HOUSING CONTINUUM
FOR ADULTS WITH MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS IN FL

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INTRODUCTION

Housing is a cornerstone for recovery. An array of behavioral health housing options working in a continuum, is critical to providing people living with mental health conditions and substance abuse disorders, the continuity of care and stability they need to achieve recovery outcomes, therefore reducing the utilization of shelters, hospitalizations and involvement with the criminal justice system.

At this time, Florida does not have a defined housing continuum structure within their behavioral health systems of care.

Goals for Adult Housing

Goals related to the adult housing system include creating local systems of care that: 1. Are responsive to individual recipient wishes and needs; and 2. Reduce institutionalization and homelessness. In this context, we recognize that:

a. Housing is a basic need and necessary for recovery
b. A system of care that is accountable includes staffed specialty housing and residential treatment programs.
c. The primary goal of housing reform will focus on the individual and emphasize expanding access to supported housing. Person-centered principles of recovery will guide this work.
d. On the community system level, the local mental health housing resources will be viewed as an asset to expand access to supported housing and to facilitate broader reforms (i.e. system accountability and a recovery focus).
e. Recipient satisfaction and recovery outcomes are essential.

FLORIDA

Our current system includes the following behavioral health housing services:

Florida Residential treatment facilities include:

Residential Level 1
These are licensed services that provide structured, live-in, non-hospital settings with 24-hour

supervision daily. There is a nurse on duty in these facilities at all times. For adult mental health, these services include two different kinds of programs: group homes and short-term residential treatment services. Group homes are for residents who may require longer lengths of stay. These facilities offer nursing supervision provided by, at a minimum, licensed practical nurses, 24 hours a day, seven days per week.

Residential Level 2
These are licensed, structured rehabilitation-oriented group facilities that have 24-hour a day, seven days per week supervision. Level 2 facilities are for persons who have significant deficits in independent living skills and need extensive support and supervision.

Short-term Residential Treatment (SRT)
These individualized, acute, and immediately sub-acute care services provide intensive mental health residential and rehabilitative services 24 hours a day, seven days per week. These services must meet the needs of individuals who are experiencing an acute or immediately sub-acute crisis and who, in the absence of a suitable alternative, would require hospitalization. SRT services provide intensive residential treatment for individuals in need of acute care for up to 120 days.

Rehabilitation Options Include:

Supportive Housing
Supported housing/living services are designed to help people with substance abuse or psychiatric disabilities find and keep living arrangements of their choice. They also provide services and supports to ensure continued successful living in the community. The goal of Supportive Housing is to ensure that everyone has the opportunity to live as independently as possible.

Residential Level 3
These are licensed facilities, structured to provide 24-hour a day, seven days per week supervised residential alternatives to persons who have developed a moderate functional capacity for independent living. For adults with serious mental illnesses, these are supervised apartments.

Support Options Include:

Residential Level 4
The facility may have less than 24 hours per day, seven days per week on-premise supervision. This is the least intensive level of residential care and is primarily a support service. For adults with serious mental illnesses, this includes satellite apartments, satellite group homes, and therapeutic foster homes.

Room and Board with Supervision Levels 1-3
This pays room and board costs for people living in Medicaid-funded residential programs. Medicaid pays for the clinical services, and the SAMH program pays for the rest.

However, at this time, Florida does not have a defined *Housing Continuum* within our behavioral health systems of care. What this means is that there is not a public mental health structure that integrates housing and other living resources into our mental health services which follows a *Housing Continuum* to provide medical treatment and support so persons can successfully progress from dependent to independent living.

Florida Assertive Community Treatment (FACT) Teams are perhaps the only service available that offers a housing, medication, and flexible funding subsidy to enrolled individuals in the community. However, each team is mandated to serve no more than 100 individuals, and there are only 31 teams to serve all our state. This is in marked contrast to other states, while Florida has 31 ACT Teams, Michigan has 100 and New York State has 80 ACT Teams. Adding to the compounded public mental health community support & services scarcity, and lack of organization.

How well are these options working? Let's look at Miami Dade County.

MIAMI DADE COUNTY

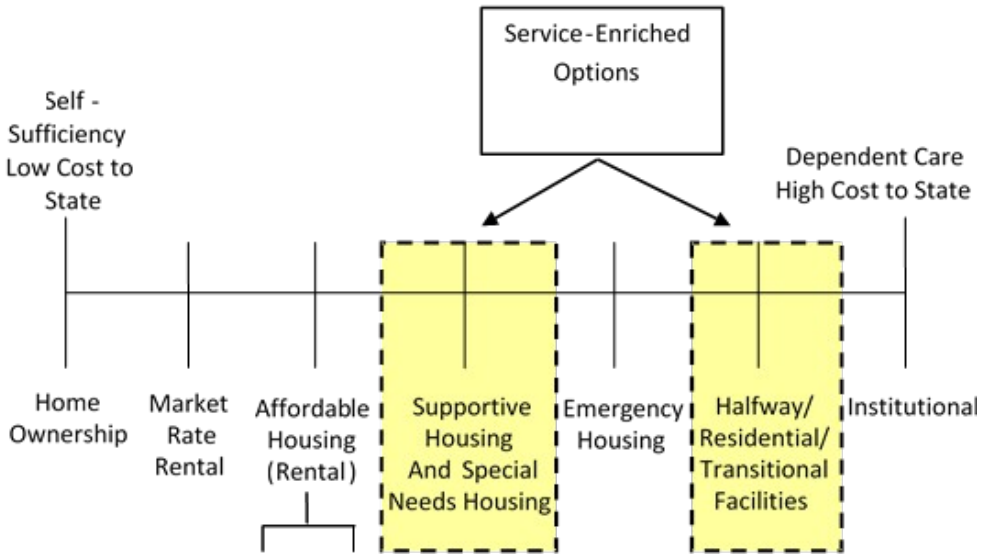
Here you may find the latest version of Miami Dade County's Housing Directory **http://sfbhn.org/consumers/resource-manual/** The Table of Content shows various types of Residential programs. "Transitional Housing" are scattered and provided by agencies such as Agape, Fellowship House, etc. Those are funded through South Florida Behavioral Health Network (SFBHN). The Directory also lists the HUD Permanent Housing Programs, most of which require homelessness, have a mental health or substance abuse disorder and *be medically stable* (within these circumstances). There are funds from the state that go to these programs. Here is a page from SFBHN's FY12-13 audited statement that shows the "cost centers" that receive funding from SFBHN https://drive.google.com/file/d/0B1_R_SC-UBQTelhEaGJIcm1aM2pYbGdYZHJpc0lTZXNoSmRz/view?usp=sharing
It would be good to find out exactly how many units and how many people with mental health and substance abuse disorders these programs serve so we could figure out how many more are needed, based on waiting lists.

At this time, the manual is constantly being opened with the hope that within its 86 pages we will find response to the need of so many persons in our community. However, with despair, we discover that due to the programs' requirements, lack of availability and long waiting times, it is not possible to help most of the times.

In Miami Dade County persons are struggling to find a place where to live or just spend the night. The few existent residential programs which include behavioral health treatment and/or services are working in isolation from each other, there is not a continuity of care which can help persons in their recovery by providing them with assistance to progress from dependent to independent living. Instead, persons are being discharged from a shelter into independent living or from a hospital into independent living, to locations with inadequate services or even into homelessness. There is no order or structure to help persons progress in their recovery journey, and locations which are supposed to have support services, lack quality and the appropriate environment conducive to health and healing. So, often, persons are discharged and lost in the system until they have another crisis.

WHAT IS A *HOUSING CONTINUUM*?

General Information



Housing for persons with mental health and substance abuse disorders can be viewed along a continuum of options from full self-sufficiency to full dependent care at high cost to the state.

In a perfect world, the goal is *home ownership*, however, persons with these conditions are less likely to be able to secure a home on the private market or maintain a mortgage.

Renting a home is probably the most common option. However, market rate rentals may be out of reach simply because of poverty. Affordable housing (whether subsidized or unsubsidized), although scarce, may be a viable option for those that are not highly disabled. But barriers exist

to obtaining affordable housing. These programs usually have very strict eligibility criteria and long waiting lists.

The next housing option*, supportive housing* are permanent housing options coupled with support services on-site. These types of housing are most often partially or wholly supported by HUD (U.S. Department of **H**ousing and **U**rban **D**evelopment) and specifically designed to support homelessness and/or disadvantaged populations. Regardless of program length or permanency, supportive or service-enhanced housing programs usually offer a range of services aside from housing, including family counseling, case management, medical services, mental health treatment, substance abuse counseling, socialization skills groups, anger management, vocational training, and assistance with obtaining vital documents such as Social Security cards and birth certificates. Services may also include income support, education, transportation, clothing, advocacy, and child care (Burt et al., 2004).

Service configurations vary from community to community, as well as within community. This variation is not always deliberate, as the variety of stakeholders involved must sort through availability of services and capacity of stakeholders that include funders, housing developers, property managers, and on-site and off-site program staff. Housing configurations will vary across programs.

Federal, state and local funding streams have also been developed to fund supportive housing. These “special needs” programs often define eligibility for housing funding based upon the disability or health profile of individuals, rather than on the individual’s homelessness status. For most programs though, including most of the few housing options available in Miami Dade County, homelessness is a primary requirement for program eligibility. We are coming to recognize the need for permanent housing units accessible to people that lack the necessary credentials that are typically necessary to secure permanent housing, such as rental histories, identification and employment histories.

Unlike transitional programs, permanent housing programs typically require residents to sign a tenancy agreement and although programs may have social service assistance on-site, participation is not a requirement for eligibility. Supportive housing programs are often financed by a creative blending of funds on part of the provider. Financing can come from residential rents, traditional bank loans, federal, state and local government loans or grants and outside contributions by foundations and community organizations.

Moving along the continuum, the next option is *emergency shelters*. Although emergency shelters may cost less per consumer than transitional housing, emergency shelters are not desirable because they do not support a person’s transition to more stable housing. For the most part, emergency housing simply acts as an option when no other housing is available. In Miami Dade County multiple calls per week during a period of time which may last several months is required to secure shelter placement regardless of medical or homeless status.

Transitional housing falls after emergency housing but before full dependent care through any type of institution (prison or a psychiatric hospital). Transitional housing is an umbrella term to capture any housing that is not permanent, but is designed to provide at least some type of service that assists persons with establishing community reintegration or residential stability.

Some housing experts make the distinction between short-term or long-term transitional housing. Short-term transitional housing programs have a finite length of stay, which may vary anywhere from one month to three months (or more depending on definitions). In most cases, consumers do not have occupancy agreements or leases. Social service provision is often the primary focus of short-term transitional programs, rather than housing. Hence, most often, services are structured and high demand. Configurations of transitional housing programs vary widely from barracks-type facilities, to shared living spaces, to individual apartments or houses. Programs most often will be site specific, but programs exist that are scattered site. Long-term transitional housing programs generally have a time limit spanning from three months up to two years. These programs offer an extensive range of services that include case management, mental health and medical services, counseling and general issues groups, life and social skills groups, anger management, vocational and educational training, advocacy, and assistance obtaining benefits and identification information.

HOUSING MODELS

Housing First versus Housing Ready: Housing models generally exist on a continuum of approaches from "housing first" to "housing ready."

Housing first: The housing first approach offers the direct placement from streets to housing with support services available, but not required. Often, the only requirements are that individuals not use substances on the premises and abide by the traditional lease obligations of paying rent and refraining from violence and destruction of property. Tenant stability is a central factor in the housing first approach, with the idea that mentally ill and chemically dependent tenants will be unable to fulfill the obligations of their lease without taking advantage of the support services available to them. Services are viewed as separate from housing and are usually off-site with little to no mandated participation. Staff often use motivational techniques to suggest services and services are made available when they are desired. Some housing first approaches, however, institute some requirements for services, but the general philosophy tends towards non-integration of housing with services. *Supported housing* can be done (housing with no on-site services, independent off-site organizations provide services). In summary, critical elements of this approach include: Generic housing widely dispersed in the community; Provision of flexible individualized supports at varying levels of intensity and times; Consumer choice; and Assistance with locating and maintaining housing.

Housing ready: Housing ready housing starts with treatment and progresses through a series of increasingly less service-intensive options with the promise of permanent supported housing as people are "ready." Housing transitional models feature services that are in high demand (generally some form of residential treatment), and in order to receive this package of services, the individual must participant fully in services that are required of the program. As residents progress through levels of readiness, they are often moved from apartment to apartment. However, *it is important to note that many housing ready options do not provide or have access to an adequate supply of permanent supported housing.*

Service-Related Approaches:

Low Demand versus High Demand: "Service-related approaches" is the term used to capture the expectations and requirements for service participation and the ways in which housing models sanction noncompliance with services. Although requirements and configurations of services vary tremendously across models, service-related models cluster along a continuum from low demand to high demand.

Low Demand: The U.S. Department of Housing and Urban Development defines low demand as: "The provision of health care, mental health, substance abuse, and other supportive services and referrals for services in a non-coercive manner, which may include medication management, education, counseling, job training, and assistance in obtaining entitlement benefits and in obtaining other supportive services including mental health treatment and substance abuse treatment." There is often great variation in the types of services provided across low demand programs. These flexible programs are designed to be conducive to engaging individuals who are distrustful of the service system*. Case managers or house staff are expected to establish trusting relationships with residents and to help with services when requested.*

High Demand: Housing programs with high demand services are usually those programs designed to target special needs populations and provide services matched to particular needs. Intensive services are intended to facilitate the transition to permanent housing. The underlying premise of structured services is that structured, intensive services provide individuals with mental illness or chemical addiction the skills needed to function independently. *Case managers are utilized as advocates, counselors, skills instructors and service brokers.* Programs may use either team case management or individual case management approaches. Clinical treatment is usually a requirement of these programs, and residents often engage in other life skills training. As with low demand programs, there is wide variation in the specific types of services provided, as well as combinations of services. Supervision is usually provided around the clock and residents' sobriety, medication compliance, and attendance at services are closely monitored. Residents often have curfews, are required to submit to random drug testing, and to sign attendance forms for off-site programs. Most often, these programs are transitional in nature, providing housing from three months to two years. As residents gain control and independence by demonstrating compliance and skills development, they are deemed ready to graduate.

Housing Models: Evidence of Effectiveness

An evaluation of ten supportive living demonstration projects funded by the National Institute of Mental Health (Livingston, et al., 1991) found that supportive housing can successfully serve persons with severe mental illness. Service integration varied widely across the demonstration project, but most demonstrations used scattered site housing where off-site teams provided support. Some projects utilized 24-hour availability of services and some relied on traditional office hour supports. The study found that use of hospitals and crisis services decreased after

program entry. Housing stability outcomes were positive for those who chose their housing facility and for those who had fewer psychiatric disabilities.

A number of studies have found high retention rates in housing programs originating from New York/New York (NY/NY) Agreement to House Homeless Mentally Ill Individuals, a joint city and state initiative that created roughly 4,000 units of affordable housing supported with clinical and social services (Eichenberg, 2000; Lipton et al., 2000). The housing agreement provides housing and social services in a variety of configurations.

An evaluation examining outcomes of 53 residents of Seattle's Lyon Building, a permanent supportive housing program for person with disabilities, found that residents maintained consistent residence at the Lyon Building, compared to previous levels of housing stability (Northwest Resource Associates, 2002). Residents also perceived increased access to medical care, and an increase in overall quality of life compared to their past experiences. Housing was provided in a semi-structured environment, utilizing a harm reduction approach.

Although the evaluation literature provides evidence that supportive housing models offering permanent housing lead to good outcomes, some researchers and practitioners advise caution for those developing low-demand supportive housing approaches. Trainor et al. (1993) mention in their research review that it is not always advisable to rely on the supportive housing model in jurisdictions where community services are scarce, fragmented or not easily accessible. The authors stressed that those with severe mental illness who do not have intensive case management services may be at greater risk for a range of adverse outcomes because the needed supports are not available or accessible. Case managers play a fundamental role (Dadich, et al 2013).

Similarly, the National Evaluation of the Shelter Plus Care Program found that the program's intention to move persons with disabilities from the street directly into permanent housing proved impractical (Fosburg, Locke, Peck and Finkel, 1997). The study concluded that most persons would have had better outcomes if they completed a transitional program using intensive case management, life skills training, and treatment before moving into the more permanent and independent structures. Thirty-four percent of the study participants had severe mental illnesses, 33 percent were chronic substance abusers, 8 percent had AIDS, and 25 percent had multiple disabilities.

In a randomized study comparing a housing first approach to a housing ready approach, Gulcur and colleagues (2003) tracked 225 clients over two years. Of the total, 126 participants (56%) were assigned to the control group (using a "continuum of care" housing ready approach), while 99 participants were assigned to a program known as Pathways to Housing (housing first). In the continuum of care model, clients begin at a drop-in center and move to a series of congregate living arrangements with varying levels of on-site support before moving to permanent independent living arrangements. The Pathways to Housing program is a housing first, harm reduction, supported housing model that provides immediate access to independent apartments and supportive services. At Pathways to Housing, ACT (Assertive

Community Treatment) teams are used to provide case management services, however clients in this program are given the opportunity to choose the frequency and types of services they receive. The study found that the Pathways to Housing program was successful in reducing homelessness and psychiatric hospitalization.

With regard to building configuration and size, there is some consensus from studies spanning two decades that tenants are less residentially stable in buildings with more units (Harkness, Newman, Galster and Reshcovsky, 2004). It has been hypothesized that buildings with fewer units are more likely to foster a sense of community among residents. Regarding housing & community integration and inclusion, the presence of peers can be beneficial.

Cost Effectiveness of Housing Program Models:

A few studies have attempted to quantify the costs of transitional programming and permanent supportive permanent housing. The small body of research tying costs to outcomes suggests that increasing housing stability can lead to a reduction in service utilization, mostly by saving public resources in providing emergency or fragmented services. This cost savings is purported to offset the upfront investment in providing supportive housing.

The most widely-cited study on costs of providing housing to our population is the research conducted by Culhane, Metraux and Hadley (2002). The authors used databases from eight government agencies to track 3,365 participants in New York/New York (NY/NY) housing, a program providing housing and social services in a variety of configurations. The researchers quantified costs for each participant in government services two years before and two years after being placed in NY/NY housing. The study, which also tracked a control group of mentally ill homeless individuals who were not participating in the NY/NY program, found that while NY/NY participants cost the government roughly the same per year as those in the control group, there were significant cost reductions in service utilization (an average reduction of $16,282 per housing unit, per year) after NY/NY participants moved into supportive housing. The most significant reductions in service use were among shelter, health, and corrections services. The study found that NY/NY supportive housing resulted in a $12,145 net reduction in shelter, health, and corrections service use annually per person, over each of the first two years of the intervention.

Finally, a large study estimating the cost of serving the homeless population in six settings in nine cities found the median daily costs of the settings to be (The Lewin Group, 2004):

- $25.48 for shelters
- $30.48 for supportive housing;
- $59.43 for prison;
- $70 for jail;
- $451 for a psychiatric hospital; and
- $1,590 for a regular hospital.

(****Please note that these estimates cover only the cost of the bed – doesn't include services associated with the program)

NAMI CONTINUUM MODEL HOUSING OPTIONS

Supervised Group Housing

This type of housing provides the most care for its residents. Residents generally share a room with at least one other person. These facilities need to be licensed by the state. The license must be posted in the facility for the public to view. The license requires that the facility provide safe and clean conditions in which to live. Residents have their own bed, dresser and closet space. Bathrooms and common areas are shared. Some supports supervised group housing can provide are:

- 24-hour supervision and assistance.
- Assistance in performing basic daily living skills.
- Assistance with medication.
- Food and meals (no less than three meals per day).
- Assistance with paying bills and managing money.
- Company from other residents and house managers, which can help to ease loneliness.
- Assistance with making doctor's appointments and usually assists with transportation.
- Day programs.

Partially Supervised Group Housing

This type of housing provides support for its residents, but staff is not there 24 hours a day. Residents can be left alone for several hours and are able to call for help if needed. Generally, residents share a room with at least one other person.

- Provides minimal supervision and assistance
- Daily living skills are performed independently or semi-independently
- Most residents help with cooking and cleaning
- Residents are usually encouraged to participate in a day program or hold a part-time job
- Other residents help to ease loneliness

Supportive Housing

This type of housing provides the least amount of assistance. Residents are left alone for large amounts of time. However, there is usually someone they can call for assistance. Some houses will have residents sharing a room; others will not. (e.g., group homes with no on-site 24 hour care).

- Residents are able to live fairly independently
- Residents are able to call someone if a problem arises
- Other residents help to ease loneliness

Rental Housing

Subsidized or Independent funds (e.g., private market, public and non-profit housing). This type of housing is for someone who is completely independent. Tenants are able to care for all their basic needs. Representative payees and caseworkers can still be a vital part of the tenant's life.

- Residents are able to live independently
- Resident may pay own bills or have a representative payee
- Resident has own space and privacy
- Resident is responsible for cleaning home
- Resident can take medications and cook for self
- Resident may have a caseworker to assist with making doctor's appointments and arranging transportation
- Resident will call landlord for repairs
- Resident has custody of children or is seeking custody of children
- Resident may be active in day programs or has a job

Home Ownership

Owner is able to live completely independent. The owner has all the responsibilities of day to day living and then all of the responsibilities of caring for and maintaining the home.

- Homeowner is able to live independently
- Homeowner is able to care for a home (clean home, maintain yard, complete home repairs) or pay someone to assist them
- Homeowner is willing to stay in one location for longer periods of time than a renter
- Homeowners handle their bills and money themselves

- Homeowners have custody of their children or are seeking custody
- Homeowners should have a steady job or income; income can be Social Security Disability
- Homeowners are able to maintain taxes and insurance on home
- Homeowners must seek out social interaction and be willing to stay active in the community. Homeowners may still participate in day programs, but if not, needs to be willing to stay socially active
- Homeowners must know where main cutoff valves for water and gas are and know how to disconnect electric in case of emergency or repairs
- Homeowners set aside funds for emergencies (about 5 percent of monthly income).

OTHER STATES' HOUSING CONTINUUM STRUCTURES

States such as New Hampshire, Michigan, Arizona and New York have defined housing continuum structures within their statewide behavioral health systems of care. These integrate housing and other living resources into their mental health services.

ARIZONA

Arizona has an entire publication devoted to its policies and programs for housing that is part of its behavioral health care service system (https://drive.google.com/file/d/0B1_R_SC-UBQTNks5emdGd1VMc2NkMzFLZFJsUER2emhYMDFr/view?usp=sharing). It also has flowcharts to help people access the right services (https://drive.google.com/file/d/0B1_R_SC-UBQTN0Z2ZGE4US1tN3dKVlVaQTF1TE84VUVGSXVz/view?usp=sharing).

NEW YORK

The New York State Office of Mental Health (OMH–Website: http://bi.omh.ny.gov/adult_housing/index?p=res-programs) is committed to maximizing access to housing opportunities for individuals with diverse service needs. OMH funds and oversees a large array of adult housing resources and residential habilitation programs in New York State, including congregate treatment, licensed apartments, single room residences, and supported housing. OMH works assertively and strategically with local government, consumer, family advocate, and provider stakeholders to educate, inform and incorporate flexibility into housing funding, regulation, and oversight.

NY Residential Program Descriptions

Congregate Treatment - Licensed transitional, rehabilitative residential programs that teach skills, offer support, and help residents achieve the highest level of independence possible. These residences are single-site facilities, with private or shared bedrooms, for up to 48 individuals. Meals are provided, as well as on-site rehabilitative services and 24 hour staff coverage. This level of housing is appropriate for individuals who need rehabilitative services in a non-hospital setting prior to placement in more permanent community-based housing.

Congregate Support - Single-site residential programs that provide support designed to improve or maintain an individual's ability to live as independently as possible and eventually access generic housing. Interventions are provided consistent with the resident's desire, tolerance, and capacity to participate in services. Staff is on-site 24 hours per day.

CR/SRO (Community Residence/Single Room Occupancy) - Service enriched, licensed, extended stay housing with on-site services for individuals who want private living units, but who have minimal self-maintenance and socialization skills. Living units are usually designed as studio apartments or as suites with single bedrooms around shared living spaces. A CR/SRO must maintain 24 hour front desk security and make services available (i.e., case management, life skills training, etc.).

SP/SRO (Supported/Single Room Occupancy) - Provides long-term or permanent housing where residents can access the support services they require to live successfully in the community. There is no OMH certification or licensing process. An SP/SRO can be located in a building existing solely as a SP/SRO, or integrated into a building that serves other population groups. Front desk coverage is proved 24 hours per day. However, other 24 hour staffing is not required. An SP/SRO must make services available to residents.

Apartment Treatment - Provide a high level of support and skills training to individuals in apartment settings. This licensed program is designed to be transitional in nature, with an average length of stay of 18 months. Residents gain skills and independence, learn to use community programs, and develop a community support system of friends and family. Apartment sites are usually scattered-site rental units located in the community. Staff work on-site with each resident, providing rehabilitative and supportive services designed to improve an individual's ability to live as independently as possible, and eventually access more independent housing options.

SOCR (State-Operated Community Residence) - Licensed residential program designed to provide a therapeutic living environment for residents with mental illness. SOCR assists residents to develop skills necessary for successful reintegration into the community at a pace commensurate with their levels of functioning. The program is both rehabilitative and transitional in nature and provides access to necessary treatment services.

Supported Housing - As an alternative program to licensed transitional housing Supported Housing enables individuals to live more independently in the community. Supported Housing recipients may be able to live in the community with a minimum of staff intervention from the sponsoring provider.

NATIONAL HUD CONTINUUM OF CARE (CoC) Program

The five program components that can be funded through HUD CoC Program are listed below.

Permanent Housing

Permanent housing (PH) is defined as community-based housing without a designated length of stay in which formerly homeless individuals and families live as independently as possible. Under PH, a program participant must be the tenant on a lease (or sublease) for an initial term of at least one year that is renewable and is terminable only for cause. Further, leases (or subleases) must be renewable for a minimum term of one month. The CoC Program funds two types of permanent housing: permanent supportive housing (PSH) for persons with disabilities and rapid re-housing. Permanent supportive housing is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability. Rapid re-housing (RRH) emphasizes housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.

Transitional Housing

Transitional housing (TH) is designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing may be used to cover the costs of up to 24 months of housing with accompanying supportive services. Program participants must have a lease (or sublease) or occupancy agreement in place when residing in transitional housing. The provisions of the CoC Program's TH program component have not changed significantly from the TH provisions under SHP.

Supportive Services Only

The supportive services only (SSO) program component allows recipients and sub-recipients to provide services to homeless individuals and families not residing in housing operated by the recipient. SSO recipients and sub-recipients may use the funds to conduct outreach to sheltered and unsheltered homeless persons and families, link clients with housing or other necessary services, and provide ongoing support. SSO projects may be offered in a structure or structures

at one central site, or in multiple buildings at scattered sites where services are delivered. Projects may be operated independent of a building (e.g., street outreach) and in a variety of community-based settings, including in homeless programs operated by other agencies.

Homeless Management Information System

Funds under this component may be used only by Homeless Management Information System (HMIS) leads for leasing a structure in which the HMIS operates, for operating the structure in which the HMIS is housed, and/or for covering other costs related to establishing, operating, and customizing a CoC's HMIS. Other recipients and sub-recipients may not apply for funds under the HMIS program component, but may include costs associated with contributing data to the CoC's HMIS within their project under another program component (PH, TH, SSO, or HP).

Homelessness Prevention

Recipients and sub-recipients located in HUD-designated High Performing Communities (HPCs) may use CoC Program funds for homelessness prevention assistance for individuals and families at risk of homelessness. The services under this component may include housing relocation and stabilization services as well as short- and medium-term rental assistance to prevent an individual or family from becoming homeless. Through this component, recipients and sub-recipients may help individuals and families at-risk of homelessness to maintain their existing housing or transition to new permanent housing. Homelessness prevention must be administered in accordance with 24 CFR part 576.

SAMHSA NREPP EVIDENCE BASED HOUSING PROGRAMS

Modified Therapeutic Community for Persons with Co-Occurring Disorders

Website: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=379

The Modified Therapeutic Community (MTC) for Persons with Co-Occurring Disorders is a 12- to 18-month residential treatment program developed for individuals with co-occurring substance use and mental disorders. The intervention is a structured program based on community-as-method (that is, the community is the treatment agent) and mutual peer self-help. A comprehensive treatment model, MTC for Persons with Co-Occurring Disorders adapts the traditional therapeutic community (TC)--designed to treat substance abuse--to respond to the psychiatric symptoms, cognitive impairments, and reduced level of functioning of the client with co-occurring mental disorders. Treatment encompasses four stages (admission, primary treatment, live-in reentry, and live-out reentry) that correspond to stages within the recovery process. The stage format allows gradual progress, rewarding improvement with increased

independence and responsibility. Goals, objectives, and expected outcomes are established for each stage and are integrated with goals specific to each client in an individual treatment plan. Staff members function as role models, authority figures and guides.

Oxford House Model

Website: http://nrepp.samhsa.gov/ViewIntervention.aspx?id=223

The Oxford House Model provides housing and rehabilitative support for adults who are recovering from alcohol and/or drug use and who want to remain abstinent from use. The model is a confederation of chartered community-based, self-supported rental homes that are operated under the umbrella of Oxford House World Services. Each house is self-governed and has at least six same-sex residents, who have a shared responsibility for adherence to Oxford House traditions, on-time payment of household expenses, completion of chores, and successful integration into the community neighborhood. Oxford Houses do not employ professional treatment staff, but residents are free to decide whether to seek psychological or substance abuse treatment by professionals or participate in 12-step self-help organizations (e.g., Alcoholics Anonymous, Narcotics Anonymous) while receiving social support and guidance from fellow residents.

Pathways' Housing First Program

Website: http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=365

Housing First, a program developed by Pathways to Housing, Inc., is designed to end homelessness and support recovery for individuals who are homeless and have severe psychiatric disabilities and co-occurring substance use disorders. Pathways' Housing First model is based on the belief that housing is a basic right and on a theoretical foundation that emphasizes consumer choice, psychiatric rehabilitation, and harm reduction. The program addresses homeless individuals' needs from a consumer perspective, encouraging them to define their own needs and goals, and provides immediate housing (in the form of apartments located in scattered sites) without any prerequisites for psychiatric treatment or sobriety. For consumers with high needs, treatment and support services are typically provided through an Assertive Community Treatment (ACT) team consisting of social workers, nurses, psychiatrists, vocational and substance abuse counselors, peer counselors, and other professionals. These services may include psychiatric and substance use treatment, supported employment, illness

management, and recovery services. Consumers who have more moderate needs, are further along in recovery, or participate in smaller programs may receive support through an intensive case management approach, obtaining services both directly from their own program and through referrals to other agencies.

Consistent with the principles of consumer choice, Housing First uses the harm reduction approach in its clinical services to address both substance abuse and psychiatric issues. The treatment team recognizes that consumers can be at different stages of recovery and that interventions should be tailored to each consumer's stage. Consumers' tenancy is not dependent on their adherence to clinical treatment, although they must meet the obligations of a standard lease. The team works with consumers through housing loss, hospitalization, or incarceration and helps consumers obtain housing after these episodes. While consumers can refuse formal clinical services, the program requires them to meet with a team member at least four to six times per month to ensure their safety and well-being.

NATIONWIDE WELL ESTABLISHED HOUSING CONTINUUM PROGRAMS

1.CooperRiis – North Carolina
Website: http://www.cooperriis.org
Contact: Elaine Vance, MS (Alumni and Marketing Director)
Email: elaine.vance@cooperriis.org Tel. 828-899-0815
CooperRiis Clinical Director – Dr. Sharon Young

Housing ready, High demand

Residents may apply for entry into the Asheville or Mill Spring/Tryon Community Program where they will focus on retaining and strengthening their recovery. The Community Program, whether in Asheville or Mill Spring/Tryon, provides residents with *supportive shared home living*.

CooperRiis owns, or leases, furnished shared homes to residents and will lease or purchase additional housing as needed; members may also eventually lease their own housing and still receive support from CooperRiis through their Extended Community Services. Each member is required to work, volunteer or attend school for a minimum of 20 hours per week and be able to self-administer their medications and supplements consistently.

2.Equinox – New York, NY
Website: www.equinoxinc.org
Contact:
Housing Program Director: Ilene Cote 518-435-9931 xt. 5265 Email: icote@equinoxinc.org

Equinox operates four New York State Office of Mental Health-certified residential programs in Albany County. Staffed around the clock, the residences provide medication supervision and a safe place to live while working on rehabilitation goals, training in self-advocacy and preparing to re-enter the community to live healthy, productive lives.

a. **Holt House** - Albany. The specialized program here serves **11 adults with both mental illness and developmental disabilities**.

   A structured daily schedule and intensive staffing give residents the support necessary to live more independently. Treatment planning reflects the complex issues involved with this dual diagnosis.

   Skills are taught through experiential opportunities and modeling. Staff encourages residents to take ownership and pride in Holt House by having them plan special activities and assist in evaluating house rules.

b. **Cohoes Residence** serves **14 adults** and is located in a quiet residential neighborhood. Each resident has his or her own bedroom and shares a large living room, dining room, and family room with other residents.

   Staff is available to help with day-to-day issues and to teach a wide variety of living skills**.** Cohoes Residence offers recreational activities at the house and in the community, encouraging residents to lead full, active lives. Many activities involving residents' families are scheduled throughout the year.

c. ***Recovery Residence*** - This community residence program, located in a quiet Albany neighborhood, serves **12 men who have both a mental illness and an addiction**. The program helps residents build skills necessary to live successfully in the community.

   Required programming includes attending Alcoholics Anonymous or Narcotics Anonymous meetings, which encourage residents to develop a community support network, as well as other groups designed to support sober, clean living.

d. **The Apartment Program** accommodates **36 adults who live in one-, or two-bedroom apartments** in the city of Albany. Eighteen of the residents live in individual apartments with staff available on site 24 hours a day, seven days a week.

   The Apartment Program provides **regular case management support** for individuals who are ready for **less structure and more independence**. The program's goal is to help residents acquire the skills needed for independent living in the community.

e. **Transitional Program** - For those who are ready, Equinox supervises a ***Supported Apartment Program* for 12 individuals**. This transitional program enables **individuals to live independently** in the community while benefiting from the support of **regular meetings with a housing specialist**.

3.SHALOM HOUSE - Maine
Website: http://www.shalomhouseinc.org/httpdocs/programs_housing.htm

a.RESIDENTIAL TREATMENT: TRANSITIONAL HOUSING

These programs provide temporary housing and support services for individuals with serious and persistent mental illness who are homeless and are working on a permanent housing plan.

Long-Term Transitional- *These homes provide rehabilitation and personal care services for individuals with serious and prolonged mental illness who need a highly supportive environment. Up to two years.*

b. BRAP & SHELTER PLUS CARE PROGRAMS

c. SUPPORTIVE HOUSING – ACTION PROGRAM
These supportive housing options are for individuals accepted into the ACTION Program only. Action Program residences provide housing to individuals who have specialized support needs around their housing and treatment.

d. ***SUPPORTED HOUSING***
Shared living options- *These are rooming houses where support is offered to enhance daily living skills.*
Apartments- These are primarily individual apartments where support is offered to enhance daily living skills. Medication supervision is provided.

e. INDEPENDENT LIVING

Independent apartments- Shalom House owns several apartment buildings where clients access the support they need from community resources.

CONCLUSION

Service and support should be person-centered, community-based and results-oriented. Understanding the nature and structure of promising models is paramount to establishing and moving the services towards evidence-based programming and practice.

Common themes or program aspects that emerged across this literature and program review include:

- a reliance on housing ready, supportive housing approaches,
- need for supported housing
- integration of housing and services,
- case managers' role,
- a structured daily routine,
- a central community location,
- single-site or multiple-site configuration
- a supportive peer community that acts as agent of change

It is clear that a one-size-fits-all or a scattered non-continuous approach to housing will not work. We need a system that will ensure continuity of care and help with community integration and recovery.

Additionally, although the programs and evidence discussed can provide guidance to help us develop and expand housing options, funding is a limitation. It is imperative that we get organized in order to create and maintain successful housing models. Without a systematic focus on what works, promising efforts simply remain promising efforts, and the critical goal of increasing quality of life for individuals and communities remains unrealized.

We need to establish a reliable and well organized source of funding in Miami Dade &Florida and tackle Sadowski Act Funds in an effective way. We can learn from the programs we have reviewed, in which funding comes from diverse sources: The Housing and Urban Development Deparment (HUD) grants, the DHHS Department of Health and Human Services and Shelter+Care grants (Shalom House), SSI, private funds, contract with local government, federal and state agencies (e.g. NY State Office of Mental Health). We need to work assertively and strategically with our local government, consumer, family, advocates and provider stakeholders to educate, inform and incorporate flexibility into housing funding, regulation and oversight.

Let's keep working on this.

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The Corporation for Supported Housing

NAMI Continuum Model Housing Options. Available at http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Mental_Illness/About_Treatments_and_Supports/Housing_-_Continuum_Model_Housing_Options.htm

The New York State Office of Mental Health (OMH–Website: http://bi.omh.ny.gov/adult_housing/index?p=res-programs)

www.equinoxinc.org

www.cooperriis.org

Shalom House http://www.shalomhouseinc.org/httpdocs/programs_mental.htm

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