Part 2: An Implementation Guide for Behavioral Health Program Administrators

Part 2, Chapter 1

IN THIS CHAPTER

Introduction

Part 2 of this Treatment Improvement Protocol (TIP) is directed to administrators and senior staff persons and is designed to prepare you to help behavioral health staff persons in their work with clients facing homelessness and the specific challenges that homelessness presents. It can serve as a resource for you to use as you support and challenge your staff to become part of a community-wide response to the problem of homelessness. How can you support your staff members in these efforts? Do they need further training? What additional services and collaborative arrangements does your organization need? Where does funding come from? What do model programs look like?

It is important to emphasize that homelessness is a problem that deserves the attention of behavioral health organizations. Some of the clients your program is currently treating may be homeless or at high risk of becoming homeless within months of their discharge from the program. People who are homeless report more problems related to alcohol use, drug use, and mental disorders than those who are not homeless. Findings from studies of Midwest urban samples of people in shelters, food programs, or living on the street report high rates of problems related to substance use (58 percent of women; 84 percent of men [North, Eyrich, Pollio, & Spitznagel, 2004]; 55 percent of women; 77 percent of men [Forney, Lombardo, & Toro, 2007]).

A meta-analysis of studies done between 1979 and 2007 (Fazel, Khosla, Doll, & Geddes, 2008) revealed a pooled prevalence rate among homeless men for alcohol and substance dependence of 37.9 percent (10 studies) and 24.4 percent (7 studies), respectively. Providing adequate shelter for people who are homeless can be the first step toward engaging in behavioral health treatment. Transitional supportive and permanent supportive housing provided

by either behavioral health programs or other programs in the community have become integral components of recovery promotion in both mental health and substance abuse treatment. (See the online literature review in Part 3 of this TIP for more details.)

Why Is an Implementation Guide Part of This TIP?

Part 1 of this TIP provides the knowledge and many of the tools behavioral health workers in your program will need for working with people who are homeless and those facing the immediate threat of homelessness. But without specific attention to program development, staff support, and specific implementation strategies, the tools your counselors have developed are likely to go unused or will be used ineffectively. Part 2 will give you, in your role as program administrator or senior staff person, ideas and strategies for program development and implementation to support programming for clients in behavioral health treatment who are homeless or at risk of becoming homeless.

Programming for people who are homeless and have behavioral health issues occurs in a variety of settings: criminal justice programs, homelessness programs (e.g., shelters, outreach services, permanent supportive housing services, intensive rehabilitation environments), community assistance programs, community health centers, and other community settings, in addition to more traditional behavioral health programs. Although this TIP is directed primarily at professionals working in more traditional programs, much of the information will also be useful to administrators and senior staff members in other settings serving people experiencing homelessness and substance use or mental disorders.

Developing Services for Clients Who Are Homeless

Your behavioral health program may be interested in serving people who are homeless or at risk of becoming so for a number of reasons, many of which also apply to homelessness programs that want to develop or expand services for clients with mental illness and/or substance use diagnoses.

First, serving people with substance abuse and mental disorders who are homeless often is not a matter of choice. The clients are there! Implementing specific programmatic elements to meet their needs serves to make interventions more successful and cost-effective. It also enables staff to work more efficiently. In this sense, specialized homelessness services are an essential ingredient for quality and effective care in your organization. Many of the clients you serve are not homeless when they come into treatment but, for a variety of reasons, become homeless *during* treatment and have no place to live once they complete intensive treatment. Other clients receiving behavioral health services are just one paycheck or one personal or family crisis away from homelessness. Still others enter treatment because they need shelter. Having a staff with the knowledge and skills to anticipate and address these issues will help your program run more smoothly and with better outcomes.

As the behavioral health field moves toward outcome-based funding, serving clients more efficiently becomes a higher priority. When program staff members are aware of the effects of homelessness on treatment, not only does it lessen problems associated with housing instability; it also reduces the severity of social and behavioral crises that interfere with treatment. This, in turn, increases staff efficiency and client retention.

Additionally, making homelessness services a priority for your program will increase the capacity of the program and the skills of the clinical staff responding to various other social and health needs your clients may have, such as transportation services, health care, financial management, and responses to criminal justice issues. In this sense, programming for homelessness benefits all clients, not just those who are currently or potentially homeless.

Specific services for homelessness may be an opportunity for your program to find additional sources of funding to support client services. A variety of community funding resources are available to address the needs of people who are homeless, particularly those in need of behavioral health services. These additional funding streams can help stabilize your funding base and increase your program's capacity to meet the needs of clients.

Some people in the community may question the costs for intensive and supportive care for people who are homeless and whether the benefits of such care are cost-effective. The reality is that supportive housing is cost-effective when compared with alternatives. The Corporation for Supportive Housing (CSH) report, *Costs of Serving Homeless Individuals in Nine Cities* (The Lewin Group, 2004), presents estimates of the costs of serving people who are homeless in various settings: supportive housing, jails, prisons, shelters, psychiatric hospitals, and acute care hospitals (Exhibit 2-1). Estimates represent the average cost of providing 1 day of service to an individual in each setting and capture the underlying costs of providing services, compared with the payments received from public payers. The CSH report defines supportive housing as a combination of program-building features and personal services to enable people to live in the community.

The Housing First Approach

One of the first decisions you will make in developing services for people who are homeless is whether a Housing First approach is suitable for the clients you expect to serve and for your community. Housing First approaches are used to engage people into services who are homeless and have behavioral health conditions. They are low demand, offer permanent housing for people who are homeless, and do not require the client to enter treatment or document abstinence. Many, though not all, Housing First participants receive Federal disability benefits, and many programs encourage clients to participate in money management programs that ensure payment for housing. Housing First programs provide substance abuse, mental health, and medical services through community case management or multidisciplinary teams. Clients choose which

Exhibit 2-1: Range of Estimated Service Costs per Day by Setting

Setting	Cost per Day
Supportive housing	$20.54 (Phoenix, AZ)—$42.10 (San Francisco, CA)
Jail	$45.84 (Phoenix, AZ)—$164.57 (New York, NY)
Prison	$47.49 (Atlanta, GA)—$117.08 (Boston, MA)
Shelter	$11.00 (Atlanta, GA)—$54.42 (New York, NY)
Psychiatric service hospital	$280 (Phoenix, AZ)—$1,278 (San Francisco, CA)
Acute care hospital	$1,185 (New York, NY)—$2,184 (Seattle, WA)

Ranges established across: Atlanta, GA; Boston, MA; Chicago, IL; Columbus, OH; Los Angeles, CA; New York, NY; Phoenix, AZ; San Francisco, CA; and Seattle, WA.

Source: The Lewin Group, 2004.

services to receive. More information about these programs is available on the Corporation for Supportive Housing Web site (http://www.csh.org).

Housing First programs demonstrate substantial enrollment into services and housing stability for individuals who are chronically homeless and have long-standing mental illness and, in most cases, substance use disorders (Pearson, Locke, Montgomery, Buron, & McDonald, 2007). Enrollment status is determined more by continued contact with case managers and other service providers and less by whether the client is continuously residing in program housing. Temporary departures from housing are not uncommon; program staff continue to follow up with clients even when they are away from their housing. Many programs hold units for up to 90 days and encourage clients to return.

Housing First programs range from scattered-site independent housing leased from private landlords (thus increasing individual choice in both housing and neighborhoods) to congregate living programs in which the program owns or controls the housing (allowing staff to provide a high level of onsite supervision and response to client crises). Staff members are available around the clock to help clients maintain their housing and meet their other needs.

Implementing Housing First models in suburban or rural areas can present challenges that require modifications to the model. Staffing may need to be composed of smaller teams resembling assertive community treatment (ACT) teams, which maintain low caseload ratios and broker some services from community providers. Teams can feature interdisciplinary staff from different organizations. Resources may be needed to purchase or use extra vehicles. Housing choices may be restricted to renting a room in someone's home, sharing a house, or waiting until a single unit is found. (For descriptions of Housing First programs, see U.S. Department of Housing and Urban Development [HUD], 2007b.)

Communication among staff members is often accomplished through daily team meetings so that they can respond immediately to client needs. Many programs also have automated documentation services for collecting information on client status and outcomes.

Funding for Housing First programs comes from diverse sources. The programs seek Medicaid reimbursement for mental health case management services and State or county funding for clinical services. Additional sources of funding might include foundations and other private sources. HUD assistance programs provide rental assistance. State or local funds may cover short-term stays in a hotel while a client seeks housing, or rental assistance may be provided to clients who are ineligible for HUD assistance programs.

These programs often use a representative payee system to handle clients' income. This is a money-management system that assigns a third party to handle disbursement of funds for individuals receiving Supplemental Security Income or Social Security Disability Insurance (American Association of Community Psychiatrists, 2002). It is often a practical need and helps people develop independent living and money management skills.

Many Housing First programs strongly encourage representative payee arrangements for certain clients. People with representative payees at baseline are more likely to stay housed (HUD, 2007b). Although representative payee arrangements can be a valuable intervention for individuals who are severely disabled, you and your staff should carefully consider potential consequences of removing client responsibility for deciding how and when to spend

money. Power struggles can result when a client's request for money is denied to cover higher priority needs (e.g., when the request conflicts with paying rent). One way to reduce power struggles is to have personnel other than the counselor act as the "banker," permitting the counselor to work more effectively with the client on money management skills. For more on representative payee arrangements, see the Social Security Administration's Web site (http://www.socialsecurity.gov/payee/).

Unless you do adequate groundwork, the process of establishing a Housing First program may run into unexpected obstacles. First, it is important to separate a client's clinical issues from his or her responsibilities as a housing tenant (Stefancic & Tsemberis, 2007). This may represent a significant change for staff.

One challenge in implementing Housing First programs is the presence of preexisting agency policies that couple housing with requirements that the client maintain abstinence. Rigid, rigorous housing eligibility requirements that often discriminate against clients with psychiatric symptoms or substance abuse can also be challenging. Housing First programs usually accept clients on a first-come, first-served basis.

Another challenge is ensuring collaborative agreements with the immediate neighborhood where any congregate facility is to be located. Steps toward collaboration include:

- Involvement of neighborhood associations or boards on the board of advisors for the program.
- Development of a good neighbor code of conduct.
- Development of shared responsibility in use and maintenance of public resources (such as parks or gardens).
- Rapid response to security or sanitary issues, including police attention.

Challenges in Adapting Programs To Address the Needs of People Who Are Homeless

You may decide to add homelessness rehabilitation services to your existing programming rather than choosing a Housing First approach. When you decide to implement specialized homelessness programming in your behavioral health organization, you will find some special challenges, the solutions to which can be ultimately productive for your program. Still, to institute new services, you must overcome several hurdles.

It is imperative to conceptualize, develop, and implement services for homelessness in the context of your current programming. In effect, the new services need to be natural additions that complement existing programs. Not to do this would mean having a unique homelessness program that is not integrated but rather a separate, isolated entity. In this context, the new service elements have to be conceptualized in response to the question "How can this new service integrate with and complement the services we already offer?"

Second, instituting a new service component for homelessness in your behavioral health program means staff development to confront the myths about people who are homeless, the services they need, and how the services can and should be provided. Staff development may mean additional skills development or enhancing and specializing skills that already exist among staff members, who will need to learn about additional resources in the community and how to collaborate with the organizations and people that provide them. They might need cross-training to work with the specific needs of people who are homeless while maintaining their skills in behavioral

health services. Working with homelessness may require case management and outreach skills unfamiliar to most of the staff. For instance, behavioral health counselors working with clients who have substance use disorders may end up doing outreach with clients who show no interest in changing substance use patterns; mental health workers may feel uneasy at first seeing clients in settings other than their office.

You and your staff will need to interact with a different network of community services. Programs primarily addressing homelessness in the community may have a different orientation to services. For instance, programs for homelessness may have a social service orientation; behavioral health programs, a healthcare-focused perspective. Rehabilitation in homelessness programs may be more oriented to life skills development, whereas behavioral health programs focus on treatment and specific psychological strengths. Thus, community programs created for homeless populations may have different goals, staffing patterns, funding streams, or client goals. Behavioral health program administrators, who often are more experienced in working in the health, substance abuse, and mental health fields, should recognize these different perspectives and view them as strengths, not impediments.

In addition to formal relationships among organizations, an informal system of community involvement, interorganizational relationships, and services planning is required to bridge gaps between traditional behavioral health and homelessness services. Later in this chapter, the discussion of collaborative partnerships and service modification highlights this issue.

Special Needs of Behavioral Health Clients Who Are Homeless

Most clients who are homeless and need substance abuse or mental health treatment (and many clients in substance abuse or mental health treatment who enter treatment without housing or become homeless during treatment) have needs distinct from those of other clients. Some problems may resemble those experienced by many clients but differ in severity and incidence. These problems extend beyond lack of housing and include psychiatric impairments, drug use, financial mismanagement, criminal justice issues, and healthcare needs. Thus, special program elements may need to be developed. These include outreach and client retention programs, specialized case management efforts, and treatment planning and approaches that integrate life skills development and specialized resources for relapse prevention and recovery promotion.

Different Clients, Different Needs

The three groups of clients who are homeless, as defined in Part 1, Chapter 1, present different needs to your program. Some clients are homeless for the first time in their lives. Your program needs policies and procedures to guide counselors and clinical supervisors in helping in these emergencies. Clients who are transitionally homeless and are recovering from substance use disorders may benefit from transitional living facilities, such as Oxford Houses, described in Part 1, Chapter 1, of this TIP. Most communities have a variety of established resources for clients who are transitionally homeless. For instance, the Salvation Army, along with other faith-based resources, offers services for the transitionally homeless in many communities. These resources are especially valuable for families facing the crisis of first-time homelessness and can serve to prevent the development or exacerbation of other psychosocial and health problems.

Clients who are episodically homeless need clinical workers who recognize and focus on the stressors that caused the homeless episode. Administrators need to have established

linkages with such community resources as vocational rehabilitation, employment resources, financial and health services, and other community resources so that people who are episodically homeless can quickly get back on their feet once they are stabilized and on a recovery path. It is useful for administrators to have open conduits to local entitlement agencies (e.g., Social Security, public assistance) and to ensure that counselors are well trained to negotiate these systems to help clients in crisis obtain or maintain the financial supports to which they are entitled.

Clients who are chronically homeless are often the most visible subgroup of people experiencing homelessness in a community. They also may be beset with the widest variety of co-occurring mental health, health, financial, criminal justice, and employment issues in addition to their homelessness. Seldom is a community behavioral health program capable of addressing all of the needs of people who are chronically homeless; thus, they must depend on linkages with housing, medical, entitlement, and other resources to begin to bring stability to the lives of these clients.

Regardless of the housing status of your program's clients at intake, it is important to build in resources for eliciting housing information early in treatment to ensure that potential or actual homelessness does not present as a crisis when a client prepares for discharge.

Modifying Behavioral Health Services To Meet the Needs of Clients Who Are Homeless

To serve people who are homeless, your organization can adapt its programs to provide services that were not previously available. These service modifications to meet the needs of people who are homeless take different routes based on knowledge about the target population. A bottom-up approach to service modification (described below) begins by evaluating the needs of the people who will receive the services. In a top-down approach, the impetus for change comes from administrators, boards of directors, funding resources, and the like. If you are unfamiliar with your community's homeless population, a bottom-up approach is best; top-down integration works best when you know the population well and can assess in advance the major barriers to care and the broad initiatives needed to overcome them. Top-down modifications often require some bottom-up information to make the right choices. You can tentatively commit to a plan but then engage in community discussion before acting, making modifications as necessary.

Bottom-Up Service Planning

Bottom-up service planning is a process of using peer workers, case managers, clinicians, supervisors, and administrators to develop a program that meets identified needs of a special client population. It often starts with a few unique, complex cases—for example, developing services for people who often use emergency shelters, emergency rooms (ERs), or detoxification centers. The project scale increases incrementally as effective practices are established and resources become available. The first stage of bottom-up service integration is to identify the target population and engage people in services and then develop feedback mechanisms to identify what works and how to improve program efficiency. Ask people from the target population about their priorities informally or via surveys or focus groups. The National Health Care for the Homeless Council Web site (http://www.nhchc.org/advisory.html) offers a manual for involving a formal consumer advisory board.

Collaborating with partners to identify and engage the target population

Bottom-up service modification can be a collaboration between nongovernmental organizations (NGOs) or between programs within an NGO. The first step is small but dynamic: collaborating with other service providers who can help identify your target population and introduce you to new clients. These collaborations can be informal or formal. Documentation at this stage is simple: tracking where people are identified and their progress through the system. Exhibit 2-2 lists some helpful elements in bottom-up modification.

How do you perform bottom-up services modification?

Step 1: Perform a needs assessment. The needs assessment includes gathering data not only on the demographics and expressed needs of the homeless population to be served, but also on how those services can be most effectively delivered, which services seem to result in client change, and which services can be offered over time (see needs assessment steps listed on p. 164).

Step 2: Get internal buy-in. Take your needs assessment to the CEO, chief clinical officer, and/or board members and develop a plan for how to proceed that includes identifying potential funding sources, stakeholders, staff members, and services that can reasonably be added to drive the initiative.

Step 3: Make contact with funding sources. Organization administrators seek funding to meet the needs of the population. Once the possibility of funding exists, go to Step 4.

Step 4: Identify stakeholders. Identify other participants in your effort, begining with your clinical staff and fellow administrators. Other

Exhibit 2-2: Key Components for Bottom-Up Modification

1. **Sense of urgency.** Frontline staff may fear that failing to engage people in services will lead to victimization on the streets, untreated physical illness, or deteriorating life situations. This fear propels the staff into a sense of urgency about helping people get the services they need.
2. **Support personal responsibility.** Clinical supervisors and administrators support the frontline staff in embracing personal responsibility for the advocacy for each case. This includes understanding the staff's experiences and providing flexible support (e.g., willingness to modify team structures) so the staff can more easily accomplish its work.
3. **Negotiate, collaborate, and advocate.** Frontline staff members, supervisors, and administrators who are committed to providing services to the target population negotiate, collaborate, and advocate with other service providers to meet each client's needs. Interorganizational partnerships facilitate this through joint supervision of day-to-day activities.
4. **Hold weekly frontline staff meetings.** Case managers, clinicians, and supervisors meet weekly to capture the collective wisdom gained in this learning process and channel their enthusiasm into understanding how to do the work effectively. They discuss and develop methods to address missed opportunities to connect with other service providers and potential clients.
5. **Hold monthly administrator meetings.** You and other administrators discuss the learning process and set principles of practice and procedures as needed (e.g., through case descriptions, understanding barriers to services and missed referrals, advocating for access to services on a case-by-case basis with State administrators). You'll gain a better understanding of the work by meeting clients and providing some direct services.
6. **Include appropriate partners.** As you identify new service needs and resources in your organization or in the community, include appropriate partners in the learning process.
7. **Obtain new funding resources.** New funding allows the project to serve more clients.

Sources: Rowe, Hoge, & Fisk, 1996, 1998.

potential stakeholders include:

- Your board of directors.
- The local continuum of care (housing providers; mental health, substance abuse, and medical treatment providers; hospital emergency departments; and staff members of criminal justice programs).
- Local business owners and legislators with whom your organization has strong relationships.
- Program alumni and other community supports (e.g., faith-based institutions).
- Community boards.
- Private foundations for matching funds.

Step 5: Create and formally present a concept paper. A strong grant-writing team or consultant creates the concept paper. Critical issues to address include:

- A clearly articulated problem statement, proposed plan, implementation process, timeline, and evaluation process. Describe the problem using a combination of statistics and short personal stories.
- How the resources you are seeking fit your organization's mission/strategic plan.
- The roles to be played by your partners.
- If you are seeking private funding, a plan for transitioning to public funding.

Step 6: Conduct postpresentation activities. Homelessness is a politically charged issue; handle contacts with funders with tact.

Step 7: Receive funding. Designing and funding your initiative ends; implementation begins.

Adapting clinical services to meet the needs of the target population

At this stage, you and the clinical staff learn to adapt clinical practices to meet the needs of clients and influence institutional policy. Focusing on individual cases of homelessness makes it easier to understand the context of counselor–client work and the barriers to doing the work. For example, counselors in a detoxification program (in the same organization as an intensive substance abuse treatment program) request case-by-case exceptions for people who are homeless to a policy barring readmission of clients within 30 days of discharge. In each case, the counselors argue that the policy is a barrier to rapid readmission to substance abuse treatment, which would reduce the relapse severity and the length of treatment needed by the client. As the cases brought to the administrator accumulate, he or she eventually changes the policy.

As project scale increases and clients engage, you will identify other components of care:

- Frontline staff note good collaborative experiences with some NGOs, whereas others do not meet the expected clinical standards when working with people in intensive substance abuse treatment who are homeless. Referrals are withheld from the latter, which may stimulate development of more flexible services in the community and a corresponding increase in referrals. Counselors, case managers, and supervisors realize the need for service and policy modifications to better meet the population's needs. For example, after observing that some people feel isolated when placed in their own apartments, create an alumni program to facilitate connection to community recovery supports and help people successfully transition to permanent housing.
- Documentation and use of surveys and feedback loops become more sophisticated and formalized to enable sharing of information with funding sources and State authorities.
- As clinical and administrative leaders formalize the integration of people who are homeless into the organization and the treatment system, their bottom-up efforts lead, directly or indirectly, to top-down integration opportunities.

Top-Down Service Modification

Top-down service modifications work when you are familiar with the target population and can assess and overcome the barriers to care. You can develop service modifications through negotiations with other providers within and across service systems. Such strategies are informed by bottom-up processes, such as solving dilemmas that arise in frontline work.

How do you perform top-down services modification?

Step 1: Allocate money. A request for proposals is issued or a service need is identified.

Step 2: Identify stakeholders/collaborators.

- Identify stakeholders—representatives of local governments, businesses, employers, recovery communities, and other service providers who will want to refer clients to your program.
- Identify partners—outreach teams, housing providers, mental health treatment providers, vocational and recovery service providers, financial and health benefit providers, and primary healthcare providers who want to develop new capacities in existing programs or create new interagency programs.
- Identify the scope of the project and the role of each partner.
- Get letters of support from partners, recognized advocacy groups, and other stakeholders.

Step 3: Find local or regional resources to help you develop the program. Bring in resources as needed to help you define the services you wish to provide, the adaptations your program will need to make, and a timeframe for implementing services.

Step 4: Write a proposal or concept paper. Include a budget; bring all collaborators to the table.

Step 5: Implement the plan once a contract is awarded.

- Hold an upper-level advisory and implementation meeting:
  - Administrators involved in the partnership (interorganizational) or programs (intraorganizational) meet and identify what needs to be done, what needs further investigation, and who will be responsible for doing so.
  - A memorandum of understanding (MOU) or memorandum of agreement (MOA) between the NGOs (interorganizational only) is drafted and describes tasks and roles. (A sample MOU appears in Part 2, Chapter 2.)
- Assemble an implementation team:
  - During the startup period, program directors work together to coordinate services.
  - The team identifies other committees (e.g., screening, case management) and persons (e.g., consumers, senior clinical staff members, line counseling staff members, peer counselors, program evaluators) to be involved in administering the project.
  - The team addresses confidentiality agreements, admission criteria, and intake forms.
- Form a team of service providers; define their roles. Staff members from collaborating programs create a core team to provide services and cross-train and educate each other about their programs, organizations, and roles. Potential members include:
  - Peer counselors.
  - Outreach workers.
  - Case managers.
  - Substance abuse and mental health treatment counselors.
  - Team leader(s) who collaborate with peers in other NGOs, provide some clinical services and supervision, and are trained to work with people who

have been diagnosed with co-occurring disorders (CODs).
  - Consultants on medical and mental health needs of individuals who are homeless who facilitate petitions for involuntary transport and hospitalization when necessary.
  - Liaisons to detoxification services, criminal justice, and financial and health benefits.

Step 6: Schedule regular interorganizational meetings. Address policies and procedures that inhibit service provision to people who are homeless. Regular working groups can include:

- Advisory board. Upper-level managers from each collaborating organization or the head administrators from each organization to be involved in proposal creation, addressing outcome measures, data, reports for the funder, and the like.
- Client selection committee. Midlevel clinical/program directors from each organization.
- Interorganization/interdisciplinary clinical case management team. Direct service staff meet weekly to discuss new admissions, people in transition, and particularly challenging cases.
- Stakeholder advisory group. Keeps community stakeholders aboard as program starts.

Example of successful service modification: Health Care for the Homeless

In practice, programming changes often combine bottom-up and top-down strategies. Health Care for the Homeless (HCH) in Baltimore, MD, provides an excellent example of this combination, which results in comprehensive services provided when the client is ready.

Bottom-up service modification

Begun in 1985 as a small triage and outreach unit, HCH is now accredited by the Joint Commission on the Accreditation of Healthcare Organizations. By adding programs as needs were identified, HCH now offers a broad range of services: street outreach, primary health care, mental health services, intensive outpatient substance abuse treatment, medication-assisted treatment, and referrals to residential treatment. A bottom-up modification resulted from an analysis of intakes that revealed that people purchased buprenorphine on the street when they could not access detoxification services. This suggested a need for a buprenorphine initiative to improve engagement and treatment retention. Funding for a nurse and case manager was sought and won, but for only one position. A nurse/case manager was hired for a caseload of five clients daily. When he left, a substance abuse case manager was hired and an agreement was created with the health center staff to administer and store the medications.

Top-down service modification

A top-down modification was prompted by requirements from funding sources that influenced the length of service delivery and program development. Separate funding streams for mental health (mostly third-party billing systems) and substance abuse treatment services (mostly public funding and grants) created differences in approaches to service delivery. Federal requirements for more formal data and reporting mechanisms led to State service outcome benchmarks for the substance abuse treatment program that focused heavily on abstinence, program use, and retention. To meet these benchmarks and the engagement needs of people who are homeless, HCH created a pretreatment phase supported by the City of Baltimore. People in precontemplation for substance abuse treatment receive readiness

counseling focused on health education that engages them in treatment at their own pace.

Interacting With Community Resources To Build a Continuum of Care

HUD defines a continuum of care as a local planning process involving the range and diversity of stakeholders in a community in assessing and planning for the needs of people who are homeless. Normally, one superagency is designated as the coordinator of the continuum of care planning process, and one application is made on behalf of the community for HUD funding. "Community" is defined by the continuum of care planning process as the geographic area included in the application. The application is based on assessed needs for three types of housing in the community: emergency shelter, transitional housing, and permanent housing, along with the supportive services needed to address each of these housing needs. One of the features that makes the continuum of care process unique is that it may include nonprofit agencies, governmental agencies, community-based organizations, agencies in the community that provide supportive services (such as mental health and substance abuse treatment programs), local businesses, law enforcement, and consumers who are homeless or were formerly homeless.

Rarely is one program able to meet all of the client's needs, as the continuum of care implies. As a result, collaboration among programs is essential. Although your program's counselors may interact with other agencies at the level of the individual client through outreach, treatment planning, case management, treatment, and follow-up, administrators must work to develop collaborative continua of care, overcome interagency barriers, and ensure that there is "no wrong door" through which to enter services. This is particularly true when addressing the needs of clients who have two or more urgent, severe problems—homelessness and substance abuse or mental illness. Likewise, although a homelessness program may employ behavioral health counselors, they are seldom equipped or funded to provide the full complement of services necessary for comprehensive substance abuse and mental health treatment.

An integrated system of care that provides a continuum of housing services increases communication among the organizations involved, improves coordination among providers, and serves more people who are homeless. Examples of the interrelationship of a continuum of care, organizational strategies for supporting program development and service modification, and strategies for effective service delivery appear later in this chapter. Exhibit 2-3 highlights the benefits of an integrated system of services for people who are homeless.

Collaborative Partnerships

In interacting with other community resources and becoming part of your community's continuum of care, you can establish collaborative partnerships with other agencies that serve substance abuse and mental health clients who are homeless. These partnerships can help your organization expand its range of services, link up with other systems, and foster innovative programming, funding, and community acceptance (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

Successful collaboration requires negotiation, compromise, and commitment to address a problem about which all stakeholders experience a sense of urgency and responsibility. An early step in forming partnerships is sharing different perspectives on the problem (e.g., lack of treatment resources versus lack of

Exhibit 2-3: Integrated System of Homelessness Services

Components	Description	Goals
Continuum of Care	A plan and infrastructure of formalized operations and coordinated services provided by multiple organizations. Involves a continuum of care plan, MOUs, sharing of information, resources, and improved access to services.	Collaborate to offer an array of needed services: • Develop procedures that allow for interaction of agencies as needed. • Document the changes in procedures. • Identify and share best practices.
Service Providers	Providers collaborate to secure funding and provide an array of housing, substance abuse treatment, mental health services, support services, health centers, and other services.	Increase effectiveness of services delivered through organizational change processes: • Assess service outcomes and staff skills to deliver services. • Collect information to track and analyze change. • Engage in activities to support change.
Services	Housing, support services, and substance abuse treatment and mental health services are tailored to be responsive to the needs of people who are homeless.	Identify and provide: • Acceptable services and treatment to help people access and maintain stable housing. • Effective strategies for people with complex housing, service, and treatment needs.

Source: Leginski, 2007. Adapted with permission.

appropriate housing stock) and establishing guiding principles or assumptions for the collaboration. Failure to resolve different perspectives can cause covert power struggles. Other barriers to overcome when pursuing partnerships include:

- Competition for scarce resources among community organizations.
- Unwritten policies of daily service delivery.
- Service organizations that resist change.

Creating Interorganizational Partnerships

To address system and service delivery problems with people who are homeless, assess the problem and gather information about the target population and the strategies needed to resolve the problem.

Interorganizational needs assessment

To assess the needs of an interorganizational continuum of care, determine the size and characteristics of the population that is homeless and assess issues raised by community members, governmental agencies, and service providers. One way to start is by talking with other service providers who work with people who are homeless and working with the organization that will apply or has applied for HUD funds. In some localities, a single organization or agency represents the community's needs. The information contained in the "Continuum of Care" application often provides a thorough review of strengths and gaps in the community's services.

Intraorganization assessment

To assess your organization's ability to assist people who are homeless, analyze the number and characteristics of people seeking services who are homeless or at risk of homelessness. Start by counting the number of people who are homeless or at risk of homelessness who are admitted to substance abuse or mental health treatment during a 2- to 4-week period. Other measures include the number of people admitted with criminal justice involvement and the number discharged without employment, job training, or stable housing. This type of assessment includes staff discussion of findings at team meetings to better understand how organizational factors influence findings.

Steps in the assessment process

- Determine the population's gender, ethnic, and racial makeup; criminal justice experience; family status; language; and nature of homelessness (i.e., situational, episodic, chronic).
- Determine whether these characteristics are reflected in the staff providing services.
- Identify gaps in the continuum:
  - Are people not staying in treatment?
  - Are some counselors seeing 1 client who is homeless per month while others see 10?
  - Are clients referred from other services in a coordinated fashion, or are they walking in without referrals?
  - Are clients transitioning out of substance abuse or mental health treatment without employment and housing?
  - Do clients have a primary care provider and affordable access to needed medication?
  - Are some programs in the organization declining referrals because the clients are homeless?
  - Do some programs in the organization have particular difficulty working with clients who have either substance use disorders or mental illnesses?
- Identify policies and procedures contributing to service gaps and consider how to change them; use a formal continuous quality improvement methodology. See the Network for the Improvement of Addiction Treatment's *Primer on Process Improvement* (2008). The Addiction Technology Transfer Center Network (2004a,b) also offers useful publications on the topic.
- Identify issues in the community, such as:
  - More people living on the streets.
  - Legislation that handles homelessness through arrest rather than social services.
  - Insufficient affordable housing stock.
  - Insufficient mental health, substance abuse, and medical treatment services.
- Determine whether this is an opportunity to partner with other providers to improve access to services, create resources to meet the needs of people who are homeless, and reduce costs to the community:
  - If services to address these issues are compatible with your organizational mission and strategic plan, then develop programming.
  - If these services aren't part of your strategic plan or mission, look for community partners.
  - If other providers can't offer needed services, consider developing them in your agency.

Exhibits 2-4 and 2-5 provide information on forming and documenting partnerships.

Exhibit 2-4: How To Develop Partnerships

1. Identify organizations in your community affected by homelessness and NGOs and government entities that already provide services or interact in the community with people who are homeless.
2. Reach out to and become familiar with potential partners (e.g., police, emergency services, businesses, elected officials, neighborhood organizations, health centers); the key to partnerships is finding a shared objective.
3. Agree on a definition of the problem; assess your readiness to partner with them and theirs with you.
4. Form a partnership that benefits both organizations.
5. Define the benefits for each partner.
6. Identify the contributions each organization must make in order to realize these benefits.
7. Sustain partnerships by negotiating agreements that capture the basis of the partnership and the active linkages between partners that allow monitoring of both challenges and successes.

Source: SAMHSA, 2006. Adapted from material in the public domain.

Example of Successful Partnership: Downtown Emergency Service Center

In Seattle, WA, the Downtown Emergency Service Center (DESC) has used partnerships to improve housing services, integrate treatment services, access other community resources, and create innovative housing programming (SAMHSA, 2006).

Internally, DESC integrated its shelter, clinical services, and housing programs. Staff members from each clinical program (i.e., outreach and engagement case managers, substance abuse treatment counselors, and crisis respite program workers) are co-located in the shelter. DESC provides intensive support for housing stability by having one project manager supervise the staff responsible for supportive housing property management and the staff responsible for supportive services. DESC uses information technology to make information about people receiving services available to staff members in different programs. In daily meetings, outreach and engagement, housing, and clinical services staff members discuss new clients and emerging client problems.

DESC partners externally with community services and political organizations. Community partners include the Seattle Department of Social and Health Services, the police department, mental health and drug courts, and the local emergency center. Political partners include the county executive, mayor, and downtown association president. To increase access to benefits for people who can't tolerate the regular process, the staff represents them and works directly with benefit managers,

Exhibit 2-5: How To Document Partnerships

A memorandum of agreement is a written agreement between parties (e.g., NGOs, Federal or State governments, communities, and/or individuals) to work together on a project or meet an objective. An MOA outlines the responsibilities and benefits of each partner. It can be a partnership agreement or a legally binding document that holds parties responsible to their commitment.

A memorandum of understanding is less formal than an MOA. Many NGOs and government agencies use MOUs to define relationships between departments or NGOs and to ensure smooth operations of shared resources and service provision. MOUs can address intraorganizational connectivity, communications, escalations, and response patterns. See Part 2, Chapter 2, for a sample MOU.

resulting in more successful benefit applications. A mutually beneficial collaboration with the police includes offering a standardized program for police trainees to work alongside service providers, making shelter space available as an alternative to incarceration, assisting with safety issues, and meeting regularly to address issues.

DESC provides case management, substance abuse treatment, and mental health and employment services to people referred by the drug court. Shelter staff communicate daily with the ER to increase the shelter's access to emergency medical care. DESC obtains donations from businesses by showing that the housing program decreases the use of emergency services, jail, court, and detoxification, and saves the community money while providing more humane, respectful services for people who are homeless. DESC maintains a strong relationship with political partners by showing that programs effectively meet the needs of people who are homeless and by advocating for policies that facilitate innovative programming, funding, and support. DESC's relationship with political partners supported the creation of an innovative housing and treatment program in Seattle.

Internet Resources

Becoming informed about housing programs is one way you can help your program create relationships with other community agencies serving people who are homeless. A great deal of information is available on the Internet from the following Web sites:

- U.S. Department of Housing and Urban Development: http://www.hud.gov
- National Alliance to End Homelessness: http://www.naeh.org
- Corporation for Supportive Housing: http://www.csh.org
- SAMHSA's National Registry of Evidence-Based Programs and Practices: http://nrepp.samhsa.gov
- National Health Care for the Homeless Council: http://www.nhchc.org
- U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration Information Center: http://www.hrsa.gov
- U.S. Department of Veterans Affairs (VA) Web site on reaching out to veterans who are homeless: http://www1.va.gov/homeless
- VA Web site on health benefits eligibility for veterans: http://www.va.gov/healtheligibility
- National Resource Center on Homelessness and Mental Illness: http://www.nrchmi.samhsa.gov

Integrating Behavioral Health Services With a Community System of Homelessness Services

Across the continuum of rehabilitation services for people who are homeless, a variety of community care providers may be engaged with the client. Some of these services include mental health and substance abuse treatment, housing and rehabilitation services specifically for people who are homeless, general healthcare programs, and other community social and rehabilitation services. Your program may be a small part of the larger services continuum, or may be a major provider of care that spans several of these domains. In either case, it is important that programs have a common goal of quality care for people experiencing homelessness, a recognition that homelessness in the community cannot be addressed by simply providing shelter, and a commitment to and a strategic plan for the coordination and nonduplication of services.

Additionally, there are distinct phases of care for persons who are homeless and are affected by substance abuse or mental illness. These are described in Part 1, Chapter 1, and include engagement, intensive care, and ongoing rehabilitation (McQuistion, Felix, & Samuels, 2008). Two additional transition phases (from engagement to intensive care and intensive care to ongoing rehabilitation) are critical times during which clients may regress from their homelessness rehabilitation, experience a relapse to their substance use or psychiatric symptoms, or drop out of treatment; these phases are therefore important to consider in your community programming.

In a few communities, the entire continuum of care might be offered by one comprehensive program, but it is more likely that different organizations work at different points on the continuum. Be aware of services provided in your community, the scope of the services in an individual agency, and the extent to which outreach and treatment services for behavioral health are provided. This will allow you to identify gaps in services and develop programs to address them.

The phases of rehabilitation form a framework that can guide your decisionmaking about program development, implementation, management, and evaluation. The outline below lists the ways your agency can prepare for and participate in providing services to clients who are in each phase of rehabilitation from homelessness.

Outreach and Engagement

In this first phase of rehabilitation, counselors begin to build and leverage relationships to offer the kinds of help needed by people with substance use and mental disorders who face homelessness. As an administrator, you can:

- Establish collaborative relationships with community organizations.
- Form interdisciplinary teams from several organizations that are coordinated through a single entity. Teams can provide direct access to services that meet client needs and help clients transition from this phase into intensive care. Outreach services that respond to community stakeholders' needs include taking hotline calls from individuals and neighborhood and civic association representatives, in addition to forging strong relationships with local police precincts and ERs.
- Schedule staff members to be off site and available to potential clients.
- Ensure that your staff has the training and experience to perform outreach and engagement and to work with individuals and families experiencing crises related to homelessness. This also entails being aware of community resources for emergency and temporary housing, their restrictions and limitations on services, and their admission requirements.
- Provide funding for practical goods and resources that can be offered to prospective clients (e.g., specific needs of children who live in families who are homeless, battered and abused women and children, people who live on the street).
- Develop tools to document outreach contacts. (See Part 2, Chapter 2, for a sample Homelessness Outreach Contact Form and a sample Daily Contact Log.)
- Provide training for staff members to prepare them for the realities of outreach work (e.g., working outside the office setting; working with individuals and families who are experiencing immediate crises; working with people who want resources but resist or only passively comply with treatment services; tolerating clients who are inconsistent in their contacts and appear one day, then disappear for several days).

- Ensure that your staff is trained in the appropriate interventions for this phase of homeless rehabilitation (such as rapport building) and that staff members are able to rapidly develop case management plans for services.
- Ensure that staff members can recognize signs that a potential client is ready to make a transition to the intensive care phase of homeless rehabilitation or the contemplation stage of change for substance abuse or mental health treatment.
- Provide supervision for outreach workers.
- Provide a forum for discussion of policies and procedures related to conduct and safety on the street and in shelters; formalize policies and procedures (see Part 2, Chapter 2, for samples). Policies should require that staff members work in pairs, carry cell phones, and be able to contact a supervisor when needed. Policies and procedures should require teams to leave situations in which any one member feels unsafe and to choose next steps together.
- Plan and structure critical incident debriefings.
- Discuss steps necessary for quality assurance.

Transition to Intensive Care

This phase begins when the client agrees to accept case management, entitlements, housing, treatment, health care, or other services—or when there is a need for acute medical or mental health treatment. As an administrator, you can:

- Formalize policies and procedures for recordkeeping for potential clients entering the system.
- Provide for delivery of tangible benefits, such as food, clothing, and transportation.
- Enlist help from emergency shelters for pretreatment beds to house clients while they wait for treatment slots.
- Assign case management specialists to provide flexible services, such as housing negotiation, completion of financial and/or health benefit applications, and assistance with using public transportation.
- Provide intensive case management (ICM) and critical time intervention (time-limited ICM) to potential clients as appropriate. These strategies help the agency keep track of clients, help clients stay connected to the agency, and provide access to a variety of services and agencies.
- Offer attractive support services for clients, such as employment, financial and health benefits, and medical and mental health services.
- Offer peer-led services to encourage engagement in services and enhance empowerment and confidence.
- Coordinate transition planning with local agencies, such as jails, hospitals, and substance abuse and mental health treatment programs, to provide housing resources for clients being discharged or released.
- Develop protocols for transition planning.
- Offer transportation to housing for clients exiting jails, hospitals, or treatment programs.
- Ensure that your staff is familiar with your community's housing resources, their requirements, and their limitations.

Intensive Care

Intensive care begins when a person engages in a clinic, shelter, outpatient, or residential treatment program, accepts ACT team services, or obtains transitional or permanent supportive housing (McQuistion et al., 2008). Treatment of substance use and mental disorders and medical conditions is the primary focus during this phase. You can:

- Develop MOAs and MOUs with collaborating housing resources in the community (e.g., programs providing transitional and

permanent supportive housing) so clients do not fall through the cracks in transitioning between or working with two different community systems (housing and behavioral health).
- Provide thorough screening and assessment by behavioral health professionals that includes assessment of substance use and mental health as well as housing needs, financial status, employment status, and other areas of life functioning.
- Fully accomplish active introduction to ongoing and nonemergent general health and wellness services, whether off site with active case management or on site through implementing models of behavioral health and primary care integration.
- Increase engagement and retention by reducing or eliminating waiting time; using peer facilitators, mentors, and senior program participants to orient people to services right after they are assigned to a treatment program; and providing educational sessions for the client's family as appropriate.
- Provide peer mentoring to strengthen connections to recovery supports.
- Develop methods to improve compliance with treatment of substance use, mental illness, and medical disorders and conditions.
- Address, through your programming, the needs of parents with children. Provide services or care for children in your agency or by referral. Offer treatment with a family focus. Assess the safety of children who do not accompany their parents to treatment.
- Ensure that the services you provide are trauma informed. Offer anger management and assertiveness training. Provide training to staff in nonconfrontational methods of addressing conflict and in strengths-based approaches. Offer gender-specific treatment groups (see the planned TIP, *Trauma-Informed Care in Behavioral Health Services* [SAMHSA, planned h]). Be familiar with behavioral health treatment models for people who are homeless and how your community uses those models.

Behavioral health treatment models for people who are homeless

You should be familiar with rehabilitation models for people who are homeless. Your agency may want to partner with other agencies in your community; your staff members may want to be involved with clients from other programs. This section describes three approaches. Assertive community treatment was first used for people with serious mental illness (SMI) at high risk of institutionalization and modified for people who are homeless. HCH is a model program designed to engage people who are homeless into housing, services, and substance abuse recovery. Modified therapeutic communities (MTCs) combine housing and treatment program models.

ACT teams

SAMHSA has designated this evidence-based practice as appropriate for clients who have extensive histories of psychiatric hospitalization, are homeless, have co-occurring substance abuse or medical problems, and/or are involved in the criminal justice system. ACT services are sometimes used in Housing First programs, but ACT teams also function independently of housing programs and are often part of a behavioral health organization. A team-based approach is used to offer substance abuse and mental health treatment, housing, healthcare, medication, and employment services; help with family relations; and recreational opportunities. People can refuse formal treatment without losing housing. Even then, the team visits at least weekly to assess the person's safety, well-being, and living conditions and to keep communication channels

open between the client and the team. On visits, the team notes the person's mental and physical state, follows up on outstanding issues from the last visit, and offers help with whatever the individual wishes to address. The team often helps with routine chores and conveys to the individual that he or she matters to the team (Hackman & Dixon, 2006).

Health Care for the Homeless

HCH combines comprehensive services in a manner that is appealing to people who are homeless. Substance abuse treatment intake, assessment, and engagement occur on a flexible walk-in basis to accommodate clients' difficulty with keeping appointments. Participants who meet the criteria for outpatient or intensive outpatient treatment are encouraged to engage in treatment at HCH. Those needing inpatient medical care, methadone maintenance, or residential treatment are referred to other programs. People too ill to navigate the shelter system are provided shelter and nursing services in a convalescent care program.

Counselors assess for substance use, symptoms of mental illness, housing, criminal justice system involvement, social supports, job interests, work history, and goals, then reframe this information to reflect client strengths and increase motivation to complete treatment and pursue stable employment when possible. Each counselor sees 15 to 20 clients. Each caseload is a mixture of people in various stages of treatment preparedness. Clients receive individual counseling once a week or as often as determined by their recovery plans, including walk-in sessions. The group counseling program is based on the stages of change.

Modified therapeutic communities

MTCs are specialized residential settings staffed by workers who are trained to address both mental and substance use disorders. This model includes a supportive housing component in continuing care.

Following the client's decision to accept MTC services, a structured daily regimen is gradually introduced. Services emphasize personal responsibility and mutual support in addressing life difficulties, peers as role models and guides, and the peer community as the healing agent. Staff and clients create action plans to monitor short-term goals. These goals build as success accumulates, adapt to reflect relapses and return of symptoms of mental illness, and reflect the unique needs and readiness for change of the individual.

At program entry, clients join a housing preparation group and receive other initial services. Staff members build trust, increase motivation, and provide education on homelessness, mental illness, and substance abuse through multiple contacts and a weekly orientation group. The group also strengthens peer affiliations and provides information on program structure and activities.

MTCs operate on token economies. Points are won for behaviors, such as medication compliance, abstinence, attendance at program activities, follow-through on referrals, completed assignments, and activities of daily living. Negative behaviors result in loss of points. Points can be exchanged for phone cards, toiletries, and so forth. Peer facilitators act as role models to encourage the involvement of people who are newly admitted, build hope, and plan for the future.

Teaching vocational and independent living skills is a key part of an MTC program. Vocational activities begin shortly after entry, and work experience begins in a peer work group. Vocational exploration and work readiness assessments detail client work history, interests, attitudes, and ability to find a job (e.g., applications, interviewing, interpersonal relationships).

Basic vocational skills training in maintenance, clerical, and inventory tasks are taught, with weekly job assignments and peer group review.

Interested individuals who show commitment to the program, personal progress, and ability to help others are recruited into peer counselor training near the end of residential treatment. They get didactic and practical experience as role models, group facilitators, and counselors and attend briefing and debriefing sessions before and after each group and activity. The supervisor or program director provides supervision each week and a written evaluation each month, and other staff members, assisted by senior trainees, run weekly peer counselor training groups. Trainees are paid a stipend. Those who successfully complete both peer counselor training and the MTC residential program can become counselors in the MTC or comparable programs.

Transition to Ongoing Rehabilitation

This transition is gradual and is a high-risk time for dropout and/or relapse. Much of the programming that behavioral health programs can undertake at this phase relates to building recovery skills, reducing relapse risks, and encouraging participants to increase their involvement in the community through 12-Step programs and other community support efforts. Transitional housing for individuals leaving intensive behavioral health treatment, as described in Part 1, Chapter 1, may become a primary support for the transition to ongoing rehabilitation. Halfway and ¾-way houses for individuals graduating from intensive behavioral health treatment and Oxford Houses for people recovering from substance use disorders are examples of housing resources that can benefit individuals making the transition to ongoing homelessness rehabilitation. To make your program most effective at this stage, you can:

- Facilitate staff efforts to plan for discharge from substance abuse or mental health treatment for clients facing homelessness.
- Plan for clients' ongoing medical and rehabilitation needs, including continuing care, relapse prevention training, support services, transportation, and other recovery supports (see the planned TIP, *Recovery in Behavioral Health Services* [SAMHSA, planned e]).
- Include ICM and other evidence-based practices that support recovery.
- Maintain agency contacts with the housing network, particularly transitional supportive and permanent supportive housing.
- Facilitate connections in the community that could provide opportunities for clients to obtain paid or volunteer work.

Ongoing Rehabilitation

In this open-ended stage, the client self-identifies as no longer homeless, sustains and further incorporates changes made in intensive care, and works to avoid relapse (McQuistion et al., 2008). Administrators can:

- Support staff members as they continue to devote time to clients in ongoing rehabilitation and abstinence (e.g., by helping clients establish roles in the community).
- Provide a means for clients to contact the agency in case of a relapse to substance use, a return of symptoms of mental illness, or a crisis in housing.
- Provide ongoing support for clients, including regular follow-up meetings or phone calls.

Service approaches—model programs

Permanent supportive housing

Permanent supportive housing for persons with psychiatric disabilities offers individuals who are homeless, at risk of homelessness, or precariously housed an opportunity to obtain

and maintain a residence in the community. The residence can be a single-occupancy house or apartment (scattered-site housing) or single-site housing, in which residents share apartments in a single building or cluster of buildings. Permanent supportive housing offers people the opportunity to be integrated within the larger community, to have a home of their own, and to have choice in where and how they live.

SAMHSA's *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010) lists 12 elements of permanent supportive housing programs that form the core guiding principles of these programs and differentiate them from other forms of housing assistance. The 12 elements are:

1. Tenants have a lease in their name; thus, they have full rights of tenancy under landlord–tenant law, including control over living space and protection against eviction.
2. Leases do not have any provisions that would not be found in leases held by someone who does not have a psychiatric disability.
3. Participation in services is voluntary, and tenants cannot be evicted for rejecting services.
4. House rules, if any, are similar to those found in housing for people without psychiatric disabilities and do not restrict visitors or otherwise interfere with life in the community.
5. Housing is not time limited, and the lease is renewable at the tenant's and owner's option.
6. Before moving into permanent supportive housing, tenants are asked about their housing preferences and are offered the same range of choices as are available to others at their income level in the same housing market.
7. Housing is affordable; tenants pay no more than 30 percent of their income toward rent and utilities, with the balance available for discretionary spending.
8. Housing is integrated. Tenants have the opportunity to interact with neighbors who do not have psychiatric disabilities.
9. Tenants have choices in the support services they receive.
10. As needs change over time, tenants can receive more intensive or less intensive support services without losing their homes.
11. Support services promote recovery and are designed to help tenants choose, get, and keep housing.
12. The provision of housing and the provision of support services are distinct.

The ultimate goal of permanent supportive housing is to reduce discrimination and social stigma experienced by people with psychiatric disabilities; to offer choice in housing and de-emphasize institutional and custodial care, which invites withdrawal from family and the community; and, especially, to reduce relapse leading to the need for specialized intensive mental health treatment. Several types of rental assistance can be provided through permanent supportive housing, including:

- Project-based rental assistance: Housing subsidies are tied to a specific housing unit.
- Sponsor-based rental assistance: The tenant leases a unit owned by a nonprofit group that rents to people qualified for the program.
- Tenant-based rental assistance: Qualified tenants receive a voucher that can be applied to rent in a housing unit that agrees to accept the voucher for part of the rent.

Oxford Houses

The Oxford House movement began in 1975 in Silver Spring, MD, with the establishment

of a house, in a residential neighborhood, for persons in recovery from substance use disorders. The houses are democratically run by the residents and are drug free. There are now more than 1,200 houses throughout the United States. Each house operates under the guidelines of the Oxford House World Council and is guided in its operation by the *Oxford House Manual*. Some houses are exclusively for men or for women; others accept both sexes. A few houses operate exclusively for individuals with children who also reside in the house. Participation in 12-Step and other community change resources is strongly encouraged. Though most residents stay less than 2 years, there is no fixed time for residence. Individuals can live in the house as long as they share in the rent and share in the operation and maintenance of the house. For more information on Oxford Houses, see Part 1, Chapter 1, of this TIP or the organization's Web site (http://www.oxfordhouses.org).

Building Linkages Among Services

Individuals facing homelessness deal with multiple stressors in their lives. In many communities, services to address these stressors have historically been segregated, making it difficult for the client to access and use them. The lack of access to primary healthcare services can be a major difficulty. In recent years, however, community health centers have become an integral component of healthcare delivery for individuals and families affected by homelessness. Some community health programs provide only primary healthcare services, but others have expanded to outreach, behavioral health, health promotion, and other activities.

Federally Qualified Health Centers

The "Federally Qualified Health Center" (FQHC) designation is given by the Health Resources and Services Administration and the Centers for Medicare and Medicaid Services to nonprofit public or private clinics that provide care to medically underserved areas or populations. FQHCs provide a comprehensive range of primary healthcare, behavioral health, and supportive services to patients regardless of ability to pay. A key function of FQHCs is thus to provide care to people who are homeless in their communities.

These centers are supported in part by grants from the Community Health Center program. Some, in communities that have high rates of homelessness, may receive Federal HCH Program grants; in fact, some FQHCs are supported solely by these grants.

The HCH care delivery approach involves a multidisciplinary integration of street outreach, primary care, mental health and substance abuse treatment, case management, and client advocacy. Coordinated efforts between FQHCs and other community health service providers and social service agencies characterize this approach to serving homeless populations. According to the National Academy for State Health Policy, the ability of these coordinated efforts to improve the quality and efficiency of care is increasingly important, given the emphasis in healthcare reform legislation on consolidated, integrated care (Takach & Buxbaum, 2011).

The National Association of Community Health Centers (NACHC) offers technical assistance to all HCH health centers. For resource materials relevant to the provision of care to people who are homeless, visit their Web site (http://www.nachc.com/homeless-healthcare.cfm).

It is critical that behavioral health programs providing services to people who are homeless coordinate their services with community healthcare and other primary healthcare providers. Clients facing homelessness may enter the system through a variety of doors, and the locus of care may depend in part on primary symptoms exhibited by the client. An integrated approach, however, remains essential to quality care.

Clients may enter the system in primary healthcare settings, State psychiatric hospitals or jails, community substance abuse treatment facilities, or community mental health centers, but should have access to care for primary health, substance abuse, and mental health services regardless of entry point. Depending on the symptom presentation, clients may have one predominant need at the point of entry to the system. Symptom severity may define how services are provided, but the important element of integration of care exists throughout the range of services available.

Integrating Other Community Support Services

Most individuals recovering from both homelessness and a mental and/or substance use disorder need a variety of supportive services, especially in early recovery. Permanent housing is not sufficient to address the urgent needs they experience. The supportive resources provided by a variety of community agencies are essential. As opposed to the typical experience in institutional settings, clients in permanent supportive housing always have a choice in which supportive services they will use. Additionally, the services offered need to be tailored to the unique needs of the individual client. Some people in recovery might need transportation, whereas others need case management services to orchestrate their path through a maze of social services. Still others may need financial management, including a designated payee to help handle their income and expenses; others may benefit from peer mentoring. Most will need a variety of supportive services. Contrary to their past experiences, individuals entering permanent supportive housing can choose which services they will use.

SAMHSA's *Permanent Supportive Housing Evidence-Based Practices (EBP) KIT* (2010) lists several domains of relevant services, including:

- Services to support housing retention, such as helping clients understand their rights and obligations as renters in the program, crisis intervention, using peer mentoring and support groups, and developing recreational and socialization skills.
- Independent living skills, including communication skills, conflict management skills, budgeting, personal hygiene, and housekeeping.
- Recovery-focused services, such as participating in recovery support groups, becoming an advocate for mental health and substance abuse recovery, and being a peer mentor to new clients entering permanent supportive housing.
- Community integration services designed to help the individual become part of the larger community and thereby develop a sense of belonging and connection to the neighborhood and the larger community through participation in community events, such as recreational activities, spiritual programs, community educational activities, and community events.

Other service domains include involvement in traditional community support programs, which can include:

- Mental health services.
- Substance abuse treatment.
- Health and medical services.
- Vocational and employment services.
- Family services.

Funding Community Homelessness Services

Various community, State, and national resources provide funding for homelessness services. These funding sources may be private foundations, government entities, or community groups. Only rarely can health insurance be a reliable funding source for homelessness services. Funding may be for "bricks and mortar," for provisions such as food or clothing, or for the targeting of specific needs, such as substance abuse treatment, mental health services, primary health care, or case management. One place to start with program development is to survey what resources for homelessness exist in your community, what services those resources provide, and who offers the funding for available services. Ideally, services should arise from identified community needs (bottom-up planning); however, it is not uncommon that services arise from available funding (top-down planning) or a combination of both.

Federal funding for homelessness services can be divided into two major categories: direct funding for housing and funding for services that support individuals who are homeless. The primary source of direct funding for housing is HUD. In fiscal year 2011, $1.63 billion was available for Continuum of Care (CoC) grants. CoC programs are based on community needs assessment and have a goal of helping individuals and families who are homeless quickly transition to self-sufficiency and permanent housing. In a CoC community, a local or regional planning board coordinates funding for housing and homelessness services for the geographic area. Local programs seeking funding apply jointly with other community programs in a single application to HUD. The four primary components of CoC are:

- Outreach, intake, and assessment.
- Emergency shelter to provide immediate and safe alternatives for people who are homeless.
- Transitional housing with supportive services.
- Permanent supportive housing.

The four primary programs available to provide these services are:

- Supportive Housing Program, now part of the Continuum of Care program.
- Shelter Plus Care Program, now part of the Continuum of Care program.
- Section 8 Moderate Rehabilitation Single Room Occupancy Program.
- Dwellings for Homeless Individuals (Section 8/SRO) Program.

Other HUD-sponsored housing programs include:

- Base Realignment and Closure.
- Housing Opportunities for Persons With AIDS Program.
- Veterans Affairs Supportive Housing Program.
- Disaster Housing Assistance Program.
- Housing Choice Voucher Program (Section 8).
- Public Housing Program.
- Section 202 Supportive Housing for the Elderly Program.
- Section 811 Supportive Housing for Persons With Disabilities.

Additionally, a variety of funding is available for supportive services for individuals and families who are homeless or at risk of homelessness. Some of these programs can also fund housing services, but often only on a temporary or transitional basis. In addition to HUD funding for services, programs from HHS, VA, the U.S. Department of Justice, and the U.S. Department of Labor contribute substantial funding to address homelessness.

Projects for Assistance in Transition from Homelessness (PATH) is a SAMHSA-supported formula grant program to provide homelessness services for people with serious mental illness, including those with co-occurring substance use disorders. The program provides funding to all 50 States and the U.S. Territories and possessions through almost 600 local agencies. Services include community-based outreach, mental health and substance abuse treatment, case management and other support services, and limited housing options. Application for funding is made through each State's Single State Agency designated to manage PATH funding. The services provided in a particular State depend on that State's needs. For instance, in rural areas, funding may be available for outreach in areas where homelessness services have not traditionally been available. Some States have support programs for special populations with SMI. Other States coordinate services with local community mental health centers to ensure that individuals who are homeless or at risk of homelessness receive comprehensive care for mental illness or CODs. PATH monies are also available for training local providers on effective strategies to assist people with SMI who are homeless.

Other programs available through HHS for persons and families who are homeless include:

- Health Care for the Homeless. This multidisciplinary, comprehensive program provides primary health care, substance abuse treatment, emergency care with referrals to hospitals for inpatient care services, and outreach services to help difficult-to-reach people who are homeless establish eligibility for entitlement programs and housing.
- Services in Supportive Housing (SSH) (SAMHSA). The SSH program helps prevent and reduce chronic homelessness by funding services for individuals and families experiencing chronic homelessness and living with a severe mental and/or substance use disorder. Grants are awarded competitively for up to 5 years to community-based public or nonprofit entities. Services supported include, but are not limited to, outreach and engagement, intensive case management, mental health and substance abuse treatment, and assistance with obtaining benefits.
- Grants for the Benefit of Homeless Individuals (GBHI) (SAMHSA). GBHI is a competitively awarded grant program that helps communities expand and strengthen their treatment services for people experiencing homelessness. Grants are awarded for up to 5 years to community-based public or nonprofit entities. Funds may be used for substance abuse treatment, mental health services, wrap-around services, immediate entry into treatment, outreach services, screening and diagnostic services, staff training, case management, primary health services, job training, educational services, and relevant housing services.

VA provides a variety of programs to assist veterans who are homeless. In cooperation with HUD, VA provides permanent supportive housing and ongoing case management services for veterans who require those supports to live independently. HUD has also allocated more than 20,000 Housing Choice Section 8 vouchers to Public Housing Authorities throughout the country for eligible veterans who are homeless. The Housing Choice Section 8 vouchers program is particularly beneficial to female veterans, veterans recently returned from overseas, and veterans with disabilities. Housing is permanent and accompanied by supportive services; the voucher is portable, allowing users to move to different locations or get better housing solutions as they become available.

VA also funds community-based agencies to provide transitional housing and supportive services for veterans who are homeless through the Capital Grant Component program. For more information on this program and the Homeless Providers Grant and Per Diem Programs, contact Jeff Quarles toll-free at 1-877-332-0334.

Stand Down programs, located throughout the United States, are developed and operated by veterans service organizations, local CoC programs, community groups, military personnel, and other interested citizens to provide shelter, meals, clothing, employment services, and medical care for veterans who are homeless. Normally, Stand Down programs are time limited (1–3 days). VA funding is available for up to $10,000 to conduct events each year.

The Interagency Council on Homelessness and the HEARTH Act

The United States Interagency Council on Homelessness (USICH) is an independent agency of the Federal executive branch and is composed of 19 Cabinet Secretaries and agency heads. Its mission is to coordinate the Federal response to homelessness and to work with State and local governments and the private sector to end homelessness in the Nation. The blueprint for this monumental task is provided in USICH's strategic plan, *Opening Doors* (http://www.usich.gov/opening_doors/). The plan calls for heightened dedication to solving the problem, with an emphasis on increasing economic security, improving health and stability, and returning people experiencing homelessness to safe housing as soon as possible. The Council was established by the Stewart B. McKinney Homeless Assistance Act of 1987 and was reauthorized by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, which amends the McKinney-Vento Act.

Under the HEARTH Act, programs for housing assistance were consolidated as follows:

- The Shelter Plus Care Program, Supportive Housing Program, and Section 8 Moderate Rehabilitation Single Room Occupancy Program have been consolidated into the Continuum of Care Program. The Act added 12 services to those eligible for funding: housing search mediation or outreach to property owners; credit repair; provision of security or utility deposits; rental assistance for a final month at a location; assistance with moving costs; and/or other activities that help individuals who are homeless move immediately into housing or would benefit individuals who have moved into permanent housing in the past 6 months.
- The Emergency Shelter Grant program has been modified and renamed the Emergency Solutions Grants (ESG) Program. The ESG Program is meant to fund not only traditional shelter and outreach activities, but also more prevention, rapid rehousing, and emergency shelter activities. Family support services for youth who are homeless, victim services, and mental health services now appear on the list of eligible services that shelters or street outreach teams can provide. Homelessness prevention activities are also expanded to include prevention and rehousing activities—such as short- or medium-term housing assistance, housing relocation or stabilization services, housing searches, mediation or outreach to property owners, legal services, credit repair, security or utility deposits, utility payments, and assistance with moving costs—for people who are homeless or at risk of homelessness.

In addition, the HEARTH Act creates the "Collaborative Applicant." This allows a single entity to submit one application for McKinney-Vento funds for all agencies in the community. Each geographic area has its own Collaborative Applicant, which is not necessarily a legal entity.

Changes in funding are likely to be made by future State and Federal legislation. Requirements, eligibility, levels of funding, and types of favored programs can change, as can the community agencies with whom you collaborate to provide services. A skillful administrator is proactive, anticipating modifications in policies and opportunities covered by the new laws.

Chapter 2 of this section introduces you to the types of policies and procedures that behavioral health agencies have found helpful in working with clients who are homeless or at risk of homelessness. The intent is to provide administrators with a starting point for handling issues of safety, transportation, medical emergencies, and the like, along with procedures for tracking your staff's contacts and actions with clients.

Part 2, Chapter 2

IN THIS CHAPTER

Introduction

This chapter provides program descriptions and sample policies, procedures, and forms that support development of programming to meet the needs of people who are homeless. All documents are meant to serve as starting points; you must adapt them to suit the philosophy and procedures of your organization.

Our thanks to Deborah Fisk, LCSW, Director, Connecticut Mental Health Center Outreach and Engagement Project in New Haven, CT, and Douglas J. Warn, LCSW, Director, Project Renewal Chemical Dependence Outpatient Clinic in New York, NY, for providing some of the materials in this section. Additionally, a number of programs described below offered program descriptions illustrating different approaches to programming for homelessness.

Organizational Approaches to Programming for Homelessness Services

Homelessness services may be provided by a variety of community-based organizations: mental health clinics, substance abuse treatment programs, developmental disability service agencies, organizations specifically concerned with housing and homelessness, or as part of the community's criminal justice system or social service organizations. Additionally, these programs may be part of a faith-based organization, part of a national organization (such as Volunteers of America or the Salvation Army), or an element of State or local government. Few programs at the community level attempt to meet all community housing needs. Some may focus primarily on emergency homelessness needs, others on Housing First, and still others on individuals with substance use disorders or mental illness in remission.

Following are descriptions of four programs that reflect the range of available homelessness services in various communities. Their organizational scope, target population, staff size, funding, and responses to community needs differ, yet all four have their origins in an identified community need that was addressed by program development and implementation.

Responsibility House

Responsibility House in New Orleans, LA, began in 1994 as a halfway house for people recovering from substance use disorders. The programs of Responsibility House focus on providing services to, and improving the lives of, the most underserved populations in the New Orleans area: indigent adults who have disabilities, such as substance use disorders, serious mental illness, and/or HIV/AIDS, and people who are homeless.

Contact person

Mike Martyn, Executive Director: 504-367-4426; mmartyn@rhousela.org

Programs

The Men's Residential Treatment Program offers 3 to 6 months of treatment services in a modified therapeutic community setting for people who have substance dependence. Clients begin working on the 12 Steps, connect with sponsors, and perform community service while transitioning through four phases of treatment: discovery, primary, work search, and reentry. Funding is contracted through the State with the Jefferson Parish Human Services Authority.

Housing Opportunities for Persons With AIDS (HOPWA) programming and services are available for adult men who have substance dependence and are HIV positive. Funding comes from a U.S. Department of Housing and Urban Development (HUD) HOPWA grant to the City of New Orleans; Responsibility House is a subgrantee. Following primary treatment, those interested in living in a drug- and alcohol-free, recovery-focused setting may apply for the Sober Living Program. The program is designed for adult men who have at least 2 months of demonstrated abstinence and are employed.

Responsibility House also offers an Outpatient Treatment Program for men and women who have a substance use disorder and/or a co-occurring mental illness and who are at least 18 years old. Group, individual, and family counseling are offered for recovery from substance use disorders. Funding is from the U.S. Probation Service, Access to Recovery, private pay, and some insurance providers.

In 2000, Responsibility House began offering supportive housing to individuals and families who have disabilities and experience chronic homelessness. The goals of this program are to enable people who are homeless to maintain permanent independent housing, to assist clients in improving their financial independence and living skills, and to support clients in their quest for self-sufficiency.

Community collaboration

In 2011, Responsibility House was presented with an award for Outstanding Homeless Service Provider by UNITY of Greater New Orleans, the lead agency for the local Continuum of Care. Funding for the agency comes from HUD, the Jefferson Parish Community Development Block Grant, and several one-time grants from private foundations (Entergy, Orange County Foundation, and Greater New Orleans Foundation).

Center for Urban Community Services

The **Center for Urban Community Services** (CUCS) of New York, NY, provides a wide range of services to help individuals and

families who are homeless or were previously homeless (particularly those with behavioral or other disabling conditions) live full and satisfying lives in the community. In 2011, CUCS provided supportive housing services to 2,000 people and mental health services to 3,000 people; provided legal services, benefits, and/or other financial counseling to 5,500 adults and families at four sites, including one inside Rikers Island jail; helped 13,000 people gain access to housing and/or case management services, working under contract to city and State mental health authorities; and trained more than 3,000 service providers from 300 nonprofit organizations.

Contact person

Tony Hannigan, Executive Director: 212-801-3300

Programs

Clients' mental health and substance use issues are addressed in an integrated manner as appropriate to the program. Street outreach and placement programs follow a strict Housing First approach, aided by motivational interviewing to address specific aspects of mental illness or substance abuse. Transitional programs maintain the same tight focus on obtaining permanent housing but are able to offer integrated psychopharmacology using onsite psychiatric and medical treatment, along with an array of evidence-based practices, including motivational interviewing, illness management and recovery, and co-occurring disorders skills groups. Permanent supportive housing programs use these same evidence-based practices to help tenants pursue a broad range of personal goals and aspirations in addition to embedded supported employment. Medical detoxification and residential rehabilitation are handled by partnering agencies. CUCS case managers follow clients entering such programs, helping inform treatment and coordinate transition planning.

Community collaboration

CUCS is passionate about the welfare of all its clients, the quality of all its programs, and the skills and commitment of all its staff members. Recent highlights include the agency's lead support role in the Manhattan Outreach Consortium, which has reduced the Manhattan street homeless population by almost half by using an intensive Housing First model. The agency's Project for Psychiatric Outreach to the Homeless recently received an American Psychiatric Association Silver Achievement Award for providing services to thousands of people who are currently homeless and people who had previously been homeless at 54 sites across the city. Another accomplishment is CUCS's shift to a culture of evidence-based practice and continuous, data-driven quality improvement. Serious challenges remain, however. Perhaps the most important is the need to fully integrate primary medical care with mental health and substance abuse services. Even harder to solve is how to address the needs of New York City's undocumented immigrants who are homeless, given restrictions imposed by most major funders.

Open Arms Housing

Open Arms Housing, Inc. (OAH) of Washington, DC, provides permanent housing with ongoing supportive services for unaccompanied women who have lived on the streets or in shelters in Washington, DC. The organization is dedicated to providing permanent housing for vulnerable women who have previously been overlooked by current housing programs and services for the homeless. OAH owns a building in Northwest Washington, DC, that opened in 2009 to house 16 women who have experienced a range of mental health issues, substance use disorders, and medical conditions.

Contact person

Marilyn Kresky-Wolff, Executive Director: 202-525-3467

Program

The OAH model is unique in DC in that it operates under a Housing First approach, which holds that all individuals are entitled to safe and decent housing and that access to this housing should not be contingent on participation in services. Those services can come later, but housing is first. The OAH model is one of only a few similar programs across the country because:

- The OAH model rests on the premise that stable, safe housing is necessary to promote the physical, mental, and emotional well-being of all persons, particularly women with a history of chronic homelessness.
- OAH offers onsite supportive services that are tailored to each individual's needs and are designed to prevent a return to homelessness.
- The building is designed to feature efficiency units with a full set of kitchen appliances and a private bathroom, and community rooms with shared phones, TVs, computers, and space for workshops, meetings, and get-togethers.
- Additionally, the building has three wheelchair-accessible units and a unit equipped for a deaf person; units like these are scarce.

Onsite services provided by staff include:

- Outreach and engagement.
- Orientation to community living and assistance in obtaining housing subsidies.
- Financial management and help with activities of daily living.
- Supportive counseling and crisis intervention.
- Linkage to mental health treatment, alcohol and drug abuse counseling, assertive treatment teams, employment counseling, day programs, volunteer opportunities, self-help groups, medical treatment, home health care, and food and clothing resources.

Community collaboration

During the period from the founding of the organization until its opening in 2009, OAH received:

- Financial support from the DC Department of Housing and Community Development (DHCD) via a permanent loan and a grant jointly from DHCD and the DC Department of Mental Health.
- A Supportive Housing Program grant from HUD via the DC Community Partnership for the Prevention of Homelessness.
- Critical early support from private lenders (e.g., acquisition loan from the OpenDoor Housing Fund).
- Predevelopment and construction funds from Cornerstone, Inc., construction loans from Local Initiatives Support Corporation and Enterprise Community Partners, and a capacity-building grant from the Corporation for Supportive Housing.
- Ongoing support through the DC Housing Authority's Local Rent Supplement Program.

Open Arms has served 17 tenants. Fourteen of the initial residents are still in the building. One original resident moved out after reconnecting with family, and another moved to an apartment. No Open Arms resident has returned to homelessness.

Project Renewal

Project Renewal in New York, NY, is designed to help people who are homeless empower themselves and leave the streets for a return to health, homes, and jobs. Since 1967, it has created innovative strategies to address the barri-

ers that these men and women face. Services range from outreach to permanent housing and span case management, substance abuse and mental health services, primary medical care, and vocational rehabilitation.

Contact person

Mitchell Netburn, President and CEO: 212-620-0340

Programs

One innovative program of Project Renewal is In Homes Now (IHN), a Housing First model for chronically relapsing individuals who have substance use disorders and are homeless. It is designed to meet the special needs of people who have experienced long-term homelessness and have active substance use disorders. The program leases 110 apartments in the Bronx, Manhattan, and Brooklyn for participants, and a multidisciplinary team provides intensive case management, medical and mental health services, and occupational therapy, as well as socialization and recreational activities. All services are delivered in either the program office or the client's home. Staff members receive ongoing training in motivational interviewing and trauma-informed care. The culture of the program is one of nonjudgmental acceptance, and all interactions are centered on clients' needs rather than program rules. The relationship that develops between the staff and the clients becomes a stabilizing force in the clients' lives, allowing the staff to help guide clients toward a healthier lifestyle.

Nearly all (97 percent) tenants have remained stably housed over the past year. This success has led to the inclusion of harm-reduction beds in a key New York City–New York State supportive housing agreement. IHN operates from an office in Upper Manhattan that is viewed as a key factor for success because the office models itself after a drop-in center. Tenants come for socialization, for recreation, to meet with staff, or just to relax in a supportive community environment. Another program success is the ability to work with clients with co-occurring disorders and cognitive impairments. The team's psychiatric nurse practitioners treat such clients (about 75 percent), allowing integration of treatment for mental illness with other services. Occupational therapists help clients who have never lived independently master activities of daily living.

Community collaboration

Clients in In Homes Now are linked to community hospitals, methadone programs, and outpatient clinics. About 25 percent of clients are veterans and receive services at the local VA medical center. Funding is received from HUD, the Substance Abuse and Mental Health Services Administration, and the New York City Department of Health and Mental Hygiene.

Sample Policies and Procedures

As your organization increasingly provides services to people who are homeless, the need for policies and procedures to cover staff members working off site, dealing with other community agencies and partners, and responding to situations that are new to your organization will become clear. The policies and procedures presented in this section may alert you to areas where your organization needs additional guidelines. They refer to safety outside the office (for example, the "No Heroes Policy"), safety during outreach activities, client transportation, and handling medical and psychiatric emergencies in outreach settings. A sample memorandum of understanding (MOU) is also included at the end of this chapter.

No Heroes Policy

Policy

[Name of program] recognizes the need to address the safety of clinical and case management staff persons who deliver services to clients outside of the organization setting and to provide resources to facilitate safe practice.

Procedures

- A wide range of service activities are undertaken outside the office by clinical and case management staff affiliated with the [name of program]. Community-based work with clients includes, but is not limited to:
  - Services within other organizations and agencies (e.g., Social Security, residential facilities, primary care clinics, drop-in centers).
  - Services in public settings (e.g., grocery store, coin-operated laundry facility, library).
  - Offsite groups or community outings (e.g., theater, picnics).
  - Home visits.
  - Walks with clients.
  - Street-level outreach (e.g., city green, under bridges).
  - Outreach to shelters, soup kitchens, etc.
  - Crisis intervention to known and unknown individuals.
  - Transporting clients.
  - Medicating clients in the community.
- The safety of any plan to provide service to a client in the community must be carefully assessed before undertaking the planned service. Base the number of workers and other resources needed to facilitate safety upon consideration of the following:
  - The extent to which staff members are familiar with the client, the client's environment, and other people likely to be present in that environment.
  - The extent to which staff persons are familiar with the community or particular section of the community in which the service will be provided.
  - The extent to which staff persons are aware of client, environmental, or other risk factors that might contribute to unpredictability.
  - The time of day, season, and so forth during which service is to be provided.
  - The nature of the service to be provided and the client's likely response to the service or task to be accomplished (e.g., transporting or accompanying a client to a medical or dental procedure or an appointment that may elicit distress or other unpredictable response from the client—such as a court, probation, or Department of Child and Family Services appointment).
- Routine community-based contacts with clients who are assessed to present low risk can be accomplished by an individual staff member according to the procedures outlined in this policy.
- Under no circumstances will any staff member enter any situation that is felt to be unsafe:
  - Any questions regarding the safety of an intervention or activity will be reviewed and cleared by the Director of [name of program] or his/her designee prior to undertaking the activity or intervention in question.
  - Local police will be involved in all community visits that have been assessed as having significant potential for violence.
  - When there is disagreement among the staff regarding the safety of a particular situation, the planned activity will be suspended until consultation with the Director of [name of program] or his/her designee takes place.

  - The circumstances listed below will trigger particular attention to safety concerns and will result in the abbreviation or suspension of direct clinical contact in the community, pending consultation with the Director of [name of program] or his/her designee. Such consultation will address concerns about the safety of the staff and of the client and/or others in the client's environment or network. If further intervention is indicated, develop a plan to ensure the safety of involved staff members, including consideration of the need for police escort during:
    a. Outreach to a client who is suspected of being under the influence of nonprescribed substances at the time of contact or whose environment includes other individuals who are using substances.
    b. Outreach to a client who is suspected of or known to be carrying a weapon at the time of contact or whose environment includes individuals suspected of or known to be carrying weapons.
    c. Outreach to a client who becomes volatile or threatening during contact or in a setting in which volatile or threatening behavior is observed or anticipated.
    d. Outreach to a client who has a known history of physical violence.
- All community visits for the purpose of client contact require that workers bring an activated beeper and cellular phone.
- Established sign-out procedures will be used to facilitate awareness of staff whereabouts and attention to the safety of staff persons working outside the office setting.
- Sign-out information will include:
  - Name(s) of all staff members to be involved in outreach activity.
  - Destination.
  - Time of departure.
  - Anticipated time of return.
  - License plate number of vehicle being used.
  - Cellular phone number.
  - Beeper number (if applicable).
- If, in the course of providing community outreach, the staff begins to suspect or observe that the behavior of a client is exposing a child, elderly person, or individual served by the Department of Mental Retardation to abuse or neglect—including exposure to illicit activity or to circumstances that might imminently compromise the safety of these individuals—reports must be filed with the appropriate protective services agency according to established procedures for such reporting.
- All incidents that trigger safety concerns and/or require police/ambulance intervention will be reported to the Director of [name of program] or his/her designee immediately following the incident. Also:
  - Following interventions triggering safety concerns and/or the assistance of the police or an ambulance, staff will complete the Outreach Incident Report and an emergency response form documenting the circumstances of the need for emergency services. A review will be scheduled.
  - Team- and project-based reviews will be held as quickly as possible following all such incidents to facilitate discussion of issues related to staff safety, client treatment planning, and the interface between the project and the local police, as well as other emergency personnel.

Ensuring Safety During Street and Community Outreach

Policy

Street-level and community services will be provided through an interorganizational collaboration between [name of program] and other service agencies. The following street-level and community outreach procedures will serve as addenda to those outlined in the "No Heroes Policy" and will inform the work of all outreach staff. They will be reviewed and revised yearly in collaboration with the involved network service agencies.

Procedures

These procedures will guide the work of project staff members providing clinical or case management services in outdoor public places, such as street corners, the public green, under highway bridges, and the like:

- The safety of all street outreach sites will be reviewed and approved by [name of program] leaders prior to providing outreach to those sites. Review will include the following factors:
  - Street outreach locations cannot be isolated and desolate. Staff members must always be visible to the street and be able to access other people (including the general public) for assistance in a crisis situation.
  - The time of day is relevant to the safety of any specific street outreach site.
  - Differing numbers of staff members may be required to sustain safety at any particular outreach site.
  - Safety issues known to exist in the general area of any specific outreach site may vary.
- The safety of all approved outreach sites will be reviewed quarterly and as needed so that changes in the safety of specific sites are reflected in the day-to-day list of approved outreach sites.
- Street-level outreach may be conducted from 7:00 a.m. until 8:00 p.m.
  - Between 7:00 a.m. and 4:00 p.m., conduct street-level outreach with at least two staff members.
  - Between 4:00 p.m. and 8:00 p.m., conduct street-level outreach with at least three staff members; one stays in the driver's seat of the outreach vehicle.
  - Street outreach to individuals with whom the outreach staff has little or no familiarity will be guided by the following principles:
    a. Such individuals will not be invited into an organization vehicle for purposes of engaging in an interview or for the provision of transportation.
    b. Efforts will be made to interview such individuals in community agencies or public buildings (e.g., the library, a train station) instead of on public streets.

The following procedures will guide the provision of clinical and case management services that take place inside community settings (e.g., local shelters, soup kitchens, train stations, public libraries):

- All indoor sites will be established in collaboration between the [name of program] leaders and the proposed community organization sites before using those sites for outreach. The safety of each proposed community outreach site depends upon the following factors:
  - The community organization must agree to have outreach staff members visit their site.
  - A contact person must be identified within each community organization and must be available to outreach workers when they are on site to provide support.

  - The community organization must agree to allow workers telephone access for emergencies.

The following guidelines apply to outreach and clinical/case management services provided in either outdoor locations or specified indoor community sites:

- At least one member of the outreach team will have an activated beeper and cellular phone.
- Street-level outreach activities may be conducted in [name of program] vehicles. [Name of program] staff can be granted permission to drive the vehicles through a process initiated by the Director of the [name of program]. Use of vehicles belonging to any one of the involved affiliated organizations will be guided by the policies and procedures established by that organization.
- Outreach activities will end if any outreach team member indicates serious concerns about the safety of any particular activity.

All outreach workers will receive yearly project-based training in clinical and community safety, and they will be eligible to participate in the Clinical Safety Training offered at [name of program], regardless of organization affiliation.

Client Transport Policies and Procedures

Policy

The Director of [name of program] will establish procedures to guide staff decisionmaking regarding the transport of clients to enhance both the safety of the staff members providing transportation services and the safety of the clients they transport. This policy will serve as an addendum to the "No Heroes Policy."

Procedures

- Organization vehicles may be driven only by staff persons who possess valid State drivers' licenses.
- Under no circumstances will a staff member use his/her personal vehicle to transport a client.
- Organization vehicles will be used only to carry out work-related duties. Vehicles are available primarily to facilitate the care of registered clients of [name of program]. However, it is recognized that the transport of a client's nonregistered significant others is indicated at times and that the organization's ability to provide transportation can also facilitate the process of engaging nonregistered individuals who might otherwise be reluctant to accept services. These circumstances will be viewed as exceptions and will be discussed and approved by the relevant team leader, program leader, project director, or his/her designee.
- The provision of transportation to clients and their significant others will be regarded as a service, and the staff members who transport these individuals will be expected to maintain the same professional standards of practice that guide the provision of all clinical services at [name of program]. Clients' rights to safety and confidentiality will therefore be respected and protected at all times.
- Staff persons will carry an activated cellular phone when transporting clients.
- Organization vehicles used for client transport will be equipped with the following items for emergencies (e.g., accidental injuries, inclement weather):
  - An operable flashlight
  - Snow scraper
  - Personal protection gloves
  - First-aid kit
  - List of emergency phone numbers

  - Information regarding vehicle insurance coverage
  - Reflective safety triangles
- Staff will make a general inspection of the organization vehicle before driving it to make sure that there is adequate fuel and that there are no objects within or outside the vehicle that might compromise the safety of the driver or other vehicle occupants.
- The driver of any organization vehicle will maintain responsibility for ensuring that all vehicle occupants honor relevant seatbelt laws, including laws governing the use of child safety seats when applicable.
- The number of passengers transported in an organization vehicle will not exceed the vehicle's stated capacity, and team-, program-, and project-identified staff-to-client ratios will be honored.
- Clients who are symptomatically unstable and whose behavior may be impulsive and/or unpredictable will not be transported in an organization vehicle, including clients suspected of being under the influence of any nonprescribed drug. Safety concerns that arise at any point during the course of transporting a client will result in termination of the transport.
- Clients will not be left unattended by the staff in an organization vehicle.
- Clients needing hospitalization will generally be transported via ambulance. Any exceptions will be reviewed and approved by the appropriate team leader, program leader, project director, or his/her designee and will be based on a thorough assessment of client needs and the availability of the resources necessary to facilitate safe transport. Factors that will **preclude** the transportation in a vehicle of a client needing hospitalization include, but are not limited to:
  - The presence of medical needs better addressed in an ambulance.
  - Client history of violence, impulsivity, substance use, or other factors that might contribute to unpredictability during transport.
  - The lack of at least two clinicians or case managers available to assist in the transport of the client.

Management of Psychiatric and Medical Emergencies

Policy

Procedures will be established to guide the handling of psychiatric or medical emergencies within the office or in the community that require resources beyond the scope of [name of program] services. When a medical emergency occurs, basic life support, first aid, and immediate emergency care will be given until the arrival of emergency medical service (EMS) personnel, who will provide any further emergency treatment and transport to the emergency department (ED).

Purpose

To facilitate the safety of clients served by the [name of program] and the safety of team or project staff.

Procedures

Section A: Psychiatric/medical emergencies that occur within the office will be managed as follows:

- Staff members involved in the management of a psychiatric or medical emergency will dial 911 to access emergency services or will use the panic button system available within the office. If possible, one staff member will announce a Code 3 on the overhead telephone paging system, specify whether the code is medical, and note the location of the code.
- All available clinical staff persons will respond.

- The first senior staff member on the scene will take charge of a psychiatric code. The first senior medically trained staff member on the scene will take charge of a medical code. If the code bag and first-aid kits are not present, the staff member will direct another staff member to bring this equipment to the scene. If no medical personnel are available, the first person on the scene will be in charge of the code, direct basic support and first-aid to the victim, and designate someone to bring the code bag and first-aid kit.
- A staff member should gather relevant client data to provide to EMS and the ED. When EMS arrives, care of the victim in a medical code will be handed off to them. In the event of a psychiatric code, the staff member in charge of the code will manage the code collaboratively with EMS.
- The staff member in charge of the code will gather interim assistance from other staff working in the office at the time of the emergency. If the incident is in the office, a program supervisor will also facilitate the management of other clients who may be on site at the time of an emergency. These interventions will be guided by an appreciation of the importance of protecting all clients exposed to emergencies and of the need to preserve the rights, dignity, and well-being of all involved clients.
- The clinician and supervisor managing in-house psychiatric or medical emergencies are responsible for the completion of documentation needed to facilitate transport to an ED and will facilitate continuity of care for the client by communicating relevant information to ED care providers.
- After the care of the victim has been completely assumed by EMS, staff should:
  - Inform the client's family or emergency contact persons.
  - Inform appropriate administrative staff persons.
  - Address and allay the anxiety of clients who witnessed the incident.
  - Meet to review the incident as soon as possible after it occurs.
- The involved clinician will complete an incident report and an emergency response form documenting the circumstances of the need for emergency services, and a review will be scheduled.
- A note will be entered into the medical record reflecting the circumstances of the emergency and the outcome of planned interventions.
- Following a medical code, the [position of person responsible] will direct a member of the nursing department to check the lock on the code bag. If the lock is broken, the nursing staff member will call [name, phone number] to check and replace contents.

Section B: Psychiatric or medical emergencies that occur in the community will be handled as follows:

- Staff members involved in handling a psychiatric or medical emergency in the community will use their cell phones to call the local police department directly or to call 911 to access emergency services. A call to 911 from a cell phone will access State Police, who will contact local police.
- A program supervisor will be notified of the emergency and will facilitate the deployment of additional staff resources as needed.
- A first-aid kit is kept in each vehicle to facilitate interim management of medical emergencies. No code bag is stored in vehicles.
- Documentation needed to facilitate transport to an ED will be completed by the clinician most involved in the emergency situation. The involved clinician will also give relevant client information to ED

care providers to facilitate continuity of care.
- Procedures 3 through 9 as outlined in Section A of this policy will be followed.

Sample Forms

Recordkeeping is a necessary part of engaging people who are homeless in services and tracking the course of these individuals' contacts with service organizations. When possible, records should be kept electronically and updated as new information becomes available. Sample forms presented in the following pages include:

- *Sample Memorandum of Understanding.* MOUs document tasks and roles of partnership organizations.
- *Sample Homelessness Outreach Contact Form.* A sample of the type of form that can be used to document information gathered during early encounters between a service provider and a potential client. This sample form (along with the Sample Contact Log) is intended to be used during the outreach phase of homeless rehabilitation and illustrates the kinds of information you might want to record from outreach sessions. Although this form includes information that is useful, there is no expectation that it will be completed during the first several contacts with a potential client. Information gathering with people who have substance use disorders and are homeless is ongoing.
- *Sample Contact Log.* A sample of the type of form that can be used to capture case-finding work during outreach and engagement activities.
- *Sample Case Management Discharge or Transfer Note.* A sample of the type of form that is suited to record the circumstances of discharge or transfer.
- *Sample Interagency Referral Form.* A sample of the type of form that is designed to accompany an individual who is referred to an outside agency. It provides the information the client has disclosed that is relevant to the referral.

These documents are provided as a starting point for your organization. Each must be adapted to suit the particular philosophy and procedures of your organization.

Sample Memorandum of Understanding

[Name of program]

[Address]

Dear [Name of partnering colleague]:

This letter constitutes a memorandum of understanding between the [name of partnering organization], located at [address] and the [name of program] with its main office located at [address].

This understanding is solely for the purposes of clients associated with the [name of program]'s Section 8 supportive housing program for people with psychiatric disabilities that include a serious and persistent mental illness. This program intends to provide housing services to a maximum of [number] clients who will live at [address], subject to getting all zoning and commission approvals.

The [name of partnering organization] agrees to work collaboratively with the [name of program] to provide community-based psychiatric and case management services to the [number] individuals who occupy the apartments noted above through the [name of program] based at [address], provided that the clients meet the admission criteria for the [name of program]. Every effort will be made to ensure that the [name of program] is the sole source of referral for these [number] apartments. In the rare event that individuals not referred by the [name of program] are accepted for apartments, it is the expectation that the [name of program] will refer these individuals to appropriate psychiatric and case management services, including those provided by [name of program] when appropriate.

The [name of program] will be responsible for all management, upkeep, repairs, insurance, liability, and total operation of the building and program located at [address].

Please contact me at [telephone number; email address] if you have any questions.

Sincerely,

[Your name]

Director of [name of program]

CC: [relevant others]

Sample Homelessness Outreach Contact Form

Date: _____ **Name:**_____
Last First Middle

DOB:_____ **Age:**_____**SS#:**_____

Gender: Male Female **Veteran:** Yes No Unknown

Race/Ethnicity (voluntary)**:**

American Indian or Alaskan Native
Asian or Pacific Islander
Black
Hispanic/Latino
Native Hawaiian/Other Pacific Islander
White
Other: _____
Unknown

Entitlements:

SS Disability: SSI: $_____ SSR: $_____

VA Pension: $_____ VA Service Connected: $_____ SAGA Cash: $ _____

SAGA Medical: Y N Title 19: Y N Medicare/Medicaid: Y N
A: Y N B: Y N D: Y N

Employment:

Job Title: _____ Wage: _____

Employer: _____

Education: High School Graduate: Y N GED: Y N Highest Grade: _____

College: Some Associate Bachelor's Master's

Where has the person slept the past 2 weeks? How many nights in each place?

Own apartment: # _____ Someone else's apartment: #_____ Jail or prison: # _____

Shelter: # _____ Institution (hospital, nursing home): # _____ Outdoors: # _____

Public building: # _____ Abandoned building: # _____ Other: # _____

In your opinion, is the person served homeless? Yes No

Comments:

Length of time homeless this episode:

Fewer than 2 days: ___ 2–30 days: ___ 31–90 days: ___ 91 days to 1 year: ___
More than 1 year: ___ Unknown: ___

Number of episodes homeless and length of time:_____
Brief Description**:**

Eviction History: _____
Brief Description:

Where is person staying a majority of the time?

Outdoors
Short-term shelter
Long-term shelter
Own or another's apartment, room, or house
Hotel, SRO, boarding house
Jail or correctional facility
Halfway house, residential treatment program
Institution (psych, hospital, nursing home, etc.)
Unknown
Other:_____

Medical History: Does the person describe any significant medical problems? Yes No
Brief Description:

Psychiatric History: Does the person describe any significant current psychiatric symptoms or say he or she has received a psychiatric diagnosis in the past? Yes No
Brief Description:

Who was with the person at the time of contact?

1. Person was alone
2. Person was with children
3. Person was with spouse/partner
4. Person was with spouse/partner & children
5. Person was part of nonfamily group
6. Other: _____

How was contact initiated?

1. Outreach
2. Referral by shelter
3. Referral by mental health agency or provider
4. Self-referral
5. Other_____

How responsive was the person to contact?

1. Talked briefly; did not want to talk further
2. Would talk but not interested in services
3. Interested in basic services (food, clothing)
4. Interested in referral to non-PATH program
5. Interested in outreach services
6. Other: _____

GOAL:_____

Interviewer's Name:_____ **Date:**_____

Duration of Contact: 5 min 10 min 15 min 30 min 45 min 60 min 61+ min

Sample Contact Log

Counselor Name:	Date:	__Mon __Tue __Wed __Thur __Fri					
SECTION A: SCHEDULED OUTREACH RUNS							
Client Name		# of Hours		Client Name			# of Hours
SECTION B: CASE MANAGEMENT CLIENT CONTACTS (OPTIONAL)							
Client Name	Contact Type*	Contact Location†	Amount of Time‡	Client Name	Contact Type*	Contact Location†	Amount of Time‡
SECTION C: ALL NON-CASE-MANAGEMENT CONTACTS (REQUIRED) §							
Contact Name	Contact Type*	Contact Location†	Amount of Time‡	Contact Name	Contact Type*	Contact Location†	Amount of Time‡

* L=looking for/waiting with client; WC=with client; C=collateral; CI=crisis intervention (must do a critical incident report).
† O=office; CH=client home; C=community; OA=other agency.
‡ Hours and minutes in 5-minute intervals.
§ *Instructions for Section C:* (1) Include **all** contact with non-case-managed clients. (2) Include clients whose cases are managed by another outreach and engagement staff person. (3) Put case manager's name in parentheses. (4) Do not include outreach contacts that occur during a scheduled outreach run (these go in Section A).

Sample Case Management Discharge or Transfer Note

Client Name _____SS# _____ DOB _____

Admission Date _____ Case Manager _____

Discharge Date _____ New Case Manager/Clinician _____

☐ Transfer within O&E team ☐ Transfer to other provider agency_____

☐ Discharge

Reason for Discharge

☐ Dropped out/missing ☐ Incarcerated ☐ Moved away

☐ Tx continued elsewhere ☐ Facility Concurs ☐ Deceased

☐ No referral—services not needed ☐ No referral—client refused

Housing Status

☐ Homeless ☐ Private residence w/supports

☐ Institution at Discharge ☐ 24-hr residential care

☐ Private residence w/o supports ☐ Unknown address

Comment _____

Name of Program/Facility _____

Employment Status

☐ Not in labor force (disabled) ☐ Unemployed ☐ Unknown

☐ Supported/sheltered ☐ Employed F/T ☐ Employed P/T

Summary of Services

Why/how was client referred to O&E? (include referral source):

Services Provided:

Recommendations:

_____ _____ _____ _____

Case Manager **Date** **Supervisor** **Date**

Sample Interagency Referral Form

Community-Based Clinical Services

Date of Referral:_____ Referring Person:_____ Team/ Agency:_____

Phone:_____ Client's name:_____ MPI#: _____

Address:_____ CMHC#:_____

Phone: _____ DOB: _____

SSN: _____ Marital Status: _____ # of Children (if any):_____

Race/Ethnicity: _____ Emergency Contact: _____ Relationship:_____

Phone: _____ Manages Own Finances? Yes No Conservator?_____

DSM-IV-TR Diagnoses: Axis I:
Axis II:
Axis III:

Check all social/environmental factors that make it necessary to provide this level of services:

___Social isolation
___Presence of relapse trigger(s)
___Threatening spouse/significant other
___Homelessness
___Unsafe living environment or victimization
___Critical life event (or anniversary)
___Complicating medical condition(s)
___Denial of illness
___Ineffective support system
___Previous attempts to complete treatment
___History of multiple hospitalizations/ER contacts within past 2 years
___History of multiple arrests/incarcerations within past 2 years
___Active substance abuse or dependence
___Failure to take prescribed medications
___Inadequate financial support

Describe current symptoms:

Describe current case management needs:

Nature of client's involvement in treatment (including both substance abuse and mental health treatment): Describe attempts to engage client in treatment. What has worked and what hasn't?

Nature of client's community adjustment:

1. Describe current living circumstances and composition of household (include plans for housing if client is currently homeless and/or in transition):

2. Client has history of placement in residential housing program: Yes No

3. Describe current entitlement status (adapt choices to reflect specific entitlements in your area):

___Basic Needs ___ADC ___SAGA Medical ___AD
___SAGA Cash ___SSI ___Title XIX ___SSD
___Medicare ___Other (please describe):_____

4. Describe available family/other support:

5. Describe risk management issues (history of violence toward self or others):

6. Describe nature of any past arrests/incarcerations, including current legal status (name and phone # of probation officer if applicable):

7. Describe current medical problems, including name/phone of physician and/or medical clinic if applicable:

8. Describe nature of current substance abuse:

To be completed by intake clinician: Rationale for accepting or denying referral: