Shifting transitional housing models for permanent housing outcomes

Washington Low Income Housing Alliance
Annual Conference on Ending Homelessness
May 17, 2012

Presented by:
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Heartland Human Care Services, Inc.
Goals of Presentation

- Discuss considerations and process for shifting transitional housing models and resources
- Provide an overview of Heartland’s signature family supportive housing model, demonstrating the organizational and Chicago systems level factors that led to a change in program philosophy and operations
- Discuss tools that assisted with the change process and lessons learned from program outcomes
Heartland Alliance for Human Needs & Human Rights

- *Heartland Alliance*, tracing its roots to 1888, provides services in healthcare, legal protections, housing, and economic security.

- *Heartland Alliance* served over 100,000 people last year.
Heartland Human Care Services

- The human services provider of **Heartland Alliance for Human Needs & Human Rights**.
- Signature programs: Supportive Housing, Transitional Jobs, Outpatient Mental Health and Addictions Treatment, and the Juvenile Detention Alternative Initiative
- The largest agency within **Heartland Alliance** serving over 65,000 people each year with a $40M budget.
Heartland Human Care Services

Housing Experience

- Services provided to more than 800 units throughout Chicago for families, single adults, seniors and individuals with chronic health conditions
- Full spectrum of housing assistance from homeless prevention through permanent supportive housing
- Funded through HUD SHP, HPRP, HOPWA, City of Chicago Department of Public Health/Family & Support Services, State of Illinois, private foundation support
Who have we served with transition in place?

- Homeless families and individuals transitioning from shelter
- Women leaving the sex-trade with criminal justice involvement – a partnership with the county court system
- Young mothers with children under the age of 5; prioritizing moms with mental health diagnosis, foster care history through Family Assertive Community Treatment Collaboration
- Individuals living with HIV, co-occurring substance use and mental health conditions
Why shift transitional housing resources?

- Emerging community needs and limited resources
- Changing service philosophies from housing ready to housing first
- HEARTH System Performance Measures
  - Reducing the duration of homeless episodes through rapid re-housing and reducing barriers to access to housing
Conversion considerations & components

- Organizational commitment at all levels
- Flexibility with change
- Intentional training and staff development
- Organizational/program model culture shift
- What component is changing – shelter or housing?
- Research models and best practices
- Develop a planning committee
- Create an implementation strategy and evaluate it

Heartland Human Care Services, Inc.
Chicago’s system conversion

- Ten Year Plan to End Homelessness, “Getting Housed, Staying Housed,” challenged Chicago to move from a chronological path from shelter to transitional housing to permanent housing to an Interim Housing model in which short-term housing is provided for the minimum time needed to access permanent housing.
- Currently developing Plan 2.0 to build on strategies that worked and support HEARTH outcomes.
Families Building Community (FBC)

- Families move from homeless shelters to permanent housing through a rental subsidy and intensive case management services.

Families Building Community

- Began in 1993 as a result of a research project “Promises Made, Promises Broken” which was completed by Heartland’s Mid America Institute on Policy (now Social IMPACT Research Center)

- Identified the need for a “housing-first” supportive housing model to assist homeless families toward self-sufficiency
The Original FBC Model

- Housing First
- Intensive Family Case Management Services
- 12 months of housing services & 12 months of follow-up services
FBC service goals

- Increased housing stability.
- Increased income/skills
- Increased self-determination
- Family health and wellness
What services does FBC provide?

- Housing location, inspection and advocacy
- Shelter transition services
- Community resource linkages
- Case management
- Life skills training
- Children’s development
- Parenting skills training
- Workforce Development
- Asset Development/Matched Savings
10 and 15 Year Program Data

- In 2003 and 2008, worked with an independent researcher who collects FBC Annual Progress Report Data to analyze the first ten and then 15 years of the program.

- Issued an analysis of APR data and environmental factors in Chicago and federally.
Demographics of participants (1993-2007)

**Race**
- 84% African American, 7% White, 8% Hispanic, <1% Other

**Household Type**
- 91% Single Female Headed, 6% Two Parent, 3% Single Male Headed

**Average Number of Children Per Family**
- 2.5

**Living Arrangements Prior to Program Entry**
- 82% Emergency Shelter, 4% Transitional Shelter, 5% Treatment Facility, 3% With Relatives, 4% Rental Housing
Demographics continued

**Primary Reasons for Services**
- 40% Domestic Violence, *40% had spent time in jail or prison, 35% Alcohol/Substance Abuse, 22% Insufficient Income

**Education Status at Program Entry**
- 64% of program entrants achieved either a high school diploma or a GED
FBC outcomes (1993-2007)

- **Housing**
  - 80% of program participants who completed program supported themselves in unsubsidized housing after program departure.

- **Income**
  - FBC participants experience an average monthly increase of 50% from program entry to program departure.

- **Housing costs as a percentage of income**
  - On average, participants spent 97% of income on housing costs at program entry.
  - On average, participants spent 45% of the income on housing costs at program departure.
Housing ready vs. housing First

- Income requirement
- Responsible for security deposit
- Work ready or assessed as having the ability to become self-sufficient within one year
- Sobriety requirements
- If survivor of violence, no contact with abusive partner
- Citizenship status sometimes an issue if applicant could not work
Standard service requirements

- Required groups and case management sessions
  - I.e. must attend a parenting group series within the first month of program and non-engagement could result in termination from program
- Maintaining lease compliance
  - If family had lease violations, the program could pursue termination from program
Chicago system changes

- Chicago’s evaluation tool for the NOFA process began prioritizing eligibility criteria, flexible service delivery and harm reduction.
- Tool reviewed number of departures for non-compliance with rules on APRs
- RFPs for bonus projects began focusing on harm reduction and approaches that facilitated access to housing.
PRIORITY #5: Housing First and Flexible Service Delivery: 7 points

1. Please provide a letter signed by the Executive Director outlining the intake and program retention criteria for the project. The letter must directly address the intake and program retention criteria questions (below in questions 2 and 3) for all questions where a response below is "yes". Please note, if reviewers find policies inserted for other sections of the Evaluation Instrument, that are contradictory to what is stated in Priority 4's submission, projects will not receive points.

2. Intake criteria: Please respond yes or no to the questions below:

<table>
<thead>
<tr>
<th>Intake Criteria Questions (1 point per question, 6 points possible)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Project accepts all clients regardless of length of sobriety and history of substance use. Project does not have a policy stating required treatment and/or days of sobriety to enter project.</td>
<td>Yes</td>
</tr>
<tr>
<td>b. Project accepts all clients regardless of mental illness. Project does not have a policy stating medication and/or treatment compliance is required to enter project.</td>
<td>Yes</td>
</tr>
<tr>
<td>c. Project accepts all clients regardless of criminal history or background. Exceptions for sex offenders, if dictated by law.</td>
<td>Yes</td>
</tr>
<tr>
<td>d. Project accepts all clients regardless of poor rental history or past evictions.</td>
<td>Yes</td>
</tr>
<tr>
<td>e. Project accepts all clients without regard to lack of financial resources.</td>
<td>Yes</td>
</tr>
<tr>
<td>f. Project accepts all clients with past non-violent rule infractions (does not bar clients).</td>
<td>Yes</td>
</tr>
</tbody>
</table>

3. Program retention: Please respond yes or no to the question below:

<table>
<thead>
<tr>
<th>Program Retention Question (1 point possible)</th>
<th>Response</th>
</tr>
</thead>
</table>
| a. Upon entry into the project, the project agrees to keep clients in the project despite any of the following (less than 30 days):  
  - substance use or mental health relapse/treatment intervention,  
  - brief hospitalization, and/or  
  - brief incarceration. | Yes | No |
Changing system priorities, changing model

Original Model
- Income
- Sobriety
- Work ready

Housing Stability at Exit

Adapted Model
- Harm reduction
- Flexible services
- Funder eligibility only

Housing Stability at Exit

Heartland Human Care Services, Inc.
Heartland Alliance Changes

- Development of a Philosophy of Care
  - Human rights
  - Strength-based assessment and intervention
  - Trauma-informed care organization
  - Harm reduction
  - Embracing differences
Heartland Alliance Changes

- Investment in Philosophy of Care “in action”
  - Practice Institute
  - Training tool-kits
  - Consultation groups
Philosophy of Care Fidelity Scale

- Families Building Community program staff and management committed to evaluating the program’s fidelity to the POC Core values.
  - policies and procedures
  - participant forms – rights and participation agreements
  - language
New FBC Model

- No additional eligibility criteria beyond HUD requirements
- Flexible service delivery
- Harm reduction, strength-based, trauma informed approach embedded into program expectations, policies & procedures
- Individualized services based on family need/interest
Changes in program operations

- Assessment for service needs, not program acceptance
- Services are individualized and based on family goals, not on a program-required timeline
- Adjustment in length of time in program – rather than an automatic 12 months, frequent evaluation of progress and continued need.
  - May be less than 12 months or up to 24 months
- Increased focus on outreach & engagement by staff
- If families struggle in housing, we move them to new units
Challenges of change process

- Staff reaction to change
- Managing anxiety around meeting outcomes and maintaining service flexibility/serving families with multiple barriers
- Enhancing skills and knowledge around “new” areas of services – criminal justice/corrections, young adults, serious mental illness, active substance use
- Balancing services and resources with varying levels of participant need
Service improvements

- Organizational capacity to engage families who have historically been “hard to house” with multiple barriers
  - Individuals with criminal justice backgrounds, serious mental illness, active substance use, chronic health conditions, young mothers with foster care experience.

- Improved cultural competency
  - Intentional increase in bilingual and bicultural staff to reflect families served and use of interpreting services when appropriate
Service improvements

- Focused training and professional development around issue areas such as harm reduction, mental health conditions, trauma, motivational interviewing and abuse and neglect prevention improved the skill sets of program staff.
- Result is confidence in adjusting services to the needs of any family and intentional targeting of the most vulnerable.
Service improvements

- Streamlined and improved landlord relationships and housing location services
- Improved capacity to move families to new units and negotiate out of leases when needed
- Led to a dedicated housing location team with our Homeless Prevention & Rapid Re-housing program
Service improvements

- Mainstream benefit screenings – staff SOAR-trained to assist with SSI/SSDI application process
- Addition of clinical staff as case managers for adults and children
- New focus on child development to improve child outcomes and family well-being
- Employment services that incorporate harm reduction and strength-based components
- Increased participant choice
Program level resources & tools

- Program policies and procedures that are consistent with program philosophies (strengths based, etc.)
- Focused staff development and supervision
  - Ongoing support with application of service philosophies and modalities
  - Managing anxiety around meeting outcomes and maintaining service flexibility/serving families with multiple barriers
Program level resources & tools

- Tools to assess service intensity of families and adequately balance caseloads with mix of high, moderate and low intensity households

- Participant-based service planning questionnaire
Organizational level resources & tools

- Practice Institute
  - Interview tools with vignettes to assess fit with Philosophy of Care values
  - Philosophy of Care In Action consultation groups
  - Training toolkits on each core value
  - CEUs offered for consultation groups and trainings
The Heartland Alliance Way
accountable contact, care, coordination, and contribution

Heartland Alliance Way out of Danger and Poverty

1. contact
- Relentless outreach and follow-up
- Identifies those most marginalized or vulnerable

2. care
- Person-centered engagement
- Recommends critical needs
- Comprehensive Care
- Direct services, with accountabilities for Heartland Alliance staff and program participants based on ACC plan

3. coordination
- Accountable Care Coordination (ACC) Plan based on primary and secondary needs
- Engages in advocacy
- Participation in a community group
- Contribution to others in need (food pantry, emergency fund)
- Joining a green team
- Joining a Heartland Alliance give-back group
- Mentoring and leadership

4. contribution
- Provides ongoing supports to people as they move to social and economic success
- Facilitates participants’ move from being helped to helping others

Heartland Alliance Way to Success

Safety Stability
Housing Stability Outcomes

- 72% of households maintained unsubsidized housing at program exit
- 15% of households exited to other subsidized housing (PSH, PHA, Chicago Low Income Housing Trust Fund)
- 13% of households exited to temporary situations with family/friends, jail, or shelter

(Families Building Community Program (1993-2011)
Program outcomes: FBC today

- Portfolio of 140 units
  - Added Permanent Supportive Housing, Shelter Plus Care and Chicago Low Income Housing Trust Fund Units

- Family Assertive Community Treatment Collaboration
  - Young mothers with children under the age of 5; prioritizing moms with mental health diagnosis, foster care history
  - HHCS is the housing partner and staffs a housing locator and case manager on the team.
System improvements and outcomes

- Funder support and advocacy
- Permanent Housing with Short-term Supports
  Centralized Referral System Pilot
  - Common application without program specific eligibility criteria
  - Start of Chicago’s coordinated entry process
    - Interim shelters trained and referring
System improvements and outcomes

- Permanent Housing with Short-term Supports as a bridge to permanent supportive housing or long-term subsidies
  - Working with City of Chicago and Chicago Housing Authority to identify vouchers for families only needing subsidy and minimal services and move them off PHwSS programs faster
  - Increased local discussions around targeting resources to prepare for HEARTH system outcomes and Plan 2.0
For more Information

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