

**Government of the District of Columbia
Department of Mental Health
Supportive Housing Strategic Plan
2012 – 2017**

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**Completed by:
Technical Assistance Collaborative**

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I. Introduction

A. Overview of the Task/Key Objectives of the Plan

The Washington, D.C. Department of Mental Health (DMH) has committed its efforts to developing a system that supports individuals with mental illness in integrated, community-based settings. Accordingly, DMH recognizes the important role that community-based housing – particularly Permanent Supportive Housing – has in achieving this objective. The United States Substance Abuse and Mental Health Services Administration (SAMHSA) describes Permanent Supportive Housing (PSH) as “decent, safe, and affordable community-based housing that provides tenants with the rights of tenancy under state and local landlord tenant laws and is linked to voluntary and flexible support and services designed to meet tenants’ needs and preferences.”¹

In April 2012, DMH initiated a process to evaluate its current system of DMH-supported housing and to identify strategies to ensure a continuum of community-based housing and support services that meet consumer needs, are built on best practices, are consistent with DMH priority population needs, and are cost-effective.

DMH retained The Technical Assistance Collaborative, Inc. (TAC) through a competitive Request for Proposals (RFP) process to facilitate a strategic planning process with stakeholders, DMH staff, and other partners that would result in a strategic plan that includes a series of recommendations for DMH to work from as it advances its supportive housing objectives over the next five years.

Between April and June 2012, TAC evaluated the current system of housing and supports for individuals with serious mental illness, engaged stakeholders through a workgroup process, interviewed key informants and met with DMH leadership and key staff to formulate strategic recommendations.

The result of this work is the five year Strategic Supportive Housing Plan, a document that establishes the guiding strategies for DMH’s future activity in PSH and contains specific actions to be implemented by DMH. This Strategic Supportive Housing Plan will not be a static document but will evolve over the next five years as circumstances dictate.

DMH would like to thank the workgroup members and other key stakeholders who participated in this process for their frank, honest feedback during meetings and interviews, and for their commitment and desire to strive for the strongest system possible. A list of workgroup members and other key informants is included in **Appendices B and C**.

¹ SAMHSA. (2010). Permanent Supportive Housing Evidence-Based Practices (EBP) KIT. PowerPoint Presentation: <http://store.samhsa.gov/product/SMA10-4510>.

B. Policy Framework for DMH Strategy

Like other jurisdictions across the country, DMH is responsible for managing a public mental health system that meets the diverse needs of its residents. Whereas the mental health needs of individuals are frequently complicated by other complex social problems, DMH has had to venture into non-traditional areas in order to best meet the needs of individuals. Often, this means directly providing rental assistance and capital funding or playing a central role in organizing housing-related resources so that consumers have access to quality, affordable housing. Part of this strategic planning process was to help DMH re-balance its responsibilities as the mental health authority and its role in housing.

DMH has demonstrated a commitment to enabling people with mental illness served by the Department to live in integrated, community-based settings. Over the past several years, DMH has substantially increased its capital and rental assistance funding for PSH. In Fiscal Year 2013, DMH added another \$5 million to its capital funding pool, bringing the total amount allocated to this program to \$19 million, and added an additional \$1.2 million to the DMH Home First Program. Between Fiscal Years 2012 and 2013, DMH created 300 new Home First rental subsidies. Approximately 54% of DMH's housing resources provide funding to individuals in PSH settings.

The move toward PSH is consistent with best practice. While DMH has articulated the need to provide a continuum of residential options for individuals based upon their needs, it desires to increase its emphasis on the use of PSH within its system for individuals with a range of mental health needs. PSH is known to be effective for a wide range of individuals who need intensive supports, including those with severe mental illness who are chronically homeless, those leaving long-term hospitalization, and those who are highly symptomatic. For the sake of brevity of this report, a list of resources demonstrating the effectiveness of PSH is attached in **Appendix H**.

Further, the emphasis on true community integration and the increasing acceptance of person-centered, recovery-oriented services at the federal, state, and local level is pushing jurisdictions like the Department of Mental Health to create systems of housing and services that enable individuals to lead normalized, non-segregated lives in communities of their choice. The literature also suggests that the move toward integrated, PSH settings is also more cost-effective than older, more traditional program and staffing-based models of residential care.

This strategic plan comes at an important time for DMH. In December 2011, the Department entered into a Settlement Agreement, establishing final exit criteria from the long standing *Dixon* case which has roots dating back to 1974.² One of the requirements of the Agreement was to develop a strategic plan to address the needs for supportive housing within the District. This Supportive Housing Strategic Plan is intended to satisfy that requirement.

² Dixon Settlement Agreement;
http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/DixonSettlementAgreement/Settlement_Agreement.pdf

Earlier this year, Mayor Vincent Gray established the Comprehensive Housing Strategy Task Force (HTF).³ In creating the HTF, Mayor Gray stated, “The goal of the Comprehensive Housing Strategy Task Force is to help city leaders ensure the creation of more affordable housing for residents of the District of Columbia.” The DMH Supportive Housing Strategic Plan contains several strategies to maximize the use of various funding sources for housing development that can inform this district-wide process.

Over the past several years, DMH has structured its service delivery system through the Mental Health Rehabilitation Services (MHRS) option. While the MHRS is a Medicaid-based system and does not pay for non-Medicaid eligible services, the flexible structure of the program is designed to support individuals in independent, community-based settings rather than siloed, program-based approaches and is consistent with the PSH model. “The Department’s goal is to deliver mental health services that promote recovery, respect cultural and linguistic diversity, and are choice-driven through the Mental Health Rehabilitation Services system for community-based care. The MHRS system is based on individualized services and supports.”⁴

The strategies in this report build on this policy framework, and help position DMH to achieve its objectives of facilitating a continuum of integrated, affordable housing options for people with mental illness, and serving as many people in PSH as possible.

II. Methodology

In order to assist with the development of the strategic plan, DMH issued a competitive Request for Proposals in February 2012. The Technical Assistance Collaborative, Inc. (TAC), a Boston-based, nonprofit consulting firm, was awarded the contract and began facilitating the strategic planning process with the Department in April 2012. Between April and June 2012, a TAC team of multi-disciplinary professionals with expertise in mental health and affordable housing systems met with DMH staff, stakeholders, and other government agencies within the District to help formulate the basis for the strategic recommendations identified in this report.

As part of this strategic planning process, DMH requested that TAC incorporate the following components as a framework for the Strategic Supportive Housing Plan:

1. A description of the range of housing offered to individuals with a severe mental illness, including a description of the DMH’s full array of services and other services that should be offered by the Department;
2. An inventory of both supportive and non-supportive housing offered by DMH and other District agencies and/or providers for individuals with a severe mental illness. This includes the identification of areas of duplication, gaps in services and unmet needs, and a description of specific strategies to meet identified unmet needs;

³ Comprehensive Housing Strategy Task Force: <http://www.taskforce2012.org/Purpose/tabid/250/Default.aspx>

⁴ DMH webpage: <http://www.dmh.dc.gov/dmh/cwp/view.a,3,q.515826,dmhNav,%7C31250%7C.asp>

3. A uniform and objective methodology for evaluating need for supportive housing, establishing different levels of priority of need, and assigning all supportive housing using the proposed methodology and system of prioritization;
4. A description of a proposed mechanism for determining the need for supportive housing, including an articulation of the eligibility requirements that should be used to distribute available housing vouchers and other supports;
5. A proposed strategy for integrating the services of Peer Specialists into the housing service delivery system to assist individuals with mental illness to move to a less restrictive alternative housing option and to maintain community tenure; and
6. Development of a five-year plan to expand housing.

A. Planning with DMH Staff

TAC met with DMH leadership, including Director Baron and Senior Deputy Director Bazron, and with housing and program staff at a kick-off meeting on April 12, 2012, and on several other occasions throughout the process to evaluate findings, debrief on workgroup meetings and key informant interviews, and formulate strategic actions. Director Baron and Senior Deputy Director Bazron also facilitated access to key informants in the Mayor's office, the District's Housing Finance Agency (DCHFA), and various providers.

B. Housing and Services Inventory Analysis

Over the years, various assessments of the public mental health system in Washington, D.C. have been conducted that continue to move the system to a recovery-orientation. Among these are two reports from RAND: *A Guide to the Behavioral Health System in the District of Columbia* and *Behavioral Health in the District of Columbia: Assessing Need and Evaluating the Public System of Care* (October 2010)⁵ that broadly assessed the behavioral health system and provided useful background information for this focused planning effort.

As part of this process, TAC specifically evaluated the current array of housing and housing-related supports in order to inform the thinking of the workgroups and DMH staff, and to better understand existing pathways and operations in order to identify potential areas for improvement. The consultants reviewed various sources of information, including budget documents, regulations, contracts, existing housing inventory information, federal housing and services data and grant information, census data, Requests for Proposals, and provider documents related to DMH housing programs. In addition, regulations, contracts, the SAMHSA block grant, DMH program summary documents, census data, and budget information were reviewed. Key informant interviews were conducted for both housing and services to inform the planning process and to formulate the recommendations to be contained within the Supportive Housing Strategic Plan.

⁵ RAND: http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR914.sum.pdf, and: http://www.rand.org/pubs/working_papers/2010/RAND_WR777.pdf

C. Stakeholder Participation and Meetings with Key Informants

Consumers and other stakeholders were actively involved in the planning process. As a result, this effort included: four separate workgroups with 51 different stakeholders representing various groups; 32 key informant interviews; a focus group of housing operators; and numerous phone calls and on-site discussions with DMH staff. Stakeholders from various interested groups included housing and service providers, consumers, family members, advocates, and other relevant District agencies. Key informant interviews included specific provider agency staff, housing developers, and staff within Mayor Gray's office. The focus group with housing operators discussed the issues that they experience when providing housing to people with mental illness and working with provider staff.

The general purpose of the workgroups was to provide guidance and information to be used by TAC to develop a series of recommended strategies for DMH to consider. At the kick-off meeting for each workgroup, a PowerPoint (**Appendix E**) was presented that briefly described this process and preliminary findings relevant to each group. (See **Appendices B, C, and D** for a list of workgroup members, key informants interviewed, and workgroup descriptions and summaries.) The four workgroups included:

1. Housing Utilization and Maximization Workgroup: This workgroup generally explored ways to increase and maximize the supply of affordable housing.
2. Service Needs and Realignment Workgroup: This workgroup generally identified strengths, duplication, and gaps in the residential services continuum and suggested ways to improve the continuum of residentially-based services.
3. Supportive Housing Eligibility and Allocation Workgroup: This workgroup generally examined mechanisms to establish uniform and equitable eligibility and allocation criteria for PSH.
4. Workforce and Training Workgroup: This workgroup generally examined workforce issues in PSH settings and suggested mechanisms to increase the competency and quality of the workforce in residentially-based settings.

D. DMH Needs Assessment

To help inform DMH, as well as the Mayor's Comprehensive Housing Strategy Task Force, TAC developed a methodology to identify the affordable housing and permanent supportive housing (PSH) needs for people with mental illness living in the District. The methodology and needs assessment is further detailed in Section IV. The intent of this process was to: 1) establish an estimate of the supply of affordable housing that should be available in the District to meet the affordable housing needs of people with mental illness; and 2) establish an estimate of PSH still needed for people with mental illness living in the District.

III. Baseline Description of Housing and Services

Section A below provides a description of the range of housing offered to individuals with a serious mental illness, including an inventory of both supportive and non-supportive housing offered by DMH and other District agencies and providers. Section B presents the array of services and ancillary supports available to consumers.

A. Description of Available Permanent Supportive Housing (PSH)

DMH and its partner agencies have developed an array of PSH that is available to DMH priority consumers. This includes a total of 2,434 PSH units throughout the District. The breadth and array of PSH available is a real strength of the system. In addition, DMH and its provider network have embraced and offer a broad range of PSH which is often not the case in many communities that still maintain rigid allegiance to outdated housing models. As a byproduct of the range and quantity of PSH options available, there are several pathways or entry points to access these PSH opportunities, including PSH programs sponsored by DMH, the D.C. Department of Human Services (DHS), or specific providers (e.g. funded directly by the HUD McKinney-Vento Supportive Housing Program). This often presents challenges for the overall system in offering transparent and fair access to these resources. Below is a baseline discussion of the PSH resources in the District, as well as, a description of other housing services available to consumers.

1. DMH-Sponsored Permanent Supportive Housing (PSH)

Home First Rental Assistance Program – DMH provides 675 Home First tenant-based vouchers for DMH priority consumers. The purpose of the Home First program is to provide a temporary rent subsidy until the consumer is able to access a Section 8 Housing Choice Voucher. The Home First program generally mirrors the Section 8 Housing Choice Voucher Program except that contract rents are capped at 80% of FMR. The D.C. Public Housing Authority (DCHA) administers the rental assistance on behalf of DMH. The DMH Housing staff serves as the access point and manages the waiting list for the Home First vouchers.

Local Rent Subsidy Program (LRSP) – DCHA administers 121 project-based rent subsidies assigned to nine DMH-sponsored projects. These projects accept referrals of DMH priority consumers for these targeted units. The District of Columbia locally provides the resources to support the LRSP vouchers.

DCHA Partnership Program/Section 8 Project-Based Vouchers – DCHA administers its Section 8 Project-Based Voucher Program, named the Partnership Program. There are 117 project-based vouchers assigned to 11 DMH-sponsored projects. Referrals are made by both DMH and its Core Service Agencies (CSAs).

Shelter Plus Care Program – DMH is the grantee for 15 Shelter Plus Care tenant-based subsidies targeted to homeless individuals with serious mental illness. The Community Partnership administers the Shelter Plus Care Program on behalf of DMH.

2. DCHA-Sponsored Permanent Supportive Housing (PSH)

Non-Elderly Disabled Vouchers – The D.C. Housing Authority (DCHA) oversees and administers 200 non-elderly disabled (NED) vouchers on behalf of the District of Columbia. Of this allocation, DCHA targets 182 of these tenant-based Section 8 vouchers for DMH priority consumers. DMH coordinates referrals to DCHA for these housing resources.

St. Elizabeth’s Hospital Section 8 Housing Choice Voucher Set-Aside – As part of its Section 8 Housing Choice Voucher Program, DCHA has elected to establish a Section 8 set-aside for 50 tenant-based vouchers made available for non-elderly persons with a disability who are making the transition from St. Elizabeth’s Hospital to community-based living. DMH coordinates referrals to DCHA by identifying eligible DMH consumers from St. Elizabeth’s Hospital.

Chronically Homeless Set-Aside – As part of its Section 8 Housing Choice Voucher Program, DCHA has also established a Section 8 set-aside for up to 447 tenant-based vouchers for chronically homeless individuals and families. As part of this, 75 tenant-based vouchers are set-aside for chronically homeless individuals with serious mental illness. DMH makes the referrals to DCHA to take advantage of this resource when available.

Mainstream Disability Vouchers – DCHA was competitively awarded 100 tenant-based vouchers through HUD’s Mainstream Program. These tenant-based vouchers must be utilized by persons with a disability. Forty of these tenant-based vouchers are set-aside for persons with a serious mental illness. DMH coordinates all referrals to DCHA upon turnover.

3. D.C. Department of Human Services-Sponsored Permanent Supportive Housing (PSH)

DHS Permanent Supportive Housing Program – The D.C. Department of Human Services (DHS) manages the Permanent Supportive Housing program (PSHP) serving 800 homeless individuals and 250 families. The program offers a rental subsidy linked with case management services provided by DHS. DHS assesses and coordinates access to the PSHP using a vulnerability index (VI) assessment tool to identify the “most in need” households. The District of Columbia supports the program with local resources.

4. The Community Partnership (TCP)-Sponsored Permanent Supportive Housing (PSH)

TCP’s Shelter Plus Care Program – As part of the District’s homeless Continuum of Care, the Community Partnership (TCP) administers the Shelter Plus Care resources comprised of 1,650 rent subsidies for homeless individuals and families with a disability. Many of these S+C vouchers serve homeless individuals with serious mental illness. TCP manages the waiting list and referral process for these housing resources with its homeless service provider network. Many of these service providers are also DMH Core Service Agencies (CSAs).

5. DMH Provider Owned and Managed Housing

DMH Provider Owned and Managed Housing – Several DMH providers own and manage supportive housing for individuals with serious mental illness. These housing options are typically comprised of site-based PSH projects. The providers manage these PSH units and coordinate the outreach and referral to identified eligible tenants. These projects have received capital financing and operating subsidy support from a variety of sources including HUD homeless vouchers for the disabled and DMH subsidy and capital funding.

Tables 1 and 2 below provide an inventory of PSH and other DMH housing programs. This information is used in Section IV to develop an assessment of affordable housing and PSH need for consumers with mental illness living in the District.

TABLE 1: NUMBER SERVED IN PSH IN DMH OR OTHER HOUSING PROGRAMS

Program	Numbers Served in PSH (High Estimate)	Numbers Served in PSH (Low Estimate)
DMH Programs		
Supportive Housing - Home First	675	675
Supportive Housing - LRSP	121	121
Supportive Housing – DCHA Partnership Program (Section 8 PBV)	117	117
Supportive Housing – S+C	15	15
Supportive Housing – Non-Elderly Disability Vouchers	182	182
Supportive Housing – St. Elizabeth Section 8 Set-Aside	50	50
Supportive Housing – Chronic Homeless Set-Aside	75	75
Supportive Housing – Mainstream Vouchers	40	40
Non-DMH Programs (Estimated % MI)		
DHS PSH (800)	480*	264**
The Community Partnership (1,650)	990*	544**
Provider Managed Housing	351	351
Total	3,096 (high)	2,434 (low)

* Based on USICH estimates that 60% of those who experience chronic homelessness have current or past mental illness.

** Rather than use 60% estimate, a 33% estimate was used.

TABLE 2: NUMBER SERVED IN OTHER DMH HOUSING PROGRAMS

Program	FY 12 Capacity
Contract Community Residential Facilities (C-CRFs) ⁶	221
Independent Contract Residential Facilities (I-CRFs) ⁷	468
Supportive Independent Living (SIL) ⁸	397
Total	1,086

B. Description of Available Services & Supports

DMH consumers have access to an array of available service resources to support housing stability in the community. These include DMH housing-related services delivered in residential and non-residential settings, as well as non-DMH resources for housing-related services and supports. The system strengths, challenges, and opportunities that have been identified with regard to service access and coordination are briefly mentioned here and are further elaborated upon in the strategic recommendations section of this report.

1. Standardized Assessment Tool

All adult consumers seeking or enrolled in mental health services receive an individualized assessment that includes a standardized tool called the LOCUS (Level of Care Utilization System). The LOCUS is “designed to create a level of care recommendation based on a multi-dimensional functional assessment of individual consumers. The LOCUS provides a framework for determining the appropriate nature and intensity of services and resources to meet consumer needs.”⁹ Core Service Agencies (CSAs) are responsible for conducting the LOCUS assessments at: intake; at regular intervals (i.e. every 90 days); whenever a change in service is requested that requires authorization; or on an as-needed basis.¹⁰

2. DMH Housing-Related Services: Residential Based

Presently, DMH consumers have access to three types of residentially-based services: Contracted Community Residential Facilities (C-CRFs), Independent Community Residential Facilities (I-CRFs) and Supported Independent Living (SIL). These programs are structured as non-supportive housing, though SIL has elements of supportive housing. Each varies in terms of the level and type of services provided to consumers as well as the housing setting, with the

⁶ These are group home facilities

⁷ These are group home facilities

⁸ These are scattered-site apartments and single room occupancy dwellings

⁹ DMH background statement on LOCUS:

https://docs.google.com/document/d/1mN0Tq3K6kPJkVX1w6MxUZfaP4LLnasPcVKotYpUJFKT8/edit?hl=en_US&pli=1

¹⁰ DMH Policy 300.1:

http://dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/TrainingInstitute/LocusCalocus/DMH_Policy_300.1_TL-70_-_L_-_LOCUS_CALOCUS.pdf

most variation occurring in the SIL program which offers a mix of residential and more independent apartment options. DMH has identified consumers pending discharge from Saint Elizabeth's Hospital; homeless consumers with serious mental illness; and consumers who are moving to a less restrictive environment as its priority populations within the total range of housing and residential services.

Contracted Community Residential Facilities (C-CRFs) provide structured housing supports in a supervised residential setting. DMH currently contracts with five providers for a capacity to serve 221 consumers. On behalf of consumers, providers receive \$1,083 per month (SSI \$698 + State Optional Supplement \$485) and a negotiated per diem between \$78 - \$82.¹¹ Services offered in these settings include 24-hour awake supervision, medication monitoring, assistance with money management, access to treatment and medical care, and assistance with activities of daily living to assist consumers in achieving a greater level of independence. DMH also contracts with one provider to operate twelve transitional CRF beds at a rate of \$51 per day. The intent of the program is to prepare consumers for moving to more independent living; however, the program has functioned more like long term group housing.

- **CTI Step Down Pilot** – Following recommendations from the Community Residential Facility (CRF) Task Force (See **Appendix G** regarding CRFs), DMH recently began a pilot initiative to step down thirty consumers from CCRFs to supportive housing using an adaptation of the Critical Time Intervention (CTI) model. Three DMH staff (one Care Manager from the Integrated Care Division and 2 Peer Transition Specialists) are providing an 'overlay' (i.e. in addition to the assigned CSA and treatment team) of time-limited (9 month) services to support the successful transition of these individuals from congregate care to supportive housing. DMH has devised a clear reinvestment strategy that will result from the reduction in C-CRF beds with 1/3 being used to develop a flexible fund pool to be managed by DMH for non-billable housing related activities, 1/3 to develop new housing subsidies, and the remaining 1/3 to preserve capacity for consumers that require a C-CRF level of care.

Independent Community Residential Facilities (I-CRFs) are operated by private housing owners/operators and have current capacity to serve 468 consumers. Services include 24-hour supervision, monitoring, and assistance with transportation and activities of daily living. While DMH licenses I-CRFs, they are not expected to provide the same level of services that CCRFs do. Consequently, I-CRFs receive the same \$1,083¹² per month from consumers for room, board and support, but do not receive any additional per diem allowance.

Supported Independent Living (SIL) provides congregate or independent living with minimal supervision and some monitoring. The program has the capacity to serve 397 consumers and is operated somewhat differently across the six providers DMH currently contracts with who receive \$13.50 per diem to provide supports needed to assist consumers in transitioning to a less restrictive level of care. Services include at least weekly home visits from a Community

¹¹ Consumers receive \$100 per month personal needs allowance out of this total.

¹² Consumers in I-CRFs also receive \$100 per month personal needs allowance out of this total.

Support Worker and assistance with life skills activities based on individual needs. (See Appendix F)

3. DMH Housing-Related Services: Non-Residential Based

Peer Transition Specialists – The DMH conducts a Peer Certification Specialists program. Individuals who have self-identified as having received or are presently receiving mental health services in personal recovery and have undergone certification training by DMH on how to assist others in recovery and resiliency and pass a competency exam are given this designation. Under general supervision, a certified Peer Specialist performs a wide range of tasks to assist individuals to regain control over their lives and their own recovery process. To date, 22 persons in recovery have been certified as Peer Specialist.

Currently, these individuals provide 1:1 support and intervention for consumers, help individuals enrolled in the public mental health system to acquire daily living skills in the DMH Training Apartment, and implement the Critical Time Intervention methodology to assist consumers in their transitions to the community. Peers also participate in involuntary medication panels.

CSA Housing Liaisons – CSAs are responsible for referring consumers with housing needs to DMH as appropriate. Ten of the 23 CSAs have the capacity to designate a Housing Liaison, an agency-supported position that serves as the central point of contact for accessing DMH housing resources. The role of Housing Liaisons varies by CSA but in general they wear many hats (e.g., some carry caseloads in addition to their housing responsibilities) and serve as a resource within their agency regarding the availability of housing resources, application and referral processes, and as point of contact with DMH on housing-related issues including level of care determinations and monitoring/ troubleshooting of consumer housing and clinical issues as they arise.

Mental Health Rehabilitation Services (MHRS) – DMH provides a range of community-based outpatient services for consumers through its Medicaid-funded MHRS program. MHRS services are provided by a network of 33 DMH-certified community providers (26 Core Service Agencies (CSAs), 5 sub-providers, and 2 specialty providers) that provide specified MHRS services. Consumers served in both DMH residential and supportive housing programs typically receive one or more of these services which include: Diagnostic/Assessment, Medication/Somatic Treatment, Counseling, Community Support, Crisis/Emergency, Day Services, Intensive Day Treatment, Community-Based Intervention, and Assertive Community Treatment (ACT).

The primary MHRS services used to support people in community-based housing are Community Support and Assertive Community Treatment (ACT). Community Support Workers (CSWs) provide much of the supports to consumers in DMH housing programs. These services are designed to assist consumers of mental health services to achieve rehabilitation and recovery goals. DMH significantly expanded ACT teams over the past several years, and now funds seven providers to operate a total of 15 ACT teams with a capacity of 1,450 consumers. ACT is an intensive, integrated, rehabilitative, crisis, treatment and mental health rehabilitative

community support service provided twenty-four hours per day, seven days per week to individuals with who require significant support to function successfully in the community.¹³ Individuals in DMH-supported housing have the benefit of these flexible Medicaid plan services. However, providers are varied in their ability to maximize Medicaid billing for housing-related service provision and the opportunity exists to enhance this capacity among providers.

PUSH Funds – DMH also offers PUSH bridge fund loans that may be requested for consumers being discharged from Saint Elizabeth’s to Community Residential Facilities. These are short-term (3 month) loans made by DMH to consumers and paid to CRF operators which are then repaid from initial Social Security benefits payments to consumers.

New Directions Program – The New Directions Program at Washington Hospital Center was established to provide a higher level of support for individuals who have experienced long term episodes of care at Saint Elizabeth’s and are being discharged to the community. The program is designed to provide a creative approach to service delivery utilizing mental health and non-mental health services and supports. The work is supported by a case rate payment methodology allowing flexible funds to do “whatever it takes” to ensure consumers stay in their communities and families to their maximum ability and desire. Currently, there are 30 individuals enrolled in this program.

Benefits Assistance & Representative Payee Services – DMH operates the D.C. SSI/SSDI Outreach, Access and Recovery Services (SOARS) project which assists consumers who have experienced homelessness with accessing Social Security Administration benefits. The Initiative developed a plan to improve processing times for access to SSI/SSDI benefits, and conducted training for case workers who assist consumers in applying for benefits. Additionally, DMH contracts with Bread for the City to manage a representative payee program for 800 consumers who are referred by a DMH case manager or CSA. Upon enrollment, Bread for the City applies to the Social Security Administration or Office of Personnel Management to become the client’s representative payee. The consumer’s mental health case manager then meets regularly with the consumer to review his/her monthly budget, and informs Bread for the City of any changes that might affect the consumer’s budget or benefits.

My House Housing Mediation Services – DMH contracts with Advanced Dispute Resolution Services for mediation and dispute resolution services for consumers housed or eligible to be housed by DMH. DMH and CSAs can refer consumers for assistance with resolving pre-lease issues such as poor credit or criminal history, and for services to assist with landlord-tenant relations and facilitate conflict resolution to preserve tenancy and prevent eviction.

Supported Employment – DMH has expanded Supported Employment services throughout the system and funds six agencies to provide specialized Supported Employment Services to consumers for whom competitive employment has been interrupted or intermittent as a result of their mental illness. Services include ongoing work-based vocational assessments, job development, job placement and coaching, crisis intervention services, development of natural

¹³ MHRS definition of ACT: http://www.dmh.dc.gov/dmh/frames.asp?doc=/dmh/lib/dmh/pdf/website_mhrs_services.pdf

supports and follow-up for each consumer, including offering job placement that includes permanent employment.

4. Non-DMH Programs and Services

DHS PSHP Case Management – The Department of Human Services’ (DHS) Permanent Supportive Housing Program (PSHP) is an initiative that provides permanent housing and supportive services to over 800 chronically homeless individuals and 250 families to ensure housing stabilization and self-sufficiency. Non-clinical case management services are provided to ensure that individuals and families are connected to needed support services and achieve the highest degree of stabilization and self-sufficiency possible. DHS PSH program participants also have access to move-in resources such as security deposits, gift cards to purchase home establishment items, and furniture. Mental health consumers who are chronically homeless and eligible for PSH according to a Vulnerability Assessment and other factors may gain access to this resource. DHS contracts with eight community providers, some of whom are also DMH-certified providers of MHRS services.

IV. Estimated Need for Affordable Housing for Persons with Serious Mental Illness Living within the District of Columbia

A. Methodology Used to Determine Need

TAC devised a methodology for DMH to project the need for both affordable and permanent supportive housing (PSH) among persons with serious mental illness (SMI) and serious and persistent mental illness (SPMI) living within the District of Columbia. People with disabilities including mental illness are overrepresented among those in poverty and have a need for affordable housing. To project this need, 2010 U.S. Census Bureau and Social Security Administration data were examined to obtain basic demographic, poverty, and Supplemental Security Income (SSI) utilization information. Prevalence estimates from DMH’s most recent SAMHSA Block Grant application were then applied to project the District’s adult population with mental illness living in poverty and therefore the supply of affordable housing that should be available.

Since not all people in need of affordable housing would necessarily choose to live in or meet the definition of being in need of PSH, the number of individuals with mental illness who have the unmet, highest priority need for PSH was also estimated. Included were: a) the number of non-elderly people with mental illness receiving SSI disability payments, which is considered a reliable proxy of the need for both public sector human services and affordable housing; and b) the number of homeless individuals with mental illness identified through the D.C. homeless Continuum of Care’s (CoC) 2011 point-in-time (PIT) count who are likely not yet enrolled but qualified for SSI. This estimate was then applied to the number of consumers currently served in supportive housing and other residential programs to reach a projected need for DMH housing.

The 2010 Census, poverty, and SSI data examined is summarized in the tables that follow and indicate that 24,371 (4.05%) of D.C.’s total population receive SSI benefit payments, with the

largest portion of these being disability-related payments. Of those under 65 receiving SSI, approximately 31% qualify due to a mental illness or other mental disorder not categorized as a developmental disability. However, it is difficult to separate out non-elderly adults in these figures as SSI data does not provide information on mental disorders for the under age 18 or aged 18-64 populations specific to D.C.

TABLE 3: DISTRICT OF COLUMBIA DEMOGRAPHIC CHARACTERISTICS & SSI UTILIZATION, 2010¹⁴

Population Category	District of Columbia	United States
Total population	601,723	308,745,538
Pop < 18	101,090 (16.8%)	74,098,929 (24%)
Pop 18-64	432,037 (71.8%)	194,509,689 (63%)
Pop 65+	68,596 (11.4%)	40,136,920 (13%)
Percent with disability	11.1%	11.9%
Total SSI	24,371 (4.05%)	7,912,266 (2.56%)
SSI-Disabled	22,354 (3.71%)	6,659,124 (2.16%)
SSI: under 65	20,182*	5,870,776
% Any Mental Disorder	64%	60%
% Mental Illness or non-MR Mental Disorder	31%	30%

* Includes 4,391 SSI recipients under the age of 18.

D.C. has the third highest poverty rate in the U.S., behind Mississippi and Louisiana. 2010 U.S. Census Bureau data indicates that nationally people with disabilities are overrepresented among those in poverty. In D.C., people on SSI comprise 20.35% of those in poverty.

TABLE 4: POVERTY¹⁵ & SSI RATES IN THE DISTRICT OF COLUMBIA, 2010

Population Category	District of Columbia	United States
Poverty Rate	19.9%	15.1%
Number in Poverty	119,743	46,620,576
Total SSI	24,371	7,912,266
Percent SSI of Poverty	20.35%	16.97%

As shown in the next section, prevalence estimates from DMH's 2012 SAMHSA Block Grant application, displayed in **Table 5**, were applied to the data above in order to understand what portion of the adult population in poverty is likely to have a mental illness and be in need of affordable housing.

¹⁴ U.S. Census Bureau QuickFacts: <http://quickfacts.census.gov/qfd/states/11000.html>; SSI Annual Statistical Supplement, Social Security Administration, 2011.

¹⁵ *Income, Poverty, and Health Insurance Coverage in the United States: 2010*. U.S. Census Bureau, 2011.

TABLE 5: DISTRICT OF COLUMBIA PREVALENCE ESTIMATES, 2010¹⁶

Population Category	DMH Estimated Number of Cases
People with Serious Mental Illness (6.10%)	27,889
People with Serious and Persistent Mental Illness (2.73%)	12,472
Total	40,361

B. Projected Need

TAC estimates that 8,797 people with mental illness within the District have a need for affordable housing based on the number of adults with SMI and SPMI who are in poverty as shown in **Table 6** below. Since many of these individuals may already be in some form of affordable housing, this figure represents an estimation of the supply of affordable housing that the District should have available to meet the needs of District residents with mental illness rather than unmet need.

TABLE 6: ESTIMATED NEED FOR AFFORDABLE HOUSING FOR PEOPLE WITH MENTAL ILLNESS

Poverty Population with MI	Estimate
Total Population	601,723
Population >18	500,633
Poverty Population (19.9%)	119,743
18+ Population in Poverty (83.2%)	99,625
18+ in Poverty with SMI (6.10%)	6,077
18+ in Poverty with SPMI (2.73%)	2,720
Total	8,797

To project the number of people with mental illness who have the highest priority, unmet need for PSH, the number of non-elderly adults with mental illness receiving SSI disability payments was estimated and added to the most recent CoC PIT estimate of the number of homeless individuals with mental illness as shown in **Table 7**. Based on this, 6,088 people with mental illness are projected to have the highest priority need and qualify for PSH.

TABLE 7: HIGHEST PRIORITY NEED FOR PSH

Population Category	Estimate
Total SSI	24,371
SSI 18-64	15,791
SSI <65	20,182
SSI<65 with MI	6,355
SSI 18-64 with MI*	4,957
PIT Homeless with MI	1,131
Total	6,088

* Removes 22% of the <65 SSI population under 18.

¹⁶ Prevalence rates are from the most recent DMH SAMHSA Block Grant application. Includes those in institutions in group quarters.

In order to project unmet need for DMH supportive housing and other residential program beds, the number of consumers currently served in supportive housing and other residential programs were considered. Data from the inventory of DMH and non-DMH housing resources summarized in **Table 8** shows an estimated 1,275 consumers are currently being served in DMH supportive housing. It also demonstrates that DMH consumers make up a portion of those housed in non-DMH supportive housing through local homeless programs including those operated through The Community Partnership (TCP) and the Department of Human Services' (DHS), as well as some community provider managed supportive housing. Since accurate estimates were not available regarding the number of homeless program units occupied by DMH consumers, both a high and low end estimate were determined. The high end estimate assumes the figure used by the U.S. Interagency Council on Homelessness that 60% of those who experience chronic homelessness have current or past mental illness. Since this figure may overestimate serious mental illness, a low end estimate based on the literature that demonstrates approximately one-third of those who are homeless have a serious mental illness is also used.

TABLE 8: CONSUMERS CURRENTLY SERVED IN DMH & NON-DMH SUPPORTIVE HOUSING PROGRAMS

Program	Numbers Served in PSH (High Estimate)	Numbers Served in PSH (Low Estimate)
DMH Supportive Housing Programs	1,275	1,275
Non-DMH Programs (Estimated % MI)		
DHS PSH (800)	480*	264**
TCP (1,650)	990*	544**
Provider Managed Housing	351	351
Total	3,096 (high)	2,434 (low)

* Based on USICH estimates that 60% of those who experience chronic homelessness have current or past mental illness.

** Rather than use 60% estimate, a 33% estimate was used.

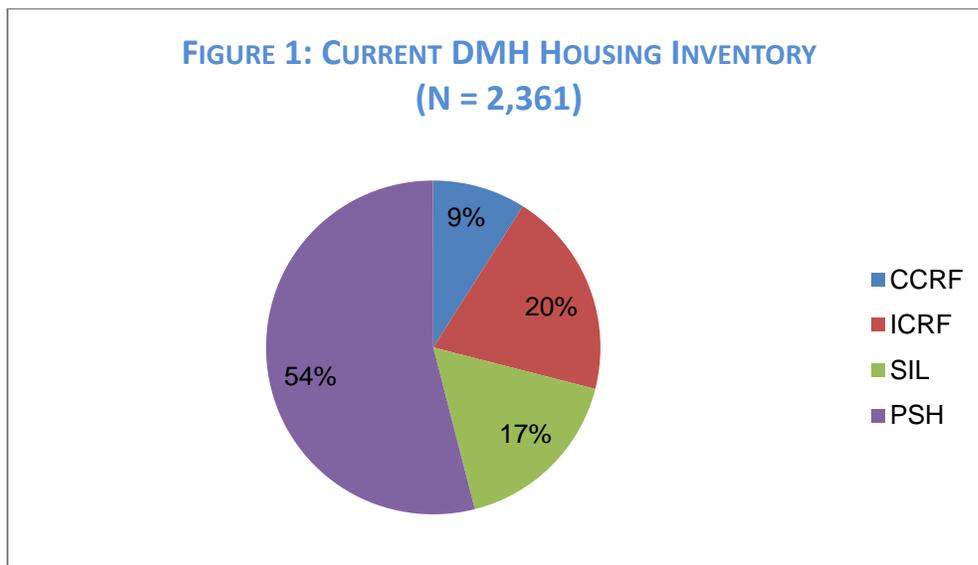
TABLE 9: UNMET NEEDS FOR BEDS

Need	6,088	6,088
Currently housed - PSH	-3,096	-2,434
Currently housed – DMH Other	-1,086	-1,086
Total Unmet Housing Need	1,906 (low)	2,568 (high)

Table 9 shows that adding the capacity of other DMH programs including C-CRF, I-CRF and SIL to serve 1,086 consumers, and subtracting those served in these and supportive housing programs from the projected need for PSH produces a low end estimate of unmet need for beds of 1,906 and a high end estimate of 2,568.

One of DMH's major goals is to increase the proportion of PSH within its housing inventory over the next several years. **Figure 1** below demonstrates the current breakdown, with PSH

comprising just over half (54%) of the current DMH housing inventory, and can serve as a baseline for DMH to measure its progress in expanding PSH.



To begin to project need by DMH housing program type, need for additional PSH and for other housing settings should be estimated. The example presented in **Table 10** is for illustration purposes and may be adjusted based on more accurate estimates of the assumptions it presents. Using the current DMH supportive housing waiting list as a proxy for need, it was predicted that about 75% of the population in need could live in PSH based on the assumption that consumers with LOCUS scores of 1, 2, 3 and possibly 4 (with adequate support services) could live in PSH, and that the other 25% with LOCUS scores of 5, 6 and some with a 4 would need other settings. This does not account for consumer choice of housing setting which cannot be accurately predicted.

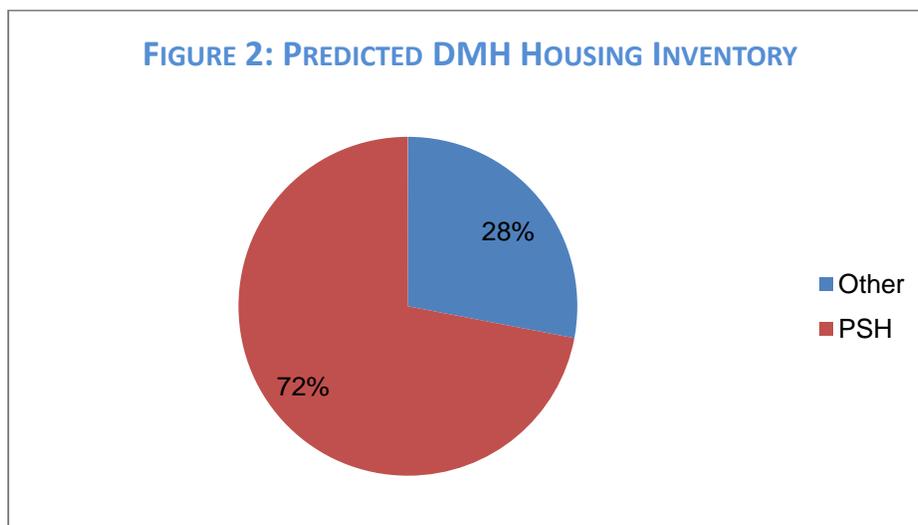
Based on assumptions regarding the proportion of those in DMH non-supportive housing settings who could move to PSH, percentages were applied to predict the numbers who could move requiring additional PSH units, and the numbers who would need to stay in their current housing thereby preserving that bed capacity. It was estimated that 40% of individuals in C-CRFs, 50% of individuals in I-CRFs and 100% in SIL could move to PSH with appropriate supports. It should be noted here that the percentages applied are for illustration purposes and actual LOCUS score or other data for consumers in these settings can be applied to obtain more accurate figures.

These assumptions are presented in **Table 10** and lead to the predicted need for 2,149 – 2,645 additional PSH slots and for a total of 844 – 1,009 other housing program beds.

TABLE 10: PROJECTED NEED BY HOUSING PROGRAM TYPE

Category	Projected Need for Additional PSH		Total Projected Need for Other Settings	
Unmet Need (1,906) or (2,568)	1,430 (75%)	1,926	477 (25%)	642
Served in CRF (221)	88 (40%)		133 (60%)	
Served in ICRF (468)	234 (50%)		234 (50%)	
Served in SIL (397)	397 (100%)		-	
Total	2,149 (low)	2,645 (high)	844 (low)	1,009 (high)

Over time this could result in PSH comprising nearly three-quarters of DMH’s housing inventory, making it the Department’s base housing model available to consumers.



V. Strategic Goals and Findings

A wide range of topics were discussed with stakeholders, DMH staff, and other partners throughout this process. Similar to other mental health authorities across the country, DMH is tasked with broad responsibilities in managing the public mental health system with finite staffing and financial resources. As a result, DMH has identified six strategic goals over the next five years that form the Strategic Supportive Housing Plan. These goals were formulated based upon the input received from stakeholders. A discussion of the findings and recommendations used to formulate each strategic goal is provided below, including the identification of areas of duplication, gaps in services, and unmet needs. A chart of actionable implementation steps that will guide DMH follows each section. (**Appendix A** contains a consolidated chart of strategic goals.)

DMH has demonstrated significant leadership over the past several years dedicating substantial local resources for both capital financing and rental assistance in order to create over 2,400

permanent supportive housing (PSH) opportunities for DMH priority consumers. These efforts provide a solid foundation on which to build for future PSH efforts. Across Workgroups, there was agreement from members of the need for DMH leadership to provide clear, deliberate direction to the DMH provider community and its stakeholders regarding DMH's community-based housing efforts and priorities.

The Strategic Supportive Housing Plan is consistent with broader national efforts of: 1) promoting and advancing the civil rights of individuals with disabilities, consistent with the Americans with Disabilities Act (ADA) community integration goals affirmed in the U.S. Supreme Court's *Olmstead* decision, to enable individuals with disabilities to live in the least restrictive, most integrated settings possible; and 2) ending homelessness and chronic homelessness among people with disabilities. The Plan further builds upon DMH's existing Values¹⁷ to promote the recovery of individuals through the availability of affordable housing coupled with an array of treatment, psychosocial rehabilitation, and peer specialist services, and strives to enable as many individuals as possible to live in Permanent Supportive Housing.

FIGURE 3: DEPARTMENT OF MENTAL HEALTH VALUES

Respect. All persons who come in contact with the public mental health care system are treated with dignity and valued for their abilities and contributions.

Accountability. DMH is responsible to consumers and family members for support and unobstructed access to services. The agency encourages all interested parties to participate in the planning, development, implementation, and monitoring of treatment, services, and policy.

Recovery. DMH services are provided based on the belief that people can recover from mental illness. Services and support for consumers and their families are tailored to:

- Empower them to improve their quality of life
- Address individual needs
- Focus on strengths and resiliency
- Provide choices and immediate access
- Provide opportunities to participate in rehabilitation, regardless of disability

Quality. The system is responsive, cost-effective, and incorporates high standards, best practices, cultural sensitivity, and consumer satisfaction. Service providers are committed to professional integrity, objectivity, fairness, and ethical business practices.

Education. DMH takes the following actions to improve the service delivery system:

- Shares information among consumers, family members, providers and the public
- Promotes prevention, wellness, and recovery
- Reduces stigma
- Recognizes the needs of others for information
- Communicates in an open and candid manner

Caring. DMH encourages genuine partnerships among consumers, family members, providers, and others that foster an unconditional positive regard for the concerns of those who seek and receive services.

¹⁷ DMH Webpage: <http://www.dmh.dc.gov/dmh/cwp/view,a,3,q,515980,dmhNav,%7C31244%7C.asp>

Goal One: Align District Policy and Improve Interagency Coordination in regards to Permanent Supportive Housing

Goal Formulation:

Create a District-wide Standard Permanent Supportive Housing (PSH) Policy

The District of Columbia has a strong track record of local investment in PSH development, particularly for tenant-based rental subsidies linked with appropriate supportive services assisting chronically homeless people. However, these investments are primarily project-by-project driven rather than directed by a comprehensive community-wide PSH policy – a circumstance not unique to D.C. DMH will work with all City agencies (DCHA, DHCD, DMH, DHS, DOA, DDS) involved in the development of permanent supportive housing (PSH) targeted for their priority consumer populations to adopt and incorporate a District-wide standard PSH policy and definition.¹⁸ Through a standard D.C.-wide policy framework, the District will be able to better align and coordinate development, operating subsidies, and supportive services resources across the various District agencies.

District-wide Eligibility Criteria for PSH

Further, DMH will work closely with its fellow District Agencies (DCHA, DHCD, DMH, DHS, DOA, DDS) to assess the feasibility of standard, basic eligibility criteria for all PSH throughout the District. The District could use this as baseline eligibility, and specific agencies may then have additional criteria depending on specific requirements. Consumers often enter the system through different portals overseen by various agencies, particularly DMH, DHS and DCHA. Sometimes this is by chance and sometimes it is because of how consumers have been directly or indirectly steered as a result of how various agencies structure their service delivery systems. This will ensure a simpler, more streamlined and navigable process for consumers and helping staff that tend to be heavily involved. Potential District-wide eligibility criteria could include:

- a. Income Requirements: PSH is targeted to extremely low income households (30 percent of Area Median Income and below); and
- b. Age: The PSH head of household is generally, but not exclusively 18-61 years old; and
- c. Disability: A PSH household is a household in which a sole individual or an adult household member has a serious and long-term disability that:
 - Is expected to be long-continuing, or of indefinite duration;
 - Substantially impedes the individual's ability to live independently;
 - Could be improved by the provision of more suitable housing conditions; and
 - Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post traumatic stress disorder, or brain injury; is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002); or is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.

¹⁸ The SAMHSA definition described in Section V.B: Strategies Designed to Improve Service Delivery could be adopted by the District.

Improve Interagency Coordination and Data Sharing with Regard to PSH

Through the workgroup process, key informant interviews and discussions with DMH staff, it was clear that planning and coordination between sister agencies could be improved. DMH will establish a DMH/DHS working group to streamline and better coordinate potentially duplicative or redundant services provided between DMH and DHS programs, with an emphasis on PSH settings. This group should meet regularly and have staff identified from each agency responsible to attend.

The development of a data sharing protocol between DMH, DHS, and DCHA would serve to compare and coordinate waitlist management activities. The purpose of this interagency effort would be to review and compare waitlists and active referrals; recommend transfer of individuals to another agency as appropriate; discuss and resolve current tenant issues as appropriate; and review application processes and paperwork in order to streamline access to services and housing for consumers and providers. TAC recommends that DMH and DHS use the lessons learned from the recent data sharing efforts between DMH and DHS/DCHA in regards to the award of new non-elderly disability housing vouchers to inform such efforts. Also, the DHS/DCHA real-time data sharing process may be a possible model for future DMH data sharing and data base development efforts. DMH intends to integrate this housing data sharing effort to the extent possible with DMH's ongoing database development project.

Coordinate Efforts with the DC Mayor's Office Integrated Case Management Initiative

The Mayor's office has initiated an Integrated Case Management Initiative designed to coordinate public benefits, services, and supports to individuals or families who display various risk factors across multiple District health and human service agencies. This may provide an additional opportunity to address the information sharing authorizations needed to readily share consumer housing information across agencies. Consumers served by DMH are frequently served by several agencies that manage distinct data sources, yet the information could be useful across agencies in order to improve efficiency and services for consumers. Given that DMH has experience navigating public benefits and entitlements, housing, primary healthcare and other systems, it is uniquely situated to inform data sharing processes, compliance with privacy laws, and ways to improve efficiency.

Goal One: Align District Policy and Improve Interagency Coordination in regards to Permanent Supportive Housing (PSH).			
Objective #1: Create a District-wide Standard Permanent Supportive Housing (PSH) Policy.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Convene District Agency partners (DMH, DCHA, HCD, DHS, DOA, DDS) to develop a PSH policy to be adopted across all City agencies involved in the provision of PSH throughout the District. 2. Propose standardized District-wide eligibility criteria for PSH. 3. Incorporate the final District-wide PSH policy into each Agency's regulatory structure concerning PSH. 	DMH, DCHA, HCD, DHS, DOA, DDS	<ol style="list-style-type: none"> 1. Adoption of a permanent supportive housing policy across all City agencies. 2. Modifications of regulatory standards. 	<p>December 2012</p> <p>Upon renewal of regulations.</p>
Objective #2: Improve Interagency Coordination and Data Sharing with Regard to Permanent Supportive Housing (PSH).			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish a DMH/DHS workgroup to streamline and better coordinate potentially duplicative or redundant services provided between DMH and DHS programs with an emphasis on PSH settings. 2. Develop a formal data sharing protocol between DMH, DHS and DCHA to compare and coordinate waitlist management activities. 3. Integrate this housing data sharing effort to the extent possible with DMH's ongoing database development project. 4. Develop a Memorandum of Understanding (MOU) between DMH and DHS which would formalize all efforts to coordinate the provision of PSH including data sharing protocols, waitlist management, and provision of supportive services. 	DMH and DHS	<ol style="list-style-type: none"> 1. Establish Workgroup. 2. Adoption of data sharing protocol. 3. Establish MOU to coordinate PSH. 	October 2012

5. Incorporate these formal data sharing protocols into the MOU between DMH and DCHA regarding PSH.			
Objective #3: Coordinate efforts with the DC Mayor's Office Integrated Case Management Initiative.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Participate fully in the Mayor's Office Integrated Case Management Initiative in order to improve communications and information sharing in regards to the provision of case management services to consumers residing in PSH. 2. Take the advantage of this effort to extent possible to assist in addressing the need for information sharing authorizations needed to readily share consumer housing and case management information across agencies. 	Deputy Mayor for Health & Human Services	<ol style="list-style-type: none"> 1. Establishment of communications and information sharing protocol. 	To Be Determined

Goal Two: Develop a Pipeline to create 350-450 new permanent supportive housing (PSH) opportunities over the next 5 years for mental health consumers in need of PSH across the District.

Goal Formulation:

As mentioned previously, DMH has experienced a great degree of success in developing PSH across the District with a past emphasis on tenant-based opportunities. As a way to provide a broader balance of PSH available to priority consumers, DMH intends to develop and implement a Permanent Supportive Housing (PSH) Development Pipeline to create a range of 70 to 90 PSH units per year with a five year goal of 350 to 450 PSH units. DMH will also pursue reasonable set-asides of PSH units in multi-family housing developments (typically up to 25% of the units in a project) produced through Low Income Housing Tax Credit (LIHTC) and bond-financed properties. The primary driver of the PSH development pipeline will be the \$5 million per year for the next five years (FY 2013-2017) of DMH Capital included in the District's Long-Term Capital Budget. Based on TAC's recommendations, DMH will incorporate the following approaches for the implementation of the Five Year PSH Development Pipeline.

Pursue a Streamlined Approach to Identify New Permanent Supportive Housing for DMH Capital Investment.

DMH will work to sustain and further develop the DHCD Consolidated and Comprehensive RFP processes as the mechanism to solicit and identify new PSH projects to invest in. As part of this process, DMH will continue its collaboration with DHCD in the underwriting and selection process of projects supported by DMH capital resources in order to create PSH that is consistent with DMH needs and model approaches. DMH Housing staff should continue to maintain the right of 'final approval' of all projects to be supported with DMH capital resources. DMH Housing staff will continue to have direct involvement in the proposal review to ensure selected PSH projects are marketable and meet the needs of DMH consumers. PSH marketing considerations will include: location, affordability of rent, accessibility of community amenities and supportive services, and accessibility to public transportation.

DMH will collaborate with DHCD to conduct a marketing effort prior to the formal Request for Proposal process to better communicate the DMH Capital program to the District's developers of affordable, multi-family rental housing. The focus of this outreach should be on addressing barriers to participation and stressing the benefits of PSH. A marketing plan agenda may include topic areas such as the DMH referral and waiting list process, role of the supportive service provider, and role of the housing liaison.

Better Align Long-Term Operating Subsidies with the PSH Development Pipeline

DMH will work with its District Agency Partners, specifically D.C. Department of Housing and Community Development (DHCD), D.C. Housing Authority (DCHA) and D.C. Department of Human Services (DHS), to develop a process to program the required long-term operating resource commitments to annually support 70-90 PSH units for DMH consumers within the DHCD-sponsored Consolidated and Comprehensive RFP processes. This annual resource

planning process of identifying operating subsidy commitments should consider all available operating resources to include the District's Local Rent Subsidy Program, the Section 811 PRA Demonstration, Section 8 Project-Based Vouchers (DCHA's Partnership Program), and DCHA's public housing operating subsidies. Additionally, DMH will take advantage of new federal funding resources as part of this process – specifically the HUD Section 811 project rental assistance (PRA) Demonstration Program.

The process would also seek to identify operating resource commitments for all the District's PSH priority populations to include people who experience chronic homelessness. The proposed resource planning process would transition an ad hoc, project-by-project resource discussion to a systematic process to identify and set aside operating resource commitments to support the District's annual PSH development goals. This systematic process will provide greater predictability for both District Agencies and its development partners. The process will also allow the Districts Agencies to better prioritize and control decisions and placement of scarce operating subsidies to support the District wide permanent supportive housing goals. The timing of this resource planning process should be aligned with both the District's budget cycle as well as the DHCD procurement process to incorporate all new operating subsidy resources that are available.

To support this annual planning process for operating subsidies, DMH will sustain a leadership role in the District's efforts to effectively compete for project-based rental assistance through HUD's Section 811 PRA Demonstration.¹⁹ TAC estimates that the District could access project rental assistance for 60 to 80 PSH units to support the District's PSH pipeline over the next five years through this Demonstration program.

Establish a Capitalized Operating Reserve Pilot

As a complementary strategy to assist with identifying the needed operating subsidies for 70-90 PSH units annually, DMH will consider establishing a Capitalized Operating Reserve Pilot²⁰ funded with DMH Capital resources to support PSH units. Offering a pilot to support a limited number of PSH units (e.g. 20-30 units), DMH will be able to better test the viability and sustainability of the model with several D.C.-based developers of multi-family housing. The purpose of the Capitalized Operating Reserve Pilot would be to capitalize an operating reserve fund over a 10 to 15 year period in order to subsidize the difference between the operating cost of a one bedroom apartment in a multi-family housing project and the rental income which a disabled household with SSI income (approximately 11% of Area Median Income in the District of Columbia) can afford.

This is an approach already considered by D.C.-based developers. In the latest DHCD Multi-Family Request for Proposals (May/June, 2012), a well known D.C.-based developer, SOME,

¹⁹ DMH led the process for the HUD Section 811 PRA Demonstration application submitted on July 31, 2012.

²⁰ The Corporation for Support Housing published a white paper titled "Capitalized Rental Subsidy Reserve in March of 2006. The white paper provides a detailed discussion of this operating subsidy model as well as suggested protocols to administer and disburse funding under such a program. The CSH white paper is available at www.csh.org.

proposed this financing strategy as an alternative strategy to underwriting the long-term operating subsidies of its' PSH project, Altamont Place. This strategy was proposed as an alternative to the preferred approach of dedicating a long-term operating subsidy such as Section 8 Project-Based Vouchers to the PSH units. Moreover, TAC recommends that the DMH commitment of capital to fund a capitalized operating reserve for a PSH project should be made *in lieu of* a DMH capital commitment so as to not place an overly burdensome cost per unit on the DMH Capital Program. The Capitalized Operating Reserve Pilot could be highlighted as part of the District's upcoming Comprehensive Housing Strategy.

Figure 4 below presents an example of how a Capitalized Operating Reserve Pilot may be structured.

FIGURE 4: SAMPLE CAPITALIZED OPERATING RESERVE PILOT	
Number of PSH Units. 20	
Term of Pilot. 15 Years	
D.C. Example.	
Operating Cost Per Unit:	\$7,088
Tenant Rent Share:	\$2,512
<hr/>	
Cost of the Operating Subsidy (Year 1):	\$4,576
Required Operating Reserve (Per Unit/15 Yr Term):	\$88,374
Required Operating Reserve (20 Units/15 Yr Term):	\$1.76 million
Assumptions:	
<ul style="list-style-type: none"> • Operating Costs – based on average operating costs for multi-family properties provided by DC DHCD's Portfolio and Asset Management Department from the period 1/1/2010 to 12/30/2010. • Tenant Rent Share based on 30% of \$698 (current SSI Monthly Income for a Single Person Household). • Operating Costs expected to increase at a 3% rate annually. • Tenant Rent Share expected to increase at a 2% rate annually. 	

Implement Permanent Supportive Housing Capacity Building Activities

Workgroup members suggested that there is a need for capacity building for those providers or developers interested in developing PSH. DMH will assist in linking its provider agencies that are either interested in PSH development or have some degree of experience and background with future capacity building and training opportunities. Specifically, DMH and its provider agencies will take full advantage of and maximize participation in the upcoming Corporation for Supportive Housing (CSH) Academy to build capacity and understanding of PSH development finance within the District's mission driven developer network. Recent projects such as

Hyacinth's Place have indicated a need for technical assistance throughout the development of projects for new or less experienced developers.

Goal Two: Develop a Pipeline to create 350-450 new permanent supportive housing (PSH) opportunities over the next 5 years for mental health consumers in need of PSH across the District.

Objective #1: Pursue a Streamlined Approach to identify new permanent supportive housing for DMH Capital Investment.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Utilize the DHCD Consolidated and Comprehensive RFP processes as the mechanism to solicit and identify new PSH projects. 2. Sustain close collaborative with DHCD on the review and approval of DMH Capital commitments to new PSH projects. 3. Collaborate with DHCD to conduct a marketing effort to attract new developers to participate in the DMH Capital Program. 4. Require routine process for reaching DMH's production goals. 	DMH and DHCD	<ol style="list-style-type: none"> 1. DMH part of RFP review process. 2. Develop marketing plan to attract developers to apply for DMH capital. 3. Development goals met annually and after 5 years. 	<p>Annual</p> <p>November 2012</p>

Objective #2: Better Align Long-Term Operating Subsidies with the PSH Development Pipeline.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Develop/convene an annual resource planning process among District Agency partners to identify long-term operating subsidies to support a range of new PSH units to include the 70-90 PSH units created by the DMH Capital Program. 2. DMH will continue to play a leadership role in organizing District Agency partners to successfully compete for future operating subsidies made available through HUD's Section 811 PRA Demo Program. 	DMH	<ol style="list-style-type: none"> 1. Annual set-aside of long-term operating subsidies to support new development. 2. Submission of annual HUD Section 811 application, pending future NOFA from HUD. 	Annual

Objective #3: Establish a Capital Operating Reserve Pilot.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish a workgroup comprised of DMH and DHCD staff to develop a plan to guide the establishment of a Capital Operating Reserve Pilot. 2. Identify a fiduciary agent to oversee/manage distribution from the capital operating reserve fund to the program sponsor. 3. Coordinate implementation of this pilot with the DC Affordable Housing Task Force to support further expansion. 4. Assess the pilot's success in order to inform plans to transition to a permanent program. 	DMH and DHCD	<ol style="list-style-type: none"> 1. DMH and DHCD workgroup established. 2. Implementation of Capital Operating Reserve Pilot. 3. Pilot evaluation 	<p>November 2012</p> <p>Fiscal Year 2013</p> <p>FY 2014</p>
Objective #4: Implement Permanent Supportive Housing Capacity Building Activities.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Identify the specific training and capacity building needs around PSH development. 2. Coordinate the provision of training and capacity building activities with the Corporation for Supportive Housing's Training Academy. 	DMH	<ol style="list-style-type: none"> 1. Training module for PSH developers. 2. Included in CSH Training Academy 	FY 2013

Goal Three: Maximize Existing PSH Resources to Meet the Needs of Mental Health Consumers Across the District.

Goal Formulation:

DMH has sponsored an impressive array of existing PSH opportunities throughout the District. TAC worked closely with DMH housing staff in the development of DMH's current permanent supportive housing (PSH) inventory, and estimates that there are approximately 2,434 existing PSH opportunities available to DMH consumers. Assuming that this PSH turns over conservatively at a rate of between 3-5% annually,²¹ the existing PSH portfolio will generate an estimate of 80 - 134 PSH opportunities annually. To maximize existing PSH resources, DMH will implement strategies and protocols to effectively manage these existing PSH opportunities.

Focus Role of DMH Housing Staff

Given the importance that the Department places on PSH and the volume of PSH opportunities DMH has created, designated position(s) are needed to effectively manage, monitor and oversee the implementation of an expanding PSH program. Comparatively, DMH has more housing staff (six) than many larger state mental health authorities. This positive feature has enabled DMH to grow the supply of affordable housing for individuals with mental illness living in the District.

However, over time, absent clearly defined roles and responsibilities and the basic need to get the job done, the housing staff has assumed various housing responsibilities that should be managed at the provider level or by other District agencies. Moving forward, DMH intends to delegate more of these responsibilities (e.g. annual re-certification process, role in crisis intervention/landlord mediation of DMH consumers residing in permanent supportive housing) to the CSAs. As recommended elsewhere, Housing Liaisons can perform several of these tasks. DMH should assume a greater oversight role for the management, quality and performance of residential and supportive housing.²² It is recommended that housing staff be re-tasked to perform these functions.

The housing office should be re-configured to do less direct consumer case management and more housing system management, including implementation of several recommendations in this report such as outcome development and monitoring. DMH housing staff plays an important role in the oversight and proper utilization of both DMH-sponsored housing resources as well as all other housing resources targeted to non-elderly people with disabilities. In this critical role, DMH Housing staff will focus its efforts on the following activities:

- Management of the waiting list for DMH-Sponsored Housing;
- Oversight of the PSH screening and certification process;
- Management of the DMH housing database and tracking system for DMH consumers;

²¹ Based on turnover rates in a sampling of Public Housing programs.

²² CSWs and Housing Liaisons at the provider level should be responsible for direct consumer-related service and housing work. DMH housing staff should only become involved in situations under emergent or extenuating circumstances.

- Implementation and management of an online Housing Resource Guide to assist DMH consumers and service providers in identifying an appropriate PSH opportunity;
- The consolidation and regular review/update of a comprehensive Memorandum of Understanding between DMH and DHCA to guide the effective management and targeting of special purpose housing vouchers including all Non-Elderly Disability vouchers (NED, Mainstream, Designated), Section 8 HCV set-asides (i.e. St. Elizabeth's Hospital and Chronically Homeless), Section 8 PBV resources (the Partnership Program) supporting DMH-targeted PSH, and LRSP resources supporting DMH-targeted PSH;²³
- Active participation in the DHCD project review process;
- Compliance oversight and coordination of the Housing Liaisons' role throughout the DMH system;
- Coordination of regular data sharing, and coordination with DHS and DHCA to ensure fair access of their housing opportunities;
- Compliance oversight to ensure DMH consumers are assessed on an ongoing basis to facilitate movement from transitional housing to permanent supportive housing; and
- Evaluation of outcomes across housing programs and informing program, clinical, and contracting staff regarding provider performance necessary for decision-making. Housing staff could also become part of provider and clinical site review teams.

Implement Home First 'Bridge' Rent Subsidy Program Enhancements

DMH will implement enhancements and changes to the structure of the Home First Rent Subsidy Program. As initially envisioned, the Home First Program was designed as a time-limited, tenant-based rent subsidy designed as a "bridge" to the Section 8 Housing Choice Voucher Program. Philosophically, the DMH Home First Program should not be seen as permanent rental assistance program. DMH acknowledges the realities of extremely long wait times on the Section 8 Housing Choice Voucher (HCV) Programs nationally including DCHA's program. However, DMH could gain significant benefits from implementing a series of enhancements to the Home First Program in order to strengthen the bridge to the Section 8 HCV Program, encouraging some level of flow from Home First to DCHA's federally-funded Section 8 HCV Program.

Most importantly, DMH will advocate with District and DCHA leadership to establish a set-aside within the District's Section 8 HCV program a defined number of vouchers for graduates of the Home First Bridge Subsidy Program. TAC recommends a reasonable set-aside of 50-60 Section 8 vouchers annually for graduates of DMH's Home First Program. Currently, DCHA's Section 8 HCV Program has three set-asides – chronically homeless households (447 vouchers), non-elderly disabled persons transitioning from St. Elizabeth's Hospital (50 vouchers), and individuals transitioning to independent living from a Long-Term Housing

²³ In TAC's environmental scan, TAC identified two Memorandums of Agreement between DMH and DCHA from 1999 and 2004 concerning the agencies' collaboration on the administration of Mainstream Vouchers for people with disabilities respectively. These agreements are in addition to the contract between DCHA and DMH to administer the Home First Rent Subsidy Program.

Settings (65 vouchers).²⁴ DCHA would establish this Section 8 HCV set-aside incrementally over time taking advantage of regular turnover within its Section 8 HCV program. The primary purpose of the set-aside is to create a small degree of 'flow' from the two programs on an annual basis.

In addition, DMH will consider the following enhancements to the Home First Program. DCHA is the current Administrator of the Home First Program. DMH will initiate conversations with DCHA to redefine the responsibilities of the Home First Subsidy Administrator to include all day-to-day administration of the rental subsidy program including annual and special re-certifications. Alternatively, DMH may consider issuing a solicitation for this function to allow for consideration of other options. Within this process, DMH will also explore feasibility of creating a financial incentive within the subsidy administrator's fee structure to transition a specific number of DMH consumers to the Section 8 HCV program annually.

DMH will also seek to improve linkages and communication protocols between DMH Housing Staff and the DCHA staff managing the Section 8 HCV Program. For example, DCHA staff could provide DMH Housing staff and its provider agency network with early notification that the Section 8 Waiting List will be open at a specific time giving DMH and its provider adequate time to mobilize and prepare the Home First voucher holders to apply for entry to the Section 8 waiting list. In addition, DMH and DCHA should establish standard protocols that DCHA shall notify DMH Housing staff (in addition to the DMH consumer) of any requests for information to stay on the DCHA Section 8 Waiting List. This would ensure that DMH consumers receive the support needed to submit information in a timely manner to maintain their place on the waiting list.

In order to strengthen linkages with the Section 8 HCV Program, DMH will amend Chapter 22, Title 22-A 52 DCR 7026 for supported housing to: 1) formally require all Home First participants to apply for the DCHA Section 8 HCV Program (at the earliest possible time) as a condition of entry; and 2) formally require that the Home First participant agree up front as a condition of entry into the program to transition to a Section 8 voucher or similar type of rental subsidy if offered. Failure to accept the permanent rental subsidy is grounds for termination of assistance. In addition, DMH should consider defining an eligible household and the process to determine the bedroom size that the household is qualified for under the Home First Program. All program requirements should generally mirror requirements set forth by DCHA's Section 8 HCV program.

Several stakeholders also suggested that DMH increase the Home First contract rent to 100% of Fair Market Rent (FMR) to better align the Home First Program with the Section 8 HCV policies as well as provide the Home First participant greater 'buying power' and choice in identifying a rental unit in a broader selection of neighborhoods throughout the District. Absent new funding to pay for this change, DMH will need to consider the effect of fewer consumers

²⁴ TAC's Section 8 Made Simple Guidebook (2nd Edition, June 2003) highlights a PHA's discretionary authority to establish a "needs based" preference or set-aside within their Section 8 Housing Choice Voucher Program.

being served against the potential benefits of securing housing in better neighborhoods.²⁵ Alternatively, DMH will consider setting the contract rent for the Home First Program to the 80% of the current year's FMR in order to keep pace with the current rental market in the District. Currently, the contract rent is set at 80% of the 2011 FMR and does not change annually. This type of policy change would require modest budget growth annually in order to implement successfully.

Over the long-term, DMH will assess with DHS the feasibility of combining the Home First Rent Subsidy Program and DHS's PSH Program. A merger of these District-funded rental assistance programs would likely lead to greater efficiencies in the staffing model, streamlined/combined program regulation for both subsidy streams, and a consolidated waiting list. Given these potential benefits, TAC recommends further discussion between the two agencies and possibly a formal assessment further exploring the benefits and policy trade-offs from such a merger.

Expand and Enhance the Housing Liaison Position

The six existing Housing Liaisons play a critical role in supporting the provision of PSH and supporting successful tenancy. Recognizing their benefit, as well as acknowledging the need to devolve some consumer-level responsibilities from the DMH Housing staff as discussed earlier, DMH will explore ways to support the expansion of Housing Liaisons to support all Core Service Agencies (CSAs) throughout system. As part of this expansion, DMH will standardize the role and functions of the Housing Liaisons across the CSAs, including a reasonable caseload size. To promote consistency and competency, DMH will support an ongoing training and capacity building program for the Housing Liaisons. Finally, DMH may consider a certification initiative for the Housing Liaison role modeled after the DMH's Community Support Worker (CSW) Certification Program.

Since most functions performed by Housing Liaisons are not reimbursable through MHRS, there is currently no funding mechanism to support these positions. DMH will need to identify a funding source to support these positions.

Develop and Manage an On-line Housing Resource Guide

Workgroup members stated that CSWs and consumers are often confused about the requirements for and availability of various housing resources. As a mechanism to maximize the use of existing PSH opportunities throughout the system, DMH will develop and maintain an online Housing Resource Guide to provide consistent and up-to-date information on all housing programs to facilitate system-wide understanding of resources and effective, efficient referrals. The Housing Resource Guide will include: a description of each housing program (Home First, LRSP, DHS PSHP, Continuum of Care funded housing for the homeless, etc.), and real time information on the availability, eligibility criteria, requirements and applications procedures for all housing opportunities available to DMH consumers across the District. The purpose of the Housing Resource Guide is to streamline and facilitate the application process, increase

²⁵ TAC estimates that DMH will be able to serve approximately 162 less DMH consumers through the Home first Program if the contract rent limit was raised to 100% of FMR.

availability and accuracy of information on housing opportunities across the system, and improve transparency and information sharing across the DMH provider network. DMH should coordinate online Housing Resource Guide development efforts with The Community Partnership and the District's Interagency Council on Ending Homelessness.

Sustain DMH Capital Support (HIPi Program) to Preserve Existing DMH-sponsored PSH

Providing capital funds to preserve existing DMH sponsored housing was noted to be important, and TAC supports DMH's current efforts to offer capital funds through the Housing Improvement Program initiative (HIPi)²⁶ to rehabilitate and preserve existing DMH sponsored housing. In the future, DMH will focus its preservation resources primarily on sustaining the permanent supportive housing portfolio. Over the next 5-10 years, preservation activities will become an increasingly important element of DMH Housing Program activities as existing PSH (10-15 years of operation) could be in need of a moderate rehabilitation. Over this period, DMH will consider utilizing the HIPi Program to assist PSH owners in sustaining the housing stock as well as leverage both private and public capital resources.²⁷ DMH will also continue to pursue efforts to utilize the HIPi Program to address accessibility needs on the first Floor of DMH sponsored residential programs including permanent supportive housing.

²⁶ The HIPi Program is a program administered by Cornerstone through a grant of \$1 million through the DC Department of Community Development. These funds are appropriated capital funds from the DC Department of Mental Health.

²⁷ To the extent possible, DMH should require that all PSH development build in operating reserves sufficient to prepare for and pay for all necessary repair, maintenance and capital expenses.

Goal Three: Maximize Existing PSH Resources to Meet the needs of Mental Health Consumers Across the District.

Objective #1: Focus Role of DMH Housing Staff.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Redefine the roles and responsibilities of the DMH Housing Staff focusing on the broader role of housing systems management. 2. Shift direct DMH consumer support on housing matters to the DMH-sponsored Housing Liaisons consistent with expansion of this program. 	DMH	<ol style="list-style-type: none"> 1. DMH should develop an Office of Housing scope of work as well as individual job descriptions. 	December 2012

Objective #2: Implement Home First 'Bridge' Rent Subsidies Program Enhancements.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Advocate with both Mayor's Office and DCHA Leadership to establish a set-aside within the District's Section 8 HCV Program of a defined number of vouchers for graduates of the Home First Subsidy Program. 2. Redefine the roles and responsibilities of the Subsidy Administrator that manages the Home First Subsidy Program. 3. Establish more formal linkages and communications protocol between DMH Housing Staff and DCHA staff, to be memorialized in an updated Memorandum of Understanding between the two agencies. 4. Amend the DMH Supportive Housing Program Regulations in Chapter 22, Title 22-A 52 DCR 7026 to generally mirror the requirements set forth in DCHA's Section 8 HCV program. 5. Assess the feasibility of establishing the Home First Contract Rent at 100% of Fair Market Rent (FMR). 	DMH	<ol style="list-style-type: none"> 1. Set-aside of Section 8 HCV's for graduates of Home First Subsidy. 2. Revised MOU between DMH and DCHA. 3. Amended DMH PSH regulations to be more consistent with DCHA Section 8 HCV program. 	Fiscal Year 2013

6. DMH and DHS jointly assess the feasibility of combining the Home First Subsidy Program and the DHS PSH Program.			
Objective #3: Expand and Enhance the Housing Liaison Position to Provide Adequate Coverage Throughout the District.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Expand the number of housing liaison positions to provide adequate coverage. 2. Formalize the roles and responsibilities of the Housing Liaison within the DMH system. 3. Devolve the responsibilities of direct DMH consumer support on housing matters from the DMH Housing Staff to the Housing Liaisons as part of this effort. 4. Provide on-going training and capacity building support to the Housing Liaisons in order to promote consistency and competency. 5. Consider a certificate program for the Housing Liaisons modeled after the DMH's Community Support Workers Certification Program. 	DMH	<ol style="list-style-type: none"> 1. Define role of Housing Liaison. 2. Incorporate role of Housing Liaison into regulation. 3. Identify funding source to procure additional Housing Liaison positions. 4. Development of training module for Housing Liaisons. 	Fiscal Year 2013
Objective #4: Develop and Manage an Online Housing Resource Guide on PSH Opportunities Within the District.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish a DMH-led workgroup to develop an implementation plan to guide the development of an online Housing Resource Guide. 2. Coordinate implementation efforts with all District Partners to ensure DMH's efforts are aligned properly with other PSH information sharing efforts as well as reduce the risk of duplication of effort among District Partners. 	DMH	<ol style="list-style-type: none"> 1. DMH Workgroup to guide development of Housing Resource Guide (HRG). 2. Completion of on-line HRG, incorporating it as part of the DMH website. 	<p>January 2013</p> <p>June 2013</p>

Goal Four: Restructure DMH Residential and Housing Programs into Two Primary Program Models - Permanent Supportive Housing and Transitional Residential Services

Goal Formulation:

Approach to Residentially-based Services

Over time, many mental health systems have built discreet programs designed to meet varying **levels** of need. However, systems with multiple programs tend to be rigid and inflexible to meet consumers' dynamic needs, and result in being bound by the requirements within the program. Rather than focus on levels of service by program, DMH intends to organize the current continuum of residential programs into **Transitional Housing Services** and **Permanent Supportive Housing** in order to clearly articulate the purpose of housing support services in the District. This will enable DMH to deliver or wrap services around individuals based upon their changing needs rather than by the program they are in.

Standard Permanent Supportive Housing (PSH) Definition

Absent a clear definition of permanent supportive housing (PSH), the implementation of PSH in the District is loosely defined. In order to ensure consistent implementation of PSH services, DMH will establish and adopt a standard PSH definition and principles to guide the creation and management of all PSH sponsored by the Department. The following principles outlined in the SAMSHA PSH Evidence-Based Practice KIT shall serve as a guide:

- PSH is permanent, community-based housing targeted to extremely low income households with serious and long-term disabilities;
- PSH tenants have leases that provide them with all rights under tenant-landlord laws. Generally, PSH provides for continued occupancy with an indefinite length of stay as long as the PSH tenant complies with lease requirements;
- At a minimum, PSH meets federal Housing Quality Standards (HQS) for safety, security and housing/neighborhood conditions;
- PSH complies with federal housing affordability guidelines – meaning that PSH tenants should pay no more than 30-40 percent of their monthly income for housing costs (i.e., rent and tenant-paid utilities);
- PSH services are voluntary and cannot be mandated as a condition of admission to housing or of ongoing tenancy. PSH tenants are provided access to a comprehensive and flexible array of voluntary services and supports responsive to their needs, accessible where the tenant lives if necessary, and designed to obtain and maintain housing stability;
- PSH services and supports should be individually tailored, flexible, accessible by the tenant, and provided to the extent possible within a coordinated case plan;
- PSH provides a level of choice of unit in response to consumer preferences;
- Variety and range of PSH models - best-practice PSH approaches include a variety of evidenced-based, flexible models to include tenant-based and project-based initiatives. Successful approaches in other communities include the cross-disability model, small

set-asides of PSH units in multi-family housing developments produced through Low Income Housing Tax Credit (LIHTC) and bond-financed properties, as well as the single purpose single population PSH model; and

- As an evidence-based practice, the success of PSH depends on ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise.

Permanent Supportive Housing Eligibility and Allocation Criteria

As DMH moves toward a PSH-based system, it will be important for DMH to develop and adopt a set of standardized eligibility criteria in order to manage access to DMH-controlled permanent supportive housing opportunities for priority populations as effectively as possible. Based on feedback from stakeholders, DMH will develop and incorporate the following PSH eligibility criteria:

- Screening and Certification Process
- Basic Eligibility for DMH Priority Populations
- System-wide Allocation Process

Below is a detailed discussion of these elements:

1. Standard PSH Screening and Certification Process:

A concern raised by workgroup members was that eligibility determinations by agency could result in inconsistencies and inequitable access to PSH, and that a standardized, initial PSH Eligibility Determination questionnaire should be developed that can be used by all DMH contract agencies that come in contact with individuals who may need PSH to determine initial eligibility. The screening form should obtain information regarding whether the person needs services only and/or rental assistance, as well as information that may also be used by other agencies, like DHS, to satisfy their requirements for housing assistance that the person may be eligible for.²⁸ To the extent possible, DMH Housing staff should manage this process electronically through a web-based system so that information from multiple agencies is entered into a consolidated planning list.²⁹ DMH Housing staff intends to certify eligibility and authorize a process whereby a consumer accesses PSH or is placed on a planning/waitlist.

2. PSH Eligibility for DMH Population:

Despite finite resources, basic eligibility criteria should be flexible enough to include consumers with serious mental illness with a range of needs. As a result, DMH intends to implement the following basic eligibility criteria:

²⁸ DMH would need to establish requirements to safeguard protected information.

²⁹ Community agency staff may initially take the information on a hard copy that can be entered electronically later.

- a. Income Requirements:³⁰ PSH is targeted to extremely low income households (30 percent of Area Median Income and below); and
- b. Age: The PSH head of household is generally, but not exclusively 18-61 years old;
- c. Disability: A member of the household has a serious mental illness that qualifies them for Medicaid-funded or other funded supports and services operated by the Department of Mental Health; and
- d. Qualify as 'In Need of PSH': A person shall be considered to be 'in need of permanent supportive housing' if a person has a serious mental illness that is expected to be of long, continued or indefinite duration; substantially impedes their ability to live independently without supports; and is of such nature that such ability could be improved by more suitable housing conditions. A person assessed as having a LOCUS Level between 1 and 4 shall be considered to satisfy this criterion.

3. DMH PSH Allocation Process:

For DMH controlled PSH resources, DMH will implement a process to allocate resources to those who meet basic eligibility criteria for PSH. This process should balance the need to target resources to priority populations, but also be flexible enough to include those who develop or present with extenuating circumstances. DMH intends to allocate PSH based on a process that considers the following criteria:

- a. Whether the consumer meets the general eligibility criteria above;
- b. Whether the consumer is considered one of the three priority populations (i.e. Discharge from Saint Elizabeth's, homeless, or moving to less restrictive setting), or;
- c. Whether an exception to the priority population criteria is justified based upon extenuating circumstances, such as an emergent housing crisis or specialized need for PSH.

Supported Independent Living (SIL) Program

As part of this process, TAC began an initial evaluation of the Supported Independent Living (SIL) Program. It was clear that services provided in SIL support consumers with a variety of needs. However, there is variability in how the program is operated throughout the system with models ranging from traditional continuum congregate residential programs (with the only difference being less than 24/7 on-site staffing), to housing and services aligned with principles and practices of permanent supportive housing. In addition, there was variability in how funds are used to support the programs. As DMH moves to a model of Permanent Supportive Housing and Transitional Residential Services, SIL will need to be reorganized to be consistent with this approach.

Appendix F has more detailed discussion about the Supported Independent Living (SIL) Program.

³⁰ These criteria reflect the need for both services and subsidized housing. For individuals who already have access to subsidized housing, income requirements used to determine eligibility for Home First rental assistance would not apply.

Contracted Community Residential Facilities (C-CRF)

In April 2010, DMH established the Community Residential Facility (CRF) Task Force that resulted in a pilot to re-balance CCRFs so that individuals could transition to PSH settings and others with higher needs in ICRF settings could gain access to CCRFs. This pilot is an opportunity to better assess, plan for, and provide linkages to services based on individual need so the system can wrap the right services around individuals, regardless of setting, and develop clear transition plans for consumers who want to move to supportive housing. It may also help to ensure flexible housing and service options for consumers with more challenging short or long-term needs (e.g., medically fragile, forensics, transition age youth).

As part of this initiative, DMH desires to reduce CCRF beds from 225 to 150 while preserving availability of more supervised services for those with higher needs. The dollars saved by decreasing the number of Contract CRF slots will be used to increase the current number of housing subsidies available to consumers in need of affordable housing and to develop a 'flexible funding pool' to fund non-Medicaid billable services and supports required to assist consumers in CRFs to maintain their community tenure.

DMH is cognizant that there are consumers in the system with complex needs that may benefit from CCRF level of services, such as those who are transition-age youth, older adults, forensically-involved or have co-occurring disorders. As DMH re-balances CCRFs and PSH resources, it must also continue to assess the need for CCRF's and other program models and develop clear strategies to provide supportive housing opportunities to these populations.

Appendix G has more detailed discussion about Contracted Community Residential Facilities.

Revise Regulation and Contract Requirements to Align with and Articulate New Models

DMH will utilize regulations and contract requirements as a framework to institute many of these changes, with caution exercised so that over-regulation does not become an unintended consequence.

As discussed above, DMH will organize regulations into ***“Transitional Residential Services”*** (i.e. for C-CRF, and transitional services, components of SIL) and ***“Permanent Supportive Housing”*** for supportive housing and independent housing-related services. Establishing standards for Transitional Housing Services and Permanent Supportive Housing will provide DMH the ability to establish minimum expectations, infuse performance measures, and ensure consistency of services across the system.

Standards for services delivered in Permanent Supportive Housing will be organized into Chapter 22, Title 22-A 52 DCR 7026 regulations for supported housing. PSH services should delineate: 1) the services that are available within the community to individuals living in PSH or other community settings; and 2) need and eligibility for Housing Assistance (i.e. Home First rental subsidy, deposits, etc.). Regulations related to PSH should discuss what is expected to be provided, consistent with MHRS, be aligned with PSH principles and definition, and include

requirements for delivery of best practice services and outcomes. DMH will make the distinction that Housing Assistance (i.e. rental subsidy, deposits, etc) will only be made available to eligible consumers moving into housing and services consistent with the definition of PSH. Language will be incorporated that balances consumer choice of services with need to monitor housing units.

In ***Transitional Residential Services***, it is important to state that the purpose of program(s) is intended to be transitional and to prepare individuals to move to PSH or independent living. Regulations should incorporate the expectation that all residents of C-CRF, I-CRF and SIL have, as part of their Individual Recovery Plan, a goal of PSH or other more independent living setting.

Regulations should require the development of a specific Transition Plan, incorporated into the IRP/IPC to support the move to PSH or independent housing. All individuals approved for PSH will have as part of his/her overall service plan an initial transition plan that specifies the activities, roles, and responsibilities to support the person during pre-tenancy and initial move in, including the use of Peer Support Specialists. This plan will be developed with the individual, staff from existing setting (Saint Elizabeth's, CRF, SIL, CTI, etc), and the CSA staff who will support the person once in PSH. While it is not necessary to use a formal CTI process, concepts from that model should be used to ensure seamless and coordination of services and supports. DMH may want to review outcome data for people who have failed during transition and review what supports could have been put in place.

In both Transitional Residential Services and PSH services regulations, DMH will establish a more detailed quality improvement process that defines the activities that providers should adhere to and outlines the roles and responsibilities that DMH will engage in from a quality oversight perspective.

DMH will also consider incorporating and implementing other evidence-based practices, including Illness Management and Recovery and Motivational Interviewing/Enhancement techniques, especially in the C-CRFs, to promote transition to PSH and other independent settings.

<p>3. DMH will require each SIL provider to submit a plan to re-align its existing program model with the DMH-desired model, including timeframes and specific changes to program operations.</p>	<p>DMH, SIL providers</p>	<p>2b. Budgets developed for each SIL program reflecting total operation costs as new program designation (PSH or TRS).</p> <p>2c. Based on operating costs of SIL programs when operating under new model, DMH will decide on reallocation of any available SIL funds</p> <p>3. Plans submitted by providers detailing transition process and timeframe to be fully operational as new program model (PSH or TRS)</p>	<p>October 2012</p> <p>October 2012</p> <p>October 2012</p>
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Objective #3: Use procurement and Contracting Process to Align Existing Programs with New Models, Set Performance Expectations and Budget

Action:	Responsibility:	Performance Criteria:	Timeframe:
<p>1. DMH will assess the need for C-CRF beds for emerging populations (i.e. transition-age youth, older adults, forensically-involved, co-occurring disorders).</p>	<p>DMH</p>	<p>1. Assessment summary of priority emerging populations and estimated need for C-CRF (TRS) bed.</p>	<p>October 2012</p>
<p>2. DMH will target TRS beds (formerly C-CRF) for prioritized emerging populations and reduce the number of C-CRF beds to be replaced in the system by PSH slots. DMH will use contracting and procurement processes to transition existing C-CRF consumers to PSH units. As individuals move to PSH, DMH will take C-CRF bed off-line.</p>	<p>DMH</p>	<p>2. Draft RFP or RLI for transitioning current C-CRF consumers to PSH and converting identified beds to TRS for prioritized emerging population.</p>	<p>October 2012</p>

Goal Five: DMH will improve the quality of services delivered in PSH.

Goal Formulation:

While increasing and maximizing the supply of affordable housing is important to supporting individuals in integrated, community-based settings, the quality of services delivered to consumers is critical to their readiness for independent living and community tenure. Some of the areas identified as challenges include the need to utilize outcome measures to drive system quality and accountability, clearly articulated roles and responsibilities, minimize redundancy across provider systems, and ensure the delivery of best practice services, including care coordination.

Develop and Implement Outcome/Performance Measures

DMH will establish system-wide outcomes related to PSH and Transitional Residential Services programs, and incorporate performance into decision-making. By proactively developing a set of performance measures specific to housing and housing supports, DMH can evaluate consumer-level outcomes, provider performance, and program model performance. More specifically, DMH may begin to more proactively improve residentially-based program models or favor some models based upon outcome evaluation.

DMH collects a significant amount of data from providers through its electronic consumer management and billing system, known as eCura, as well as housing information gleaned from various documentation sources. However, this information is not coordinated, and DMH housing staff must extract data from eCura and upload it into a housing database for housing management purposes. It is recommended that DMH Housing staff be provided with access to a data base that allows them to collect, track and analyze housing related data that can be used for quality improvement, monitoring and oversight. DMH is in the process of implementing a more comprehensive system that better coordinates information and is more user-friendly and accessible to DMH staff and the provider community. This will be an important tool for DMH once implemented.

Nevertheless, DMH will adopt and initiate various performance measures specific to housing and housing supports now that can be built into the new system once developed. DMH currently evaluates various indicators throughout the system to understand program and consumer level outcomes, but outcome measures in the context of housing could be incorporated to assess whether housing and/or the quality of housing and the housing model have had a positive or negative impact on an individual consumer.

For example, as part of the SAMHSA Block Grant National Outcomes Measures (NOMS), DMH collects, through the MHSIP survey, various measures. For example, one goal is to increase the social supports and social connectedness of individuals. DMH will consider refining this measure to evaluate an individual's social connectedness depending on the type of housing they are in, and/or the quality of the program. Another goal for which data is collected concerns improving an individuals' level of functioning. Similarly, DMH will evaluate the degree of

progress individuals make depending on access to housing, type of housing or the provider operating the housing.

Examples of process measures that DMH will consider include various recommendations in this report, such as revisions to regulations; evaluation and modifications to SIL; the implementation of training modules in the Learning Management System; revising the roles of DMH housing staff; and improving the proportion of PSH compared to C-CRFs. DMH will also consider adopting and evaluating outcome measures such as a person's health status, employment, personal relationships, community inclusion, self-determination, and choice, using access to housing and housing supports as variables. As part of this process, DMH will refer to the Substance Abuse Mental Health Services Administration's (SAMHSA) National Outcomes Measures³¹ and the National Core Indicators³² for more information.

In addition to the redefined roles identified in Goal Three for the DMH Housing Staff, if new outcome measures specific to housing are developed and there is greater attention to quality oversight of housing providers, DMH housing staff are uniquely positioned to assume these roles, especially in coordination with the Department's Applied Research and Evaluation Unit (ARE). This could include evaluating outcomes across housing programs and informing program, clinical and contracting staff regarding provider performance necessary for decision-making. It also could involve designated housing staff becoming part of provider and clinical site review teams.

Improve Provider Performance and Accountability

As DMH moves toward a more performance-based system, it will review its requirements for CSAs and ensure they are providing the proper case management for individuals, including for those who are difficult to engage or are treatment resistant. DMH will establish a review process/function to ensure that providers are held to standards and that quality, best practice services are being delivered to consumers and worked into service plans. Individual service plans should have a housing component built in with clearly identified responsibilities (i.e. securing apartments, skill training for housing-related tasks, contacts with landlords). As discussed above, these requirements will be incorporated into regulation and contracts.

Good care coordination can ensure the availability of flexible, responsive wrap-around supports needed to promote tenure over time. Because individuals have complex needs, they frequently receive more than one service from more than one program; sometimes these programs are operated by different agencies and funded by different government agencies (e.g., DMH, DHS, DCHA). CSAs play a role of coordinating services for individuals, but there is inconsistency in how care is coordinated, who's accountable, and the roles and responsibilities of providers in each person's care. DMH will clearly define the role of care coordination, incorporate it into regulation and hold providers accountable to the role. This does not suggest additional staffing, but rather clearly articulating the basic roles and responsibilities for direct care staff that function in the role of 'care coordinator' in each individual's Individual Recovery Plan/Individualized Plan

³¹ SAMHSA NOMS: <http://integratedrecovery.org/wp-content/uploads/2010/08/SAMHSA-National-Outcome-Measures.pdf>

³² <http://www.nationalcoreindicators.org/resources/guides/>

of Care (IRP/IPC). DMH will apply this across the system so that there is a basic expectation of consistent care coordination for every individual. For individuals who are involved in DMH services and DHS case management, this will serve to minimize the redundancy and confusion around roles and responsibilities.

However, non-billable service coordination was identified as a challenge, and there is a real need for funding flexibility to provide this service. While MHRS offers a good set of clinical services for DMH consumers living in supportive housing, providers still struggle with the flexibility of MHRS to keep people in housing, with community support offering the least flexibility and ACT being more flexible. Opportunity exists to enhance care coordination by assigning responsibility and ensuring accountability across Core Service Agencies (CSAs) for DMH consumers in housing settings, particularly when a consumer is involved with more than one provider. This will help to minimize potential duplication of services as well.

Increase the Supply of Peer Support Specialists Working in Community Programs

Peer Support Specialists are increasingly well-received in the District. The role of Peer Support Specialists during the transition process is valuable and could be expanded to all consumers transitioning to community living and extended throughout tenancy. By increasing the frequency and number of trainings, DMH will increase the supply of certified Peer Support Specialists available to work in PSH, hospital, and transitional residential settings.

DMH will need to explore flexible funding mechanisms in order to increase the supply of Peer Support Specialists working in community programs. Many services provided by Peer Support Specialists are Medicaid reimbursable, and DMH should maximize the use of MHRS to bill for eligible services delivered by Peer Support Specialists. In addition, DMH will explore non-Medicaid funding sources to support important, yet non-billable, services.

Improve Overall Engagement and Retention

Occasionally, consumers reject PSH services once they access affordable housing, and providers become concerned about consumer well-being and their own liability. A combination of workforce training specifically related to engagement strategies (See Goal Six for workforce and training), clearly defined program requirements upon admission, and transition to other rental assistance resources can improve overall engagement and retention.

As an engagement strategy, DMH could consider requirement of consumer agreement to minimum of one contact per month by CSW. While the individual may still terminate or refuse services, s/he will have been told upfront that staff will continue to engage, outreach and contact.

In addition, DMH could expand the Monthly Visit Report that is currently used to include more than just unit inspection. Or, create a similar monthly report that the CSW is to complete beyond any case notes as required by MHRS. This recommendation is based on consistent concerns expressed in workgroups and by Property Managers that CSW visits to consumers are

inconsistent. Where they exist, the Housing Liaison completes this form currently (hence its focus on inspection of unit).

Goal Five: DMH will Improve the Quality of Services Delivered in PSH			
Objective #1: Develop and Implement Outcome/Performance Measures			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. DMH will develop an internal workgroup to develop a set of performance measures specific to housing and housing supports.	DMH	1. Establish workgroup.	October 2012
2. DMH will establish a process for evaluating outcomes across housing programs to drive decision-making.		2. Housing staff participate in provider site review teams.	Fiscal Year 2013
Objective #2: Improve Provider Performance and Accountability			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. DMH will clearly define the role of care coordination and incorporate it into regulation.	DMH	1. Care coordination definition and role incorporated into regulation.	Fiscal Year 2013
2. Individual service plans should have a housing component built in with clearly identified responsibilities.		2. Regulations to require housing component addressed in service plans.	
3. DMH will evaluate mechanism for funding for non-billable service coordination.		3. DMH to establish a mechanism for flexible funding for non-MHRS service coordination services.	
Objective #3: Increase Supply of Peer Support Specialists Working in Community Programs.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. DMH will expand roles of Peer Support Specialists in regulations for PSH and Transitional Residential Services.	DMH	1. Amendments to regulations.	Annually 2012-2017
2. DMH will explore flexible funding mechanisms in order to increase the supply of Peer Support Specialists working in community programs.		2. Identification of flexible funding mechanism in order to increase the supply of Peer Support Specialists.	
(Note: See additional information in Goal Six regarding training of Peer Support Specialists.)			

Objective #4: Improve Overall Engagement and Retention

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none">1. Establish requirement in Home First program of minimum of one contact per month by CSW.2. Expand the Monthly Visit Report to include content about consumers' level of engagement.	DMH	<ol style="list-style-type: none">1. Incorporate requirement into regulation for Home First.2. Measure number of consumers who are terminated from program for failure to comply with requirement.3. Monthly Visit Report modified.	Fiscal Year 2013

Goal Six: Strengthen and Increase Community Workforce Capacity to Meet the Needs of Increased Numbers of Consumers Living in PSH

Goal Formulation:

Goal Five discussed the importance of the quality of services delivered to individuals. A core component of quality services is the quality of the workforce providing them. Workforce issues, particularly at the Community Support Worker (CSW) level, surfaced throughout this process and were identified as effecting the quality and consistency of services across programs and providers, success during transition, consumer engagement, and tenure in housing. As a result, workforce training is included as Goal Six in this plan. In order to ensure that training requirements are implemented, DMH will incorporate training topics into PSH and Transitional Residential Services regulations.

Training Institute and Learning Management System

DMH will explore the feasibility of funding courses within the DMH Training Institute to enable on-going training for staff specifically on the PSH model and philosophy, housing competency, and skill development related to independent living, recovery and wellness. The Learning Management System (LMS) implemented by DMH may be a tool that can be used to support this effort. LMS is intended to provide web-based training to DMH, provider agency staff, and peer specialists. Staff from Saint Elizabeth's should also be able to receive training through the institute specific to the PSH model, capacity of PSH services to meet the needs of individuals with complex needs, preparing individuals to move to PSH at discharge, and coordinating the transition to PSH with the CSA and individual. Landlord/Property Manager training can also be made available regarding the PSH model, as can training on application processes, roles of CSAs and CSWs, services provided to individuals, and who to contact regarding consumer housing concerns.

CSW Certification and Training Module

Due to the wide variability in knowledge of CSWs regarding housing resources and requirements and how to access them, DMH will develop a housing module for CSW certification. DMH's plan to develop CSW certification provides an opportunity to develop competencies necessary to support people living in PSH settings. A housing module will be included that covers: recognizing early signs of potential housing crisis and intervening in an effective, timely way; engaging individuals who are refusing services or contact; flexible approaches to service delivery that allow for responsive and timely increase or decrease in frequency or intensity; and assisting individuals to develop critical skills, knowledge, and resources for successful and sustained independent living in the community.

Housing Liaison Training

In addition to a CSW certification housing module, DMH will develop a certification or standardized training for Housing Liaison positions. The training module will be competency-based and emphasize the critical knowledge, skills, and resources staff need in order to effectively deliver PSH and Housing Liaison services. The training module will also include, at

minimum, material covered in the Housing Resource Guide, and how to develop transition and housing stability-focused service plans.

Goal Six: Strengthen and Increase Community Workforce Capacity to Meet the Needs of Increased Numbers of Consumers Living in PSH

Objective #1: Increase role of Peer Specialists in PSH.

Action:	Responsibility:	Performance Criteria:	Timeframe:
1. Designate specific roles of Peer Specialist in supporting individuals living in PSH.	DMH	1. Draft position description	September 2012
2. Require Peer Specialist role for each CSA team providing MHRS to individuals living in PSH settings.	DMH	2. Requirement added to PSH program standards and inserted into FY13 contract requirements.	January 2013
3. Review and revise as needed Peer Specialist Certification Training to ensure curriculum is competency based, includes structured practice and evaluation. Content to include housing specific knowledge and skill areas, and includes a component for Supervisors	DMH Training Institute	3. Revised Peer Specialist Curriculum	October 2012
4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory training for staff, # of Peer Specialists for every X # of PSH tenants)	DMH regulation revision workgroup	4. See Goal 4: Objective #1 Incorporate Peer Specialist staffing requirements into CSA regulations	May 2013
5. Increase the frequency and number of trainings for Peer Support Specialist certification.	DMH	5. Increased number of Peer Support Specialists for each year of Plan as compared with previous year.	Annual

Objective #2: Strengthen Community Support Worker Service Delivery Through Increased Training and Certification

Action:	Responsibility:	Performance Criteria:	Timeframe:
1. Implement CSW Certification process.	DMH Training Institute	1a. CSW Certification curriculum developed.	December 2012
2. Develop/implement competency-based curriculum that includes structured practice and evaluation, and PSH as first module.	DMH Training Institute	1b. Deliver first round of training. 2. Housing Module developed.	March 2013 December

<p>3. Develop competency-based component for Supervisors.</p> <p>4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory staff training, CSW caseload size for PSH tenants)</p>	<p>DMH Training Institute</p> <p>DMH regulation revision workgroup</p>	<p>3. Supervisor Module developed.</p> <p>4. See Goal 4: Objective #1 Incorporating CSW staffing and training requirements into pertinent regulations.</p>	<p>2012</p> <p>December 2012</p> <p>May 2013</p>
<p>Objective #3: Standardize and Provide Training/Capacity Building for Housing Liaison Services across all PSH Programs.</p>			
<p>Action:</p>	<p>Responsibility:</p>	<p>Performance Criteria:</p>	<p>Timeframe:</p>
<p>1. Develop Job Description and delineate minimum functions for Housing Liaison position.</p> <p>2. Determine HL to PSH tenant ratio necessary to meet housing coordination, landlord relations, and HQS related responsibilities.</p> <p>3. Develop and implement HL certification process. Curriculum is competency based and includes structured practice and evaluation.</p> <p>4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory staff training, HL caseload size for PSH tenants)</p> <p>5. Provide on-going training and capacity building support to the Housing Liaisons in order to promote consistency and competency.</p>	<p>DMH Housing Staff in conjunction with DMH Training Institute</p> <p>DMH Housing Staff</p> <p>DMH Housing Staff in conjunction with DMH Training Institute</p> <p>DMH Regulations Revisions Workgroup</p> <p>DMH Training Institute</p>	<p>1. Document delineating DMH expected roles and responsibilities for position that can be incorporated in regulations, training materials, provider contracts</p> <p>2. Minimum HL to PSH tenant ratio established</p> <p>3a. HL Roles & Responsibilities Curriculum developed</p> <p>3b. First round of HL training begun</p> <p>4. See Goal 4 : Objective #1</p> <p>5. Monthly meetings with designated DMH Housing Staff and community provider HL staff.</p>	<p>November 2012</p> <p>November 2012</p> <p>December 2012</p> <p>March 2013</p> <p>May 2013</p>

Appendix A

Department of Mental Health Supportive Housing Strategic Plan Consolidated Goals Chart 2012-2017

Goal One: Align District Policy and Improve Interagency Coordination in regards to Permanent Supportive Housing (PSH).			
Objective #1: Create a District-wide Standard Permanent Supportive Housing (PSH) Policy.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Convene District Agency partners (DMH, DCHA, HCD, DHS, DOA, DDS) to develop a PSH policy to be adopted across all City agencies involved in the provision of PSH throughout the District. 2. Propose standardized District-wide eligibility criteria for PSH. 3. Incorporate the final District-wide PSH policy into each Agency's regulatory structure concerning PSH. 	DMH, DCHA, HCD, DHS, DOA, DDS	<ol style="list-style-type: none"> 1. Adoption of a permanent supportive housing policy across all City agencies. 2. Modifications of regulatory standards. 	<p>December 2012</p> <p>Upon renewal of regulations.</p>
Objective #2: Improve Interagency Coordination and Data Sharing with Regard to Permanent Supportive Housing (PSH).			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish a DMH/DHS workgroup to streamline and better coordinate potentially duplicative or redundant services provided between DMH and DHS programs with an emphasis on PSH settings. 2. Develop a formal data sharing protocol between DMH, DHS and DCHA to compare and coordinate waitlist management activities. 3. Integrate this housing data sharing effort to the extent possible with DMH's ongoing database development project. 4. Develop a Memorandum of Understanding (MOU) between DMH and DHS which would formalize all efforts to coordinate the provision of PSH including data sharing protocols, waitlist management, and provision of supportive services. 	DMH and DHS	<ol style="list-style-type: none"> 1. Establish Workgroup. 2. Adoption of data sharing protocol. 3. Establish MOU to coordinate PSH. 	October 2012

5. Incorporate these formal data sharing protocols into the MOU between DMH and DCHA regarding PSH.			
Objective #3: Coordinate efforts with the DC Mayor's Office Integrated Case Management Initiative.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Participate fully in the Mayor's Office Integrated Case Management Initiative in order to improve communications and information sharing in regards to the provision of case management services to consumers residing in PSH. 2. Take the advantage of this effort to extent possible to assist in addressing the need for information sharing authorizations needed to readily share consumer housing and case management information across agencies. 	Deputy Mayor for Health & Human Services	<ol style="list-style-type: none"> 1. Establishment of communications and information sharing protocol. 	To Be Determined

Goal Two: Develop a Pipeline to create 350-450 new permanent supportive housing (PSH) opportunities over the next 5 years for mental health consumers in need of PSH across the District.

Objective #1: Pursue a Streamlined Approach to identify new permanent supportive housing for DMH Capital Investment.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Utilize the DHCD Consolidated and Comprehensive RFP processes as the mechanism to solicit and identify new PSH projects. 2. Sustain close collaborative with DHCD on the review and approval of DMH Capital commitments to new PSH projects. 3. Collaborate with DHCD to conduct a marketing effort to attract new developers to participate in the DMH Capital Program. 4. Require routine process for reaching DMH's production goals. 	DMH and DHCD	<ol style="list-style-type: none"> 1. DMH part of RFP review process. 2. Develop marketing plan to attract developers to apply for DMH capital. 3. Development goals met annually and after 5 years. 	<p>Annual</p> <p>November 2012</p>

Objective #2: Better Align Long-Term Operating Subsidies with the PSH Development Pipeline.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Develop/convene an annual resource planning process among District Agency partners to identify long-term operating subsidies to support a range of new PSH units to include the 70-90 PSH units created by the DMH Capital Program. 2. DMH will continue to play a leadership role in organizing District Agency partners to successfully compete for future operating subsidies made available through HUD's Section 811 PRA Demo Program. 	DMH	<ol style="list-style-type: none"> 1. Annual set-aside of long-term operating subsidies to support new development. 2. Submission of annual HUD Section 811 application, pending future NOFA from HUD. 	Annual

Objective #3: Establish a Capital Operating Reserve Pilot.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish a workgroup comprised of DMH and DHCD staff to develop a plan to guide the establishment of a Capital Operating Reserve Pilot. 2. Identify a fiduciary agent to oversee/manage distribution from the capital operating reserve fund to the program sponsor. 3. Coordinate implementation of this pilot with the DC Affordable Housing Task Force to support further expansion. 4. Assess the pilot's success in order to inform plans to transition to a permanent program. 	DMH and DHCD	<ol style="list-style-type: none"> 1. DMH and DHCD workgroup established. 2. Implementation of Capital Operating Reserve Pilot. 3. Pilot evaluation 	<p>November 2012</p> <p>Fiscal Year 2013</p> <p>FY 2014</p>
Objective #4: Implement Permanent Supportive Housing Capacity Building Activities.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Identify the specific training and capacity building needs around PSH development. 2. Coordinate the provision of training and capacity building activities with the Corporation for Supportive Housing's Training Academy. 	DMH	<ol style="list-style-type: none"> 1. Training module for PSH developers. 2. Included in CSH Training Academy 	FY 2013

Goal Three: Maximize Existing PSH Resources to Meet the needs of Mental Health Consumers Across the District.

Objective #1: Focus Role of DMH Housing Staff.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Redefine the roles and responsibilities of the DMH Housing Staff focusing on the broader role of housing systems management. 2. Shift direct DMH consumer support on housing matters to the DMH-sponsored Housing Liaisons consistent with expansion of this program. 	DMH	<ol style="list-style-type: none"> 1. DMH should develop an Office of Housing scope of work as well as individual job descriptions. 	December 2012

Objective #2: Implement Home First 'Bridge' Rent Subsidies Program Enhancements.

Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Advocate with both Mayor's Office and DCHA Leadership to establish a set-aside within the District's Section 8 HCV Program of a defined number of vouchers for graduates of the Home First Subsidy Program. 2. Redefine the roles and responsibilities of the Subsidy Administrator that manages the Home First Subsidy Program. 3. Establish more formal linkages and communications protocol between DMH Housing Staff and DCHA staff, to be memorialized in an updated Memorandum of Understanding between the two agencies. 4. Amend the DMH Supportive Housing Program Regulations in Chapter 22, Title 22-A 52 DCR 7026 to generally mirror the requirements set forth in DCHA's Section 8 HCV program. 5. Assess the feasibility of establishing the Home First Contract Rent at 100% of Fair Market Rent (FMR). 	DMH	<ol style="list-style-type: none"> 1. Set-aside of Section 8 HCV's for graduates of Home First Subsidy. 2. Revised MOU between DMH and DCHA. 3. Amended DMH PSH regulations to be more consistent with DCHA Section 8 HCV program. 	Fiscal Year 2013

DMH and DHS jointly assess the feasibility of combining the Home First Subsidy Program and the DHS PSH Program.			
Objective #3: Expand and Enhance the Housing Liaison Position to Provide Adequate Coverage Throughout the District.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Expand the number of housing liaison positions to provide adequate coverage. 2. Formalize the roles and responsibilities of the Housing Liaison within the DMH system. 3. Devolve the responsibilities of direct DMH consumer support on housing matters from the DMH Housing Staff to the Housing Liaisons as part of this effort. 4. Provide on-going training and capacity building support to the Housing Liaisons in order to promote consistency and competency. 5. Consider a certificate program for the Housing Liaisons modeled after the DMH's Community Support Workers Certification Program. 	DMH	<ol style="list-style-type: none"> 1. Define role of Housing Liaison. 2. Incorporate role of Housing Liaison into regulation. 3. Identify funding source to procure additional Housing Liaison positions. 4. Development of training module for Housing Liaisons. 	Fiscal Year 2013
Objective #4: Develop and Manage an Online Housing Resource Guide on PSH Opportunities Within the District.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish a DMH-led workgroup to develop an implementation plan to guide the development of an online Housing Resource Guide. 2. Coordinate implementation efforts with all District Partners to ensure DMH's efforts are aligned properly with other PSH information sharing efforts as well as reduce the risk of duplication of effort among District Partners. 	DMH	<ol style="list-style-type: none"> 1. DMH Workgroup to guide development of Housing Resource Guide (HRG). 2. Completion of on-line HRG, incorporating it as part of the DMH website. 	<p>January 2013</p> <p>June 2013</p>

<p>3. DMH will require each SIL provider to submit a plan to re-align its existing program model with the DMH-desired model, including timeframes and specific changes to program operations.</p>	<p>DMH, SIL providers</p>	<p>2b. Budgets developed for each SIL program reflecting total operation costs as new program designation (PSH or TRS).</p> <p>2c. Based on operating costs of SIL programs when operating under new model, DMH will decide on reallocation of any available SIL funds</p> <p>3. Plans submitted by providers detailing transition process and timeframe to be fully operational as new program model (PSH or TRS)</p>	<p>October 2012</p> <p>October 2012</p> <p>October 2012</p>
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Objective #3: Use procurement and Contracting Process to Align Existing Programs with New Models, Set Performance Expectations and Budget

Action:	Responsibility:	Performance Criteria:	Timeframe:
<p>1. DMH will assess the need for C-CRF beds for emerging populations (i.e. transition-age youth, older adults, forensically-involved, co-occurring disorders).</p>	<p>DMH</p>	<p>1. Assessment summary of priority emerging populations and estimated need for C-CRF (TRS) bed.</p>	<p>October 2012</p>
<p>2. DMH will target TRS beds (formerly C-CRF) for prioritized emerging populations and reduce the number of C-CRF beds to be replaced in the system by PSH slots. DMH will use contracting and procurement processes to transition existing C-CRF consumers to PSH units. As individuals move to PSH, DMH will take C-CRF bed off-line.</p>	<p>DMH</p>	<p>2. Draft RFP or RLI for transitioning current C-CRF consumers to PSH and converting identified beds to TRS for prioritized emerging population.</p>	<p>October 2012</p>

Goal Five: DMH will Improve the Quality of Services Delivered in PSH			
Objective #1: Develop and Implement Outcome/Performance Measures			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. DMH will develop an internal workgroup to develop a set of performance measures specific to housing and housing supports.	DMH	1. Establish workgroup.	October 2012
2. DMH will establish a process for evaluating outcomes across housing programs to drive decision-making.		2. Housing staff participate in provider site review teams.	Fiscal Year 2013
Objective #2: Improve Provider Performance and Accountability			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. DMH will clearly define the role of care coordination and incorporate it into regulation.	DMH	1. Care coordination definition and role incorporated into regulation.	Fiscal Year 2013
2. Individual service plans should have a housing component built in with clearly identified responsibilities.		2. Regulations to require housing component addressed in service plans.	
3. DMH will evaluate mechanism for funding for non-billable service coordination.		3. DMH to establish a mechanism for flexible funding for non-MHRS service coordination services.	
Objective #3: Increase Supply of Peer Support Specialists Working in Community Programs.			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. DMH will expand roles of Peer Support Specialists in regulations for PSH and Transitional Residential Services.	DMH	1. Amendments to regulations.	Annually 2012-2017
2. DMH will explore flexible funding mechanisms in order to increase the supply of Peer Support Specialists working in community programs.		2. Identification of flexible funding mechanism in order to increase the supply of Peer Support Specialists.	
(Note: See additional information in Goal Six regarding training of Peer Support Specialists.)			

Objective #4: Improve Overall Engagement and Retention			
Action:	Responsibility:	Performance Criteria:	Timeframe:
<ol style="list-style-type: none"> 1. Establish requirement in Home First program of minimum of one contact per month by CSW. 2. Expand the Monthly Visit Report to include content about consumers' level of engagement. 	DMH	<ol style="list-style-type: none"> 1. Incorporate requirement into regulation for Home First. 2. Measure number of consumers who are terminated from program for failure to comply with requirement. 3. Monthly Visit Report modified. 	Fiscal Year 2013

Goal Six: Strengthen and Increase Community Workforce Capacity to Meet the Needs of Increased Numbers of Consumers Living in PSH

Objective #1: Increase role of Peer Specialists in PSH.

Action:	Responsibility:	Performance Criteria:	Timeframe:
1. Designate specific roles of Peer Specialist in supporting individuals living in PSH.	DMH	1. Draft position description	September 2012
2. Require Peer Specialist role for each CSA team providing MHRS to individuals living in PSH settings.	DMH	2. Requirement added to PSH program standards and inserted into FY13 contract requirements.	January 2013
3. Review and revise as needed Peer Specialist Certification Training to ensure curriculum is competency based, includes structured practice and evaluation. Content to include housing specific knowledge and skill areas, and includes a component for Supervisors	DMH Training Institute	3. Revised Peer Specialist Curriculum	October 2012
4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory training for staff, # of Peer Specialists for every X # of PSH tenants)	DMH regulation revision workgroup	4. See Goal 4: Objective #1 Incorporate Peer Specialist staffing requirements into CSA regulations	May 2013
5. Increase the frequency and number of trainings for Peer Support Specialist certification.	DMH	5. Increased number of Peer Support Specialists for each year of Plan as compared with previous year.	Annual

Objective #2: Strengthen Community Support Worker Service Delivery Through Increased Training and Certification			
Action:	Responsibility:	Performance Criteria:	Timeframe:
1. Implement CSW Certification process.	DMH Training Institute	1a. CSW Certification curriculum developed.	December 2012
	DMH Training Institute	1b. Deliver first round of training.	March 2013
2. Develop/implement competency-based curriculum that includes structured practice and evaluation, and PSH as first module.	DMH Training Institute	2. Housing Module developed.	December 2012
3. Develop competency-based component for Supervisors.	DMH regulation revision workgroup	3. Supervisor Module developed.	December 2012
4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory staff training, CSW caseload size for PSH tenants)		4. See Goal 4: Objective #1 Incorporating CSW staffing and training requirements into pertinent regulations.	May 2013

Objective #3: Standardize and Provide Training/Capacity Building for Housing Liaison Services across all PSH Programs.

Action:	Responsibility:	Performance Criteria:	Timeframe:
1. Develop Job Description and delineate minimum functions for Housing Liaison position.	DMH Housing Staff in conjunction with DMH Training Institute	1. Document delineating DMH expected roles and responsibilities for position that can be incorporated in regulations, training materials, provider contracts	November 2012
2. Determine HL to PSH tenant ratio necessary to meet housing coordination, landlord relations, and HQS related responsibilities.	DMH Housing Staff	2. Minimum HL to PSH tenant ratio established	November 2012
3. Develop and implement HL certification process. Curriculum is competency based and includes structured practice and evaluation.	DMH Housing Staff in conjunction with DMH Training Institute	3a. HL Roles & Responsibilities Curriculum developed 3b. First round of HL training begun	December 2012
4. Revise program rules and regulations to articulate eligibility requirements, functions, expectations for CSA certification (e.g. mandatory staff training, HL caseload size for PSH tenants)	DMH Regulations Revisions Workgroup	4. See Goal 4 : Objective #1	March 2013
5. Provide on-going training and capacity building support to the Housing Liaisons in order to promote consistency and competency.	DMH Training Institute	5. Monthly meetings with designated DMH Housing Staff and community provider HL staff.	May 2013

Appendix B

	Name	Organization	Position/Title	Phone Number	Email Address
1	Hammere Gebreyes	DC Housing Authority (DCHA)	Chief Of Staff	(202) 535-1513	HGebreye@dchousing.org
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12	James Knight	Jubilee Housing Inc	President	202-299-1240	mailto:jknight@jubileehousing.org

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Appendix C

**Key Informant Interviews conducted by the Technical Assistance Collaborative
For the
Department of Mental Health Strategic Supportive Housing Planning Process**

1. Adrienne Todman, Executive Director, DC Housing Authority
2. Alexis Haynes, Director, Adult Services, Department of Mental Health
3. Ariana Quinones-Miranda, Chief of Staff, Office of the Deputy Mayor for Health and Human Services
4. Barbara Bazron, Deputy Director, Department of Mental Health
5. Brandy Gladden, Program Analysis Officer, Department of Mental Health – Housing Office
6. Carroll Parks, CEO, Capital Community Services
7. Christy Respress, Executive Director, Pathways to Housing DC
8. Eugene Wooden – Department of Mental Health, ACT Coordinator
9. Fred Swan, Department of Human Services
10. Hammere Gebreyes, Chief of Staff, DC Housing Authority
11. Harry D. Sewell, Executive Director and CEO, DC Housing Finance Agency
12. Jackie Richardson, Department of Mental Health
13. Janna McCargo, Director, CareCo Inc.
14. John E. Hall, Director, DC Department of Housing and Community Development
15. John E. McGaw, Director, Capital Improvements Program, Mayor’s Office of Budget and Finance
16. Ken Ellison, Senior Housing Advisor, SOME, Inc.
17. Kimberly Black - CSH Mid-Atlantic Office, Washington DC
18. Kim Cole, Acting Chief of Staff, DC Housing Authority
19. Laressa Poole, Director of Programs and Policy, Department of Mental Health
20. Michael Neff -Chief of Administrative Operations
21. Nancy Lieberman, President, Cornerstone, Inc.

22. Peggy Power, Department of Mental Health
23. Richard Bebout, Chief Clinical Officer, Community Connections and Cheryl Bleakly, CFO, Community Connections
24. Robert Pohlman, Executive Director, Coalition for Nonprofit Housing and Economic Development
25. Ronald McCoy, Director, Housing Choice Voucher Program, DC Housing Authority
26. Shannon Hall, Executive Director, DC Behavioral Health Association
27. Steve Baron, Director, Department of Mental Health
28. Sue Marshall, Executive Director, The Community Partnership to Prevent Homelessness
29. Susan M. Banta, Revenue and Economic Development, Mayor's Office of Budget and Finance
30. Suzanne M. Fenzel, Assistant Attorney General
31. Tim Sawina COO & Gail Chow Housing Director, Green Door
32. Todd Garcia, Department of Mental Health

Appendix D

Overview

As discussed in Section II: Methodology, the general purpose of the workgroups was to provide guidance and information for TAC to develop a series of recommended strategies for DMH to consider. The four workgroups are described below and included:

1. Housing Utilization and Maximization Workgroup: This Workgroup met four times and:
 - Reviewed and commented on housing inventories and pathways;
 - Identified strategies to determine unmet supportive housing needs within the District;
 - Discussed ways to maximize affordable housing resources administered by DMH and the local housing agencies for people served by DMH, including leveraging DMH capital and rental assistance;
 - Recommended strategic options to meet unmet supportive housing needs for the defined target populations;
 - Discussed potential action steps and housing targets for the next five years; and
 - Considered the role of the DMH housing office and alignment with DC Housing Task Force efforts

2. Service Needs and Realignment Workgroup: This Workgroup met four times and:
 - Evaluated services provided in the residential continuum and identified strengths, duplication, and gaps;
 - Suggested feasible mechanisms for linking person-driven, wraparound community services and supports for people before, during and after tenancy in supportive housing, including the use of Peer Specialists;
 - Made suggestions regarding best practice housing models, reallocation of resources, and considered transition issues to supportive housing;
 - Identified gaps between MHRS reimbursable services and needed, but unreimbursable services; and
 - Made suggestions regarding provider accountability and desired outcomes to ensure consumers are receiving high quality, person-centered and recovery-oriented services.

3. Supportive Housing Eligibility and Allocation Workgroup: This Workgroup met three times and:
 - Discussed the role of LOCUS (Level of Care Utilization System) for assessing housing and service needs;
 - Considered criteria for establishing person-centered eligibility for supported housing that builds upon a standardized level of care assessment; and
 - Considered criteria for establishing an equitable allocation methodology for prioritizing access to supportive housing for eligible individuals

4. Workforce and Training Workgroup: This Workgroup met three times and:

- Evaluated workforce issues related to supportive housing and residential services that should be addressed;
- Considered the redevelopment and redeployment of existing residential program staff by developing competencies necessary in supportive housing;
- Considered training issues for new staff associated with the successful delivery of supportive housing services;
- Suggested strategies to enhance and expand utilization of Peer Specialists in supportive housing settings; and
- Considered the training needs for Saint Elizabeth's staff in preparing individuals to transition into supportive housing settings

Findings

Overall, workgroup members were supportive of the Department's efforts to support individuals in integrated, community-based settings, and workgroup dialogue was focused on strengthening the system. Similar themes emerged in each of the workgroups that informed the strategic recommendations in this report. Among these included the need: for clear policy direction from DMH regarding PSH; to improve the quality of care coordination throughout the system; to increase accountability at the CSA level; to identify and establish a proper balance of CRF and PSH; to develop housing models for emerging sub-groups (e.g. transition-age youth, older adults, forensically involved); to pay for non-MHRS reimbursable, but important services; to reduce duplication/redundancy of services for individuals served by multiple systems (i.e. DMH and DHS); to sustain operating funds for rental housing and capital funded projects; to develop a workforce that has housing competency; and to de-link housing and services. A general summary of each workgroup's findings is described below.

The Housing Utilization and Maximization Workgroup:

TAC held four sessions with the workgroup members to discuss strategies to both create new permanent supportive housing (PSH) opportunities for DMH consumers as well as maximize the use of existing housing opportunities. Emerging from these discussions was agreement from workgroup members that there is a need to provide a clear, deliberate direction to the DMH provider community and its stakeholders regarding DMH's community-based housing efforts and priorities over the next 5 years. As part of its areas of focus, the workgroup laid out the various pathways in which DMH consumers currently enter PSH. Within this context, the Workgroup members acknowledged the lack of systematic sharing of information regarding PSH opportunities. In addition, the workgroup also recognized the lack of systematic efforts between the various PSH pathways to coordinate waiting list activities. From a housing production standpoint, there was agreement that the D.C. Comprehensive Funding Competition Round established a useful process for DMH to blend their DMH Capital funds with other housing development resources in order to develop a variety of new PSH projects. There was general agreement that new DMH resources should focus on the development of new PSH. In terms of gaps within DMH's existing PSH portfolio, workgroup members agreed that new

housing opportunities for youth aging out (19-24 years old), DMH consumers with forensic backgrounds, and aging consumers with co-existing medical conditions should be created.

The Service Needs and Realignment Workgroup:

This workgroup discussed a range of topics and highlighted several strengths and weakness in the system. The workgroup mostly favored increasing the supply of PSH, and several members expressed concern that there was not enough of a “Housing First” approach to housing. Similar to discussions in the Housing Utilization and Management Workgroup, there emerged a theme that DMH should demonstrate increased leadership on PSH, through standards for providers to follow, and training for providers on the model. However there was caution that before any re-purposing or development of 'transitional' services, a better evaluation of the need for this level or type of service should be done by DMH, particularly for emerging populations with complex needs (e.g. transition-age youth, older adults, forensically involved).

Fragmentation and disparities between DMH and DHS community services was identified as an issue by members. A picture emerged of two systems that offer varying levels of services depending on which ‘door’ a consumer enters - through the DHS homeless system or DMH. Service coordination was identified as a challenge when a consumer is involved with more than one provider. If there is no accountability or assigned responsibility, consumers could fall through the cracks.

In addition, it was generally felt that MHRS offers a good range of services, but that providers do not have a mechanism of reimbursement for some non-Medicaid, but critical types of services (e.g. housing liaison, case management). Some of these services are reimbursed through the DHS PSHP, but not DMH. There is a real need for flexibility to do non-billable service coordination.

Members also noted that there is variability in the quality of services in the District and that DMH should exercise more leadership in setting system-wide standards, monitoring performance as it relates to housing supports, outcome evaluation, and overall provider accountability.

The use of peer support specialists was encouraged, and, overall, Workgroup members felt DMH should invest in more workforce training and development, particularly for CSWs. Transition planning was identified as an area for improvement, and members felt that better workforce training could help in this area.

The Supportive Housing Eligibility and Allocation Workgroup:

There was general recognition that navigating the network of housing options is complex and often confusing for consumers and providers. There was a suggestion to develop a quick reference document regarding the different types of housing resources and their eligibility criteria that can be available on various websites or handouts. With a multitude of pathways, often with varying requirements and information, there was some discussion about the need to

streamline the process so that it is more understandable to both frontline direct service workers and consumers.

Though not the focus of this workgroup, several workforce issues were raised, including turnover of case managers and other direct services staff; importance of standardization of service knowledge and delivery across providers; and the need for increased housing competence among staff. It was recognized that DMH has held housing trainings to address confusion on accessing housing and housing programs.

The requirement to be linked to a CSA in order to receive DMH housing funds was seen as a potential barrier since some of the most vulnerable people with mental illness are reluctant to engage with a CSA. It was noted that DMH is reluctant to support a non-linked person. The point was made that a non-linked person presents a risk elsewhere and that if DMH would follow more of a Housing First approach, difficult to serve consumers might experience better outcomes.

For housing purposes, the Workgroup generally agreed with the priority populations identified by DMH, and believed that additional sub-groups (i.e. transition-age youth, older adults, forensically involved) would generally fit into the priority population categories. However, for individuals who do not meet the three priority areas, but have emergent or extenuating circumstances, DMH should build in an exception process to its eligibility and allocation criteria.

The Workforce and Training Workgroup:

Assisting individuals to obtain and maintain PSH requires knowledge, skills and resources specific to housing settings and tenancy goals. Two critical staff positions in PSH and other housing settings are the Community Support Worker (CSW) and the Housing Liaison. Consistent themes surfaced in all 4 workgroups related to workforce issues. Across the CSW workforce, there is a lack of a) consistent knowledge about housing resources, and b) competency in interventions to support individuals' transition into, and long term tenancy. Various factors contribute to this such as a high rate of CSW turnover and lack of on-going training and supervision specific to housing and PSH issues. Key topical areas of concern that were routinely mentioned are lack of knowledge about the different housing programs, including eligibility, application and tenancy requirements; lack of structured transition planning for individuals moving from one level of care into PSH; lack of goal planning specific to getting and keeping housing; engagement strategies; and recognizing early warning signs of potential housing crisis and appropriate preventative interventions. Where Housing Liaisons exist, there is anecdotal evidence to suggest these positions contribute to successful tenancy. However, these positions are not available across all CSAs nor are they implemented in a consistent manner among the six agencies that do have this position.

To emphasize and advance PSH as the preferred and primary model of housing within the DMH system, there needs to be a clear connecting thread across key DMH Program Rules. These include all residential and housing programs, and MHRS standards. Rules should consistently address staff credentials, mandated staff training topics, program purpose (e.g. C-CRFs are

transitional and intended to prepare individuals for move to PSH or other independent housing setting), and service activities directly related to getting and keeping housing including housing focused assessment and goal planning. Opportunities to develop the workforce include moving forward with the CSW certification process beginning with a Housing and PSH module, a Housing Resource Guide that is available on line and updated as needed, and creating a standardized Housing Liaison job description.

Housing Operator Focus Group:

TAC conducted a one-time focus group meeting with six property managers identified by DMH as key housing partners to discuss the issues that they experience when providing housing to people with mental illness and working with provider staff. The property managers included: Urban City Management, CPM Housing Group, Jubilee Housing, the Village at Chesapeake, Daffodil House and Hyacinth House. Properties ranged from scattered site apartments, set-aside units in larger buildings, and single purpose buildings. Eligible applicants for housing operated by these property management groups were directly identified and referred by DMH or a DMH contracted provider. A few of the operators develop and manage housing for tenants other than those with special needs, others in the group developed/managed housing specifically for individuals with special needs. All six acknowledge a shared commitment to providing and managing decent, affordable housing to DMH consumers. Two primary themes that are areas of concern emerged from the discussion: 1) working with DC Housing Authority (DCHA) for housing application approval and rental payment; and 2) inconsistency among Community Support Workers in service delivery and communication.

All voiced frustration with the DCHA housing application and approval process. DCHA has a Memorandum of Understanding (MOU) with DMH to manage the Home First subsidy program. As such, they receive, process and approve housing applications and manage the subsidy rental payment to operators. Common challenges include application paperwork lost once at DCHA, lengthy timeframe from application submission to disposition notification, units held open awaiting disposition of applications resulting in vacancies, and lack of clear point of contact at DCHA to address issues with applications. It is interesting to note that similar issues with DCHA were not mentioned in relation to the DHS PSH program or The Community Partnership (TCP) HUD McKinney-Vento programs.

As has been raised in all workgroups, inconsistency among the CSW workforce regarding knowledge, competence and communication pertaining to supporting individuals in housing was expressed by the property managers. Most believed this to be unique to CSWs in general and not to particular CSAs. Such staff performance issues become most concerning when an individual's behavior is such that housing is potentially jeopardized. All property managers expressed the desire for successful tenant outcomes and reluctance to move to eviction, and stated that being able to work closely with the support worker is critical. There is lack of clarity in who to contact when, and for what issues. Some begin with the CSW while others go directly to DMH Housing staff when issues arise.

Appendix E

**District of Columbia
Department of Mental Health
Housing Inventory**

Presented to the
Housing Utilization and Maximization
Workgroup



Agenda/Outline

- Welcome and Introductions 1000-1015
- Background and Purpose 1015-1030
- Housing Inventory 1030-1115
 - Capital Resources
 - Operating and Rental Assistance Resources
 - Current Supportive Housing Inventory
 - Strengths and Challenges
 - Opportunities
- Housing Inventory/Pathways 1115-1145
- Next Steps 1145-1200



Background & Purpose

- DMH is committed to development of a Strategic Supportive Housing Plan to provide increased supportive housing opportunities for consumers & to identify the best use of available resources to achieve this goal.
- The Plan is a requirement of the *Dixon* Settlement Agreement.
- *Dixon* requires development of a uniform & objective methodology for evaluating a consumer's need for supported housing, for prioritizing levels of need for access to supported housing & for ensuring all available supported housing is assigned using the methodology & prioritization.



Workgroup Charge

- Stakeholder workgroups will help inform recommendations for DMH to consider for inclusion in the Plan.
- This Workgroup will meet 4 times to discuss and recommend:
 - Review and comment on housing inventories and pathways;
 - Identify strategies to determine unmet supportive housing needs within the District;
 - Maximize affordable housing resources administered by DMH and the local housing agencies for people served by DMH;
 - Develop and recommend strategic options to meet unmet supportive housing needs for the defined target populations;
 - Explore and recommend implementation action steps and performance and housing targets for the five year period of the SSHP.
- Considerations: Role of DMH Housing Department, PSH Gaps, future PSH production pipeline goals, Maximize/Leverage DMH Capital and Rental Assistance, Alignment with DC Housing Task Force efforts



Capital Resources

Department of Housing and Community Development

- HOME
 - FY 12 - \$4.3 million
 - Potential FY13 reduction
- CDBG
 - FY 12 - \$13.9 million
 - Potential FY 13 reduction
- LIHTC (9% Credits)
- DC Housing Production Trust
 - FY 12 - \$12.8 million



Capital Resources

DC Department of Mental Health

- DMH Capital \$14 million committed
- DMH Capital \$5 million available in upcoming funding rounds
- HIPI - preservation funds

Community Partnership – HUD CoC Resources

- Capital and Operating through the CoC
- Exclusively supports renewal projects
- Potential for new project subject to HUD NOFA



Operating and Rental Assistance Resources

DC Housing Authority

- Section 8 Housing Choice Voucher Program
 - 350 Set-aside vouchers
- Section 8 Project Based Vouchers (Partnership for Affordable Housing)
 - 96 PBV vouchers targeted for DMH projects
- Local Rent Supplement Program (LRSP)
 - 67 rent subsidies
- Non Elderly Persons with Disabilities Vouchers – 547 rent subsidies
- VASH – 489 vouchers

DC Department of Mental Health

- Home First II Housing Subsidy Program – 675 rent subsidies



Operating and Rental Assistance Resources

Community Partnership (DC Continuum of Care)

- Shelter Plus Care
- Supportive Housing Program

DC Department of Human Services

- PSH Program – 800 vouchers with services
- VASH - 105 vouchers

Community Connections

- Mainstream Vouchers – 150 Mainstream vouchers



Current Supportive Housing Inventory

- DMH Managed Housing
 - Home First II – current capacity 706 tenant based vouchers
 - DMH Capital Portfolio – 146 units online/ 102 units in pipeline
 - S+C Vouchers – 15 tenant based vouchers
 - DMH Housing Waitlist – 1,300 consumers
- Community Partnership/ Provider Managed Housing
 - Permanent Support Housing for Ind. – 1,650 PSH units (CoC Inventory)
 - Community Connections – 115 individual vouchers
 - Pathways – 86 individual vouchers
 - Community Connections – 150 Mainstream vouchers
- DCHA Managed Housing
 - DMH Section 8 HCV Set-aside – 350 tenant based units
 - LRSP – 67 rent subsidies
 - VASH – 489 vouchers (including 29 PBV subsidies)
 - Non-Elderly Persons with Disabilities vouchers – 547 vouchers
- DHS Housing
 - Permanent Supportive Housing Program – 800 rent subsidies linked with case management services
 - VASH – tenant based vouchers – 105 per HUD/VA data



Strengths

- Diversity of Resources
 - Significant commitment of Local Resources to PSH
- Provider Experience
 - National Models – Housing First and VASH Plus
- Use of Medicaid in conjunction with PSH
- System has embraced and offers a range of PSH



Challenges

- Future Federal Resources
- Limited Non-Profit Development Capacity
- Willingness of Developers to embrace PSH embedded within the project
- Multiple pathways to access PSH



Opportunities

- DC's Comprehensive Housing Strategy Task Force
- Comprehensive City NOFA for Affordable Housing/PSH Development
- Section 811 Resources (FY 12)



Discussion of Housing Inventories and Pathways

- Various pathways into permanent supportive housing
- Housing the 'right people at the right time in the right setting'
- Benefits and drawbacks to consolidating pathways (for example, coordinated access, PSH Clearinghouse model, etc.)



Next Steps

- Review Focus Area for May 29th Meeting
 - Identify any research requirements
- Property Manager's Focus Group
- Feedback on Process



D.C. Department of Mental Health Strategic Supportive Housing Plan

Service Needs & Realignment Workgroup

May 15, 2012



Agenda/Outline

10:00 – 10:15	Welcome & Introductions
10:15 – 10:30	Background & Purpose
10:30 – 11:00	Review of Services Inventory
11:00 – 11:15	Best Practice Models/Permanent Supportive Housing & Care Coordination
11:15 – 11:45	Populations of Focus & Service Needs
11:45 – 12:00	Wrap- Up



Background & Purpose

- DMH is committed to development of a Strategic Supportive Housing Plan to provide increased supportive housing opportunities for consumers & to identify the best use of available resources to achieve this goal.
- The Plan is a requirement of the *Dixon* Settlement Agreement.
- *Dixon* identifies the following priority populations for supported housing:
 - Consumers pending discharge from Saint Elizabeth's Hospital;
 - Homeless Consumers with a serious mental illness; and
 - Consumers who are moving to a less restrictive environment.



Best Practice Models – Permanent Supportive Housing (PSH)

- PSH is an evidence-based, cost effective model that combines permanent affordable rental housing with voluntary, flexible & individualized services to maximize independent living.
- SAMHSA's PSH Evidence-Based Practice Toolkit defines key elements of the model:
 - Integrated, community-based permanent housing that is safe & secure;
 - Housing that is affordable with tenants paying no more than 30% of their income toward rent & utilities;
 - Leases that are consistent with local landlord-tenant law & held by the tenants without limits on length of stay as long as the tenant complies with lease requirements;
 - Individually tailored & flexible supportive services that are voluntary, accessible where the tenant lives, available 24 hours a day/7 days a week & are not a condition of ongoing tenancy; and
 - Ongoing collaboration between service providers, property managers & tenants to preserve tenancy & resolve crisis situations that may arise.



Workgroup Charge

- Stakeholder workgroups will help inform recommendations for DMH to consider for inclusion in the Plan.
- This Workgroup will meet 4 times to:
 - Evaluate services provided in the residential continuum & identify duplication, gaps or the need for modifications to services to meet the needs of consumers to be served in residential programs & supported housing
 - Suggest feasible mechanisms for linking person-driven, wraparound community services & supports for people before, during & after tenancy in supported housing
 - Make recommendations regarding best practice housing models, rebalancing & reallocation of resources & considerations for transitioning to supported housing.
 - Make recommendations regarding provider accountability & desired outcomes to ensure consumers are receiving high quality, person-centered & recovery-oriented services to facilitate consumer independence.
 - Suggest strategies to incorporate Peer Specialists into the delivery of services within DMH housing programs.



Array of Available Services & Supports

- DMH consumers have access to an array of service resources to support their housing stability in the community.
- DMH resources:
 - Residential-based services (CRF/ICRF/SIL)
 - Non-residential services:
 - Mental Health Rehabilitation Services (MHRS)
 - CSA Housing Liaisons
 - Peer Transition Specialists & PUSH Funds
 - SOAR project & rep payee services
 - Housing mediation services
 - Supported Employment
- Non-DMH resources:
 - DHS Permanent Supportive Housing Program (PSHP) case management (for consumers who have been homeless) & move-in resources (e.g., security deposits, gift cards, furniture)



Mental Health Rehab Services (MHRS)

- DMH provides outpatient services for consumers through the MHRS program (Medicaid-funded). Services include:
 - Diagnostic/Assessment
 - Medication/Somatic Treatment
 - Counseling
 - Community Support
 - Crisis/Emergency
 - Day Services
 - Intensive Day Treatment
 - Community-Based Intervention
 - Assertive Community Treatment (ACT)
- Consumers in both DMH residential & supported housing programs likely to receive one or more of these services.



Strengths

- System has an array of available resources to support consumers in housing.
- Medicaid plan services (e.g. Community Support & ACT) offer flexibility to provide supports in supported housing.
- DMH pilot to step-down consumers from CRF to supported housing using time-limited Critical Time Intervention (CTI) services - opportunity to assess what services consumers need in order to transition to more independent living.



Challenges

- Potential for duplication of services within DMH service programs (e.g., consumer living in CRF/SIL may be receiving residential program-based services, along with one or more MHRS services such as Community Support, Day Treatment, etc.)
- Potential for overlap between MHRS services like Community Support & ACT with DHS PSH case management services for homeless consumers.
- Provision of non-billable housing supports such as housing location, move-in costs, landlord liaison activities, etc.
- Assessing needs in order to 'right size' system & offer more wrap around supports to those who want to move to supported housing while preserving some residential/transitional housing & service capacity for consumers with more challenging short or long-term needs (e.g., medically fragile, long-term institutionalized, forensics, transition age youth)



Opportunities

- Examine areas of service duplication to streamline coordination & free up resources to fill gaps to best meet housing & support service needs.
- Adoption/expansion of CTI pilot –use some supports/case management on a time-limited basis during critical transition periods (e.g., homelessness to housing, hospital to housing, move to less restrictive environment). Allow for some reinvestment of savings to flexible fund to cover costs of non billable housing related costs.
- Adopt PSH service delivery model & philosophy across providers - enhance person-centered recovery planning that incorporates assessment of housing support service needs to maximize independence, identify & track expected outcomes.
- Enhance capacity to transition more consumers to independent housing by incorporating Peer Specialists with clearly established roles and responsibilities into service teams.



D.C. Department Of Mental Health Strategic Supportive Housing Plan

Supportive Housing Eligibility
& Allocation Workgroup

May 15, 2012



Agenda/Outline

10:00 – 10:15	Welcome & Introductions
10:15 – 10:30	Background & Purpose
10:30 – 10:45	Populations of Focus & Best Practice/ Permanent Supportive Housing
10:45 – 11:15	System Touch Points
11:15 – 11:45	Assessing Housing & Service Needs
11:45 – 12:00	Establishing Eligibility Criteria



Background & Purpose

- DMH is committed to development of a Strategic Supportive Housing Plan to provide increased supportive housing opportunities for consumers & to identify the best use of available resources to achieve this goal.
- The Plan is a requirement of the *Dixon* Settlement Agreement.
- *Dixon* requires development of a uniform & objective methodology for evaluating a consumer's need for supported housing, for prioritizing levels of need for access to supported housing & for ensuring all available supported housing is assigned using the methodology & prioritization.



Workgroup Charge

- Stakeholder workgroups will help inform recommendations for DMH to consider for inclusion in the Plan.
- This Workgroup will meet 3 times to discuss and recommend:
 - Processes and standardized level of care assessment tools such as the LOCUS for assessing housing and service needs
 - Factors to consider in establishing person-centered eligibility criteria for supported housing that builds upon a standardized level of care assessment
 - Criteria for establishing an equitable allocation methodology for prioritizing access to supported housing for eligible individuals
- Considerations: requirements for the allocation and use of federal rental assistance, potential application of non-federal rental assistance and transition to federal rental assistance, priority populations for DMH, consumer choice, *Dixon* requirements, resource availability, and equitability of the process.



Populations of Focus

- *Dixon* identifies the following priority populations for supported housing:
 - Consumers pending discharge from Saint Elizabeth's Hospital;
 - Homeless Consumers with a serious mental illness; and
 - Consumers who are moving to a less restrictive environment.



Best Practice – Permanent Supportive Housing (PSH)

- PSH is an evidence-based, cost effective model that combines permanent affordable rental housing with voluntary, flexible & individualized services to maximize independent living.
- SAMHSA's PSH Evidence-Based Practice Toolkit defines key elements of the model:
 - Integrated, community-based permanent housing that is safe & secure;
 - Housing that is affordable with tenants paying no more than 30% of their income toward rent & utilities;
 - Leases that are consistent with local landlord-tenant law & held by the tenants without limits on length of stay as long as the tenant complies with lease requirements;
 - Individually tailored & flexible supportive services that are voluntary, accessible where the tenant lives, available 24-hours a day/7 days a week & are not a condition of ongoing tenancy; and
 - Ongoing collaboration between service providers, property managers & tenants to preserve tenancy & resolve crisis situations that may arise.



Housing Access Points: DMH Housing Programs

- Eligibility/Referral: Consumer must be enrolled with a Core Service Agency (CSA); CSA responsible to refer consumers with housing needs to DMH.
- **CRF, Transitional CRF & ICRF** – A CRF application is required for any enrolled consumer moving from hospital to a CRF or between CRFs. CRF Certification Team (CRT) reviews applications, makes level of care decision. If CRF Level of Care Certificate (LOCC) issued, consumer can move to an available CRF bed; if not, DMH reviews decision with referring agency's CSW and/or Clinical Team Supervisor.
- **SIL** – Providers with SIL determine own eligibility and referral process.
- **Supported Housing** – CSA assists with application & refers, DMH places on wait list, consumer is offered what's available based on needs/priorities. Priority populations include discharges from Saint Elizabeth's Hospital, homeless individuals & CRF residents transferring to more independent living.



Housing Access Points: Provider Operated/Managed Housing

- Consumers may access housing resources that their CSA operates/manages access to.
- Providers may offer: a full range of options from CRFs to SIL to Supported Housing (independent housing with vouchers they directly manage from the homeless continuum or other sources such as DCHA, DHS, etc).

OR

one or more housing options (e.g., provider directly offers CRFs & SIL but no Supported Housing, or Supported Housing but no CRF/SIL.)



Housing Access Points: DHS PSHP for Homeless

- Mental health consumers who are chronically homeless may access Supported Housing through the Department of Human Services' (DHS) Permanent Supportive Housing Program (PSHP).
- Must be determined eligible through a Vulnerability Assessment Survey & other factors.
- Access to permanent subsidy resources (Homeless continuum resources, DCHA managed local subsidies and Federal vouchers) & case management for housing stabilization.
- Potential for some of these resources to be part of providers' portfolio of supported housing resources e.g., DMH provider also has contract with DHS & receives allocation of PSH subsidies to directly engage & house homeless individuals.



Strengths

- DMH commitment to supported housing options for consumers.
- System has a full range of housing options available including local and federally-funded rental subsidies.
- DMH established clear process for determining level of care for CRF program resources.
- DMH/Community Connections pilot to step-down consumers from CRF to supported housing using Critical Time Intervention (CTI) model to support consumers' transition, establish needed service linkages, etc.



Challenges

- Length of DMH Waiting list for supported housing (1,300) & average wait time (36 months) – implications for 'lower' priority populations gaining timely access.
- Opportunities to move to supported housing for consumers enrolled with CSAs that do not operate/manage their own housing resources potentially limited.
- Increasing needs among returning citizens from jails/prisons & transition age youth.
- Ability to access supported housing resources via multiple pathways (e.g., DMH wait list, DHS, provider operated/managed) presents challenges for keeping DMH wait list current & to consumers/providers assisting them to get on multiple lists in some instances.



Opportunities

- Explore more streamlined/equitable allocation strategy for supported housing resources taking into account DMH populations of focus, requirements and/or flexibility of various subsidy resources, programs, etc.
- Explore systematic strategies for cross-referencing and/or streamlining waiting lists for supported housing resources.
- Explore alternative housing/service options for forensic and transition age youth populations.
- Expand CTI pilot to give more CRF residents opportunity to move to supported housing.



D.C. Department of Mental Health Strategic Supportive Housing Plan

Workforce Development and Training Workgroup

May 15, 2012



Agenda/Outline

10:00 – 10:15	Welcome & Introductions
10:15 – 10:30	Background & Purpose
10:30 – 11:00	Review of Services Inventory
11:00 – 11:15	Best Practice Model: Permanent Supportive Housing & PSH Related Services
11:15 – 11:45	Discussion of current workforce capacity, training efforts and workforce development needs to meet the needs for PSH expansion
11:45 – 12:00	Wrap- Up



Background & Purpose

- DMH is committed to development of a Strategic Supportive Housing Plan to provide increased supportive housing opportunities for consumers & to identify the best use of available resources to achieve this goal.
- The Plan is a requirement of the *Dixon* Settlement Agreement.
- *Dixon* identifies the following priority populations for supported housing:
 - Consumers pending discharge from Saint Elizabeth's Hospital;
 - Homeless Consumers with a serious mental illness; and
 - Consumers who are moving to a less restrictive environment.



Workgroup Charge

- Stakeholder workgroups will help inform recommendations for DMH to consider for inclusion in the Strategic Supportive Housing Plan (SSHHP).
- This Workgroup will meet 3 times to:
 - Evaluate workforce issues related to supportive housing and residential services that should be addressed in the SSHHP;
 - The redevelopment and redeployment of existing residential program staff by developing competencies necessary in supportive housing;
 - The training of new staff in skills associated with the successful delivery of supportive housing services;
 - Suggest strategies to enhance/expand utilization of Peer Specialists in supportive housing settings; and
 - Training needs for Saint Elizabeth's staff in preparing individuals to transition into supportive housing settings



Array of Available Services & Supports

- DMH consumers have access to an array of service resources to support their housing stability in the community.
- DMH resources:
 - Residential-based services (CRF/ICRF/SIL)
 - Non-residential services:
 - Mental Health Rehabilitation Services (MHRS)
 - CSA Housing Liaisons
 - Peer Transition Specialists & PUSH Funds
 - SOAR project & rep payee services
 - Housing mediation services
 - Supported Employment
 - Non-DMH resources:
 - DHS Permanent Supportive Housing Program (PSHP) case management (for consumers who have been homeless) & move-in resources (e.g., security deposits, gift cards, furniture)



Mental Health Rehab Services (MHRS)

- DMH provides outpatient services for consumers through the MHRS program (Medicaid-funded). Services include:
 - Diagnostic/Assessment
 - Medication/Somatic Treatment
 - Counseling
 - Community Support
 - Crisis/Emergency
 - Day Services
 - Intensive Day Treatment
 - Community-Based Intervention
 - Assertive Community Treatment (ACT)
- Consumers in both DMH residential & supported housing programs likely to receive one or more of these services.



Strengths

- System has a an array of available resources to support consumers in housing.
- Medicaid plan services (e.g. Community Support & ACT) offer flexibility to provide supports in supported housing.
- DMH pilot to step-down consumers from CRF to supported housing using time-limited Critical Time Intervention (CTI) services - opportunity to assess what services consumers need in order to transition to more independent living.



Challenges

- Potential for duplication of services within DMH service programs (e.g., consumer living in CRF/SIL may be receiving residential program-based services, along with one or more MHRS services such as Community Support, Day Treatment, etc.)
- Potential for overlap between MHRS services like Community Support & ACT with DHS PSH case management services for homeless consumers.
- Provision of non-billable housing supports such as housing location, move-in costs, landlord liaison activities, etc.
- Assessing needs in order to 'right size' system & offer more wrap around supports those who want to move to supported housing while preserving some residential/transitional housing & service capacity for consumers with more challenging short or long-term needs (e.g., medically fragile, long-term institutionalized, forensics, transition age youth)



Opportunities

- Examine areas of service duplication to streamline coordination & free up resources to fill gaps to best meet housing & support service needs.
- Adoption/expansion of CTI pilot –use some supports/case management on a time-limited basis during critical transition periods (e.g., homelessness to housing, hospital to housing, move to less restrictive environment). Allow for some reinvestment of savings to flexible fund to cover costs of non billable housing related costs.
- Adopt PSH service delivery model & philosophy across providers - enhance person-centered recovery planning that incorporates assessment of housing support service needs to maximize independence, identify & track expected outcomes.
- Enhance capacity to transition more consumers to independent housing by incorporating Peer Specialists with clearly established roles and responsibilities into service teams.



Best Practice Models – Permanent Supportive Housing (PSH)

- PSH is an evidence-based, cost effective model that combines permanent affordable rental housing with voluntary, flexible & individualized services to maximize independent living.
- SAMHSA's PSH Evidence-Based Practice Toolkit defines key elements of the model:
 - Integrated, community-based permanent housing that is safe & secure;
 - Housing that is affordable with tenants paying no more than 30% of their income toward rent & utilities;
 - Leases that are consistent with local landlord-tenant law & held by the tenants without limits on length of stay as long as the tenant complies with lease requirements;
 - Individually tailored & flexible supportive services that are voluntary, accessible where the tenant lives, available 24 hours a day/7 days a week & are not a condition of ongoing tenancy; and
 - Ongoing collaboration between service providers, property managers & tenants to preserve tenancy & resolve crisis situations that may arise.



What services are provided in PSH?

- Pre-tenancy & move-in assistance
- Access to benefits
- Employment
- Money management
- Activities of daily living
- Providing education about medications & medication management support
- Crisis prevention & intervention planning
- Assisting tenants to develop skills needed to live in the community
- Eviction prevention
- Assistance with legal & credit issues
- Supporting tenants' recovery from substance abuse
- Social & peer support
- Linkages to other needed services in community



Core Activities of PSH

- Engagement
- Assessment
 - Goals and Aspirations
 - Understanding Barriers to Housing
- Education
 - Expectations of Tenancy and Housing Options
 - Available Resources for Support
- Negotiating Common Goals
- Housing Stabilization Plans
- Services:
 - Using treatment as a Link
 - Using Evidence-based Practices as Tools
- Linkages
 - Community, Services, Treatment Resources
- Evaluate Progress and Re-Negotiate Goals



Core Services and PSH Tasks

PSH Tasks	Supportive Housing Tasks
<ul style="list-style-type: none"> •Assessment 	<ul style="list-style-type: none"> Pre-Tenancy <ul style="list-style-type: none"> •Becoming interested in housing •Setting housing goals: Success and Satisfaction •Becoming eligible for housing •Completing housing applications •Choosing housing among options •Linking to resources in new neighborhood
<ul style="list-style-type: none"> •Goal Setting and Service Planning 	
<ul style="list-style-type: none"> •Crisis Prevention Planning and Intervention 	
<ul style="list-style-type: none"> •Resource Coordination 	<ul style="list-style-type: none"> Move In <ul style="list-style-type: none"> •Setting housing goal for initial move in and successful tenancy •Acquiring resources and making the move •Becoming familiar with neighborhood •Establishing daily structure and activities
<ul style="list-style-type: none"> •Skill Building 	
<ul style="list-style-type: none"> •Wellness Self Management and Symptom Management 	<ul style="list-style-type: none"> Sustaining Housing <ul style="list-style-type: none"> •Establishing new housing related and personal goals •Meeting obligations as tenant
<ul style="list-style-type: none"> •Building natural support networks 	



Discussion: Workforce capacity and needs

- Capacity of current workforce in delivering services relevant to PSH
 - Community based workforce
 - Saint Elizabeth's workforce
- Current workforce development efforts and activities
- Possible workforce development issues and needs to meet expanding PSH



Next Steps

- Agenda for May 29th meeting
 - Utilization of Peer Specialists in Residential Continuum
 - Training for Saint Elizabeth's staff and other non-residential program staff
- Agenda for June 7th meeting
 - Redevelopment and redeployment of existing residential program staff by teaching them skills necessary in supportive housing
- Other agenda items to cover?



Appendix F

Supported Independent Living Program and Program Variability

As part of this process, TAC began an initial evaluation of the Supported Independent Living Program (SIL). It was clear that services provided in SIL support consumers with a variety of needs. However, there is variability in how the program is operated throughout the system with models ranging from traditional continuum congregate residential programs (with the only difference being less than 24/7 on-site staffing) to housing and services aligned with principles and practices of permanent supportive housing. In addition, there was variability in how funds are used to support the programs. As DMH moves to a model of Permanent Supportive Housing and Transitional Residential Services, SIL will need to be reorganized to be consistent with this approach.

At one end of the spectrum, one provider operates a SIL program that is reflective of a continuum model where individuals are most often referred from within the provider's C-CRF programs and are moved to facilities with decreased on site staffing support as SIL staff assess the person to be ready for less on site support. This provider's SIL contract is for 20 SIL slots. These slots are provided within four – 4 bedroom single family homes, each housing 5 individuals. In each house, two unrelated individuals share a bedroom. Residents of each house are of the same gender. Each resident pays \$600 per month in program fees and receives a minimum of \$100 per month in personal allowance. Residents sign program agreements and do have rights of tenancy. Two houses are staffed on-site for a minimum of 5 hours per day with evening hours Monday – Friday. Two houses are staffed on-site for a minimum of 2 hours per day with evening hours Monday – Friday. In addition to these 20 DMH contracted sites, this provider operates an additional 22 SIL slots in similar manner, which includes two – 2 bedroom apartments.

At the other end of the spectrum is the largest SIL provider that has a contract for 216 SIL slots, although serves up to 260 individuals through their SIL program agency-wide. All units are individual apartments, mostly efficiency and one bedroom units. The few two bedroom units have been transitioned to provide SIL services to families with a member eligible for SIL services. Most are 'clustered', meaning that between 8-15 units in connected row house-type structures, each forming a community with a staff team that provides individual services. All 216 contracted SIL slots have one of the various housing subsidy programs attached, i.e. DMH Home First, DHS PSH, HUD McKinney-Vento, LRSP or DCHA. Staff are assigned to and work with individuals in a particular 'community' but are not located on site and provided services to each individual separately as described in the individual's Recovery Plan. All residents have leases and in addition to meeting the DMH eligibility criteria, must also meet the criteria of each subsidy program.

In the middle lies one provider who operates an SIL program contracted for 17 slots. Housing settings consist of 3 single family homes with 4-6 bedrooms, and one 2 bedroom apartment. All residents have a private bedroom and 3 have private baths. The provider owns 3 of the homes. All residents have leases and rights of tenancy. Eleven slots are subsidized through the HUD McKinney-Vento Homeless Assistance programs (SHP and Shelter Plus Care). As such, this

funding dictates eligibility that includes history of homelessness in addition to a serious mental illness.

At the time of this writing, the remaining 3 SIL providers have not responded to requests for phone interviews. It is assumed that program models of these providers will be similar. One of these providers specializes in serving individuals with mental illness who are also deaf or hard of hearing.

Use of DMH SIL Funds

All providers interviewed use DMH funds primarily for staffing and services. All access MHRS services and state that SIL funds augment staffing needs for activities that are assumed to be incompatible with MHRS allowable activities. These include Housing Liaison positions or functions and possibly property management type activities. All providers mentioned that current revenue generated from MHRS service delivery would not support existing (and needed) staff support. The largest provider also uses SIL funds for housing specific expenses such as move-in costs, utility start up, payment of arrears to allow move in, and household set up. All stated these funds are essential to operate their SIL program.

Recommendations

Current SIL contracts expire on June 30, 2013. Prior to then, DMH should further evaluate the program, and refine it based on this information. Consistent with the recommendations earlier to organize housing-related services in a manner that identifies supervised residential services (Residential Services) and more independent services (Community Living Services) DMH could fold many SIL services into Community Living Services since they are aligned with PSH and independent settings.

For SIL services that are more supervised in nature, DMH could decide to convert those to PSH or fold them into Residential Services, depending on District needs. The SIL program servicing individuals who are hard of hearing and/or deaf may be a model use for the SIL program for housing for special subpopulations. Other subpopulations routinely mentioned in the workgroups include Transition Age Youth, older adults with co-existing mental illness and medical conditions, and individuals with challenging forensic backgrounds.

SIL program purpose and intent are described in program materials and the 2008 solicitation. However, variability in program operation should encourage DMH to rethink the purpose and model of the SIL program to make best use of these funds. No matter the direction that DMH evolves SIL in to, the purpose should be clearly articulated prior to contract renewals and the program should be proactively monitored and evaluated for performance.

Reclassifying as appropriate SIL programs that are aligned with basic tenets of PSH would correctly reflect how the program is both operated and administered, and relieve an inherent conflict between DMH's current description of the SIL program being 'independent but not

permanent housing' and the rules governing certain housing subsidy programs (HUD McKinney-Vento programs, DHS PSH, and LRSP) as permanent housing.

DMH should re-evaluate its use of funding associated with SIL, and more clearly identify how funds should be used. If it is determined that efficiencies can be found, DMH can re-purpose some of the funds. Options could include increasing the amount of funding that goes toward rent in Home First as currently, Home First funds up to approximately 80% of the Fair Market Value of an apartment in the District. Funds could also be used to serve more people with Home First, to support non-Medicaid reimbursable services or supports in settings that meet the definition of PSH, or to support Housing Liaison positions.

DMH is encouraged to request of each SIL provider a break-down of how the SIL funds are applied to determine:

- Which staffing position the funds are applied towards (Housing Liaison, Property Management functions, Case management or CSW);
- How best to maximize MHRS services, yet caution against over-serving those who do not require increased services; and
- The extent to which SIL funds may be augmenting operating costs associated with non-SIL programs operated by the agency

As DMH clarifies intent of the SIL program and model, it should incorporate changes into the regulatory and procurement process. In the meantime, DMH should require each SIL provider to submit a plan to re-align its existing program model with the DMH-desired model, including timeframes and specific changes to program operations.

Appendix G

Findings and Discussion

In April 2010, DMH established the Community Residential Facility (CRF) Task Force. The outcome of these deliberations was to:

1. Re-align DMH's current housing delivery system to provide *supportive housing*, as defined in Substance Abuse and Mental Health Administration's Permanent Supportive Housing Evidence-Based Practice Tool Kit (2010).
2. Relocate individuals with LOCUS Level 1 and LOCUS Level 2 scores from CRFs to less restrictive housing arrangements.
3. Develop a methodology and timetable for reducing the number of Contract Residential Facility slots from 225 to 150 by Fiscal Year 2015. The dollars saved by decreasing the number of Contract CRF slots will be used to increase the current number of housing subsidies available to consumers in need of affordable housing and to develop a 'flexible funding pool' to fund non-Medicaid billable services and supports required to assist consumers in CRFs to maintain their community tenure.
4. Develop and implement a mechanism to provide temporary financial support to assist consumers functioning at LOCUS Levels 5 and 6 who are currently residing in Independent CRFs to maintain their community tenure during a defined transition period within which a more appropriate housing option with necessary supports will be secured.
5. Establish clear communication and service guidelines for Community Service Agencies (CSAs) with consumers residing in ICRFs and Contract CRFs.

While DMH recognizes the need to support a continuum of residential options for consumers, it desires to expand PSH and reduce C-CRF beds from 225 to 150. The Task Force's original recommendation supported the transition of individuals with a LOCUS Level 1 or 2 into PSH. DMH further desired to include consumers at all LOCUS levels based on consumer choice and the ability to provide sufficient supports. In practice, though, consumers with LOCUS levels higher than Level 2 are less likely to be referred by providers to PSH. DMH could more strongly encourage providers to refer consumers with higher LOUCS levels who desire PSH and whose needs can be met with adequate wrap-around supports. This would enable DMH a greater likelihood of reducing C-CRF beds to its intended target and freeing up resources to meet the needs of individuals through MHRS in PSH settings. It would also result in greater C-CRF availability for individuals in I-CRFs identified as needing higher levels of support.

The methodology used in Section IV: Estimated Needs for Affordable Housing identifies a range of housing needed for people with mental illness in the District, but TAC did not have sufficient time to evaluate specific housing needs for unique populations. Within this context, DMH should further identify specific housing and service needs for individuals with complex needs and circumstances. Populations identified throughout this process include transition-age youth, older adults, and individuals who are difficult to place due to involvement with the criminal justice system. (Note: These individuals may or may not need C-CRF level services.) To the

extent that DMH realizes excess capacity in C-CRFs as a result of people moving into PSH, DMH could re-purpose existing C-CRF stock to meet newly identified needs.

Until: 1) a better analysis of current C-CRF individuals who may move to PSH is done, and 2) an analysis of I-ICRF individuals who may need C-CRF is done, it is difficult to predict the length of time it would take to achieve a level of 150 C-CRF beds in the system. Rather than solely rely on the number of C-CRF beds in the system as a gauge of quality, DMH could also utilize the percentage of PSH to C-CRF beds as an alternate measure of system performance.

Ultimately, DMH should use its contracting and procurement process to adjust C-CRF services according to its needs based on this evaluation. In addition, DHS should evaluate the scope of services needed within C-CRF programs. In some instances, Assertive Community Treatment (ACT) is delivered to individuals residing in C-CRFs, and may not be the most appropriate use of ACT services. C-CRF services should be designed to meet the residential service needs of individuals. Lastly, DMH should use this opportunity in regulations to more clearly articulate the purpose, scope, and practice and program performance standards of Residential Services.

Appendix H

Permanent Supportive Housing Research Bibliography

Authors: Anderson, T.L., Shannon, C., Schyb, I., Goldstein, P.

Title: **Welfare Reform and Housing: Assessing the Impact to Substance Abuse.**

Source: Journal of Drug Issues 32(1): 265-295, 2002. (Journal Article: 32 pages)

Abstract: This article studies the effects of terminating the addiction disability on the housing status of former addiction disability recipients, and explores how disruptions in living situations increased risks for drug and alcohol use, criminal participation and victimization. The authors utilize insights from both individualistic and structural theories of housing or homelessness. A qualitative analysis, featuring in-depth interviews with 101 nonrandomly selected former recipients, revealed that disability benefits promoted housing autonomy, successful cohabitation, and overall housing stability. The termination of benefits, at a time of diminishing social services and a housing market explosion, increased various types of homelessness for respondents and dependency of family and friends. Such negative living outcomes, in turn, further escalated the risk of drug and alcohol use, criminal participation and victimization. Individual-level factors also complicated the matter. Implications for research and policy are discussed (authors).

Authors: Barrow, S.M., Soto-Rodriguez, G., Cordova, Pilar

Title: **Closer To Home: Final Report on the Evaluation of the Closer to Home Initiative**

Source: New York, NY: Corporation for Supportive Housing, 2004. (Report: 105 pages)

Abstract: The Closer to Home Initiative was a five year program – funded by the Hilton Foundation and administered by the Corporation for Supportive Housing – devoted to developing new approaches to helping the “hardest to serve” among the homeless make the transition from homelessness to housing. The study focuses on how six agencies serving "street" homeless have implemented interim housing to help their clients gain access to housing that suits their preferences and needs. The interim housing programs examined here consist of shared apartments and single or double rooms in SROs and YMCAs. Although the sites vary in administrative structure and in the amenities and service they offer, the interim accommodations all provide greater privacy, stability and protection than the streets, op-in centers or church shelters. They also give programs a means to engage clients who are ambivalent about services and enhance their interest in seeking housing.

Authors: Bernstein, N.

Title: **Once Again, Trying Housing as a Cure for Homelessness.**

Source: New York, NY: The New York Times, June 23, 2002. (Newspaper: 4 pages)

Abstract: This article describes New York City's ambitious new policy to deal with people who are homeless, giving an old idea a whole new life. The idea is to subsidize more housing so the number of homeless will drop. If the plan succeeds it will move 9,250 homeless families from city shelters to subsidized housing over the next year, nearly triple the number placed this year, and be well above the 1990 peak. Much of the increase will come from giving more of the scarce subsidized apartments to homeless mothers and children and fewer to other needy people. That change is a significant marker of shifting attitudes in the history of the city's homeless policy. This idea is back, with fresh vigor, not only in New York City but nationwide. More sophisticated research, the expensive growth of an improved, service-rich shelter system, and the galloping rise in family homelessness in the welfare-to-work era have made it inescapable, say veterans of

homeless policy debates (authors).

Authors: Beyond Shelter, Inc.

Title: **Housing First: Ending and Preventing Family Homelessness.**

Source: Los Angeles, CA: Beyond Shelter, Inc., 2003. (Program Description: 6 pages)

Abstract: This program description highlights Beyond Shelter, Inc., an organization which implements a housing-first approach to ending homelessness. It has assisted more than two thousand families who are homeless to rebuild their lives through affordable housing in residential neighborhoods throughout Los Angeles county. The process by which families are served, research design, demographics and findings of housing-first research, in correlation with Beyond Shelter, Inc., organization are also discussed (authors).

Authors: Beyond Shelter.

Title: **The "Housing First" Program for Homeless Families: Methodology Manual.**

Source: Los Angeles, CA: Beyond Shelter, Inc., 1998. (Manual: 158 pages)

Abstract: This methodology manual provides a step-by-step guide to adapting Beyond Shelter's Housing First Program, which essentially bypasses completely or limits transitional housing and instead moves families who are homeless directly to permanent housing with supportive services provided after the move. The manual is targeted to program developers, directors and front-line staff working with families who are homeless.

Authors: Blanch, A.K., Carling, P.J., Ridgway, P.

Title: **Normal Housing with Specialized Supports: A Psychiatric Rehabilitation Approach to Living in the Community.**

Source: Rehabilitation Psychology 33(1): 47-55, 1988. (Journal Article: 9 pages)

Abstract: This article presents a conceptual and historical overview of residential services for individuals with psychiatric disability and challenges the appropriateness and effectiveness of the "continuum of services" model. The authors propose that the goal of residential services should be to assist all people with psychiatric disabilities to choose, get, and keep normal housing and that rehabilitation technology is currently available to accomplish this goal. Data are presented that indicate that despite high costs, most state mental health systems are continuing to make large scale investments in facility-based residential programs (authors).

Authors: Bridgman, R.

Title: **Housing Chronically Homeless Women: "Inside" a Safe Haven.**

Source: Housing Policy Debate 13(1): 51-81, 2002. (Journal Article: 31 pages)

Abstract: This article examines an innovative safe haven model for providing services targeted at hard-to-serve clients - chronically homeless, mentally ill women. This model is designed as an unlimited stay and low-demand environment, with high support from staff. This article challenges conventional static understandings of the concepts of "private" and "public" and explores issues related to spatial privacy and communality, sense of ownership, ideas about the safe haven being both a home and a hostel, planning for flexibility, accountability to public funders, and

accommodation of individual needs (authors).

Authors: Brown, M.A., Wheeler, T.

Title: **Supported Housing for the Most Disabled: Suggestions for Providers.**

Source: Psychosocial Rehabilitation Journal 13(4): 59-68, 1990. (Journal Article: 10 pages)

Abstract: This article describes supported housing services provided to individuals targeted by the Oregon Mental Health Division as most at risk of psychiatric hospitalization. The authors believe that the process of engaging clients and building relationships is the key to the program's effectiveness. Eight skills and supports, such as managing money, structuring time, and setting limits, are outlined, as is a process for determining the correct mix of skill development and modification of the environment for each person. Information on staff skills and attitudes and organizational support is also provided. Case vignettes are used to provide a sense of the process of serving supported housing clients (authors).

Authors: Burt, M.R., Aron, L.Y., Lee, E., Valente, J.J.

Title: **Helping America's Homeless: Emergency Shelter or Affordable Housing?**

Source: Washington, DC: Urban Institute Press, 2001. (Book: 355 pages)

Abstract: This book, based largely on findings from the National Survey of Homeless Assistance Providers and Clients (NSHAPC), provides a wide overview of homelessness, homeless services, and recommendations on what actions need to be taken to alleviate the problem. Chapter topics include: how many people are homeless; homeless families, singles, and others; alcohol, drug, and mental health problems among those who are homeless; issues in child and youth homelessness; patterns of homeless; comparing homeless subgroups within community types; factors associated with homeless status; homeless programs in 1996 compared to programs in the late 1980s; and program structures and continuums of care.

Authors: Carling, P.J., Curtis, L.C.

Title: **Implementing Supported Housing: Current Trends and Future Directions.**

Source: New Directions in Mental Health Services 74: 79-94, 1997. (Journal Article: 16 pages)

Abstract: This article summarizes the supported housing approach to responding to the housing and support needs of people with psychiatric disabilities. The authors describe the critical elements of supported housing and summarize the major implementation challenges that agencies and practitioners face. The authors describe the history of dissemination of the supported housing approach into national and state mental health policies and into local communities, and describe the four emerging models for implementing supported housing. Also included are key strategic decisions to consider in implementing supported housing. The authors conclude by summarizing the most critical challenges that mental health systems, organizations, and practitioners will face in the future (authors).

Authors: Center on Budget and Policy Priorities.

Title: **Research Evidence Suggests that Housing Subsidies Can Help Long-Term Welfare**

Recipients Find and Retain Jobs.

Source: Washington, DC: Center on Budget and Policy Priorities, 2000. (Report: 4 pages)

Abstract: This brief report discusses the impact of housing subsidies on the success of welfare recipients to find and maintain employment. The research indicates that government housing subsidies can help to promote work among long-term welfare recipients when they are combined with a well designed welfare reform program. The report explores the policy implications of these findings.

Authors: Cho, R., Gary, D., Ball, L., Ladov, M.

Title: **A Guide to Reentry Supportive Housing: A Three Part Primer for Non-profit Supportive Housing Developers, Social Services Providers, and Their Government Partners.**

Source: New York, NY: Corporation for Supportive Housing, 2002. (Guide: 30 pages)

Abstract: This guide is intended to provide supportive housing providers with a basic introduction to community reentry supportive housing, that is, supportive housing targeted towards formerly incarcerated individuals or ex-offenders, including those living with special needs. The objectives of this guide are: to provide a basic understanding of the need for supportive housing targeted towards returning prisoners; to provide a general overview of the criminal justice system (its values, function, and practice) as relates to the community reentry of ex-offenders; and to discuss crucial issues surrounding both the partners (project sponsors) and the people (target population) involved in community reentry supportive housing (authors).

Authors: Cohen, M.D., Somers, S.

Title: **Supported Housing: Insights from the Robert Wood Johnson Foundation Program on Chronic Mental Illness.**

Source: Psychosocial Rehabilitation Journal 13(4): 43-50, 1990. (Journal Article: 8 pages)

Abstract: This article discusses the Robert Wood Johnson Foundation national demonstration program for persons with chronic mental illness. It presents an analysis of organizational, administrative and political changes that have occurred within mental health systems participating in the Program. The authors discuss the housing development process and the need for systems integration (i.e., housing and support services). The need for states, local governments, and mental health providers to work collaboratively to develop comprehensive approaches to housing persons with chronic mental illness is addressed.

Authors: Corporation for Supportive Housing.

Title: **Supportive Housing for Youth: A Background of the Issues in the Design and Development of Supportive Housing for Homeless Youth.**

Source: New York, NY: Corporation for Supportive Housing, 2002. (Report: 50 pages)

Abstract: This report provides an initial assessment of the scope and breadth of the needs of homeless and at-risk youth, and highlights several promising residential program models. It concludes with some preliminary systems change recommendations. This exploration is based primarily on conversations and visits with youth providers in five markets. Though literature from other

localities has been reviewed, this work was not meant as a complete national survey. Rather, the research presented is a background to the major issues facing some young adults today and some innovative program models that have been developed to address their needs (authors).

Authors: Corporation for Supportive Housing.

Title: **An Introduction to Supportive Housing.**

Source: New York, NY: Corporation for Supportive Housing, 1996. (Guide: 12 pages)

Abstract: The guide examines the problem of homelessness and possible solutions; supportive housing definition, questions and answers; the effect on communities; how supportive housing breaks the cycle of homelessness; and cost effectiveness. Several specific case studies are described and supportive housing studies are discussed.

Authors: Corporation for Supportive Housing.

Title: **Supportive Housing for Youth: A Background of the Issues in the Design and Development of Supportive Housing for Homeless Youth**

Source: New York, NY: Corporation for Supportive Housing, 2002. (Report: 50 pages)

Abstract: This report provides an initial assessment of the scope and breadth of the needs of homeless and at-risk youth, and highlights several promising residential program models. It concludes with some preliminary systems change recommendations. This exploration is based primarily on conversations and visits with youth providers in five markets. Though literature from other localities has been reviewed, this work was not meant as a complete national survey. Rather, the research presented is a background to the major issues facing some young adults today and some innovative program models that have been developed to address their needs (authors).

Authors: Culhane, D.P., Metraux, S., Hadley, T.

Title: **Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing.**

Source: Housing Policy Debate 13(1): 107-163, 2002. (Journal Article: 56 pages)

Abstract: This article assesses the impact of public investment in supportive housing for people who are homeless with severe mental disabilities. Data on 4,679 people placed in such housing in New York City between 1989 and 1997 were merged with data on the utilization of public shelters, public and private hospitals, and correctional facilities. A series of matched controls, people who were homeless but not placed in housing, were similarly tracked. Regression results reveal that persons placed in supportive housing experience marked reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated (authors).

Authors: Culhane, D.P., Metraux, S., Hadley, T.

Title: **The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections and Emergency Shelter Systems: The New York-New York Initiative.**

Source: Washington, DC: Fannie Mae Foundation, 2001. (Report: 62 pages)

Abstract: The study reported here examines services use by persons with severe mental illness (SMI) who are formerly homeless before and after being placed into a large supportive housing program in New York City. Administrative data from large public medical, psychiatric, criminal justice, and shelter service providers were used to assess an aggregate level of services demand for pre- and post-placement periods for this study group and for a set of controls. The extent to which reductions in these services are present and can be attributable to a supportive housing placement stand to foster broader insight into both services use patterns among homeless people with SMI and the effectiveness of supportive housing, especially in terms of cost (authors).

Authors: Dolbeare, C.

Title: **Out of Reach: The Gap Between Housing Costs and Income of Poor People in the United States.**

Source: Washington, DC: National Low Income Housing Coalition, 1999. (Report: 14 pages)

Abstract: Millions of households in the U.S. cannot afford to pay for decent housing. This document was produced in an effort to provide information to policymakers and advocates on the extent of the affordability problem. It contains income and rental housing cost data for the fifty states and District of Columbia by state, metropolitan area, and county or, in the case of New England, town. For each, it calculates the income that renter households need to afford rental housing and estimates how many of these households cannot afford to pay the Fair Market Rent (FMR). It also calculates what they would need to earn to pay the rent and keep their housing cost at 30 percent of their income, the generally accepted standard for affordability established by Congress and HUD.

Authors: Emerson-Davis Family Development Center.

Title: **Supportive Residential Services to Reunite Homeless Mentally Ill Single Parents with their Children.**

Source: Psychiatric Services 51(11): 1433-1435, 2000. (Journal Article: 3 pages)

Abstract: This article outlines the Emerson-Davis Family Development Center in Brooklyn, New York City, which was opened in May, 1994. This residence is a renovated former college dormitory, where single parents separated from their families because of their mental illness and homelessness were reunited with their children and provided a healthy and safe home of their own. The article describes the staff, funding, program innovations, service delivery and community involvement associated with Emerson, and concludes that the family reunification process leads to gains for most participants, especially the children, even when reunification is not successful. Emerson services cost only 71 percent of traditional New York City shelter and foster care, and offers substantially more therapeutic and rehabilitative alternatives (authors).

Authors: Family Housing Fund.

Title: **The Supportive Housing Continuum: A Model for Housing Homeless Families.**

Source: Minneapolis, MN: Family Housing Fund, 1999. (Report: 30 pages)

Abstract: The Twin Cities are experiencing a growing problem with family homelessness. The primary response has been the development of transitional housing to provide a bridge for families between emergency shelters and permanent housing. The transitional housing programs provide families with a housing unit, usually for a period of six to 24 months, along with supportive

services. This report proposes the development of a more comprehensive system of supportive housing that combines affordable housing with services for homeless families. While transitional housing is one type of supportive housing, a comprehensive supportive housing system encompasses a wider range of programs, including housing with very intensive services to meet the needs of severely troubled families (author).

Authors: Galster, G., Pettit, K., Santiago, A., Tatian, P.

Title: **The Impact of Supportive Housing on Neighborhood Crime Rates.**

Source: Journal of Urban Affairs 24(3): 289-314, 2002. (Journal Article: 26 pages)

Abstract: In this article, quantitative and qualitative methods are employed to investigate the extent to which proximity to 14 supportive housing facilities in Denver, CO, affect crime rates. The authors used focus groups with homeowners living near supportive housing as context for interpreting the economic results. The authors' findings suggest that developers who pay close attention to facility scale and siting can avoid negative neighborhood impacts and render their supportive housing invisible to the neighborhood. Implications for structuring local regulations and public education regarding supportive housing facilities follow (authors).

Authors: Goldman, H., Rachuba, L., Van Tosh, L.

Title: **Methods for Assessing Consumer Preferences for Housing and Support Services.**

Source: Baltimore, MD: The Housing Center, University of Maryland, 1993. (Report: 24 pages)

Abstract: The growing consumer movement has placed the assessment of consumer preferences for housing and supports at the center stage of planning for community mental health services. Research suggests that allowing consumers to choose where they want to live, with the supports they need and prefer, will help improve their housing stability and quality of life. While assessment of consumer preferences is rapidly becoming standard operating procedure, very little is known about the validity and reliability of these assessments. This paper provides an overview of current methods, discusses the validity and reliability of current instrumentation, and concludes with a proposal for new methods development (authors).

Authors: Herr, S.S. and Pincus, S.M.

Title: **A Way to Go Home: Supportive Housing and Housing Assistance Preferences for the Homeless.**

Source: Stetson Law Review 13(2): 345-399, 1994. (Journal Article: 54 pages)

Abstract: This article examines the role Public Housing Agencies (PHAs) can play in providing permanent solutions to homelessness. Interestingly, new rules about public housing have given PHAs the latitude to move away from giving preferences to "worst-case" scenarios. According to the authors, PHAs sometimes have trouble in reconciling the objective of maintaining housing projects that are socially and economically viable. To balance these objectives, the authors contend that PHAs could selectively recruit homeless people already involved in service programs. The authors also review major supportive housing programs and call on communities to attack the root causes of homelessness by providing more services.

Authors: Hogan, M.F., Carling, P.J.

Title: **Normal Housing: A Key Element of a Supported Housing Approach for People**

with Psychiatric Disabilities.

Source: Community Mental Health Journal 28(3): 215-226, 1992. (Journal Article: 12 pages)

Abstract: This article summarizes current thinking in the field about the types of housing environments which are most relevant both to the overall goal of community integration, and to the variety of specific support needs of individuals with psychiatric disabilities. Within the context of a "supported housing" approach, which focuses on maximizing consumers choices and preferences, using integrated regular housing stock, and making full array of community supports available, the authors propose a number of specific criteria which can be useful to community mental health organizations in planning for, or selecting housing (authors).

Authors: HomeBase, The Center for Common Concerns.

Title: **Transitional Housing: A Bridge to Stability and Self-Sufficiency.**

Source: San Francisco, CA: HomeBase, The Center for Common Concerns, 1998. (Report: 163 pages)

Abstract: This report was developed in response to requests for information and technical assistance from local governments, service providers, advocates, churches, and community groups looking to develop or enhance transitional housing programs in their communities. This report both introduces communities to the questions to be considered in pursuing transitional housing as a strategy to address homelessness and it lays out concrete recommendations for how to design and operate these programs (authors).

Authors: Hutchings, G.P., Emery, B.D., Aronson, L.P. (eds).

Title: **Housing for Persons with Psychiatric Disabilities: Best Practices for a Changing Environment.**

Source: Alexandria, VA: National Technical Assistance Center for State Mental Health Planning, 1996. (Toolkit: 180 pages)

Abstract: This toolkit examines key issues in housing for persons with psychiatric disabilities in eight topic areas: (1) planning; (2) finance; (3) development; (4) rental assistance; (5) consumer preference; (6) managed care; (7) services and supports; and (8) rights and roles of landlords. The authors identify best practices in housing and supports that can be customized to meet the unique needs of particular communities.

Authors: Millennial Housing Commission.

Title: **Meeting Our Nation's Housing Challenges.**

Source: Washington, DC: Millennial Housing Commission, 2002. (Report: 130 pages)

Abstract: This report presents facts and figures describing the current state of housing in the US, particularly for low income families; explores why affordable housing is important with relationship to family stability and childhood outcomes, neighborhood quality, household wealth, and economic growth; and offers detailed recommendations to address the nation's housing challenges. While the findings and recommendations obviously reflect the great diversity of philosophy and experience represented, some fundamental precepts are agreed on. First, that housing matters, and second, that there is simply not enough affordable housing (authors).

Authors: National Alliance to End Homelessness, Inc.

Title: **Tools to End Homelessness Among Families: Best Practice. Community Care Grant Program.**

Source: Washington, DC: National Alliance to End Homelessness, Inc., 2003. (Program Description: 4 pages)

Abstract: This program description outlines the history and background, program structure, eligibility, program services, and housing access of the Community Care Grant Program, which helps families access housing without ever entering a homeless shelter program, and offers transitional, intensive case management services to ensure the family stabilizes in housing. Case management, funding and outcomes from 1998-2002, and recommendations are also discussed (authors).

Authors: Newman, S., Ridgely, M.S.

Title: **Organization and Delivery of Independent Housing to Persons with Chronic Mental Illness.**

Source: Administration and Policy in Mental Health 21(3): 199-215, 1994. (Journal Article: 17 pages)

Abstract: This article provides insights into alternative approaches to organizing -- and in some cases reconceptualizing -- mental health systems. Housing development and delivery are highlighted. It is based on research conducted as part of the national evaluation of the Robert Wood Johnson Program on Chronic Mental Illness (PCMI). The authors focus on four features of the organization and delivery of housing to chronically mentally ill individuals: (1) the structure of the housing development entity; (2) linkages between the housing and mental health systems; (3) targeting of tenant applicants for independent housing; and (4) special issues in providing housing assistance to the homeless mentally ill (authors).

Authors: Newman, S.J.

Title: **Housing and Mental Illness: A Critical Review of the Literature.**

Source: Washington, DC: The Urban Institute, 2001. (Literature Review: 81 pages)

Abstract: This book presents a critical review of the last 25 years of research on the role of housing and neighborhoods in the lives of persons with serious mental illness. Only studies with specific measures of housing and neighborhood attributes are included. This review is similarly limited to research that provides a description of the specific service context of study subjects, particularly the nature and extent of service availability and use. The author found that the majority of the studies suffer from one or more methodological weaknesses. These include unsystematic samples, poor documentation of measures or methods, selectivity bias, and potential endogeneity in key relationships. In addition, a number of the analyses are not grounded in a conceptual framework that can be tested. Further, most studies rely on correlational analysis, which cannot establish causation. As a result much remains unknown. In spite of these weaknesses, some tentative findings can be distilled, as well as hypotheses worth exploring using more rigorous research designs and methods (author).

Authors: Nolan, C., Broeke, C., Magee, M., Burt, M.

Title: **The Family Permanent Supportive Housing Initiative: Family History and Experiences in Supportive Housing**

Source: Washington, DC: The Urban Institute, August, 2005.

Abstract: In March 2003, the Charles and Helen Schwab Foundation, the Urban Institute, and Harder+Company launched an evaluation of the Family Permanent Supportive Housing Initiative. The evaluation was designed to assess the impact of the Initiative's approach to meeting the long-term needs of formerly homeless families in permanent supportive housing. This report presents findings from interviews with 100 families that were conducted between November 2003 and April 2004, as well as descriptions of the seven housing programs from which the study sample was drawn.

Authors: O'Hara, A., Day, S.

Title: **Olmstead and Supportive Housing: A Vision for the Future.**

Source: Lawrenceville, NJ: Center for Health Care Strategies, 2001. (Report: 29 pages)

Abstract: The Supreme Court's *Olmstead v. L.C.* decision of 1999 had major implications for consumers, multiple state and federal agencies, and health care providers. This report offers a basic primer on supportive housing, as well as a thorough review of states' current *Olmstead* planning efforts in this area. The authors hope that this report will help spur more state and local stakeholders to expand community-based supportive housing opportunities for people with disabilities (authors).

Authors: O'Hara, A., Miller, E.

Title: **Going It Alone: The Struggle to Expand Housing Opportunities for People with Disabilities.**

Source: Boston, MA: Technical Assistance Collaborative and the Consortium for Citizens with Disabilities Housing Task Force, 2000. (Report: 64 pages)

Abstract: The goal of this report is to assess and document what is and is not working in local communities to expand affordable housing opportunities for people with disabilities. The purpose of this work was three-fold: (1) to document the barriers which have constrained the disability community's housing efforts; (2) to identify existing examples of communities that have moved most successfully towards "best practices" to expand both homeownership and rental housing options for people with disabilities; and (3) to assess the need for a comprehensive program of housing technical assistance targeted to the disability community. The results of this analysis are presented as eight major findings, and the authors provide policy recommendations based on these findings.

Authors: Rafferty Zedlewski, S.

Title: **The Importance of Housing Benefits to Welfare Success.**

Source: Washington, DC: The Brookings Institution, 2002. (Report: 9 pages)

Abstract: This brief analyzes data from the Urban Institute's 1999 National Survey of America's Families on current and former welfare recipients to assess the importance of housing benefits for welfare success. The data show that despite reporting significantly more personal challenges that make employment difficult, poor families that had left welfare but received housing assistance did better at work than those without it. Also, families leaving welfare tend to retain housing benefits, unlike other work supports such as food stamps and Medicaid. The brief concludes that housing assistance can clearly make a difference in moving families from welfare to work (authors).

Authors: Reynolds, S.

Title: **Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing.**

Source: New York, NY: Corporation for Supportive Housing, 1997. (Report: 146 pages)

Abstract: Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles. It provides worksheets and sample legal documents to help groups maximize their potential for success.

Authors: Ridgway, P., Zipple, A.M.

Title: **The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches.**

Source: Psychosocial Rehabilitation Journal 13(4): 11-31, 1990. (Journal Article: 21 pages)

Abstract: The field of residential services has used the residential continuum as its predominant model or paradigm for the last decade. The old paradigm is breaking down under pressures that demand attention to basic housing needs. This article describes the basic concepts inherent in the paradigm shift that is moving the field toward supported housing models (authors).

Authors: Rog, D.J., Gilbert-Mongelli, A.M., Lundy, E.

Title: **The Family Unification Program Final Evaluation Report.**

Source: Washington, DC: Child Welfare League of America Press, 1998. (Report: 62 pages)

Abstract: The intent of the Family Unification Program (FUP) is to reunify children with their parents or to prevent the out-of-home placement of children by providing timely housing assistance coordinated with child welfare services. Results show 85% of the families participating in the FUP were still housed after 12 months. Overall, FUP families made significant strides toward becoming reunified or being preserved as a family. Upon closure of the child welfare case 62% of the families needing reunification had all of their children returned to them, and 90% of the at risk families were able to keep all of their children. The authors conclude that FUP is a promising model because families who remained residentially stable were more likely to keep their children or have their children return home.

Authors: Rog, D.J., Holupka, C.S., Brito, M.C.

Title: **The Impact of Housing on Health: Examining Supportive Housing for Individuals with Mental Illness.**

Source: Current Issues in Public Health 2: 153-160, 1996. (Journal Article: 8 pages)

Abstract: This article begins by reviewing the research on the relationship between homelessness and health, followed by a review of the housing literature for individuals who have serious mental illness. The authors examine the impact of supportive housing, residential stability and

rehospitalization, and quality of life. Factors moderating the impact of supportive housing are also discussed, including consumer preference, housing quality, and housing characteristics.

Authors: Rog, D.J., Gutman, M.

Title: **The Homeless Families Program: A Summary of Key Findings.**

Source: In Isaacs, S.L., and Knickman, J.R. (eds.), *To Improve Health and Health Care*. Indianapolis, IN: Jossey-Bass Inc., 1997. (Book Chapter: 23 pages)

Abstract: This chapter presents findings from the formal evaluation of the Homeless Families Program (HFP), which was jointly funded by the Robert Wood Johnson Foundation and the Department of Housing and Urban Development. The chapter offers insights into the problems faced by homeless families as well as the obstacles faced by program managers trying to bring about system reform. The authors also discuss the challenges involved in designing and implementing "enriched services" accompanying housing for the homeless. The authors state that gains in residential stability achieved by the families in the HFP are encouraging, but families' reliance on federal support for their basic needs and their lack of progress in employment raise questions about how long their situations will remain stable.

Authors: Sard, B., Harrison, T.

Title: **The Increasing Use of TANF and State Matching Funds to Provide Housing Assistance to Families Moving from Welfare to Work - 2001 Supplement.**

Source: Washington, DC: Center on Budget and Policy Priorities, 2001. (Report: 18 pages)

Abstract: The paper "The Increasing Use of TANF and State Matching Funds to Provide Housing Assistance to Families Moving from Welfare to Work" provides a detailed look at eight state and local programs that use federal TANF or state MOE funds to provide housing assistance to families attempting to make the transition from welfare to work. It also explains the issues that states and counties should consider in deciding which funding sources to use for particular housing programs. Since that paper was published, four additional states and localities, Michigan, Pennsylvania, Virginia, and Denver, CO have initiated housing programs using TANF funds. This supplemental paper first reviews HHS' relevant guidance and states' ability to transfer TANF funds to the Social Services Block Grant. It then explores the six new state and local initiatives that use TANF or MOE funds to help subsidize families' ongoing housing costs. These recent efforts provide further evidence that an increasing number of state and local governments are recognizing the importance of addressing families' housing needs as part of state welfare reform efforts (authors).

Authors: Straka, D., Tempel, C., Lipson, K.

Title: **TANF Funding for Services in Supportive Housing for Homeless Families and Young Adults.**

Source: New York, NY: Corporation for Supportive Housing, 2001. (Report: 25 pages)

Abstract: This report sets forth a legal and policy analysis to support a model approach to using federal and state welfare funds to finance essential services for homeless families, families at risk of becoming homeless, homeless youth and young adults aging out of foster care, who face multiple barriers to stability and self-sufficiency. Many states have available large sums of money in the form of a federal Temporary Assistance for Needy Families (TANF) block grant surplus and a potential shortfall in State Maintenance of Effort (MOE) expenditures. These funds are well-

suited to fill the gap in financing for supportive housing for homeless families, those at risk of homelessness, and young adults who would otherwise become homeless. In the fifth year of welfare reform, the time is ripe to implement family and young adult supportive housing initiatives (authors).

Authors: Tanzman, B.

Title: **An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services.**

Source: Hospital and Community Psychiatry 44(5): 450-455, 1993. (Journal Article: 6 pages)

Abstract: The author examined the methodology and results of studies that surveyed mentally ill clients' preferences related to housing and support services to gain an overview of demographic characteristics, current and preferred housing situations, and preferred types of staff supports and social and material supports in a nationally representative sample of clients. Consumers consistently reported that they would prefer to live in their own house or apartment, to live alone or with a spouse or romantic partner, and not to live with other mental health consumers. Consumers reported a strong preference for outreach staff support that is available on call; few respondents wanted to live with staff. Consumers also emphasized the importance of material supports such as money, rent subsidies, telephones, and transportation for successful community living.

Authors: Tanzman, B.

Title: **Researching the Preferences of People With Psychiatric Disabilities For Housing and Support: A Practical Guide.**

Source: Burlington, VT: Center for Community Change Through Housing and Support, 1993. (Monograph: 165 pages)

Abstract: This manual is designed to be a guide for systematically collecting information about the housing, support and service preferences of people with psychiatric disabilities. Using actual studies as case highlights, this monograph provides a discussion of the purposes of gathering preference information, ways in which this information can be collected, and how different groups and systems have made use of preference findings (author).

Authors: Technical Assistance Collaborative, Inc.

Title: **HUD's HOME Program: Can It Really Work for People with Disabilities?**

Source: Opening Doors: Issue 16, December 2001. (Newsletter: 12 pages)

Abstract: The HOME Investments Partnership (HOME) Program is the largest federal program available exclusively to create new affordable housing. This issue of Opening Doors is designed to help the disability community learn more about the HOME program, how it works, and how it can be used to expand affordable housing for people with disabilities (authors).

Authors: Technical Assistance Collaborative, Inc.

Title: **Piecing it All Together in Your Community: Playing the Housing Game.**

Source: Boston, MA: Technical Assistance Collaborative, Inc., 1999. (Guide: 59 pages)

Abstract: This guide provides useful information to help the disability community understand the

Department of Housing and Urban Development's (HUD) Consolidated Plan (ConPlan) and learn how to best advocate for safe, affordable, and decent housing. The guide describes the ConPlan, outlines what is included in a ConPlan, describes HUD's other strategic plans, such as the Continuum of Care and the Public Housing Agency Plan, and how they relate to the ConPlan, suggest how the disability community can become involved, and offers strategies that work.

Authors: Technical Assistance Collaborative, Inc.

Title: **Permanent Supportive Housing: A Proven Solution to Homelessness.**

Source: Opening Doors 20: January 2003. (Newsletter: 16 pages)

Abstract: This issue examines the federal government's recent focus on chronic homelessness and provides important research, data, and a concrete solution: permanent supportive housing. Permanent supportive housing is an effective solution for people with disabilities who have experienced long term homelessness. This type of housing is defined as decent, safe, and affordable community-based housing that provides residents with rights of tenancy and is linked to voluntary and flexible supports and services. Because so many people with disabilities experience chronic homelessness, it is important for the disability community to know more about the emerging federal policies, which are intended to end chronic homelessness in ten years. This issue provides specific recommendations directed to key federal programs that could provide the foundation for a significant expansion of permanent supportive housing. This issue also highlights national efforts that are working to end long term homelessness, establish a national housing trust fund, and create permanent supportive housing.

Authors: Technical Assistance Collaborative.

Title: **Creating Housing and Supports for People Who Have Serious Mental Illnesses.**

Source: Rockville, MD: Center for Mental Health Services, 1994. (Monograph: 74 pages)

Abstract: This monograph, commissioned by the Center for Mental Health Services, provides a historical perspective and offers practical advice on developing supported housing for people with serious mental illnesses. Topics include: developing a plan bringing key organizations together; housing management; planning for supportive services; basic financing; and mechanisms for coordination. Case studies state projects in Connecticut and Massachusetts, as well as community projects in Lasalle County, Illinois; Baltimore, Maryland; and Philadelphia, Pennsylvania are also included.

Authors: Technical Assistance Collaborative, Inc.

Title: **Section 8 Made Simple: Using the Housing Choice Voucher Program to Assist People With Disabilities.**

Source: Boston, MA: Technical Assistance Collaborative, 2002. (Report: 98 pages)

Abstract: This report covers the United States Department of Housing and Urban Development's Section 8 Housing Choice Voucher Program in detail, including: overview of the Section 8 Program; how the Section 8 Program is administered; eligibility, applications, and waiting list process; screening, verification, and appeals; determining the total tenant payment and the Section 8 rent subsidy; getting a Section 8 voucher and obtaining housing; keeping a Section 8 voucher; reasonable accommodation and reasonable modification; Section 8 project-based assistance; and Section 8 homeownership assistance.

Authors: Tsemberis, S.

Title: **From Streets to Homes: An Innovative Approach to Supported Housing for Homeless Adults with Psychiatric Disabilities.**

Source: Journal of Community Psychology 27(2): 225-241, 1999. (Journal Article: 17 pages)

Abstract: This article describes a supported housing program that provides immediate access to permanent independent housing to individuals who are homeless and have psychiatric disabilities. Following housing placement, assertive community treatment (ACT) teams provide treatment, support, and other needed services. The residential stability of tenants in this supported housing program was compared to that of tenants in a linear residential treatment program that serves the same population, but uses a step-by-step sequence of placements moving to supervised independent living. The 139 tenants of the supported housing program achieved a housing retention rate of 84.2% over a three-year period while the rate for 2,864 residents of the comparison program was only 59.6% over a two-year period. Additional data from direct interviews with the supported housing tenants were used to identify factors that predicted client participation in, and satisfaction with, particular services received (author).

Authors: Tsemberis, S., Asmussen, S.

Title: **From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model.**

Source: Alcoholism Treatment Quarterly 17(1/2): 113-131, 1999. (Journal Article: 19 pages)

Abstract: This article describes essential elements of the Consumer Preference Supported Housing (CPSH) Model of homelessness prevention in use at Pathways to Housing, Inc. in New York City. This intervention prevents homelessness by engaging and housing homeless substance abusers with psychiatric disabilities whom other programs have rejected as "treatment resistant" or "not housing ready." The CPSH model is built on the belief that housing is a basic right for all people. As opposed to the housing continuum model, housing is based on consumer choice and is not connected to compliance or treatment. Housing is provided immediately, and there are separate criteria for housing and treatment needs. Support services are aimed at integration of mental health and substance abuse services (authors).

Authors: Tsemberis, S., Eisenberg, R.F.

Title: **Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities.**

Source: Psychiatric Services 51(4): 487-493, 2000. (Journal Article: 7 pages)

Abstract: This study examined the effectiveness of the Pathways to Housing supported housing program over a five-year period. Unlike most housing programs that offer services in a linear, step-by-step continuum, the Pathways program in New York City provides immediate access to independent scatter-site apartments for individuals with psychiatric disabilities who are homeless and living on the street. The authors concluded that the Pathways supported housing program provides a model for effectively housing individuals who are homeless and living on the streets. The program's housing retention rate over a five-year period challenges many widely held clinical assumption about the relationship between the symptoms and the functional ability of an individual. Clients with severe psychiatric disabilities and addictions are capable of obtaining and maintaining independent housing when provided with the opportunity and necessary supports (authors).

Authors: Turner, L., O'Hara, A.

Title: **Supported Housing and Services: A View From the Field.**

Source: The Housing Center Bulletin 3(3): 1-9, 1995. (Newsletter: 10 pages)

Abstract: This article discusses supported housing and its purposes: (1) to assure consumers of mental health services access to affordable, decent and permanent housing of their choice;(2) to provide a flexible and responsive system of community supports that can assist consumers in maintaining independence and a positive quality of life in the community. The authors' technical assistance experiences in helping systems to implement successful supported housing programs are discussed. Common core services in supported housing programs and the process of developing these services are explored from the point of view of service providers.

Authors: Witheridge, T.F.

Title: **Assertive Community Treatment as a Supported Housing Approach.**

Source: Psychosocial Rehabilitation Journal 13(4): 69-75, 1990. (Journal Article: 7 pages)

Abstract: This article examines the contributions of the assertive community treatment field to the development of a supported housing approach. The author highlights some of the residential strategies used by assertive community treatment workers, recommending continued experimentation at the local level. The article concludes with a description of the Thresholds Bridge Program in Chicago and a case illustration of the use of supported housing by that inner-city service provider (author).

Authors: Wong, Y., Hadley, T., Culhane, D., Poulin, S., Davis, M., Cirksey, B., Brown, J.

Title: **Predicting Staying in or Leaving Permanent Supportive Housing That Serves Homeless People with Serious Mental Illness**

Source: US Dept. of Housing and Urban Development, Office of Policy Development and Research, March 2006

Abstract: This study examines the experience of some 943 residents of permanent supportive housing in Philadelphia during the period from 2001 to 2005. The capability to merge Homeless Management Information System (HMIS) data and administrative data in Philadelphia, Pennsylvania, made possible a viable strategy to track over time a highly elusive population – formerly homeless people with mental illness who had left permanent supportive housing.