

The Supportive Housing Provider Group:  
Addressing the mental and chemical health needs of families in supportive housing  
December 2009

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# Acknowledgements

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## THE EXECUTIVE SUMMARY

*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.*





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### 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.

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#### **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



## THE FULL REPORT

*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 homeless families having mental illness and chemical dependency. By trusting each other enough to share internal program weaknesses, they found a collective solution. Their willingness to see beyond the lack within our community and find the resourcefulness within themselves produced a series of strategies to equip and empower supportive housing staff. As part of a much larger local and national story of responses to family homelessness, they modeled how to leverage shared wisdom and resources for vigilant effective service.*



## 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. Few sponsors of supportive housing define their key mission as being to develop, own and manage housing, having begun offering it primarily as a means of enhancing access and outcomes associated with their services.<sup>1</sup> 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. Many are dependent on public assistance, some with life-time limits looming in the near future. Nearly all have long histories of poor housing experiences: evictions, doubling up, and multiple episodes of homelessness.

Families prioritized for supportive housing are often challenged by a number of disadvantages, including mental illness, chemical dependency, and chronic homelessness. They cycle in and out of shelters and their children in and out of home placement. Traditional social services have had limited success in assisting these families.

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. On-site case managers help each entering family develop a personal plan for stability and then accordingly coordinate access to on-site and community-based services designed to lower the family's risk of exhausting their MFIP benefits or returning to homelessness. Each personal plan addresses the challenges which compromise residents' ability to seek, gain, and retain employment: literacy gaps, chemical dependency, and mental illness, along with inadequate access to quality child care, transportation, and employment advocacy and support. Tailored to each family's needs, the plans establish the outcomes to be measured and reported in determining success. Unique to family-centered supportive housing is the recognition of children as fully franchised members of the community with needs of their own. Family centered supportive housing plans prioritize the inclusion of personalized plans for each family member.

## Changing Landscape of Supportive Housing:

Supportive housing designs and staffing patterns have historically responded to families who were homeless for the first time, openly seeking change in their lives, and wanting support to resolve the issues that contributed to their housing crisis. These residents required moderate to episodic staffed support (e.g. once bi-weekly or once monthly face-to-face contact). Generally, staffing ratios were one case manager/advocate per 12 to 15 families, with the primary (and sometimes sole) service focus on the head-of- household.

In recent years providers have been experiencing dramatic shifts in their tenant referral base. Supportive housing referrals have reflected a national and state priority for serving the long-term homeless, requiring multiple (4 episodes in the last three years) or extensive periods of homelessness (a minimum of 12 consecutive months in duration). 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. Hence the needs among participating families in supportive housing 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, and especially with the advent of the federal and state focus on "long-term" homelessness, eligibility has come to *require* households with disabilities. As a result, new residents often enter supportive housing already in the midst of active dys-regulation or a significant state of relapse (mental or chemical). These disruptions often take the form of:

- Children returning to out-of-home placement;
- School disruptions and truancy;
- Mental health crises involving both parents and child(ren);
- Isolating behaviors in residential units;
- Hospitalizations; and
- Absences from units without notification to staff, collateral providers, or family members.

## 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. Together, they currently provide affordable housing and services to over 900 families with over 2,000 children on any given day, through multifamily and scattered site housing programs.

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. The Group helps bring the voices of homeless families and their children to the attention of the community. <sup>2</sup>

Beginning in 2003 Provider Group staff were reporting significant resident turnover - linked, at least in part, to their incapacity to engage tenants during severe episodes of psychosis, depression, and anxiety --- all typically presenting within the first 90 days of occupancy and tending to worsen over time. There were rising incidents of police and 911 calls to the sites. And "sober program" staff, in particular, were feeling inadequately equipped to manage the issues of those who were now more frequently being referred to their programs - residents dually diagnosed with chemical dependency and mental illness. Without early intervention, such residents often tend toward interpersonal conflicts, parental neglect, and other harmful behaviors that cause distress not only for their families but also for other residents and housing staff, and thus 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). (The Group learned from the contemporaneously released Wilder Research Center's Tri-annual Statewide Homeless Study (2003) that, overall, 54% of residents of supportive housing had mental illness or chemical dependency or both.)

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. Those most immediately obvious include transportation and child care. Less obvious are the fear residents often feel in the usually institutional contexts of therapeutic services and the distrust they experience as minorities or immigrants when faced with a predominantly white, western health care system. 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. (At the time of the study, only one organization had such a clinician on staff, none were offering any mental health services to children, and few had any referral procedures already set in place.)

The Children's Committee recognized the uniqueness of what the Providers had been attempting to offer: "Family Centered Supportive Housing." Most supportive housing has been focused on parent outcomes. A few sites have staff committed to serving children, though that staff reported rarely having impact on the support and expectations of the parent. They identified this approach as not fully integrating concerns for parents with those of their children. Whereas, the Children's Committee recognized that a "resident" must be considered any person living in supportive housing, regardless of age. Children are not just adjuncts to their parents. They are people in their own right - with their own strengths and needs. If the parent achieves stability, so will the children. However, we also know the reverse is true. "A parent can only be as happy as their unhappiest child." This old adage is continuously borne out in supportive housing. 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. In their effort to collect information about the unmet mental health needs of both adults and children in Provider Group housing, they conducted a site-by-site survey of case management staff. Combined, the group during that year served 1147 children and 734 adults. Among these,

- The percentage of children with diagnosed or undiagnosed mental illness ranged from 0 to 60%, with a per program average of 16.5%; the figure for chemical dependency ranged from 0 to 5%, with a per program average of 1.6%.
- The percentage of adults with diagnosed or undiagnosed mental illness ranged from 25% to 95%, with a per program average of 65.9%; the figure for chemical dependency ranged from 17% to 100%, with a per program average of 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

Contemporaneous with this dedicated committee activity, supportive housing providers were experiencing the first of six continuous years of serious reductions in service funding. In 2004, Providers reported a 38% reduction in private philanthropic support for

services. Similarly targeted funding from federal, state and county resources decreased from 2% to 16%, with the infusion of new funds restricted to the expansion of supportive housing, and not its improvement.

In the midst of these decreases in funding, despite growing unmet needs, 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 in inaugurating these shared clinical services. The Fund formed a subsidiary called The Family Supportive Housing Center, LLC (the Center) to provide an administrative home for these services. 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 for 200 children living in the supportive housing sponsored by 14 of 17 Provider Group members. Using a NIMH recognized evidence-based, direct-service intervention for school children (ages 5-12), this project focused on building resiliencies as well as psycho-social and academic skills of the Group's children. Called "Early Risers," this study was the first of its kind to forge a community/university partnership to serve formerly homeless children in a community-based setting. (Beginning in the fall of 2009, Early Risers will be publishing a series of reports on its findings regarding prevention and intervention strategies.)
- In 2006, the Center launched a pilot project, hiring a mental health clinician for case management consultation, case manager support, and staff training for Provider Group members. Reviews of resumes suggested that the best candidate would have cross cultural competence and a strong commitment to community-mental health practices rooted in home-based services. Because more than 80% of supportive housing residents are people of color, the committee established an unwavering commitment to securing clinical services from a therapist who specializes in serving constituents within the context of their culture. Eventually, the HFN committee completed their search activities for a clinician with the selection of Kevin Hardwick, a licensed Marriage and Family Therapist with concentrated experience in community and home-based mental health services.

### Site Consultations: A Shared Clinician

Working with the clinician, eleven (11) provider group sites participated in monthly or bimonthly on-site clinical consultations. The ninety-two (92) staff and interns involved included site-based and scattered-site case managers. Consultations were conducted within the context of regular case management meetings, with staff encouraged to come with specific incidents or family intervention issues having surfaced between consultations. The consulting clinician focused recommendations within the context of a number of evidence-based mental health theories.<sup>3</sup>

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

7. How does service delivery engage both individual and family needs?
8. How does family engagement differ from individual engagement?
9. What factors determine how much is an appropriate level of outreach—particularly in terms of face-to-face contacts?
10. How does a family member's stage of change affect the negotiation of expectations in terms of case plan goals and outcomes?
11. 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.)
12. 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?

In addition, the clinician identified a number of “red flags” which could reasonably predict the necessity of higher support levels:

- A mental health diagnosis that is incomplete on all five (5) axes using DSM-IV and few or no recommendations for support;<sup>4</sup>
- An Adult GAF (Global Assessment of Functioning Scale) score of 40 or lower on a scale of 1-100.<sup>5</sup>
- A presentation of active psychotic features;
- A pattern of medication non compliance;
- An acknowledged mental illness diagnosis with a history of inconsistent or non-existent provisions of in-home or community mental health services;
- A mental health assessment reflecting a diagnosis of major depression, anxiety disorder, or PTSD; and
- A diagnostic assessment providing insufficient information to indicate the levels of support for independent living.<sup>6</sup> (Because supportive housing requires a documented disability, residents must have corroborating evidence. Often this evidence does not provide sufficient documentation to confirm a resident’s readiness for independent living and indicate levels of support needed.)

## Provider Group Recommendations: Four Strategies

In the fall of 2007 the Provider Group formed the Behavioral Services Committee, to develop consensus on priorities and build a plan of action for a pilot to be launched among interested members of the Provider Group, both site-based and scattered site programs. Comprised of eighteen (18) staff, representing twelve (12) Providers<sup>7</sup>, the Committee identified the following goals:

2. Maximize the opportunity to address de-stabilizing issues, beginning with the first contact of a prospective resident through move-in, with intensive contact being maintained through the first 90 days of initial occupancy.
6. Build staff capacity to understand and respond to mental illness and chemical dependency issues.
7. Create housing environments which avoid pathologizing residents and embrace a common language of empowerment for addressing mental and chemical health dys-regulation.
8. Provide opportunities for staff self-care and peer reflection to limit the second-hand trauma and burnout which can occur with repeated crisis interventions and responses.
9. 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.

Based on these goals, the Committee launched a pilot concept, “The 90 Day Window”, comprised of the key case management and support strategies to be emphasized during a resident’s first 90 days of introduction, move-in, and occupancy in supportive housing. “The 90 Day Window” has 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. It is the prime time to discern and develop the motivation necessary to begin achieving outcomes. After studying DiClemente and Prochaska’s Stages of Change<sup>8</sup>, and family strengths theories of Whitaker and Satir, the Committee created an engagement strategy based on three key observations:

1. There have been significant shifts in discerning resident families’ readiness for change. Program admission processes, when based on more thorough evaluations of psychological reports, diagnostic assessments, and UAs, confirm some residents’ inability to embrace recovery. Rather than being at DeClemente and Prochaska’s action and maintenance stages of change, these adult family members are often instead at the pre-contemplation and contemplation stages of change.
2. Whitaker’s and Satir’s experiential family therapy theories, focused on establishing a structure for change, suggest that the initial integration of tenants into supportive housing needs to assume that the urge and the felt need to change self-destructive behaviors are not yet in place.

3. Staff need a model of intervention showing them how to increase their capacity to support family members through episodes of significant emotional and behavioral dys-regulation. Such a model especially needs to incorporate elements of staff self-care.

The Committee identified five (5) contact opportunities for influencing a family's successful engagement within the first 90 days of occupancy:

2. First Contact: Beginning with the screening process for supportive housing, a strategic window of time opens during which both program staff and families can work to identify important areas of need and link community and program resources to those needs. One important aspect of wellness to be integrated and assessed during this critical window is the family's commitment to recovery in terms of both mental illness and chemical dependency: Do they see this commitment as part of their work? Is change something they want to work toward?
3. Before Move In: Retooling the front end intake and orientation process facilitates open dialogue, enabling a better understanding of a family's current circumstances and potential triggers that could lead to their early destabilization. Engaging in conversations prior to move-in gives staff information key to guiding a family's successful orientation and entry into the supportive housing community and/or their successful leasing of their housing, according to Provider expectations.
4. At Move-In: Completion of a number of assessments that gauge the tenants' functional and emotional status will assist both the tenant and the staff in determining the family's capacity for stress and change, as well as begin the process of establishing a structure necessary for change and wellness. It is critical at this juncture to understand if the tenant (head of household) is functioning sufficiently for the demands of independent living, especially if children are present in the family.
5. Initial Occupancy: During the first 90 days of occupancy, there is a critical window of 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, the change environment becomes an opportunity to recognize triggers for relapse, build supports for overcoming those triggers or working through the relapse. By including intentional conversations about change, staff can more readily identify how problems with health and wellness may have hindered a family's housing stability and undermined their ability to cope with stressful events. Staff can assess families' base-line levels of functioning and then redefine family engagement within a preventative rather than a reactive, crisis-driven framework. By cultivating a non-pathologizing approach to family engagement, staff can empower skill-oriented conversations with and among families on the importance of recognizing and managing emotional and relational dys-regulation in maintaining stable housing. (The foundational construct for this empowerment of families to own their own recovery can be found in Dialectical Behavior Therapy, or DBT.)
6. 90 Days After Move-In: Within three months, residents and staff have had the opportunity to assess needs, build individual plans for change, experience the ups and downs of the contemplative process of change, and become ready to engage in a deeper process of support and engagement. Having learned DBT-based skills, staff and residents are at a point of being able to share new language and concepts within the context of the stages of change and support. This may be the time to reaffirm commitments, re-exam and re-prioritize personalized plans. The new conversations can establish new structure for the case manager and tenant relationship; relaxing and tightening supports and engagement as is mutually determined.

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

The Behavioral Health Committee 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. One member of the Provider Group, East Metro Women's Council, had made a commitment to use Dialectical Behavioral Theory-based skills<sup>9</sup> to build staff and resident capacity to understand crises rooted in mental illness and chemical dependency.

After learning from EMWC's experience and other research, the Committee decided that the Center would provide a series of DBT 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. The Behavioral Health Committee also added DBT adaptations to their front-end engagement approaches and their life skills training models, calling their practice *DBT-Based Family Skills Coaching*.

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.* This is the same intensive introductory course used with Masters level therapists, with demonstrations and examples having been adapted to the specific context of family supportive housing. Staff enrollment is limited to twenty-five participants, with each participant receiving an extensive training manual. Completion of Level 1 results in 31 CEU's authorized through the MN Board of Psychology. As of June 2009, 97 case managers have completed the full session, earning a total of 3,007 CEUs.

**Level 2:** *A 20-week workshop series which meets once a week for two hours.* Set at a much slower pace and smaller group size, these sessions allow for greater levels of interaction and participation. Unlike Level 1, which is designed for individual participation, Level 2 sessions require cohort groups of dyads, triads, or quads to strengthen case managers' ability to use DBT coping skills with supportive housing families by having them first use the skills in their own lives. Staff enrollment is limited to 25 participants, with 40 CEUs awarded to each participant upon completion of the series. As of June 2009, 17 case managers have completed all sessions, earning 680 CEUs.

**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 among staff and residents on site. Upon completion of Level 3, staff have earned 28 CEUs and are ready to implement DBT skills coaching with residents. Staff enrollment is limited to 25 participants. As of June 2009, 14 were enrolled, but the Center has not been able to continue to fund these workshops.

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

One of the first strategies requested by the Provider Group, and a central aspect of the Center's services, was the monthly case management consultation. Based on the 90 Day Window model, the consultations would weave service strategies and DBT training, together with independent reviews by a licensed therapist.

Thus far, 92 staff from 11 Provider Group programs have participated in either monthly or bi-monthly consultations. Building on the trust and value of a 10 year collaborative of the Provider Group, staff have presented case management challenges specifically associated with resident care needs. As case management consultations have continued into 2008 and 2009, the clinician was able to build on DBT training and introduce practice-based experience into group discussions, applying skills specific to actual situations. In addition, the clinician has been available for telephone consultations and emergency consultations.

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

In addition to structuring specialized proactive interactions with residents, building competencies for addressing mental illness and chemical dependency, and providing monthly case management consultations, the Center also encouraged specialized supports for front-line staff themselves, primarily case managers and advocates. These supports included: monthly case manager support groups, monthly specialized training in a variety of applicable theories and interventions, and a financial incentive program for Providers to recognize and reward staff in their efforts to increase their capacity. These supports have continued to the present.

This strategy included a "Self Care Fund," a special, unrestricted fund which sites applied for to encourage and recognize staff through recognition events, social events, special self-care incentives, and awards. Grants were distributed to 17 organizations for a total of \$32,000.

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.

These monthly meetings provide a regular opportunity for staff to recognize the personal impact which working with homeless families entails and to identify ways to resolve the burnout and emotional fatigue common to those working in an atmosphere of chronic crisis. This is a confidential and self-directed group experience.

As noted earlier in this report, The Center has also been sponsoring monthly family mental health trainings focused especially on the needs of children. In partnership with the University of Minnesota, coordinators Beth Haukebo and Dr. Abi Gewirtz select topics

based on issues generated by staff, especially with respect to serving families with children who have experienced trauma. This training and networking opportunity broadens the scope of mental and chemical health theories and approaches, providing more tools and understanding for front line staff.

### Looking Back: A Successful Pilot

The last five years of the Supportive Housing Provider Group's work has been nothing less than extraordinary. As they have in the past, the Provider Group has demonstrated once again the wisdom and capacity of shared, collaborative service. They came together, trusted each other enough to share internal program weaknesses, and distilled for the broader community a major problem for providing and sustaining supportive housing: a serious lack of resources and accessible mental health services undermines the stability and resiliency of supportive housing residents - and the staff who serve them. They committed enormous time and energy to looking beyond the scarcity of resources in the community and find the requisite resourcefulness within themselves. The Provider Group's several committees wrestled with and then produced a series of strategies focused on health, empowerment, shared skills, cooperative communication, and vigilant service. 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.

The success of this venture has led several members of the Provider Group (13) to explore the development of a shared contract for services with the clinical services manager. Reaching beyond the Center, the Provider Group is seeking to embed the valuable results of this work into everyday support services and through securing independent contracts for case management consultations with the clinician.

A legacy from this experience is the Center's plan to develop a similar collective 90 Day Window response to the needs of the children living in supportive housing. A new committee of the Provider Group has been established to work with Sharon Henry-Blythe, the Center's director of Children and Family Policy and Research. Together they will be exploring 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. Beginning in 2010, the Center will share reports on the process and outcomes of this new important work.

## End Notes:

1. Supportive housing can take many forms: short-term, extended stay shelter, transitional housing (often referred to as "program housing"), and permanent supportive housing (housing without program required time limits). Supportive Housing can be site-based (e.g. multifamily apartments), scattered-site, and mixed use (a few units set aside within a larger affordable housing project). The housing can be owned or leased by the supportive housing sponsor. If owned, there may be regulatory agreements placed on occupancy eligibility by the capital funders. If leased, it can be master-leased by the sponsor, or tenant leased.  
Support services provided are drawn from a broad spectrum of nonprofit social service missions and delivery approaches.
2. [www.familysupportivehousingcenter.org](http://www.familysupportivehousingcenter.org)
3. The following key theories most shaped the clinical consultations:  
DeClemente and Prochaska's Stages of Change model;  
Whitaker's and Satir's family therapy theories;  
Reuben Hill's ABCX model of family strengths (family stress theory);  
Dialectical Behavioral Therapy skills-based model;  
Motivational Enhancement Therapy skills-based model; and a  
Trauma/Historical Trauma model.
4. The Five Axes of the DSM-IV:  
According to Dr. Brian Burke, "The multi-axial system of the *DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th edition, 1994)* is the way in which the *DSM-IV* tries to address "the whole person". It grows out of the professional conviction that, in order to intervene successfully in an emotional or psychiatric disorder, we need to consider the affected person from a variety of perspectives. Axis I: refers broadly to the principal disorder that needs immediate attention; e.g., a major depressive episode, an exacerbation of schizophrenia, or a flare-up of panic disorder. Axis II: refers to the personality disorder that may be shaping the current response to the Axis I problem. Axis II also indicates any developmental disorders, such as mental retardation or a learning disability, that may be predisposing the person to the Axis I problem. Axis III: lists any medical or neurological problems that may be relevant to the individual's current or past psychiatric problems; for example, someone with severe asthma may experience respiratory symptoms that are easily confused with a panic attack, or indeed, which may precipitate a panic attack. Axis IV: codes the major psychosocial stressors the individual has faced recently; e.g., recent divorce, death of spouse, job loss, etc. And Axis V: codes the "level of function" the individual has attained at the time of assessment, and, in some cases, is used to indicate the highest level of function in the past year. This is coded on a 0-100 scale, with 100 being nearly "perfect" functioning (none of us would score that high!)." *Abnormal psychology* (n.d.). Retrieved October 24, 2009, from [http://faculty.fortlewis.edu/burke\\_b/Abnormal/Abnormalmultiaxial.htm](http://faculty.fortlewis.edu/burke_b/Abnormal/Abnormalmultiaxial.htm)
5. Global Assessment of Functioning Scale: The Functioning scale is based on the Axis V noted above. GAF scores of 40 or less indicate: (41-50) serious symptoms or serious impairment in one of the following: social, occupational, or school functioning; (31-40) Some impairment in reality testing or impairment in speech and communication or serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood; (21-30) presence of hallucinations or delusions which influence behavior or serious impairment in ability to communicate with others or serious impairment in judgment or inability to function in almost all areas; (11-20) there is some danger of harm to self or others or occasional failure to maintain personal hygiene or the person is virtually unable to communicate with others due to being incoherent or mute; (1-10) persistent danger of harming self or other or persistent inability to maintain personal hygiene or person has made a serious attempt at suicide. *Global assessment of functioning scale* (n.d.). Retrieved October 24, 2009, from [psyweb.com/Mdisord/DSM\\_IV/jsp/Axis\\_V.jsp](http://psyweb.com/Mdisord/DSM_IV/jsp/Axis_V.jsp)
6. Such diagnostic assessments may include Uncorroborated Rule 25 Assessments (rare to have corroborated assessments for supportive housing review) *Rule 25 assessments* (n.d.). Retrieved October 24, 2009, from [www.mncourts.gov/?page=1915](http://www.mncourts.gov/?page=1915)  
Vocational Assessments to identify mental health issues impairing work readiness (more commonly available)  
Psychological reports from an outpatient, community mental health provider (more commonly available)  
Psychiatric and/or medication evaluation reports (rarely provided)  
Prior mental health hospitalization reports (rarely provided)

Fetal Alcohol Syndrome and Fetal Alcohol Effect assessments (rarely provided)

7. Members of the Behavioral Services Committee: Emma Norton Services; Minnesota Indian Women's Resource Center; Perspectives, Inc; YWCA of St. Paul; Model Cities, Inc.; Wilder Foundation; Lutheran Social Services; Wayside Inc.; Simpson Housing Services; Tubman; New Foundations; RS Eden;
8. The Stages of Change formulations presented by Carlos DeClemente and James Prochaska (originally developed for smoking cessation, but since applied to numerous addiction recovery models). Simply stated, the Stages of Change can be summarized as follows:  
*Pre-contemplation* –The family member has no intention to take action within the next 6 months.  
*Contemplation* –The family member intends to take action within the next 6 months.  
*Preparation* – The family member intends to take action within the next 30 days and has taken some behavioral steps in this direction.  
*Action* –The family member has changed overt behavior for less than 6 months.  
*Maintenance* –The family member has changed overt behavior for more than 6 months.  
*Relapse* –The family member experiences a recurrence of symptoms and must now cope with the consequences, as well as decide what to do next.  
*Understanding how people change is first step in*

*changing unhealthy behavior* (n.d.). Retrieved October 24, 2009, from [www.psychologymatters.org/diclemente.html](http://www.psychologymatters.org/diclemente.html)

9. Dialectical behavior therapy (DBT) is a therapeutic methodology developed by Marsha M. Linehan, a psychologist researcher at the University of Washington. DBT has been identified as an evidence-based, harm-reduction oriented strategy and creatively combines theories of change from behavioral science with a mode of acceptance derived from practices of contemplative spirituality. Central to the approach are the practices of mindfulness, willingness, and acceptance...all uniquely suited for integration into support services offered families who have experienced homelessness, especially long-term homelessness. Although DBT was designed to work specifically with persons experiencing severe and chronic personality disorders, others with milder mental health issues have found DBT helpful as well. In addition, DBT prescribes self-care as crucial for practitioners; it can be as helpful to the caregiver as well as the client and can address issues that lead to the high staff turnover often experienced in supportive housing. *Dialectical behavioral therapy* (n.d.). Retrieved October 24, 2009, from [www.en.wikipedia.org/wiki/Dialectical\\_behavioral\\_therapy](http://www.en.wikipedia.org/wiki/Dialectical_behavioral_therapy)



### **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.  
Dakota Woodlands  
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**  
[familysupportivehousingcenter.org](http://familysupportivehousingcenter.org)

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