Center for Mental Health Services and Center for Substance Abuse Treatment
Collaborative Program to Prevent Homelessness: Project Summaries

Background

CMHS and CSAT are collaborating in the administration and evaluation of a three year program that will document homelessness prevention models for adults with serious mental illnesses and/or substance use disorders who are formerly homeless or at-risk for homelessness, and who are engaged with the mental health and/or substance abuse treatment systems. In Phase 1, which began in FY 1996 and will last one year, cooperative agreement grants were awarded to projects to develop manuals documenting homelessness prevention interventions that are focused on the target population. Applications were invited that document homelessness prevention initiatives in four areas: housing loss/eviction prevention; discharge planning from psychiatric and/or substance abuse treatment facilities; family support and respite interventions; and resource management/representative payee models.

$2.5 million

In Phase 2, which will begin in FY 1997 and will last a maximum of 24 months, each grantee will conduct process and outcome evaluations of homelessness prevention approaches documented in Phase 1 that address the multiple needs of individuals with psychiatric and/or substance use disorders who are formerly homeless or at-risk for homelessness, and who are engaged with the mental health and/or substance abuse treatment systems.

Summary Descriptions of Funded Projects

The following are brief descriptions of projects by the focus of the homelessness prevention intervention to be documented:

Intervention Focus: Housing Loss

- **Arapahoe House, Inc., Thornton, Colorado:** The project proposes to document and evaluate its PROUD program (Project to Reduce Over Utilization of Detoxification services), and the use of their dyadic Intensive Case Management Program as an effective homelessness prevention intervention. The dyadic case managers (one trained in the provision of mental health services; the other in substance abuse services) provide an array of client services, including: case finding and identification, needs assessment, formulation of the client plan, appropriate treatment placement, housing locating, housing skills building, services coordination and linkage, and developing education and job/employment options. The project will target dually diagnosed women.

- **Boley Center for Behavioral Healthcare, Inc., St. Petersburg, Florida:** The project will collaborate with the Florida Mental Health Institute of the University of South Florida to develop a manual that documents and describes their evaluation design for housing-related services provided by Boley to persons with serious mental illnesses (including those with co-occurring substance use disorders) who are at-risk for homelessness. Housing-related support services include: in-home skills training and counseling,

vocational training and placement, landlord or management negotiation, orientation to their new neighborhood and community, and linkages to additional services from either Boley or the appropriate community agency.

- **Catholic Community Services, Everett, Washington:** The project proposes to manualize and evaluate their supportive housing model as a effective homelessness prevention with women (many who are living with their children) with substance use disorders who are formerly homeless or at-risk for homelessness. Of the women participating in the project, one-half will reside in Shelter Plus Care housing in the Family Tree apartments, where treatment services are provided. The other half will reside in Shelter Plus Care off-site housing. All women will receive chemical dependency treatment and, if needed, mental health services; case management; and wrap-around services, as well as a broad range of parenting and child care education.

- **Central City Concern, Portland, Oregon:** The project will document and evaluate the Estate Transitional Alcohol and Drug-Free Community (ADFC) housing program as a prevention to homelessness. The ADFC is a 52-unit single room occupancy transitional housing program that provides supervised and supportive housing for newly recovering homeless chemically dependent individuals. The major elements of the intervention include: a continuum of housing, the provision of treatment coordinated with housing, and the development and maintenance of a supportive community. Counseling, case management, and treatment are provided off-site. There are five outpatient programs that provide treatment to their client population under the Homeless Alcohol and Drug Intervention Network (HADIN). ADFC and HADIN staff work closely together and share information to insure that clients/residents are engaged in their treatment and housing plans, and are progressing in their recovery.

- **Community Connections, Washington, D.C.:** The project will collaborate with the New Hampshire-Dartmouth Psychiatric Research Center to manualize and evaluate its clinically-managed Housing Continuum (HC) model of housing as an effective strategy of homelessness prevention. The HC model features a broad range of housing options supported by a team of clinical housing specialists (housing is seen as an extension of mental health treatment). Key functions of the clinical housing specialists include: goal planning with the client and case manager to explore consumer housing preferences and identify specific monitoring issues (e.g., substance use and medication management); ongoing monitoring and support through group meetings and planned events; development of social supports; crisis stabilization; planned use of respite beds or detox facilities during progressive crisis; coordination of housing moves; and advocacy with property managers. The client population includes persons with serious mental illnesses and those with co-occurring substance use disorders.

- **National Development and Research Institutes, Inc., Center for Therapeutic Community Research, New York, New York:** The applicant proposes to document, in manual form, a modified therapeutic community for the treatment and prevention of homelessness in a population of homeless substance abusing mothers and their children. The program, New Image, is located in Philadelphia and, along with Kindred House in West Chester, is operated under the auspices of Gaudenzia, Inc. Clients move from residential to transitional to permanent housing through a continuum of treatment, preparatory, and homeless prevention activities; services are also incorporated for the children in placement with their mothers. The activities to be documented are grouped in five major goal areas: housing stabilization, entering the world of work, family preservation, building a supportive community, and social reintegration.

- **Pathways to Housing, Inc., New York, New York:** The project will develop and evaluate a manual that documents their Consumer Preference Independent Living (CPIL) model, where clients with serious mental illnesses (and those with co-occurring substance use disorders) select their own independent apartments and receive an array of services, case management, money management, training/skill building, and supports. The intervention includes: apartment/logistic skill building, such as apartment finding and selecting furniture; relationship building with the case manager and building interpersonal skills; and training in housing maintenance, working with the landlord, and locating community resources. Other services that are part of their program includes assessment, development of a comprehensive service plan, assistance with entitlements, legal aid, medical services, and vocational and recreation programs.

- **Philadelphia Health Management Corporation, Philadelphia, Pennsylvania:** The project will to document and evaluate Project H.O.M.E. (Housing, Opportunities, Medical care, and Education), a multi-faceted housing intervention with support services to prevent homelessness. The client population is primarily those with mental illnesses, but includes a high proportion of those with co-occurring substance use disorders. The intervention consists of three components: (a) support services that include food/shelter, medical care, mental health and substance abuse services, & case management; (b) an employment program that includes developing job training and educational skills, job readiness training, literacy, and hands-on work experience in sheltered settings; and (c) education and advocacy that include client presentations before school and community groups and contact with service providers, religious organizations, and policy makers. The interventions are operated in conjunction with their housing program, a continuum that flows from street outreach, to emergency/low-demand residences, to highly supportive housing, to permanent housing.

Intervention Focus: Family Support/Respite

- **Barbour and Floyd Medical Associates, Lynwood, California:** The project will describe, manualize, and evaluate their family support and respite services model as an

effective intervention to prevent homelessness in an at-risk population. Their client population are families who are caring for family members with serious mental illnesses (including those with co-occurring substance use disorders). Components of the family support and respite services model include: (a) home visits for relationship building and *in-vivo* skill building and education; (b) case management that includes counseling, crisis intervention, and conflict resolution; (c) family education that addressed conflict/problem resolution skills, medication management, budgeting/use of resources, and decision making skills; (d) family groups for information and social support; and (e) respite care through day rehabilitation services or short-term (2-3 days) in a board-and-care type facility that houses other program members.

- **Connecticut Department of Mental Health and Addiction Services, Hartford, Connecticut:** The project will develop and evaluate a manual for working with families who are caring for a dually diagnosed family member as an effective homelessness prevention intervention. The family education and training program is based on the expended stress-vulnerability model. It includes both multiple family groups and single family sessions, and is aimed at both reconnecting families with weak or severed ties, as well as reducing stress in the family and enhancing the collective ability of members to impact positively on the outcome of dual disorders. The single family psychoeducation program is divided into five components: engagement, assessment, education, problem-solving training, and stage-wise dual diagnosis treatment. The multi-family groups are conducted on a monthly basis to provide education to family members about coping with dual disorders and to generate social support. The 90-minute meetings include presentations on topics chosen by clinicians and family members. The manual will be based on observations of family work currently under way, as well as interviews will clinicians, clients, and relatives, and focus groups with families to explore perceptions of needs and beneficial aspects of family training and education.

Intervention Focus: Money Management/Representative Payee

- **Mental Health Services West, Portland, Oregon:** The project will document and evaluate the Money Management (MM) program as a homelessness prevention intervention for clients receiving primarily mental health services from their agency. The program provides consumers a place to obtain help in budgeting their income to meet their basic needs and skills training in personal finances. The agency acts as a representative payee for Social Security (SSI/SSDI) recipients who are found to be unable to manage their funds independently. The program operates a MM account, with sub-accounts developed for each enrolee and each client is assigned a money manager who works as part of the treatment team to develop a highly individualized money management plan. The program services include: working with landlords to ensure that timely and direct payments are made for rent, fees, and deposits; client skills training in money management and banking; client training in apartment living skills; enrolling clients in local restaurant

meal programs, to help reduce cash on hand (and to reduce the trigger for substance abuse); and automatic bill paying.

- **University of Chicago, Chicago, Illinois:** The project will document and evaluate the Community Counseling Centers of Chicago (C4) representative payee program. The predominantly voluntary program operates a client "bank" that receives client's bills; pays rents, utilities, and doctor bills; and provides financial counseling. The bank is operated similar to a regular bank, and case managers, who are the gatekeepers for funds, can issue voucher slips to clients that can be redeemed for cash. The program helps clients manage their money for basic needs and in paying rent. The goal of the program is to help clients develop skills to independently manage their own financial affairs. Their client population is primarily those with serious mental illnesses, but includes a high proportion of those with co-occurring substance use disorders.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Substance Abuse and Mental
Health Services Administration
Rockville MD 20857

October 16, 1996

Molly Brostrom
Domestic Policy Council
Old Executive Office Building, Rm. 207
Washington, D.C. 20502

Dear Ms. Brostrom:

Enclosed is the information you requested regarding the Center for Mental Health Services and Center for Substance Abuse Treatment Collaborative Program to Prevent Homelessness. I have included relevant portions from the Guidance for Applicants and summaries of each of the funded projects.

If you have any questions about the program, please telephone me on (301) 443-3707.

Sincerely

Lawrence Rickards

Lawrence D. Rickards, Ph.D.
Homeless Programs Branch
Center for Mental Health Services

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PUBLIC HEALTH SERVICE

SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

CENTER FOR MENTAL HEALTH SERVICES (CMHS)
CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)

COOPERATIVE AGREEMENTS FOR CMHS/CSAT COLLABORATIVE PROGRAM TO PREVENT HOMELESSNESS

Short Title: Homelessness Prevention Project

Guidance for Applicants (GFA) No. SM 96-01

Catalog of Federal Domestic Assistance No. 93.230

Under the authority of Section 501(d)(5) of the Public Health Service Act, as amended (42 U.S.C. 290aa), and subject to the availability of funds*, SAMHSA's Center for Mental Health Services, in conjunction with the Center for Substance Abuse Treatment, will accept applications in response to this announcement for the single receipt date of June 10, 1996.

***This program is being announced prior to the full annual appropriation for fiscal year (FY) 1996 for the Substance Abuse and Mental Health Services Administration's (SAMHSA) programs. Applications are invited based on the assumption that sufficient funds will be appropriated for FY 1996 to permit funding of a reasonable number of applications being hereby solicited. This program is being announced in order to allow applicants sufficient time to plan and to prepare applications. Solicitation of applications in advance of a final appropriation will also enable the award of appropriated grant funds in an expeditious manner and thus allow prompt implementation and evaluation of promising projects. ALL APPLICANTS ARE REMINDED, HOWEVER, THAT WE CANNOT GUARANTEE SUFFICIENT FUNDS WILL BE APPROPRIATED TO PERMIT SAMHSA TO FUND ANY APPLICATIONS. Questions regarding the status of the appropriation of funds should be directed to the grants management officer listed under Contacts for Additional Information in this announcement.**

SAMHSA will publish a notice in the Federal Register regarding the amount of funding available for its programs when the final appropriation is enacted.

Bernard S. Arons M.D.
Director, CMHS

David Mactas
Director, CSAT

Nelba Chavez, Ph.D.
Director, SAMHSA

Date of Issuance: April 1996

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I. PROGRAMMATIC GUIDANCE

INTRODUCTION

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) announce the availability of support for projects that will document homelessness prevention models for individuals with serious mental illnesses and/or alcohol or other drug use disorders (hereafter abbreviated as substance use disorders) who are formerly homeless or at-risk for homelessness, and who are engaged with the mental health and/or substance abuse treatment systems. In addition, such projects must document their potential effectiveness.

Funds will be awarded through a cooperative agreement mechanism that allows the Federal Government or its representative contractors to provide technical assistance to projects, coordinate the development of manuals, design evaluations, collect and analyze data, and convene meetings.

This program will be divided into two phases. During Phase 1, the awardees will develop a manual that documents a currently existing and operating intervention to prevent homelessness and a plan for the evaluation of the prevention approach. Continuation of the grants for Phase 2 will be based on an assessment of the quality of the manual and evaluation plans, and the availability of funds. During Phase 2, grantees will, using an experimental or quasi-experimental design, conduct an evaluation of the documented intervention.

NOTE: Cooperative agreements awarded under this GFA are for the development of homelessness prevention manuals and the evaluation of prevention approaches, and may not be used for treatment, services, or providing the intervention.

Healthy People 2000

The Public Health Service (PHS) is committed to achieving the health promotion and disease prevention objectives of **Healthy People 2000**, a PHS-led national activity for setting priority areas. This GFA, CMHS/CSAT Collaborative Program to Prevent Homelessness, is related to **Healthy People 2000** objectives established for Alcohol and Other Drug Abuse (Chapter 4), Mental Health and Mental Disorders (Chapter 6), and HIV Infection (Chapter 18). Potential applicants may obtain a copy of **Healthy People 2000** (Full Report: Stock No. 017-001-C0474-0; or Summary Report: Stock No. 017-001-00473-1) through the Superintendent of Documents, Government Printing Office, Washington, D.C., 20402-9325 (Telephone: 202-783-3238).

PROGRAM DESCRIPTION

History

CMHS, a center within SAMHSA, was created by the ADAMHA Reorganization Act of 1992 to provide national leadership in the prevention and treatment of mental illnesses. CMHS also serves as the lead within the Department of Health and Human Services (HHS) for administering programs and interdepartmental initiatives that meet the treatment, support, and housing needs of homeless persons with mental illnesses, and for knowledge development and dissemination regarding the target population. In this capacity, CMHS has initiated a broad array of demonstration, technical assistance and national leadership projects to assist States and localities in meeting the needs of homeless individuals with mental illnesses.

Specifically, CMHS currently administers two programs funded by resources created under the McKinney Act: the Projects for Assistance in Transition from Homelessness (PATH) Formula Grant Program and the Access to Community Care and Effective Services and Supports (ACCESS) Program. CMHS also provides professional leadership for interdepartmental initiatives designed to assist the homeless population with serious mental illnesses.

CSAT [formerly the Office for Treatment Improvement (OTI)], a center within SAMHSA, was created in 1992 to improve the Nation's addiction treatment and recovery system by providing funds to States and treatment providers to assist them with increasing the efficacy of treatment for those who suffer from alcohol and drug problems. Among numerous initiatives, CSAT funded grant demonstration programs in FY 1990 and 1991 to assist States and communities to enhance existing drug abuse treatment programs for "critical populations," with the ultimate goal of improving treatment outcome for these groups. The critical populations under this announcement were adolescents, racial/ethnic minorities, women, and residents of public housing projects. In addition to focusing on one or more of the critical populations listed above, CSAT funded projects that addressed special subgroups of these critical populations, particularly homeless persons and those individuals with co-occurring alcohol and/or other substance use disorders and diagnosable mental illnesses.

SAMHSA's CMHS and CSAT are currently collaborating in the sponsorship and administration of cooperative agreements under the Collaborative Demonstration Program for Homeless Individuals, a 3-year program to document and evaluate effective treatment interventions for co-occurring substance abuse and serious mental illnesses in homeless adults.

Numerous CMHS and CSAT service and demonstration initiatives have explored how to work with and provide the necessary mix of

treatments, services, and housing options for homeless individuals with serious mental illnesses and/or substance use disorders. However, little attention has been focused on the prevention of homelessness among persons with serious mental illnesses and/or substance use disorders who are engaged with the treatment system. This new program will expand the knowledge base in this critical area. Four pathways have been identified which contribute to homelessness within these vulnerable populations:

1) Housing loss. Eviction from or other loss of housing is a major cause of homelessness among adults with mental illnesses and substance use disorders. Housing instability and homelessness are correlated with loss of contact with treatment and support services, relapse, and poorer physical and mental health.

2) Inadequate discharge planning from inpatient and residential psychiatric and substance abuse treatment facilities. Effective discharge and aftercare planning (the preparation for discharge and active linkage of the patient to case management and community-based services) can be effective in engaging clients in appropriate services, reducing hospital recidivism, and preventing homelessness. The critical elements of a comprehensive model of discharge planning have yet to be defined or evaluated.

3) Exhausting the family support system/lack of family respite services. The stress of serving as a caregiver can extract a heavy toll on the family members who provide daily oversight, deal with crises, and function as case managers for an individual with a serious mental illness and/or substance use disorder. The caregiver role has been associated with a higher incidence of depression and stress-related health problems. The consequences to the target population may include eviction and loss of support or estrangement from the family. Models of effective respite services for adult family members caring for the identified target population have not been defined or evaluated.

4) Misuse of resources/lack of adequate representative payee models. Financial instability or misuse of resources among persons with serious mental illness and/or substance use disorders is a cause of homelessness. Although receiving representative payee services (money management assistance) is believed to be associated with client/consumer housing stability and reduced substance abuse, measurement of these client outcomes has not been conducted.

There are many programs that are currently providing services to individuals who are homeless and who have serious mental illnesses and/or substance use disorders. Yet providers consistently identify the prevention of homelessness in this

population as a critical unresolved issue. The prevention of homelessness is important for two primary reasons: the human misery associated with the condition of homelessness and, because of the insufficiency of service funding to meet current needs, the competition between homeless programs and other special populations for limited resources. After a decade of focusing on improving services to homeless individuals, an orientation shift to homelessness prevention should begin to reduce the number of persons who become homeless and need to receive services. We hope this program will draw upon the wealth of experience from current strategies to document and evaluate the most promising approaches to the prevention of homelessness among the target population.

Program Goals

The primary goal of the CMHS/CSAT collaborative program is to answer the following question:

> What is the relative effectiveness of alternate models for preventing homelessness among adults with serious mental illnesses and/or substance use disorders who are engaged with the treatment system?

A second goal of the collaborative program is to document and evaluate appropriate homelessness prevention interventions for individuals with serious mental illnesses and/or substance use disorders that address one or more of the following four topic areas:

- Housing instability and eviction from housing;
- Discharge planning from psychiatric and substance abuse treatment facilities;
- Models of family support and respite services; and
- Resource management and representative payee models.

A third goal of the collaborative program is to disseminate information about effective homelessness prevention interventions which can be replicated by State and local programs serving homeless persons with serious mental health illnesses and/or substance use disorders within their service population.

Target Population

The target population includes adults who are formerly homeless or at-risk for homelessness and who have a diagnosable serious mental illness, substance use disorder, or both a diagnosable substance use disorder and a serious mental illness, and who are

engaged with the mental health and/or substance abuse treatment system.

Definitions

The term "homeless" includes persons who lack a fixed, regular, and adequate nighttime residence. It also includes persons whose primary nighttime residence is either a supervised public or private shelter designed to provide temporary living accommodations; time-limited/nonpermanent transitional housing arrangements for individuals engaged in mental health and/or substance abuse treatment; an institution that provides a temporary residence for individuals not intended to be institutionalized; a public or private facility not designed for, or ordinarily used as, a regular sleeping accommodation for human beings; or an institution (e.g., psychiatric hospital or substance abuse treatment facility) where the individual was admitted without housing or housing was lost during the course of institutionalization. The term "formerly homeless" includes persons who are currently housed, but have experienced one or more episodes of homelessness within the past two years. The term "at-risk for homelessness" includes persons who are in unstable or precarious housing circumstances and are, therefore, vulnerable for becoming homeless.

The term "engaged with the treatment system" refers to a level of contact with the treatment system whereby the individual is identifiable by actual name, code name, or unique identifier; has a case record or clinical chart; and is receiving services from the organization.

The term "prevention" encompasses those activities directed toward identifying individuals who are within the target population and vulnerable for becoming homeless, addressing risk factors for homelessness, and taking action to avoid the onset of homelessness. Programs for the prevention of homelessness should be primarily proactive, supportive, or educational rather than clinical or treatment in conception. Individually targeted interventions operate with the ultimate goal of strengthening the individual's capacity for increasing competency over his or her own life. Systems level interventions operate with the goal of enhancing the capacity of the environment and community in which the target population resides for addressing the pathways to homelessness. These goals may be achieved by preventing the homeless condition from occurring or by detecting or identifying the conditions and circumstances that lead to homelessness and developing and implementing interventions to remedy them.

For the purposes of this announcement, an "intervention" is defined as "a targeted attempt to produce favorable consumer/client/patient outcomes that reduce the risk of or prevent homelessness." Examples of interventions to prevent

homelessness include, but are not limited to (for additional examples see section on Examples of Interventions):

- case management to help consumers/clients/patients manage their living arrangements and avoid eviction/loss of housing;
- discharge planning from psychiatric or substance abuse treatment facilities to link clients/patients/consumers without a fixed address to housing and support services;
- the provision of respite care services enabling families to rejuvenate and maintain or enhance their supportive roles; and
- the development and implementation of representative payee programs to help the target population manage their financial resources to avoid housing loss.

For this announcement, homelessness prevention interventions do not include mental health or substance abuse treatment services that are targeted to the disorders of mental illness or substance abuse. For example, psychotherapy, community-based detoxification, or treatment for alcohol or other drug abuse would not be acceptable homeless prevention interventions. The treatment services needs of the target population should be addressed, but must be funded from other sources.

Diagnosable substance use disorders include both DSM-IV abuse and dependence categories. Substance use dependence or addiction is a biopsychosocial disease phenomenon and is known to be a chronic relapsing disorder for many individuals. Relapse tends to be an inherent characteristic of the disease of addiction and is often exacerbated for those experiencing a significant degree of socio-economic dysfunction.

For purposes of this announcement, adults with "serious mental illness" is defined as follows:

> "Persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-IV that has resulted in functional impairment which substantially interferes with or limits one or more major life activities.
>
> "These disorders include any mental disorders listed in DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious mental illness. All of these disorders have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

"Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing); instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and functioning in social, family, and vocational/educational contexts. Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses."

Examples of Interventions

All applications should identify an intervention from one of the following four categories and describe, at a minimum, screening and assessment procedures to assure inclusion of the target population, the homelessness prevention intervention(s), frequency and duration of the intervention, and where the intervention is delivered. Examples of interventions within the four major categories that are appropriate for evaluation under this GFA include, but are not limited to, the following:

- Housing-related interventions that assist at-risk or formerly homeless individuals achieve housing stability and/or avoid housing loss or eviction, such as: (1) home management skills, tenant responsibilities and rights, and training in complying with essential lease provisions; (2) behavioral management techniques that address threatening, destructive, or bizarre conduct; (3) income and entitlement assistance and resource management; (4) landlord education and conflict mediation programs; (5) multi-disciplinary case management teams trained to serve the target population and provide services throughout or during critical times; or (6) the provision of other types of supportive services. Inherent in these interventions are considerations of the fundamental role of housing and neighborhood quality and consumer choice in contributing to housing stability. The purpose of these interventions must be to assist the target population in maintaining themselves in housing.

- Discharge planning from psychiatric and/or substance abuse inpatient or residential treatment facilities and linkage to housing, continuing care services, and support services to help individuals with serious mental illnesses, substance use disorders, or co-occurring disorders in the transition from residing in institutions to successful community living and residential stability.

- Family interventions targeted to family members who are providing housing to a live-in adult relative with a serious mental illness and/or substance use disorder. Such

interventions include: respite care models; family education and training programs (e.g., conflict resolution skills); or adult day activities and services that help maintain successful community and residential stability for adults with serious mental illnesses, substance use disorders, or co-occurring disorders.

- Financial management programs, such as trust funds, cash accounts, and the development of budgeting skills; and representative payee models to assist the identified target population manage their financial resources to avoid housing loss.

Project Requirements

Where homelessness prevention interventions are targeted to individuals with serious mental illnesses (disorders that include, but are not limited to, schizophrenia, major affective disorders, schizoaffective disorders, and severe personality disorders), the applicant must provide evidence that a comprehensive community support system, either within or outside of the applicant organization, is accessible to the clients who are the focus of this demonstration. In order to assure the evaluation of a stable and ongoing intervention, the applicant is required to document that the applicant has provided homelessness prevention services for a minimum of 2 years prior to the date of application (see section on Eligibility Requirements).

Additionally, all proposed projects must meet the following requirements:

- Applicants must concisely describe screening and assessment procedures in place for identifying serious mental illnesses and/or substance use disorders in the target population and describe client relationships to the mental health and substance abuse treatment systems.

- Applicants must indicate how they have assessed the risk of homelessness in the target population (e.g., formerly homeless clients/consumers; clients/consumers with clear prior risk profile; clients/consumers whose families have threatened to evict them or who are returning to a family after eviction; clients/consumers who were homeless prior to being institutionalized in a treatment setting, or who became homeless while institutionalized).

- Applicants must provide documentation regarding the availability, accessibility, and quality of a community support system. Such documentation must be in the form of a letter from the Single State Agency for Alcohol and Drug Treatment (SSA), from the State Mental Health Authority (SMHA), or the local governmental entity (e.g., county,

regional, or city) immediately responsible for monitoring, overseeing, or administering addiction treatment, mental health, and homelessness services in the applicant's jurisdiction. Documentation must be provided in Appendix I, entitled "Community Support System Documentation."

- During Phase 1 of this project, each grantee will be expected to develop a manual that includes the following:

  - a description of a currently existing/operational homelessness prevention intervention for the target population (it is not acceptable to propose the future implementation of an intervention);

  - documention of the potential effectiveness of the intervention through case studies;

  - a logic model of the intervention that depicts the interrelationships among the target population and environment; theory and methods; intervention(s); and goals, objectives, and desired outcomes of the intervention;

  - a description of the implementation of the intervention;

  - an evaluation plan for conducting a systematic assessment (process evaluation) of whether the Phase 2 intervention is faithful to the manual;

  - an evaluation plan, using an experimental or quasi-experimental design, for conducting a systematic assessment (outcome evaluation) of the effectiveness of the intervention on a client/consumer cohort that will be completed during Phase 2 of the program.

- During Phase 1 of this project, each grantee will be expected to develop a budget for implementing the Phase 2 evaluation plan.

- If more than one homelessness prevention intervention is proposed, or the proposed intervention has more than one component (e.g., it includes both conflict mediation and case management components), the applicant must describe the anticipated effect of each component and address in their evaluation plans how the relative effects will be determined.

In order to be considered for Phase 2, grantees must submit continuation applications that include the above-mentioned products. Continuation applications for Phase 2 will be assessed by a panel comprised of Federal and non-Federal experts from the fields of alcohol and drug abuse, mental health, and homelessness. Continuation of grant funds for Phase 2 will be

based on the assessment of Phase 1 progress and the availability of funds. Phase 1 progress assessment will be based on the following review criteria: adequacy and appropriateness of the manual and thoroughness in describing the homelessness prevention intervention; significance and potential effectiveness of the intervention; a cogent logic model; thoroughness in describing the implementation of the intervention; adequacy, appropriateness, and quality of the process and outcome evaluation plans; adequacy, appropriateness, and quality of staffing, project organization, and resources; and appropriateness of the proposed budget for implementing the evaluation. Not all Phase 1 grantees will necessarily move to Phase 2.

It should be noted that the evaluation designs for the projects should be developed with the understanding that some modifications may be necessary in order to support the types of cross-site analyses that will be discussed and agreed upon during the initial meetings of the Phase 2 grantees. However, there are certain design features that are likely to be necessary to address the primary question raised under Program Goals. First, a necessary feature includes the use of an experimental or quasi-experimental design that includes the identification and study of an appropriate comparison group that is not involved in the intervention. Second, it is anticipated that some follow-up over time of individuals receiving the intervention, as well as the comparison group, will be required to access outcomes. Third, because of the importance of understanding issues from a consumer perspective, it is expected that individuals who are representatives of the target group will be involved in the planning and implementation of the proposed evaluation. Elaboration of these design features will be provided during the first year of the award.

Technical Assistance

Technical assistance for Phase 1 and 2 activities will be provided by CMHS and CSAT staff and through their representative contractor(s) that will assist grantees in refining the intervention; developing the logic model, manual, and evaluation design; implementing the evaluation; and analyzing the data.

Description of Manual

The manual which is to be submitted at the END of Phase 1 should provide a thorough description of the homelessness prevention intervention which includes, at a minimum, the following information:

- Specification of the Problem
  - A general discussion of the needs of the target population and how they are addressed by the intervention
- Relationship of the Intervention to Existing Literature
  - A discussion of published research and other literature which provides empirical support for the intervention
- Principles of the Intervention
  - The theory or assumptions that govern the intervention
- Goals of the Intervention
  - A description of what the intervention is designed to accomplish (i.e., the overall goals and objectives)
- Description of the Intervention
  - Detailed description of the intervention, including intensity and duration
  - Description of current linkages, if any, to primary care and mental health and substance abuse service providers
- Description of the Implementation of the Intervention
  - Step-by-step instructions for implementing the intervention
- Logic Model of the Intervention
  - A description of the intervention which depicts the interrelationship among the target population and environment; theory and methods; intervention(s); and goals, objectives, and desired outcomes of the intervention, including client functioning or symptomatology as relevant
- Setting for the Intervention
  - Location of the intervention (e.g., urban, rural, inner-city, suburban; institution, apartment/home, agency settings)
- Clients Targeted for the Intervention
  - A description of the clients that includes age, gender, ethnicity, education, diagnosis, history of mental illness and/or substance abuse, history of homelessness or at-risk status

- Materials, Activities, and Administrative Arrangements
  - Descriptions of the client screening and assessment measures
  - Detailed description of support activities necessary for implementing the intervention, including administrative, management, and fiscal plans
- Staff and Funding Resources
  - Staff resources, including qualifications and training of staff (whether paid or volunteer) providing or engaged in the intervention
  - Description of ongoing staff training activities
  - Intervention cost and funding sources
- Case Studies

Description of Evaluation Plan

The evaluation plan submitted at the END of Phase 1 should clearly describe the design for Phase 2, how it will be implemented, how the evaluation will be managed, and how the data will be analyzed. At a minimum, the plan should include the following information:

- Purpose of the Evaluation
  - Identify the goals or objectives of the process and outcome evaluations
  - Specify the questions or hypotheses that will be tested
- Evaluation Design
  - Describe the experimental or quasi-experimental design to evaluate the homelessness prevention intervention
  - Describe the plans to document whether the intervention was implemented in the way it was described in the manual (process evaluation) and whether it has some positive impact on client outcomes (outcome evaluation)
  - Explain how participants will be recruited into the evaluation study
  - Define the criteria for participation in the evaluation study

- Indicate the number of individuals expected to participate in the evaluation study

- Discuss any threats to internal validity (e.g., data collection problems, data on refusers, validity and reliability of data collection procedures, including training of staff, inter-rater reliability, diagnostic standardization, objectivity of the evaluators)

o **Measures**

- Describe the data to be collected, including any cost data. Also describe the instruments and their reliability and validity coefficients.

- Describe the data analysis as it pertains to the evaluation questions or hypotheses

o Data Collection: Describe the schedule for collecting data (i.e., instruments to be administered or observations made, data collection intervals, and who will collect the data).

o Protection of Human Subjects: Discuss confidentiality issues and participant protection; provide protocols for protecting the confidentiality of clients, for informing potential clients of the nature of the evaluation, and for obtaining appropriate informed consent for their participation

o Staffing and Management of Evaluation Project: Describe the staffing for the evaluation and management of the data collection and analysis

o Budget for the Evaluation: Provide an appropriately detailed budget for the costs of personnel, data collection and processing, equipment, office space, analytic tasks, payments to clients/patients (if appropriate), and other tasks associated with the conduct of the evaluation

ELIGIBILITY REQUIREMENTS

Applications may be submitted by public organizations, such as units of State or local government, and by private nonprofit and for-profit organizations, such as community-based organizations, universities, colleges, hospitals, and family and/or consumer operated organizations.

Capability statements must accompany each proposal, and must include one of the following:

1. Documentation regarding an infrastructure in which the homelessness prevention program can be provided for the target population and documentation that the applicant has