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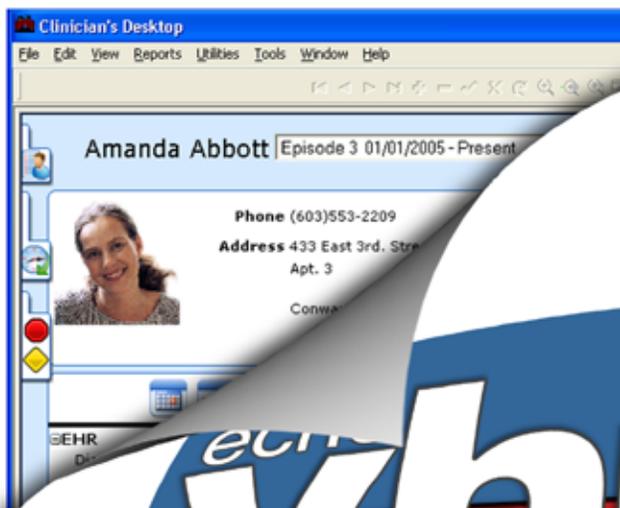
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Beyond the Open Door **Housing for People with Mental and Addiction Disorders**

Housing is a basic right for all people, including those with mental illnesses and substance use disorders. Today there is growing recognition of the fact that persons with psychiatric disabilities need stable housing to support their recovery and integration into the community. Supported housing – which allows persons with psychiatric disabilities and substance use disorders to live independently and privately in subsidized apartments and link to support services such as home visits by case managers and supports for community integration – is becoming increasingly popular and has a growing evidence base of effectiveness.

National Council members across the nation who provide critical housing services discuss their accomplishment and barriers in this issue. Housing experts share best practices and provide policy perspectives. And most importantly, persons with mental illnesses and addictions that have received housing and support services share their stories of recovery through exclusive interviews for National Council Magazine (their stories are featured throughout this issue). We are grateful to all our contributors and appreciate your commitment to making a difference.

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Beyond the Open Door

Challenges in Housing for People with Mental Illness

Peter C. Campanelli, PsyD, President and CEO, Institute for Community Living and Board of Directors, National Council for Community Behavioral Healthcare



Peter Campanelli is the founder, president & CEO of the Institute for Community Living, which provides residential, treatment and rehabilitation services to people with psychiatric, intellectual and developmental disabilities in New York City and Montgomery County, Pennsylvania. ICL has engaged in creating community-based housing for people with serious mental illness for close to a quarter century. A graduate in Clinical Psychology from Rutgers University in New Jersey, Dr. Campanelli is licensed to work both in New York and New Jersey—specializing in

anxiety disorders, behavioral pain management, and marital and family therapy. He has received the 1995 Dean Donald L. Peterson Award of the Graduate School of Applied and Professional Psychology of Rutgers University, the 1991 Significant Award of the Hospital and Community Psychiatry Rehabilitation Model, and the 1993 Community Residential Treatment Service Award given by the American Psychiatric Association in recognition of outstanding clinical and administrative achievement.

Housing for people with mental illness is as much a place as it is an ongoing process to engage and promote their recovery. Helping consumers easily access and maintain stable housing must remain at the heart of any service system.

The suitability of certain types of housing for people with mental illness is a discussion as relevant today as it was thirty years ago. Recently, a New York State judge made a landmark decision regarding the rights of people with mental illness residing in adult homes in New York City (Disability Advocates, Inc. vs. NYS Governor David A. Paterson et al, 2009). He ruled that the adult homes provide little opportunity for people with mental illness to integrate within the community. **The judge also noted that keeping them in adult homes is more expensive by several thousand dollars per person per year than providing these individuals with supported housing and community services.** The court ordered the state to create a plan to transition these residents from adult homes into supported housing or smaller group residences.

This decision, though right now limited to New York City, could set a nationwide precedent, particularly in states that rely heavily on board and care homes, as well as nursing homes, to house people with mental illness. Given the potential changes ahead, it is vital we understand the questions and issues posed by supported housing. What follows is a brief discussion of four critical questions that every mental health and housing provider must consider in order to create stable housing and successful community inclusion for people with mental illness.

What works best for different people?

The Housing First model has had an undeniable positive impact on how we approach housing for people with mental illness. This model unconditionally offers consumers an apartment of their own and then crafts personalized supports for them that range from flexible case management to community-based mobile treatment in the form of Assertive Community Treatment. Since not everyone wants to live in his or her own apartment, a range of options that includes small congregate housing programs and other alternatives with flexible supports is necessary and appropriate.



Wrapping in appropriate supports for people with serious mental illness living in communities can be expensive but by no means more expensive than the alternatives—emergency room visits, hospitalizations, psychiatric emergencies, incarceration... However, there needs to be a means of aggregating all available funding into a single payer silo and allocating a fair share to supported housing.



What clinical supports do clients need in communities and how best can these be provided?

A recent article in the New York Times (For Families of Mentally Ill, Mixed Feelings Over Push Away From Adult Homes, October 8, 2009) voiced concerns pertaining to the court's ruling on adult homes. Relatives of people living in adult homes fear that their loved ones do not have the skills to survive in their own apartments and have previously failed in similar circumstances.

Supported housing that provides small studio apartments within congregate buildings might address those concerns. This type of congregate model has been shown to be very cost-effective and programmatically responsive for clients who otherwise might not be successful in a scatter-site apartment arrangement. These buildings generally consist of approximately 40 studio apartments and, while congregate, are small enough to foster a sense of community inclusion and privacy and maintain a very high retention rate. People who live in these small buildings typically have access to a front desk attendant round the clock.

How can supported housing and its necessary supports best be financed, especially in a recessionary economy?

Wrapping in appropriate supports for people with serious mental illness living in communities can be expensive—but by no means more expensive than the alternative. Most state budgets are strained and the largest single cost escalator is Medicaid, especially for people with serious mental illness. Medicaid costs are ballooning for people with mental illness because of the heavy utilization of hospital emergency rooms and subsequent hospitalizations due to avoidable medical and psychiatric emergencies.

In an effort to stabilize medical care received by people with mental illness in the community and reduce emergency costs, there is a national movement to create “medical homes.” Medical homes provide continuous and consistent medical care to people with mental illness. However, stable consumer housing is a necessary

precursor to the implementation of an effective “medical home” intervention.

Supported housing is less expensive than all costs associated with adult home care. However, there needs to be a means of aggregating all available funding into a single payer silo and allocating a fair share to supported housing. Otherwise, it will be difficult to make supported housing universally available. One major barrier is that Medicaid defines eligible costs as those that are medically necessary, thereby limiting Medicaid participation to an illness model. It would be more productive and cost-effective to permit Medicaid's participation in prevention planning and implementation. Additionally, supported congregate housing, in contrast to the general housing market, requires a capital investment to finance the building of efficiency unit-housing facilities and a long-term commitment to support affordable rents despite market escalations.

What types of risk management approaches most effectively respond to legitimate community safety issues?

It only takes one or two well-publicized allegations of crime to further ingrain the stigma against people with mental illness. Widespread use of supported housing will force community-based agencies to train case management staff differently and develop clinical support tools to assist in consumer risk assessment and monitoring. Additionally, for parents with mental illness raising their children in supported housing, case managers with family development skills will be required to ensure child safety within the context of supporting the whole family.

Many of the lessons we at the Institute for Community Living have learned about community-based housing were gained through our work with the people we serve. One of the most important design elements is to enlist consumer participation in housing decisions. It is my hope that the topics and articles presented in this special National Council Magazine issue on housing will raise more questions than provide answer, thereby fueling the national dialogue on how to help people with mental illness—an incredibly diverse population—best integrate within the community.



.....
Ann O'Hara, Associate Director, Housing and Homelessness Team, Technical Assistance Collaborative;
Andrew Sperling, JD, Director of Federal Legislative Advocacy, National Alliance on Mental Illness

State governments' evolving community integration policies—developed as a result of the 1999 U.S. Supreme Court's *Olmstead* decision and Mental Health System Transformation initiatives—have prompted a reexamination of the government's supportive housing and residential services policies for people with serious mental illness, including the continued reliance on nursing homes and segregated board-and-care homes. In fact, some states' community integration policies no longer permit development of the kind of highly concentrated housing settings that are still the norm in many federal programs.

Through these new policies, a housing and services paradigm has emerged that seeks to fulfill the vision of community integration embedded in the Americans With Disabilities Act of 1990. This paradigm envisions that people with disabilities who have an extremely low income will have access to an increasing supply of decent, safe, affordable, accessible, and integrated rental housing. Moreover, this housing will be produced routinely and at scale through mainstream affordable rental housing programs, particularly the federal Low-Income Housing Tax Credit program, the U.S. Department of Housing

and Urban Development's HOME program and, most important, the new National Housing Trust Fund authorized by Congress in 2008.

The principles, financing, and supportive services approaches for people with mental illness and other disabilities have also evolved; they have developed from models that required mandatory site-based services to evidence-based best practice models that emphasize voluntary, individualized, and flexible services that can be adjusted to a person's changing needs in the permanent housing of his or her choice. Many states are in the process of designing and implementing these community-based supportive services policies through a realignment of Medicaid and state financing strategies.

Two states, North Carolina and Louisiana, have already adopted housing policies that demonstrate the feasibility and cost-effectiveness of integrating permanent supportive housing set-asides for people with disabilities within LIHTC-financed affordable housing developments. The North Carolina Housing Finance Agency has financed more than 2,000 units, and Louisiana has approximately 1,000 units in the pipeline financed with recovery funds from Hurricanes Katrina and Rita.

SECTION 811 HAS FAILED TO KEEP UP

To ensure expansion of supportive housing options that achieve the goals of community integration, consumer choice, and recovery, agencies must ensure that the programs and resources they have conform to this model and maximize their capacity to develop new affordable and accessible units. One critical federal program that has failed to keep pace with changes in disability policy is the HUD Section 811 program.

Historically, Section 811 has been one of the few programs that focuses resources on the housing needs of adults with severe disabilities, including serious mental illness. Despite setbacks in recent years, the program is still able to create new supportive housing units, although budget cuts and operating subsidy renewal costs have significantly eroded its capacity to develop new units (only 930 new units were funded nationally in 2008). In reality, the future of Section 811 is being jeopardized by an outdated statute and program models, excessive HUD bureaucracy, and rapidly declining production levels.

WHY SAVE SECTION 811?

Many in the disability field have asked, "Why save Section 811? Other HUD programs can create per-



manent supportive housing.” The reasons to save the Section 811 program are clear and compelling. **Most important, Section 811 is the only federal program dedicated to addressing the housing crisis facing millions of extremely low-income people with significant and long-term disabilities who also need access to services and supports to live successfully in the community. In addition, Section 811 is one of the few remaining HUD programs that can provide the essential project-based rent subsidy needed to ensure that rents in new permanent supportive housing units are affordable for the most vulnerable people with disabilities and with the lowest incomes.**

Merely tinkering with the Section 811 statute will not be enough to save it. To effectively respond to the housing choices and service approaches preferred by most people with disabilities—and to produce new permanent supportive housing units at the scale needed—Congress must reform and revitalize the Section 811 program. This new approach to Section 811 must bring the program into alignment with the other major government programs that fund affordable rental housing in the United States today—particularly the new National Housing Trust Fund program as well as the federal LIHTC program and HUD’s HOME program.

Section 811 needs to coordinate effectively with these programs to develop new, high-quality rental units that are targeted for the lowest income peo-

ple with serious mental illness and linked with the community-based supportive services they want and need. The vision for this new Section 811 approach includes small set-asides of permanent supportive housing units integrated within larger rental housing developments funded routinely each year by state and local governments. For example, a new 100-unit LIHTC property could include 10 permanent supportive housing units funded by Section 811. Alternatively, a nonprofit organization could create a “mixed-income” rental property that incorporates into a 60-unit building 15 permanent supportive housing units financed with Section 811 funds.

How can these reforms be achieved? **Congress is moving forward on legislation to reform HUD Section 811 and ensure its long-term viability as a critical source of integrated housing for people with severe disabilities.**

NEW SECTION 811 LEGISLATION

The Frank Melville Supportive Housing Investment Act of 2008 (HR 1675 and S 1481) will spur the creation of thousands more new Section 811 units every year by

- >> Authorizing a new Section 811 Demonstration Program that fulfills the promise of true community integration as envisioned in the Americans With Disabilities Act.
- >> Enacting long-overdue reforms and improvements to the existing Section 811 production program that

are essential for the program’s long-term viability.

The basic structure of the Section 811 program is quite simple. Under current federal law, Section 811 is a competitive program with three distinct components:

1. A Section 811 Capital Advance (essentially a grant with a 40-year use restriction) to help nonprofit organizations buy, rehabilitate, or newly construct supportive housing.
2. A 5-year renewable Section 811 Project Rental Assistance Contract linked to Capital Advance projects that helps cover project operating costs (insurance, utilities, maintenance, etc.) and ensures that tenants pay no more than 30 percent of their income for housing.
3. A separate Section 811 tenant-based rental assistance program administered primarily by public housing agencies such as the Section 8 Mainstream Housing Opportunities for Persons With Disabilities program.

Section 811 projects financed through the Capital Advance/PRAC components are single-purpose properties that fall into two basic categories: (a) Small group homes with no more than 8 units, and (b) Independent living facilities, which can have up to 24 units. An extremely small number of the estimated 30,000 funded Section 811 units are condominiums or cooperative units that are integrated within other housing settings. This approach has proven extremely difficult to implement under current Section 811 rules, however.

KEY FEATURES

The primary goals of the new Section 811 legislation are to create more units of permanent supportive housing every year, to produce these units more efficiently by leveraging other affordable rental housing financing, and to promote more integrated Section 811 housing opportunities.

The key provisions of HR 1675 and S 1481 are summarized in the sections below.

Section 811 Demonstration Program

The most innovative and exciting component of the legislation is a proposed PRAC-ONLY Demonstration program. The PRAC-ONLY Demonstration could create 2,500 to 3,000 new integrated Section 811 units each

Congress must reform and revitalize the Section 811 program to bring it into alignment with the other major government programs that fund affordable rental housing in the United States today—and to develop new, high-quality rental units that are targeted for the lowest income people with serious mental illness and linked with the community-based supportive services they want and need.



year without increasing current Section 811 appropriations. The demonstration has been designed to take advantage of the hundreds of thousands of “affordable” units routinely produced each year by states and localities through the new National Housing Trust Fund program, as well as through the LIHTC and HOME programs and perhaps other sources of affordable housing financing.

The PRAC-ONLY Demonstration would provide a long-term commitment of Section 811 PRAC funding to ensure that a small but significant percentage of permanent supportive housing units—not to exceed 25 percent of the total units—could be set aside in projects financed by the National Housing Trust Fund, HOME, or LIHTC. The demonstration program would be administered through state housing agencies and local governments willing to create set-aside policies that align with the community integration goals of state disability and supportive services policies.

Under the PRAC-ONLY demonstration, rents for Section 811 units would be set at 30 percent of monthly income, and the Section 811 PRAC would provide the long-term rental subsidy up to the “affordable” rent charged in the LIHTC, HOME, or similar affordable rental housing financing program. This cost-effective approach means that the annual cost of a Section 811 unit could be as low as \$3,000 per year and would require no Section 811 capital funding to implement.

Section 811 PRAC funding could be linked when projects are financed or could be provided at any time as long as the project owner is willing to accept the long-term commitment of PRAC funding. Linkages to supportive service resources would be structured through formal partnerships with state health and human services agencies and Medicaid agencies implementing policies focused on community integration.

Improvements to the Existing Section 811 Program

HR 1675 and S 1481 also propose changes to the existing Section 811 production program to encourage nonprofit Section 811 grantees to better leverage other capital funding and to eliminate barriers

to mixed-finance Section 811 projects that target LIHTC investment. These long-overdue reforms include the use of Section 811 Capital Advance and PRAC funding to support a percentage of the units—not to exceed 25 percent of the total units in the project—in a multifamily rental housing development project. The legislation would also streamline HUD Section 811 processing requirements and remove outdated HUD regulatory barriers to help increase the number of new units that can be created each year by nonprofit organizations through the Section 811 Capital Advance/PRAC program.

Shifting Renewal of Section 811-funded Mainstream Vouchers to the Housing Choice Voucher Program Budget

Since its inception, the Section 811 tenant-based rental assistance program has been plagued with problems. The provisions of HR 1675 and S 1481 related to this component of Section 811 are essential for two reasons:

1. HR 1675 and S 1481 finally will undo the ill-advised and ill-fated HUD decision made in the 1990s to convert Section 811 tenant-based rental assistance funding to Section 8 Mainstream Housing Choice Vouchers administered primarily by public housing agencies.
2. HR 1675 and S 1481 could free up more than \$80 million in Section 811 funding, which could be redirected to the PRAC-ONLY Demonstration program.

Many problems arose when HUD created the Mainstream Voucher Program. Stated simply, although they were funded and renewed from Section 811 appropriations, more than 14,000 Mainstream Housing Choice Vouchers were awarded to public housing agencies, which issued them to people with disabilities who were on Section 8 Housing Choice Voucher waiting lists. The Section 811-funded vouchers were rarely—if ever—used by public housing agencies to provide permanent supportive housing, and they were not necessarily targeted to people with the most serious and long-term disabilities. Ineffective tracking of the Mainstream program by HUD and public housing agencies compounded the problems.

YOUR VOICE CAN MAKE A DIFFERENCE

Time is running out on the Section 811 program, and the need to create new permanent supportive housing units has never been greater. Disability housing policy is at a critical juncture as the community integration paradigm takes hold—unfortunately, without the housing resources to ensure its success. Section 811 legislation that supports this new paradigm is essential, because it will provide important new resources to ensure its implementation in states and localities around the country.

Even a reinvigorated and modernized Section 811 program cannot be expected to address the full extent of the unmet need for permanent supportive housing for people with the most significant and long-term disabilities. Nonetheless, a newly authorized Section 811 program that truly supports community integration for people with disabilities will symbolize a renewed, serious, and sustainable commitment from the federal government to respond to this housing crisis.

By enacting new Section 811 legislation, Congress can ensure that a reinvigorated Section 811 program is ready to create thousands of new permanent supportive housing units every year without the need for Congress to double or triple appropriation levels. The removal of many bureaucratic barriers that cause protracted delays in Section 811 project development will also produce new units more efficiently. Shifting renewal costs associated with the flawed 811-funded Mainstream Housing Choice Voucher program—which has drained funding away from essential permanent supportive housing production since 1997—also is long overdue.

Ann O'Hara is nationally known for her public policy work to expand affordable housing opportunities for people with disabilities and her expertise in housing programs for people who are homeless or at risk of homelessness. She has over 25 years experience in the development and administration of the full range of subsidized rental and homeownership programs. She has successfully advocated for national housing policy initiatives and helped numerous federal and state agencies address housing problems of low-income people with special needs.

Andrew Sperling leads NAMI's legislative advocacy initiatives in Congress and before federal agencies. He works on issues affecting the mental health community with a focus on improving the lives of people with severe mental illnesses. Since 1994, Mr. Sperling has also served as Co-Chair of the Consortium for Citizens with Disabilities Housing Task Force.



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Reprint from NY Daily News, October 6, 2009

Ruling Gives the Mentally Ill Chance to Live with Dignity

Linda Rosenberg, MSW, President & CEO National Council for Community Behavioral Healthcare

It's being able actually to live like a human being again.

That is what Irene Kaplan said about her new life in a supported apartment after 16 years of living in one of New York City's largest state-funded adult homes for people with mental illnesses.

Now, as a result of Judge Nicholas Garaufis' ruling last month that the state denied basic rights under the Americans With Disabilities Act to the mentally ill, most of the 4,300 men and women who still live in those institutions can have the same opportunity for freedom.

The fears expressed by local civic leaders in a Daily News article last Sunday ("Ruling may force mentally ill to move from Rockaways facility") are based on an insufficient understanding of both the nature of supported housing and the characteristics of the people who will occupy it.

As one of the experts, I testified before Garaufis in this case. My 30-years plus with the New York State Office of Mental Health — beginning as an assistant social worker, then running clinic and hospital programs that treated both adult home and supported housing residents and ultimately serving as the senior deputy commissioner — allows me to inject some clarity and experience into the discussion.

A couple of decades ago, when psychiatric hospitals were being downsized, the state needed alternatives for the people who were being discharged "into the community."

Because New York had not developed adequate services for the people being deinstitutionalized, for-profit adult homes became an alternative to the streets.

The adult homes, many with hundreds of beds, are fully institutional — places in which the residents can not make the most basic of decisions, such as choosing a roommate or what to eat or what time to eat.



Having a guest for dinner or overnight is out of the question.

In adult homes, the needs of the institution always trump the needs of the individual.

There are more than 13,000 persons with mental illness who successfully live in supported housing in New York State.

They are living in an apartment — alone or with a roommate of their choosing — to which supportive services are added.

They are your neighbors, but you probably do not know it.

The assistance they get runs the gamut, from help with finding a job to help with laundry and food shopping to bringing treatment, counseling and medication into the apartment.

Supported housing allows people who are diagnosed with serious mental illnesses, people no different from those warehoused in adult homes to achieve independent lives in the community.

It is only happenstance that determines who lives in supported housing and who lives in an adult home.

The Office of Mental Health created an array of outstanding programs and services for people with mental illnesses, helping many to recover and help-

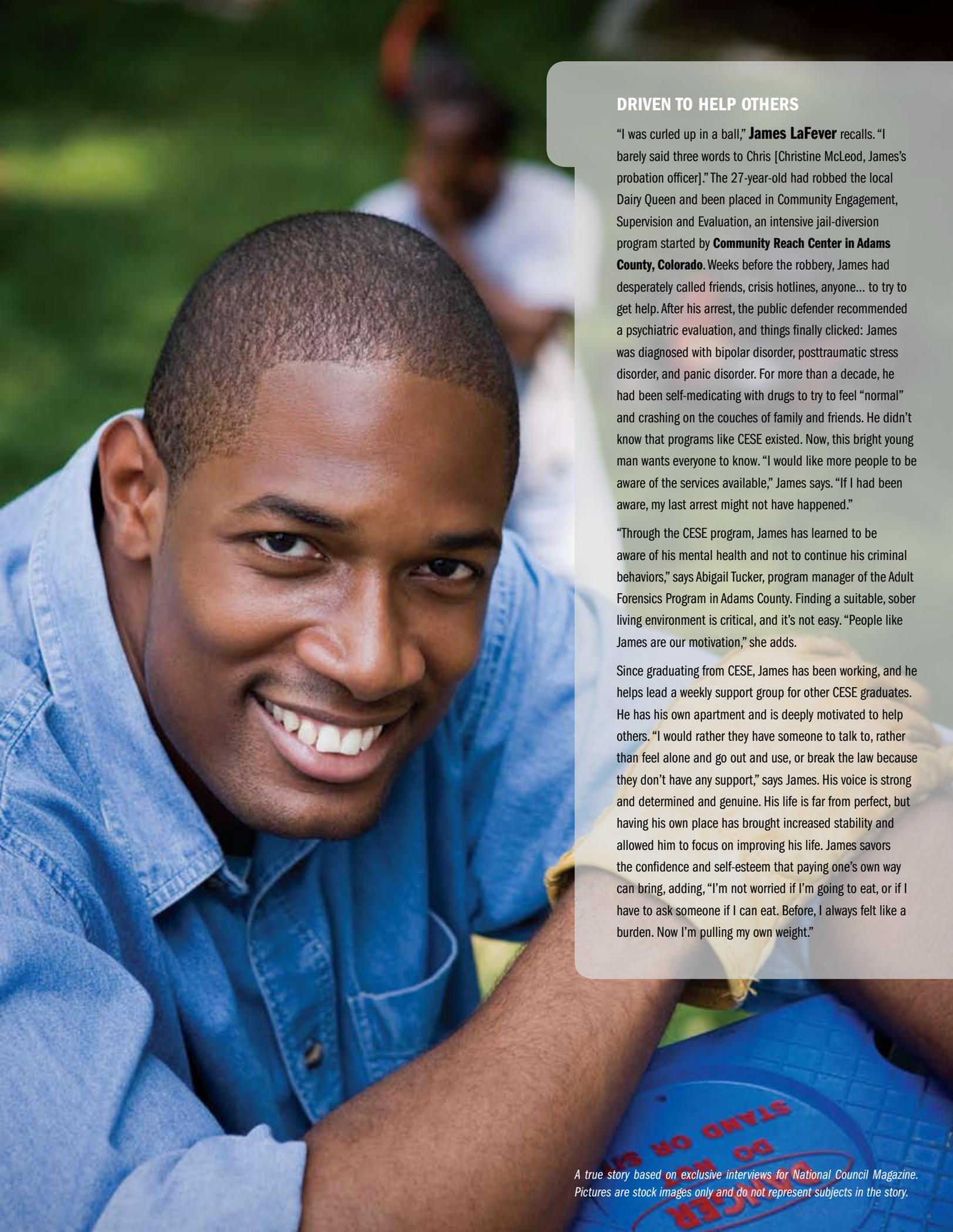
ing others gain a degree of self-sufficiency once only dreamed about.

But adult homes do not do us proud.

Once upon a time they were a bad solution to a state hospital problem.

Now adult homes are an expensive tragedy visited upon those some people still view as less worthy. We can and must do better.

With more than 30 years of distinguished service in mental health policy, services, and system reform, Rosenberg is a leading mental health expert. Under Rosenberg's leadership since 2004, the National Council for Community Behavioral Healthcare has grown to 1,600 member organizations, employing 250,000 staff and serving 6 million adults and children in communities across the country. Prior to joining the National Council, Rosenberg was the senior deputy commissioner for the New York State Office of Mental Health. In addition to responsibility for New York's state-run adult, child, and forensic hospitals, she tripled New York's assertive community treatment capacity, expanded children's community-based services, developed an extensive array of housing options for people with mental illnesses and addictions, implemented a network of jail diversion programs including New York's first mental health court, and promoted the adoption of evidence-based practices and consumer and family programs. A certified social worker, as well as a trained family therapist and psychiatric rehabilitation practitioner, Rosenberg has held faculty appointments at a number of schools of social work, serves on numerous agency and editorial boards, and writes and presents extensively on mental health and addictions issues including the impact of organizational and financing strategies on consumer outcomes.



DRIVEN TO HELP OTHERS

“I was curled up in a ball,” **James LaFever** recalls. “I barely said three words to Chris [Christine McLeod, James’s probation officer].” The 27-year-old had robbed the local Dairy Queen and been placed in Community Engagement, Supervision and Evaluation, an intensive jail-diversion program started by **Community Reach Center in Adams County, Colorado**. Weeks before the robbery, James had desperately called friends, crisis hotlines, anyone... to try to get help. After his arrest, the public defender recommended a psychiatric evaluation, and things finally clicked: James was diagnosed with bipolar disorder, posttraumatic stress disorder, and panic disorder. For more than a decade, he had been self-medicating with drugs to try to feel “normal” and crashing on the couches of family and friends. He didn’t know that programs like CESE existed. Now, this bright young man wants everyone to know. “I would like more people to be aware of the services available,” James says. “If I had been aware, my last arrest might not have happened.”

“Through the CESE program, James has learned to be aware of his mental health and not to continue his criminal behaviors,” says Abigail Tucker, program manager of the Adult Forensics Program in Adams County. Finding a suitable, sober living environment is critical, and it’s not easy. “People like James are our motivation,” she adds.

Since graduating from CESE, James has been working, and he helps lead a weekly support group for other CESE graduates. He has his own apartment and is deeply motivated to help others. “I would rather they have someone to talk to, rather than feel alone and go out and use, or break the law because they don’t have any support,” says James. His voice is strong and determined and genuine. His life is far from perfect, but having his own place has brought increased stability and allowed him to focus on improving his life. James savors the confidence and self-esteem that paying one’s own way can bring, adding, “I’m not worried if I’m going to eat, or if I have to ask someone if I can eat. Before, I always felt like a burden. Now I’m pulling my own weight.”

Can We Afford to Fully Support a Return to the Community?

Debra L. Wentz, PhD, Chief Executive Officer, New Jersey Association of Mental Health Agencies

For hundreds of people in New Jersey's state psychiatric institutions, the wait to return to the community has been far too long. But now, with the settlement recently announced between the New Jersey Department of Human Services and Disability Rights New Jersey, the time has come for them to return to independent living in the community.

The ruling resolves a long-standing case that challenged the constitutionality of New Jersey's practice of keeping people hospitalized on "Conditional Extension Pending Placement" status for long periods. Although these consumers were deemed ready for release from state institutions, the state denied their release because of a lack of appropriate community services and living options.

At times, more than one-third of the residents in New Jersey's institutions were on CEPP status. The lawsuit, originally filed by New Jersey Protection and Advocacy, maintained that the practice violated the Americans With Disabilities Act and the U.S. Supreme Court's Olmstead ruling, which mandates that services be provided in the least restrictive setting possible.

Although the members of the New Jersey Association of Mental Health Agencies, opposed the practice of keeping people hospitalized long after they were ready for release, we felt just as strongly that it would be cruel to return them to the community without appropriate plans in place for their continued treatment and services. In the past, New Jersey has witnessed the devastation and homelessness that occurred when institutions were closed without appropriate services arranged for displaced patients.

Over the past several years, New Jersey has committed to increase the number of residences for people with mental illness and has been reducing the census at state hospitals. In 2005, the state created the Special Needs Housing Trust Fund, setting aside \$200 million with a goal of creating 10,000 residences over

Supportive Housing to be Cornerstone of New Jersey Settlement for Confined

Advocates who have fought against New Jersey's practice of keeping hundreds of individuals with mental illness on conditional commitment status in state psychiatric hospitals are heartened that the settlement of a lawsuit challenging this action features development of supportive housing as the key to establishing community alternatives. The settlement finalized last month in the case now known as Disability Rights New Jersey v. Velez calls for a phased discharge of 297 patients who were hospitalized under the state's "Conditional Extension Pending Placement" (CEPP) prior to July 1, 2008. The state has used CEPP commitment to maintain hospitalization for individuals with mental illness who are ready for discharge to the community but for whom there are no appropriate community services available. The complaint filed by the state's protection and advocacy agency for mental health consumers and by Bazelon alleged that the confinement of these individuals violated the Americans with Disabilities Act and also flies in the face of the U.S. Supreme Court's Olmstead decision mandating services in least-restrictive settings.

*As reported in Mental Health Weekly
August 10, 2009*



10 years for mental health consumers, people with developmental disabilities, and youths aging out of foster care.

NJAMHA members have partnered with the state to create unique living options, such as a program run by Community Hope and Comprehensive Behavioral Healthcare, Inc., on the grounds of Greystone Psychiatric Institution. This program provides long-term patients—some who were institutionalized for more than 20 years—the opportunity to gradually transition to independent community living.

The recently announced settlement calls for a phased discharge of another 297 patients on CEPP status. The state budget includes \$5 million for fiscal year 2010 to develop new supportive housing for the first year of the plan. The 125 community providers that are members of NJAMHA are committed to partnering with the state to ensure the successful transition of these patients to community life. We are concerned, however, that the fiscal realities of state government grappling with a deficit-riddled budget will leave these former patients without the services they need in the future.

Institutionalization is expensive, whereas community treatment and services are a wise investment that can save the state resources in the long run. The state cannot view deinstitutionalization as a means of filling budget holes, however, and it must not simply look to the least expensive option. Each patient must be fairly assessed and provided with the appropriate treatment and services.

Although supportive housing is a valuable component of the community mental health continuum, people sometimes require more intensive treatment and services. A well-funded full continuum of care is particularly necessary for patients who have comorbid medical conditions or have been institutionalized for so long that daily living presents enormous challenges.

Additionally, the commitment to reducing the census at state institutions must not be achieved at the expense of people living in the community. In addition to the hundreds of consumers who are on CEPP status at state institutions and awaiting release, thousands in the community are awaiting housing and services. According to the New Jersey Housing and Mortgage Finance Agency, in 2006 more than 17,000 people were in shelters and other homeless housing locations in the state, many with special needs. Untold thousands also live in substandard circumstances or with aging parents and await the opportunity for independent living. Moreover, the state's jails and prisons remain the primary location to house people with mental illness.

If the state does not concurrently address the needs of everyone with mental illness, the demand at the front door of institutions will continue. In New Jersey, the wait for outpatient services can stretch to months, and emergency rooms back up with people in crisis.

The state has been instituting various pilot programs to address these needs, such as intensive outpatient treatment and jail diversion. Although New Jersey's commitment to these new programs is admirable, the state continues to let the core of the system founder. New Jersey must make a commitment to meeting the ongoing needs not just of people released from institutions but also of people with mental illness who are still in the community.

Additionally, we must all commit to battling the stigma and discrimination that continue to plague people with mental illness and hamper their reintegration into

the community. The public blogs that followed the lawsuit settlement stories were a sad commentary on the antiquated attitudes of some members of the public.

We must continue to tell the stories of successful recovery and reintegration of people with mental illness who work, care for their family, and contribute to society. Last year, NJAMHA featured the story of Cyndy Walters, who lost her children and her home and nearly lost her life when she tried to commit suicide. She speaks to others about her time in crisis, saying, "I actually think I would've been dead if I didn't have the services because . . . I tried to commit suicide and somebody intervened and took me into their arms and wouldn't let me go."

Cyndy publicly discusses her recovery and tells the story of how she has regained her life, home, and children. She is now successfully employed and helps others who face similar crises. Thousands of Cyndys in New Jersey live, work, and contribute to their community. We must ensure that the state and all residents commit to supporting these people's successful recovery and life in the community.

Debra L. Wentz, PhD is chief executive officer of the New Jersey Association of Mental Health Agencies, Inc., which represents 125 nonprofit hospital-based and freestanding behavioral healthcare providers that collectively treat more than 400,000 children and adults in need of mental health services and supports annually. Dr. Wentz is also the executive director of the New Jersey Mental Health Institute, a private, nonprofit charitable organization that promotes quality mental health services through policy development initiatives, training, technical assistance, research, data collection, best practice development and anti-stigma and anti-discrimination campaigns. A recipient of more than 60 national, state and local awards, Dr. Wentz serves on numerous statewide councils and task forces addressing issues impacting the mental health community.

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Innovative Financing Options for Supported Housing

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Jeffrey Brown, Executive Director, Oakland County Community Mental Health Authority; Marc Craig, President, Community Housing Network, Troy, MI

OCCMHA serves a county with a population of more than 1 million in Detroit's northern suburbs. Through its network of providers, OCCMHA offers an array of community-based services to thousands of citizens with developmental disabilities and mental illness. Through the 1970s and 1980s, more than 200 six-person group homes were developed in scattered locations across the county, principally to serve people with developmental disabilities who were leaving state institutions that were closing. People with mental illness residing in the state mental health facility in Pontiac were later offered housing in apartments and scattered single-family residences as that facility was closing.

In 2001, OCCMHA recognized the need to achieve a number of policy objectives in housing for consumers:

- >> Separation of housing from supports
- >> Control of housing by consumers
- >> A wider array of integrated housing choices in scattered locations
- >> Affordable housing that does not contribute to a concentration of poverty
- >> Reduced dependence on the group home model
- >> Creation of new housing options and affordable housing resources
- >> Increased access to housing resources outside the mental health community
- >> Up-to-date housing information and referral for OCCMHA consumers and providers
- >> Coordinated, centralized management of existing housing resources.

To achieve these objectives, OCCMHA provided start-up funding to the newly formed Community Housing Network, a 501(c)(3) nonprofit organization under contract to serve the housing needs of people receiving services from OCCMHA. Jeff Brown, OCCMHA's executive director, views housing as a critical service area, saying, "Access to affordable housing is the foundation for full

citizenship and community integration for persons we serve. It is essential to providing effective community supports."

In 2001, CHN's first responsibility was to coordinate the leasing and property management of 225 group homes that housed people served by OCCMHA. Nearly all the homes were owned by private investors and leased back under a variety of leasing arrangements with the state of Michigan, OCCMHA, or service providers. CHN took assignment of all but the state leases and assumed responsibility for making new leasing or other housing arrangements as the remaining state leases expired.

Although leasing and property management accounted for the majority of dollars in the contract between OCCMHA and CHN, other services provided by CHN proved to be more vital to achieving the long-term policy objectives. CHN launched an innovative Housing Resource Center to serve people with disabilities and their families and those who support them. Marc Craig, CHN president, notes "The HRC is at the heart of our service to the community. The tremendous response has shown us that this resource is valued by persons with disabilities, service agencies, and other area residents."

The HRC operates a number of programs and services. Information and referrals regarding programs such as Housing Choice (formerly Section 8) vouchers can be obtained in person, by phone, or through the CHN website, which receives, on average, more than 2,900 visits per month. The HRC manages a home-buyer assistance program for people with disabilities—the program provides home-buyer counseling, help with housing searches and, ultimately, access to a number of down-payment assistance programs. This kind of program allowed Jack Dobrecki to own a home for a monthly payment that is less than he had been paying to rent a small apartment.

HRC staff members are actively engaged in the community; for example, they conduct outreach programs and maintain Housing Choice voucher alert lists to inform people with disabilities about voucher availability. An independent living club provides social networking opportunities and timely information



Jack Dobrecki, now 58, was raised in an institution for people with developmental disabilities in Lapeer, Michigan, from the time he was 5. Beginning at age 19, Jack lived in a series of foster care homes and other residential programs in Oakland County. Now he is a homeowner and receives supportive services through the Oakland County Community Mental Health Authority.

about housing and supportive services. Several HRC staff members have received (or currently receive) services through OCCMHA.

To attract additional resources, CHN is an active participant and has taken various leadership roles in the local U.S. Department of Housing and Urban Development's Continuum of Care planning group, the Oakland County Taskforce on Homelessness and Affordable Housing. Among its activities, this all-volunteer group is responsible for the annual application for HUD funding under the McKinney Vento Homeless Assistance program. In the past 8 years, CHN has become the area's largest provider of permanent supportive housing; it now attracts more than \$2 million annually to provide housing to more than 200 formerly homeless people with disabilities and their families.

CHN also serves as the lead agency for the county's Homeless Management Information System program. This congressionally mandated program tracks utilization of homeless shelters, people participating in permanent supportive housing, and data obtained from a communitywide homeless street count. "The HMIS data prove what we've suspected all along, that people with disabilities are disproportionately represented among the homeless population," Craig says. "This information helps us to secure more resources."

Other grant sources CHN has used to attract housing resources to benefit people with disabilities include the HUD Section 811 program, the Affordable Housing Program from members of the Federal Home Loan Bank system, and funds from the HOME program administered by Oakland County government and the Michigan State Housing Development Authority. These grants have attracted more than \$5 million to produce new units of both affordable home ownership and rental housing.

For the near future, CHN is ramping up to administer newly available funds under the Homeless Prevention and Rapid Rehousing Program, which was created under the American Recovery and Reinvestment Act. Plans to create additional housing units through the Low Income Housing Tax Credit program are also underway.

"We are delighted with the results of our partnership with CHN," Brown says. "It gives people with disabilities a seat at the table in housing planning and has effectively leveraged our resources to attract millions of new dollars to benefit them."

Jeffrey Brown is a member of the board of directors for the National Association of County Behavioral Health and Developmental Disability Directors, an affiliate of the National Association of Counties. He was recently elected to the executive committee of the Michigan Association of Community Mental Health Boards as treasurer. Brown has nearly 30 years experience as a hospital social worker, mental health clinician and manager, and community leader.

Marc Craig has been an affordable housing advocate for more than 25 years. He is founding president of Community Housing Network, a nonprofit organization that helps people in need find long-term housing solutions. He is also the founder of Springhill Housing Corporation, an organization that focuses on affordable housing development and management. Craig serves on the board of the Community Economic Development Association of Michigan and has been a member of numerous affordable housing and mental health advocacy organizations. Throughout his career, he has attracted housing resources in excess of \$15 million.

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Spotlight on Sam Tsemberis: Why Housing First Works

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 Sam Tsemberis, PhD, Founder and Executive Director, Pathways to Housing in an interview with Meena Dayak, Vice President, Marketing and Communications and Nathan Sprenger, Marketing and Communications Associate — National Council for Community Behavioral Healthcare



Back when New York City Health and Hospitals psychologist Sam Tsemberis was treating homeless people for their mental health and substance abuse problems, he recognized that “business as usual” was not working. The most vulnerable population cycled repeatedly through the streets, emergency rooms, drop-in centers, shelters, and jail cells. When he asked them, “What is the first thing you want?” They invariably answered, “A place to live.” From this concept came the Housing First program that Sam established with Pathways to Housing in 1992.

Unlike traditional programs for the homeless, Housing First offers clients immediate access to housing without requiring sobriety or psychiatric treatment first. And it does so with a client-directed focus. The housing is permanent and independent—regular apartments scattered throughout residential buildings in various neighborhoods. Rather than exclude homeless people in isolated enclaves, Housing First seeks to bring them back into the greater community. Tsemberis believes not only that housing is a basic right but also that people with psychiatric disabilities have the inherent ability to improve their lives.

Results demonstrate the success and cost-effectiveness of Housing First:

- » *The number of chronically homeless people in the United States dropped by almost 30 percent between 2005 and 2007. Administration officials attribute much of that one-third drop to the Housing First Strategy.*
- » *More than 200 cities in the United States and Canada have adopted 10-year plans to end chronic homelessness; 67 percent of these plans include a Housing First program.*
- » *The annual public cost of an average chronically homeless person living on the streets and in shelters is \$40,000; the annual public cost of the average chronically homeless person living in a supportive housing program like Pathways to Housing is \$16,000.*
- » *Pathways to Housing clients have an 85 percent 5-year retention rate and drastic drops in emergency room visits, contacts with law enforcement, and psychiatric hospitalizations.*

The National Council spoke to Sam Tsemberis about the possibilities and challenges of Housing First.

National Council: *You were quoted as once saying “The answer to homelessness is simple, it’s housing.”*

Sam: I actually regret that quote because it oversimplifies the problem. Housing only cures homelessness, not mental illness. Mental health and addictions issues need clinical support and intervention. My staff is not in the housing business; we’re a clinical agency. Ninety percent of our staff are social workers, psychiatrists, nurses, employment specialists, and so on, and they intervene before and after the person has received housing. Ending homelessness is a relatively short-term and easy-to-accomplish goal. The hard part is dealing with the mental illness and addiction.

National Council: *Is giving persons with mental illness and addictions a home the right thing to do?*

Sam: If you don’t give them a home, homeless persons with mental illness are going to ricochet through different acute care services. Your keynote speaker at the 2010 conference, Malcolm Gladwell, paints a picture of Million Dollar Murray. Murray was homeless in downtown Reno, Nev., for 10 years and cost the city over a million dollars in services (ERs, homeless shelters, drop in centers, jails)—all acute, expensive interventions not terribly helpful in the long run though intended to serve as programs of last resort for homeless people. Finally, Murray is still homeless and dies of neglect. It’s a tragic story and a poignant example of a system that is failing people.

If you look at why we are failing Murray and many others like him, it’s because our values get in the way. Holding on to old ideas, such as the person has to be clean and sober and on medication before the person can be housed, keeps us from long-term solutions.

National Council: *Does housing really change people?*

Sam: Housing First provides a safe, affordable, and effective intervention—an apartment of one’s own—to a group of people who previously wouldn’t have had access to this resource. Once housed, these persons can begin to address other issues. Overnight, they go from thinking about how to survive on the streets to thinking about “Where did I leave my keys; how am I going to pay the rent this month; when do I go grocery shopping?” It’s not just a transformation of address but a transformation of lifestyle. After they get into a house, they can then think about leaving their phone number with a relative and what they are going to do with their day rather than where they are going to eat. They can start to address the issues of why they are anxious all the time, or not sleeping, or the fact that their addictions are making it difficult to pay the rent. Then they pull their lives together in a more meaningful way.





National Council: *Where does funding come from for the housing you provide?*

Sam: We apply for government contracts that provide funding for both the rent and the service component. We identify a neighborhood and then an apartment that is suitable for homeless persons, and we help them rent the apartment. Or we rent it and sublet it to them, depending on what the persons wants, or the program allows, or the landlord allows. People pay 30 percent of their income (disability income, in most cases), and the rest of the rent is paid through various government programs such as [U.S. Department of Housing and Urban Development], Section 8, and Office of Mental Health supportive housing contracts.

National Council: *Government doesn't always allow for funding to go to people with criminal records, and private landlords are often hesitant to rent to those with criminal records. How do you deal with this?*

Sam: I've been doing this for 15 years, and even when someone has committed a felony, we've been able to house them. It's more of an imagined problem than a real one. If you really want to house people, criminal issues are not going to be a big deal.

Many of those who come to us with criminal records don't have records for violent crimes that would preclude them from living in an apartment. They have poverty-level crimes, such as drug use, turnstile jumping—misdemeanors that turn into worst case scenarios because of repeated infractions. If the landlord is uncomfortable renting to someone with a criminal record, then the agency will rent the apartment and sublet it to the tenant.

The issue of criminal backgrounds only comes up with poor people. Funny how it's a nonissue when it comes to white-collar crimes. No one talks about the Wall Street executive convicted of fraud having a hard time buying a co-op or condo!

National Council: *Do you have instances of people accepting housing but refusing treatment?*

Sam: People do have a choice about whether or not to accept treatment, but it's not a carte blanche choice. There are limits—they must pay 30 percent of the rent and must respect the terms and conditions of living in the apartment. Folks we house are also required to accept weekly program visits from our staff. These visits are the most clinically artful piece of the Housing First program. The visits allow us to monitor the condition of the clients, introduce new ideas, open new doors, and gently challenge them to do better.

We'll take them to the hospital if they are found to be a danger to themselves.

National Council: *Do you ever encounter problems with people saying, "I don't want a person with mental illness as my neighbor?"*

Sam: NIMBY [Not in My Backyard] only comes up when you have a whole apartment building or other congregating setting for people with mental illness. We rent scattered apartments from community landlords. The issue of mental illness doesn't come up in community discussions, as long as they are good tenants..

National Council: *What supports do you offer to integrate persons with mental illness that you house into the community?*

Sam: The social inclusion piece is a huge part of the recovery process. The scattered-site model requires persons with mental illness to live among people in the community [who] have no disability. It changes the context of their lives right away. They live in a regular apartment the way everyone else does. They need to go out to make contact with others, to greet neighbors, check the mail, take out laundry...They are no longer standing in soup lines and only talking to social workers. But there are a lot of challenges with community integration. People with mental illness tend to be shy in public settings [and] are more isolated, and it is a challenge to overcome this emotional vulnerability. This is where the support services kick in—community integration doesn't happen by itself. And we have all types of programs to nurture people's varied interests and activities.

National Council: *What happens when there is a relapse or people cannot stay in their homes?*

Sam: If someone messes up or has a problem at their apartment, we are able to move them and start all over in a new apartment, using the learning experience. That helps them get it together the second time. You don't have to get it right the first time. We're here to help them learn. The amazing thing about the program is that we're able to house 85 percent of those [who] are believed by others to be unhousable. It says a lot about what people with co-occurring disorders are able to do when given a chance to succeed.

The other 15 percent [who] don't make it after three or four times are typically those who can't quite get their addictions under control. We don't discharge them; we instead move them to a place where there is security or someone monitoring the front door, [because] they need a more restrictive setting. Most

housing programs start by placing people into a more restrictive setting first and then graduating people to an independent apartment, so many never make it. I think these programs have the whole thing backward. People don't need that structure to start out with, and they don't need to be symptom free to live independently.

National Council: *What's your advice for providers wanting to adopt Housing First?*

Sam: Start small and take on one component at a time. Make sure your off-site and support services are strong. Pick "less visible" clients to start with, until you can demonstrate results. And don't alienate supporters of transitional housing—show them that they won't be put out of business with Housing First but that they'll be a part of the change.

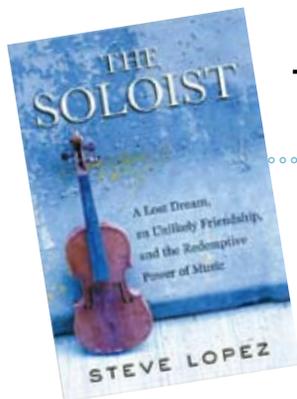
National Council: *Tell us how Housing First models are being replicated elsewhere and what type of support you offer them.*

Sam: Across the United States, there has been a big wave of expansion. It's all about funding. When the Inter Agency Council coordinated a chronic homelessness initiative grant of \$35 million about 5 years ago, suddenly organizations were competing for the money. It was a real shift in funding for these programs, even though only 10 or 11 cities received any of the \$35 million in funding. But many others that applied ended up getting local funding. The Canadian government put together a \$110 million initiative to end chronic homelessness in a country of only 30 million people. They chose Housing First as a model program for ending chronic homelessness. We're helping them set up programs in different Canadian cities. Amsterdam and Lisbon have also started Housing First programs.

National Council: *What's your vision for Housing First?*

Sam: My hope is that we have learned how to end homelessness and support people in a dignified way. I hope people with psychiatric disabilities will be integrated into our society and that they will be able to live, work, and love in the communities of their choice, just like the rest of us. My hope is we'll have the political will to take this problem on. This isn't curing cancer; in this case, we know what the cure is — housing and support services, and a government that will fund the programs.

And if we open a museum of homelessness 5 to 10 years from now, I hope we can show shelters and drop-in centers as things of the past!



The Soloist: Moving Beyond Our Comfort Zone

A book and movie review by Jacqueline M. Duda, Freelance Health Writer, for National Council Magazine

THE BOOK >>

The Soloist, by Steve Lopez, is a story of faith, lost dreams,

and determination, set against a backdrop of classical music, mental illness, and the utter despair of Los Angeles' desolate Skid Row. It is a true story that chronicles the unlikely friendship between cynical *Los Angeles Times* reporter (Lopez) and homeless violin virtuoso (Nathaniel Ayers), starting with the pair's initial meeting in Pershing Square to the book's ending on an upbeat, symphonic note. The first few pages of dialogue describing the chance encounter between the two men, hit the ground running. The reader is enormously intrigued, just as Lopez was when he happened upon Nathaniel.

Lopez starts out hunting for a story, as many writers do. He spies Nathaniel playing a beat up violin with ease, miraculously coaxing beautiful music out of the instrument's two strings. Nathaniel, a classically trained bass student from Julliard, whose former classmates included the renowned Yo-Yo Ma, illuminates what many of us might fear, but are otherwise too terrified to say out loud—that homelessness and mental illness can, and does, happen to beautiful people like Nathaniel. Nathaniel is a mixture of wit, grace and charm, his sentences punctuated by nonsensical ramblings about Colonel Sanders and his disdain for cigarette smokers.

When Lopez's columns about Nathaniel appear, he's flooded with responses—readers concerned about Nathaniel's well being and wanting to send new instruments; others more accusatory—that Lopez was using Nathaniel for his own benefit simply to write a column. Only the latter doesn't quite add up. As Lopez becomes inextricably involved in Nathaniel's life, he sacrifices precious time with his wife and his two-year-old daughter, while pushing tumultuous concerns about the ever shrinking news industry and the precariousness of his own job to the back of his mind. Lopez gives a compelling, honest account of wrestling with his own internal conflicts. He yearns to spend more time with his family, while continuing to seek out Nathaniel to coax him into the safety of the Lamp Community. Only through talking with Lamp staffers does Lopez come to realize what he has gotten himself into. He's unabashedly self-critical about his attempts to help Nathaniel—some-

thing that every reader can identify with. Lopez dishes it up brutally straight, without being preachy.

Throughout the book Lopez deeply probes his own inner dialogue regarding his frustrations with Nathaniel and his haunting fears for him as well, while grappling with his own understanding of mental illness. In doing so, he challenges the human condition and the dilemmas society faces as it struggles to help the disenfranchised. Do we furtively drop a few quarters in the can and dart away feeling guilty and helpless that there's nothing else we can do? And if we were to help—what could we realistically do? The book doesn't provide a pat answer, and it shouldn't. Lopez worries that giving Nathaniel the new instruments may actually place him in more danger and make him easy prey for theft and beatings. He can't understand why Nathaniel simply won't go live at the Lamp. But when he begins to share a connection with Nathaniel through his music, his impatience with results eventually begins to dissolve.

Who better than a mainstream writer/columnist to sound the alarm that among all the other problems around the world—the U.S. has its own great big mess right here—the fact that human beings with serious mental illnesses are living in tents, sleeping in doorways, or under highway overpasses. No one even knows their names. They live in filth and degradation, surrounded by danger and ridicule and misunderstanding. And when they die on the streets, no one is aware. The rest of the world goes on just as before. Through his expertise as a writer and having access to a far reaching pulpit like the *LA Times*, Lopez tips off the general American public that outside of their comfortable homes exists a third world horror story. The lost souls that live on Skid Row mirror back into society, what society might not otherwise be able to see.

And finally, *The Soloist* emphasizes the idea that cookie cutter methodologies, or a one size fits all approach, when it comes to the treatment for mental illness, won't cut it for everyone. Wouldn't it be easy if we could each pick up a homeless person off the street, and take them to a Lamp-like community and simply drop them off, knowing the person will safely remain in the shelter and get better? And then we could neatly return to the daily business of our own lives. Instead, what Lopez discovered in getting to know Nathaniel, resonates with what everyone, especially the homeless, really needs — a good friend.



THE MOVIE >>

The book was engaging as it fleshed out the nuances of mental illness and the striking friendship between Lopez and Nathaniel; however, the movie, while good, falls flat in some key aspects. For one, Lopez' character in the movie is divorced, so there's no angst over family man versus helpful man trying to get a guy off the streets. The movie itself seems a little frantic, to be expected I would imagine when condensing a 270 page novel into a 109 minute film.

There are some melodramatic scenes that are slightly overplayed, a prerequisite for Hollywood — in the beginning, Lopez is involved in a bike accident and rushed to the hospital, bloodied and dazed. And a brilliant scene in the book describes Nathaniel verbally flogging Lopez after he feels that Lopez betrayed him. In the movie, the verbal abuse changes to a physical beat down delivered by Nathaniel, and I'm not quite sure that the melodrama couldn't have been re-captured had they simply replicated the scene from the book. To read Nathaniel's verbal tirade, was quite intense. The scene where Nathaniel "sees" the music he hears at the Disney Concert Hall is a little too reminiscent of a "Fantasia" sequence, but then again, how else could the movie show the audience Nathaniel's oneness with the music?

Director Joe Wright is to be applauded for showing real life inhabitants of Skid Row in the movie. This gives the audience an authenticity that couldn't have been captured by the best of actors. In the end, even if viewers haven't read the book, they get the sense that everyone has a story to tell. Robert Downey Jr. and Jamie Foxx turn in stellar performances and are able to skillfully channel the personalities described in Lopez's book. If the movie raises the level of awareness of mental illness and homelessness in this country, then it has more than achieved its purpose.

IT STOPS WITH ME

Sophie (real name withheld at her request), a 23-year-old mother of three, grew up as a ward of the Department of Child and Family Services. She was entangled in an abusive relationship and had been shot by her abuser. After Sophie was evicted from an apartment she was struggling to live on her own, her children became DCFS wards. For Sophie, a horrific cycle was repeating itself, and she was determined to stop it. She found her way to the **Chestnut Health Systems housing program in Granite City, Illinois**. She had been diagnosed with anxiety and depression, and she was also using drugs. "Physically, you can do anything. But if you're not there mentally, you can't even begin to make the effort to change your life," Sophie explains. Having a home of her own meant that Sophie could get her life in focus. "The greatest thing about the housing program is the level of support we get from the case managers," Sophie says.

JoEllyn Patterson, director of Adult CD Services, comments that Sophie was pregnant when she was brought into the housing program. Months later, she gave birth to a drug-free son. "Because of that, Sophie was able to keep him with her. And then, she worked hard to get her two older children back," JoEllyn explains. "That's a testament to Sophie pursuing the housing program and a stable environment for her children. You can see it in all of her children...and in the smile of her beautiful baby boy."

"The greatest thing about my life now," says Sophie, her voice breaking with emotion, "is that every day when I wake up, I'm greeted by my kids. I have this amazing purpose in my life. I look forward to each day. It's hard to do that when you have no idea where you're going to sleep." For Sophie, having a home means being with her children and making them donuts and pancakes. "And enjoying my recovery time," she says. "The more effort I put in, the more successful I am. I consider myself lucky to have survived. I'm happier now, my kids are happy. We're safe."

Sophie pauses. "Not just safe...We're comfortable."



Effective Risk Management in Supported Housing

Michael Blady, LCSW-R, Associate Executive Vice President, and Elizabeth Cleek, PsyD, Vice President of the Program Design, Evaluation, and Systems Implementation Department — Institute for Community Living, Inc.

Every agency director's worst nightmare: a suicide attempt or violent action by a consumer. And even more troubling is the nagging possibility that the incident could have been anticipated and avoided. If their clinical information had been more complete, if their assessment had been more thorough, if the intervention plan had been more targeted toward increasing consumers' awareness of their issues and self-management techniques, if staff had intervened earlier or more effectively... the action might not have occurred.

The Institute for Community Living is a behavioral healthcare network based in New York City, was founded in 1986 as a residential provider for people with severe mental illness. ICL offers a coordinated and integrated array of special needs housing, mental health and medical treatment, rehabilitation, outreach, and support services to more than 8,000 people with mental disorders and intellectual disabilities annually. The agency operates more than 1,300 supportive housing placement options, distributed among over 55 discrete programs, for people with serious mental illnesses. These housing programs include every major program type and serve a broad variety of target populations, including people with co-occurring substance abuse and chronic medical conditions and the homeless, single parents, and veterans.

More than 4 years ago, ICL established a risk management system to provide staff with additional tools and strategies for coordinated assessment and intervention for clinical risk. The purpose of this system is to facilitate communication, supports, and a culture of mutual responsibility and cohesion that emphasizes integrated care and preventive case management interventions. The system comprises four essential elements and a focus on staff empowerment.

1. At the Front Door

The first component of ICL's risk management system focuses on the "front door" of the agency's residential system, the admissions process. The Special Admissions Review Committee was developed to review referrals of consumers who have a documented history of violence and endangering behavior toward



ICL's risk management system facilitates communication, supports, and a culture of mutual responsibility and cohesion that emphasizes integrated care and preventive case management interventions. An agency-wide culture of learning and support has provided more opportunities for residential line staff to share challenges and get usable tools.

others. SARC is composed of senior-level agency staff with a strong clinical background who review candidates for admission to residential programs at the request of program directors who have questions about their program's ability to safely manage the consumer in the community. Through this process, many clients with a history of hospitalization, incarceration, and institutionalization have successfully transitioned to community living. SARC helps service providers conceptualize the type of support and treatment needed to help a client safely manage life in the community. It also helps to determine

whether those interventions are feasible in the setting and, if so, whether they will be delivered by ICL, through linkage and referral to other agencies, or with targeted consultation and support.

2. Scattered-site Supported Housing

The second component of the risk management system was developed in response to the agency's recognition that scattered-site supported housing, with its reduced level of staff oversight, represents an area of risk greater than the agency's congregate housing, with its 24-hour on-site staff presence. ICL formed a supported housing task force



to identify and develop tools and training that would better facilitate staff identification and intervention in high-risk situations. The group developed two assessment instruments for administration on a monthly basis: the Clinical Risk Assessment and the Apartment Maintenance Checklist. The former focuses largely on clients' risk of self-harm. The latter has two purposes. The first is to identify consumers' problems with activities of daily living and help them learn the skills and habits of maintaining an apartment. The second is to sensitize and alert staff to the fact that changes in a consumer's management of his or her environment are often an early warning sign of relapse.

3. Clinical Risk Consultation Team

A third component of ICL's clinical risk management system is the clinical risk consultation team. The CRCT provides clinical consultation to staff by request on difficult and complex but nonurgent situations—that is, situations that do not need immediate or emergency action to prevent harm. The CRCT is chaired by an experienced senior clinician, who reviews a referral form along with the most recent psychiatric evaluation, psychosocial summary, current service plan, and any other relevant documents. Within two business days of receipt of a referral, the CRCT chair responds to the program with treatment recommendations.

One of the possible recommendations is for all the staff involved in the consumer's care to convene, including the consumer and involved family and staff from other agencies. Such a meeting occurs within ten days of receipt of the original referral to CRCT. Minutes of this conference are kept and incorporated into the client's chart, and the recommendations are integrated into his or her service plan, which is reviewed on a quarterly basis with the client and the worker's supervisor. Follow-up with the CRCT chair ensures that the interventions have been effective or remain productively in place. Additional consultation is sought and provided as needed.

4. Sentinel Review

The final component of ICL's clinical risk management system is the sentinel review. Despite everyone's best efforts and attention, violent and self-injurious incidents occur from time to time. The sentinel review process is a specialized case conference held after an incident to determine what we can learn from the situation and to apply it in a proactive manner in the future. The sentinel review process is part of ICL's in-

cident review and quality assurance process. Sentinel reviews are cochaired by the chief program officer and the senior vice president for quality assurance.

STAFF EMPOWERMENT

At ICL, an agency-wide culture of learning and support has provided more opportunities for staff to raise concerns and share challenges they are facing. A renewed focus on clinical risk assessment and intervention came in part from residential line staff, who voiced concerns that they did not have the tools to safely work with the consumers being admitted into our programs, who were increasingly coming from forensic settings, long-term homelessness, and psychiatric hospitalization and often had a history of endangering behaviors toward themselves and others. In residential settings, the bulk of the direct work is done by case managers, who generally have a bachelor's or associate degree and varied levels of experience. Staff with graduate or more advanced degrees are typically in supervisory positions. This structure creates a need to put easily usable tools in the hands of line staff and provide their supervisors with clear guidelines, distinct procedures, and access to specialized consultation services provided by senior clinicians.

Two senior staff—the vice president of program design, evaluation, and systems implementation and the chief program officer—were given the responsibility of developing an agency-wide system for risk assessment. They convened a workgroup that represented each functional component of the agency's operations—residential services, clinics, outreach, and community support programs. Subcommittees were formed to identify available risk assessment instruments or develop new ones, formulate policy and procedure for the various areas of operation, and assess the training needs of the staff in each of these areas.

The common goal of all these groups was to develop systems that assist staff in collecting the pertinent data, help them convert the data to clinically relevant information regarding factors that indicate the potential for risky behavior, and then offer staff the support and skills to work with consumers to identify their triggers and to intervene early and effectively, either with the services available within the program or through outside services (e.g., urgent clinic treatment visits, mobile crisis teams, and inpatient hospital services), to prevent the behavior.

Each workgroup created both an initial and a continuous clinical assessment process for its functional area. This process began with a revision of the assessments already in use to include questions that elicited more detailed information about the circumstances (stressors, patterns, targets, access to weapons) surrounding previous instances of self-harm and violence toward others as well as information on current risk factors. The results were used to assign a risk level for each consumer—low, medium, or high.

The assignment of a risk level is an important component of the supervisory and case review process. Consumers who present the highest risk are discussed at every supervision meeting and are on a "high risk" list that is maintained by the program director. Consumers who are assessed to be at lower risk levels are continually monitored for any changes in behaviors, and cases are reviewed at least quarterly.

As part of the residential risk management program, ICL also has reinforced the linkages among its many residential and clinic programs that provide expedited access to clinic resources. Residential program directors concerned about a consumer can, during clinic operating hours, secure an urgent assessment appointment even for people who are not clients of that clinic. The purpose is to prevent unnecessary emergency room visits.

ICL's clinical risk management system continues to be an evolving process. In an agency with as many functional program areas as ICL has, the challenge of designing program-specific forms, policies and procedures, and training and then evaluating their utility is ongoing.

Michael Blady oversees the Institute for Community Living's outpatient and residential mental health and health programs for adults, children and families, persons with HIV/AIDS, and adults with intellectual disabilities. He has worked in clinic, day treatment, and residential settings with adults and children and has specialized in working with adults with co-occurring mental illness and substance abuse disorders.

Elizabeth N. Cleek, Psy.D., is the Vice President of the Program Design, Evaluation, & Systems Implementation Department at the Institute for Community Living, Inc. The PDESI department is ICL's commitment to providing evidence-based, outcomes driven, and best practice programming throughout its comprehensive network of residential, outpatient, and community support services. Dr. Cleek has participated in numerous residential program development initiatives serving individuals with histories of homelessness, serious mental illness, and often, co-morbid health and/or substance use histories.

Oxford Houses Reduce Substance Abuse and Increase Employment

Leonard A. Jason, PhD, Director, Center for Community Research and Julia DiGangi, MA, MS, Clinical-Community Doctoral Student – DePaul University

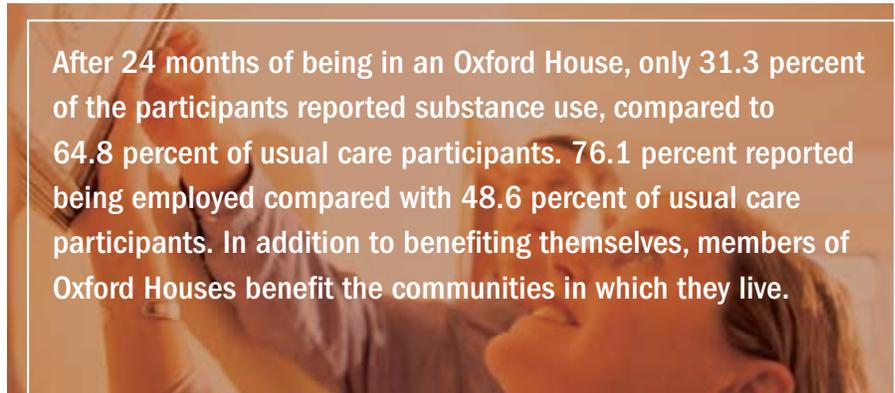
In addition to benefiting themselves, members of Oxford Houses benefit the communities in which they live. For people suffering from addiction, the road to recovery is paved with grave challenges. Many such people, in their quest for treatment, end up warehoused in psychiatric hospitals, prisons, nursing homes, or other institutions, where their needs are neglected and their rights denied. Too frequently, our healthcare system prematurely discharges people into communities where they have few prospects for stable housing or employment and little encouragement to succeed. A more sustainable solution for providing long-term support in an economically feasible way involves the use of community-based support programs. These programs provide the most potent and least expensive treatment for addictions.

Although a variety of community-based treatment options exist, this article focuses specifically on the Oxford House model. OHs are self-governed rental residences for people recovering from alcohol and drug addictions. They are single-sex dwellings with approximately 7 to 12 residents in each house. Although the houses are entirely self-governed, residents of all houses must follow three rules

1. Pay rent and contribute to the maintenance of the home.
2. Abstain from using alcohol and other drugs.
3. Avoid disruptive behavior.

Today, more than 1,300 OHs house in excess of 10,000 people in the United States. OHs are also beginning to open in other countries, such as Canada and Australia. They are located in multiethnic communities with access to public transportation and employment opportunities. Unlike other after-care residential programs, OHs have no prescribed length of stay for residents.

The OH story began in the mid-1970s with a single rented residence in Maryland. In 1992, Lenny Jason, a professor at DePaul University, watched an interview with Paul Molloy, the founder of OH, on CBS' "60 Minutes." Intrigued by the description of OH,



After 24 months of being in an Oxford House, only 31.3 percent of the participants reported substance use, compared to 64.8 percent of usual care participants. 76.1 percent reported being employed compared with 48.6 percent of usual care participants. In addition to benefiting themselves, members of Oxford Houses benefit the communities in which they live.

he contacted Molloy; out of that initial conversation grew a long-term collaborative partnership between DePaul University and OH.

Since 1992, DePaul University has secured funding from the National Institutes of Health for several studies on OH. In early 2000, the National Institute on Alcohol Abuse and Alcoholism provided support for DePaul researchers to recruit 150 people who had completed treatment at alcohol and drug abuse facilities in the Chicago metropolitan area. Half the participants were randomly assigned to live in an OH, whereas the other half received community-based aftercare services (i.e., usual care).

The findings of this study suggest many positive outcomes associated with placement in an OH. In terms of substance use, 31.3 percent of the participants assigned to the OH reported substance use at 24 months, compared to 64.8 percent of usual care participants. Likewise, OH residents demonstrated impressive gains in employment: 76.1 percent reported being employed at the 24-month assessment compared with 48.6 percent of usual care participants.

In addition to benefiting themselves, members of OHs benefit the communities in which they live. Another DePaul study found that OH members reported 10.6 hours of community service per month (Jason, Schober, & Olson, 2008). The majority of these service hours were related to recovery efforts. Sixty-three percent of study participants were involved in mentoring others in recovery, and 44 percent

were involved in administering and running support groups. Involvement with recovery also included participation in larger community initiatives. For example, 39 percent of participants reported advising local agencies or leaders, and 32 percent reported involvement in community antidrug campaigns. Other participants had spoken at political events (16 percent) and attended community meetings (30 percent) and public hearings and forums (21 percent). These findings indicate that OH residents not only work on their own recovery but also strive to make positive changes in their communities.

To continue building on the practical and empirical success of OHs, we are implementing three additional studies. In one, funded by NIDA, ex-offenders are being randomly assigned to professionally led therapeutic communities, OHs, or usual care post-release settings. We are examining program effects (i.e., substance use, criminal, and health outcomes) and economic factors associated with these models. The aims of this project are important from a public health perspective, because health providers may be able to manipulate treatment matching, case management, and financing factors to enhance the cost-effectiveness of community-based substance abuse treatment for offenders leaving prison.

In the second study, funded by the National Center on Minority Health and Health Disparities, women being released from jail are being assigned to an OH or usual aftercare. In this study, a community advisory board will link with a network of existing



coalitions in Chicago. The board will further effect community-based changes for formerly incarcerated women by integrating and supporting service networks from which these women historically have been isolated. The community advisory board is involved in all aspects of this project, which will lead to more efficient translation of the research findings into practice.

Finally, with new funding from NIAAA, we are in the process of evaluating culture-specific OHs for Spanish-speaking substance abusers. We are comparing the outcomes of Hispanic and Latino participants assigned to culturally modified OHs with the outcomes of those assigned to a traditional OH. Culturally modified OHs may be a more effective option for Hispanic and Latino people who are Spanish dominant, are less

comfortable with U.S. culture, or identify more strongly with their ethnic culture. In addition, residents of culturally modified OHs are more likely to use culturally congruent communication styles, characterized by an emphasis on relationships and minimization of direct conflict in relationships to preserve harmony, and respect.

With these three studies, we will continue to collaborate with our OH partners and to explore the many complicated issues involved in transitioning people back into healthy community living. A recent book, *Rescued Lives* (Jason, Olson, & Foli, 2008), chronicles the stories of people living in these innovative settings. It describes how OHs started, how they have grown, and how they have transformed lives. The authors of this book are fortunate to be the primary

social science researchers involved in studying this innovation for the past 15 years.

Dr. Leonard A. Jason has published numerous books and articles on recovery homes for the prevention of alcohol, tobacco, and drug abuse; preventive school-based interventions; media interventions; chronic fatigue syndrome; and program evaluation. He has served on review committees of the National Institute of Drug Abuse and the National Institute of Mental Health. He is a former president of the Division of Community Psychology of the American Psychological Association.

Julia DiGangi has been involved, for more than a decade, in community organizing and advocacy. She has developed and managed numerous prevention and education programs in the United States and abroad. Julia holds a masters degree in foreign service from Georgetown University and a masters in clinical-community psychology from DePaul University.

Housing for Homeless Veterans

Dennis Upper, PhD, Vice President of Clinical Strategic Initiatives and Matthew Idzik, Housing Services Coordinator – New England Center for Homeless Veterans

As a result of years of being homeless and of having alcohol, drug, or mental health disorders, many homeless men and women have long-standing deficits in their performance of even the most basic societal roles. They typically are isolated, chronically unemployed, in poor physical health, lack the skills to live independently, and have a marginal quality of life. They also are likely to be the victims of crime. Homeless veterans with addiction and mental health disorders tend to have difficulty with interpersonal relationships and with achieving and maintaining competitive employment and housing. In short, they lack the basic survival skills necessary for coping in society.

Given these impairments and consequent disabilities, homeless people need therapeutic and skills-training programs to give them the physical, emotional, social, and intellectual resources they need to live in the community with the least amount of support from members of the helping professions. One program that is addressing these needs is the New England Center for Homeless Veterans, in Boston, Massachusetts.

Founded in 1989 as the Vietnam Veterans Workshop, Inc., the organization is now one of the nation's lead-

ing advocates and providers of shelter, programs, and services for homeless veterans. Our mission is to extend a helping hand to homeless men and women who have served the United States honorably in peace and war; who are faced with the challenges of addiction, trauma, severe and persistent mental illness, or unemployment; and who will commit themselves to sobriety, nonviolence, and working for personal change.

NECHV provides beds and meals for up to 306 homeless veterans (including up to 20 women) on any given night. The population is generally 97 percent male and 3 percent female. Last year, 84 percent of the 1,005 clients served had a diagnosed substance abuse history, 54 percent were chronically mentally ill, and 40 percent were physically disabled; many clients had multiple diagnoses. Vietnam-era veterans composed 40 percent of the population, 15 percent had a service-connected disability, and 94 percent listed an "extremely low" income.

Over the past 20 years, NECHV has developed a comprehensive continuum of care that strives to transition homeless veterans from emergency shelter to supportive housing to independent living. To help clients

achieve self-sufficiency, NECHV provides a wide spectrum of therapeutic services designed to address their unique needs. This programming includes one-on-one case management; specialized mental health counseling for dually diagnosed clients and for veterans with posttraumatic stress disorder; job and life-skills training; addictions counseling and support groups; Veterans Administration benefits assessment; legal assistance; financial planning; permanent housing placement; an on-site health center; and a Veterans Training School that provides life-skills, preemployment, and employment training.

Among the NECHV programs specifically geared to prepare homeless veterans for independent living and to aid their transition to community-based residences are the model apartment, single-room-occupancy units, the Rental Assistance Program, and other supportive programs.

MODEL APARTMENT

NECHV recently converted 1,040 square feet of unused space on site into a two-bedroom, four-person model apartment, where clients preparing for the transition into supportive or permanent housing can

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Continued from page 21

be trained in the adaptive living skills they need to function in the community and with one another.

Appropriate clients are selected by their clinicians and case managers and move as a group of four into the model apartment for a 3-month period of life-skills training. Then they move (either individually or as a cohort) into an apartment in the community, where they can continue to help and support one another, with the assistance of the shelter's housing placement and stabilization specialist. The life-skills curriculum, taught by instructors from our on-site Veterans Training School, includes education in money management and budgeting, basic cooking, house cleaning, and laundry as well as navigating public transportation, and other basic competencies required for independent living. Four groups of homeless clients per year are expected to move from the model apartment into the community.

SINGLE ROOM OCCUPANCY UNITS

For some NECHV clients, the move to the community is no longer than an elevator ride. In 1997, we rehabilitated four floors of our 10-story building to create 59 single room occupancy units. Many SRO residents have benefited from this proximity to follow-up case management, support groups, and job- and life-skills training. The fact that housekeeping services are provided makes the SROs attractive to clients, and for some formerly homeless veterans, the communal living provides important social support. For this reason, many NECHV clients also transition to two nearby veterans' SRO communities: the Chelsea Soldiers' Home and the Bedford Veterans Quarters. Both of these programs provide supportive case management and services to their residents.

RENTAL ASSISTANCE

Not all clients are attracted to congregate living, however, and supportive services for these veterans are tailored accordingly. NECHV's housing services coordinator helps clients obtain public housing, project-based subsidies, tenant-based vouchers, and market-rate units. Eligible clients may receive a one-time grant of up to \$2,000 through the NECHV's Rental Assistance Program to help with rent and security deposits. NECHV staff refer and accompany transitioning clients to local furniture banks as needed to ensure that they move into

adequately furnished apartments with sufficient household goods. Telephone outreach is made to all permanently housed former clients, and clients who seek additional support may participate in one or more of NECHV's other programs.

OTHER PROGRAMS

NECHV's Bridges Program provides intensive case management to chronically mentally ill clients to support their transition to the community. The multidisciplinary Bridges team begins providing support 3 months before the client transitions from the Center, using a critical-time intervention model. Case workers work closely with clients during the first year in the community, identifying and building relationships with community supports. During the second year, client support is gradually shifted from the Bridges team to these community resources.

For clients who desire long-term support, the NECHV administers 51 tenant-based vouchers through the U.S. Department of Housing and Urban Development's Shelter Plus Care program, which provides lifetime supportive case management to clients with qualifying mental illness or substance abuse diagnoses. Recently, many clients have benefited from the expanded Veterans Affairs Supportive Housing program, which offers participants strong case management along with a tenant-based voucher.

PREPARING FOR THE FUTURE

NECHV recognizes that the development and expansion of supportive housing and stabilization programs are critical as the nation's approach to homelessness evolves and changes. Housing First and rapid rehousing initiatives are shortening and even eliminating many shelter stays. It is important, however, that these programs do not inadvertently deny or distance veterans from the therapeutic services that are essential for their personal growth. NECHV, with its "veterans helping veterans" model, has a proven track record of success in helping homeless and at-risk veterans find employment and housing, identify and treat their physical and mental illnesses, and overcome their varied addictions. Our helping hand and commitment to improving the lives of veterans will not change in light of these housing initiatives; we may have to modify programming or stretch our arm a little farther into the community, but we will continue our mission and leave no veteran behind.



The New England Center for Homeless Veterans has developed a comprehensive continuum of care that strives to transition homeless veterans from emergency shelter to supportive housing to independent living. To help clients achieve self-sufficiency, NECHV provides a wide spectrum of therapeutic services including one-on-one case management, specialized mental health counseling, job and life-skills training, addictions counseling and support groups, and employment training.

Dennis Upper is a clinical psychologist who received a BA degree in English from Yale University and a PhD degree in clinical psychology from Case Western Reserve University. His professional career has included clinical/ administrative positions at the Brockton V.A. Medical Center, Lahey Clinic Medical Center, and May Behavioral Health/McLean Hospital, as well as adjunct teaching positions at Harvard and Northeastern Universities and the Harvard Medical School.

Matthew Idzik, has experience working with chronically mentally ill veterans in a supportive residence. A combat veteran of the first Gulf War, he works to find appropriate permanent housing for all clients, and he is committed to helping homeless veterans achieve personal growth.

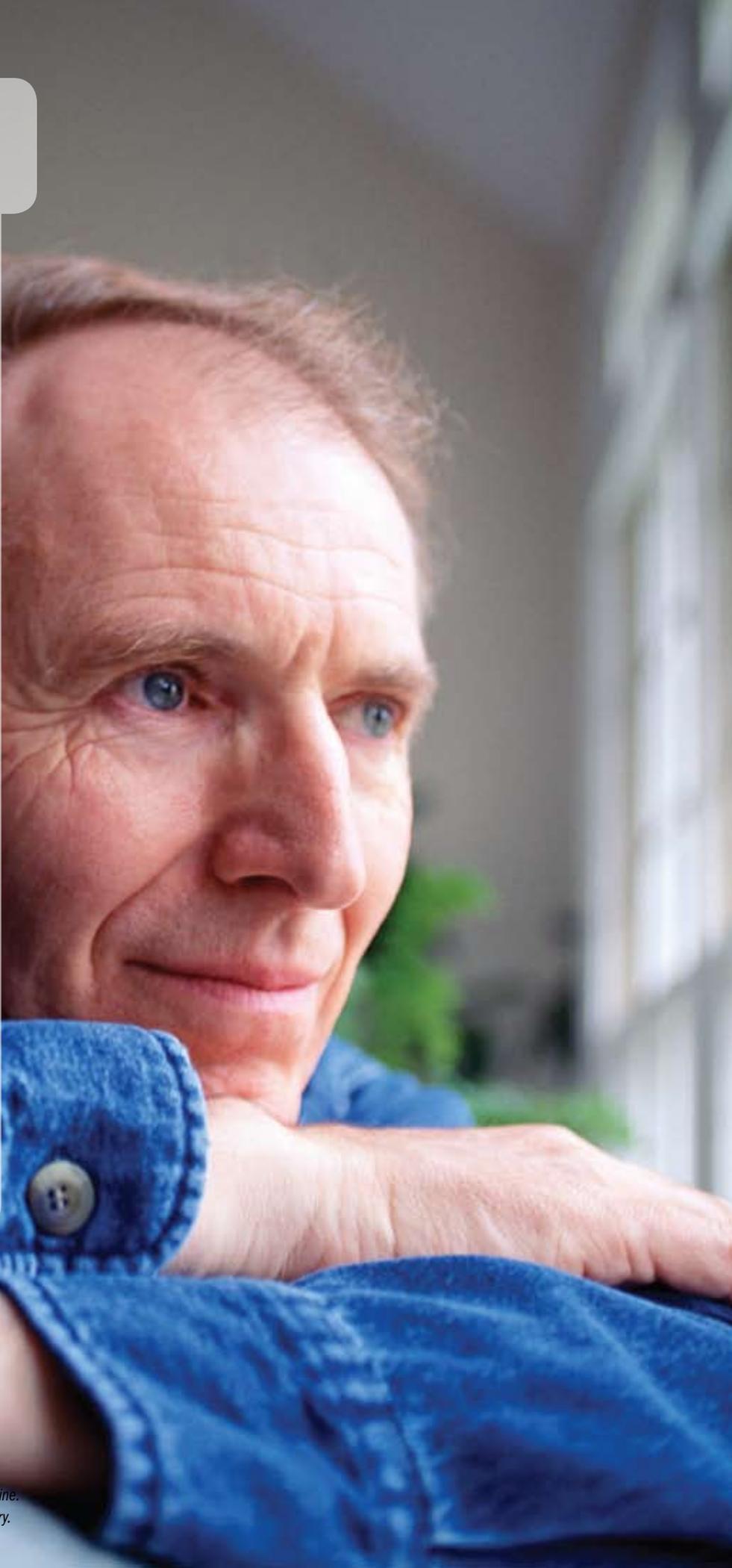
A HOME SWEET HOME, ONCE AGAIN

Carl Smith was working full time—and then the unimaginable happened. He lost his job, his savings, and his home. Faced with few alternatives, Carl made his way to a homeless shelter in Hyannis. He needed healthcare for his injured back. “And I needed a real place to live to get healthcare,” he says. Carl eventually found the **Duffy Health Center in Hyannis, Massachusetts**.

Once Carl was placed in a sober living environment, he was able to get healthcare and Social Security benefits; he had been eligible for the latter all along, but because of his homelessness, he was unaware that he qualified. “Duffy helped provide medical care along with housing and counseling, things I could never afford on my own,” says Carl.

Today, Carl lives in a nice rental home. “I don’t have to worry about where my next meal is coming from or looking for a warm place to sleep. Being homeless complicates everything,” Carl explains. A recovering alcoholic, Carl says lots of people on the streets use drugs and alcohol and that being homeless while trying to stay in recovery is impossible. “You take the first chance you can to escape reality,” he laments. “Being homeless and hungry is a very lonely place.”

Carl says that guidance and help from someone else are critical for a person with few options. He credits the Duffy staff for doing all they can to help him. “They’re wonderful people,” he says. Having his own place again got him back into the real world. “I truly appreciate the fact that I’m warm and that I have food in the house,” he says. “I have choices now, whereas my choices before were slim to none.” He realizes that life won’t always be “peachy and rosy” and that homelessness can happen to anyone. Carl’s ultimate goals are to stay safe, happy, and self-sufficient. With stable housing, he’s already on his way.



National Council member organizations-mental health and addictions services providers in communities across the country-share successes and challenges in providing housing for persons they serve.

Allegheny's Housing Support Team Takes an Individualized Approach

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Kelly Primus, MS, Director of Quality Improvement and Evaluation, Emily Heberlein, MA, Manager of Evaluation and Outcomes, and Rachel Carey, MS, Quality Analyst – Allegheny HealthChoices, Inc., Pittsburgh, PA / KPrimus@ahci.org

In 2006, the Allegheny County Department of Human Services' Office of Behavioral Health partnered with the nonprofit provider Transitional Services, Inc., to launch its Permanent Supportive Housing program. The program was developed with the help of the Technical Assistance Collaborative.

The PSH program helps people with serious mental illness living in county-funded residential programs and state institutions find, get, and keep permanent, affordable housing in the community. This scattered-site, low-density program mirrors the Section 8 program and provides bridge rental subsidies until persons can access vouchers. The PSH program also offers a housing support team that works with people on defining housing preferences, conducting a housing search, negotiating a lease, moving, maintaining residency, and connecting to other services and supports.

Although clinical service use is not required for residents to maintain housing, services such as assertive community treatment teams and case management are readily available when and where people need them. Funding for the program comes from Medicaid reinvestment dollars.

Since 2006, the PSH program has helped 170 people (71 percent of those accepted to the program) find an apartment that meets their criteria and budget. Because the housing support team takes an individu-

alized approach to each apartment search, the process takes an average of 4.5 months. One of the keys to the program's success has been the relationships staff have built with community landlords, which have helped them overcome the initial reluctance of some to participate in the Section 8 program.

As of April 1, 2009, people have been in their housing 11 months on average, and 50 people have maintained their housing for more than 1 year so far. During this time, only four people have been evicted—two found other apartments and continued with the program, one preferred to be discharged, and one chose to move to a more structured setting.

The first three months are especially critical as people transition to apartment living from more structured settings. Just 9 percent were hospitalized during their first three months in housing; in comparison, 66 percent of participants had been hospitalized during the two years before moving into their apartment. These preliminary results indicate that far fewer people have needed intensive hospital-based treatment services while living in their own apartments and receiving community-based services.

Another critical indicator of the PSH program's success is that people are accessing the treatment and rehabilitation services they need. While in PSH, a majority of participants have accessed a combination of outpatient mental health services (63 percent) and

case management (75 percent). Nearly one-third have an ACT team. Contacts with the ACT are usually frequent (a median of four contacts per week), and contacts with case managers occur regularly (a median of one contact per week).

The PSH program is proving to be a cost-effective alternative to residential programs. With an average cost of \$1,764 per person per month for rental subsidies, housing support team services, and behavioral health treatment, PSH costs significantly less than other residential and inpatient care options, which range in monthly costs from \$4,000 to \$15,000.

Just as important as the preliminary outcomes of the program are stories from the people who have benefited from the program. Renee S., who has been renting since August 2007, summarizes her situation well: "What I like is the quietness, the environment; it's safe, and I feel very comfortable." Having an apartment with supports can be the best of both worlds. According to Lorraine N., who has been renting since December 2008, "Having my own apartment makes me feel a part of the community...It's a footloose and fancy-free feeling. But I don't feel like I was left alone."





AVITA's Services Come Out of the Clinic to the Community

Michelle Thompson, Residential Services Supervisor, Supported Housing Program, AVITA Community Partners, Gainesville, GA
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AVITA Community Partners' Supported Housing Program was developed to provide safe, stable, affordable housing options for people with mental illness, addictive diseases, and developmental disabilities in the 13 North Georgia counties served. The program addresses the growing homeless population and promotes independence, stability, and happiness.

AVITA started the Supported Housing Program in the 1990s with seven units in a self-contained building. We realized the need for tenants' further integration into the community and began looking for alternative sites to increase opportunities for expansion and community inclusion. This task proved to be a challenge, because many apartment complex managers were unsure about the population such a program would bring into their community. Through education and outreach, we have gained increased support in the community and have developed successful partnerships with two apartment complexes in Gainesville, Georgia: The Pines of Lanier and Towne Creek. Without these partnerships, successful integration for people served in a real community setting would be difficult.

U.S. Department of Housing and Urban Development grant funding awarded in 2004 allowed for implementation of an additional 18 Shelter Plus Care units and

funding to serve 36 homeless people in Hall County, Georgia. The units are scattered within the complexes, so residents' opportunities to build natural supports in their community are increased. The scattered units promote residential and emotional stability, community involvement, and greater independence. All units are located directly on the public transportation bus lines, so residents have easy access to community resources.

Staffing for the supportive housing program consists of one director, three masters-level clinicians, two bachelors-level clinical staff, and one administrative employee. The program is staffed at least 8 hours per day, 7 days a week, and is funded through state contract dollars as well as the federal grant funding.

Community-based services are in place to promote development of daily living skills, symptom recognition and management, coping skills, medication management, financial management, and socialization skills. Individual and group therapy and training are available to the residents on site. All residents also have access to the full array of services offered in the traditional clinic setting.

With stable housing and community-based support, we have seen decreased hospitalizations; increased functioning and stability; successful transitions from more

restrictive living environments, such as group homes or long-term stays in institutions; and many formerly homeless people provided with a home. A sense of community has developed, peer interactions have increased, and natural supports have been created.

Several residents have gained and maintained employment and bought cars. One resident was even able to purchase her own home with family support. Many others have moved on to more independent living and have an apartment of their own with a lease and utilities in their name. The pride that they have when inviting people into their home is evident in the smile on their face and the new confidence that surrounds them.

A huge part of the success that AVITA's Supported Housing Program has experienced can be attributed to its efforts to bring the services out of the clinic and into the community. On-site services increase the agency's opportunities to engage residents; this structure has led to greater participation, allowed treatment goals to be achieved, and stability to be gained and maintained.

Even with the current economic setbacks, we anticipate continued growth and success in our program through enhanced support services and through our application for an expansion of grant funding to supplement state contract dollars.

Bayview Finds Consumer-Provider Collaboration Critical in Supported Housing

Ted Miller, LCSW-C, Manager and Nicole DeChirico, LGSW, Clinical Supervisor — Johns Hopkins Bayview Medical Center, Adult Psychiatric Rehabilitation Program, Baltimore, MD / TEMiller@jhmi.edu

The Adult Psychiatric Rehabilitation Program, a component of the Johns Hopkins Bayview Medical Center's Community Psychiatry Program in Baltimore, Maryland, has a Supported Housing Program that has been highly successful in helping consumers achieve their housing goals. People who want to acquire and maintain their own home receive assistance from rehabilitation staff in developing and implementing an individualized rehabilitation plan. The plan includes a wellness component and the steps needed to remove any barriers that prevent the client from obtaining his or her desired living arrangement.

The outcome data over the past 5 years reveal that people who have acquired their desired living arrangement successfully maintain their home. From July 1, 2004, to June 30, 2009, 53 clients of Adult PRP moved from a higher level of care to an independent living arrange-

ment. Ninety-six percent of those clients successfully maintained their home, and 57 percent are employed.

Interventions for success are

- >> Consumers select their desired living arrangement with help from staff.
- >> Consumers access independent living skills training. ILS groups are offered as part of the clinical day schedule. Consumers select groups on the basis of their needs and desired outcomes. Staff provide any necessary ILS assistance in the home.
- >> Consumers' stay on budget and staff help them obtain any additional financial assistance through local agencies and government. Staff also help the consumers complete applications for resources and entitlements, such as Section 8, Public Housing, food stamps, and medical assistance.

>> Consumers establish community resources and support networks. Staff assist with introductions and resources to ensure that supports are established.

>> Supported employment services that incorporate evidence-based practice are available to consumers. Employed consumers are able to supplement their income and enhance their autonomy.

>> Staff develop partnerships with housing and apartment properties. These partnerships give the consumers access to housing, which they would otherwise be denied because of poor credit or a criminal background.

In today's economic environment, when resources are limited, collaboration between consumers and mental health providers is essential for development and maintenance of independent living.

BOTH's Outreach and Housing Support Counselors Keep Mentally Ill Off the Streets

Deborah Putnam, Director of Program Development, Hope Found, Boston, MA / DPutnam@hopefoundboston.org

Numerous studies over the past decade have demonstrated the Housing First model as an effective intervention for homeless people. Boston Outreach to Housing, a program of HopeFound in Boston, Massachusetts, engages street-dwelling men and women with addictions and co-occurring mental health disorders and helps them find and retain permanent housing, treatment, and ongoing community resources.

BOTH's model integrates homeless, substance abuse, mental health, and other care systems with housing resources to support tenancies. In 2009, BOTH will house 40 people, of whom 80 percent will retain housing for at least 1 year, 80 percent will achieve increased harm reduction behavior, 80 percent will demonstrate improved independent living skills, and 40 percent will find employment.

BOTH case management services are funded by the Massachusetts Department of Public Health's Bureau of Substance Abuse Services, and housing vouchers are provided by the city of Boston's McKinney Vento Continuum of Care and other sources.

Clients are recruited directly from the streets of downtown Boston or in HopeFound's emergency shelter by master's-level outreach counselors trained in harm reduction, motivational interviewing, case management, and behavioral health issues. Sobriety is not a requirement, although a commitment to finding and maintaining housing is. Outreach counselors also use assertive outreach, in which they target a geographic area and continually canvass it to build relationships with difficult-to-engage homeless people. A downtown office location with drop-in hours 5 days a week gives clients a place to receive mail, make phone calls, complete applications, or seek confidential support.

As case managers, outreach counselors act as bro-

kers to identify resources and match them with clients' needs, advocate on behalf of clients to ensure access to services, and coach clients to encourage or model skills and behaviors that will afford access to a resource or yield a positive outcome. Outreach counselors anticipate the natural course of addiction and mental illness, understand the options available to manage those disorders, and take appropriate action.

Although it is intense and often life changing, outreach is designed not as an ongoing service but as a link to stability. Thus, as clients move toward housing or treatment as a goal, outreach counselors begin to link them with long-term support. This process involves diligent "use of self" on the part of the outreach counselors, anticipatory guidance and coaching, and case conferencing with new providers as much as possible.

A housing search specialist maintains relationships with landlords to help identify openings in low-income housing as well as keep up-to-date listings of apartment vacancies, public housing openings, and other available housing options. The specialist also consults with the outreach counselors and client and helps the client with a housing search, including public and private housing applications, screenings, mitigation and appeals, assessment of available apartments, discussion of the client's corrections history, lease signing, and moving plans. When necessary, rental assistance funds provide the security deposit; first month's rent; and other up-front cash requirements, such as utility arrears, that may be a barrier to housing.

As housing is identified, outreach workers transition client care to one of two mobile housing support counselors who are trained in behavioral health and

who conduct home visits using a housing-based case management model. Similar to outreach counselors, housing support counselors broker agreements and advocate and coach tenants to maintain housing, pursue recovery, and find employment and community resources. Housing support counselors use a harm-reduction approach both as a relapse prevention strategy and to engage tenants in behavioral health treatment. Goal-driven outcomes are established and monitored regularly, and a self-sufficiency assessment tool measures clients' progress. Weekly clinical supervision is provided; caseloads are 1:12.

Housing support counselors maintain strong relationships with property owners and management companies to address tenancy issues and act as an early warning system to prevent homelessness. At the first sign of a lease violation, such as nonpayment of rent, counselors intervene proactively to prevent eviction and convene discussions with both the landlord and the tenant to develop an action plan. HopeFound's own continuum of care is a resource for this plan. For example, if tenancy is threatened by relapse, expedited admission can be made to HopeFound's addiction treatment programs, where spots are reserved for clients in BOTH. Rental assistance funds can be accessed to pay rent while the tenant is in treatment. If tenancy is threatened by loss of income, referral can be made to HopeFound's IMPACT Employment Services.

Alternatively, the housing support counselors may conduct mediation between housemates to address common living issues. In all cases, the housing support counselors mobilize community resources to sustain housing and help their clients develop long-term self-sufficiency and recovery.

Chestnut's Housing Program Provides a Haven for Women and Children

Susan Taylor, Director of Adult Substance Abuse Services, Chestnut Health Systems, Inc., Granite City, IL / mailto:STaylor@chestnut.org

For the women and children in Chestnut Health Systems' Families in Safe Recovery housing program, recovery truly is a journey to a better life. A case manager explains it well: "When a woman finally real-

izes she can feel at home in our program—maybe for the first time in a long time—you can see her eyes light up. When I see that, I know we're really going to get somewhere together." Homeless women and their

minor children in the program live in 17 scattered-site supportive housing apartments in southwestern Illinois communities. Therapists provide wraparound treatment addressing co-occurring mental illness



and substance abuse, and case managers help families with parenting, homemaking, transportation, and all the other tasks associated with full community living. Women in the program typically have struggled with poverty, toxic relationships, and significant victimization throughout their life.

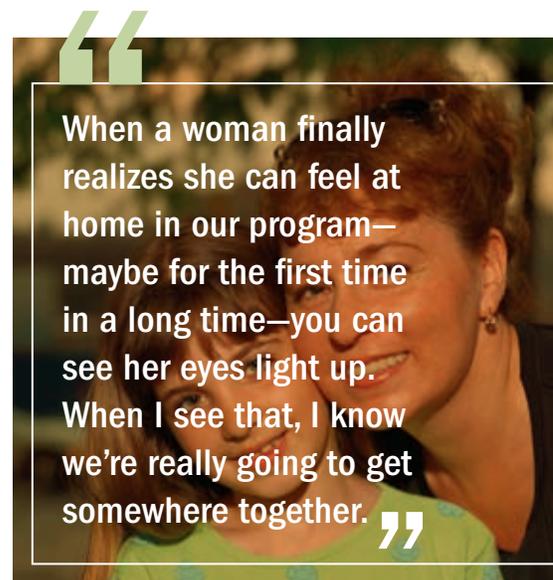
Families in Safe Recovery offers a first opportunity for a safe, stable, and inviting living environment where women and their children experience an atmosphere of healthy trust. Recovery begins with an emphasis on the need for safety, along with strong staff support for the often-unrecognized personal strengths that come from surviving a life of pain and chaos.

The program began with an investment by the Illinois Department of Children and Family Services in a transitional housing program for families in the child welfare system. When it was founded in 2001, the program was housed in an older public housing complex and offered four women and their children subsidized housing, group treatment, vocational education, and recovery support. By blending child welfare and treatment funding for behavioral health with vocational, child care, housing, and educational resources, our agency was able to open the first residential program of its kind in the area. With increased need for more housing, three more housing units were eventually added.

As we grew, it became clear that scattered-site apartments with wraparound support would provide the best

opportunity for achieving full integration into community life. In 2003, Chestnut Health Systems applied successfully through the local Continuum of Care for U.S. Department of Housing and Urban Development funding for supportive housing for homeless women with co-occurring behavioral disorders and their minor children. With this award, the agency added 10 permanent supportive housing units to the seven transitional housing units funded for mothers in the child welfare system. The housing case managers provide service and support to match families' intensity of need across both programs, and a child and adolescent therapist attends to the developmental needs of children affected by a family history of substance abuse and trauma. Now, all family housing is in scattered-site apartments, and children attend local schools wherever the family has significant ties.

In July 2008, with the help of energetic staff and community support, we were able to realize our dream of opening a family center. In a refurbished house in a local community, we have comfortable rooms for groups, staff offices, play areas for the children, and a kitchen for cooking and serving communal meals. The family center is a place for celebrations and special occasions as well as a setting for the work of recovery. We have a variety of ongoing groups: a Sober Kitchen group, where participants learn about cost-effective home cooking; Our Own Words, where women and children decide what programs and activities they will



undertake together; an art therapy group for children; Creative Hands, a group to help women learn to sew; and Everyday Matters, a health and wellness group that uses journaling and art to help women learn to tell their unique stories.

Whether they are celebrating a year of sobriety, getting a 3.5 grade point average at a local community college, obtaining employment, or giving birth to a drug-free baby, the women in our program—consumers as well as staff—do indeed have heartfelt accomplishments to celebrate.

CODAC Supports a Collaborative Approach for Community Integration

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CODAC Behavioral Health Services was one of the original federally funded drug abuse treatment administrative agencies and last year served 10,066 clients in its adult network and 8,770 in the children and family services system.

CODAC has long realized the importance of housing for people trying to achieve stability. The area's Regional Behavioral Health Authority, Community Partnership of Southern Arizona, has received Shelter Plus Care funding since 1992 and contracts with CODAC for supportive housing services. CPSA oversees public behavioral health services in southern Arizona. The collaborative effort with CODAC is part of CPSA's system-wide emphasis on housing, employment, peer support, and health and wellness as critical elements of its members' recovery.

CODAC has used this program to provide scattered-site rental assistance throughout the community. CODAC

members now reside in more than 90 tenant-based rental assistance apartments. CODAC has been successful in two Supportive Housing Program applications through the U.S. Department of Housing and Urban Development's homeless continuum of care process. SHP is also a scattered-site model and has a total of 50 units and intensive case management and support services.

Using targeted funds from the Arizona Department of Health Services' Division of Behavioral Health Services, in 2003 CODAC purchased a 16-unit apartment complex and, later, two duplexes. Additionally, CODAC administers a 12-unit complex for CPSA. This variety of housing options allows members to choose to live in CODAC-operated housing or in private rental units in Pima County. In all housing options, residents pay 30 percent of their gross adjusted income toward rent and utilities.

CODAC employs community support specialists to enhance the housing options and support residents. Specialists are available to the residents on the weekend and during evening hours in addition to during the standard work week. Some of the CSS staff are in recovery themselves, so they can relate to the members and help with sensitive issues, such as personal disclosure. The CSS staff are enthusiastic about the positive changes they have seen and the opportunities that housing with support services can offer. CSS staff members assist in interviewing and screening people for selection; conduct house meetings; and guide the residents in activities of daily living, including budgeting and grocery shopping. They teach a survival skills class, which includes housekeeping tips, and help residents navigate unfamiliar situations and difficult family dynamics. They may negotiate or intervene with

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landlords, role-play with residents to practice for job interviews, and make referrals for needed resources. A critical role they play is helping the residents set boundaries and determine appropriate socialization. Many residents have not lived as functional community members for a long time. One of the housing program's goals is to support people to become good neighbors and increase their civic engagement. CODAC also encourages residents to become competent

problem-solvers.

All the project residents met at least one goal of their Individual Service Plan in the past year. Sixty percent of the residents who attended the housing survival skills class resolved their issues satisfactorily and did not have any further problems with their lease or landlord. Three-quarters of SHP residents have resided in the same place since the start of the program.

Also, 90 percent of these residents now have an income. These measurable changes show that CODAC's SHP is helping residents lead a more sober, healthy, and stable life. Without supportive housing in behavioral health treatment, it would be a much greater challenge for CODAC's members to achieve sustainable success.

COMHAR Houses Persons With Mental Illness and AIDS Diagnoses

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Participants in the COMHAR AIDS Supporting Services and Housing program—consumers, professionals, and those whose identities span both categories—have a tacit understanding of the relationship between hope, empowerment, and a person's well-being. Housing is key—it resides at the most basic level in the hierarchy of needs, is indispensable for personal safety, and nurtures aspirations toward greater personal fulfillment.

COMHAR, Inc.—the parent agency of the CASSAH program—is a community-based health and human services organization in Philadelphia. The CASSAH program was founded in 1995, following COMHAR's reply to a request for proposals from the Philadelphia Office of Housing and Community Development regarding the use of Housing Opportunities for People With AIDS funding. The HOPWA program was created following a joint initiative of the Department of Housing and Urban Development and the Centers for Disease Control; its impetus was the realization that people with AIDS—people with a compromised immune system and, at one time, overwhelmingly complex medication regimens—do not have a fighting chance at maintaining their health without decent, stable, and affordable housing. Although as a base service unit, COMHAR's main target population consists of consumers of mental health services and people with intellectual disabilities, the agency saw

the opportunity to use HOPWA funding for members of its target population who also meet the HOPWA criteria.

A stipulation of CASSAH at its inception was that, in addition to housing assistance, the program would provide mental-health-oriented supportive services.

Mental health services are provided through CASSAH's partnership with its sister programs in COMHAR's Specialized Services array: the TRIAD partial hospitalization program, the Community Living Room psychosocial rehabilitation program, and the PACTS outpatient treatment program—all of which are geared toward providing services to people who have been dually diagnosed with mental health issues and HIV/AIDS. Partnership with other agencies is also invaluable, and our efforts are further strengthened by the medical and case management services provided at area agencies, such as Action AIDS, the Mazzoni Center, the Jonathan Lax Treatment Center, the Care Clinic at St. Joseph's Hospital, the Partnership Clinic at Hahnemann, and Calcutta House.

Having grown from an initial census of 12 units, the CASSAH program is currently funded to provide assistance to 70 households. Our participants are leaseholders, and the program currently works with 38 participating landlords in the Philadelphia area. Consumers are empowered to select their own land-

lords and to find their own apartments in the neighborhoods they choose. CASSAH staff provide routine visits to ensure that properties remain in compliance with quality standards and that the consumer's needs for support and for supportive services are being met.

Emphasizing recovery and self-determination, we strive to offer each client as much independence as he or she desires, and we endeavor to limit policies and parameters to those that make intuitive sense in light of the consumer's natural roles and obligations in life. Because every consumer in the CASSAH program is also a tenant and leaseholder involved in a binding contractual relationship with a third-party landlord, we ask that participants in CASSAH be responsible tenants with regard to the terms of their lease. Because every consumer in CASSAH is a member of society in a larger sense, we expect participants to be law abiding. Perhaps most important, because HOPWA funding was created to provide people with an opportunity to lead healthier lives, we ask that participants in CASSAH take care of themselves. All the policies specified in our brief, two-page member agreement can be traced to one or more of these basic premises. Although CASSAH does not always reach a consensus on what constitutes the best possible self-care, the program does not assume that staff members are infallible arbiters in this regard.

Community Bridges Fosters Collaboration for Truly Integrated Treatment

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Community Bridges is a collaboration of agencies, services, and personnel funded by a grant from the Substance Abuse and Mental Health Services Administration and administered by the Clare Foundation.

Our goal as we developed the grant was to house 300 of Santa Monica's most vulnerable citizens at the end of five years. We defined vulnerable citizens as people who are homeless and have a clinically established

mental health disorder and a substance abuse disorder. We knew that no single agency was equipped to address mental health disorders, substance abuse, and homelessness at once. We determined that

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THE ROSE THAT GREW FROM CONCRETE

Six years ago, **Allan Curtis** was homeless and heavily into crystal meth. The 25-year-old former college student and football player weighed only 115 lbs. Despite a tumultuous childhood spent mostly in the foster care system and battling schizoaffective disorder, attention-deficit/hyperactivity disorder, and posttraumatic stress disorder, Allan made it far enough to attend California Polytechnic State University. He excelled at sports and academics. His mental disorders, however, derailed his plans, and Allan wound up living in his car and in short-term residential treatment programs. When a spot opened up at Building Hope, the **Mental Health Association of Santa Barbara County's** new apartments, Allan got in. "Being in my own place has helped me with my drug addiction problems and with life in general," Allan says. He got his fresh start in the beautiful Santa Barbara setting, a community that resembles a spacious European retreat.

Allan wears baseball hats and jerseys all the time, and he looks younger than his years. "When I was homeless," he says, "my life wasn't worth living. I didn't have many friends. Now I know everyone in this building, everyone says hi to me." During his childhood as a ward of the court, Allan says, people were always telling him what to do. Now, he says, "I feel like an adult. Having my own place gives me a chance to slow down and enjoy life again." It's also a boost to Allan's self-esteem.

"The most compelling thing is his attitude about telling his story," says Annmarie Cameron, executive director of the Mental Health Association in Santa Barbara County. "Allan sees this as his opportunity to give something back, not just to the people here but to the whole mental health movement, and [to erode] the stigma."

Allan is heading back to school and thinking about giving journalism a whirl. "I'm a very good writer, and I think I have a lot of good things to say," he says, adding that he was inspired by a poem written by Tupac Shakur, "The Rose That Grew From Concrete."

"To grow and survive the concrete," Allan starts and then, after a contemplative pause, adds, "I've survived with nothing also. And life is good right now."



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homelessness was both a cause and an effect of the other problems and that this cause-effect relationship was ongoing and self-perpetuating. To work toward a common goal, the partner agencies would have to collaborate in treatment planning, case management, funding, philosophies, and resources.

Five organizations have joined in our collaboration – three are nonprofits, and two are government entities. The collaborating agencies have disorder-specific services – the Clare Foundation’s focus is substance abuse and recovery, Ocean Park Community Center addresses harm reduction, the Los Angeles County Mental Health Department is concerned with mental health, the Venice Family Clinic provides health and wellness care, and Integrated Substance Abuse Programs of UCLA is focused on mental health.

We chose to organize ourselves around dual disorders treatment, as described by Kenneth Minkoff. The integrated model stresses the importance of intervention that is based on the diagnosis of each disorder, phase of recovery or stage of change, and level of functioning of the person. This is a significant change for individual agency staff, because most have been trained in and are committed to the work of their par-

ticular agency, each of which has its own priorities.

Rather than focusing on a particular problem or disorder, Community Bridges focuses on the person and his or her specific constellation of needs and concerns. We have adapted the “no wrong door to treatment” approach, which is informed by evidence-based studies about access to services and clients’ readiness for change.

The Community Bridges client experiences a seamless transition among and coordination of services, as a result of the determined cooperation of the staffs of the partner agencies. The staff of Community Bridges meet weekly to coordinate care. They bring to these meetings the expertise and experience of their respective agencies. Each week, they arrange for services and offer suggestions, solutions, and support. In addition, they engage in an ongoing discussion of harm reduction and abstinence. Each agency is still responsible for any person who passes through its doors. It has its own internal policies and regulations governing case management, record keeping, confidentiality, and liability.

Crucial to our work are the evaluations of UCLA’s ISAP. The ISAP evaluation team tracks our compliance with

the terms of our SAMSHA grant and explains why we are getting specific results. Through the work of the evaluators, staff gain insights that allow us to adapt, adjust, and learn.

Through our collaborative efforts, we are beginning to recognize that the transition from homeless to housed is a state of mind as well as a physical reality. The ISAP evaluation team is considering the possibility that changing the consciousness of being homeless to the consciousness of being housed may take at least a year. The consumer is changing personal relations, patterns of survival, and a sense of time and future. Ongoing case management is critical to maintaining housing after the consumer has moved indoors.

Consistent with research on other grants developed by SAMSHA, we have found a high turnover rate in the personnel of Community Bridges. These are intense jobs and progress is slow and difficult to measure. Maintenance of staff cohesion, fidelity to the integrated model of treatment, and coordination among agencies require regular attention. Nevertheless, we are halfway through our 5-year grant period and more than halfway to our goals.

Community Counseling Center Learns that Housing “Takes a Village”

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When case managers couldn’t find decent, safe, and affordable housing for the Community Counseling Center of Northern Madison County’s consumers in Alton, Illinois, board president Jeanne Yakubian decided it was up to the agency to create it. Since that moment nearly 20 years ago, CCC has created four projects with a total of 66 units of permanent housing for adults with mental illness. One is named for Yakubian, who died in 1996.

Three developments are U.S. Department of Housing and Urban Development Section 811 properties. HUD funds a portion of each facility’s capital expenses, and each facility also has a project rental assistance contract. A full-time HUD-funded service coordinator links residents to community-based services as they need them.

The newest housing program for CCC is Theodoro Place Apartments, a 12-unit single-room-occupancy building for adults who are homeless and have a dis-

abling mental illness. Funded by a HUD Supportive Housing Program grant, the project offers on-site supportive services. Residents can access counseling, life skills training, employment coaching, and more in the building where they live. The staff includes a case manager, life skills instructors, a MISA counselor, and consumer/provider employees who run the 24-hour entry desk.

Theodoro Place residents sign a 1-year lease at entry. By signing an agreement for services, residents also commit to completing 15 hours of productive activity each week. Activities can include peer-led groups, treatment, training, volunteering in the community, school, or work.

The HUD SHP grant and rent collected cover most operating costs for Theodoro Place. Many of the homeless residents have no income at entry; as they gain income from employment or public benefits, their rent is set at 30 percent of their income. Residents

complete collaborative recovery plans when they move in and are linked to public benefit programs and other treatment options.

Each efficiency apartment is approximately 300 square feet and is fully furnished and equipped at move-in. Apartments contain a limited kitchen with a half-size refrigerator and a microwave, ample closet and pantry space, an open area with a bed and dresser, and a full bath. Other building amenities include a common area with a large-screen TV, Internet access, a pool table, and exercise equipment. Theodoro Place has a large community kitchen and dining area where residents can share one communal meal per day—typically, dinner. Shopping and a bus stop are nearby.

Efforts to finance Theodoro Place brought the entire community together. The Village of East Alton offered advance approval for zoning. Capital and operating dollars came through the Madison County Continuum



of Care with a HUD SHP grant, in addition to HOME funds and an Affordable Housing Trust Fund loan from the Illinois Housing Development Authority. In addition to HUD funds for supportive services, an Illinois Department of Human Services grant and Medicaid reimbursement help to fund on-site supportive services.

CCC learned some valuable lessons in its housing development. First and foremost, community support is essential. With Theodoro Place, the village was very supportive, which was a crucial factor for zoning approval. When neighbors of the site became concerned, CCC staff met with them individually and answered questions. Construction and opening for the project

included a communication strategy for the neighborhood. As a result, Theodoro Place has become an accepted part of the community and has good relations with its neighbors.

Illinois advocates have worked for supportive housing funding for years through the Supportive Housing Providers Association and the Corporation for Supportive Housing. This advocacy has led to services funding from the Illinois Department of Human Services and capital funds through the Illinois Housing Development Authority. A recently published report, *Supportive Housing in Illinois: A Wise Investment*, underscores the impact of supportive housing in Illinois. The authors found that

supportive housing reduced the volume of publicly funded services residents used, changed the kind of services used, and resulted in a significant cost savings over time. Advocacy has led Illinois to commit to developing 7,700 units of housing over the next 10 years, the result of a task force appointed to determine statewide need and resources.

Since opening in 2005, Theodoro Place has served 41 adults who were homeless. Many were successful; they have secured income and moved on to other permanent housing in the community.

Community Psychiatry Clinic Offers Hope and Recovery for Homeless Families

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The Community Psychiatric Clinic in Seattle, Washington has created one of the largest continuums of supported housing and integrated residential treatment in Washington state and has received numerous local and national awards for innovation and excellence.

The University of Washington Department of Psychiatry's Parent Child Assistance Program is a paraprofessional home visitation model that has been replicated nationally and internationally and is a legacy member of the National Registry of Evidence-Based Practices. PCAP employs paraprofessional advocates who provide home visitation intervention with women who abuse alcohol or drugs during pregnancy to prevent future alcohol- and drug-exposed births. PCAP also helps mothers complete substance abuse treatment and stay in recovery.

In 2002, CPC was approached by the Bill and Melinda Gates Foundation's Sound Families Initiative. The clinic was asked to consider a collaboration with the PCAP to create a new housing resource for homeless, dual-disordered families. The Sound Families Initiative was a 5-year demonstration project that provided significant funding to create new transitional housing for homeless families and to investigate the housing's effectiveness.

In 2005, the partnership resulted in the construction of a 15-unit, 24-hour staffed facility built, owned, and operated by CPC for high-risk homeless and pregnant or postpartum women with dual disorders and their children. They are among the most seriously challenged clients: 93 percent have been incarcerated, 88 percent have had prior inpatient drug or alcohol treatment, 52 percent had a psychiatric diagnosis before beginning the program, 74 percent experienced childhood sexual abuse, and many are currently struggling with metham-

phetamine or heroin addictions.

CPC's Willows program provides integrated housing and services for these families before, during, and after their residency:

- >> Before being referred to the Willows, each mother is enrolled in an intense inpatient chemical dependency recovery program with a collaborating agency, Perinatal Treatment Service. CPC engages each family in mental health treatment while they are in the inpatient setting.
- >> While the family is at the Willows, an interdisciplinary team of CPC staff, PCAP staff, and staff from other collaborators provides treatment and support for the mothers and their children, including skills training and parenting classes, employment opportunities, family reconciliation support for mothers with children living out of their care, and a highly supportive environment designed to foster recovery and prepare families for independence.
- >> After families graduate from the Willows, PCAP and CPC continue to follow them to ensure housing stability and ongoing recovery.

The Willows represents a level of integrated housing, treatment, and provider collaboration not previously available for this population in Washington state. It also targets a significantly disabled and difficult-to-serve population. In its four years of operation, the Willows has provided transitional housing to 69 homeless families, including 84 children. Of the 69 women who have resided at the Willows, 51 have completed the program and moved into permanent housing, a nearly 74 percent success rate.

"The outcomes for this program have been far beyond

our expectations," says Shirley Havenga, chief executive officer of CPC. "To have helped so many families end the cycle of homelessness and addiction is very gratifying."

Resident success stories include the following:

- >> A resident started community college while living at the Willows. She graduated from the program and moved into her own permanent apartment. She remains clean and sober and is now completing her senior year toward a bachelor's degree in psychology.
- >> A resident entered an electrician apprentice program on graduating from the Willows and moved into her own permanent apartment with her infant daughter. This graduate now makes a substantial living wage and continues in her recovery.
- >> A resident who completed the program is now working as a dental assistant. She continues to be clean and sober and acts as a sponsor for others who are early in their recovery.
- >> A resident received her driver's license — 12 years after it had been revoked — and completed a program to receive a commercial driver's license. She graduated from the Willows, moved into an apartment, and is volunteering at a local senior center while looking for a job driving a commercial truck.
- >> A resident completed a certificate program to become an administrative office professional. She graduated from the Willows, moved into an apartment, and found a job as an associate chemical dependency counselor. She will begin a chemical dependency professional training program this fall.

Community Services Northwest Uses Rapid Rehousing to Introduce Independent Living

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In 2008, Washington State legislature approved funds for nine counties to implement programs to reduce chronic homelessness. Clark County, where Vancouver is located, received one of the grants. Stakeholders have collaborated on the service model through the entire first year of the grant. The four specific areas of focus are chronic homelessness, homeless prevention for reentry, landlord development, and system improvement.

Community Services Northwest received the contract to provide services. The organization hired a team modeled on assertive community treatment, including two full-time-equivalent case managers, two FTE peer counselors, one FTE mental health professional, one FTE chemical dependency professional, one FTE employment specialist, 0.50 FTE registered nurse, and 0.01 FTE program manager. The target population was identified as people who have been homeless and living in encampments without services. CSNW was to use the evidence-based PACT model of service in conjunction with a “housing first” philosophy to minimize the barriers the system presents for this population as well as to adjust for behaviors that might normally result in a discharge.

Additionally, the grant identified a service delivery dynamic that would rapidly house 25 people from encampments; each participant would receive a 6-month subsidy with no strings attached. Once in housing, the participants receive supportive housing services on the basis of their statement of need, with the ultimate goal of self-sufficiency. After that initial period, the team reviews each case for any documentable progress on which further subsidy can be authorized.

This dynamic is supported and monitored by the county through quarterly meetings with several stake-

holders (local shelters, law enforcement, the Council for the Homeless, and the state) who were directly involved in the planning process and subsequent feedback on the implementation, as well as partners in portions of the service delivery.

In the beginning stages of the program, most of the participants were moved with other members of their encampments into shared living to maintain a sense of community and social support despite a significant life change. To meet these needs, the team rehousing approximately 20 people. Given the successes of the first few months, the county requested that CSNW increase to the contract’s second-year subsidy level of 50 participants, which the team was able to accomplish within the first year. As the program progressed, most of the recipients requested help finding housing that was more suited to their specific needs (transportation, location, noise level, landlord). Accordingly, the team rehousing approximately 25 people. The team also provided mental health, addiction, peer counseling, and employment services, which helped many participants obtain employment, benefits, medical services, and identification.

With the exception of one participant, everyone who was offered a subsidy was successfully housed and has maintained housing.

Beyond the numbers, the program has seen many heartwarming success stories. One woman the team encountered in the encampment was 9 months pregnant. The team was able to provide her with a furnished apartment with supplies for her, her boyfriend, and the coming baby. The day after she moved in, she went into labor and gave birth to a healthy baby boy. Since then, she has worked and volunteered part time, her boyfriend has acquired and maintained employment, and her baby is healthy and receiving weekly

visits from the team’s part-time registered nurse.

Another resident reported that he had been in his homeless encampment for more than 2 decades. He described himself as the “father” of the encampment and declined to take a subsidy until all of his “people” had been helped first. After the team had successfully housed the entire encampment, he accepted a subsidy; he reported that it was the first time he had slept indoors in more than 20 years. He is still in housing today and has his own fully furnished one-bedroom apartment, which he shares with his girlfriend.

The program has not been without its share of challenges. Staff must be hired and trained to conduct outreach, engagement, rapid rehousing, and supported housing and to deliver PACT-model-level services with a housing first approach. In addition, they must simultaneously develop relationships with landlords and grapple with the plethora of documentation requirements that accompany subsidies. These challenges have resulted, especially in the initial stages, in staff turnover.

CSNW’s initial contract had a staffing pattern that varied significantly from the PACT model. The variation left the team with 3.5 fewer clinical FTE employees, 1.4 of whom (the team lead and the psychiatrist) are responsible for the daily supervision and service delivery of the team. This reduction is partially justified by the differences in the target population but certainly contributed to a lack of access and support in the early stages of the program. We firmly believe that a strong supervisory presence is essential to this kind of model and new service.

Initially, the county resisted changing the staffing pattern and adding more supervision, which probably contributed to the staff turnover. Eventually, supervision time was increased, which helped stabilize the staffing.

Duffy Delivers Integrated Care with Housing

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In 1994 the Duffy Health Center began as a volunteer clinic in Hyannis, Massachusetts, next to the county’s sole emergency shelter. In 1997 it was in-

corporated with a license for primary care and mental health, and in 2002 the clinic received Federally Qualified Health Center status through the Health Re-

sources and Services Administration’s 330(h) Health-care for the Homeless program.



In 2005, we started to partner with other agencies to develop transitional housing solutions for our population in order to avoid sending them back to shelters and the streets. Pilot House is a modified therapeutic shelter for 27 chronically homeless people with addictions. Operation In From the Streets is a regional effort that provides short-term motel subsidies to divert people from the emergency shelter. Both programs provide access to Duffy's primary care, behavioral health, and case management services.

In 2004 the Massachusetts Behavioral Health Partnership (the behavioral health arm of MassHealth) and the Massachusetts Shelter and Housing Alliance developed a statewide Housing First demonstration project offering intensive case management for chronically homeless clients. We leapt at the chance to get involved, and we partnered with a local housing agency. We found that permanent housing with support services was transformative for our clients. With housing and with case managers providing frequent (at first, daily) supportive services (e.g., transportation to appointments, court advocacy, benefits enrollment, supportive counseling, and follow-up), clients began to take incremental steps toward self-esteem and self-sufficiency.

Duffy now manages several housing programs and has a staff of 11 case managers, 5 behavioral health clinicians (and 2 fee-for-service clinicians), a medical director, a physician's assistant, 5 nurse practitioners, 3 registered nurses, a part-time psychiatrist, and a medical assistant. Case management, medical, and behavioral health department staff support each other, and the directors of each department meet weekly and again as a part of the Duffy leadership team. All provider staff use the same patient electronic medical record, and informal and formal interdisciplinary consultations are routine.

Duffy's model requires individual or group behavioral health counseling in addition to medical treatment and client monitoring by an OBOT RN case manager. We are at the maximum of 100 patients (mainly young adults) and are seeing increases in employment and housing as a result of this integrated care model. In 2008 we received a five-year Substance Abuse and Mental Health

Services Administration grant for three case managers to provide intensive case management and supportive counseling to at least 65 clients with addictions each year (including veterans). Clients' ability to attain housing and employment as well as to access behavioral and medical care has increased. The SAMHSA grant initiated our first research affiliation with Brandeis University, which will evaluate program outcomes. In 2009 we received additional HRSA operational funding for two more behavioral health clinicians and two case managers.

Duffy's Housing First program is going strong, with three case managers offering supportive counseling to 10–15 clients each per year. We have placed more than 100 chronically homeless people (most with comorbid disorders) in our Housing First program, with an 85 percent housing retention rate. MBHP provides a per diem rate of \$16.72 for 40 clients per year to help subsidize this program.

In 2008 the Cape and Islands United Way awarded Duffy \$50,000 to implement our Help for Housing project, which provided gradually declining subsidies to homeless people over the course of a year. Of those funds, \$40,000 went to short-term housing subsidies for 22 people. Duffy provided in-kind staff support, funded partially through the MBHP funds. Through careful budgeting and supportive counseling, our case manager and clients exceeded their goals. We had a 95 percent housing retention rate and exceeded by 30 percent the number of clients we had anticipated serving. Again, integrated care and wraparound services made a difference for clients. We saw an increase in client employment and income stability (through enrollment in state health programs, SSI/SSDI, and assistance with legal and tax issues). Case managers helped all clients access Duffy medical services, and 63 percent also accessed mental health counseling (either individual or group). Three of these clients were veterans; half were reconnected to their family support system.

Duffy is part of the local Department of Housing and Urban Development Continuum of Care (a regional network to end homelessness) and provides supportive services to eight HUD clients who have been given

permanent housing through the Barnstable Housing Authority. Last year we received our first HUD permanent housing vouchers for chronically homeless clients, and this fall we expect to apply for two more HUD vouchers.

Our case managers support behavioral health and medical goals by empowering clients to become active partners in their own plans of care and personal goals. Louise Patrick, MSW, LICSW, director of behavioral health services, remarks that, once housed, "Clients achieve increased stability in recovery, enabling them to be more responsible for self-care, including basic needs: shelter, nutrition, and overall physical health. Recovery inspires a sense of belonging or fitting into a community."

Duffy case managers have developed relationships with private landlords, and they mediate with landlords and clients to ensure a successful tenancy. As a result, we maintain a list of landlords who have written letters of support for grant applications on our behalf. These businesspeople now stand as supporters of our model in the community.

A significant challenge at Duffy is a scarcity of psychiatrists. Many of our consumers have co-occurring disorders and need psychotropic medications. Our program currently has only a part-time psychiatrist. Clients often are ultimately referred elsewhere, which diminishes the effectiveness of the integrated care treatment model.

Another challenge for clients is the transition they face once they are housed. Once the daily chaos of homelessness is no longer keeping them busy, they must find other things to do. A lack of knowledge about how to fill their days productively and maintain a schedule of daily activities may lead to relapse, so case managers must focus on developing self-sufficiency with their clients. Clients would benefit by having more volunteer opportunities in the community.

As elsewhere, the impact of the current economic downturn has increased anxiety in the general population. We are currently confronted by a lack of suitable, affordable housing, as Cape Cod is a resort community with high housing costs and limited public transportation.

DuPage County Adopts Housing First in a Paradigm Shift

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Had James, age 32, entered the MISA/CAP program as recently as 4 years ago, he might have been identified as noncompliant, resistant, defiant, and too

high a risk for residential services, then discharged. James was born to a family of addicts and witnessed both of his parents abuse alcohol, cocaine, marijuana,

and narcotics to self-medicate anger, depression, and despair. He was referred for services after finding him

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self homeless as a result of his 20-year history of abusing alcohol and drugs and insufficient treatment of his mental illness. James had been denied benefits, was unemployed, and was still using alcohol.

Twenty years of residential experience with the seriously mentally ill population did not prepare the health department of DuPage County, Ill., for its venture into housing funded by the U.S. Department of Housing and Urban Development. Health department staff expected that the homeless people they served would assimilate into an existing program model and succeed simply because others had. This was not the case.

The foundation of the program was solid. The clustered apartment programs, which housed residents in several six-unit buildings, would support the consumers with two full-time mental health workers and evening and weekend support staff. A comprehensive service package was available to each participant, including community support, case management, benefit advocacy, counseling, nursing, and psychiatric services. Many considered the program to be the state of the art. How could it fail?

But the requirements – including mandatory treatment hours, unconditional compliance with program rules, and complete abstinence from all substances – which were intended to support the treatment, instead proved to be an obstacle to consumers’ attainment of treatment goals. The recurrent discharges and empty program beds indicated that consumers did not belong to the Axis I population the DuPage County Health Department was familiar with. This new population was seriously mentally ill and heavily substance abusing and was steeped in the culture of homelessness and transiency. Traditionally, many of them had never been afforded the opportunity of housing because of their instability and often were

left to use homeless shelters, hospitals, and jails to meet their basic needs to survive. A paradigm shift was necessary, or the facility would not be able to meet the needs of the consumers, much less HUD’s expectations.

Accordingly, the DuPage County Health Department embraced the Housing First Program as an unorthodox approach to residential care. In this modality, people are selected for admission on the basis of need, not expectations for stability and success. Treatment delivery is a collaborative approach with the resident, and residents are able to choose services that they feel are beneficial to them. The premise of this approach is that it allows residents to make their own choices, thereby empowering them and increasing their motivation to help themselves.

In this approach, relationships, not consequences, are the building block to progress and successful outcomes. Participants are brought into the program without rigid treatment expectations, with the hope that building strong relationships with them and making them aware of services available to them will increase their use of such services. The program maintains an open-door policy or “drop-in center,” so that residents can come down to the office whenever they want for socialization, support, and assistance. These drop-in centers give residents a place to go when they feel alone; to participate in games and activities; to use phones and computers; and to access food pantries, clothing, and community resources. Services provided by each drop-in center are determined by residents’ needs, and the centers have been instrumental in helping staff form relationships with the residents and increase their engagement in treatment services.

In developing this model, staff worked with the resi-

dents to establish a sense of community and monitor their own buildings to ensure a safe environment. Staff use harm reduction and motivational interviewing techniques to work with the residents at their current stage of recovery. The main focus is on doing whatever is reasonably possible to help residents maintain their housing. Residents are not allowed to use drugs or alcohol in the buildings. Staff use educational resources, transportation to Alcoholics Anonymous and Narcotics Anonymous meetings, and linkage to community and treatment resources to help the residents abstain or reduce their substance abuse. Often, residents are paired with roommates who are at the same stage of treatment in their recovery; this approach encourages roommates to support each other’s recovery and ensures residents’ safety and stability.

After using these techniques for several years, the DuPage County Health Department’s MISA/CAP program not only has reduced homelessness but also has increased residents’ self-sufficiency. Eighty percent of residents have been in the program for more than a year, and several have benefits or employment. Most have not been hospitalized or incarcerated since admission into the MISA/CAP program. The drop-in centers have helped residents improve their socialization skills, build self-esteem, abstain from substance abuse, and develop a sense of community and family that they have not experienced before.

More than 5 months ago, James was admitted to MISA/CAP. He has stabilized on his medication, has reported fewer episodes of using drugs and alcohol, has improved his physical health and relations with his family, and wishes to work on becoming self-sufficient to regain custody of his 18-month-old son.

Family Health Centers Overcomes Staff and Consumer Challenges

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Family Health Centers, Inc., a Federally Qualified Community Health Center, operates a Healthcare for the Homeless program in Louisville, Kentucky, that provides services to more than 5,300 homeless people each year. In 2008, the HCH program, in collaboration with St. John Center and the Society of St. Vincent de Paul, received grants from the U.S. Department of Housing and Urban Development and the Substance Abuse and Mental Health Services Ad-

ministration to begin a permanent supportive housing project. In its first year of operation, the project provided scattered-site housing to more than 60 people with mental health and substance abuse disorders; 91 percent of the project’s participants had a history of chronic substance abuse, 66 percent had a mental illness, and 59 percent had a co-occurring disorder. We learned many lessons learned in the project’s first year.

The PSH project was structured around the evidence-based practice of Housing First and takes a harm-reduction approach to services and provides participants with choice at all levels of service delivery, from location of housing to participation in treatment programs. Because Housing First was a relatively new concept in our community, it was essential that program staff be knowledgeable about and supportive of the philosophy. Housing First was discussed in

COUNTING HER BLESSINGS

Dana Baker had spent much of her adult life in and out of psychiatric hospitals and homeless in between. The 53-year-old, who suffers from bipolar disorder, always tried to hide her symptoms, terrified that if anyone found out, she would be hospitalized forever. Instead, one hospital linked Dana to **Avita Community Partners' supportive housing program in Gainesville, Georgia.** "It was a long process, but through God's grace, I came through a lot," says Dana.

Erica Brooks, a social service tech with Avita, says that it was critical to get Dana into an environment where she would learn to trust that the staff had her best interests at heart. "She's learned different coping skills. Dana paints and does craftwork," Erica explains, "It's not just about getting on the right medication. It's about helping her to have a well-rounded life."

Dana is busy crocheting a baby blanket for her niece. "I put a lot into that, from my heart," says Dana. "There are so many things you can do to help your mind. I didn't know what coping skills were before. I'm so grateful for this program and the staff," she adds.

When Dana was homeless, she was consumed by fear where was she going to stay, and how was she going to eat? Once these basics were taken care of, her fortitude strengthened. "In the beginning," says Dana, "I couldn't walk from Point A to Point B without writing everything down make my bed, clean my room. Now it's a normal thing." Dana wants to join a walking program. She watches the news and reads the paper. "There was a time when I didn't know what the news was," she says. In addition, having her family's support has helped Dana tremendously. "I'm a great-aunt now. I can call my niece and hear her baby crying in the background. I can share in these special moments with my family. Moments like these are very special to me," she says. Dana's experience has encouraged her to give back to society. If she sees someone who needs groceries, she tries to help him or her. "I don't take my situation for granted," she says.

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detail during staff interviews and, as a result, newly hired staff were enthusiastic about the model. But case managers need to be reminded that although Housing First philosophy supports client choice in treatment, mental health and substance abuse issues cannot be ignored; we must help encourage but not require ongoing treatment.

Collaboration was critical to the successful implementation of the project. The collaborating agencies had worked together on previous projects and understood that they shared common values and could trust and challenge one another. To separate housing and supportive services, one agency is responsible for housing management, and the other agencies provide supportive services. Separation of responsibilities has been crucial to project success; for example, a participant's case manager does not have to manage rent payments or lease violations, which allows him or her to remain a client advocate.

Keeping focused on the emotional needs of par-

ticipants has been a challenge for case managers. Because the project was new, case managers' initial efforts were directed at getting 60 participants in housing as quickly as possible, and they spent most of their time searching for apartments, shopping for furniture and household goods, and helping people transition and adjust to their new environment. Only after all participants were housed could case managers fully concentrate on mental health and substance abuse issues.

Before they received housing, participants were often surrounded by other people in shelters or on the streets who served as sources of kinship and support. When they moved into housing, many participants expressed feelings of isolation and fear of being alone; a few even returned to the streets or shelters for brief periods of time. To combat isolation and help participants gain a sense of connection, the PSH project began offering weekly groups to support socialization among participants and development of life skills. Although attendance has remained strong at these

groups, participants have decreased their participation in community groups such as Alcoholics Anonymous and Narcotics Anonymous. Project staff are working to incorporate a more detailed assessment of participants' community involvement and daily living skills. As participants become stable, they will be encouraged to mentor and support other, less stable participants in a peer support program.

In its short time of operation, the project has shown positive outcomes related to substance use, severity of mental health symptoms, criminal activity, and emergency room utilization. In the first year, the project maintained a retention rate of 95 percent; three participants died, but none were dismissed or left voluntarily. Although the deaths were difficult for staff and fellow participants, other studies have shown that deaths among residents in PSH projects are not an anomaly. Participants in this project had chronic health conditions for which they were being treated at the time of their death.

Family Service Creates a Supportive Housing Continuum

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Family Service understands the importance of providing housing that is safe, permanent, affordable, and allows to community resources and transportation. We have created a supportive housing continuum to aid recovery for adults with psychiatric disabilities in a variety of community-based settings, including permanent supportive housing with intensive supports, group homes, supported apartments, transitional welfare housing, and rental housing.

Since 2004, we have expanded the scope and range of housing to target services to adults who are homeless or transitioning from institutional settings. Many people in this population fall well below the minimum income level required to obtain adequate housing, which often results in their homelessness. To help fill this void, we provide supportive housing to 123 people in a total of 62 properties throughout 19 communities. Many residents are dually diagnosed with addictions or developmental disabilities.

Our program has focused on working with state, county, and municipal officials to create diverse housing options. In one model, enhanced supportive housing wraps intensively staffed services around people who are relearning basic skills after hospitalizations. Transitional-to-permanent housing provides shelter

to 36 homeless people in single-family homes and apartments. Since its inception, this program has supported seven people in the transition into permanent housing.

Both approaches show high levels of housing retention and decreases in hospitalization. More than 90 percent of consumers have acquired educational and vocational training or employment, and 95 percent maintain stability in the community or graduate to more independent living. Supportive housing residents are committed to making positive life changes. Staff provide people with the supports they need to become contributing community participants. Consumers learn to use local resources, including banks, churches, grocery stores, and recreational facilities. The program provides rental assistance, opportunities for peer support, budget assistance, illness management, and education and workforce skills development.

Funding includes money from the U.S. Department of Housing and Urban Development, the New Jersey Housing Mortgage Finance Agency, HOME, and municipal and state rental assistance programs. Because the population we serve often has limited income (most people earn less than 30 percent of

the area median income) and rents are based on income, projects are not sustainable without a commitment for project-based rental subsidies. Capital contributors recognize this situation and do not pledge funding until such subsidies are committed to a project.

In New Jersey, a primary source of rent subsidies has been the state rental assistance program, which has not been competitively bid in 2 years. The available vouchers are tenant based and accessed through individual applications. This structure has slowed the development of our key program expansion areas. New opportunities for people transitioning out of the hospital are limited to vacancies within existing developments, and transitional housing recipients remain longer in transitional placements because we cannot convert the units to permanent housing without long-term vouchers. Consequently, people remain in shelters and in hospitals longer than necessary.

We have been able to mitigate the impact of these challenges by partnering projects. When people who receive no rent subsidies are mixed with those who have short-term subsidies, the two rents can cover the cost of the projects to a limited extent. Additionally, because the consumers who receive transitional



housing placements are disabled, they often qualify for long-term extensions and do not need to be displaced after a few months. Because we cannot draw down capital financing, however, we must use the short-term

funding to support start-up financing, which is not the most effective use of dollars. Long-term solutions require continued advocacy for a blend of tenant and

project-based vouchers from the state as well as increased access to and use of federal operating dollars at the local level through our continuum of care.

IABA-North Applies Behavior Analysis in Supported Living Services

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People with developmental disabilities are being placed in institutional settings less and seeking options for community living more. One option is Supported Living Service arrangements, allowing a person with developmental disabilities to live in a home of his or her own. With SLS, people have access to a range of supports, such as a companion to help with tasks of daily living (e.g., cleaning and budgeting), facilitate access to community life, and manage emergencies.

The decrease in disability-specific institutions has also required professionals to interact in a wide variety of settings regarding a broad range of concerns, often without training in how to serve people who face a constellation of challenges, including developmental disabilities, mental illness, and substance misuse. By analyzing two case studies of SLS clients who formerly resided in institutional settings, we discuss the potential of nonlinear applied behavior analysis in an SLS arrangement to significantly decrease the frequency of addiction relapse as well as reduce episodic severity when relapse occurs. Nonlinear applied behavior analysis involves understanding the target behavior (a) as a function for the person beyond the specific antecedent, behavior, and consequences and (b) as part of complex nonlinear relationships among the target behavior, relevant alternative behaviors, the environment, history, and other variables.

John was an African American man with a diagnosis of schizoaffective disorder, mild mental retardation, and major depression. Jane was a Caucasian woman

with a diagnosis of mild mental retardation, dysthymic disorder, somatoform disorder not otherwise specified, borderline personality disorder, posttraumatic stress disorder, and pseudoseizures. Both John and Jane had an extensive history of substance abuse during the brief periods when they were not institutionalized. In John's case, substance misuse was a factor in the incident that led to his institutionalization. As part of California's effort to decrease the number of people and length of time spent in institutional settings, both John and Jane were chosen to transition to a community-based program in which they would reside in their own home and receive 24-hour supervision and support.

John and Jane's programs included ecological strategies, (e.g., residence location, specific staff interactional styles, and social and community integration plans) as well as positive programming components, such as job development, problem solving, and relation skill development. Individual support plans included antecedent control, differential reinforcement of alternative behaviors, differential reinforcement of other behavior, and progressive differential reinforcement of other behavior. Because even with the most robust behavioral programming in place, relapse may occur, individualized reactive strategy plans were developed for John and Jane. Reactive strategies included self-monitoring and rule review, reference to reinforcement contingencies, redirection and instructional control, stimulus change, and active listening.

During his first 2 years of tenure in SLS, John main-

tained a low frequency of substance use (four confirmed instances of use) and a low episodic severity rate, as measured by his ability to resume everyday activities following each instance of substance use. Over 12 months in SLS, Jane also maintained a low frequency of substance use (five confirmed instances of use). She had a decrease in episodic severity when instances of relapse occurred, and only a single instance of use resulted in short-term hospitalization.

In contrast to the high reported frequency and episodic severity of the participants' substance use behavior during previous community placement attempts, these findings suggest that the application of a nonlinear applied behavior analysis model can decrease both the presence and the episodic severity of substance use behavior in adults with developmental disabilities and co-occurring mental health challenges.

Studies have reported that substance misuse occurs among people with mental retardation in noninstitutional settings with greater frequency than researchers previously thought. Although the present study provides preliminary data for only two participants, the findings are sufficiently provocative to merit further investigation of the efficacy of nonlinear applied behavior analysis in supported living arrangements to meet the many competing needs associated with quality of life enhancement for dually diagnosed consumers challenged with developmental disabilities and addiction, as well as the need for individual and community safety.

Institute for Community Living Turns Patients Into Neighbors

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The models for mental health housing are changing. Supportive and supported housing models are slowly replacing congregate care models. Therapeutic

communities, which have highly controlled living arrangements and rules, are being replaced by residential models, which give consumers greater input into their

recovery process and individually tailor interventions.

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The Institute for Community Living recently remodeled its programs to reflect these changes in trends and philosophies. Client choice is, in part, dictating these shifts. Consumers are less likely to choose to share bedrooms, bathrooms, and common living spaces in congregate residences after having done so in state hospitals, shelters, or prisons. As a result, the majority of ICL's newly developed beds are in supported apartments scattered throughout the community. Moreover, the agency's modified therapeutic communities, although they are still congregate in nature, are transitioning to harm reduction-based treatment. Residents of shelters (including long-term residents) are now more often transitioning directly into apartment beds funded specifically for them.

In recent years, several populations have emerged that present unique challenges for housing providers like ICL. Young adults (ages 18–24) have specialized and concrete needs. For many young adults with a serious mental illness, the stigma and shame often associated with the illness can be overwhelming. Living independently for the first time may be both exhilarating and terrifying. The diagnosis, combined

with normal developmental stressors, amplifies the situation. Young adults may act out and test boundaries as well as deny that they have any illness at all, resisting medication and treatment.

At ICL, a culture of fostering strengths and resiliency has become the norm; staff members assess the concrete skills and the emotional maturity of their young adult residents. ICL's staff often work one-on-one with young adults in their apartments, where they act as coaches and mentors. Staff encourage independence but diligently monitor age-appropriate and psychosocial issues. Funding for young adult consumers is leading to the development of housing models designed specifically for them, in addition to mixed models.

The older adult population has also presented increased challenges. People who struggle with mental illness often die as much as 25 years earlier than the average population. For older adults in independent housing, managing the grind of day-to-day living is hard enough, but for those who have a co-occurring medical condition, everyday life can be exasperating.

Additionally, mental health conditions, such as dementia and depression, may also decrease functioning. As symptoms get worse, consumers may become paranoid and more reluctant to follow through with treatment. Often, older residents are scared to leave home for doctors' appointments and hesitant to participate in social activities.

As hopelessness and despair set in, risk management becomes complex. Providers need to consider the principle of self-determination and the preservation of dignity as well as consumers' right — and wish — to remain in their own home, but they must also be aware of the potential hazards of cognitive impairment and the psychological and physiological changes that may follow. There are no easy solutions, but case managers have been working with community agencies to bring services into the home. Although the process is tedious and bureaucratic, it does give older adults an opportunity to stay in their home, to practice their skills, and to take full advantage of community support services.

Jefferson Parish Leads with Housing Support Teams

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Many local behavioral health providers are well positioned to collaborate with housing agencies, developers, and local sponsors to make sure that people with serious mental illness and co-occurring substance use disorders obtain their fair share of Permanent Supportive Housing resources. One such entity is Jefferson Parish Human Services Authority, in Metairie, Louisiana, a National Council member that plays a lead role in Louisiana's integrated and cross-disability PSH initiative.

On August 29, 2005, Hurricane Katrina slammed into the Louisiana Gulf Coast, taking more than 1,600 lives and displacing more than a million people, including thousands of the most vulnerable people with serious and long-term disabilities. Within 6 months after Katrina struck, Louisiana's homeless and disability advocates had secured a commitment from state officials to develop 3,000 scattered-site PSH units using an innovative housing development approach first pioneered by the State of North Carolina.

This approach includes setting aside several PSH units in every new rental housing development

financed with federal funds by the Louisiana Housing Finance Agency. So far, more than 800 new PSH set-aside units have been funded across Louisiana's hurricane-affected areas. Advocates and providers in Louisiana have been successful in obtaining congressional authorization for 2,000 Section 8 Housing Choice Vouchers and 1,000 Shelter Plus Care Vouchers to ensure completion of the 3,000-unit initiative.

JPHSA is playing a significant leadership role in the implementation of this initiative. Prior to Katrina, JPHSA was already a leader in providing best practice community support services and scattered-site housing assistance to people with serious mental illness or co-occurring disabilities who were homeless or at risk of homelessness. Thus, JPHSA was fully prepared to expand its service model and housing access approaches to take advantage of the new federal housing resources made available after Katrina. Because of this experience, JPHSA has also functioned as a collaborator and mentor for other agencies in the Louisiana Gulf region to help them learn the skills and develop the capacities to serve people with dif-

ferent kinds of disabilities living in scattered-site PSH units, including people who are homeless or at risk of homelessness as well as people who are leaving institutions or are at risk of institutionalization.

The Louisiana PSH initiative successfully implemented by JPHSA has two key ingredients. The first is designation as a Local Lead Agency to oversee all aspects of local housing access and supportive service delivery. The second is adoption and expansion of a best practice Housing Support Team model, which is based on JPHSA's existing experience with community support teams.

As the designated LLA for Jefferson Parish, JPHSA serves as the single point of accountability to

- >> Establish and maintain positive working relationships with LHFA developers and scattered-site property owners and managers.
- >> Conduct outreach to and communicate with key stakeholders representing PSH target populations to assess community needs and promote access to PSH units.

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AS LONG AS IT TAKES

Debra was wandering from house to house, using drugs and depressed. Her youngest daughter was living with her father. Her daughter had started to realize that her mom was around sometimes but that sometimes she wasn't. "I wanted to change my life, my thinking, and be really serious about it. I needed to not go back to where I came from," Debra explains.

After she connected with the **Cathedral Shelter of Chicago** and moved into their **Cressey House in Chicago, Illinois**, Debra got to work. She has been sober for 2.5 years, and is no longer on parole. She also earned her high school diploma. "I feel great. I've never completed anything in my life, not even parole," she adds. Debra does volunteer work and takes computer literacy and career classes. "At first," she says, "I couldn't type a word. Now I can type!" She enjoys helping others. "That's one of my goals," says Debra. The career program helps with her employment aspirations. "They train us on how to conduct ourselves on interviews and on the work site," Debra explains. "Career management teaches us to not be ashamed of what we did in the past and to take responsibility."

Having her own apartment has allowed Debra to bring her now 13-year-old daughter back to stay with her. She also reunited with her three older daughters. Debra embraces the responsibility of having her own place and encourages her younger daughter to succeed in school. "I want her to focus on getting good grades," says Debra.

Cressey House has given Debra the chance to feel responsible, to realize that she can achieve anything like getting her driver's license, a job and, one day, maybe a car. Debra adds, "To me, it's not how long it takes. It's as long as you make it. I know today that I'm not where I used to be. I'm not living at someone else's house. I have my own. I don't have to depend on someone else all the time. I'm not saying that I don't need anyone, but now I can help another person. There are so many people out there who do not have a home [who] can use the encouragement."

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- >> Conduct outreach to potential applicants.
- >> Manage open application periods and wait lists.
- >> Ensure the provision of evidence-based services and supports to help people meet tenancy obligations and remain successfully housed.

The HST model implemented by JPHSA and other LLAs in Louisiana incorporates the Housing First approach to service delivery: services are voluntary, consumer driven, and flexible to do whatever it takes for people with disabilities to get and keep housing. Two HSTs in JPHSA's service region, contracted through Resources for Human Development, comprise both clinical and nonclinical staff to meet the needs of the consumers they serve. Under the direction of a full-time director-supervisor, each team includes a team leader; two support coordinators; a peer specialist; and a tenant services liaison, who serves as the primary contact for landlords and property owners on tenancy-related matters. The teams provide an array of individualized services to help tenants obtain and maintain successful, long-term tenancy, increase their skills, and achieve greater self-determination.

Team members provide pretenancy services (e.g., assistance clearing up credit and criminal justice

issues, accessing benefits, completing housing applications, making requests for reasonable accommodations). Team members, along with the applicant, complete an immediate needs assessment and a crisis prevention and intervention plan to ensure that the household's needs are being met. When residents move in, team members help them understand landlord-tenant laws and lease requirements, access furniture and other move-in resources, and orient themselves to the new neighborhood and its amenities. Once tenancy is established, the teams help the household create an individualized housing support plan and provide housing stabilization services, service coordination, community linkage, and crisis prevention and intervention services.

JPHSA also uses best practice community service models, such as assertive community treatment, to provide flexible services and supports to help consumers achieve successful tenancy and move toward recovery in the community – the two ACT teams established in Orleans Parish (next to Jefferson Parish) are now serving more than 200 formerly homeless or high-risk people with serious disabilities in PSH.

At the time Valerie entered the PSH program in September 2008, she and her 5-year-old son had been

homeless for five years as a result of her addictive disorder. Her son had never had a home. Valerie and her son moved into their own single-family PSH unit in September 2008. Since then, she has obtained full-time employment with health benefits for herself and her son, maintained her sobriety, received counseling, enrolled her son in school, started her own housekeeping business, and successfully maintained housing for the first time in more than five years.

The success of JPHSA in housing the most vulnerable people with serious disabilities through the PSH initiative has also depended on strong commitment and support at the state level for using affordable housing resources, targeting housing to the most vulnerable people with disabilities, linking all appropriate services to tenants, and sustaining service delivery through state policy and financing initiatives. Other states, such as Pennsylvania, North Carolina, and New Mexico, have also embarked on state-local partnerships using mainstream housing and service funding, designated lead agencies, and HST service approaches to substantially expand PSH opportunities for people with serious mental illness and other disabilities, including those who are homeless or at risk of homelessness.

Linkages Uses Medicaid as Service Resource for Supportive Housing

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Linkages, the New Mexico Behavioral Health Purchasing Collaborative's permanent supportive housing program, targets people who are homeless or at risk of homelessness and have been diagnosed with co-occurring severe mental illness and substance abuse issues. The program provides rental subsidies for affordable housing coupled with individualized, community-based services. It is based on the Housing First model, which demonstrates that when consumers have access to safe, affordable housing and are linked with voluntary services, they can make a successful transition to a more productive life.

This collaborative-funded program is an innovative approach to creating supportive housing opportunities in a frontier state; it uses state and federally funded rental subsidies with innovative Medicaid-funded support services to ensure that people get and keep housing. In creating this program, the collaborative recognizes that permanent supportive housing is an extremely effective intervention that

can provide a cost-effective, quality living situation for people in a precarious housing situation. The Linkages program grew out of the Collaborative's 2007 Long-Range Supportive Housing Plan, which aims to develop 5,000 units of supportivae housing in 10 years.

The program uses a \$350,000 recurring state legislative allocation to provide 30 bridge rental vouchers. Participants choose their own living units within three areas in the state: two urban areas (Albuquerque and Santa Fe) and one rural site in Silver City. Ten percent of the rental vouchers are targeted for Native Americans living off the reservation. The Linkages pilot program is limited in scale; it is designed as a Section 8 housing choice voucher "look-alike" program in which participants pay 30 percent of their adjusted income toward rent. Housing quality inspections ensure that the consumer can easily transition to a Section 8 voucher and thus allow more consumers to be served.

Linkages is being implemented by four community services agencies – a Community Mental Health Center, a Federally Qualified Health Center, a specialty mental health provider, and an off-reservation Native American health and behavioral health services provider – in partnership with their local public housing authorities and a nonprofit housing organization. At the state level, the Collaborative is working with the statewide Medicaid managed care organization, OptumHealth New Mexico, which manages the service provider partners, and the New Mexico Mortgage Finance Authority – a member agency of the Collaborative – which oversees the administration of the Linkages rental assistance vouchers.

The program has provided the Collaborative with valuable experience about expanding and sustaining the program statewide by ensuring that Linkages consumers ultimately secure a Section 8 housing choice voucher and access community support services, primarily through a Medicaid service platform,



Comprehensive Community Support Services. Through a support services time-study analysis conducted in cooperation with the Linkages service providers, monthly reporting, site visits, and roundtable discussions, the Collaborative has learned what it needs to do to use CCSS with housing resources for a successful supportive housing initiative. Because supportive housing service needs are fairly predictable, providers can typically work within the confines of a managed care system and use the CCSS platform. This is particularly true when medical necessity criteria recognize supportive housing as an intervention necessary for rehabilitation and recovery and when (a) staff operate in an outreach mode, (b) service needs are well documented, (c) the service plan reflects both service and housing needs, and (d) staff use a recovery approach to help clients negotiate their housing arrangements and long-term tenancy.

Each agency uses CCSS in six major activities: service planning, crisis prevention and intervention, resource coordination, skill building, symptom management and self-monitoring, and development of natural supports. CCSS staff also engage in activities that are not billable but are directly related to access and retention of

when consumers have access to safe, affordable housing and are linked with voluntary services, they can make a successful transition to a more productive life.

housing: outreach and engagement, landlord recruitment, and landlord liaison activities.

Outreach and engagement are necessary for reaching people who are difficult to engage and for a Housing First approach. Landlord liaison activities are an essential component in maintaining a working relationship with a housing organization partner to build and sustain the program's credibility. This kind of partnership goes beyond what providers typically are required to do with other community organizations, in which they generally spend time building relationships that benefit consumers. The Collaborative and OptumHealth New Mexico are pursuing creative ways to help support agencies fund these nonbillable activities.

A Linkages status update revealed that (a) all 30 vouchers are being used and that a high demand exists for more vouchers; (b) the program is reaching the hardest population to serve (i.e., homeless, severely mentally

ill consumers who have been living on the streets for many years); and (c) the CCSS Medicaid service model works well for supportive housing. On the basis of the consumer eligibility criteria of severe mental illness, at least 70 percent of recipients typically qualify for Medicaid within 12 to 18 months of entering the program. Moreover, the time-study analysis revealed that approximately 60 percent of consumer support activities qualify as CCSS-billable activities.

The efficacy of using CCSS as the mainstream service resource for supportive housing is indisputable: it works. Housing is a great stabilizer, and people who refuse to enter the service system or drop out but who have compelling service needs often do well in supportive housing, particularly if they are provided the choice of an affordable housing unit and if community resources and services are flexible and accessible.

MHA-LA's Housing Project Supports Community Integration for Youth and Adults

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Julia Scalise, Chief Development Officer; Judy A. Cooperberg, MS, CPRP, Executive Director of MHA's Antelope Valley Enrichment Services; and Robert Emerson, MBA, MHA, Director of Real Estate Management — Mental Health America of Los Angeles, Los Angeles, CA

In early 2009, 375 people gathered to celebrate the opening of Mental Health America of Los Angeles's new 100-unit supportive housing project — at least 35 percent of these units are reserved for homeless and at-risk people recovering from serious mental illness, and the project includes a 23,000-sf service site that offers a range of recovery-focused services for adults and transition-age youths.

The theme running through this project is integration — MHA-LA integrated its own real estate department, its nonprofit housing development partner, and a for-profit developer. The project enables people with mental illness to live side by side with members of the community and integrates a “housing first” approach with MHA-LA's nationally recognized recovery-focused services.

In keeping with its purpose to “ensure that people with mental illness assume their full and rightful place in the community,” MHA-LA became the first nonprofit mental health provider of adult services in the Antelope Valley, a 2,200-square-mile rural and suburban area

that covers the northern part of Los Angeles County. The program uses the integrated services approach that MHA-LA pioneered for the state of California at its MHA Village in Long Beach. It offers a range of treatment, employment, housing support, substance abuse recovery support, education, and self-help services to adults and transition-age youths, with an emphasis on those who have been homeless. Called “Poppyfields” to reflect its Antelope Valley location (the area has one of California's largest poppy preserves), the project consists of an attractive, newly constructed apartment complex composed of one-, two-, and three-bedroom units and a separate building for MHA-LA's service site.

“Through our work on a state pilot to provide comprehensive services to homeless people with serious mental illness, we discovered the value of taking a Housing First approach,” says Dave Pilon, PhD, MHA-LA's newly elected president and chief executive officer. “We found that our members [clients] are much more likely to participate in services and much more likely to have successful outcomes.”

An October 2007 *Los Angeles Times* article stated that “When we add up the arrests, incarcerations, emergency medical care and other crisis interventions, the true costs of chronic homelessness are staggering: \$35,000 to \$150,000 per person per year. By contrast, the annual cost of supportive housing for a person with serious mental illness...is between \$13,000 and \$25,000.”

In its housing development model, MHA-LA formed a limited partnership with InSite Development, a for-profit housing developer with successful experience in the development and management of affordable housing projects for special needs populations. MHA-LA and InSite worked with MHA-LA's newly created nonprofit housing development arm, Clifford Beers Housing. MHA-LA activated CBH as an affiliated nonprofit with a mission to “develop quality housing that is available and supportive for low and moderate income people, particularly those with mental illness.”

The key to bringing the project together was the in

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volvement of the City of Lancaster. As part of its redevelopment efforts, the city chose MHA-LA as one of a select group of nonprofit organizations to be offered property. The apartment complex and MHA-LA's service site are colocated on 2.2 acres of land provided by the city to the limited partnership.

The first significant source of housing development funds came from California's Multifamily Housing Program (State Proposition 46), part of the state's Department of Housing and Community Development. A requirement of this source is that one-third of the units target people with disabilities; to date, MHA-LA has placed clients in 40 units. Other major financing comes from the Affordable Housing Program, tax-exempt bonds, the City of Lancaster, tax credits, and community corporations and businesses.

For the supportive services, funding includes Mental

Health Services Act contracts with the Los Angeles County Department of Mental Health for adult and transition-age youth services. These contracts are complemented by MHA-LA's existing programs, which are funded by the U.S. Department of Housing and Urban Development, the California Department of Rehabilitation, and the county's Community Development Commission.

The development has focused on transition-age youths because of a unique project funded by the United Way in partnership with the Conrad N. Hilton Foundation to reach out and provide intensive services to homeless young women with children. At this time, about a third of MHA-LA's placements are served by its Transition Age Youth Program (young adults ages 18 to 25).

"The proximity of housing to the service site is espe-

cially crucial for this age group," says Judy A. Cooperberg, MS, executive director of MHA-LA's Antelope Valley Enrichment Services. "The young women we're serving have [myriad] needs; they've been homeless or at serious risk, many have substance abuse problems, and they're learning how to be parents, all while most are living in the first home of their own."

For MHA-LA, the true example of integration is community support for the project. The organization put a lot of emphasis on its community relations activities to lay the groundwork of acceptance and support for the project. "Community development played an integral part in the formulation of a diverse partnership," Cooperberg says. "As we became immersed in all aspects of the community, a paradigm shift took place. MHA-LA is seen as a part of the community, not apart from the community."

At NAZCARE, Consumer-run Supportive Housing Teaches Life Skills

Roberta L. Howard, CEO, NAZCARE, Inc., Prescott, AZ / RHoward@nazcare.org

Hope House is an eight-unit community supportive housing model project for adults with serious mental illnesses, operated by NAZCARE, Inc., a consumer-run organization. The model is designed to incorporate recovery best practices into promising SMI supportive housing principles and research to maintain stability, develop a support network, wrap support services, and reconnect tenants to family and community.

The two-story house has eight single-family units. Each unit has a bathroom, bedroom, and living room, which allow for privacy and autonomy. The downstairs has a common kitchen, laundry room, community room, and patio to facilitate bonding, hone residents'

life skills, help them build a support network and learn coping skills, and reduce their isolation. Four of the bottom-floor units are fully handicapped accessible. The building is designed with an abundance of natural light to help diminish the effects of seasonal affective disorder.

The housing is filled with residents of both genders who have a serious mental illness diagnosis. Most have been chronically homeless and frequently hospitalized with severe and frequent relapses, and many have a dual diagnosis. Most have little or no support system and lack adequate life skills.

Tenants apply for housing and a recovery program of approximately 2 years. The program provides structure with a common set of rules and policies. It also offers life skills training based on a curriculum by Roberta L. Howard to help increase participants' recovery and independence. A wellness plan is tied into each tenant's recovery and housing goals.

Hope House is located directly behind New Hope Recovery Center, a consumer-operated recovery center that provides recovery services during the day, including general and specific support groups, psychoeducation, recreation, arts and crafts, peer support services, community integration, and employment training. All tenants participate in recovery services of their choice at New Hope Recovery Center and receive recovery assistance, support, and life skills

training inside the home setting. The wraparound recovery services for each tenant provide a network of services and supports to promote recovery and stability.

Most residents eventually find housing with another person, often a former Hope House housemate. The life skills learned become beneficial when the tenant elects to move into another living situation. Many tenants have repaired relationships with a spouse or significant other and with their family through our family services, psychoeducation, and family wellness plans and can ultimately return to a family living situation.

Twenty-four people have successfully been involved in Hope House: 15 men and 9 women, of whom 3 were veterans, 3 were handicapped, and 2 were in a court recovery program. Only four chose to return to unhealthy living situations.

The cost-benefit ratio of Hope House is enormous. If we just reduced one day of hospitalization at \$500 a day for 24 people, we would realize a cost savings of \$12,000; in reality, we have saved much more than \$12,000. One tenant was hospitalized 4 or more times a year for one or more weeks at a time during the three years prior to living in Hope House – the cost-benefit for one year for this tenant is a minimum of \$336,000. This tenant has been stable and working part time for almost three years. That's more than a cost benefit saving.





Odyssey House Provides Congregate Housing for Persons with Co-occurring Disorders

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In 1994, Odyssey House, a New York City-based community organization that provides substance abuse treatment and mental health, medical, and housing services to adults and children, recognized the need for such a program and opened the Odyssey Behavioral Health Care Residence, otherwise known as the Harbor. The Harbor is a 60-bed congregate care facility funded and licensed by the New York State Office of Mental Health; it provides enhanced supportive housing services to the serious and persistent mentally ill and chemical-dependent adult population.

Odyssey House's supportive housing model is based on individualized client progress toward service plan goals including sobriety, vocational training and education, mental health treatment, basic living skills, and independent medication management. Education about mental illness and its associated symptoms, its

relationship to substance abuse, and the importance of medication compliance is a key program goal. "We help . . . client[s] understand how substance abuse interacts with their mental health conditions and makes their lives unmanageable," says Peter Provet, president of Odyssey House. The Harbor staff strives to set with each client the realistic goal of developing a self-managed lifestyle and the hope of independent living. "The Harbor is so much more than a provider of supportive services and housing to vulnerable individuals," says Provet. "We give our clients a chance at living independent and dignified lives."

The SPMI and chemically dependent population presents a significant challenge to both chemical dependency treatment and mental health providers because of the intensity of the services needed for recovery. Historically, this population presents with poor treat-

ment and housing program compliance, unstable family relationships, financial instability, criminal behavior (including past incarceration), homelessness, and chronic hospitalization. Without the appropriate treatment and supportive services regimen, the common goal of securing independent, permanent housing for this population remains elusive.

For this population, the transition to independent living is arduous. Harbor residents, many of whom were socially and culturally isolated by their addiction and mental illness, are encouraged to engage in new activities to assist them in their recovery. Odyssey House has an active and vibrant expressive arts program based at the Harbor. Creating art helps residents discover new ways to identify and access feelings and provides a new medium to facilitate expression. The Odyssey House Art

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Show is an opportunity for the residents to display their artwork and offer firsthand interpretations to visitors. For residents in recovery at Odyssey House, developing positive socialization, new coping mechanisms, and personal interactions is integral to their continued growth.

During the average 18-month stay at the Harbor, staff prepare residents for independent living by providing case management and other supportive services

to help them plan and manage their transition to permanent housing. Once they are stabilized in their substance abuse and mental health disorders (including the development of medication management skills), residents participate in a variety of programs that promote the development of independent living skills, socialization, and management of their mental health and substance abuse disorders. Supportive services focus on the development of basic daily

living skills, such as personal hygiene, money management, and community reintegration, all within the context of the resident's co-occurring disorders. Once the client has completed this curriculum, a housing specialist works with him or her to secure affordable, independent, and permanent housing options. Odyssey House also extends our housing continuum of care to residents through referrals to permanent supportive housing programs.

Palladia Houses Individuals and Families

Joan F. Montbach, PhD, Senior Advisor to the President and Diane Bonavota, LMSW, Vice President of Program Planning and Development — Palladia, Inc., New York, NY / Diane.Bonavota@palladiainc.org

Palladia has been in the housing business since the early 1990s but in the human services business for close to four decades. We operate more than 28 programs and 350 housing units throughout Manhattan and the Bronx and are now among the largest nonprofit providers of supportive housing in New York City. Virtually all the tenants housed by Palladia have a history of homelessness and substance use or mental health disorders. We also have significant experience in housing both individuals and families. Funding for our housing programs comes from a wide variety of federal, state, and local sources.

Our decades of work with individuals and families in treatment have provided a guide for our efforts to develop and implement property management and housing services. Some of the lessons we have learned from our experience as a prevention, treatment, recovery, and supportive housing provider include:

>> **Housing models differ in significant ways, and these differences have consequences for development, operations, and service delivery.** Palladia operates two different models of supportive housing: congregate housing, in which all units are located in a single structure and services are provided on site, and scattered-site housing, in which apartment units are located in buildings throughout the city and services are provided by a mobile team. At a glance, the initial investments in time and money are so significant for the congregate model that scattered-site housing, with its quick start-up, may seem to be the preferred model. In fact, in many ways, issues related to ongoing operating costs in scattered-site housing may pose a greater problem for providers. With respect to

long-term viability, congregate models that hold operating reserves have a clear advantage. In scattered-site buildings owned and operated by independent landlords, provider agencies such as Palladia have far less control over operating costs and no built-in access to the reserve funds to assist with revenue losses.

>> **Service needs vary over time (length of stay in housing), by household composition (families vs. individuals), and by the housing model (scattered site vs. congregate).** Designing a service program for supportive housing is analogous to developing a treatment-for-service plan: One size does not fit all. Sometimes one service model is obviously preferable (e.g., unlike housing for adults only, family housing calls for services geared to the needs of the children in the household). More often, the correlations are less obvious. Any assumption that service needs will diminish over time, for example, must take intervening events into consideration: job loss, health concerns, arrests, the addition of family members, and so forth. Length of stay alone is a potential but not invariable predictor of service need.

>> **Because managing recovery in supportive housing can challenge tenants struggling with co-occurring disorders and a history of homelessness, the clinical experiences and resources available to staff are critical.** Palladia's decision to build supportive housing evolved from our experience working with men, women, and families with substance abuse and mental health disorders. Our understanding of addiction and our philosophy of treatment guide our work in supportive

housing. Just as recovery from a substance abuse disorder is a process, long-term housing stability cannot be achieved without both clinical and community supports. Recovery management is a goal for our tenants and a focus of the services offered by housing staff.

>> **One of Palladia's earliest "lessons learned" was the importance of openly acknowledging supportive housing's competing business and social service interests.** Sustainable supportive housing must rest on a firm financial footing that includes not only the capital development financing but also the long-term operating capital. Rent collection is a critical piece of this financial puzzle and an important issue for housing staff to address. When a tenant fails to pay rent or vacates an apartment (willingly or unwillingly), there are financial consequences for the agency—as well as service consequences for the tenant. The close coordination of property management and service delivery functions is essential to the viability of supportive housing.

>> **Networking with other providers is key to developing strong policy and advocacy positions.** The complexity of developing and operating supportive housing provides a strong incentive for providers to share ideas, brainstorm solutions, and develop strategies for managing community relations. Palladia is a long-term participant in several networks and work groups of providers of supportive housing. These collaborations strengthen the field and, ultimately, improve outcomes for the high-risk populations served in this housing.

ONE HAPPY LITTLE FAMILY

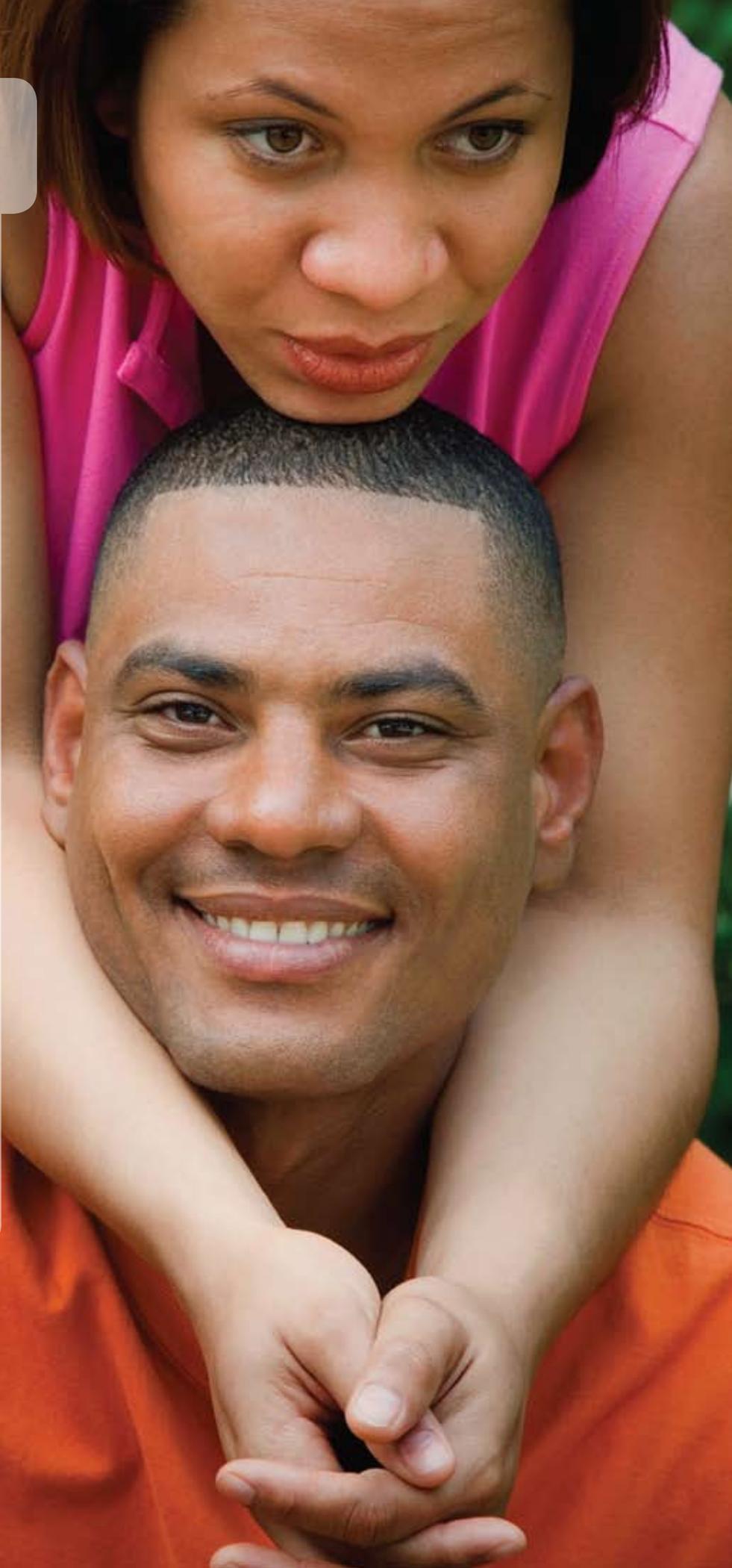
One year ago, 34-year-old **Frank Uriostegui** was homeless and surrounded by danger. A traumatic brain injury made him seem drunk, and he was an easy target for crime. Today Frank is married and rents a modest home in Silver City, New Mexico. His progress is a result of the help he received from the **New Mexico Behavioral Health Collaborative's Linkages Supportive Housing Program**.

Linkages saved Frank's life and helped him start anew. "I was homeless for a long time," recalls Frank. "Five years or more. I was really bad off." Linkages helped Frank put everything in place, got him on the proper medication, and helped him find a home. "I also have a family now," he says proudly: his wife, Marailupe, and her 12-year-old son. When Marailupe first met Frank, she often cooked him a meal at her place. At their home together, Marailupe cooks for everyone. "We even have leftovers!" she exclaims. Frank gives her interesting cooking tips. "When I met him, I said, 'Okay, I'll cook for you. Now, what are you going to do?'" she laughs. "And he said, 'I'll wash the dishes.'"

"Frank spends time with us, we play cards, and we eat dinner together," says Marailupe. Sounds of playful father-and-son banter echo in the background. "At the New Beginnings Program, Frank is a role model. He runs the store, and he's so easy to get along with. He goes to the store and starts talking with everyone," she says.

Their home has a huge yard, and it keeps a roof over their heads. It gives the couple hope that they can look forward to other things in life. "Linkages gave him hope. . . . They gave us both hope," says Marailupe before wistfully adding, "My husband wasn't the only one out there looking for a home and a family. I wish everyone could have a home." The couple married in a civil ceremony and are planning a ceremony in the Catholic church. Frank is working on his confirmation classes. Marailupe recalls that when she first met Frank, she asked him why he didn't talk, why he always sat by himself in the program.

"Now," she says, "Frank always has something to say."



Places for People Offers a Future for Persons with Co-occurring Disorders

Francie Broderick, MS, Executive Director, Places for People, St. Louis, MO / FBroderick@placesforpeople.org

Since 1972, Places for People in St. Louis, Missouri, has been partnering with people with serious psychiatric disorders to provide a wide range of services to help them live independently. Services are individualized, flexible, community based, available around the clock, and provided for as long as needed.

In our early years, most of our clients came from decades of institutionalization. Now, however, most of our new clients are homeless with untreated mental illness, addiction disorders, and serious medical conditions. To tailor our housing options to these new client demographics, we acquired a 10-unit apartment building for emergency temporary housing. Because many of our new clients were precontemplative in terms of their recovery, we did not require that consumers abstain from street drugs or alcohol to access these emergency apartments. In fact, we required almost nothing; instead, we worked to engage people in a therapeutic relationship that could begin to restore hope.

This emergency housing was a wonderful addition to our housing array, but we found that for some people, it was not enough. For many people with a long history of homelessness and co-occurring disorders, having an apartment meant sharing that apartment with old friends and acquaintances from the streets, who often moved in and took over the apartment, creating unsafe and sometimes chaotic situations. We knew we needed a new model.

Our answer was CJ's Place, an 18-unit apartment building with a small congregate area for socializing and program services. We worked closely with the architect to create an open and welcoming environment that also addressed the need to monitor entrances and common areas. The building has a locked front door with a 24-hour front-desk person to monitor visitors, provide security, and offer support. The building was named after a young woman who died because this kind of housing was not available to keep her safe.

The residents of CJ's Place all have co-occurring disorders and a long history of homelessness. About half are HIV positive. Residents are not required to be in recovery from their addiction. Rather, they are asked to abide by the rules of the house, including not using substances on site. A small team of community support staff works on site with residents on their recovery plans. Staff are certified as medication aides, so they can distribute medication. Money management services are available as well as assistance with all primary and behavioral healthcare coordination.

The project was built with U.S. Department of Housing and Urban Development 811 funding, money from a local housing trust fund, and community development dollars. Units are subsidized through Section 8. Clinical services are paid for through our state Medicaid rehabilitation program. The overnight positions are funded through grants and private donations.

Our primary objective with the development of this project was to reduce homelessness, arrests, and hospitalizations among the residents. Expectations were met and exceeded in the 5 years since CJ's Place opened. Some of our residents have stayed housed in this program longer than ever before in their adult life. Residents tell us that, for the first time in a long time, they feel safe. They appreciate having staff as well as other residents available to help when they feel vulnerable but like the independence of having their own apartment. Residents are assisted in participating in support groups aimed at people in early stages of recovery, both in the community and at Places for People. We have seen people move from precontemplation to abstinence.

Our greatest challenge initially was finding a neighborhood that would welcome this project, but by working closely with neighborhood groups, police, and elected officials, we have found acceptance and support. The biggest programmatic challenge has been working with people who have difficulty not using substances on site. We have struggled with this problem, and the only answer we have found is not to give up. The key to making supportive housing work has been to create a community where people feel accountable to each other and don't want to put other residents at risk through their substance use.

Project Hope Integrates Mental Health and Substance Use Treatment with Housing

Helen Singh Benn, PhD, LMHC, Director, Center for Drug-Free Living, Orlando, FL / HBenn@cfdfl.com

Project Hope is a collaborative effort among the Homeless Services Network of Central Florida, the Center for Drug-Free Living, and Lakeside Behavioral Healthcare. The project is funded through the Services in Supportive Housing branch of the Center for Mental Health Services. The program's uniqueness lies in its clinical integration of mental health and substance use services to treat the whole client.

For people with severe mental illness, the risk of becoming homeless increases when they abuse alcohol and other drugs – substance abuse accelerates the

appearance of disruptive behavior and the loss of social supports. Homelessness, in turn, can exacerbate addiction and mental illness and thereby create a malignant cycle of increased symptoms. Project Hope is designed to serve chronically homeless people who have mental illness or drug- and alcohol-related problems as well as their families; the program helps them transition into or live in permanent housing with support in the greater Orlando area.

In keeping with the evidenced-based PACT model, Project Hope is a culturally diverse, self-contained,

mobile team consisting of a mental health counselor, a substance abuse counselor, and a housing specialist. This approach helps improve client retention and provides services where the consumers most need them. Once a client is enrolled in the program, he or she remains an active recipient of services throughout the duration of the program.

Project Hope provides quality community-based services at no cost to consumers who are experiencing difficulties with substance abuse and mental health issues and promotes a healthy, responsible lifestyle



with continued housing stability. The program offers substance abuse and mental health services to clients in their home to respond to their needs, build on their strengths, and remain focused on outcomes. Clients' lives should reflect that they are living successfully in their community without admissions to residential facilities or involvement with the criminal justice system and that they are achieving the goals they set for themselves.

As of September 2009, Project Hope had 49 consumers in its supportive housing program. The preliminary demographics indicated that 63 percent were older than age 45 and that 53 percent were female. At baseline, 88 percent reported having used deep-end service (e.g., psychiatric hospitalizations and detoxification) during the past 3 years, with a mean of six deep-end services per consumer. Our consumers were homeless

primarily because of substance abuse issues, physical and mental health disabilities, and lack of financial resources.

Among the 49 consumers were 23 valid cases for reporting on eight of the Substance Abuse and Mental Health Services Administration's National Outcome Measures. Results of all eight measures were positive. The outcome with the greatest improvement from baseline was the client's perception of functioning, for which the rate of change improved by 37 percent from baseline. In addition, 9 percent of consumers were currently employed, and close to 9 percent were attending school. Within this time frame, no consumers had been involved with the criminal justice system in the past 6 months, and none had used inpatient psychiatric services. Moreover, 100 percent of consumers had a positive perception of care, and 74 percent reported

feeling socially connected. Consumers showed an 83 percent improvement in the eight areas of the NOMs, which is a positive data trend from baseline to reassessment. Even more amazing, the consumers who had used deep-end services in the past 3 years showed an 87 percent improvement when reassessed by Project Hope. These indicators show the initial effectiveness of a program that integrates treatment services with a housing program. We are looking forward to more dynamic changes in the lives of our consumers as Project Hope perseveres.

Project Hope has just completed its first year, and we attained our target numbers for the grant. The Project Hope team members are proud that we can provide support to the homeless population and positively affect their recovery in addiction and mental health in our community.

Project Renewal Houses Long-Term Homeless People With Active Addictions

Ryan Moser, Associate Director and Diane Louard-Michel, Director – Corporation for Supportive Housing, New York, NY / Ryan.Moser@csh.org

Serving people who experience long-term homelessness and have active substance use disorders has historically been extremely challenging for behavioral health agencies. Traditional treatment programs are frequently ineffective for this population, given that gaining and maintaining sobriety is extraordinarily hard for people living on the streets. In addition, it is incredibly difficult to help people who are actively using drugs and alcohol get into safe, affordable housing. A growing body of evidence points to permanent supportive housing as a solution to these challenges, because it provides simultaneous access to safe, affordable rental housing and support services.

Project Renewal, a housing and services provider in New York City, found itself working with a segment of the homeless population that could not access existing supportive housing resources because of restrictive eligibility criteria, sobriety requirements, unpalatable services, and mandatory treatment programs that failed to interrupt the cycle of chronic homelessness and addiction. To more effectively serve this population, Project Renewal launched a 40-unit scattered-site supportive housing initiative called In Homes Now. IHN uses a harm-reduction approach and is specifically designed to meet the special needs of people who have experienced long-term homelessness and have active substance use disorders.

The result is a program that makes the difference

for people like Javier Cotaro, a family provider for 20 years who lost his job, family, and home as a result of his deepening addiction to drugs and alcohol. After five years of living on the street and refusing to enter a shelter because he felt it was a worse place to be than prison, Javier found his way to Project Renewal. After moving into an IHN apartment, Javier recovered his sobriety, received a General Equivalency Diploma, and completed an associate's degree in occupational studies.

Across the program, tenants have successfully retained housing, and 97 percent have remained stably housed over the past year. This success led to the inclusion of harm-reduction beds in the New York–New York III supportive housing agreement, and NY-NY III funding was used to expand the IHN program to 100 units. IHN also receives funding from the Department of Housing and Urban Development's Supportive Housing Program and the Substance Abuse and Mental Health Services Administration's Treatment for the Homeless program.

To meet the clinical and housing needs of the tenants, Project Renewal has developed an interdisciplinary service team, whose staff possess a wide variety of both clinical and managerial skills. The IST is staffed by case managers, peer counselors, psychiatric nurse practitioners, an entitlements manager, a part-time physician, and an occupational therapist. The ratio of full-time staff to tenants is roughly 1:10. This allows the

staff to make at least two home visits per month and provide intensive services, according to tenants' needs. The IST operates out of an office and drop-in center in Harlem, which Project Renewal views as a key factor for success, because the drop-in center is in proximity to the majority of the rental units. Tenants can go there for socialization, for recreation, to meet with staff, or just to relax in a supportive community environment.

In addition to tracking the housing retention rate, IHN monitors 10 performance indicators, ranging from drug use to social adaptations, with data gathered through structured interviews with tenants. Each of these indicators has remained stable except the psychiatric symptoms indicator, which has shown a statistically significant decrease. Over the past year, 31 percent of tenants also accessed voluntary substance use treatment services.

The IHN model is part of a rigorous evaluation being conducted by the National Center on Addiction and Substance Abuse at Columbia University, coordinated through a technical assistance learning collaborative being led by the Corporation for Supportive Housing. This evaluation includes 500 supportive housing units operated by nine organizations and will evaluate individual and system-level effects of the harm reduction model as well as clarify the process and models used by the participating agencies. Preliminary results should be available in 2010.

RS Eden Amplifies the Support in Supportive Housing

Laura Craig, Support Services Director and Kynda Stull, Support Services Director – RS Eden, Minneapolis, MN / LCraig@rseden.org

Since 1997, RS Eden has developed or participated in the development of more than 300 units of supportive housing for youths, single people, and families in the Minneapolis–Saint Paul area. Serving as property manager in six projects and support services manager in five projects, RS Eden has developed an understanding of the key challenges and positive potential of situating an effective support service model within our housing sites that meets the needs of our core population of tenants who are homeless and have mental illness and addiction issues. Building on lessons we have learned through internal innovations to our own programs and reviews of best practices in housing formerly homeless, disabled clients, we have identified three areas of focus within our current support service delivery system.

“Vocationalizing” housing is important. The benefits of a vocational emphasis are documented as evidence-based practice and were tested by RS Eden’s development of an on-site, nonprofit business in our young adult housing site. The Fresh Grounds Café project involved tenants from the ground up and now serves as a work-training and employment site for tenants. After five years of operation, we have tracked positive outcomes in tenant employees, including longer residence and increased skills and income.

Vocationalizing our projects has also entailed the

creation of *vocational centers* at each site, with computers, Internet access, job boards, skill-building classes, and peer-to-peer support. We employ a vocational specialist, who disseminates resources and teaches job-readiness courses. Instead of focusing on disabilities and disadvantages, our case managers engage tenants around goals, needed skills, and the search for opportunities to practice. We find that even tenants with multiple or co-occurring disorders can find low-impact job experiences fairly immediately and benefit emotionally, socially, physically, and financially from rapid vocational engagement.

Over the past year, we have analyzed our “early terminators” (consumers who leave before completing one year of a lease) and have found that most consumers who exit supportive housing early do so because of chemical relapse and accompanying behavioral problems that are not resolved thoroughly or rapidly enough for the consumer to maintain housing. RS Eden projects are sober communities, and we offer relapsing tenants the opportunity to engage with support services to create a “restructure plan” – a brief, intensive plan to engage in assessment, therapy, and other appropriate services as indicated.

If consumers do not have access to immediate clinical services, the potential of the restructure plan quickly fades. In response, RS Eden has identified an

internal chemical health provider and is seeking a community mental health consultant to provide quick assessments. Both of these consultants will have substantive understanding of the supportive housing milieu and the need to respect the self-determination of tenants.

We have found that support service case managers perform a complex role that requires an array of traits and skills. Of utmost importance is the ability to partner with tenants in a strengths-based, forward-looking manner and to cultivate resources and support that extend beyond the supportive housing experience. The role demands boundary maintenance, crisis de-escalation and team facilitation skills, and continued training and support. In the effort to professionalize, share resources, and amplify the expertise inherent in our staff, RS Eden has established a support services division that meets monthly. We have situated case managers as ambassadors of information and invite each to share a technique or resource at each meeting. Part training, part conversation, these meetings have brought together staff who serve in disparate housing sites across the metro area, with the goal of creating a sense of shared purpose in our work.

Sanctuary Sees Results from Support Services Located Near Congregate Housing

Lisa B. Moschini, MA, LMFT, Clinical Director, Sanctuary Psychiatric Centers of Santa Barbara, Santa Barbara, CA / LMoschini@spscb.org

Sanctuary Psychiatric Centers of Santa Barbara’s Supported Independent Living Program is the realization of a dream made possible by the cooperative effort of a community-wide coalition. In 1991, local studies revealed that affordable supported independent living units were the single greatest need for mentally ill people struggling with addiction. SPCSB responded with a 5-year plan to meet the need through the provision of a stable road to recovery. By 1995, we had completed renovation of a community consisting of apartment buildings and a new outpatient support center next door.

With our apartment buildings completed, we dedicated ourselves to empowering each client. We believe that the ability to provide continuity in housing for this vulnerable population depends on a continuum of on-site services. Accordingly, the program offers mental health and substance use management and recovery, vocational and employment services, case management, money management, supported groups, dialectical behavior therapy, community building and tenant advocacy, and training in the life skills residents need to restore stability.

With access to care just a few steps away, tenants began their much-longed-for journey toward independence. For many, having a stable living situation was in itself an amazing accomplishment; possibly for the first time, they advocated for their needs and saw to it that the atmosphere in the building was one of compassion, understanding, and outreach. With the help of dedicated therapists, they formed a tenants’ council and turned a building into a community.

Since the inception of this project, shelters and other resources for the homeless have not fared well. Many

A LADY OF MANY TALENTS

Cynthia was homeless for more than 5 years. The amiable 56-year-old recounts living in the woods, surviving a car accident, and eventually coming to the **Duffy Health Center in Hyannis, Massachusetts**. “I just kind of bumped along,” says Cynthia. “Someone suggested I go to the Duffy, so I said, ‘Okay, I’ll give them a shot,’” she explains matter-of-factly. She pauses and then emphatically adds, “They are wonderful, wonderful people.” Cynthia was amazed when case managers told her to pack up her things, that she had a place to live. “I was like, ‘Huh, what?’” says Cynthia. “I’m still overwhelmed some days because I have a place to be.”

Cynthia not only has a place to live but also receives health-care, sees a therapist, and attends group therapy. She finds great joy in taking a shower and in laying out her clothes for the next day – in cooking on a stove instead of over a campfire and in having a refrigerator where she can store food. “I feel connected to the outside world. I can catch up on the news. ... When it rains, I can look outside and see the rain and not feel it on my head,” Cynthia adds. She has plans to save for a car and to go to college.

Cynthia has many talents – she’s a skilled hairdresser and a chef who trained at Johnson & Wales University. “I can work on boats, build a house,” she explains. “A lot of people like me have intelligence. We have gifts to give. But we don’t have that one thing – a house that will enable us to wear clean clothes to go to a job interview.”

Cynthia has made friends. “The only friend you have in the woods is a coyote,” she says. “One of the local pastors here, Pastor Steve, says there will come a day when I am going to end up helping and advocating for the homeless. I want the chance to give back,” she insists.

“I just want people to give the homeless a break,” Cynthia urges. You’ll never find a better worker, or a more appreciative worker... Homeless people can be just as productive in society as anyone else.”



Continued from page 48

facilities, because of reduced funding from cash-strapped local governments, have closed their doors and eliminated programs that can assist people who are at risk of homelessness or are on a fixed income.

Over the past 14 years, the strategy of early intervention coupled with collaborative and integrated ser-

vices has restored countless lives and fostered long-term success and independence. Within this caring environment, more than 85 percent of our clients are involved in vocational and educational pursuits, 27 percent have graduated into permanent vocational or higher educational opportunities and have therefore

moved on to other living arrangements in the larger community or out of state, hospitalizations are under 10 percent annually, relapse has averaged under 15 percent annually, and the loss of housing is no longer an inevitable consequence of setbacks suffered by people with mental illness and addictions.

SERV Demonstrates that Supportive Housing Works With Shared Living

Tracy Samuelson, MSS, Director of Quality and Compliance, SERV Behavioral Health System, Inc., Ewing, NJ / info@servbhs.org

At a time when *supportive housing* generally meant a relatively independent person living in his or her own apartment with some minimal staff support, SERV Behavioral Health System, Inc., in New Jersey created a few innovative supportive housing programs that depart from the classic model. SERV rejected the prevailing notion that a person in supportive housing has to live alone. Staff wondered, if people without a severe mental illness benefited from sharing housing with others, why were people in recovery from a severe mental illness expected to live alone as a sign of their success? With the median monthly rent for apartments in New Jersey at more than \$900-\$1,000, living alone would be cost-prohibitive for most people, let alone for people with limited income.

SERV has a shared-living supportive housing program called Bloom House in Cranbury, New Jersey. Bloom House is a former farmhouse that was donated to SERV by a consumer's parents. To provide rental assistance for its new occupants, SERV obtained five program-based, single-room-occupancy vouchers from the Department of Human Services' Division of Mental Health Services. SERV used its own resources to rehabilitate the house. Five women share the home; each has a lease for her own bedroom and shared common space. All the residents are graduates of SERV's traditional supervised residential programs, and all tend to function better in small-group settings than living alone in their own apartment.

When the Bloom House residents first moved into their new home, 24-hour staff support was provided to aid them in the transition to the new setting. SERV obtained funding from the state for one staff position and added supplemental coverage to Bloom House by borrowing staff from other sites. The understanding with the state was that as the Bloom House residents progressed and needed less staff time, the

new staff person would provide supervision for the next start-up program. Gradually, Bloom House staff pulled back, encouraging more independence as well as greater interdependence among the housemates. Now, the residents require only a minimal amount of staff support.

Unfortunately, the house is not near any public transportation; however, residents who have their own cars often offer rides to those without transportation. The women have also accompanied each other to medical appointments, helped each other find locations for upcoming job interviews, assisted each other in filling out benefits paperwork, and taken each other to their families' homes for holidays. One resident helped her housemate obtain a computer and had a family member help hook it up.

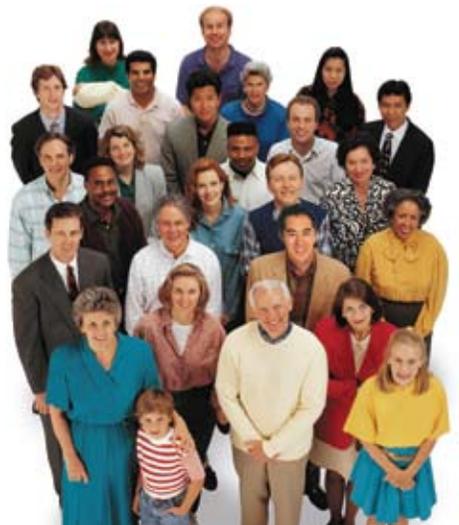
"The residents have bonded together as a family," says Program Director Tammy Wilson. "They socialize together, shop together, and support each other in their life goals. With time, they have learned to build their own foundation, individually and together, to the point of requiring only minimal support from staff. We could not be more proud of them."

SERV also created an enhanced supportive housing program for adults with both a severe mental illness and a developmental disability who also exhibited challenging behaviors. This population did not fit into the accepted notion of the supportive housing model; they were not at the more independent end of the continuum, and their conditions were not necessarily stable.

SERV opened four enhanced programs in Hudson and Mercer Counties, serving a total of 25 people. The agency obtained project-based single-room-occupancy vouchers from the Department of Community Affairs' Division of Housing. Again, SERV used its existing resources to completely rehabilitate the homes.

In the enhanced supportive housing sites, the residents have 24-hour staffing, including staff specially trained to intervene with learning difficulties and with challenging behaviors, such as impulsivity, physical aggression, and self-injury. The residents hold a lease for their own bedroom and common areas in the home. When they do get hospitalized, their home is still there for them when they are discharged. They have the option of accepting or declining any of the services available to them in the home, and their housing is not dependent on their agreement to receive certain services or interventions.

Most of the residents had spent many years in a state hospital, unable to be discharged to the community because traditional mental health programs were not equipped to deal with developmental disorders. Likewise, most developmental disability programs could not accommodate severe, persistent mental illnesses and would not accept consumers who had not received their developmental disability diagnosis at an early enough age. The residents in the Hudson locations had each spent an average of 20 years in the state hospital. One man, who had been hospitalized for 43 years, has lived in his home since April 2008. Some of the residents in the Mercer sites had attempted to live in community programs several





times in the past, but they often required rehospitalization, which caused them to lose their housing placement. When consumers in traditional residential programs are hospitalized for more than a month, agencies are under pressure to close their case and fill the bed with another consumer from a state hospital.

Having their psychiatrist regularly available to them has greatly helped the residents remain in the community and avoid crises. "I like seeing Dr. Cohen [the program psychiatrist] here at the house," says one resident when

asked about her current and past experiences with psychiatrists. Her housemate quickly jumps in to agree: "If I'm having a bad time today, I know that I'll see him again Tuesday, and that helps me get through."

Setting up the enhanced supportive housing programs was particularly challenging in that it was difficult to convince some staff that the project was significantly different from a traditional group home model. In a group home, residents are staying in a SERV house to get SERV services. In the new setting, the residents are

tenants in a property, with all the rights and responsibilities of tenants, and have SERV staff available to them. Another obstacle for both projects was the prevailing idea that living alone is the only acceptable goal for a supportive housing consumer.

The most important lesson SERV has learned from developing these innovative programs is that supportive housing can take many forms, as long as the essential elements of permanency, a lease, and freedom to choose or decline services are present.

Southwest Counseling Adds Housing First to ACT Model

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For mental health consumers who are homeless and have co-occurring mental health and addiction disorders, recovery and stability can be enhanced through multifaceted approaches. At Southwest Counseling Solutions in Detroit, Michigan, the addition of a Housing First component to the Assertive Community Treatment model has proven beneficial to clients' overall functioning and has improved housing and retention rates while containing costs.

In 2004, Southwest Counseling Solutions received Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment funding for the implementation of an ACT model for adults who are homeless and have co-occurring mental and addiction disorders. The program offers consumers housing vouchers, along with individual therapy, medication review and compliance coordination, integrated dual-disorder treatment, individual recovery planning, housing assistance and placement, entitlement referral and transportation, and group therapy. The program has provided all services, and costs have been significantly reduced by the compound funding sources for housing and grant funding for the ACT initiative. Participants are also offered other services such as supported employment and a consumer-run drop-in center.

Housing First is a significant component of the ACT program for homeless adults. The program achieved a 100 percent housing rate and an 86 percent retention rate in the final year of funding. Consumers who did not retain housing either moved or were difficult to engage. Housing First separates treatment from housing; it considers the former voluntary and the latter a fundamental need and human right. It provides scattered-site housing without on-site staff supervision and promotes harm reduction rather than requiring abstinence. This

approach results in improved client functioning for consumers who remain in treatment and housing for a year or longer.

The ACT program has benefited from its partnership with Southwest Housing Solutions, a sister agency that was established to provide affordable, permanent housing in the Southwest Detroit community. The two organizations have established a blended management model that ensures safe and affordable housing, life skills training, and strong collaboration with landlords to establish eviction prevention plans for consumers. The combined philosophy of Housing First and blended management maintains that

- >> All consumers have a right to rapid housing.
- >> Consumers who are dissatisfied with their current placement should be offered rapid rehousing.
- >> Housing and abstinence must be unbundled.
- >> Program eligibility should be based on an agreement to participate in supportive services (i.e., weekly contacts with the ACT team).

Consumer outcomes for the Homeless ACT program have been assessed variously. For example, consumer satisfaction with services was evident in interviews and social connectedness, determined on the basis of scores from the Government Performance Results Act assessment improved in 84 percent of the clients served. The Multnomah Community Ability Scale also reflected significant client improvement over time. In addition to a total score, the MCAS has four subscale scores measuring interference with functioning, adjustment to living, social competence, and behavioral problems. Repeated-measures analysis indicated that the greatest evidence of client improvement was found

between 18 and 24 months of service. By 18 months, clients displayed a 67 percent reduction in interference with functioning and by 24 months, they showed a 78 percent reduction. Additionally, 63 percent of clients served improved in social competence, and 69 percent displayed significant improvement in functioning.

Challenges that emerged during implementation of the ACT model with a Housing First component included the difficulties of meeting ACT fidelity requirements, such as time-unlimited service provision, while achieving grant goals related to number of people served; assisting consumers who experienced difficulty transitioning from homeless to housed status; sustaining sufficient funding for housing; and maintaining an adequate staff throughout the duration of the initiative. Program leaders have addressed these impediments by providing life skill groups through the blended management model, increasing the frequency of client contact, and incorporating family and community involvement. Funding challenges have been met through the use of vouchers, Tenant-Based Rental Assistance subsidies, and Shelter Plus Care grants. Finally, program leaders have enhanced staff engagement by emphasizing the team approach inherent in the ACT model.

Southwest Counseling Solutions' experience demonstrates that it is economically feasible for Homeless ACT programs to work collaboratively with the community to seek out varied resources for successfully housing clients. Although research is limited on the overall benefits of the Housing First approach for consumers with co-occurring mental health and addiction disorders, initial evidence validates the potential for significant improvement in both functional and housing outcomes.

Swords to Plowshares: Tailoring Permanent Supportive Housing for Veterans

Kelly Kent, Senior Program Manager, Corporation for Supportive Housing, San Francisco, CA / Kelly.Kent@csh.org

The Department of Veterans Affairs estimates that approximately 131,000 veterans nationwide are homeless. Homelessness among veterans stems from complex and often co-occurring health and behavioral health conditions. At least 76 percent of homeless veterans have substance use or mental health problems.

Affordable housing with flexible, client-centered supportive services or permanent supportive housing has emerged as a proven intervention that can assist the most vulnerable veterans. A 2008 evaluation clearly demonstrated that veterans who received a combined intervention of housing and intensive case management (i.e., permanent supportive housing) had an 87 percent lower risk of returning to homelessness than veterans who received case management alone and a 76 percent lower risk than those who received standard care.

A good example of how PSH works for veterans is the Swords to Plowshares' Academy at the Presidio, which provides housing for 102 formerly homeless veterans in San Francisco. The Corporation for Supportive Housing awarded this project a \$75,000 loan for predevelopment activities as well as a \$10,500 grant for programming.

Services are provided on site – including crisis intervention and counseling for PTSD and other mental health disorders, addiction treatment and recovery, benefits advocacy, and employment assistance. The Academy is located near the Veterans Affairs Medical Center, where tenants receive comprehensive medical care.

On-site program staff use a harm reduction services model, which helps people modify their behaviors to reduce their risk of harm and does not consider veterans engaging in risky behaviors (e.g., substance use) to be treatment failures. Staff also use motivational interviewing techniques to help veterans reach their goals at their own pace. Building a healthy community of peers is a particular focus. Over the years, staff have learned to more actively engage tenants in community participation, believing that a “veterans helping veterans” approach is essential to success. For this population, success equals residential stability.

The outcomes are impressive. Sixty-eight percent of current residents have maintained their housing for more than 4 years, 43 percent have maintained housing for more than 6 years, and 26 percent have maintained housing for more than 8 years. Sixty percent of those who have left the Academy have positive housing stability outcomes.

Although the housing, services, and outcomes are notable, success is best measured by the impact on tenants' lives. Paul, a 51-year-old Vietnam-era veteran who has lived at the Academy since 2002, struggles with PTSD, substance abuse, and other mental health issues. Once he moved into the Academy, he was able to stabilize many aspects of his life and regain hope and self-sufficiency within a supportive veteran community. After years on and off the streets, Paul has managed to break the cycle of chronic homelessness and establish a home. “If it wasn't for Swords, I know I would be dead right now,” he says.

Swords to Plowshares is now working with the Chinatown Community Development Corporation on the development of a new 78-unit PSH project called Veterans' Commons for homeless veterans and homeless senior veterans. Michael Blecker, executive director of Swords to Plowshares and one of the founding members of the National Coalition for Homeless Veterans, believes the Academy's “success



over the past 9+ years leaves no doubt that PSH is the cost-effective answer for ending homelessness among disabled veterans with multiple barriers.” Predevelopment monies for the new project have been provided by the City of San Francisco Mayor's Office, the Local Initiative Support Corporation, and the Corporation for Supportive Housing.

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The Centers for Medicare and Medicaid Services profiles SPQM as a "Promising Practice"

An August 2009 article in a CMS brief describes "... the experiences of Mental Health and Substance Use care organizations in three States – New Mexico, Arkansas, and Colorado – that have implemented a health information technology system – SPQM – to help them control costs and improve the quality of the services they deliver. Collectively their experiences suggest that there is much to be gained from using a system that combines claims-level data with service-level data. For example, organizations can reduce their no-show rates... encourage the use of cost-effective services..."



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Thresholds Offers Integrated Dual Disorders Treatment in Long-Term Housing

Tim Devitt, PsyD, Director of Integrated Dual Disorders Treatment, Thresholds, Chicago, IL / TDevitt@thresholds.org

Thresholds has found that the integrated dual disorders treatment and supported housing models help people with co-occurring mental and substance use disorders stay housed and engaged in services to help their recovery. The IDDT model stems from more than 25 years of research on what best helps people with CODs lead satisfying lives. The model includes a comprehensive array of integrated mental health and substance abuse services that address the multiple needs that are common for people with CODs (e.g., housing, medical care, job and educational opportunities, and attention to building a sober support network with family and friends). The model also emphasizes the provision of time-unlimited services through frequent and consistent assertive outreach, stage-based motivational counseling, substance abuse counseling, dual-disorders groups, linkage with 12-step groups, and pharmacological interventions that address CODs.

In late 1990s, Thresholds began implementing earlier versions of IDDT in combination with two supported housing programs serving homeless people with CODs – Rowan Trees, in 1997, and Grais Apartments, in 1999. Rowan Trees houses 45 people in the Englewood neighborhood on the south side of Chicago, and Grais Apartments houses 44 people in the city's north-side Rogers Park neighborhood. Both properties were uninhabitable when purchased by Thresholds and required total rehabilitation, at a cost of about \$4 million each. The bulk of financing for the building renovations came from federal tax credit funding.

Both Rowan Trees and Grais Apartments are staffed by a program director, two clinical team leaders, eight recovery specialists, and six desk clerks. Each program serves approximately 55 to 60 people at a time, including 10 to 15 former residents who have left the main apartment building and moved into apartments in the neighborhood. The programs are funded by Medicaid billing, the U.S. Department of Housing and Urban Development Supported Housing Program funding, the Illinois Department of Human Services Bureau of Homeless Services and Department of Mental Health, and grants from the Corporation for Supported Housing and private foundations. Building operating costs are paid from market-rate rents received for the units, all of which are subsidized by the HUD Section 8 Moderate Rehabilitation Single Room Occupancy Program.

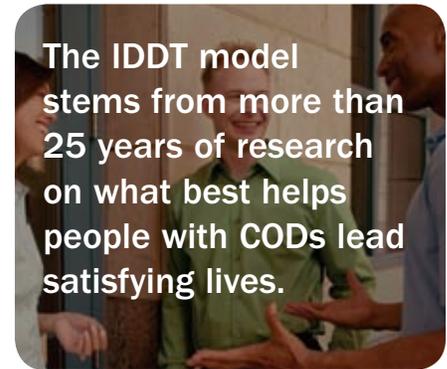
Thresholds is currently working to implement supported housing at a number of housing programs and IDDT with many outreach teams. In addition, the agency has committed considerable resources to implementing the evidence-based practices of supported employment and illness management and recovery.

Although implementing EBPs such as IDDT and supported housing has presented challenges, the hard work has led to us better emphasize the principles of recovery in our work with consumers. In particular, we have come to understand extrusion practices for on-site substance use. During the late 1990s and early 2000s, both Grais Apartments and Rowan Trees programs had zero-tolerance policies for on-site substance use. Consumers who used substances on site were helped to find other housing and provided follow-up support and services. Although some people managed to move forward in their recovery after being extruded, the fact that many did worse prompted program management to explore other ways of intervening.

At the same time, the IDDT model was endorsed by the Dartmouth Psychiatric Research Center and SAMHSA, and agency leadership began to recognize that zero-tolerance policies run counter to stage-wise motivational treatment approaches. Also, studies began showing that people with CODs tend to relapse on substances as they work toward sobriety. Research indicates that sobriety is attained over months and years and is enhanced when people have decent, safe, and affordable housing; an enjoyable activity that provides structure to their day; support from a sober person; and a positive relationship with a helping professional.

Armed with the IDDT and supported housing models and firsthand experience that the agency could do more to help people who were relapsing, Grais Apartments (in 2003) and Rowan Trees (in 2005) rescinded their zero-tolerance policies for on-site substance use. The impact of substance use on tenancy does receive attention, but residents are no longer automatically extruded for on-site use. This has led to significant decreases in turnover and better treatment responses over the long term.

In 2004, Grais Apartments was honored with the American Psychiatric Association's Silver Achievement Award for providing high-quality IDDT in a long-term housing setting. Also, in September 2007, Thresholds



received a Science to Service Award from SAMHSA for its efforts to implement IDDT.

The housing programs have had a positive impact on their communities. For example, community members' "not in my backyard" reactions were moderated by the multimillion-dollar investments Thresholds made in blighted buildings that were problems for the neighborhood. In addition, the programs have proven to be good neighbors over the years: Tenants and program staff participate in local block club meetings, CAPS meetings (i.e., a local community policing effort), and neighborhood events. The programs have also improved public safety. The people who have moved into Grais Apartments and Rowan Trees were homeless for long periods and were often involved with the criminal justice system.

Tony Zipple, chief executive officer of Thresholds, says, "If we are serious about supporting recovery, we need to make decent, safe, and affordable housing with supports a top priority. It is hard to expect 'recovery' when someone is homeless, disenfranchised, and on the street. Housing is a mental health issue."

Thresholds staff have learned a lot over the past 10 to 15 years about blending IDDT and supported housing program models. For example, we have found that offering a constellation of services based on IDDT and supported housing provides consumers with CODs the best shot for reaching their goals and having the life they want. The process of implementing EBPs is neither simple nor cheap, however. We have found that it helps to start small at a manageable number of sites and to use the EBP fidelity assessment tools to guide the implementation effort. Regular assessments measure implementation progress, consumer outcomes, and consumer satisfaction with programming and help identify the next steps.



A TENDER HEART

Bobby Reed moved to the Cape from Boston. He had just left prison and was looking for a chance to start over. But because of his prison record, he couldn't get into a halfway house. "I had no money, I couldn't get a job or anything," he recalls. Bobby slept at bus stations, outdoors in a tent, or anywhere he could find a place. That changed when he found the **Duffy Health Center in Hyannis, Massachusetts**. "It was a gift," he says. "Working with the wonderful people at the Duffy, I stay sober, and I've had a place to live for about four years now. With the help of Arlene Crosby, and everyone else... They're like my family," says Bobby. "It's an incredible journey, and I'm on a roll."

Even though it is difficult for Bobby to find steady work, he remains optimistic. "I'm pretty handy with construction," he says, and he works odd jobs, painting, landscaping—anything he can find. Bobby has even helped out at Duffy by painting walls and moving furniture. "What you do to help someone else always comes back. I'm a firm believer in that," he insists.

Living in his own home, Bobby enjoys waking up warm. "It's freezing out there," he recalls. He's lost many friends to frostbite and fires. The memory overwhelms him, and his voice audibly breaks before he continues. "The staff is helping me learn how to cook. I'm just used to sandwiches and cereal." Ever resourceful, Bobby used to live on the "tuna fish special," and he could make tuna taste good, at least a hundred different ways. It's really nice, he says, to be clean and to have clean clothes. When Bobby was homeless, he'd leave to do day labor and come back to find that everything he had had been stolen. Now, his things are still there when he comes home. He has even adopted a kitten, a darling furry creature that would otherwise have been euthanized. Bobby loves animals.

"Having your own place... it's unbelievable. My house is a castle, it's beautiful. And every day, life gets better. No one can hurt me here. I can go to sleep and be safe. I can close and lock my doors. That is a good feeling," he says.

In Touchstone’s Intentional Community, Consumers Rule

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In 2005, Touchstone Mental Health set out to answer two questions:

- >> Could 15 adults with serious and persistent mental illness, 30 percent of whom were dually diagnosed with chemical dependency, create an intentional community where they could collaborate to define their community’s guidelines and support one another to achieve their individual and community goals?
- >> Could the community’s goals and guidelines then be managed and implemented by the peer members and only guided by mental health practitioners?

The answer to both questions was a resounding yes.

An intentional community is formed by a group of people who choose to live together with a common purpose and work collaboratively to create a lifestyle that reflects their shared core values. In TMH’s IC, consumers gathered to create their own community. They defined their vision and group decision-making process, outlined their meeting procedures and conflict resolution protocol, and developed a strong financial structure.

TMH expanded the consumer-driven activities found in traditional models by removing staff-directed goals from the process. When the agency released its hold on conventional staff roles, clinical wisdom took on new forms. Staff and consumers began to place trust in the consumers’ will, wisdom, and desire to connect,

thereby creating a community that reflects health rather than illness.

Staff set out to redefine the roles of consumers and mental health practitioners by creating a vehicle for wellness driven by the consumer, where the practitioner is a backseat passenger. Staff take the role of consultants who cultivate the strengths of members as leaders and teachers.

Today, the IC’s 15 members live independently in scattered apartments across Minneapolis and convene at a central apartment that houses community space and a resident volunteer. Members work together to create opportunities for social outings, meals, and education, including gathering for breakfast at a local restaurant and taking a group yoga class. Such activities break down barriers of social isolation and help them integrate into the larger metropolitan community.

The IC incorporates best practice peer support models. Members hold each other accountable for community membership and responsibilities, including reciprocity, interdependence, and mutual support for health. When a member struggles with symptoms or relapse and peers offer support, set limits about participation if the member is actively using chemicals, and challenge each other to participate in community life despite depression or anxiety.

“I feel ownership in creating what we are,” says IC

member Dawn Christenson. “The objectives are focused on participation to the best of our abilities; a sense of empowerment is among each of us.”

Outcomes highlight the success of this model, given that 96 percent of members maintain stable, affordable housing; 88 percent live independently; and 95 percent maintain good physical health. On the basis of the success of the first IC, a 25-member IC was added in 2007. Today, both communities are thriving.

TMH’s IC effort was made possible by the commitment of the staff and consumers involved as well as the county’s financial support for the pilot program.

Members see the IC as a place to feel safe and to find meaning, friends, and something to look forward to. They see it as a place to relieve anxiety and renew hope about recovery and connection, which people may easily lose as they struggle with relationships, depression, and isolation.

“IC works because it is a true community,” shares Lantz. “On one of my first visits to our first IC, I heard the story of a female member who was crying as she was preparing to enter the hospital. She was crying not because she was entering the hospital but because her fellow IC member had just confided that she would miss her, think of her, and visit her while she was away. It would be the first time anyone other than her case manager would visit her in the hospital.”

UBHC Helps to Realize the Vision of a Life in the Community for Everyone

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University Behavioral HealthCare is a major provider of a wide array of behavioral health services throughout the state of New Jersey. UBHC has been a provider of supportive housing since it received a state grant in 1999. Subsequent awards have expanded and enhanced supportive housing services from the original 62 beds to 186 beds. The UBHC

supportive housing program is designed to provide fully integrated community housing and to support wellness and recovery for adults ages 18 and older who are diagnosed with a psychiatric disability and substance use disorders. We emphasize principles of psychiatric rehabilitation and provide consumers with housing options through direct leasing with

local landlords.

The UBHC supportive housing program is based on the belief that housing is a basic right for all people and that people with psychiatric disabilities should be fully integrated into the community. Consumers are respected as people with the ability to make informed choices regarding aspects of their life, in-



cluding treatment type and duration. The supportive housing staff work in partnership with consumer tenants to develop service plans, and they strive to inspire and assist tenants in learning the skills they need to maintain their housing, reintegrate into the community, and achieve recovery.

Supportive housing, once considered the last stop on a linear housing continuum model, is now providing housing to mental health consumers who are living on the streets, those who are directly discharged from homeless supportive shelters, and those who are discharged from the state psychiatric hospital system. Such consumers present with a high prevalence of co-occurring medical and addiction disorders; commonly are using drugs and alcohol; have a history of violence and, often, a forensic history; and are less willing than other populations to engage in mental health treatment.

Initially, the housing program was staffed with traditional case managers, who primarily provided concrete services and linkage to community-based providers. To better meet the specific challenges presented by the consumers we house and to meet the philosophy of a Housing First model, the program has expanded. Services have been enhanced and staffing has been modified

so that an interdisciplinary team can provide extensive, ongoing treatment and support based on the assertive community treatment model. Our supportive housing staffing expanded to include masters-level clinicians, a special education teacher, peer wellness coaches, a licensed clinical drug and alcohol counselor, a licensed practical nurse, and an advanced practice nurse. Therapy, evaluation of medication, supportive education, and other clinical services are now provided directly in the consumer's home. Peer counselors, who share personal recovery stories about addiction and mental illness, were added to the team to serve as role models and to provide hope that recovery is possible.

Supportive housing offers a unique setting in which to engage and assist people to live a healthier life. A recent expansion of UBHC's supportive housing program focuses on a subpopulation of residents with comorbid physical health conditions, including cancer, hepatitis C, obesity, and heart disease. Nursing staff partner with consumers to help ensure access to and utilization of primary care providers and medical specialists and to improve self-monitoring and management of health problems. Each consumer resident of the integrated health program is given a bathroom scale when he or

she moves into housing, and staff partner with residents to identify and achieve personal wellness goals. Residents also have access to other recently added health services, including walking groups, cooking classes, and wellness coaching.

Our program has not been without its fair share of challenges. The stigma associated with addiction and mental illness often affects the manner in which landlords, neighbors, and local police interact with consumer tenants. Because housing is not contingent on participation in mental health services, program staff, families, and the community have expressed concerns regarding the safety of the residents and of the community. Nevertheless, since our program's inception, people who would not otherwise have had the opportunity to live in the community have retained their housing, moved toward recovery and wellness, reconnected with estranged friends and family, continued their education, returned to work, married, raised children, managed complex physical health conditions, and led productive lives.

UBHC is making the Substance Abuse and Mental Health Services' vision of a life in the community for everyone a reality — one person at a time.

St. Vincent de Paul Village Incorporates Assertive Community Treatment into Housing

Patricia M. Walsh, Village News Editor and Kris Kuntz, MA, Clinical Teams Program Manager, St Vincent de Paul Village, San Diego, CA
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At St. Vincent de Paul Village in San Diego, California, an assertive community treatment program funded primarily by a grant from the Substance Abuse and Mental Health Services Administration has seen success at two supportive housing complexes since its January 2008 inception.

The Village ACT program assists tenants with a history of chronic homelessness and a severe and persistent mental illness, many of whom have a co-occurring substance abuse disorder. The 24-hour client-centered treatment team provides comprehensive community-based psychiatric care, rehabilitation, and support to tenants living at Villa Harvey Mandel and Village Place. The two supportive housing complexes at St. Vincent de Paul Village are operated by Father Joe's Villages, a partner agency of St. Vincent's.

"Clients who never thought of working again are putting resumes together," says Katie McGinness, ACT team lead-

er. "They have more insight into their mental health symptoms and are taking their medications more regularly."

Village ACT grew from a need identified by case managers working in the two supportive housing complexes. Struggling to manage the multiple problems and crises unique to the population, the case managers presented their needs to St. Vincent de Paul Village administrators, who responded by applying for a grant from SAMHSA. The 5-year grant for \$1.8 million was awarded in October 2007. "San Diego County had recently completed the planning process for California's Mental Health Services Act, and feedback from the community was that ACT was a strong evidence-based practice," says Julie DeDe, director of social services for St. Vincent de Paul Village. "We determined that the model was a good fit for our population."

The ACT team includes a team leader, psychiatrist, nurse, mental health clinicians, mental health special-

ists, peer support specialist, and life skills coach. Following the principles of the ACT model, the Village ACT team members equally share responsibility for supporting clients. Every service a participant requires to be stable in the community is provided by team members. The team meets daily to review the schedule for the day and to make sure that all team members are up to date on every client. A shift manager is assigned each day to manage the daily schedule and triage crises.

Village ACT has served 56 clients since its inception. Ninety-five percent of clients have remained in permanent supportive housing since enrolling in the program, and of those participants, 45 percent have remained in housing for at least 12 months. Seventy-three percent have demonstrated improved psychiatric functioning; 71 percent with a history of psychiatric hospitalizations have decreased their visits to the psychiatric hospital;

Continued on page 58

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and of those with a co-occurring substance abuse disorder, 78 percent have demonstrated improvement in sobriety.

“The impact of ACT on the community is evident by the decreased number of psychiatric and physical hospitalizations, as well as the decrease in the number of emergency room visits,” McGinness says. “The program has also created a community within the supportive housing complexes, where there is peer pressure among tenants to stop illegal activities in the two buildings.”

Through ACT, clients are improving their social and family connections: 50 percent of clients have reported increased feelings of social support and con-

nectedness with friends and family. Clients are also improving or maintaining their financial stability: 85 percent have accessed mainstream resources, and 13 percent are now employed.

Although clients’ results have been promising, the program has not been without growing pains. “Being on site where the clients live has presented challenges,” McGinness says. “Some clients are too needy, where others are hesitant to engage because it is too close, especially those with current substance abuse issues.” Clients must also undergo an intense assessment process to enroll in the program.

In addition, it has been a challenge getting staff familiar and comfortable with the ACT model and

finding and retaining staff who can be successful in the model.

“Implementing a new program has been a learning process filled with making mistakes and moving forward,” DeDe says. Developing solid partnerships has been key to ACT’s success. “From the start we received assistance from Lia Hicks with the ACT Center of Indiana/Target Solutions, which was a huge help. We definitely recommend having some outside experts involved, especially in the first year,” DeDe says. Establishing a good relationship with property management at the two buildings has also been critical.

At West Cook, Social Service Agencies Team Up for Permanent Supportive Housing

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Given the complexity of mental illness, traditional targeted housing programs have often failed to move clients into independent living. Several agencies in west suburban Cook County, Illinois, pooled their resources to address the growing needs of homeless people and to draft a proposal for a Permanent Supportive Housing program. Insights were provided by a range of community representatives,

including mental health agencies, township leaders, consumers, and consultants (e.g., the National Alliance on Mental Illness, the Corporation for Supportive Housing, and the Veterans Administration), who came together to develop a new approach to an existing problem. With past housing models and the cutting-edge philosophies of the Harm Reduction-Housing First model as a guide, the agencies designed a PSH prototype that broke down the traditional obstacles to meet the multifaceted and interconnected needs of people with mental illness who are disabled and homeless.

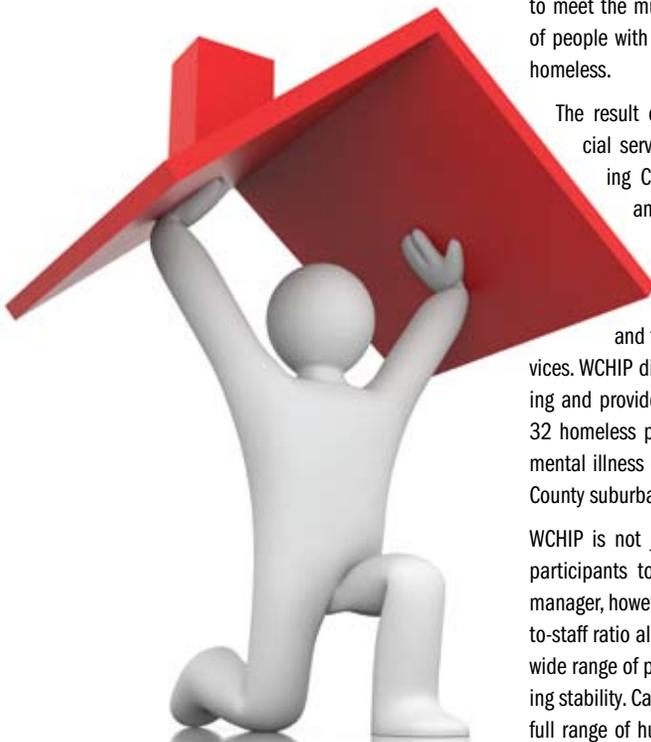
The result of these meetings was that four social service agencies (Pillars, Thrive Counseling Center, Thresholds, and Vital Bridges) and one shelter (West Suburban PADS) teamed up to create the West Cook Housing Initiative Partnership Project. Funding was provided by HUD and the Illinois Department of Human Services. WCHIP directly subsidizes scattered-site housing and provides wraparound case management for 32 homeless people (individuals and families) with mental illness disabilities throughout the West Cook County suburban area.

WCHIP is not just a housing subsidy that requires participants to check in occasionally with a case manager, however. The program’s relatively low client-to-staff ratio allows case managers to fully address a wide range of participants’ needs in relation to housing stability. Case managers have had to confront the full range of human needs for their clients, and the

unexpected has become commonplace. The services are mostly provided at the client’s home setting, so that the program can keep its focus on helping people with mental health needs stay independent with dignity.

The constant within the project is the continued collaboration at all levels among the agencies. After the program was launched in 2006, it quickly became clear to everyone involved that the spectrum of barriers that the clients faced was wider and deeper than originally conceived. A collaborative meeting process was then structured to include consulting on clients and management of programmatic issues. This produced a check-and-balance system whereby a diversity of cultures, ideas, and systems support the participants as well as the partnering agencies’ staff. Agencies have come together to create a seamless system of care for people who are homeless. The system is based on the belief that people create and strengthen communities, from the agencies involved to program participants.

WCHIP has entered its fourth year, and some light is now being shed on its effectiveness. Although the clients entering the program closely reflect the statistics about race and demographics of homeless people in Cook County, the amount of time clients maintain housing has far exceeded national averages. The key to success is collaboration, which allows the participating agencies to evolve in their ability to meet the needs of this unique client base and thus ensure that clients remain stable in their new homes and new lives.



STRONGER THAN SHE USED TO BE

“They say women are strong, but I don’t know,” **Bernadine Mustapha** muses. “When I was homeless, I was suicidal. I was always on edge. And very depressed.” She pauses. “It was so scary.”

Before making her way to **Johns Hopkins Bayview Medical Center’s Supportive Housing Services Program in Baltimore, Maryland**, Bernadine wandered from place to place, sleeping in the bus station or in vacant houses. “I never want to experience that again,” she insists. She tried day therapy, but the minute she was ready to open up and deal with her mental health issues, staff changed, and she got a different counselor. “Thank God for Nicole,” says Bernadine, referring to Nicole DeChirico, LGSW, clinical supervisor of Supportive Housing Services Adult PRP. “I was skeptical at first, but there’s something about Nicole. If not for her, I’d be dead,” she insists.

“Once I got my first place,” says Bernadine, “I would do my best to do what I had to do to stay there. To have a home, a place to call my own. . . .” Her voice trails off. “I worship my house. I love it to death. I keep it spotless.” Nicole agrees, saying, “Bernadine has the cleanest, most decorative home I’ve ever seen.”

Bernadine has come an incredibly long way. “I go to all my doctor’s appointments, all my meetings,” she says. Even temporary setbacks when she suffered an arm injury or was laid off from her job failed to throw her too far off course. “The Bernadine of the past,” says Nicole, “we wouldn’t have seen her for a while.” Instead, Bernadine focused on doing what she had to do, adjusting her phone bill and applying for food stamps and energy assistance. Anything to keep her sanctuary her home. “Nicole helped me so much to get where I am. I’m stronger than I used to be,” she explains. And it shows, says Nicole: “When Bernadine was homeless, her attendance here was poor. After we worked on her housing, her attendance immediately increased.” Bernadine’s home is her peace of mind. She breaks all the biases and the stereotypes. “She inspires me,” says Nicole.

National Council Member Spotlight

A National Council publication featuring members in action

Pete Kennemer, CEO of **Western Arkansas Counseling and Guidance Center** (Fort Smith, AR), had a Public Policy Award named in his honor from the Arkansas Mental Health Council. Pete was the first recipient for this award and it was presented August 11, 2009 at the Annual Mental Health Institute in Hot Springs, AR.

The River Oak Center for Children (Carmichael, CA) received a DIY Teen Center from Wells Fargo and the Sacramento Monarchs to provide outlets for teens to be engaged in arts activities such as fashion, music, and sports. The program at the development center is a collaborative with the Sacramento County Probation Department, the River Oak Center for Children and Quality Group Homes.

Dr. Peter Campanelli, President and CEO for the **Institute for Community Living** (Brooklyn, NY) was honored by the New York Association of Psychiatric Rehabilitative Services for his extraordinary efforts in behavioral health. Dr. Campanelli is the recipient of the Marty Smith Memorial Award that is presented to a “uniquely inspired and dedicated provider who has demonstrated exemplary contributions to the advancement of best practices in service to New Yorkers with psychiatric disabilities.”

Centerstone of Indiana and the **Dunn Center** (Columbus, IN) are officially joining forces and the new combined company began operating as Centerstone on September 1. It employs nearly 900 staff members across 17 counties throughout central and southern Indiana and serves more than 24,000 people seeking mental health and substance abuse treatment.

The Wheeler Clinic (Plainville, CT) was visited by United States Congressman Joe Courtney on August 27, 2009, resulting in his co-sponsorship of a bill before Congress supporting new legislation for gambling addiction treatment and prevention services. Mr. Courtney accepted an invitation by Donna Zaharevitz, peer counselor of the clinic's Better Choice Gambling Treatment Program in Hartford, to discuss services for people with gambling addictions, listen to the stories of current clients, and ask for his support of the Comprehensive Problem Gambling Act, or H.R. Bill 2906. The new bill will give authority to the Substance Abuse and Mental Health Services Administration (SAMHSA) to act as the lead agency in coordinating Federal action on the issue, and provide \$14.2 million in grants per year to non-profits and state agencies for prevention, research, and treatment.

Seven National Council member organizations are among the 13 community programs across the country selected to receive 4-year SAMHSA grants of \$500,000 annually for Primary and Behavioral Health Care Integration programs to address the needs of people with serious mental illnesses:

Please note the seven National Council Members who were awarded grants:

- ★ **Bridges... A Community Support System Inc.** (Milford, Connecticut)
- ★ **Care Plus NJ Inc.** (Paramus, New Jersey)
- ★ **CODAC Behavioral Health Services of Pima County Inc.** (Tucson, Arizona)
- ★ **Community Council of Nashua** (New Hampshire)
- ★ **Mental Health Center of Denver** (Denver, Colorado)
- ★ **Pennyroyal Regional MH-MR Board Inc.** (Hopkinsville, Kentucky)
- ★ **Shawnee Mental Health Center Inc.** (Portsmouth, Ohio)

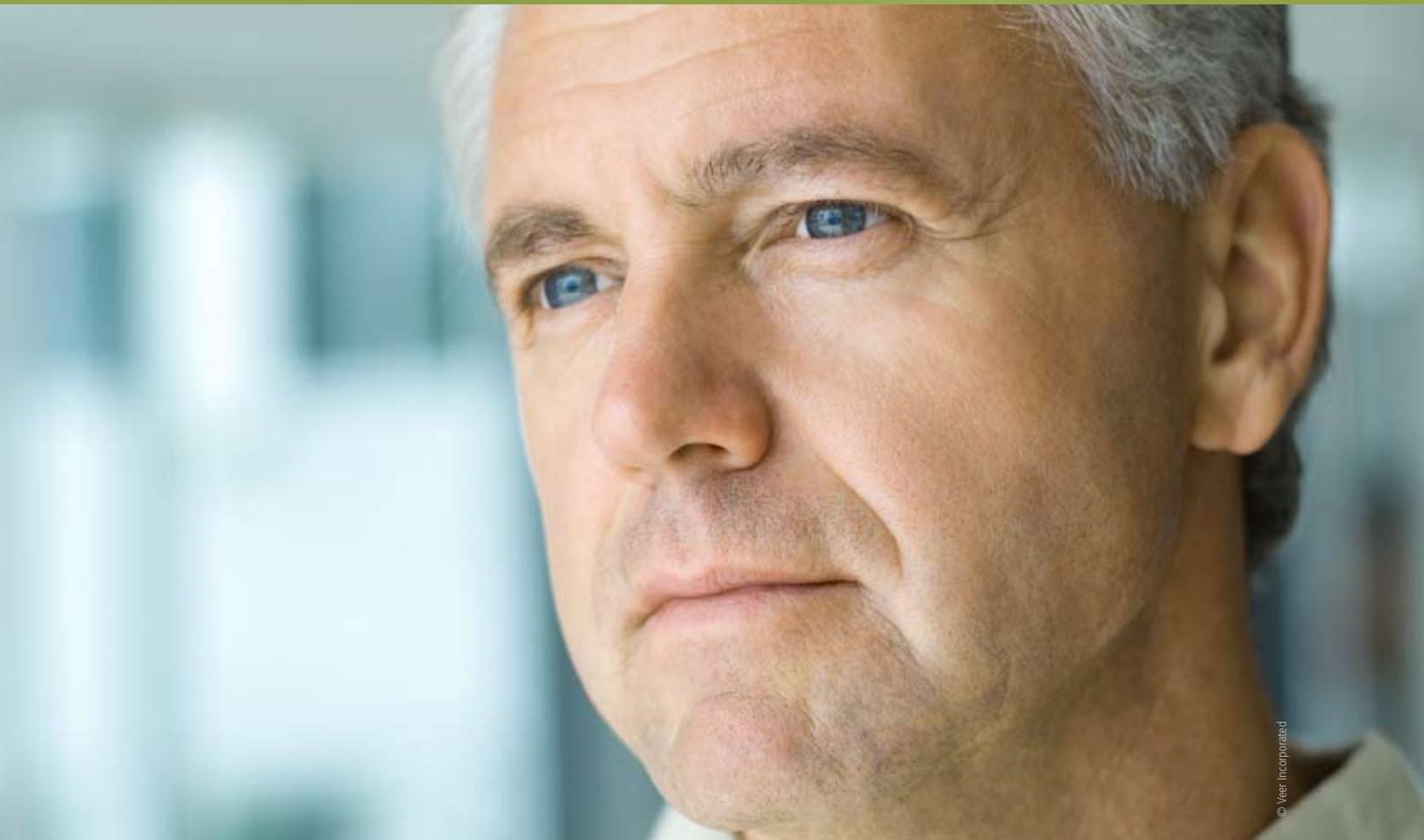
The National Council wishes to showcase members and your accomplishments. If you have a piece you would like mentioned here and in the biweekly Technical Assistance Update e-newsletter, please email TheaB@thenationalcouncil.org.





NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

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