

**The Supportive Housing Provider Group:
Addressing the mental and chemical health needs of families in supportive housing**

**EXECUTIVE SUMMARY
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This is the story of how an extraordinary group of supportive housing organizations came together to address a pressing common need – sufficient resources to support long-term homeless families having mental illness and chemical dependency.

Supportive Housing: A Definition

Supportive Housing combines access to affordable housing with support services for those who have experienced homelessness. In addition to serving families who are screened out of affordable housing due to poor financial and housing histories, supportive housing also differs from affordable housing by its ownership and management, usually nonprofit service organizations rather than housing development corporations. Affordability is key for supportive housing. Most tenants have little or no income and even if employed see great fluctuations in the sufficiency of their income. They are often challenged by a number of disadvantages, including mental illness, chemical dependency, and chronic

homelessness.

Supportive housing providers administer service strategies to increase family stability, build basic independent living skills and coordinate intervention needs. On-site case managers help each entering family develop a personal plan with each family member for stability and then accordingly coordinate access to on-site and community-based services.

Changing Landscape of Supportive Housing:

Supportive housing designs and staffing patterns have historically responded to families who were homeless for the first time. These residents required moderate to episodic staffed-support, which focused primarily on the head-of- household. In recent years tenant referrals have reflected a national and state priority for serving the long-term homeless and requiring multiple or extensive periods of homelessness. Hence the needs among participating families have become more complex, demanding more intensive case management and involving higher levels of risk not only to themselves but also to others. Over time, since eligibility has come to *require* households with disabilities, new residents often enter supportive housing already in the midst of active dys-regulation or a significant state of relapse.

The Twin Cities Provider Group: Supportive Housing Programs Facing Common Challenges

In the Twin Cities metropolitan area, 17 non-profit agencies that sponsor housing with services for homeless families have formed the Supportive Housing Provider Group. Originally convened in 1998 by the Family Housing Fund, the Provider Group shares information, staff trainings, and support services for families living in their facilities, prioritizing best practices and advocating public policies to meet the needs of homeless children and their parents.

Beginning in 2003 Provider Group staff were reporting significant resident turnover - linked, at least in part, to their incapacity to engage tenants having dual diagnoses of mental illness and chemical dependency and to respond to those in the midst of severe episodes of psychosis, depression, and anxiety. Without early intervention, such residents often tend toward interpersonal conflicts, parental neglect, and other harmful behaviors which threaten their ability to remain in supportive housing and retain custody of their children.

That same year the Provider Group formed two committees: one for better understanding and resolving adult residents' mental illness and chemical dependency needs (MI/CD Committee) and the other for addressing the healthy development of their children (Children's Committee).

Supportive housing providers first secure and maintain safe, affordable housing for families and then administer service strategies to increase family stability, build basic independent living skills and coordinate intervention needs.

Children are not just adjuncts to their parents. They are people in their own right - with their own strengths and needs.

The MI/CD committee learned that Minnesota's mental health system is overburdened with long waiting lists - especially for children. Moreover, they recognized additional barriers blocking access to services for the population served by the Provider Group. If the Providers' staffs themselves were to furnish the necessary therapeutic services on site, they concluded they would need extensive training and support from licensed therapeutic clinicians.

The Children's Committee recognized the uniqueness of Providers' "Family Centered Supportive Housing." Most supportive housing has been focused on parent outcomes. But the Children's Committee recognized that a "resident" must be considered any person living in supportive housing, regardless of age, not only parents. If the children are maladapted, suffering from anxiety and depression, their behavior can destabilize the parent and the whole family.

In February 2004, the standing committees combined their efforts to form the Healthy Families Network Advisory Committee, which conducted a site-by-site survey of case management staff. Combined, the group during that year served 1147 children and 734 adults. They learned

- the average per program percentage of children with diagnosed or undiagnosed mental illness was 16.5%; with chemical dependency 1.6%.
- the average per program percentage of adults with diagnosed or undiagnosed mental illness was 65.9%, with chemical dependency 63.5%.

In the same survey, when asked to rank possible supportive services for staff to prepare and sustain them for focusing on the needs of mentally ill and chemically dependent residents, and their children, the case managers recommended the following:

- In-service training
- Consultation services
- Crisis response
- On-site therapy services for residents

Since at the same time supportive housing providers were experiencing the first of six continuous years of serious reductions in service funding, the HFN Advisory Committee determined that a collaborative sharing of mental health resources was needed to leverage access across the Provider Group membership.

The Provider Group's Response: Shared Clinical Services

The Provider Group sought the help of the Family Housing Fund, which in turn formed a subsidiary called The Family Supportive Housing Center, LLC. Located within the offices of Hart-Shegos and Associates, the Center launched three initiatives in response to the HFN committee recommendations:

- In 2005, through a partnership with the University of Minnesota, the Center implemented the Family Mental Health series, a monthly training based on new research and practice. The series, now in its fifth year (2009), has awarded more than 3,300 CEUs to 459 supportive housing staff.
- In that same year the Center began a National Institute of Mental Health research project, called "Early Risers," for 200 school children (ages 5-12), living in the supportive housing sponsored by 14 of 17 Provider Group members
- In 2006, the Center hired a mental health clinician for case management consultation, case manager support, and staff training for Provider Group members. Per their priorities, the clinician had both cross cultural competence and a commitment to community-mental health practices rooted in home-based services.



Site Consultations: A Shared Clinician

Working with the clinician, eleven (11) provider group sites participated in monthly or bimonthly on-site clinical consultations within the context of regular case management meetings, with staff encouraged to come with specific incidents or family intervention issues having surfaced between consultations.

As a result of these clinical consultations, Provider Group staff identified six (6) common quandaries which challenge their ability to provide resident supports:

1. How does service delivery engage both individual and family needs?
2. How does family engagement differ from individual engagement?
3. What factors determine how much is an appropriate level of outreach—particularly in terms of face-to-face contacts?
4. How does a family member's stage of change affect the negotiation of expectations in terms of case plan goals and outcomes?
5. How should case managers address chemical dependency relapse or an active mental health crisis which occurs during the process of application to supportive housing or during the initial phase of occupancy? (Note: Case managers identified increasing incidents of both occur within the first 90 days of occupancy.)
6. What ethical dilemmas of care occur when adult-focused, consumer-driven, service delivery models offer services to the adult family member (s) who are not ready for change and are increasingly compromising the safety and development of their children?

Many families have been locked in years of displacement, with children who may never have experienced stability. Often a parent will have a serious and persistent mental illness without clinical supports. High levels of trauma and lifetimes of abuse are not uncommon.

Provider Group Recommendations: Four Strategies

In the fall of 2007, the Provider Group planned a pilot to be launched among interested members of the Provider Group. They identified the following goals:

1. Maximize the opportunity to address de-stabilizing issues, from the first contact with a prospective resident through move-in, with intensive contact being maintained through the first 90 days of initial occupancy.
2. Build staff capacity to understand and respond to mental illness and chemical dependency issues.
3. Create housing environments which avoid pathologizing residents and embrace a common language of empowerment for addressing mental and chemical health dys-regulation.
4. Provide opportunities for staff self-care and peer reflection, to limit the second-hand trauma and burnout.
5. Engage the larger community, especially community-based and in-home family practitioners of color, who can help providers adequately address mental illness and chemical dependency in their facilities.

Based on these goals, the Committee launched “The 90 Day Window”, using four (4) strategies:

Strategy #1: *Target initial contacts with residents as opportunities to introduce, encourage, and support change within the first 90 Days of occupancy in supportive housing.*

The window of time from the initial point of contact through 90 days after move-in is the prime time for negotiating the expectations of both family participants and provider staff and developing the motivation necessary to begin achieving outcomes. The Committee identified five (5) contact opportunities:

1. **First Contact:** Beginning during the screening process for supportive housing, staff and families identify areas of need and community and program resources to address those needs and also assess a family's commitment to recovery from mental illness and chemical dependency



2. **Before Move In:** Retooling the intake and orientation process staff open dialogue and gain a better understanding of a family's current circumstances and potential triggers to relapse.

3. **At Move-In:** Completion of a number of assessments to gauge the tenants' functional and emotional status, determine the family's capacity for stress and change and facilitates the process of establishing a structure necessary for change and wellness.

4. **Initial Occupancy:** The first 90 days of occupancy are a critical time to establish both the strength of the resident/case manager relationship and the environment to support change and recovery. Recognizing that relapse is part of recovery, staff during this time can recognize triggers for relapse and build supports for preventing, overcoming or working through relapse triggers. Staff can encourage conversations stressing the importance of recognizing and managing emotional and relational dys-regulation as essential to maintaining stable housing

and supporting the healthy development of their children.

5. **90 Days After Move-In:** With three months to assess needs, build individual plans, experience inevitable ups and downs, tenants may be ready to engage in a deeper process of support, to reaffirm commitments, and to re-exam and re-prioritize personalized plans. The new conversations can help case manager and tenant mutually determine if supports and engagements should be relaxed and/or tightened.

Strategy #2: *Build staff capacity to respond effectively to crises related to mental illness and chemical dependency*

The Provider Group worked with the clinician to identify mental health modalities which could effectively transfer knowledge, language and skills to unlicensed service staff and supportive housing residents. They decided the Center would provide a series of Dialectical Behavioral Theory (DBT)-based skills trainings which would first build knowledge and personal application, then expand as a case management tool, and ultimately build staff skills to introduce the concepts with residents. The intent was not to create unlicensed therapists, but rather to equip key staff with the awareness, knowledge and skills to better respond to tenants in crisis and then refer them to community professional resources mental and chemical health resources.

The Center has sponsored four levels of training for direct-service staff of the Provider Group to introduce and sustain their use of DBT-Based Family Skills Coaching:

Level 1: *A four day, intensive training experience, delivered by licensed therapists based on a Masters level course, demonstrations and examples having been adapted to the specific context of family-centered supportive housing.*

Level 2: *A 20-week workshop series meeting once a week for two hours. Set at a much slower pace and smaller group size, these sessions require cohort groups of dyads, triads, or quads to strengthen case managers' ability to use DBT coping skills.*

Level 3: *A 14 week series of workshops, meeting once a week for two hours. Using a "Train the Trainer" format, the participating case managers randomly select staff cohorts to team teach units of a 12-week DBT-based curriculum to staff and residents on their respective sites.*

Strategy #3: *Provide clinician-led case management consultations.*

One of the first strategies requested by the Provider Group the monthly consultations weave service strategies and DBT training together with independent reviews of staff by a licensed therapist, who is also available for telephone and emergency consultations.

...supportive housing providers were experiencing the first of six continuous years of serious reductions in service funding... In the midst of these decreases in funding, despite growing unmet needs, the Healthy Families Network Advisory Committee determined that a collaborative sharing of mental health resources was needed to leverage access across the Provider Group membership.

Strategy #4: Facilitate Case Manager Self-Care and Support

Specialized supports for front-line staff include monthly case manager support groups, monthly specialized training, and a financial incentive program for Providers to recognize and reward staff in their efforts to increase their capacity.

Since 2007, the Center has contracted with Dr. Benita Amedee, a clinical psychologist experienced in DBT and family practice, to facilitate a monthly group of case managers as a regular, confidential opportunity to recognize the personal impact working with homeless families entails and to identify ways to resolve frequent burnout and emotional fatigue .

Monthly family mental health trainings focused especially on the needs of children are coordinated by Beth Haukebo, the Center's Deputy Director and Dr Abigail Gewirtz from the University of Minnesota. They select issues identified by staff, providing a training and networking opportunity which broadens their scope of theories and approaches and provides more tools front line staff.

Looking Back: A Successful Pilot

The 90 Day Window is testament to the power of shared experience and a strong consensus to overcome a lack of resources and financial support. During the last five years the Provider Group has identified for the broader community the serious lack of resources and accessible mental health services needed to bolster the stability and resiliency of supportive housing residents - and the staff who serve them. More importantly, they have looked beyond the scarcity of resources and found the requisite resourcefulness within themselves.

Based on that success, the Center is developing a similar collective 90 Day Window response to the needs of the children living in supportive housing. A new committee of the Provider Group, working with Sharon Henry-Blythe, the Center's director of Children and Family Policy and Research, will explore key strategic touch points for engaging with children: at the time of referral, in the course of needs assessment, at move-in and orientation, and during the initial 90 days of settling into their new home



Supportive Housing Provider Group

The Supportive Housing Provider Group gives priority to identifying and addressing the needs of children living in supportive housing. The Provider Group aims to give childhood back to children who have experienced the trauma and dislocation of homelessness and aims to break the cycle of homelessness from one generation to the next and brings the voices of homeless families and their children to the community's attention.

Provider Group Partners

Breaking Free, Inc.
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East Metro Women's Council
Emma Norton Services (Emma's Place)
Indigenous People's Task Force
Jeremiah Program
Lutheran Social Services
MN Indian Women's Resource Center
Model Cities, Inc
New Foundations, Inc
Perspectives, Inc.
RS Eden
Simpson Housing Services
Tubman Family Alliance
Wayside House, Inc.
Wilder (Jackson Street Village)
YWCA of St. Paul

For this executive summary and the complete report please visit our website at
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