

2003 CMHS

E X E M P L A R Y P R O G R A M S

The Center for Mental Health Services' Homeless Programs Branch is pleased to recognize the CMHS Exemplary Programs for 2003.

Each program has demonstrated contributions to ending chronic homelessness among the members of their community who struggle with serious mental illnesses or co-occurring disorders.

An independent review panel representing consumers, local service providers, and state PATH contacts selected awardees from among many highly qualified nominees.

These six programs are honored for their commitment to serving those in need, for establishing cooperative partnerships with other community service providers, for consumer involvement, for dedication to positive consumer outcomes, and for the provision of culturally sensitive services.

We congratulate these exemplary programs!

-  Action Coalition to Ensure Stability (ACES) Project
-  Central City Concern
Community Engagement Program
-  Downtown Emergency Service Center
Homeless Outreach, Stabilization and Transition Project
-  Health Care for Homeless Veterans Program
-  Institute for Community Living, Inc.
Adult Mental Health Services Division
-  Pathways to Housing, Inc.

The Key to Ending
Homelessness



Action Coalition to Ensure Stability (ACES) Project

The Action Coalition to Ensure Stability (ACES) Project believes in the importance of building on individual strengths. This is reflected in ACES' core values through program actions: services must be member centered, member directed, and member driven with the needs of the member being the most important factor in deciding the types of services provided.

Housing First! is the approach and goal of ACES; members deserve to be housed and are capable of giving back to the community and themselves.

ACES assures that services will be community based, building on the strengths, natural supports, and resources of the member and that services respect and respond to the unique culture of each member. Training in this strengths-based approach at ACES is a continuous weekly event that acknowledges that assessing, working with, and building on a member's strengths is an advanced skill and requires an organizational culture that instills this in all aspects of the work.

ACES promotes an integrated recovery model approach that supports people in the direction of less harmful activities. Relapse is seen more as a "recurrent symptom" and an opportunity for learning. Focus is placed upon member strengths in working toward decreased quantity and frequency of recurrent symptoms of co-occurring disorders and associated problems leading toward substance abstinence, recovery, and greater self-sufficiency.

Resource Coordinators (RCs) provide intensive and assertive case management services with up to 10 members. Each member is seen as the director of his or her care, and treatment begins with a strengths-based assessment—a culturally competent approach that works to incorporate the history, beliefs, traditions, and member's individualized approach to building his or her own solutions. A guiding principle of ACES is that individuals should be given the opportunity, support, and resources to guide their own treatment planning and to make their own decisions and

choices in their lives. With the RCs implementing a system of care approach, members decide who their community-based, multi-disciplinary team members are and develop a unified, comprehensive, single plan of care, called a Resource Coordination Plan. This plan addresses the member's individual goals. These goals pertain to global outcomes of sobriety, or substance-free living, mental stability, being housed, engagement in education and training or work initiatives that will result in self-sufficiency. RCs have the benefit of being able to use flexible funds to help members access unique community-based supports, as well as traditional services. For example, one member was able to link her love of animals to a volunteer opportunity at the Indianapolis Zoo.

ACES has been effective in retaining and engaging participants. The program's high retention and engagement rates account for member successes in several areas: securing stable housing, reducing substance use, and gaining mental health stability. After three years, the retention rate for members enrolled in ACES is 80 percent (100 of 120). The average length of stay in ACES is 316 days (10.4 months). At intake, 33 (38%) members reported living in shelters. When looking at members who have been enrolled in the program for 8 to 12 months, no member reported being in a shelter and 37 (42%) reported they were in their own place. Nearly every member is housed every night. The continuous supports of the program and the community of mainstream services are built around each member.

ACES has created a culture where members come together to support one another and share the belief that they deserve to be housed and that they are capable of giving back to the community and to themselves.



Pathways to Housing, Inc.

Pathways to Housing, Inc. (Pathways) was founded in 1992. Its mission is to serve individuals who have remained chronically homeless because other service providers have considered them to be “hard-to-serve” or “not housing ready”.

The program works with people who have mental illnesses, co-occurring substance use disorders, health care problems, histories of incarceration or violence, or other difficulties. Pathways immediately offers them an apartment of their own, without requiring participation in treatment or sobriety. Many other programs link the offer of independent permanent housing to the successful completion of a prolonged period of psychiatric treatment compliance and sobriety, to develop consumers’ “housing readiness.” At Pathways, housing is offered as a right; getting or keeping an apartment is not contingent on compliance with treatment or sobriety. There are only two program requirements: consumers must meet with an Assertive Community Treatment (ACT) team member at least two times per month and they must pay 30 percent of their income (usually SSI) towards rent by participating in a money management program. This program’s unique “housing first” approach is developed to engage consumers by offering consumers what they want most—a place of their own. Housing is offered to end homelessness and to provide safety and security from the streets. Once individuals are housed, the program provides ongoing, choice-driven support and treatment services to facilitate consumers’ recovery and community integration.

In the interest of providing the best possible services for consumers, Pathways is staffed by an excellent interdisciplinary staff that offers a wide array of clinical and support services including: mental health services, primary care services, and substance use disorder counseling. Pathways also maintains close working relationships with a myriad of local agencies. Collaborations and linkages have been established in the areas of education; benefits and entitlements; and vocational and employment services. These connections to mainstream services provide consumers with

the full range of community-based services and create opportunities for community integration and recovery.

Consumers participate at many levels of the agency and program operation. Consumers participate in the design of their treatment; they have input into determining what they want for themselves, in setting goals, and in achieving those goals. Consumers choose to enter into treatment for their mental illnesses and substance use disorders on their own terms and in their own timeframes. Thus, they are intimately and always involved their own treatment plans. Housing is never rescinded from consumers if they relapse into drug use or become symptomatic, reducing the high risk of returning to homelessness.

Beyond being an effective treatment for homeless individuals with mental illnesses, Pathways to Housing is cost effective. In 2003, the average cost of rent plus ACT team services is approximately \$22,500 per person per year. This is less than the annual cost of a municipal shelter cot, which ranges between \$25,000 and \$30,000 per person per year. In a randomized experiment funded by SAMHSA comparing housing programs, at 12 months, individuals assigned to the Pathways program were stably housed 80 percent of the time compared to 23 percent for individuals assigned to continuum of care programs. Pathways currently serves approximately 450 tenants, housed in their own apartments and receiving services and support from six ACT teams.



At Pathways, housing is offered as a right; getting or keeping an apartment is not contingent on compliance...

Institute for Community Living, Inc.

Adult Mental Health Services Division

The Institute for Community Living, Inc. (ICL) program was created 17 years ago. Its purpose was to provide mainstream residential alternatives that promote the recovery of people with mental illnesses.

Ninety percent of the consumers of residential programs report that ICL services have helped to improve their quality of life.

From its inception, ICL has focused on eliminating barriers that block homeless individuals from accessing existing resources, as well as innovating new services to address unmet needs. Within the first three months of admission, 95 percent of the homeless consumers admitted to ICL residential programs have obtained entitlement assistance.

In addition to its own programs, ICL has established affiliation and linkage agreements with approximately 61 social service agencies, mental health and health care providers, and clinical training programs throughout the city to help meet the needs of its consumers.

The ICL has adopted a number of clinical, administrative, and quality assurance strategies to achieve the integration of agency services with those of other community providers. Integration systems incorporated into the agency's structure include: quality assurance and person-centered service planning; a central access department; a special admissions referral committee; case management; and a scope of practice

committee which meets quarterly to evaluate how well routine clinical care is delivered and advise staff on advances in clinical care.

For almost 14 years, ICL has been developing its capacity to identify evidenced-based practices (EBP), relevant to homeless individuals with mental illnesses and to gather the resources to implement them. This process has been administratively and clinically embedded in ICL's routine operations by means of an EBP steering committee. The committee meets regularly to monitor the implementation of existing EBP, to review the literature on promising EBP pertinent to the agency's mission, and to provide administrative support

for EBP start up. Examples of EBP throughout the ICL service network include: psycho-education and social skills training modalities (such as medication and symptom management, communication and relationship skills, and community re-entry), Assertive Community Treatment, individual placement and support, positive behavioral intervention and support, functional family therapy, cognitive behavioral therapy, integrated mental health and chemical abuse treatment, and monitoring protocols for diabetes and hypertension.

An estimated 10 percent of the agency's homeless population has a history of chronic homelessness. The ICL works collaboratively with shelter staff to actively recruit and support their long-stay shelter users in transitioning to ICL housing programs and other needed services. During the past 18 months, nearly 100 formerly homeless consumers have transitioned from congregate living programs to permanent housing in the community. Ninety formerly homeless consumers living in permanent housing have obtained competitive jobs.

The ICL promotes inclusion of consumer and community involvement. The program engages in numerous prevention of homelessness activities and is dedicated to culturally sensitive services and supports. Their efforts have resulted in residential stability, increased skills and access to mainstream benefits and services for their consumers. As evidenced by a recent consumer satisfaction survey, findings indicate that 90 percent of the consumers of residential programs report that ICL services have helped to improve their quality of life; 83 percent of consumers with co-occurring substance abuse disorder stated that ICL services have helped them learn about and manage their mental illnesses and/or substance abuse disorder and 87 percent of consumers believe that ICL services have helped them reach their personal goals.



Central City Concern Community Engagement Program

Central City Concern Community Engagement Program (CEP) serves people who are homeless and have co-occurring disorders. In addition to an addiction disorder, 28 percent of consumers enrolled have a diagnosis of schizophrenia, 35 percent have a diagnosis of major depression, 22 percent have a diagnosis of bi-polar, and 3 percent have an anxiety disorder.

Currently CEP serves 30 individuals at a time, but additional county and Federal funds are anticipated to expand CEP's capacity to serve 180. One exciting component of this program is the integration of two consumer staff onto the treatment team. These two staff members serve as recovery mentors and work in equal partnership with other team members to serve homeless persons with their complex needs.

Ninety-three percent of the individuals served by CEP are homeless upon enrollment. The majority of these individuals experienced chronic homelessness (four or more episodes in the last three years or one continuous year of homelessness). Efforts to end homelessness are initiated from the first day of program entry. Housing is made available immediately regardless of ability to pay. CEP's special needs populations have access to housing in one of the 1,200 affordable housing units owned by Central City Concern (CCC).

Individuals are able to stay in alcohol- and drug-free housing for up to 4 months while the CEP team works intensively with them to address individual needs and plan for permanent housing and continuing support services. All individuals enrolled in the program participate in alcohol and drug treatment, mental health treatment, and integrated health care. The CEP staff works with members to access benefits and entitlements, employment, and education. Members are able to access team services 24 hours per day, 7 days a week regardless of their level of participation in services.

Program participants are supported in the process of re-engaging into the recovery community. They receive assistance in finding 12-step or other groups that meet their specific cultural and ethnic needs in convenient locations. A benefits and entitlements specialist with the Disability Services Office works closely with the team. These activities work

to assure concentrated attention in assisting individuals in accessing mainstream benefits and entitlements. The program also works closely with an attorney whose primary practice is assisting individuals in the Social Security Administration appeal process upon determination of ineligibility. CEP has fostered a strong relationship with the community justice system including probation and parole officers. CEP members obtain a full array of supported housing, mental health, substance abuse treatment, and primary care services under the CCC umbrella. Through collaboration with mainstream resources, alternative services, and other community agencies the program accesses Medicaid and Medicare, SSI/SSDI, food stamps, and veterans benefits.

The CEP began in July 2002 and has successfully built upon the array of mainstream and alternative services provided through CCC and other community agencies. To date, of those served by the program, 63 percent remain successfully engaged or have made successful transitions that no longer require CEP services. Of those who did not successfully stay engaged in the program, approximately 33 percent have re-engaged at a later time, indicating the positive relationships consumers associate with the program. The CEP exemplifies the philosophy for a person to successfully achieve self-sufficiency; it is not enough to have access to housing, support services, and employment opportunities. People need to build positive relationships with those who have had common experiences and can offer support.



Housing provides the stability, warmth, and shelter necessary for a person to begin to work on the issues that keep him or her in poverty and homelessness.

Downtown Emergency Service Center

Homeless Outreach, Stabilization and Transition Project

Downtown Emergency Service Center Homeless Outreach, Stabilization and Transition Project (DESC/HOST) is located in downtown Seattle, Washington and serves a very diverse population.

Speed in making resources available to potential consumers is emphasized; it is sometimes the first gesture of sincerity by a staff member that sets the tone for a trusting and productive service relationship.

Seattle is the northernmost port city on the West Coast, with significant and long-standing African American, Asian Pacific Islander, and Latino communities. Washington is among the states with the highest proportion of refugees received. There are refugees from Northern Africa and the former Soviet Union in abundance. Additionally, the city's Latino population has increased by 400 percent.

Recruiting and maintaining a diverse staff possessing cultural competence and bilingual skills is a priority for DESC. The program maintains staff in key positions who are fluent in English and Spanish. Additionally, DESC maintains subcontracts with other providers who are able to deliver cultural consultation for a wide variety of cultures and interpretation services for any language represented within the consumer population.

DESC began in the late 1970s in an effort to address the needs of the significant numbers of Seattle's population who were struggling with homelessness and mental illnesses. DESC now serves two other populations: people who are homeless and have substance use disorders and people who are homeless and have co-occurring

disorders. The most vulnerable and chronically homeless persons receive first priority.

DESC is dedicated to serving those who have fallen through service system cracks and funding gaps. The program has not allowed itself to be steered away from controversial issues and populations. Chronically homeless persons with mental illnesses,

substance abuse disorders, HIV and AIDS, high rates of incarceration, and high utilizers of hospitals and other institutions are the very people sought by DESC. In order to get a 75-bed unit for Seattle's "chronic public inebriate" population approved and funded, DESC has shown dedication and resolution in the face of much political, legal, and community resistance.

A combination of PATH and other local sources fund the Homeless Outreach, Stabilization and Transition (HOST) program. This program delivers outreach and engagement, stabilization, mental health and substance abuse treatment, shelter, and supported housing to a population of homeless adults with severe and persistent mental illnesses and/or substance dependence.

Strong collaborative working relationships with ancillary providers promote seamless services. Linkages with the State Department of Social and Health Services assist in expediting applications for public entitlements and problem solving other situations that might otherwise result in suspension or termination of benefits. Of the 275 HOST Project members meeting the definition of "PATH Enrolled" in 2002, 48 acquired transitional or permanent housing and 57 were successfully transferred to mainstream mental health services within DESC or other agencies providing specialized services.

The multi-national group of Seattle's homeless population is able to aspire to a higher quality of life with choice, greater independence, and support through the dedication and efforts of the DESC programs and staff.



Health Care for Homeless Veterans Program

The Health Care for Homeless Veterans Program (HCHV), of Little Rock, Arkansas, realized early in its development that it could not operate as an independent entity.

As a result, the program established plans for meeting the unmet needs of homeless veterans by establishing linkages with mainstream services and resources.

The program has partnered with the Disabled Veterans, Department of Defense, and other community providers for the provision of dental and eye care, work shoes, and clothing. Since 1996, HCHV has joined with St. Francis House on eight HUD Emergency Shelter Grants that allow the program to provide meals and homeless prevention services to homeless veterans. They also joined with Volunteers of America under the HUD Continuum of Care for transitional housing, day care and job counselors. These strong relationships with mainstream providers within the community are maintained through outreach to homeless providers and potential employers of homeless veterans. Coordinated efforts through Federal, state, and local non-profit providers have contributed to veterans consistently receiving high quality care.

It has been estimated that 41 percent of Little Rock's homeless veterans were chronically homeless. Additionally, 65 percent of the chronically homeless veterans had been homeless more than two years. Because of these alarming numbers, the program has moved further to design a program specifically for homeless veterans, based on their input.

In order to address the extent of chronic homelessness in Little Rock, a two-phase project has been designed. The first phase involves engaging the veteran in the use of existing services including the development of individual service plans designed to move him or her toward permanent housing. Those services include outreach to identify homeless veterans, case management, a safe haven, and drop-in day treatment for the provision of access to transportation, laundry, and shower facilities; meals; homeless prevention services; residential treatment; VA benefits counseling; AA/CA groups; employment and housing

assistance; and engagement in other therapeutic forms of individual and group interventions. The second phase identified significant concerns of veterans contributing to their experience with homelessness.

The HCHV program collaborated with staff on plans for the delivery of services seen as essential to recovery from homelessness.

Areas of concern included: housing, legal concerns, advocacy for veterans involved in the court system

(alcohol and drug treatment designed by the court and minor offenses to avert incarceration), life skills deficits, input from consumers, family reunification, and entitlement benefits.

Program efforts have resulted in positive outcomes for veterans discharged from residential treatment. They are recognized as the only VA homeless program to have been identified as a Clinical Program of Excellence in the Care and Treatment of Homeless Veterans from 1997 to present. The HCHV program is the first VA homeless program to receive the Glaxo Smith-Kline Circle of Excellence Award. In 2001, the program was certified by the Council on Accreditation of Rehabilitation Facilities as an exemplary program in the provision of case management services to homeless veterans.



Input from veterans regarding their needs and efforts in coordinating services have contributed to veterans receiving high-quality care.

Collaboration and teamwork is evident not only within programs but between programs. If you would like more information on any of the 2003 CMHS exemplary programs, please contact:

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*Contributions to
their communities*

*Commitment
to serving those
in need*

*Collaborations with
other community
service providers*

*Consumer
involvement*

Consumer outcomes

*Culturally
sensitive services*

If you would like more information on the Homeless Programs Branch or the PATH program, please contact:

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