# Supportive Housing Services Plan Guidebook


## Providing Evidence-Based Strategies and Solutions for Housing Stability

The Housing and Community Development office in California has partnered with the Corporation for Supportive Housing to develop best practice guidelines for supportive housing providers and developers in creating organizational supportive service plans. This collaborative effort involved the Ventura County Continuum of Care and the Housing and Services Committee in adopting and revising the plan.

VENTURA COUNTY
CONTINUUM OF CARE ALLIANCE
ENDING HOMELESSNESS IN VENTURA COUNTY

# Preface

In addressing the complex and multifaceted issue of homelessness, a holistic and coordinated approach is essential. The Supportive Services Plan outlined in this document is designed to serve as a comprehensive guide for homeless service providers, offering a structured framework to enhance service delivery and promote sustainable outcomes for individuals and families who have entered supportive housing.

This plan recognizes the diverse needs of the homeless population and emphasizes the importance of personalized, client-centered services. It integrates best practices and evidence-based strategies to address the immediate needs, while also providing pathways to long-term stability through access to healthcare, mental health services, substance abuse treatment, employment assistance, and housing solutions.

Our goal is to empower service providers with the tools and knowledge required to deliver effective, compassionate, and respectful care. By fostering collaboration among community partners, leveraging available resources, and continuously evaluating and improving our methods, we aim to create a supportive network that not only meets the urgent needs of those experiencing homelessness but also facilitates their journey towards self-sufficiency and improved quality of life.

A supportive housing program's mission, vision, values, and philosophy should be rooted in Housing First principles. Housing First is the philosophy that homelessness can be most effectively ended by providing someone with access to safe, decent, and affordable housing. Research has demonstrated that this approach is effective in promoting housing stability, particularly among people who have been homeless for long periods of time and have serious psychiatric disabilities, substance use disorders and/or other disabilities.

*We extend our gratitude to the Housing and Services Committee which included our homeless service providers, City partners, education partners, healthcare providers, mental health providers, advocates, and the Making Spaces Project.*

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# *Supportive Housing Services Plan Guidebook for Service Providers*

## I. Introduction:

The purpose of this Supportive Housing Services Plan Guidebook (SHSP) is to provide guidance to permanent supportive housing programs that serve those who have experienced:

- homelessness,
- are at-risk of experiencing homelessness,
- have barriers to housing including extremely low income, disabilities, poor rental or credit histories and,
- justice-involved histories

Permanent, stable, supportive housing provides a strong foundation for individuals and their households to meet critical needs such as safety, and security and other essential needs such as healthcare, income and employment, education, and community involvement. Service providers should coordinate with property management providers to ensure that tenants have access to services both on-site and off-site to maintain stable housing. Other components of delivering quality supportive services within supportive housing include providing a variety of service offerings, frequencies to best meet the needs of individual tenants, ensure that all services offered to tenants are voluntary with a Housing First, trauma-informed, person-centered, culturally responsive, and strengths-based approach.

## II. Key Skills:

Providing supportive services to recently housed homeless individuals requires a diverse set of skills. Here are some key skills that can support a successful supportive services approach:

1. **Empathy and Compassion:** Being able to understand and connect with individuals who have experienced homelessness is crucial
2. **Active Listening:** The ability to listen attentively and understand the needs and concerns of the individuals you are supporting.
3. **Communication Skills:** Clear and effective communication is essential for building trust and rapport with clients.
4. **Problem-Solving Skills:** Being able to assess challenges and come up with practical solutions to help individuals navigate their new living situation.

5. **Cultural Competence:** Understanding and respecting the diverse backgrounds and experiences of the individuals you are working with.
6. **Patience and Resilience:** It's important to be patient and persistent in supporting individuals as they transition into stable housing.

## III. Staffing Ratios by Service Provision Models:

A supportive housing program can deploy multiple service models to be utilized with different tenants. These services must be rooted in cultural humility and be culturally responsive to the needs of individual tenants. Cultural humility requires an understanding of the historical context of various cultures and populations, as well as an ability to actively engage in self-reflection when interacting with individuals from different cultural backgrounds. Culturally responsive services respect an individual's cultural beliefs, philosophies, practices, traditions and values.

Based on the population being served and the service delivery model being used, staffing ratios can differ. When working with different populations and utilizing specific service models (mentioned below), there are best practice guidelines on staffing ratios.
As supportive housing programs identify populations to be served, service providers can identify service models to utilize and form consensus on appropriate staffing ratios. Common service provision models in supportive housing include:
*(You may find these service provision models defined on page 12 under KEY TERMS)*

Assertive Community Treatment (ACT)
- ACT is a multidisciplinary team approach with assertive outreach in the community.
- Team-based model that is recovery oriented (teams typically include: clinical expert, nurse, peer support worker, general case manager, housing specialist)
- 1:10 staffing ratio
- Offers direct behavioral health care
- 24/7 availability of at least 1 staff/team member

Intensive Case Management (ICM)
- ICM is a team-based approach that supports individuals through a case management approach, the goal of which is to help participants maintain their housing and achieve an optimum quality of life.
- Individual or team-based model
- 1:12 – 1:15 staffing ratio
- Includes crisis assessments, interventions, and de-escalations

Tenancy Support Services (TSS)

- TSS is a long-term, voluntary case management approach with services targeted in the following buckets: pre-tenancy, tenancy-sustaining, housing stabilization, and care coordination
- Individual or team-based approach
- Long-term, voluntary services
- 1:20 staffing ratio
- Individual or team-based approach
- Services are focused on sustaining tenancy and housing stabilization

Critical Time Intervention (CTI)

- CTI is a service provision approach used with participants who are able to work towards independent living within ~9 months.
- 1:15 staffing ratio
- 3-phased intervention:
  1. Transition to community
  2. Try Out
  3. Transfer of Care
- Services focused on building strong systems of community and supports for Veterans, persons exiting institutions

**Community partnerships are also essential to quality supportive housing programs. Service providers are encouraged to make formal and informal relationships with community supports sometimes referred to ancillary services such as independent living skill training, health and medical services, substance abuse services, employment services, and family support services.**

## IV. Staffing Ratios by Population:

Service provider staff generally fall into 3 categories: staff on-site during standard 9:00 AM-5:00 PM working hours, staff off-site during standard 9:00Am-5:00PM working hours (scattered site case management model) and staff on-site 24 hours a day. Service provider staffing can be a combination of all three, where a certain number of staff are on-site during working hours, and a lesser number of staff are on-site around the clock or staff are available between 9:00AM-5:00PM for scattered site models. Staff in the latter category are typically provided with a unit in the building to reside in and are always 'on call' for tenants.

Based on intended population(s) to be served and selected service delivery models, staffing ratios can vary. It is important for supportive housing programs to refer to the funding requirements and program guidelines to ensure the program meets the staffing ratios required by each funder.

In the field of homeless services, there is *no one-size-fits-all staffing ratio* that is considered a universal best practice, as it can vary depending on factors such as the specific needs of the homeless population being served, the complexity of their situations, available resources, and program goals. However, there are some general guidelines and recommendations that organizations may consider when determining staffing ratios for case workers and homeless individuals:

Below are general best practice standards based on population:

- Frequent users of crises systems – 10:1
- Transitional aged youth (TAY) – 15:1
- Chronic homeless – 15:1
- Families – 12:1.5
- Non-chronic individuals with mental health – 20:1

## V. Things to Consider When Providing Supportive Services:

Organizations in the field of homeless services can use these guidelines and considerations to determine an appropriate ratio that meets the needs of the population they to ensures quality care and support for homeless individuals. Regular evaluation and adjustment of staffing ratios based on client outcomes and feedback can help organizations optimize their service delivery.

**1. Complexity of Cases:** If working with homeless individuals who have complex needs such as mental health issues, substance abuse problems, or chronic health conditions,
a lower caseload size may be necessary to provide comprehensive support.

**2. Available Resources:** The availability of resources such as funding, support staff, and training opportunities can impact the staffing ratio. Organizations with more resources may be able to support lower caseload sizes.

**3**. **Continuum of Care:** Consider the level of care and support needed along the continuum of services for homeless individuals, from emergency shelters to transitional housing to permanent supportive housing. Staffing ratios may vary based on the type of program.

**4**. **Regular Supervision and Support:** It's important for case workers to receive regular supervision, training, and support to effectively meet the needs of homeless individuals. Adequate support for case workers can impact the optimal staffing ratio.

## VI. Staff Onboarding, Commitment to Training and Supervision:

Comprehensive onboarding procedures should be established for staff being brought into the supportive housing program. Onboarding for all staff should provide an overview of the supportive housing program's mission, vision, philosophy, and values, it should also include equity and inclusion trainings, crisis, and de-escalation strategies, as well as a baseline for core practices such as Housing First, trauma-informed care, strengths-based, person-centered, and culturally responsive approaches, while utilizing a harm reduction model.

On-going training and support to direct service staff is essential to successful supportive housing programs including but not limited to, organization-wide training program, onboarding, on-going training, and professional development opportunities for direct service staff and supervisors. Common ongoing training opportunities include; HMIS, case conferencing, addressing substance use, mental health 101, service planning, and working with landlords and property managers. Cross-training with on-site property management staff can be extremely beneficial for direct staff to understand each other's distinct roles and responsibilities and where overlap could occur. This is a proven strategy to improve communications and the complexities of each role. For the purposes of supervision, National Association of Social Workers (2013) states the following:

> *"Professional supervision is defined as the relationship between supervisor and supervisee in which the responsibility and accountability for the development of competence, demeanor, and ethical practice take place. Supervision encompasses several interrelated functions and responsibilities. Each of these interrelated functions contributes to a larger responsibility or outcome that ensures tenants are protected and that tenants receive competent and ethical services from service providers. During supervision, services received by the tenant are evaluated and adjusted, as needed, to increase the benefit to the tenant. It is the supervisor's responsibility to ensure that the supervisee provides competent, appropriate, and ethical services to the tenant. (p.6)"*

Supervision should happen in a private, confidential space and occur 1x/week at minimum.

## VII. Fair Housing:

The majority of fair housing responsibilities fall upon the property manager, but there must be coordination between the service staff and property manager to ensure that tenants' rights are protected. Supportive service providers' main responsibility around fair housing is assisting tenants who are seeking reasonable accommodations and advocating for tenants' reasonable accommodation requests.

By law, any party engaged in real estate transaction must make reasonable accommodations and modifications for persons with disabilities. The accommodation and modifications must be reasonable. "Reasonable" meaning that the cost of making the accommodation has to be financially reasonable, the definition of reasonable will vary based on the actor as well as the nature of the accommodation. The difference between accommodations and modifications is that accommodations are rules, policies, the way services are provided, parking locations, pet rules for assistance animals, rent due dates, and others. Modifications are structural changes made to existing premises such as to afford persons with disabilities full enjoyment of the premises, ramps, grab bars, adapting equipment and cabinets, and others. A service provider may help a tenant or prospective tenant request these accommodations and modifications or advocate on behalf of the tenant. A service provider may also inform tenants of how to access legal services and better understand their rights when fair housing concerns might arise. The Housing Rights Center provides this resource for filing a discrimination complaint.

## VIII. Support Plan Steps:

When meeting with a recently housed individual, a case worker should take several steps to provide effective support and assistance during this transitional period. Here are some key steps that a case worker can take:

**1. Establish Rapport:** Begin the meeting by building rapport and establishing a trusting relationship with the individual. Show empathy, active listening, and genuine interest in their well-being. You may find the Stages of Engagement Handout on Attachment E.

**2. Assessment of Needs:** Conduct a comprehensive assessment to identify the individual's *needs, goals, strengths, and challenges*. This may include housing stability, employment, health care, mental health, substance abuse, and social support. This can be completed at entry into supportive housing, intermittently, annually and at exit to evaluate progress and outcomes. You may find the Arizona Self-Sufficiency Matrix Template onAttachment A.

**3. Goal Setting:** Collaboratively set goals with the individual based on their needs and preferences. These goals should be specific, measurable, achievable, relevant, and time-bound (SMART).

**4. Develop a Housing Support Plan:** Create a personalized support plan that outlines the steps needed to achieve the individual's goals. This plan should include specific actions, responsibilities, timelines, and resources needed. You may find the Housing Support Plan Template on Attachment B.

**5. Connect with Resources:** Help the individual access needed resources and services, such as housing assistance, employment support, healthcare, mental health counseling, substance abuse treatment, and social services.

a) **Healthcare Coordination:**
    a. Facilitate access to comprehensive healthcare services, including mental health and substance abuse treatment.
    b. Collaborate with healthcare providers to address chronic health conditions (refer to Cal AIM- Care Management).
b) **Mental Health Services:**
    a. Provide mental health referrals for assessment and counseling services.
    b. Offer access to psychiatrists and support for individuals dealing with severe mental illness (refer to Ventura County Behavioral Health).
c) **Substance Abuse Treatment:**
    a. Integrate harm reduction strategies for individuals struggling with addiction (refer to Ventura County Behavioral Health).
d) **Employment Support:**
    a. Offer referrals to vocational training programs and supported employment services (refer to Pathways to Employment).
    b. Assist individuals in building job skills and securing sustainable employment.
e) **Income Support:**
    a. Help individuals access disability benefits, social security, and other income support programs.
    b. Refer individuals to Human Services Agency for access to CalFresh, CalWORKS, etc.
    c. Provide financial literacy training to enhance budgeting skills.
f) **Legal Aid:**
    a. Refer to the Ventura County Public Defender's office to address legal issues related to eviction prevention, criminal records, or outstanding fines.
    b. Advocate for individuals to access legal aid services.
g) **Community Integration:**
    a. Foster social connections through support groups and community activities.
    b. Collaborate with local organizations to create opportunities for inclusion and social engagement.
h) **Education and Skill Development:**
    a. Support individuals in pursuing educational goals, including completing high school or obtaining GEDs (GED Resources).
    b. Provide skill-building workshops to enhance independence and employability.
i) **Peer Support Programs:**
    a. Refer to peer support groups to provide mutual assistance and a sense of community (such as Turning Point Foundation Wellness Peer Support).
    b. Utilize individuals with lived experience as peer support specialists.

**6. Provide Guidance and Advocacy:** Offer guidance, advocacy, and practical assistance to help the individual navigate systems, overcome barriers, and access the support they need.

**7. Monitor Progress:** Regularly monitor the individual's progress towards their goals, adjust the support plan as needed, and celebrate achievements along the way.

**8. Crisis Intervention:** Be prepared to provide crisis intervention and support in case of emergencies, mental health crises, or other urgent situations.

**9. Coordinate Care:** Collaborate with other service providers, community agencies, and support networks to ensure coordinated and holistic care for the individual.

**10. Empowerment and Self-Advocacy:** Empower the individual to advocate for themselves, build self-efficacy, and develop skills to maintain housing stability and overall well-being.

Effective case management for homeless subpopulations involves tailored approaches to address the specific needs and challenges of diverse groups.

Here are best practices and case management models for several homeless subpopulations:

1. **Youth Homelessness:**
    a. Trauma-Informed Care: Recognize and address trauma experiences, providing a safe and supportive environment.
    b. Education Support: Assist with educational needs, including school enrollment, GED programs, and access to tutoring.
    c. Employment Support: Assist with employment needs, including access to resume building, career development/fair, and job search.
    d. Care Plan: Assist with creating a care plan tailored to the individual to provide extra support/ services/ resources on self-reported critical issues.
    e. Family Reunification: Explore options for reconnecting with family and involve family members, as defined by the youth, in the support process. Treat the need for connection with the same urgency as physical needs.
    f. Youth Voice: Youth are experts on their respective situations and should be treated as such. Empower youth to lead discussions about their futures, while providing the support they need to reach their goals. Asking questions is aa way to ensure that young adults take the lead on their case planning (You may refer to Interface Children and Family Services- Runaway and Homeless Youth Provider).
2. **Veterans:**
    a. Access to VA Services: Facilitate enrollment in Veterans Affairs (VA) healthcare and other veteran-specific services (You may refer to Veteran Affairs- Captain Rosemary Bryant Mariner Outpatient Clinic).
    a. Military Culture Competency: Learn to understand and navigate military culture.

b. Employment Assistance: Provide targeted employment services and access to job training programs through CalVET

3. **Families with Children:**
    a. Child-Centered Approach: Prioritize the well-being and stability of children in service planning.
    b. School Enrollment Assistance: Ensure children's access to education by assisting with school enrollment and transportation through VCOE Homeless Liaison Program.
    c. Childcare Support: Connect parents with affordable and reliable childcare services through Child Development Resources or Children's Home Society.
4. **Individuals with Mental Health Challenges:**
    a. Integrated Care Models: Collaborate with mental health providers for integrated care services.
    b. Crisis Intervention Plans: Develop and implement crisis intervention plans for mental health emergencies.
    c. Medication Management: Ensure access to psychiatric services and support with medication adherence.
5. **Substance Abuse Disorders:**
    a. Harm Reduction Strategies: Implement harm reduction approaches for individuals dealing with substance abuse.
    b. Access to Treatment: Connect individuals to substance abuse treatment programs and support their recovery.
    c. Integrate substance abuse treatment with supportive housing models.
6. **LGBTQIA+ Homelessness:**
    a. Culturally Competent Services: Provide LGBTQIA+ inclusive and culturally competent case management.
    b. Safe Spaces: Create environments that are inclusive and sensitive to the unique needs of LGBTQIA+ individuals.
    c. Community Connection: Facilitate connections with LGBTQIA+ community resources and organizations.
7. **Chronic Homelessness:**
    a. Housing First Model: Prioritize immediate access to stable housing without preconditions.
    b. Healthcare Coordination: Integrate healthcare services for individuals with chronic health conditions.
    c. Multi-Disciplinary Teams: Utilize multidisciplinary teams to address complex needs.

8. **Older Adults:**
    a. Access to Senior Services: Connect older adults with services tailored to their age group (You may refer to Ventura County Area Agency on Aging)
    b. Health and Mobility Support: Address health concerns and provide assistance with mobility challenges.
    c. Social Engagement: Facilitate social activities and connections to prevent isolation.
9. **Criminal Justice System Involved:**
    a. Reentry Planning: Develop plans to support individuals transitioning from incarceration to stable housing.
    b. Legal Assistance: Address legal issues such as outstanding fines or warrants to prevent re-entry into the criminal justice system, refer to Ventura County Public Defender's Office.
    c. Behavioral Health Support: Refer to mental health and substance abuse services to address underlying issues.

By following these steps, a case worker can effectively support a recently housed individual in their journey towards stability, independence, and well-being. Tailoring case management approaches to the specific needs, experiences, and backgrounds of these diverse homeless subpopulations is essential for providing effective support and promoting long-term stability. Collaboration with community organizations, cultural competency training for staff, and ongoing assessment and adjustment of services are critical components of successful case management models for homeless subpopulations.

## IX. Mitigating Case Management Participation:

Working with a recently housed homeless individual who is not interested in receiving case management services can present a challenge, but there are steps that a case worker can take to engage the individual and provide support in a respectful and client-centered manner. There is a persistent myth around reasons individuals decline supportive services, however, the declination may be a result of the services offered not meeting their immediate needs. Here are some recommendations for working with a recently housed homeless individual who is not interested in receiving case management (you may reference Attachment C, Attachment D and Attachment E for further guidance).

**1. Build Trust and Rapport:** Focus on building a trusting relationship with the individual by demonstrating empathy, active listening, and respect for their autonomy and choices.

**2. Understand Their Perspective:** Take the time to understand the individual's reasons for not wanting to receive case management services. Validate their concerns and perspectives without judgment.

**3. Explore Motivations and Goals:** Engage the individual in a conversation about their motivations, goals, and aspirations for their housing stability and overall well-being. Identify what matters most to them.

**4. Offer Choice and Control:** Offer the individual choices and control over the support they receive. Collaboratively explore alternative ways to meet their needs and goals that align with their preferences. This could include a referral to another agency or organization for support.

**5. Strengths-Based Approach:** Focus on the individual's strengths, resources, and resilience. Help them recognize their own capabilities and potential for growth and positive change.

**6. Provide Psychoeducation:** Offer information and psychoeducation about the benefits of case management services, how they can support the individual in achieving their goals, and the available resources and support.

**7. Respect Boundaries:** Respect the individual's boundaries and pace of engagement. Avoid pushing or coercing them into receiving services, as this may lead to resistance.

**8. Maintain Open Communication:** Keep the lines of communication open and check in with the individual periodically to see if their needs or preferences have changed. Show genuine interest in their well-being.

**9. Collaborate with Peers and Support Networks:** Engage the individual's peers, friends, family members, or other support networks to provide additional encouragement and reinforcement of the benefits of case management.

**10. Provide Ongoing Support:** Even if the individual initially declines case management, continue to offer support, information, and assistance as needed. Be available to help when they are ready to reconsider.

**11. Regular Communication:** Maintain regular communication through in person check-ins, and keep individuals informed about available resources and upcoming appointments.

**12. Advocacy:** Advocate for individuals in accessing entitlements, benefits, and legal assistance and help navigate systems such as healthcare, social services, and housing programs.

By taking a client-centered, empathetic, and collaborative approach, a case worker can work towards engaging a recently housed homeless individual who is not interested in receiving case management services and ultimately support them in their journey towards stability and well-being.

## X. Eviction Prevention/ Housing Retention:

The policies created under your eviction prevention strategy should be reviewed and revised on a regularly scheduled basis in collaboration with tenants. Procedures can be changed anytime in response to program changes or quality improvement strategies.

Housing retention and housing stability are critical to successful supportive housing programs. Eviction prevention strategies should focus on promoting stable tenancy through tenant skill-building and proactive intervention. Strong eviction prevention strategies should:

- **Develop** Standardized and Clear Processes.
- **Rules are written** to appropriately serve tenants with the greatest need and vulnerability, allowing tenants maximum choice in terms of substance use and housing
- **Integrate commonly used** mitigation strategies into staff trainings and workflows
- **Utilize multi-disciplinary approaches**, creative problem solving, and solutions focused brainstorming, coordinated entry system at risk cases must be presented including presenting cases at risk of returning to homelessness through Pathways to Home case conferencing. Case Conference form for at risk cases can be found here.
- **Utilize referrals** for additional supports as needed to prevent eviction (legal referrals)

## XI. Outcomes:

Below are examples of positive supportive housing outcome measures and a target goal. It is recommended that organizations know their baseline performance with regard to these outcomes and use them to set aggressive targets for improvement. In addition to understanding baseline performance, programs should be sure to incorporate the outcome measures and target goals outlined in each funding program. For example, the NOFA and/or Funding Guidelines. The goals listed below might not be adequate for all organizations.

| **Outcome Measures – Service Providers** | |
|---|---|
| The percentage of current and exited tenants who remain in supportive housing for at least 12 months or exit to other permanent housing. (HUD COC NOFA) | 85% |
| The percentage of tenants who exit to permanent housing (including other supportive housing) after leaving supportive housing. (Move-on strategy: for participants who no longer need support). | 75% |
| The percentage of tenants who have been in supportive housing one or more years self-report that their mental health has improved or stabilized since entering supportive housing. | 70% |
| The percentage of all tenants with mental health challenges who have a behavioral health care provider in the community. | 70% |
| The percentage of tenants who have been in supportive housing for one year or more, self-report that their physical health has improved since entering supportive housing. | 70% |

| | |
|---|---|
| The percentage of tenants who have a primary health care provider in the community. | 70% |
| The percentage of tenants who agree with the statement, "Staff helped me (or will help me) obtain information I needed so that I could take charge of managing my health." | 80% |
| The percentage of tenants who have been in supportive housing for one year or more, have increased their income or maintained their existing entitlement benefits (such as Supplemental Security Income) since entering supportive housing. (HUD COC NOFA) | 60% |
| The percentage of tenants who have been in supportive housing for at least 12 months, were employed in a part-time, fulltime, or transitional job at some point during the past 12 months. | 12% |
| The percentage of tenants who report that they are satisfied with their housing overall | 75% |
| The percentage of tenants who report satisfaction with the location and safety of their housing. | 75% |
| The percentage of tenants who report that they are satisfied with the services that are available to them. | 75% |
| The percentage of tenants who have been in supportive housing for one year or more, report that they participate in one or more community organizations or activities. | 60% |
| The percentage of tenants who have been in supportive housing for one year or more, report that they have strengthened their social support network since moving into supportive housing. | 75% |
| The percentage of tenant households who have voluntarily utilized at least one supportive service in the last year. | 70% |
| The percent of tenant households who exit to permanent housing destinations return to homelessness. (HUD CoC NOFA) | <5% |

## XII. Things to Avoid When Providing Supportive Services:

Avoid:

- Assuming a One-Size-Fits-All Approach
- Stigmatizing or judging individuals or making assumptions about their circumstances
- Assuming that youth or adults do not have insight on what is best for their respective situations
- Acting on behalf of the youth or adults without agreement
- Imposing conditions on support or use compliance requirements that hinder individuals form receiving assistance
- Overlooking mental health or disregarding signs of distress

- Neglecting follow-up and ongoing support after initial stabilization or assume that stability is achieved without continued assistance
- Isolating individuals from social connections or community activities
- Ignoring legal issues that may impede housing stability
- Disregarding cultural competency or cultural differences
- Rushing the process or overwhelming individuals with too many expectations too quickly
- Neglecting self-care for the individual and case manager

## XIII. KEY TERMS

### Assertive Community Treatment (ACT)

Assertive Community Treatment (ACT) is a multidisciplinary team approach with assertive outreach in the community. The ACT model offers consistent service delivery, caring, person-centered relationships with demonstrated results of a positive effect on outcomes and quality of life. Research shows that ACT reduces hospitalization, increases housing stability, and improves quality of life for people with the most severe symptoms of mental illness.

### Critical Time Intervention (CTI)

Critical Time Intervention (CTI) is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. It facilitates community integration and continuity of care by ensuring that a person has enduring ties to their community and support systems during these critical periods.

### Housing First

"Housing First" means the evidence-based model that uses housing as a tool, rather than a reward, for recovery and centers on providing or connecting homeless people to permanent housing as quickly as possible. Housing First providers offer services as needed and requested on a voluntary basis and do not make housing contingent on participation in services. "Housing First" includes time-limited rental or services assistance, so long as the housing and service provider assists the recipient in accessing permanent housing and in securing longer term rental assistance, or employment.

### Harm Reduction

Harm reduction incorporates a spectrum of strategies that includes safer use, managed use, abstinence, meeting people who use drugs "where they're at," and addressing conditions of use along with the use itself. Because harm reduction demands that interventions and policies designed to serve people who use drugs reflect specific individual and community needs, there is no universal definition of or formula for implementing harm reduction.

### Intensive Case Management (ICM)

Intensive Case Management (ICM) is a team-based approach that supports individuals through a case management approach to help participants maintain their housing and achieve an optimum quality of life through developing plans, enhancing life skills, addressing health and mental health needs, engaging in meaningful activities, and building social and community relations. ICM has a moderately strong evidence base, and it is designed for clients with lower acuity, but who are identified as needing intensive support for a shorter and time-delineated period.

### Person-Centered Care

Person-Centered Care in which individuals' goals, values, and preferences guide the care they receive. Essential elements include: an individualized, goal-oriented care plan based on the person's preferences, ongoing review of the person's goals and care plan, care supported by an interprofessional team, one lead point of contact on the team, active coordination among all health care and supportive service providers, and performance measurement using feedback from the person and caregivers.

### Strengths-Based Approach

Strengths-based practice is a collaborative process between the person supported by services and those supporting them, allowing them to work together to determine an outcome that draws on the person's strengths and assets. As such, it concerns itself principally with the quality of the relationship that develops between those providing and being supported, as well as the elements that the person seeking support brings to the process (Duncan and Hubble, 2000). Working in a collaborative way promotes the opportunity for individuals to be co-producers of services and support rather than solely consumers of those services (Morgan and Ziglio, 2007).

### Tenancy Support Services (TSS)

Tenancy Support Services (TSS) is a voluntary and long-term housing focused case management model that provides supportive housing services at a low caseload ratio. Services include the core supportive housing services: pre-tenancy, tenancy-sustaining, housing stabilization, and care coordination. Behavioral health and other clinical services are not included in this model's service plan, yet coordination with other community providers is key.

### Transitional Aged Youth (TAY)

The U.S. Housing and Urban Development (HUD) definition of Transition Age Youth includes young people, between the ages of 18 to 25, who are approaching transition from child-serving system(s) (e.g., child welfare, juvenile justice, education, behavioral health) due to "aging out" – leaving a formal system of care because of reaching a certain age – or other circumstances (i.e., achievement of case plans, graduation, etc.). While TAY have a complex set of needs and face many challenges, they also have the potential to lead successful adult lives when offered resilience-building resources, strategies, and support.

### Trauma-Informed Care

Trauma of all sorts – physical, race, emotional or sexual – is known to be both a cause and a result of homelessness. A variety of studies have shown that domestic violence can lead to homelessness for women and their children, that childhood abuse is a potential risk factor for later homelessness, that Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, and (LGBTQIA+) youth often leave home because of negative and sometime violent reactions to their coming out process. There is also a correlation between people experiencing homelessness and addictions and/or mental health. People experiencing homelessness often suffer from depression and/or post-traumatic stress disorder. These may be the cause or result of homelessness. All of this means that staff and volunteers working with people experiencing homelessness need to create and implement trauma-informed services to provide the best possible care.

Trauma-informed care is a strengths-based service delivery approach "that is grounded in an understanding of and responsiveness to the impact of trauma; that emphasizes physical, psychological, and emotional safety for both providers and survivors; that creates opportunities for survivors to rebuild a sense of control and empowerment." (Hopper, Bassuk, and Olivet, 2010, p.82).

## XIV. Evidence Based Practice Works Cited:

"Assertive Community Treatment," https://case.edu/socialwork/centerforebp/practices/assertive-community-treatment

"Critical Time Intervention," https://www.criticaltime.org/cti-model/

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## XV. Attachment A

**Self-Sufficiency Matrix** Participant Name _____ DOB __/__/____

Assessment Date __/__/____

☐Initial ☐ Interim ☐ Exit Program Name_____ HMIS ID _____

| Domain | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| Housing | Homeless or threatened with eviction. | In transitional, temporary, or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income). | In stable housing that is safe but only marginally adequate. | Household is in safe, adequate subsidized housing. | Household is safe, adequate, unsubsidized housing. |
| Employment | No job. | Temporary, part-time or seasonal; inadequate pay, no benefits. | Employed full time; inadequate pay; few or no benefits. | Employed full time with adequate pay and benefits. | Maintains permanent employment with adequate income and benefits. |
| Income | No income. | Inadequate income and/or spontaneous or inappropriate spending. | Can meet basic needs with subsidy; appropriate spending. | Can meet basic needs and manage debt without assistance. | Income is sufficient, well managed; has discretionary income and is able to save. |
| Food | No food or means to prepare it. Relies to a significant degree on other sources of free or | Household is on food stamps. | Can meet basic food needs but requires occasional assistance. | Can meet basic food needs without assistance. | Can choose to purchase any food household desires. |
| Child Care | Needs childcare, but none is available/accessible and/or child is not eligible. | Childcare is unreliable or unaffordable, inadequate supervision is a problem for childcare that is available. | Affordable subsidized childcare is available but limited. | Reliable, affordable childcare is available, no need for subsidies. | Able to select quality childcare of choice. |
| Children's Education | One or more school-aged children not enrolled in school. | One or more school-aged children enrolled in school, but not attending classes. | Enrolled in school, but one or more children only occasionally attending classes. | Enrolled in school and attending classes most of the time. | All school-aged children enrolled and attending on a regular basis. |
| Adult Education | Literacy problems and/or no high school diploma/GED are serious barriers to employment. | Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment. | Has high school diploma/GED. | Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society. | Has completed education/training needed to become employable. No literacy problems. |
| Health Care Coverage | No medical coverage with immediate need. | No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health. | Some members (e.g. Children) have medical coverage. | All members can get medical care when needed but may strain budget. | All members are covered by affordable, adequate health insurance. |
| Life Skills | Unable to meet basic needs such as hygiene, food, activities of daily | Can meet a few but not all needs of daily living without assistance. | Can meet most but not all daily living needs without assistance. | Able to meet all basic needs of daily living without assistance. | Able to provide beyond basic needs of daily living for self and family. |

| | | | | | |
|---|---|---|---|---|---|
| Family /Social Relations | Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect. | Family/friends may be supportive but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect. | Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support. | Strong support from family or friends. Household members support each other's efforts. | Has healthy/expanding support network; household is stable, and communication is consistently open. |
| Mobility | No access to transportation, public or private; may have car that is inoperable | Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc. | Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured | Transportation is generally accessible to meet basic travel needs. | Transportation is readily available and affordable; car is adequately insured |
| Community Involvement | Not applicable due to crisis situation; in "survival" mode | Socially isolated and/or no social skills and/or lacks motivation to become involved | Lacks knowledge of ways to become involved | Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues. | Actively involved in community |
| Parenting Skills | There are safety concerns regarding parenting skills | Parenting skills are minimal | Parenting skills are apparent but not adequate | Parenting skills are adequate | Parenting skills are well developed |
| Legal | Current outstanding tickets or warrants | Current charges/trial pending, noncompliance with probation/parole | Fully compliant with probation/parole terms | Has successfully completed probation/parole within past 12 months, no new charges filed | No active criminal justice involvement in more than 12 months and/or no felony criminal history |
| Mental Health | Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems | Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms | Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems | Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning | Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than everyday problems or concerns |
| Substance Abuse | Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary | Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities | Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month | Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use | No drug use/alcohol abuse in last 6 months |
| Safety | Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement | Safety is threatened/temporary protection is available; level of lethality is high | Current level of safety is minimally adequate; ongoing safety planning is essential | Environment is safe, however, future of such is uncertain; safety planning is important | Environment is apparently safe and stable |

| | | | | | |
|---|---|---|---|---|---|
| Disabilities | In crisis – acute or chronic symptoms affecting housing, employment, social interactions, etc. | Vulnerable – sometimes or periodically has acute or chronic symptoms affecting housing, employment, social interactions, etc. | Safe – rarely has acute or chronic symptoms affecting housing, employment, social interactions, etc. | Building Capacity – asymptomatic – condition controlled by services or medication | Thriving – no identified disability |
| Other | In Crisis | Vulnerable | Safe | Building Capacity | Empowered |

LifeWorks Self-Sufficiency Matrix, a modified version of the Arizona Self-Sufficiency Matrix – last updated 2017
Adopted from the LifeWorks Self-Sufficiency Matrix

## XVI. Attachment B

### Housing Support Stability Plan

**Client Name: _____ HMIS ID: _____**

| Goal | Strategies & Steps | Target Date | Goal Achieved (Yes/No) If No, Why? |
|---|---|---|---|
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**Client Signature: _____ Date:_____**
**Case Manager Signature:_____ Date:_____**

Adopted from California Housing and Community Development

## XVII. Attachment C

### Stages of Common Language Development

| Stages | Goals & Interventions |
|---|---|
| ***Understand Language*** | » Attempt to understand a homeless person's world by learning the meaning of his/her/their gestures, words, values, and actions.<br>» Interventions include: observing, listening, reflection, and directly asking what particular words and phrases mean, as well as learning what is important to the client. |
| ***Utilize Language*** | » Promote understanding by developing and using a mutually agreeable set of terms. Build, modify, and use gestures, words, and phrases from the playground of common language based on the client's cues.<br>» Interventions include: utilizing common language to ask client questions, explore the outreach worker's role, verbalize client's aspirations, and jointly define goals. |
| ***Bridge Language*** | » Connect and integrate the common language developed between the client and worker with other systems of language as defined by available services and resources (i.e., housing authorities, Social Security, medical services, mental health, clinic, self-help groups, vocational programs, etc.).<br>» Interventions include: connecting resources and services directly to client's goals, reframing commonly used words and phrases by targeted resources and services to be consistent with the playground of language developed by the client/worker.<br>» Preparing for interviews via role play and accompanying the client may also be helpful.<br>» Prepare intake personnel of needed resources and services for the language that the client speaks. If certain phrases or terms may trigger a negative reaction, reframe and redefine these terms whenever possible, or seek accommodation. |

from: Levy, J. S. (2013). *Pretreatment guide for homeless outreach & Housing First: Helping couples, youth, and unaccompanied adults.* Ann Arbor, MI: Loving Healing Press, Inc.

## XVIII. Attachment D

### Pretreatment Principles & Applications

| Principles | Application/In Action |
|---|---|
| ***Promote Safety*** | » Engage with homeless individuals in order to reduce the risk of harm and to enhance safety (e.g., provide warm blankets on a cold night)<br>» Stabilize acute symptoms via crisis intervention and utilize opportunity for further work |
| ***Relationship Formation*** | » Attempt to engage with homeless people in a manner that promotes trust, safety, and autonomy, while developing relevant goals<br>» Stages:<br>✓ Pre-Engagement<br>✓ Engagement<br>✓ Contracting |
| ***Common Language Construction*** | » Attempt to understand a homeless person's world by learning the meaning of his/her/their gestures, words, and actions<br>» Promote mutual understanding and jointly define goals<br>» Stages include:<br>✓ Understanding<br>✓ Utilizing<br>✓ Bridging Language |
| ***Facilitate & Support Change*** | » Prepare clients to achieve and maintain positive change by pointing out discrepancy; exploring ambivalence, reinforcing healthy behaviors, and developing skills, as well as needed supports<br>» Utilize Change Model & Motivational Interviewing Principles<br>» Stages include:<br>✓ Pre-contemplation<br>✓ Contemplation<br>✓ Preparation<br>✓ Action<br>✓ Maintenance |
| ***Cultural & Ecological Considerations*** | » Prepare and support homeless clients for successful transition and adaptation to new relationships, ideas, services, resources, treatment, and housing, etc. |

from: Levy, J. S. (2013). *Pretreatment guide for homeless outreach & Housing First: Helping couples, youth, and unaccompanied adults.* Ann Arbor, MI: Loving Healing Press, Inc.

## XIX. Attachment E

### Stages of Engagement

| Ecological Phase | Developmental Stage | Intervention / Action |
|---|---|---|
| ***Pre-Engagement*** | Trust vs. Mistrust<br><br>Issues of Safety | Observe;<br>Identify potential client;<br>Respect personal space;<br>Assess safety;<br>Attempt verbal and non-verbal communication;<br>Offer essential needed item, while listening for client language;<br>Establish initial communication |
| ***Engagement*** | Trust vs. Mistrust<br><br>Issues of Dependency<br><br>Boundary Issues | Communicate with empathy and authenticity;<br>Learn client's language;<br>Actively listen by reflecting client's words, ideas, and values;<br>Identify and reinforce client's strengths;<br>Provide unconditional regard;<br>Avoid power struggles;<br>Emphasize joining the resistance;<br>Introduce roles, begin & continue development of healthy boundaries;<br>Establish on-going communication;<br>Identify current life stressors |
| ***Contracting*** | Autonomy vs. Shame<br><br>Issues of Control<br><br>Initiative vs. Guilt | Further define roles and boundaries;<br>Address shame by universalizing human frailty and reviewing client strengths;<br>Negotiate reachable goals to alleviate life stressors;<br>Explore client history about goals;<br>Determine eligibility for resources and services regarding client interests;<br>Further define shared objectives by utilizing client language;44r332`2rrrwqa<br>Review & reinforce current coping strategies, jointly consider housing options |

from: Levy, J. S. (2013). *Pretreatment guide for homeless outreach & Housing First: Helping couples, youth, and unaccompanied adults.* Ann Arbor, MI: Loving Healing Press, Inc.