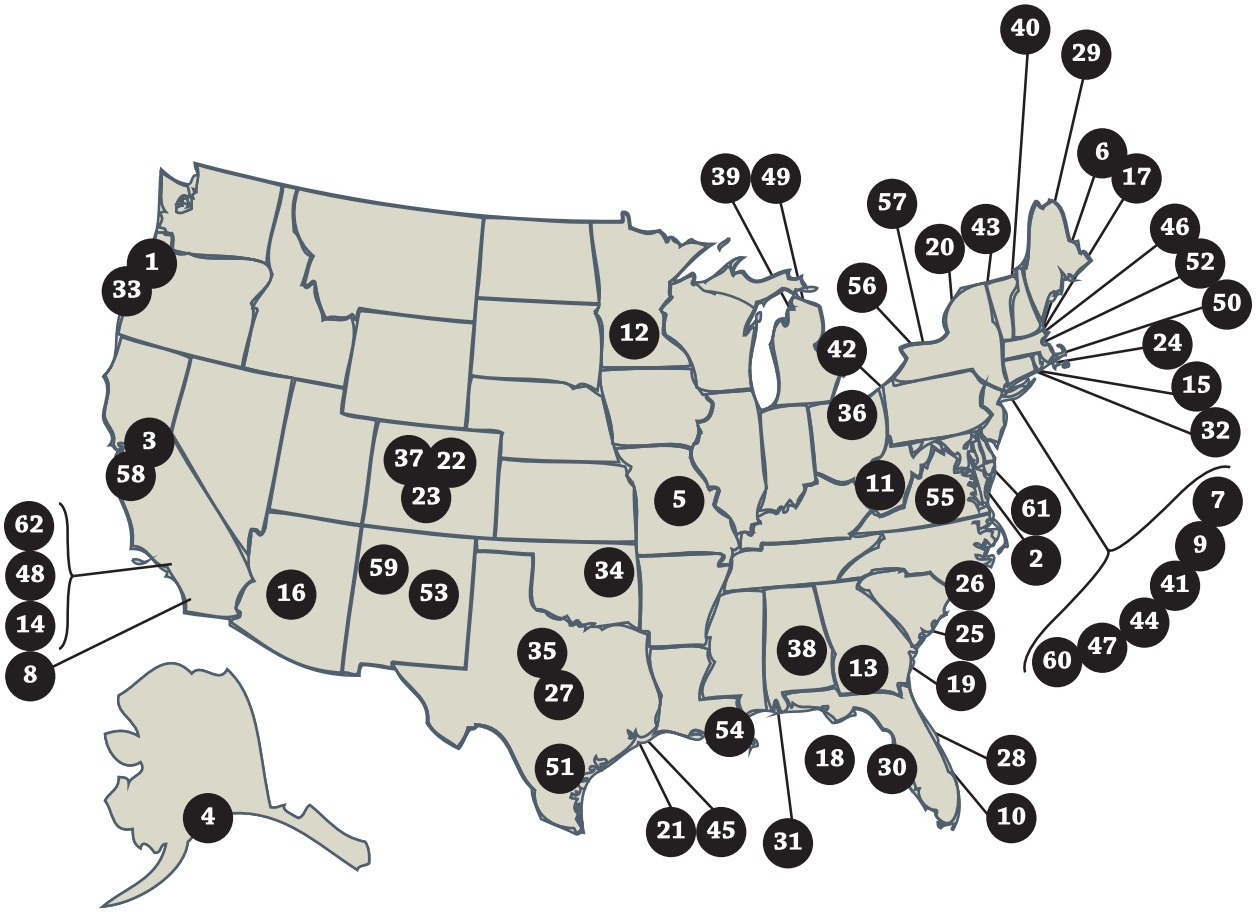
» Learn about the community before starting the program.

» Determine how the program will benefit the community.

## *In Conclusion*

The Substance Abuse and Mental Health Services Administration (SAMHSA) designed the Services in Supportive Housing program to help realize its vision of "a life in the community for everyone." Through the dedication of the program's 62 grantees in their efforts to promote consumer involvement, cultural competence, trauma-informed care, and evidence-based practices, over 3,400 individuals have been supported in their transition to permanent housing. Services in Supportive Housing (SSH) provides consumers with long-term, community-based housing options. The program gives consumers a voice in their permanent housing and supportive services and can serve as a model for ending long-term chronic homelessness.

The SSH program helps rebuild lives, offers hope, and provides real solutions.




## 2007

1. **Central City Concern**—*Portland, Oregon*
2. **Community Connections, Inc.**—*Washington, District of Columbia*
3. **Contra Costa Health Services**—*Martinez, California*
4. **Cook Inlet Housing Authority**—*Anchorage, Alaska*
5. **Phoenix Programs, Inc.**—*Columbia, Missouri*
6. **Pine Street Inn**—*Boston, Massachusetts*
7. **Project Renewal, Inc.**—*New York, New York*
8. **St. Vincent de Paul Village**—*San Diego, California*
9. **Vocational Instruction Project Community Services, Inc.**—*Bronx, New York*

## 2008

10. **Homeless Services Network of Central Florida**—*Orlando, Florida*
11. **Prestera Center for Mental Health Services, Inc.**—*Huntington, West Virginia*
12. **Resource, Inc. Spectrum Community Mental Health**—*Minneapolis, Minnesota*
13. **River Edge Behavioral Health Center**—*Macon, Georgia*
14. **Southern California Alcohol and Drug Programs, Inc.**—*Downey, California*

## 2009

15. **ALSO Cornerstone, Inc.**—*New Haven, Connecticut*
16. **Arizona Behavioral Health Corporation**—*Phoenix, Arizona*
17. **Boston Public Health Commission**—*Boston, Massachusetts*
18. **Bridgeway Center, Inc. Ft.**—*Walton Beach, Florida*
19. **CaringWorks, Inc.**—*Decatur, Georgia*
20. **Catholic Social Services of the Diocese of Scranton, Inc.**—*Scranton, Pennsylvania*

21. **Change Happens—***Houston, Texas*
22. **Colorado Coalition for the Homeless—***Denver, Colorado*
23. **Colorado Department of Human Services—***Denver, Colorado*
24. **Community Mental Health Affiliates, Inc.—***New Britain, Connecticut*
25. **Douglas County Community Services Board—***Smyrna, Georgia*
26. **Families First, Inc.—***Atlanta, Georgia*
27. **Foundation Communities—***Austin, Texas*
28. **Grand Avenue Economic Community Development Corp.—***Orlando, Florida*
29. **Harbor Homes, Inc.—***Nashua, New Hampshire*
30. **Homeless Emergency Project, Inc.—***Clearwater, Florida*
31. **Housing First, Inc.—***Mobile, Alabama*
32. **Liberty Community Services, Inc. (LCS)—***New Haven, Connecticut*
33. **Luke-Dorf, Inc.—***Tigard, Oregon*
34. **Mental Health Association in Tulsa, Inc.—***Tulsa, Oklahoma*
35. **Mental Health Mental Retardation of Tarrant County—***Ft. Worth, Texas*
36. **Mental Health Services for Homeless Persons, Inc.—***Cleveland, Ohio*
37. **Mercy Housing Colorado—***Denver, Colorado*
38. **Montgomery Area Mental Health Authority, Inc.—***Montgomery, Alabama*
39. **Neighborhood Service Organization—***Detroit, Michigan*
40. **Pathways to Housing—***Burlington, Vermont*
41. **Pathways to Housing, Inc.—***New York, New York*
42. **Pittsburgh Mercy Health System (DBA Mercy Behavioral Health)—***Pittsburgh, Pennsylvania*
43. **Project H.O.M.E.—***Philadelphia, Pennsylvania*
44. **PSCH, Inc.—***Flushing, New York*
45. **Service of the Emergency Aid Resource Center for the Homeless—***Houston, Texas*
46. **ServiceNet, Inc.—***Northampton, Massachusetts*
47. **Services for the UnderServed, Inc.—***New York, New York*
48. **Skid Row Housing Trust—***Los Angeles, California*
49. **Southwest Counseling Solutions—***Detroit, Michigan*
50. **Steppingstone, Inc.—***Fall River, Massachusetts*
51. **The Center for Health Care Services—***San Antonio, Texas*
52. **The Center for Human Development, Inc.—***Springfield, Massachusetts*
53. **The Life Link—***Santa Fe, New Mexico*
54. **UNITY of Greater New Orleans—***New Orleans, Louisiana*
55. **Virginia Supportive Housing—***Richmond, Virginia*
56. **Volunteers of America of Western New York, Inc.—***Rochester, New York*
57. **YWCA of Greater Harrisburg—***Harrisburg, Pennsylvania*

## *2010*

58. **Catholic Charities of Santa Clara—***San Jose, California*
59. **Community Area Resource Enterprise—***Gallup, New Mexico*
60. **Greenhope Housing Development Fund—***New York, New York*
61. **Woman Accepting Responsibility—***Baltimore, Maryland*
62. **Ocean Park Community***—Santa Monica, California*

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Services in Supportive Housing

The co-authors of the Services in Supportive Housing 2010 Annual Report are: Ellen Bassuk, M.D.; Kameisha Bennett; Tammy Bernstein, M.P.A.; Livia Davis, M.S.W., C.S.W.M.; Ann V. Denton, M.Ed.; Megan Edson Grandin; Susan Hills, Ph.D.; Anne Lezak, M.P.A.; Terry Murphy, Ph.D.; Alexander Steacy; and Suzanne Zerger, Ph.D. Susan Hills, Ph.D. edited the report. Jason Wharff designed the final layout.

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