

Providing Services in Supportive Housing



Written by Tony Proscio

Dear Colleague,

In 1996 we began a state-level partnership with the Michigan State Housing Development Authority, the Michigan Department of Community Health and the Corporation for Supportive Housing. Together we hoped to create *Supportive Housing* — something that did not then exist in Michigan.

We wanted new models of housing and service delivery that would enable some of Michigan's most needy citizens to get out of shelters or off the streets and move into a good home. By mixing in the right services, we hoped that people who had a history of instability in housing would feel *at home* in supportive housing and move on to establish new connections with their families and communities.

Through the vision and dedication brought to the Michigan Supportive Housing Demonstration by our local partners in Allegan, Genesee, Kent and Washtenaw counties, we have watched our dreams become reality. We now know this concept can work. It can work in a variety of ways, because no two communities have done it exactly alike.

As we move forward to a new phase in our supportive housing work, we want to help communities who are interested in developing their own brand of supportive housing learn from the experience of others. This manual on supportive services and its companion manuals on housing development and local collaboration will enable additional communities to begin their own efforts, knowing more about what works and how to avoid at least some of the pitfalls.

We are pleased to endorse this manual and its companions. Supportive housing is not yet a science, something that can be recreated by applying a formula out of a cookbook. But it is less of an experiment now that our local partners have units in place, occupied by the people we set out to serve. Additional communities are ready to undertake the challenge and hard work that supportive housing demands. These manuals will be invaluable to those Michigan communities who will be moving the supportive housing initiative to the next level.



James L. Logue III



James A. (Jack) Krauskopf



James K. Haveman Jr.





Credits and Thanks

Michigan Interagency Partnership

The Michigan Interagency Partnership was formed in 1996 to oversee the development of a state and local partnership committed to developing supportive housing for individuals and families with special needs who are homeless or at risk of homelessness. The Partnership is comprised of the Department of Community Health (DCH), the Michigan State Housing Development Authority (MSHDA), the Family Independence Agency (FIA), the Department of Career Development/Rehabilitation Services (DCD/RS), the Office of Services to the Aging (OSA), the Department of Management and Budget (DMB), and the Corporation for Supportive Housing (CSH).

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The Corporation for Supportive Housing

The Corporation for Supportive Housing (CSH) was created in 1991 with funding from the Pew Charitable Trusts, the Robert Wood Johnson Foundation, and the Ford Foundation to support the individual efforts of local nonprofit pioneers developing service-supported housing for those most in need — people coping with extreme poverty and mental illness, addiction or HIV/AIDS.

CSH supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance abuse, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy, and dignity and reach for their full potential. CSH works through collaborations with private, nonprofit and government partners, and strives to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.

The Michigan State Housing Development Authority

The Michigan State Housing Development Authority (MSHDA), created in 1966 as the state's housing finance agency, has financed over \$3 billion for rental housing which has been used to finance over 50,000 units of affordable housing. Using tax exempt bond financing and Mortgage Credit Certificates, the Authority has assisted in financing nearly \$4 billion in single family mortgages for 90,000 units occupied by homeowners. One of the nation's larger state housing agencies, MSHDA has allocated over \$150 million in Housing Tax Credits which has produced approximately 30,000 rental units. The Authority also administers Community Development programs for non-entitled communities in Michigan, makes grants to combat homelessness and runs a 15,000 unit statewide Section 8 Existing Housing voucher/certificate program.

The Michigan Department of Community Health

The Michigan Department of Community Health (MDCH) is one of 18 principal departments of state government. The department, the largest in state government, is responsible for health policy and management of the state's publicly funded health service systems. An estimated 2 million Michigan residents will receive services this year that are provided with total or partial support from MDCH. The Department was created by an executive order issued on January 31, 1996 by Michigan Governor John Engler. The executive order consolidated the Department of Public Health; the Department of Mental Health and Substance Abuse Services; the Medical Services Administration, the state's Medicaid agency; and combined all child, family and housing elements of these respective systems. The Office of Drug Control Policy and the Office of Services to the Aging were consolidated with MDCH in subsequent executive orders.

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Introduction

What is supportive housing?

By “supportive housing,” we mean permanent, independent, affordable housing for people with disabilities who are homeless or at risk of homelessness, where appropriate supportive services are provided *as part of the normal operation of the housing*, as a way of helping residents maintain the maximum possible level of independence, stability, and participation in the general community. Some definitions, like the one used by the Federal Department of Housing and Urban Development, may be narrower. But in this book, and in the Michigan Supportive Housing Demonstration Program generally, we deliberately use the phrase to represent a wide range of models, benefits, and opportunities.

It is worthwhile to distinguish supportive housing from other kinds of residential programs and facilities common in Michigan — for example, adult foster care, group residences, skilled nursing facilities, transitional housing, residential treatment programs, or assisted living facilities. Compared to these various models, supportive housing is more permanent, more independent, or both. It is in most respects like other forms of housing — it typically looks and functions exactly the same way as any kind of permanent housing for anyone — except that tenants have access to supportive services as one of the benefits of living there.

In supportive housing, residents’ disabilities may be physical, psychiatric, or developmental, they may involve chemical addictions, HIV/AIDS, or other circumstances that raise special needs. The supportive services that are part of a supportive housing program could therefore take many forms, depending on residents’ needs and available resources. Some services may be provided on-site, as a permanent feature of the supportive housing environment; others may be available nearby, possibly from unrelated providers.



In general, services in supportive housing are as accessible as possible to the residents, and are integrated as much as possible into the normal routine of managing the building and providing a quality living environment. The most important services, and the ones most thoroughly integrated into supportive housing, tend to be those that prevent emergencies that lead to homelessness.

Years of experience and a growing body of research show that this integration of housing and services materially increases residents' stability and independence, reduces their need for emergency or institutional care, and thus provides a higher quality of life — including the greatest possible productivity and self-reliance — at substantially lower cost.

What is the role of supportive housing in Michigan?

State policy strongly favors the integration of services and housing for people with long-term special needs, especially those who have had difficulty maintaining a stable residence. The Department of Community Health — which provides medical assistance to low-income people and services to those with mental illness, developmental disabilities, and chemical addictions, among many others — includes supportive housing among the required services in all its contracts with local agencies. Moreover DCH encourages supportive housing as a component of managed care in place of more restrictive service models. The Michigan State Housing Development Authority, which finances and subsidizes affordable housing through a range of loan, grant, and equity programs, has set aside a portion of its Federal HOME funds for supportive housing. MSHDA also gives applications for Housing Tax Credits a scoring advantage when the proposed housing serves people with special needs.

Since 1996, in cooperation with the Corporation for Supportive Housing, the State has conducted a supportive housing Demonstration Program, now in its second phase. The demonstration, initially in Allegan, Genesee, Kent, and Washtenaw Counties, has shown that, with careful coordination among service providers, housing developers and managers, and local government agencies, it is possible to develop housing that effectively incorporates appropriate services, and that materially improves the lives of those who live there.



Participants in the demonstrations have assembled effective funding streams for both the housing and services, developed quality housing, formed working partnerships between housing and service providers, and woven the housing-based services into the development's ongoing management, and into the tenants' overall service plan. Beginning in 2000, the demonstration will expand to four more counties and the city of Detroit.

In each of the demonstration counties, the supportive housing program has been overseen by a Consortium of local funders and government agencies, service organizations, and housing developers. These groups have identified needs, raised funds, formulated policy, and facilitated working partnerships among housing and service agencies to develop projects.

What is the purpose of this handbook?

This is the second of three related guides for those interested in forming local consortia to develop supportive housing projects. This booklet is obviously not intended to teach organizations how to be service providers, or even to lay out a “model” services program for supportive housing. Instead, we hope this guide will set out for Supportive Housing Consortia the necessary building-blocks for designing and organizing services in their developments, and for establishing a mix of services that enhance and support tenants' independence.

This booklet is therefore meant not only for service providers, but also for other members of Supportive Housing Consortia — including housing developers and managers, public and private funders, and other stakeholders. We hope it will help all participants understand better how services fit with housing to make a complete, effective supportive housing package.



These other publications may also be useful:

Beyond Housing: Profiles of Low-Income, Service-Enriched Housing for Special Needs Populations © 1995 by The Enterprise Foundation

Contact: The Enterprise Foundation, Communications Department,
10227 Wincopin Circle, Suite 500, Columbia, MD 21044, (410) 964-1230. Price: \$25

This report profiles 29 service-enriched housing programs throughout the United States. The case studies are organized so that you can cross-reference various project features to your own proposed project. The report also provides several examples of sound property management programs that are sensitive to the needs of low-income people.

Also check the Enterprise Foundation Web site: www.enterprisefoundation.org

Housing for Persons with Psychiatric Disabilities (Panel Presentation)

© 1996 by the National Association of State Mental Health Program Directors
Contact: NASMHPD, 66 Canal Center Plaza, Suite 302, Alexandria, VA 22314,
(703) 739-9333

This summary presents a vision of social satisfaction, ample support services, appropriate housing, job flexibility, and overall quality of life for persons with psychiatric disabilities. It lists the basic principles of supportive housing and compares SSI income with common measures of “housing affordability.” It also considers various ways to increase the availability of safe, decent, affordable housing for people with psychiatric disabilities.

Rural AIDS Housing © 1998 by AIDS Housing of Washington

Contact: AIDS Housing of Washington, 2025 First Ave., Suite 420, Seattle, WA 98121,
(206) 448-5242

The first book to address HIV/AIDS housing and services from a non-metropolitan perspective, this book includes an examination of the unique barriers to the provision of housing and supportive services to rural residents, and case studies of successful rural housing and services programs, plus an extensive bibliography and glossary, links to other resources, and profiles of those living with HIV/AIDS in rural and non-metropolitan parts of the United States.

Supportive Housing Technical Assistance Manual © 1996 by the Community Housing Partnership Contact: CHP, 1010 Market Street, San Francisco, CA 94102, (415) 241-9015

Written primarily by tenants living in two of CHP’s supportive housing buildings, this manual provides a tenant’s perspective on the successful elements of a support-service program. It discusses philosophical issues, program design (including policies and procedures that affect the service and property management plan), vocational/employment service delivery, and communication strategies between the various interested parties.





Providing Services in Supportive Housing

Some Basic Principles



A. Why do housing and services need to be integrated? Why not just develop more housing, and let the current service-delivery system function as usual?

Experience nationwide — and increasingly in Michigan — shows that integrating housing with supportive services can significantly reduce the incidence of crises or emergencies in tenants' lives, lower their need for institutional or emergency care, and thus save money while improving residents' independence and quality of life.

For many consumers of mental health, addiction-recovery, or long-term medical services, the current service delivery system works fine, and the main challenge is simply to find appropriate housing that's accessible and affordable. That is not a situation that supportive housing is primarily designed to address. Supportive housing works best for consumers who have had *difficulty maintaining an appropriate, independent place to live* — perhaps because they have become homeless or frequently been at-risk of homelessness, or because their housing has somehow made it difficult for them to find and use appropriate services, or because their housing hasn't offered the greatest level of independence possible for them — and that in turn has left them unnecessarily restricted, or led them to emergency situations that could have been prevented.



Among the most appropriate tenants for supportive housing are those who have a history of crises or interruptions in services and/or housing. They frequently come from institutional arrangements like hospitals or emergency shelters, from unnecessarily restrictive settings like group homes, or from transitional residences or other temporary placements. They may have arrived in those settings because they have had trouble maintaining housing, services, or very often both. (Note that not every appropriate resident comes from such places — some may simply be at risk of ending up homeless or inappropriately housed.)



B. But aren't we moving away from housing that provides constant care and supervision on site? Wasn't that a problem with the group-home model?

Absolutely. The point of supportive housing is *not* to try to meet all of a resident's service needs on site or through a single program, or to create a "supervisory" or care-intensive atmosphere. In fact, in some supportive housing, no full-time services are located on site at all. And in most cases, the on-site services represent only a *core* of essential supports that are aimed at *providing information and referrals* when residents want them, *helping residents solve problems or address dissatisfaction* with their current services, and *preventing or responding to emergencies*. Whether this core of services is located on-site or not, it is generally easily accessible and/or mobile, so that contact between residents and the core service providers is as frequent as the resident wants, and is quickly available in case of particular need.

The most important difference between supportive housing and the more traditional assisted-living or intermediate-care arrangements is that supportive housing is *responsive to residents' choice* and is geared toward *ensuring independence* in ways that suit the individual resident.



C. What if residents arrive at supportive housing with existing relationships to other service providers? Will they be expected or encouraged to change those relationships?

Not if they are satisfied with the services. In fact, most of the services provided to most supportive housing tenants necessarily come from independent agencies



that are unaffiliated with the development. If tenants want to change their service mix or providers, they can get help and referrals from the core support team. But even then, the provider may well be some other, independent agency located somewhere nearby or easily accessible.

?? D. If these existing service arrangements are working, Why do residents need a core support team at all?

The answer varies from resident to resident, and over time. Many residents of supportive housing, when they have achieved a level of stability in their new home and made arrangements for using community-based services, may see the core service providers only casually, if at all, for months at a time. At the other extreme, though, some might prefer to use the core service provider as their source of case management, or as a regular resource for other needs, possibly because they find the opportunities for on-site contact convenient. The level of interaction, barring an emergency, is *entirely the resident's choice*. Experience shows that most residents will use the core services regularly, but not always in the same way, and that the use will change over time as the resident's circumstances and preferences change.

?? E. Doesn't that mean adding additional services for these residents — essentially increasing local expenditures to provide them with an enriched service mix?

It's important to remember that the residents of supportive housing are typically those who have not managed well in more conventional arrangements for housing and services, or who are otherwise at high risk of homelessness. Or they may be people who have been housed inappropriately (and at unnecessarily high cost) in group homes. The point of blending housing and services in supportive housing is to *lower* their odds of needing emergency or institutional services, or of facing eviction and homelessness, or of decompensating so severely that an increased service regimen is required.

By *avoiding these disruptive, high-cost episodes and costly settings*, the supportive housing model actually *saves* money in aggregate.



Designing the Core Services

?? A. What should be the responsibilities of the core supportive housing service provider?

Each county, and probably each project, will answer these questions a little differently, depending on what services are already being provided, and where, and how well those services are currently meeting the needs of prospective residents. In the first phase of the Michigan Supportive Housing Demonstration, the Kent County Supportive Housing Consortium tackled this question head-on, and came up with this definition of the “core” service responsibilities:

1. Developing with the resident a service/support plan which incorporates assessment and reassessment of the needs, goals, and preferences of the person served.
2. Resource assessment and management.
3. Outreach and support (engagement) to encourage the person served to participate in the services needed.
4. Coordination and assistance in crisis intervention and stabilization as needed, including participation in a 24-hour on-call program.
5. Assistance for the person served to achieve their objectives and optimize their independence and productivity through support and training in the use of personal and community resources.
6. Assistance in the development of formal community linkages that meet the needs of the person served, particularly when residents are currently receiving outside case-management services.
7. Assistance for the person served to further develop the competencies they need to increase and enjoy social support networks.
8. Coordination of transportation as needed for the person served.
9. Assistance to enhance functioning and daily living activities.
10. Facilitating volunteer mentoring for residents who request it.
11. Maintaining all program-required records, which are not specifically the responsibility of property management staff.



12. Establishing a frequent presence at all residential sites.
13. Advocacy with property management staff for property improvement and maintenance.
14. Facilitating resident participation in property management.

The Kent plan adds that the “core” provider (which they call “Resident Services Coordinator”) will develop an Advisory Council of residents, representatives of local social-service agencies, and community members with expertise in property management and real estate.

We offer this example because it is helpfully explicit and clear — not because it will suit every locale. Among other things, it was drawn up for an urban setting in which “residential sites” are multi-unit buildings or complexes of related structures. In more rural counties, where housing is less concentrated and houses aren’t located together, a “circuit-riding” approach — where a support team regularly makes the rounds of several sites, and can be quickly dispatched to any of them in an emergency — may be more appropriate. In that case, the “core” provider’s role may be similar to the one described for Kent, but more mobile.

On the other hand, in the Allegan demonstration site, the Community Mental Health program took a completely different approach. Allegan CMH provided senior-level staff to the Consortium to coordinate the work of the county’s various contracted service providers — agencies that were *already* serving prospective supportive housing residents. In Allegan, the Consortium coordinator makes certain that providers are able to *pay regular visits* to the supportive housing residents they serve, and that the residents are able to *get transportation to community-based services* from their new homes as needed. Because the county has a relatively small population, CMH and the Consortium could work out these sometimes-complex arrangements directly with the various service providers and housing developers, while sitting around a single table. In that case, the Consortium itself performed the work of the “core” team.





B. When a service agency is designated to provide core services in supportive housing, how do we prevent that arrangement from duplicating other services already being provided to the same residents?

To some extent, the answer to this question will depend on what services are already available and working effectively for the target populations in each community. This is one reason why it's useful for the Supportive Housing Consortium to start with a simple, focused *needs assessment* that identifies *gaps in service* for the target populations, areas where current *services need improvement or are less effective* than feasible alternatives, and the *barriers to effective service* that tend to lead people into housing problems or inappropriate housing. That would entail:

- an evaluation of the services now available for the target population,
- an exploration of how to make the best use of those existing services, and
- a *realistic* assessment of affordable additions or alternatives.

(Another booklet in this series, called *Forming an Effective Supportive Housing Consortium*, deals with the needs assessment in more detail.)

One useful tool for avoiding duplication is to follow the principles of person-centered planning: Ask for residents' feedback. Residents can be a front-line defense against duplication, because they will most often be the first to point out overlapping, redundant, or time-wasting service.

Another way of guarding against duplication and excess service is to keep an eye on service utilization data. Most of the first-round demonstration counties are carefully monitoring such data for supportive housing tenants, to see the extent to which the new arrangement will improve residents' use of services. Monitoring such data not only provides a way of evaluating the program after a year or two have passed, but in the meantime, it gives service providers and residents a running estimate of how effectively they are organizing their work. If such data are collected and reviewed promptly, they can help providers adjust course along the way.





C. How does supportive housing meet the requirements of person-centered planning? If the housing comes with a dedicated service provider, doesn't that limit residents' choice?

If the services in supportive housing are not carefully planned and structured to be responsive to tenants' choices, there can be a conflict with the principles of person-centered planning. But such a conflict is both unnecessary and relatively easy to avoid — provided all participants are alert to the issue, and think through the options ahead of time. There should, in any case, be no question that *effective supportive housing enhances participants' self-determination*, and thus is not only consistent with person-centered planning, but substantially advances its goals.

In the first round of the Michigan Demonstration, participants in Washtenaw found it useful to create three tiers of service for supportive housing residents, with each tier offering a greater level of choice for residents. The first tier, “*essential on-site services*,” is the heart of the core program. It consists of services that are integral to housing satisfaction and stability, and that help prevent housing-related crises, including eviction. The services in this category, according to the Washtenaw plan, “are available to all tenants, and are designed to facilitate access to other community services, address emergent housing problems, foster the development of natural support systems among tenants, and allow for longer-term engagement for tenants whose history or current housing status suggests a need for services — but who may be reluctant to receive them.”

This category, in short, is not subject to individual choice (apart from the tenant's choice about whether to live in a particular supportive housing site), because it is *part of the housing* — something available to all residents by virtue of their being residents. The on-site service provider thus is responsible for:

- **Engaging** new or reluctant tenants;
- **Maintaining contact** with tenants whose prior enrollment [in mental-health programs] has been interrupted or who have had minimal need for contact;
- Providing **early intervention** for previously unidentified or emerging problems that threaten tenancy;
- **Introducing available services**, developing rapport with tenants, and offering any immediate assistance;



- **Making referrals, assisting with access, and facilitating enrollment** in other existing community services; and
- Coordinating joint **activities with the Tenant Organization.**

As part of these responsibilities, the core service provider also maintains “24-hour crisis response and conflict-resolution capacity,” and provides food-pantry and transportation services as needed.

The second tier, “*supportive living services*” consists of services that are normally most *convenient* to receive on-site, and that may be beneficial to receive from the core service provider — *if* the tenant wants the service and does not prefer some alternative provider. In this category, which includes one-on-one and group counseling, health-care support, recovery support, and so on, *residents are free to “opt out”* of the service, or to obtain it from an alternative provider. CMH funds the core provider for these services, but may adjust the level of funding if it appears that tenants do not need or use that provider’s services. Meanwhile, under the core provider’s contract with CMH, the provider must “participate in person-centered planning according to individual tenant wishes, and continue close coordination with case managers or others central to the tenant’s support system.” In other words, the provider must not only *honor* the residents’ choice, but *encourage* each resident to take responsibility for managing his or her own support system.

The third tier of services in the Washtenaw plan consists of “*services for separate budgeting*” — that is, services that are *not included in the supportive housing “package,”* but are arranged individually by each resident with his or her case manager. It may happen that some residents choose the supportive housing service provider as their individual provider of these services, but that would be coincidental — or at best a convenience for the resident. It would be unrelated to the supportive housing budget.

The point of this illustration is not that this three-tier structure will work in all locales, or even that the requirements of person-centered planning necessarily demand such a detailed written mechanism. In some places, the issue will be readily resolvable with less formality. Even then, however, it should be examined and thought through with equal care — not only for the sake of residents’ self-determination, but also to make sure that supportive housing remains *supportive*, and does not gradually develop the restrictive or institutional qualities that it was designed to replace.



Funding the Core Services Budget



A. How does services funding in supportive housing work? How is it different from the way services are currently funded?

To the extent possible, services in supportive housing are purchased through a consolidated fund, *blending resources* from several sources. The purpose of this blended funding is, first of all, to allow *the most flexible and accessible combination of services* for the tenants. Those eligible for support from one source of funds may derive significant benefit from services provided to a slightly different population under another source. Or two different sources may, under normal circumstances, be funding the *same* service to two different populations. By combining funds from the separate sources into a single pool of money, the core service provider in supportive housing can often achieve *greater efficiency, effectiveness, and responsiveness* to tenants' needs.

To work effectively, this naturally requires that an appropriate number of supportive housing tenants be *eligible* for one or more of these sources of funding, that the funds be applied in ways that *meet the requirements of the funding sources*, and that the supportive services are planned efficiently to *achieve better results* than the currently funded delivery mechanisms. We discuss issues of eligibility, funder requirements, and effectiveness under several headings below.

But one important element of service funding in supportive housing is *not* different from more traditional arrangements, even though many housing and service providers wish it were. In supportive housing, as in all other avenues of supportive service delivery, funding is nearly always committed *one year at a time*. This always presents a challenge for those seeking to integrate housing and services into a single program: The housing is necessarily budgeted and financed over many years — typically 15 or more — and the developers and funders would like to know that the planned services will be in place consistently over the long haul. In Michigan, as in most places, this normally isn't possible.

Nonetheless, in the first round of the Michigan Supportive Housing Demonstration Program, some sources of service funding were willing to establish supportive



housing as a *long-term priority*. That meant that supportive housing would consistently be a *strong applicant* for support in future years — as long as money was available in the funder’s year-to-year budget. That is still quite different from the kind of long-term commitment that many providers would like. But it may be the best option available.



B. How do we raise funds for core services in supportive housing?

The answer depends, first of all, on the kinds of services the tenant population needs, and the funding sources for which that population is eligible. So it’s best to discuss this issue under a few separate headings.

One general point, though, applies to all sources of funding: When seeking support from local human services agencies, other government bodies, or charitable organizations, *don’t assume they know what you mean* by “supportive housing.” Many of these organizations support other forms of residential care already (and some may have negative feelings about certain kinds of housing and residential services). Unless you can *distinguish supportive housing from these other models* — from residential treatment programs, emergency or transitional housing, group homes, assisted-living facilities, and so on — your message could be lost or distorted, and important channels of support closed off.

Another principle that applies to all services and funding sources is to accumulate *persuasive evidence of the need* for supportive housing. “Evidence” includes numerical data, of course, but numbers usually don’t tell the whole story. Funders may need compelling examples — actual case stories — of people who aren’t being served effectively in the current mix of available housing and services. These stories should obviously be altered to conceal people’s identities, but they should be detailed enough to show why current arrangements aren’t working, and exactly how supportive housing would identify and work with such tenants to achieve better results.

Mental Illness

Usually, some significant number of tenants are eligible for services offered by the local *Community Mental Health Services Program*. That’s the program that bears much of the cost of care for people with chronic mental illness who have housing problems or are housed in inappropriate settings. It therefore has, at least in principle, *both a financial and a programmatic interest* in creating effective



supportive housing alternatives. In all four first-round demonstration counties, the local CMH has been a key funder of the supportive housing service budget, generally with a grant or contract to the agency selected to provide the core services at each site.

But it's important, when seeking funding from the local mental health agency, to *make a clear distinction* between the funding of supportive housing's core services and the services CMH *already* provides to each eligible individual. The core services agency in supportive housing may end up replacing some of these existing services for some or all tenants, but not necessarily. It's essential to be clear about the areas where the core supportive housing services will supplement current CMH service, and where they will *substitute* for those services, with something that can be shown to be more effective.

If some residents happen to select the core service agency as their provider of *particular services* in their individual CMH support plan — case management, for instance, or personal care, or any service normally included in their service plan — then the funding for those services comes with the resident. But that is not, in the main, the funding you're seeking for supportive housing. Not all eligible residents will select the core agency for their individual services, nor should the agency's ability to perform its core role be affected by residents' choices about particular providers and services.

What makes the core role effective is that it is *always accessible*, based on a *consistent level of staffing and schedule of availability* that does not vary with changes in residents' individual needs.

On first hearing this argument, a CMH agency could reasonably respond by saying: "Wait — you're asking us to provide additional funding *beyond* what the residents are eligible for!" So it's important to be very clear about who the intended residents will be: people for whom *the current mix of housing and services is not effective or appropriate* — people who may therefore be relying inappropriately on costly emergency or institutional care, or who may be living inappropriately in high-cost settings like group homes. These are eligible clients for whom *supportive housing would be a better, less costly substitute*.

Negotiating and structuring CMH funding for a portion of the core services budget requires a careful analysis of *how CMH-eligible residents will benefit*, how their other services will be *supported or enhanced*, and how *projected savings* in other areas would justify the proposed funding. Each CMH program is likely to approach that analysis differently. The Supportive Housing Consortium needs to discuss these issues with the CMH leadership early on, beginning with



the needs assessment, so that it is clear what funding can be expected, on what basis, with what requirements, before any serious development planning begins.

The approach described here is also applicable to agencies other than CMH programs — such as private insurers, managed-care organizations, or other nonprofit institutions — in cases where those agencies pay for services to eligible clients. Although CMH agencies are currently the main source of support for mental health services in most counties, it's possible that the target population also gets support from other sources who could take a role in creating a supportive-housing alternative.

Developmental Disabilities

Here, the question of funding may be less complicated, but the need for a careful analysis of potential service improvement and cost saving is at least as critical. Many of the people with developmental disabilities who would be appropriate for supportive housing are now living in group homes or other more restrictive settings. Or they may be waiting and searching for a housing opportunity, and finding few options that provide an appropriate level of independence. For these recipients of CMH services, supportive housing is *highly likely to be better and less expensive* than traditional options, provided the supports are properly planned and budgeted.

CMH can normally provide essential help in this planning and budgeting process. Many, in fact, are eager to find cost-effective alternatives to their current housing and service options for developmentally disabled clients. So it's worthwhile to seek CMH guidance early on all the central issues: finding the right tenants, planning a service mix that meets their needs in the least restrictive appropriate way, and ensuring that the core provider has suitable expertise in meeting the needs of the target population.

Chemical Addictions

CMH normally can't and shouldn't be the sole source of service funding — nor are all tenants necessarily eligible for CMH support. Those whose primary source of disability is a substance addiction, for example, may not have a diagnosis of serious and persistent mental illness, but may have a long-term need for support in addiction recovery, help with employment and training, or other critical needs that have kept them from maintaining a stable, independent life in the past. Even if they have diagnoses in both mental health and chemical addiction, the services they need may not all be eligible for mental-health funding.



People with chemical addictions are, under certain circumstances, eligible for support from regional *Substance Abuse Coordinating Agencies*. In a few places, like Washtenaw and Kent Counties, the Substance Abuse agency is staffed and administered by the Community Mental Health program. That provides an opportunity for coordination between the two systems that is still not the norm in Michigan (though it is becoming more common).

Unlike programs for the mentally ill and the developmentally disabled, most Substance Abuse Coordinating Agencies (or “CAs”) *don't think of their mission as providing lifelong, or even long-term, service*. That principle is based on both clinical and fiscal considerations. Clinically, Michigan's substance abuse policy views addiction as a condition that, when properly addressed and managed, should enable people to resume fully independent lives relying on voluntary and informal supports like self-help groups, friends, and family — not ongoing services. In many places, the practical effect of this approach is that funding is available mainly to help people deal with active substance abuse problems, to become clean and sober, and to begin leading an independent life.

As one Michigan addiction-treatment expert put it:

In the substance-abuse field, we have a well-developed concept of after-care, for a period of time, but we do *not* have the concept of ‘we're here for the rest of your life to provide continuing high-level support.’ We provide periodic care and supports. We understand relapse — people may come into the substance-abuse system many times, but we don't provide comprehensive support for indefinite periods.

Fiscally, it's important to understand the *economic constraints* under which most CAs work. The funding available statewide for substance-abuse services is less than 10 percent of the amount available for mental health. Many CAs therefore believe that they can't commit to long-term services, or they would soon be unable to respond to the needs of new clients. The clinical philosophy and the fiscal necessities therefore reinforce one another. In the first round of the Michigan Supportive Housing Demonstration, it has proven extremely difficult to persuade CAs to take a role in the ongoing funding of supportive housing for these reasons.

Nonetheless, CAs do have good reasons — and *several manageable options* — for participating in the funding of supportive housing. Making those reasons and options clear, and engaging the CA in a constructive discussion of them, are among the important early challenges facing any Supportive Housing Consortium.



Perhaps the best reason for the Substance Abuse agencies to take a role in supportive housing is that (as the person we quoted earlier put it) “people may come into the substance-abuse system many times.” Those who are appropriate tenants for supportive housing — including people whose past housing has been unstable, or who have a history of crises — probably include *many people with recurring substance-abuse problems who have cycled through the CAs’ services several times*. It could be both more effective and more economical for these clients to be served in supportive housing, with some ongoing support from the CA, than to continue to need emergency services.

Also, many CAs fund “*transitional housing*” services — a six-to-18 month process that helps people integrate the requirements of clean and sober living into their regular lives, and develop the necessary skills — including social, job, and independent-living skills — to stay successful in recovery. Supportive housing may, for many clients, be a *superior alternative to “transitional” housing*, but could still offer (and typically *does* offer) these *same skill-building services*. CAs might consider providing such funding to a supportive housing development on behalf of a group of eligible clients who may be living there — and might consider renewing the funding as new eligible clients move in.

Admittedly, six-to-18 months of funding, tied to individual resident eligibility, is not an ideal source of support for a services program that needs to be ongoing. But it may at least help to *supplement the core services budget* for a time — and meanwhile provide extra help for newly arrived residents who may have a short-term need for particular supports.

Another approach — especially when many supportive housing residents are likely to have chemical addictions and histories of relapse — might be to approach CAs for direct services instead of funding. In some Substance Abuse agencies, it may be easier and more palatable to *dedicate a portion of a provider’s time to providing services at the supportive housing site*, rather than simply to make a contribution to an overall services budget. A skilled person, either full-time or with regularly scheduled visits, could conduct groups, counsel residents who request it, provide consultation and training to other staff, or help residents find outside supports as needed.

Again, this is not as desirable as direct funding, but it has the essential advantages of *meeting residents’ needs* and *engaging the CA in the supportive housing process*. As the relationship between the supportive housing development and the CA progresses — assuming the relationship is well managed and productive — the possibility of direct funding might arise over time.



It may also be worthwhile for the Supportive Housing Consortium to include (or at least consult with) *community-based providers of substance-abuse services*, some of which are likely to have contracts with the CA. They may have insights into how to provide for residents' recovery needs, and may be able to help in formulating a proposal to the CA.

Other Needs

Some tenants will not have mental-health, addiction, or other behavioral problems, but may have physical disabilities or chronic illnesses, skills deficits, or other barriers to employment, or family problems (like domestic violence) that require special attention. Finding sources of support for these “other” needs was a challenge for most of the counties in the first round of the Supportive Housing Demonstration, and it is likely to be a constant concern. Some solutions did emerge:

Communities that conduct their own *Continuum-of-Care planning process* in applying for HUD funds have sometimes set aside portions of their Stewart B. McKinney Homeless Assistance grants for use by Supportive Housing Consortia. McKinney grants include specific allocations for development of supportive housing and, under the Shelter-Plus-Care program, for services provided in conjunction with housing. Most of these funds, however, tend to be used for continued funding on previously-approved projects; commitments for new housing and services are much less common. Communities that don't apply for McKinney funds directly to HUD may apply for a portion of the state's overall McKinney grant, by contacting the Michigan Department of Community Health's Community Living, Children and Families Administration.

The Community Living, Children and Families Administration also administers the state's HOPWA program (*Housing Opportunities for People With AIDS*). Supportive housing programs that serve people with HIV and AIDS can use these funds for rent subsidies or to supplement supportive services, though the statewide funding is relatively small (just under \$700,000 in 1999). The Detroit metropolitan area has a separate, somewhat larger, allocation specifically for Lapeer, Macomb, Monroe, Oakland, St. Clair and Wayne Counties. Applicants in those counties can seek guidance from the City of Detroit Department of Health; others should contact the Department of Community Health, Community Living, Children and Families Administration for information on how to apply. In general, it's wise to include local AIDS Care Consortia in the supportive housing planning process — they may know of appropriate sources of funding for tenants living with HIV/AIDS, and of agencies that may be appropriate as core service providers in supportive housing.



Local governments and community foundations in some places were able to provide unrestricted funding to supplement the core services budget. But the amounts from these sources were not great. Among the largest sources of such funding in the first Demonstration round came from the *Family Independence Agency* — though these funds may not be available in future rounds. In many cases, the core service providers simply had to stretch the resources that came through other funding streams, in order to cover the needs of tenants who did not fit those programs' categories of eligibility.

Managing the Core Services Program

?? A. How do the core services of supportive housing relate to building management?

Building *management* is primarily the responsibility of the owner — typically the housing agency that developed the project in behalf of the Supportive Housing Consortium — or of a professional housing-management company retained by the owner. The managers' responsibilities consist of *keeping the building well maintained and running smoothly*, renting vacant units promptly, collecting rents, making repairs, and solving other building-related problems for the owner and the tenants. Managers are *not* responsible for — and usually aren't skilled at — helping residents meet their responsibilities or handle their personal problems. If a tenant is missing rent payments, becoming disruptive or destructive, or having other problems that affect the building or the tenant's ability to live there, the manager may have few alternatives other than to warn the resident and eventually proceed to eviction.

So one crucial role of the core supportive-service provider is to *prevent* those kinds of problems. In that role, the provider's greatest ally (after the tenants themselves) should be the building management. A good building manager will know when to alert service providers to potential problems, and when to seek the help of service providers in making certain that the building's management *responds* appropriately to tenants' needs. That's the point where the responsibilities of building management and supportive-service providers intersect. Clearly, they



will intersect further if problems become acute, and the management believes that eviction may be necessary. When services are not successful at preventing crises, it may be necessary to help in the eviction process.

In multifamily buildings, or in other supportive housing developments where many residents live together or nearby, it is usually necessary to develop some *formal process by which residents participate in the management of the building and services*. Here, obviously, it is the joint responsibility of building management and service providers to see that residents have opportunities to advise, volunteer, or take a leadership role where appropriate, and participate in program evaluation from time to time.



B. Beyond the core services, are there other services that are worthwhile to provide on site?

If enough residents want a service on site, then it can be cost-effective to provide it that way, besides being a convenience for residents. Support groups are frequently offered on-site, if some common space is suitable for it. Medical or other clinical services may also be offered on a regular schedule on site. On one hand, services should be as easily accessible for residents as possible; on the other, supportive housing should not be so “care-intensive” that residents no longer enjoy as much independence and privacy as was intended. How to strike this balance depends mostly on the particular *needs and wishes of residents, what services can be brought to a convenient place, and the configuration of the housing*. In some arrangements — particularly in small buildings or developments of single-family homes — there may not be enough common space to offer extensive services on-site without disturbing other tenants or compromising confidentiality.



Further Information

The information presented here is not meant to be exhaustive. But it builds on several years of experience in the four counties that pioneered Michigan's Supportive Housing Demonstration Program. Any exploration of supportive housing would therefore benefit greatly from a consultation with those who shaped and led the formative work in those four counties. Among the sources to consult are:

Allegan County

John L. Peterson
Allegan County Community Mental Health Services
705 Marshall Street
Allegan, MI 49010

Genesee County

Patricia Motter
Shelter of Flint
432 N. Saginaw - Suite 902
Flint, MI 48502

Kent County

Bob Paxton
Pathfinder Resources
245 State Street, SE
Grand Rapids, MI 49503

Washtenaw County

Carole A. McCabe
Avalon Housing
404 W. Washington Street
Ann Arbor, MI 48103

Michigan State Department of Community Health

Virginia R. Harmon
3423 Martin Luther King Blvd. - Room 218
Lansing, MI 48909

Corporation for Supportive Housing

Sally Harrison
10327 E. Grand River Ave. - Suite 409
Brighton, MI 48116

... and the Community Mental Health programs in each county.





CSH Publications:

In advancing our mission, the Corporation for Supportive Housing publishes reports, studies and manuals aimed at helping nonprofits and government develop new and better ways to meet the health, housing and employment needs of those at the fringes of society.

Under One Roof: Lessons Learned from Co-locating Overnight, Transitional and Permanent Housing at Deborah's Place II *Commissioned by CSH, Written by Tony Proscio. 1998; 19 pages. Price: \$5*

This case study examines Deborah's Place II in Chicago which combines three levels of care and service at one site with the aim of allowing homeless single women with mental illness and other disabilities to move towards the greatest independence possible, without losing the support they need to remain stable.

Work in Progress...An Interim Report from the Next Step: Jobs Initiative *1997; 54 pages. Price: \$5*

This report provides interim findings from CSH's *Next Step: Jobs* initiative, a three-city Rockefeller Foundation-funded demonstration program aimed at increasing tenant employment in supportive housing. It reflects insights offered by tenants and staff from 20 organizations based in Chicago, New York City, and the San Francisco Bay Area who participated in a mid-program conference in October, 1996.

Work in Progress 2: An Interim Report on Next Step: Jobs *Commissioned by CSH, Written by Tony Proscio. 1998; 22 pages. Price: \$5*

Work in Progress 2 describes the early progress of the *Next Step: Jobs* initiative in helping supportive housing providers "vocalize" their residences—that is, to make working and the opportunity to work part of the daily routine and normal expectation of many, even most, residents.

A Time to Build Up *Commissioned by CSH, Written by Kitty Barnes. 1998; 44 pages. Price: \$5*

A Time to Build Up is a narrative account of the lessons learned from the first two years of the three-year CSH New York Capacity Building Program. Developed as a demonstration project, the Program's immediate aim is to help participating agencies build their organizational infrastructure so that they are better able to plan, develop, and maintain housing with services for people with special needs.

Not a Solo Act: Creating Successful Partnerships to Develop and Operate Supportive Housing *Written by Sue Reynolds in collaboration with Lisa Hamburger of CSH. 1997; 146 pages. Price: \$15*

Since the development and operation of supportive housing requires expertise in housing development, support service delivery and tenant-sensitive property management, nonprofit sponsors are rarely able to "go it alone." This how-to manual is a guide to creating successful collaborations between two or more organizations in order to effectively and efficiently fill these disparate roles.

Closer to Home: An Evaluation of Interim Housing for Homeless Adults *Commissioned by CSH, Written by Susan M. Barrow, Ph.D. and Gloria Soto of the New York State Psychiatric Institute. 1996; 103 pages. Price: \$15*

This evaluation examines low-demand interim housing programs, which were developed by nonprofits concerned about how to help homeless people living on the streets who are not yet ready to live in permanent housing. Funded by the Conrad N. Hilton Foundation, this report is a 15-month study of six New York interim housing programs.

In Our Back Yard *Commissioned by CSH, Directed and produced by Lucas Platt. 1996; 18 minutes. Price: \$10, nonprofits/ \$15, all others.*

This educational video is aimed at helping nonprofit sponsors explain supportive housing to members of the community, government representatives, funders and the media. It features projects and tenants in New York, Chicago and San Francisco and interviews a broad spectrum of supporters, including police, neighbors, merchants, politicians, tenants, and nonprofit providers.

Design Manual for Service Enriched Single Room Occupancy Residences *Produced by Gran Sultan Associates in collaboration with CSH. 1994; 66 pages. Price: \$20*

This manual was developed by the architectural firm Gran Sultan Associates in collaboration with CSH and the New York State Office of Mental Health to illustrate an adaptable prototype for Single Room Occupancy residences for people with chronic mental illnesses. Included are eight prototype building designs, a layout for a central kitchen, recommendations on materials, finishes and building systems, and other information of interest to supportive housing providers, architects and funding agencies.

Next Door: A Concept Paper for Place-Based Employment Initiatives *Written by Julianne Dressner, Wendy Fleischer and Kay E. Sherwood. 1998; 61 pages. Price: \$5*

This report explores the applicability of place-based employment strategies tested in supportive housing to other buildings and neighborhoods in need of enhanced employment opportunities for local residents. Funded by the Rockefeller Foundation, the report explores transferring the lessons learned from a three-year supportive housing employment program to the neighborhoods "next door."

Understanding Supportive Housing *1997; 58 pages. Price: \$5*

This booklet is a compilation of basic resource documents on supportive housing, including a chart which outlines the development process; a description of capital and operating financial considerations; tips on support service planning; program summaries of federal funding sources; and a resource guide on other publications related to supportive housing.

The Next Step: Jobs Initiative Cost-Effectiveness Analysis *Written by David A. Long with Heather Doyle and Jean M. Amendolia. 1999; 62 pages. Price: \$5*

The report constitutes early findings from a cost-effectiveness evaluation by Abt Associates of the *Next Step: Jobs* initiative, which provided targeted services aimed at increasing supportive housing tenants' employment opportunities.

Employing the Formerly Homeless: Adding Employment to the Mix of Housing and Services *Commissioned by CSH, Written by Basil Whiting. 1994; 73 pages. Price: \$5*

Funded by the Rockefeller Foundation, this report explores the advisability of implementing a national employment demonstration program for the tenants of supportive housing. The paper is based on a series of interviews with organizations engaged in housing, social service, and employment projects in New York City, the San Francisco Bay Area, Washington, D.C., Chicago, and Minneapolis/ St. Paul, as well as a body of literature on programs aimed at alleviating the plight of homelessness.

Connecticut Supportive Housing Demonstration Program — Program Evaluation Report *Commissioned by CSH, Prepared by Arthur Andersen LLP, University of Pennsylvania Health System, Department of Psychiatry, Center for Mental Health Policy and Services Research, Kay E. Sherwood, TWR Consulting. 1999; Executive Summary, 32 pages. Complete Report, 208 pages.*

Executive Summary Price: \$5 Complete Report Price: \$15
This report evaluates the Statewide Connecticut Demonstration Program which created nearly 300 units of supportive housing in nine developments across the state in terms of tenant satisfaction, community impact — both economic and aesthetic, property values, and use of services once tenants were stably housed.

Miracle on 43rd Street *August 3, 1997 and December 26, 1999.*
60 Minutes feature on supportive housing as embodied in the Times Square and the Prince George in New York City. **To purchase VHS copies, call 1-800-848-3256; for transcripts, call 1-800-777-8398.**

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - California Edition *Commissioned by CSH. Prepared by the Law Offices of Goldfarb and Lipman. 2000; 217 pages.*

Price: \$15 or download for FREE at www.csh.org
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Landlord, Service Provider...and Employer: Hiring and Promoting Tenants at Lakefront SRO *Written by Tony Proscio and Ted Houghton. 2000; 59 pages.*

Price: \$5 or download for FREE at www.csh.org
This essay provides a close look at Lakefront SRO's program of in-house tenant employment, as a guide for other supportive housing programs that either hire their own tenants or might want to do so. The lessons of **Landlord, Service Provider...and Employer** are also of potential interest to affordable housing programs whose tenants could become valuable employees given sufficient encouragement, training, and clear policies.

The Next Wave: Employing People with Multiple Barriers to Work: Policy Lessons from the Next Step: Jobs Initiative *Written by Wendy Fleischer and Kay E. Sherwood. 2000; 73 pages.*

Price: \$5 or download for FREE at www.csh.org
The **Next Step: Jobs** initiative tested the premise that a range of employment services targeted to supportive housing tenants can help them access employment. It used supportive housing as the focal point for deploying a range of services to address the multiple barriers to employment that tenants face. It also capitalizes on the residential stability and sense of community that supportive housing offers.

Vocalizing the Home Front: Promising Practices in Place-Based Employment *Written by Paul Parkhill. 2000; 79 pages. Price: \$5 or download for FREE at www.csh.org*
Accessibility; inclusiveness; flexibility; coordinated, integrated approach to services; high quality, long-term employment; and linkages to private and public sectors are hallmarks of a new place-based strategy to help people with multiple barriers to work, find and keep employment. The 21 place-based employment programs featured in this report represent some of the most comprehensive and innovative approaches to employing persons who are homeless, former and current substance abusers, individuals with HIV/AIDS, those with physical and psychiatric disabilities and other challenges.

Supportive Housing and Its Impact on the Public Health Crisis of Homelessness *Written by Tony Proscio. 2000; 40 pages.*

Price: \$5 or download for FREE at www.csh.org
This publication announces the results of research done between 1996 and 2000 on more than 250 people who have lived at the Canon Kip Community House and the Lyric Hotel. It also looks at pre-occupancy and post-occupancy use of emergency rooms and inpatient care.

Forming an Effective Supportive Housing Consortia; Providing Services in Supportive Housing; and Developing and Managing Supportive Housing *Written by Tony Proscio. 2000; 136 pages. Price: \$5 each or download for FREE at www.csh.org*

These three manuals are designed to assist local communities and service and housing organizations to better understand the local planning consortium, service delivery and funding, and supportive housing development and financing.

The Network: Health, Housing and Integrated Services Best Practices and Lessons Learned *Written by Gerald Lenoir. 2000; 276 pages. Price: \$5 or download for FREE at www.csh.org*
This report summarizes the principles, policies, procedures and practices used by housing and service providers that have proven to be effective in serving Health, Housing and Integrated Services tenants where they live.

Closer to Home: Interim Housing for Long-Term Shelter Residents: A Study of the Kelly Hotel *Written by Susan M. Barrow, Ph.D. and Gloria Soto Rodriguez. 2000; 65 pages.*

Price: \$5 or download for FREE at www.csh.org
Evidence that a subgroup of homeless individuals have become long-term residents of NYC shelters has spurred a search for new approaches to engage them in services and providing appropriate housing alternatives. The Kelly Hotel Transitional Living Community, developed by the Center for Urban Community Services with first year funding from the Corporation for Supportive Housing, is one pioneering effort to help mentally-ill long-term shelter residents obtain housing.

COMING SOON:

Between the Lines: A Question and Answer Guide on Legal Issues in Supportive Housing - National Edition

Commissioned by CSH. Prepared by the Law Offices of Goldfarb and Lipman.
This manual offers some basic information about the laws that pertain to supportive housing and sets out ways to identify and think through issues so as to make better use of professional counsel. It also offers reasonable approaches to resolve common dilemmas.

Guide to Developing Family Supportive Housing *Written by Ellen Hart Shegos.*

This manual is designed for service providers and housing developers who want to tackle the challenge of developing permanent supportive housing for chronically homeless families. The manual will provide information on the development process from project conception through construction and rent-up. It also discusses alternatives to new construction such as leased housing. It contains practical tools to guide decision making about housing models, picking partners, and service strategies.

Please mail your request for publications with a check payable to "Corporation for Supportive Housing" for the appropriate amount to: Publications, Corporation for Supportive Housing, 50 Broadway, 17th Floor, New York, NY 10004 (212) 986-2966 x 500 (Tel); (212) 986-6552 (Fax); Or, you can print an order form from our Web site at www.csh.org.

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Mission Statement...

CSH supports the expansion of permanent housing opportunities linked to comprehensive services for persons who face persistent mental health, substance use, and other chronic health challenges, and are at risk of homelessness, so that they are able to live with stability, autonomy, and dignity, and reach for their full potential.

We work through collaborations with private, nonprofit and government partners, and strive to address the needs of, and hold ourselves accountable to, the tenants of supportive housing.



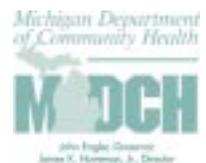


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