



# How Behavioral Health Systems are Preventing Homelessness

The District of Columbia  
Department of Mental Health's  
**Services and Supports Strategy**

National Alliance to End Homelessness  
2005 Annual Meeting



# Preventing Homelessness

Begin with the premise that providing services alone won't do it

Providing housing alone won't do it.....

- ◆ reduce barriers
- ◆ increase a person's opportunity for success
- ◆ don't deal with the issue as a project but a way of doing business
- ◆ work outside the mental health system
- ◆ with a focus on permanent solutions



# Foundation for Success

- ◆ Established Individual Recovery and Prevention of Homelessness
  - *Focused* attention at three levels: system, provider and person being served---not sufficient to focus at one level
  - Ensured *incentives* for recovery are present to reinforce direction
  - Recognized that desired outcomes are the person's desired outcomes, not the system's outcomes---often referred to as the system being *person centered*



# Four Major Strategies

1. Created an Action Plan: clear deliverables and **targets**—that drives system toward preventing homelessness..... Includes widely publicized, frequently discussed performance targets in 15 categories that range from “housing first” to shifting allocations to priority populations and priority services
2. Developed services and supports to hit **targets**: 8,000 new adults served in three years, 70% of persons requesting supportive housing get it within 45 days, etc.
3. Constantly working to make certain the service strategies make sense
4. Building partnerships that support the strategies



# Established Service Requirements That Can Make a Difference

- ✓ Consumer Choice
- ✓ Individualized Recovery Plan
- ✓ Embed Cultural Competency
- ✓ 75% of a person's billable time spent with consumer/others; 25% collateral
- ✓ 50% of the time services delivered in community
- ✓ Presumptive eligibility/ expedited benefit acquisition
- ✓ Representative Payee: outside the service system



# Service Requirements

- ✓ Supported Housing comes with requirements for providers to work with landlords, holding places, constant support
- ✓ Crisis Plan/ Emergent (one hour), Urgent Response (24 hours)
- ✓ Each consumer chooses their “clinical home” agency responsible for overall care, linkage, does not discharge someone if they go to jail or to hospital
- ✓ Increased opportunities for peer support



# Community Support

- ◆ Major service provided in our system is “Community Support”
  - Covered by Medicaid/ same service covered by local funds for persons not eligible for Medicaid
  - No limits set on the service in terms of amount of service available
  - Qualified staff can be any licensed professional or person credentialed including recovery specialists (peer counselors)
  - Preference is for staff to work in teams so back-up, synergy of a whole team focused on helping each person can be realized



# Community Support

<b>Actual Medicaid Language</b>	<b>Interpretation</b>
1. Consumer participation in the development/ implementation of their Individual Recovery Plan	The consumer always participates in “treatment” planning and tx. Planning is oriented toward a consumer’s recovery
2. Individual intervention for the development of interpersonal and community coping skills, including adapting to home, school and work environments	Assistance for the individual with financial management, personal, developmental, school or work performance
3. Develop a relapse prevention strategy and plan	Helping consumer prevent relapse through reinforcing their plan and supporting them when relapse occurs



# Community Support

<b>Actual Medicaid language</b>	<b>Interpretation</b>
4. Assist consumer to self monitor symptoms and to self management treatment	Similar to relapse prevention: guiding consumer to self monitor and managed their own treatment--use WRAP or other new ideas
5. Assist consumer to increase social support skills and networks	Team helps facilitate the consumer spending time with family and friends and building their own social network and interests
6. Develop strategies and supports for avoiding out-of-home placement	Wrap around services are mobilized when needed



# Community Support

<b>Actual Medicaid language</b>	<b>Interpretation</b>
7. Education, support and consultation to consumer's families and their support system, which is directed exclusively to the well-being and benefit of the consumer	While general education is not covered specific education for friends and family is considered a covered service
8. Assistance and support for the consumer in crisis situations	Services are available 24-7; every agency must have a crisis plan for each consumer: frequently updated, the consumer and every team member knows it; staff available within an hour, on site if necessary



# Assertive Community Treatment

- ◆ Similar focus to “Community Support” with notable differences:
  - caseload size: 10-12 (CS 20/40)
  - team composition: requires CAC
  - frequency of team meetings
  - all services provided by the team



## Seizing Opportunities and Building Alliances: Substance Abuse/ Human Services System/ MPD and Corrections/Child Welfare

- ◆ Sobering Station and other hypothermia strategies
- ◆ Integrated Treatment Strategies: Co-Sig Project, “paying for performance”
- ◆ New women’s recovery program
- ◆ Expanded jail diversion
- ◆ Choice grant: services to youth aging out of child welfare system



# Discharge Planning Task Force

- One of the first two actions in our 10 Year Plan to End Homelessness: Discharge Planning Task Force
- Agencies not normally (in some cases ever) working together have come to together to work on shifting community wide policies of discharging persons to shelters/ street from all of our institutions: jails, prisons, hospitals, treatment facilities, emergency rooms
- Survey: 9,000 discharges to shelters in the last year
- Examining options used in other cities

stay tuned.....



# Key Supports

- ◆ Adding Pathways DC first ACT “Housing First” program to fully implement HF model: 40 consumers, 6 ½ years on the street average living in their own homes
- ◆ *new* flexible vouchers for substance abuse treatment
- ◆ Effective Homeless Outreach Program (the HOP) assisting consumers to become engaged
- ◆ Establishing PUSH—teams coming together at the state hospital to work on discharge planning
- ◆ Assuring availability of flexible funds
- ◆ Recovery DC---consumers energized to play broader role offering support
- ◆ and of course housing.....



# Exhibit C

## FY 2005 Supportive Housing Work Plan Projected Budget Flowchart

