



NORTH CENTRAL REGIONAL
MENTAL HEALTH BOARD, INC.

151 New Park Ave., Suite 14A, Hartford, CT 06106
info@ncrmhb.org WWW.NCRMHB.ORG (860) 667-6388

*Region IV Supportive
Housing Programs*

**Review & Evaluation
Report 2019**

Submitted To:
**The Department of Mental Health and
Addiction Services (DMHAS)**

Submitted By:
The Review and Evaluation Committee
at North Central Regional Behavioral Health Organization
and Marcia DuFore & Quyen Truong

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OUR REVIEWERS

The North Central Regional Behavioral Health Organization's (NCRBHAO's) Catchment Area Councils (CACs), now in our 46th year, continues to provide needed evaluation, education, and advocacy opportunities for the North Central region of Connecticut. Our members are people in recovery, family members, and service providers who are all passionate about our review and evaluation role and remain committed to our mission to serve as a voice for our communities. Below are our highlighted findings.

The following community members contributed to our Review and Evaluation Committee in 2018-19 by identifying programs to review, developing survey and focus group questions, serving as reviewers on site-visits, and giving feedback to our report:

- Stacey Brown
- Erica Bodden
- Alan Coker
- Susan Coogan (R&E Chair)
- Kathleen Douglas
- Denise Hart
- Jennifer Henry
- Catherine Kriss
- George LeBoeuf
- Larry Pittinger
- Sue Raggo
- Alice Seidenberg
- Noemi Soto
- Latosha Taylor

OVERVIEW

THE COORDINATED ACCESS NETWORKS (CANS)

The Federal Department of Housing and Urban Development (HUD) through the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act requires that any recipient of Federal Continuum of Care funds must implement a coordinated entry system for all persons experiencing homelessness. As such, the State of Connecticut's Department of Mental Health and Addiction Services (DMHAS) and Department of Housing worked with housing and homeless services providers and advocacy groups to collaboratively develop Coordinated Access Networks (CANS).

Through these CANS, service providers work together to streamline and standardize the process for individuals and families to access assistance. The primary goal is to help communities focus on rapidly ending each person's homelessness by connecting them with appropriate housing and resources as quickly as possible.

Coordinated access includes a standardized assessment and referral process to help people experiencing homelessness or a housing crisis access community resources within a geographic region. Individuals and families call the 2-1-1 Info-Line from anywhere in the state to begin the process. The 2-1-1 Info-Line staff will first try to divert people from shelters and housing programs if possible by connecting them to available resources to retain their current housing. But if the person has been chronically homeless and has a

serious behavioral health diagnosis, then the 2-1-1 Info-Line staff will refer this person to the CAN in the caller's community. People can also go to a Local Mental Health Agency (LMHA) to get help calling 2-1-1. The CAN accesses available resources to address the person's needs.

The CAN process has created a streamlined way for people in need of homeless services to access assistance. It has improved collaboration, communication, efficiency, and transparency between housing and homeless service providers. It has also improved service provision to persons experiencing homelessness through a client-focused, coordinated system. Characteristics of CAN include: 1) accessibility—the CAN is easy to use and well-publicized to the individuals and families experiencing homelessness; 2) standardization—the CAN offers the same process to everyone to access resources across communities, which is a single, shared assessment process across communities to understand client need and eligibility; and 3) accountability—communities develop shared oversight mechanisms including policies, monitoring, and improvement processes via the CANs.

SUPPORTIVE VERSUS SUPPORTED HOUSING PROGRAMS

This report focuses on supportive housing programs, which is distinguished from “supported” housing programs. In **supportive housing** (the subject of this review), each individual holds their own lease and is offered optional support services provided by DMHAS-funded providers. The individual's lease is subsidized by the U.S. Department of Housing and Urban Development (HUD) or the state Department of Housing Rental Assistance Program. For placement in permanent supportive housing (PSH) programs, everyone comes in through the Coordinated Access Network (CAN), by calling 2-1-1, or via community integration programs for individuals who are formerly incarcerated, like Capitol Region Mental Health Center (CRMHC).

Supported housing are residential, supervised apartments that offers a higher level of care. In contrast to supportive housing, supported housing does not go through the CANs. In this program, each individual holds a lease or sublease, and the agency holds a master lease for those individuals. Supported housing has mandatory services and both the housing units and services are paid for by the U.S. Department of Housing and Urban Development (HUD), HUD's program “Housing Opportunities for Persons with AIDS” (HOPWA), or State of Connecticut's Department of Mental Health and Addiction Services (DMHAS).

Housing for both programs include scattered sites and single sites. For scattered sites, supports go out to the units once a month on a client by client basis as needed, with a recommendation that meetings occur at least once a week. For single sites, case management is offered at the building where everyone is housed.

To transition out of supportive housing, individuals can apply to Section 8 or choose to live in other mainstream apartments. Once out of the supportive housing program, the individual can continue to maintain their own lease on Section 8 or other mainstream housing, but no longer has the services available via a dedicated case manager.

OVERALL PROGRAM THEMES

We reviewed one supportive housing program in each of our Catchment Areas, with the exception of Capitol Region Mental Health Center (CRMHC). Although CRMHC offers housing subsidies, they do not offer supportive services that accompany the subsidies.

During the course of our reviews, we kept hearing about the importance of housing and related supports to long-term recovery efforts. Supportive housing programs are a particular kind of program that offer supports to people at a federally-defined level of need, based on a defined diagnosis. The two requirements to get DMHAS supportive housing are 1) the person must meet HUD's definition of "chronic homelessness"¹ and 2) the person must have a "serious" mental health, substance use, or co-occurring diagnosis².

Our reviewers noted that the staff are on average about 30 years old, while the clients are on average about 60 years old. None of the residents we interviewed were younger than 35, and the majority – over 86% are over 45 years old (the largest group – 64% was in the 55-64 age bracket). One question that came up during the review is whether either group has mechanisms to learn how to work with folks from another generation.

All the supportive housing staff we reviewed were thoughtful and knowledgeable about community resources for recovery, tenant rights, and actively advocated for their clients or coached clients to handle landlord disputes. However, supportive housing is a small program with low turnover, and many people with behavioral concerns continue to struggle with chronic homelessness and thus cycle in and out of emergency care. Therefore, when individuals or heads of households call 211 for housing supports, there is an attempt to "divert" people from homelessness or from the need for shelter. Our reviewers were concerned that the CAN system offers only supports to people who meet HUD's definition of "chronic homelessness." As stated by one supportive housing provider we interviewed, "Supportive Housing is the only service offered by our agency that is not available through an internal referral process. All the people placed with our agency are sent to us by the CAN." In sum, while the CAN system offers certain efficiencies, many service providers and individuals facing homelessness struggle with HUD's "chronic homelessness" requirement and feel that this limits the flexibility to connect more people with necessary resources.

¹ HUD defines "chronic homelessness" as having been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least four separate occasions in the last 3 years, where the cumulative total of the four occasions is at least one year.

² Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

CONCLUSION

Throughout our review, we are reminded of a study we conducted in 2010 entitled “The Day in the Life” – featuring the experiences and stories of people with mental health issues. Here is a pertinent quote that continues to resonate with our review team.

“When I was homeless, you know, you are very vulnerable when you are out on the streets all day ... I was homeless for 3 years, now I have a place. I feel very ... it’s strange, you know, to be living normal again, to be in a house, a secure house. So, I am kind of learning to be a human, a dweller.” – East Hartford Resident

Recovery is a long-term process that can take months or years to address. In order to promote stability and recovery, we need to prioritize housing as a foundation for recovery. Given the progress that has been made ending chronic homelessness in Connecticut, it is imperative that more of DMHAS’s limited resources are reinvested into homelessness prevention. In other words, more services need to be available to those who do not meet HUD’s definition of “chronic homelessness,” to those who are not yet or who do not want to become homeless.

Cuts to the DMHAS budget for housing supports and services have resulted in significant gaps in the continuum of care for individuals served by DMHAS, some of whom struggle with significant mental health and substance use challenges. This includes people who need higher levels of care such as group homes, transitional housing, or supported housing (supervised apartments). This also includes individuals who are housing insecure. While there is no official definition of “housing insecure,” these services should be available for those who do not meet HUD’s definition of “chronic homelessness,” who are couch surfing, living in substandard housing, or spending up to 90% of their income on housing.

INTERCOMMUNITY PROGRAM REVIEW

OVERVIEW OF INTERCOMMUNITY

Intercommunity (IC) has a mission to help people improve their quality of life by providing physical, mental health and addiction services for optimum health and recovery. IC is unique as a FQHC-LA (Federally Qualified Health Center Look-Alike) that offers primary care and behavioral health services. Hence, they can connect clients with other specialty services as needed and when appropriate. For example, when their clients need dental services, IC can bring them to a local provider. IC aims to provide whole-person care.

CASA Hope is a housing program for the chronically homeless and follows the “Housing First” Model. The philosophy of the program is to provide quality housing to serve a foundation for recovery while meeting the client where they are at. The “Housing First” philosophy makes it unique to other housing programs and rent is based upon a percentage of client income. Clients are not required to engage in any services—they have the choice to pursue recovery with supports as needed. This allows them to work on their own recovery at their own pace without being at risk of losing housing. The client only has to meet with staff to complete annual recertification which covers any changes in income and to make sure their apartment still meets quality standards.

The program is stage-based meaning IC meets the clients where they are at in their recovery so at times motivation can be a barrier but not a disqualifier from the program. By far the biggest barrier is limited availability to income-based housing outside of this program. This means there are not enough affordable units for clients in the area.

People lose their supportive housing only if 1) they fail to complete their annual recertification, 2) if they break the conditions of their lease, or 3) if they are absent from their home for more than 90 days.

CASA Hope regularly works with other organizations including food banks/pantries, Bob's Discount furniture, DSS (security deposit, Medicaid and food stamps), local town halls, Social Security, faith based organizations, all in attempt to best support the client in their recovery. For the most part, IC has positive interactions with community organizations and interact often with many different landlords who are willing to help clients.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation Committee, comprised of CAC members across our region, conducted a site visit on April 22, 2019 at InterCommunity's office at 991 Main St., East Hartford, CT to review their Supportive Housing Program. Since the housing is in scattered sites, the review team was not able to see the housing. The Committee met with Supportive Housing residents and staff separately, in two focus groups, and then administered surveys to residents. Our key findings are below:

- **Merits:**
 - There were a number of long-term success stories. The residents who we spoke with have all been in the program for over 9 years.
 - The staff (Shawna) is friendly, encouraging, and will hold residents accountable so that they are more likely to meet their goals.
 - Excellent support: Numerous services are available to the residents including: help identifying a primary care physician and therapist, transportation to appointments, information about services clients can access to improve lives, help getting utilities set up in homes, substance use disorder support, food support and more.
 - Suitable housing: The housing consists of scattered sites so the review team did not actually see the condition of any units. However, most of the focus group participants described their housing as suitable. One person was particularly positive about her housing and landlord. All, but one participant seemed very pleased with the way their landlord responded to concerns.
 - Knowledgeable about residents' needs around maintaining housing.

- **Unmet Needs Noted:**
 - a. Everyone agrees that there is not enough good, quality, affordable housing in the area.
 - b. CASA Hope does not have resources for individuals who need a higher level of care than the case management services that accompany supportive housing. However, InterCommunity is a Local Mental Health Agency that has psychiatric and substance use supports, among other services that an individual can access as a member of the town in which they are residing. Therefore, an individual can also be referred to other statewide "higher levels of care" such as a group home if the need is indicated.

- **Concerns:**
 - a. One participant was not aware that her housing was permanent, as long as annual inspections were successful. She indicated that she did not truly unpack and get settled in her home for three years as she was concerned that she would be asked to leave.
 - b. There is clearly not enough adequate and affordable housing available. People complained of long waiting lists to receive housing. In addition, while it appears that the CASA Hope staff are very helpful in assisting people with transitional supports (e.g. setting up utilities, locating furniture and cooking supplies, etc.), getting utilities turned on in a timely manner can be challenging when people have past balances. Further, some landlords are unreasonable or unresponsive to needs. As stated in the previous meeting with staff, some landlords require that residents show income three times that of their rent, which is exorbitant.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Offer monthly networking meetings: Residents mentioned that InterCommunity once offered a monthly meeting where everyone could meet, connect, complete paperwork, learn about resources, etc. This meeting is no longer offered, but is missed.
- Offer incentives to maintain stable staff: Staff turnover is probably a challenge in many organizations, but both the staff and residents specifically mentioned this problem as significant at InterCommunity. Two of the focus group participants stated that they have had 5 to 7 different caseworkers since they've been with InterCommunity (approximately 10 years).
- Improve communications to residents Some participants stated that communication can be improved. When things change (e.g. changes in housing costs, meetings rescheduled, etc.) they are often not informed or informed late.
 - Residents stated that actively participating in caseworker services (e.g. substance use disorder counseling) was a requirement for maintaining housing. However, in the earlier discussion with staff, they stated that residents are not required to engage in any clinical services in exchange for housing. This disconnect seems to go along with the people's concern that communication needs to be improved.
- Improve outlets to share community resources: Some residents stated that community resources could be better communicated. One person specifically said that there are a lot of resources, services, information out there that the staff at InterCommunity either doesn't know about or is ineffective at sharing with residents.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

Advocate for more housing with policy makers and legislators. Housing is a constant barrier for our most vulnerable in many of our communities. Without a safe and affordable place to live, recovery can be very difficult. All of our community members deserve safe and affordable housing. This is one of the basic needs for success!

The definition of chronic homelessness currently requires the client to be homeless for 12 months (either consecutively or cumulative over 3 years) but there are so many clients that are struggling with shorter term homelessness that could benefit from additional financial and support services.

InterCommunity managers noted that people who are coming from a higher level of care, such as hospital or inpatient settings, struggle when they transition straight into supportive living services in the community. There are gaps in the continuum of care. Other types of residential care, such as group homes or supported housing do not exist in InterCommunity's Catchment Area.

Moreover, InterCommunity managers recommended that legislators should be made aware that any thoughts about increasing taxes could negatively impact our most vulnerable communities. For example, raising sales taxes or adding tolls could impact someone's already overburdened budget.

CHRYSALIS PROGRAM REVIEW

OVERVIEW OF CHRYSALIS

Community Supportive Housing Services is a “best practice” national model proven to end long-term homelessness through the “Housing First” philosophy. Housing is the most important basic need for the individuals we serve to gain stability. Chrysalis Center has provided supportive housing services for over twenty years.

In recent years, through the formation of the Chrysalis Center Real Estate Corporation, we have expanded to include our own housing development, building and owning single site projects, and providing all social services. Developing, operating and serving the residents has created a seamless system with the standards of excellence Chrysalis Center adheres to in all services.

Through the Supportive Housing program, residents are offered case management, employment services, entitlement connection, health and wellness services, connections to health insurance, primary care, crisis intervention, housing search, landlord and tenant rights education, fair housing education, lease compliance education, budgeting, life skills, navigating systems, and re-connection to natural supports.

Unique to Chrysalis is the access to wellness services, housing coordination services, and on-site employment and recovery services. Interagency collaboration takes place through the Greater Hartford Coordinated Access Network (CAN), via weekly case conferencing and through other collaborations with employment service agencies.

People lose housing if they are evicted multiple times from a unit and do not desire to be rehoused. Otherwise, it is very difficult to lose supportive housing. Discharge depends on each situation and participant motivation.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation Committee, comprised of CAC members across our region, conducted a site visit on March 14, 2019 at Chrysalis’s Cosgrove Commons, located at 815 Wethersfield Ave., Hartford. Cosgrove Commons is a newer housing development that is bright, well-maintained, and has laundry on-site. The facility has common spaces and is right on the bus line. The Committee met with Supportive Housing residents and staff separately, in two focus groups, and then administered surveys to residents. Our key findings are below:

- **Merits:**
 - Chrysalis has created a real estate arm called Chrysalis Real Estate Corporation (CREC), which develops units and fosters strong relationships with developers. This has led to a large capacity: 517 units.
 - Chrysalis offers a combination of scattered sites (individual units in the community) as well as agency-owned apartment buildings. The agency-owned

building shown to the review team was in excellent condition and was centrally-located on a bus line. Chrysalis provides on-site community case management services to tenants in agency-owned buildings and at scattered sites that are not Chrysalis owned as well.

- Supports offered include problem solving, social recreation, budgeting, intervention with landlords, medical transportation, parenting classes, home economic classes, help with paperwork to keep benefits, and access to Chrysalis's Recovery Empowerment Center (REC) which offers social and educational activities. Services are also offered to veterans.
- Laundry on-site at the single site in Hartford that the review team visited.

- **Unmet Needs Noted:**

- a. DMHAS funding is lacking and there has been a 5% cut across the board, so Chrysalis cannot expand its programs to meet the growing need of people who need housing. Over the years, Chrysalis has had great success developing relationships and offering advantages to developers who were willing to set aside a percentage of their housing units at affordable rates. Chrysalis was then able to offer supportive services to the tenants to ensure their success in those units. With the 5% cut in service dollars and reduction in bond funding, it has become increasingly challenging to secure those relationships with developers. In some cases, Chrysalis is not able to offer supportive services that make the relationship appealing to housing developers.
- b. The resident acuity level is higher due to chronic homelessness, so Chrysalis needs more service capacity. The optimal case load for staff is 15:1 but the average Chrysalis caseload is 24:1.
- c. Some staff noted lack of support from other agencies (i.e. Veterans Administration) and the need to develop resources internally rather than trying to coordinate with and rely on other agencies that have different priorities.
- d. Reviewers expressed sympathy for people struggling with homelessness, who do not qualify for supportive housing because they do not meet the stringent requirements of "chronic homelessness" that would enable them to access the Coordinate Access Network. Reviewers wanted clinical, social, and recreational programs to be available to people regardless of their housing status, and they expressed that some people in supportive housing may need more support than currently offered.
- e. Resident income limits, where people are concerned with having too much household income due to taking on additional jobs or where people are considering including a family into the household, means that people are disincentivized from working more and discouraged from inviting other friends and family from moving in.

- **Concerns:**

- a. The Supportive Housing does not address higher levels of care or people served by Chrysalis who are housing insecure.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Offer training for new staff regarding better use of community resources.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

As a follow-up to the site review NCRMHB staff met with Sharon Castelli, Chrysalis CEO, to talk about system concerns for addressing unmet housing and level of care needs. She had a couple of recommendations that she has shared with our new Governor: 1) work with housing authorities to ensure they are meeting the set aside requirements for persons with disabilities in their housing; and 2) work with individuals who are ready to transition to independent living with Section 8 or other mainstream subsidized vouchers and create program openings for people who truly need the supportive housing subsidies and support services. Ms. Castelli also reiterated her concerns with us about gaps in the care continuum for individuals who need higher levels of support than are available through supportive housing.

CHR-ENFIELD PROGRAM REVIEW

OVERVIEW OF CHR-ENFIELD

CHR-Enfield is one of the most underserved communities in terms of supportive housing in Region IV. Unlike CHR-Manchester, which contracts with HUD and has access to a lot of affordable housing, there is a dearth of available, affordable, rental housing units in Enfield, and there is a lack of funding in Enfield allocated to housing programs. Therefore, the area has a lot of people struggling to get permanent, affordable housing, and only a few have a case manager for supportive housing.

CHR-Enfield Supportive Housing assists individuals and families struggling with mental illness and homelessness to be housed in permanent, quality, lease-based, affordable housing. CHR endorses and utilizes a “Housing First” approach. The “Housing First” model is based on the belief that permanent, quality and safe affordable housing is an essential first step towards recovery for individuals with a mental illness. CHR believes a homeless individual’s or household’s first and primary need is to obtain housing. CHR staff work with identified clients to obtain permanent, quality, lease-based, affordable housing. Once housed, Supportive Housing Case Management helps tenants to maintain their housing and to work on their recovery.

Housing vouchers are provided by a local housing authority and case management and community support services focusing on barriers related to mental health, including a housing search, are provided to individuals who are considered chronically homeless and disabled by serious mental illness. People are at risk of losing housing if they are evicted; however, there are ways to avoid loss of a voucher if case management actively advocates for a resident.

CHR-Enfield maintains consistent communication with the Coordinated Access Network, doctors and other provider that are outside of CHR’s network, housing authorities, landlords, local social service agencies, and DSS.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation Committee, comprised of CAC members across our region, conducted a site visit on March 11, 2019 at CHR-Enfield’s office at 153 Hazard Ave., Enfield to review their “Next Steps” Supportive Housing Program. Since the housing is in scattered sites, the review team was not able to see the housing. The Committee met with Supportive Housing residents and staff separately, in two focus groups, and then administered surveys to residents. Our key findings are below:

- **Merits:**
 - a. Residents expressed a positive, strong connection to their community support specialist Aisha. They feel she genuinely cares and supports them.

- b. Supports offered include help with paperwork, medical appointments including transportation, problem-solving, and reassurance.
 - c. Aisha is clear about promoting residents' independence and has a plan to help them transition out of Supportive Housing into the Section 8 housing program.
 - d. The housing units were reported to be in good condition by residents.
- **Unmet Needs Noted:**
 - a. **Not enough housing units:** Enfield has a problem with finding enough landlords who can offer affordable units to people with behavioral health diagnoses. A lot of stigma and "not in my backyard" (NIMBY) mentality exists in the area, preventing the development of affordable housing units. There are only 14 Supportive Housing slots for all of CAC 17. It is difficult to finding housing for people with no income.
 - b. **Difficulty with accessing housing:** There appears to be low turnover of people in the Supportive Housing program. The only way people can get housing is to meet the HUD criteria for chronic homelessness while having a behavioral health diagnosis, and to go through 2-1-1's Coordinate Access Network (CAN). This is challenging for people who are unable to self-advocate.
 - c. **Available housing is not transportation-friendly:** most of the residents only have access to public transportation, and many of the housing locations were not located near any bus lines. This proved especially challenging in the winter and resulted in reliance on the community support specialist for transportation.
 - d. **Need more community support specialists:** Residents depend on their community support specialist to offer advice, coordinate social events, and help with landlord issues. Many do not have anyone else to rely on or call in case of an emergency.
 - e. Rent leaves people with little money left for necessities.
 - **Concerns:**
 - a. Some residents struggle with issues with landlords and property managers, and would benefit from some additional advocacy.
 - b. Residents may rely on Aisha, the community support specialist, too much. There would be a gap if she were to leave.
 - c. Transportation, especially medical transportation, is a big issue in Enfield.
 - d. Residents mentioned case workers (who play a different role from Aisha, the community support specialist) who are unresponsive and do not return phone calls.
 - e. Since Enfield has a paucity of housing and resists community efforts to develop affordable units, there is a shortage of housing. People come into respite, and do not have a place to go. Currently, CHR-Enfield can only house 14 people in its Next Steps program.
 - f. There is some work that needs to be done to repair CHR residents reputations with local landlords. Residents struggling with mental health and substance use disorders are known in Enfield for property damage.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Next Steps program supervisor should meet with residents to gather specific examples of the case worker not returning calls or following up. Perhaps conversations can improve this issue.
- Consider offering a mobile healthcare van for homeless individuals. The New Haven area has such a van and it has proven to be an effective way of ensuring that people get preventive care. The mobile van can provide some dental services, health services, social services, and can address transportation issues since it travels to different neighborhoods.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

- Work with CHR-Enfield to advocate for the development of affordable housing units in the area, including a CHR-owned single site. This will ease the reliance on private landlords who discriminate against people with behavioral health concerns.

CHR-MANCHESTER PROGRAM REVIEW

OVERVIEW OF CHR-MANCHESTER

CHR's mission is to help adults, children and families find Real Hope for the challenges of Real Life through an array of community-based mental health, substance use, child welfare, supportive housing, foster care, prevention and wellness services, and integrated care. CHR's name embodies our commitment to community-based care, instilling hope for a healthy, happy and productive future, and utilizing all available resources to achieve change. CHR is proud to provide services that achieve Real Quality with Real Results.

Supportive Housing assists individuals and families struggling with a mental illness and homelessness to be housed in permanent, quality, leased based, affordable housing. CHR endorses and utilizes a "Housing First" approach. CHR believes a homeless individual or household's first and primary need is to obtain housing. Once housed, Supportive Housing Case Management helps tenants to maintain their housing and to work on their recovery. CHR-Manchester is active with its local Coordinated Access Network to share resources and maintain partnerships.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation Committee, comprised of CAC members across our region, conducted a site visit on February 25, 2019 at CHR-Manchester's Center Street housing, located at 497 Center St., Manchester. Center Street is a relatively new housing development that consists of 2 well-maintained brick buildings. The facility has common spaces and is right on the bus line. The Committee met with Supportive Housing residents and staff separately, in two focus groups, and then administered surveys to residents. Our key findings are below:

- **Merits:**
 - a. Beautiful apartments – spacious layout and great windows – with proximity to services. Handicapped-accessible spaces.
 - b. People feel supported and respected in their homes.
 - c. On-site case manager. CHR supports are available, and the ACT team is close by.

- **Unmet Needs Noted:**
 - a. High turnover with case managers.
 - b. People feel the need for more help and advocacy with the property manager. Some residents felt that certain building issues were not fixed in a timely manner.
 - c. Lack of understanding about the connection between the two buildings at Center Street.
 - d. The Greater Hartford Coordinated Access Network is too large, so communication in the CAN is inefficient and difficult at times.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

- Perhaps some orientation materials or regular communications about available services would be helpful to some clients who miss the initial announcements. CHR-Manchester has responded that they give tenants handbooks that include resources and that staff organize frequent tenant meetings.
- Connect residents with resources or training to advocate with the property managers and to speak up about building concerns.
- Organize a CHR Open House to explain available CHR programs.
- Hire additional case managers and try to decrease turnover for current staff.
- Create a Memorandum of Understanding (MOU) for community meetings – to enable access to the Community Room for everyone. CHR-Manchester has responded that this MOU actually exists with the property manager, and that CHR staff will provide education around this so that all tenants are aware.
- Consider the development of an outdoor play area for children. CHR-Manchester has responded that there is an ongoing effort to secure funding for this play area.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

The review team should look into the impact of the cuts to DMHAS Supportive Housing funding and bond funds to assess our ability to address the housing needs of people in our region.

CMHA PROGRAM REVIEW

OVERVIEW OF CMHA

CMHA is a leading provider of an integrated health and behavioral health care system for children, families and adults. By fostering improvement in the quality of life for their clients, CMHA contributes to the well-being of the communities it serves.

As part of CMHA's commitment to assisting people to meet their individualized goals, CMHA values mutual respect, consistency, and a focus on individual strengths in our interdisciplinary approach. In addition, CMHA has committed to the Trauma Informed and Gender Responsive (TAG) Initiative where shared values of physical and emotional safety, Empowerment to achieve and be heard, Choice in treatment and life, Collaboration with one's treatment team and natural supports, and Trust in one's self and others are essential. CMHA offers a wide spectrum of client-centered, recovery-focused services that strive to be culturally and linguistically appropriate to assist our clients in reaching a state of wellness. We encourage and seek to build our clients' and their families' participation at every level of service. These services range from brief, educational interventions aimed at prevention, to residential facilities with twenty-four hour supervision for those needing a greater level of assistance.

CMHA's recovery planning approach is flexible, holistic, and collaborative. CMHA's integrated services are provided by highly competent professionals across varied mental health disciplines and tailored to meet each client's needs and goals. Decision-making is based upon clinical expertise, client values, CMHA core values, and evidence-based practices. Emphasis is placed on continuous quality improvement, by tracking outcomes and adapting best/evidence based practices to maximize the health and wellness of each person in treatment.

This program can fully pay for a resident's subsidy when they are unable to work (there is no income requirement). This program is embedded within CMHA services and residents have access to all integrated teams including outpatient services, in home care, case management, vocational, social club etc.

CMHA participates in the Coordinated Access Network process, attends various meetings to ensure collaboration. CMHA is also a leader on the Mayor's Task Force to End Homelessness.

SUMMARY OF KEY FINDINGS

Our Review and Evaluation Committee, comprised of CAC members across our region, conducted a site visit on March 13, 2019 at CMHA's office at 233 Main St., New Britain to review their Supportive Housing program. Since CMHA Supportive Housing operates from scattered sites, we were not able to view individual apartments. The Committee met with

residents and staff separately, in two focus groups and administered surveys to residents. Our key findings are below:

- **Merits:**

- a. Connection to multiple programs, offered by CMHA. The social club is the heart of the program, fostering friendship. The residents, while living separately in scattered sites, all seemed to know one another and are in contact with each other via fun activities at the social club. Several actively supported one another during the meeting.
- b. The location of the Supportive Housing office is beautiful and inspiring: ideal for instilling hope, recovery and creative supports. Program staff responsibilities are well managed and within a unified-team.
- c. Supportive housing under CMHA is about pro-active case management where residents are regularly visited and engaged with services and monitored in their routine living environments to identify and address gaps in self-sufficiency skills.
- d. Staff are seen as partners and are on equal footing with residents. There seems to be a close partnering and family atmosphere at CMHA – staff know each other’s clients, so that if one staff is absent, others can fill in. Clients trust the community of staff to address their needs.
- e. Some residents want more space for themselves and opt for two-bedroom apartments but then invite others to come and live with them, which can result in damage to the property or increased income to the household, which raises the rent. Therefore, CMHA staff encourage single people to find one bedroom apartments.

- **Unmet Needs Noted:**

- a. The program needs to expand its capacity to other members of the community. The fact that there is no program exit strategy for beneficiaries greatly limits the programs potential in the community.

- **Concerns:**

- a. Some people have no income and it can take a long time to qualify for benefits if at all.
- b. Program is at capacity.
- c. Residents need more notice from landlords if they are not going to renew leases.
- d. The Warmline shut down – this could mean either clients may not be fully aware of this service, may be afraid to place a call for the first time, or it could mean that everybody is happy where they are and don't currently need it.

RECOMMENDED ACTION STEPS

Based on the data collected, here are our recommended action steps:

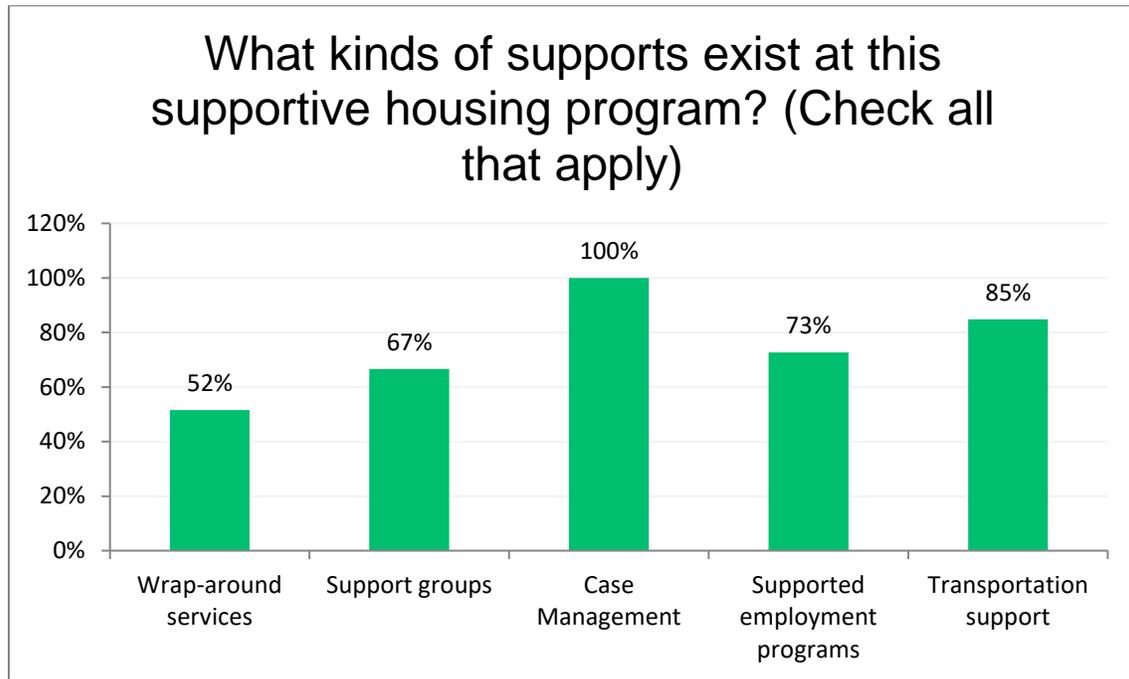
- Encourage staff to continue to teach residents about achieving more independence and possibly graduate from the Supportive Housing program and leaving case management, with the condition that they can ask for help in this area if they need it again, so case management can still be a safety net should it be needed.
- CMHA has effectively implemented an exemplary model for supportive housing and case management in general. Perhaps CMHA can share their excellent model with other similar programs.

NEXT STEPS FOR REVIEW AND EVALUATION TEAM

The review team should look into the impact of the cuts to DMHAS Supportive Housing funding and bond funds to assess our ability to address the housing needs of people in our region.

STAFF SURVEYS

These charts and graphs aggregate information from all the surveys administered to the supportive housing program staff that we interviewed across the North Central region in Connecticut. For individual program reviews, please contact our organization.



What could make this program better?

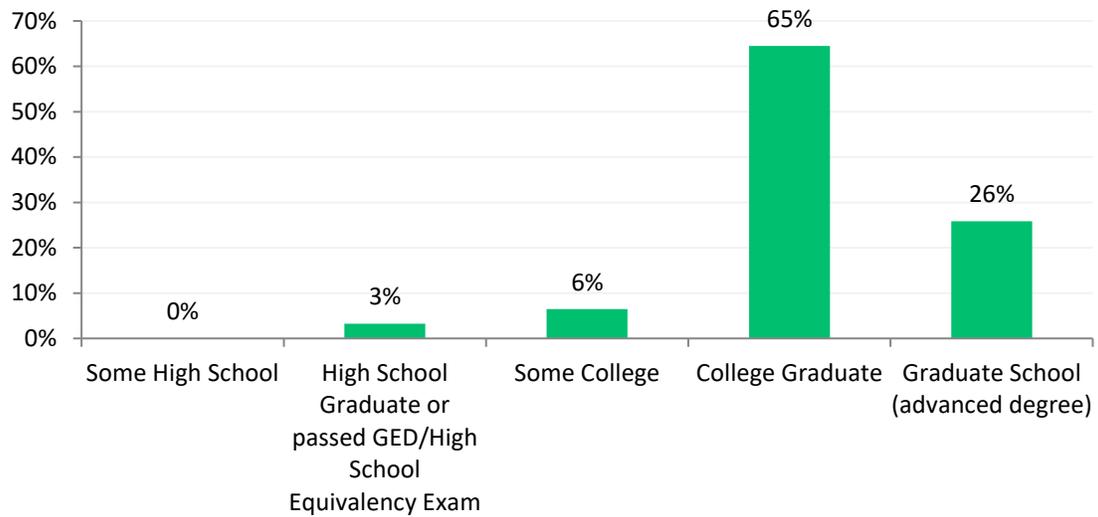
- Making engagement in service a requirement (*However, please note that this suggestion goes against “Housing First” principles, and that this suggestion came from one staff – this is not a philosophy that program management embraces)
- Additional supports for case managers
- More user friendly data systems and less time consuming documentation. This would allow for more time with the clients
- Less paperwork - more time with clients
- More user friendly systems (i.e. HMIS).
- More employment services specifically for people in permanent supportive housing
- Offering more on-site social events for the tenants to participate in with one another. Activities that could take place in the community room creating a more community like environment for tenants in both buildings.
- I think our program does a great job. Recently this agency has been doing as much as they can to make the program as efficient and as good as it can be.
- More connections with community resources.
- More consistent staff.

- Tighter rules
- Better training
- More specific individual expectations
- Required case management services, and increased supportive group activities in the community.
- Clients should have more accountability for things, possible requirements that is given to them to keep their housing. Example you have to volunteer or work part-time to keep your housing etc. (*However, please note that this suggestion goes against “Housing First” principles)
- Hands on groups
- Ways of incorporating more alternative programs and better eating habits.
- Holding participants accountable for themselves, despite their challenges and disabilities.
- Additional funding to allow case managers to project future purchases for clients who move into their first apartments to allow us to accommodate them.
- Cash fund to help tenants get things they need that they can’t afford on limited incomes dedicated transportation (not staff cars), cheaper or free transportation services
- Soft hand-offs between shelters and housing programs
- More close links to employment programs specifically for people who are in permanent housing.
- Less forms, more time for direct services
- Discretionary funds
- This program would be better serviced by having a pool of funds for client activities to help with getting them out into the community to broaden their community involvement. Also this program would be better served by having our current Program Manager be permanent for our program instead of being split among five programs. We would also benefit from having more groups throughout each month, funds would help this to occur. These things would help us to better the program as a whole.
- Requiring substance abuse treatment for all who are actively using drugs and alcohol (*However, please note that this suggestion goes against “Housing First” principles)
- Additional funding
- Having more group activities to increase participation in outside activities.

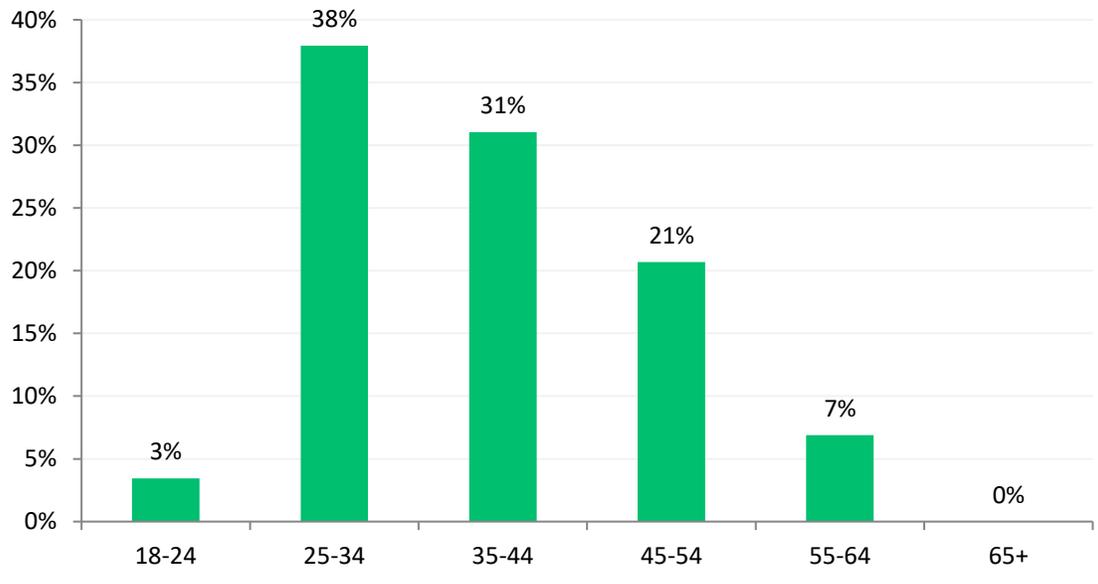
Your Ethnic, Racial, Cultural Background:

Answer Choices	Responses	
Asian/Pacific Islander	0%	0
Black or African American	41%	11
Hispanic/Latino	15%	4
White/Caucasian	44%	12
American Indian or Alaska Native	0%	0
Other (please specify)		3
	Answered	27
	Skipped	6

Which of the following best describes your level of education?



Age



Gender		
Answer Choices	Responses	
Female	90%	26
Male	10%	3
Other (please specify)		1
	Answered	29
	Skipped	4

Which of the following best describes your annual income?

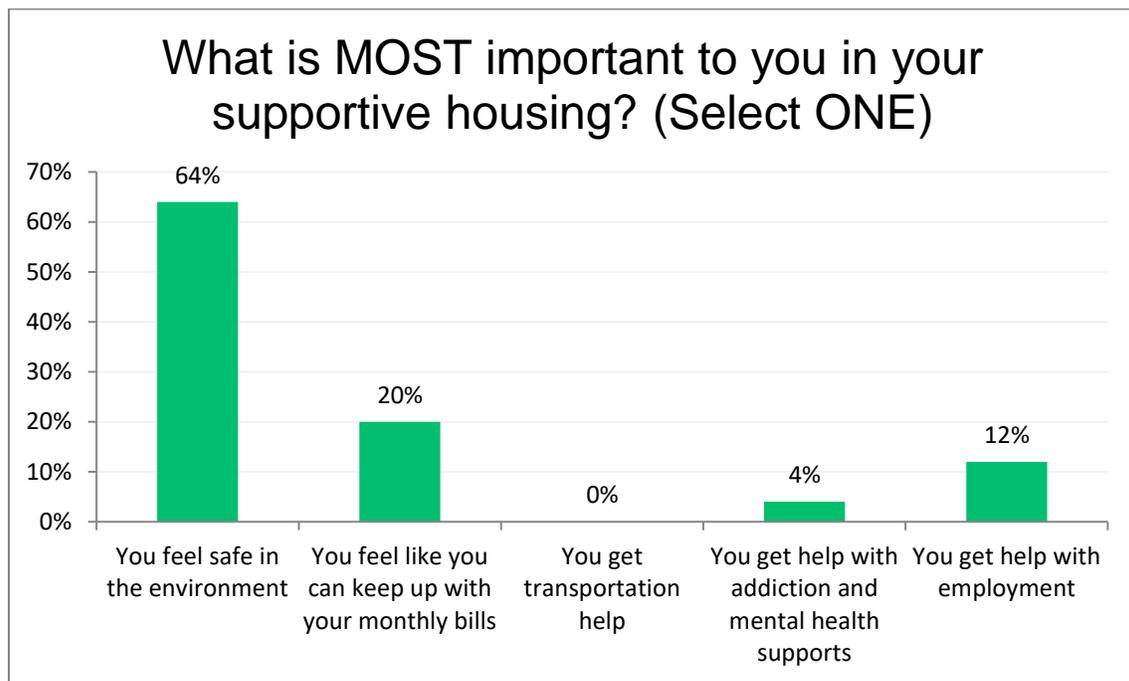
Answer Choices	Responses	
Under \$15,000	7%	2
Between \$15,000 and \$29,999	11%	3
Between \$30,000 and \$49,999	79%	22
Between \$50,000 and \$74,999	0%	0
Between \$75,000 and \$99,999	4%	1
Between \$100,000 and \$150,000	0%	0
Over \$150,000	0%	0
	Answered	28
	Skipped	5

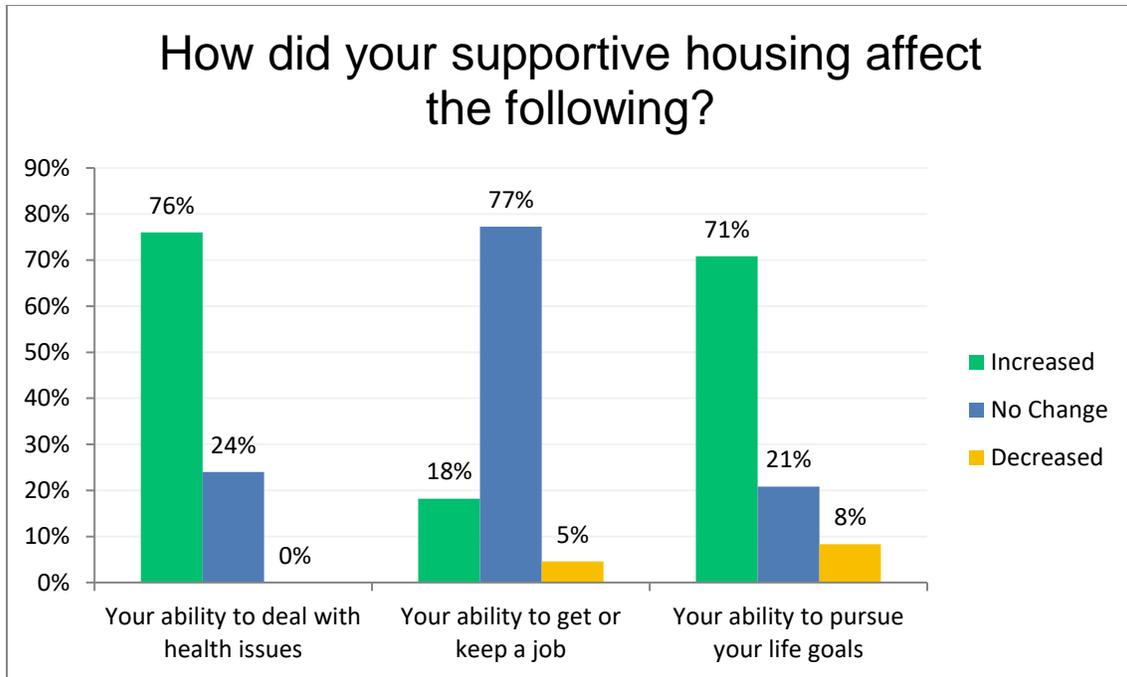
CLIENT SURVEYS

The following charts represent only clients who chose to participate in our client focus groups. Due to the small sample size, please note that these numbers are **not representative** of the entire client population at these supportive housing programs. The charts are included to give readers information about those who shared feedback for the report in our focus groups.

Our reviewers highlighted these interesting observations from this data:

- The majority of respondents have achieved a high level of education – 74% have completed high school or above and 43% of those we interviewed have some college education.
- None of the residents we interviewed were younger than 35, and the majority – over 86% are over 45 years old (the largest group – 64% was in the 55-64 age bracket).
- Supportive housing greatly increased residents’ ability to deal with health issues (76%) and to pursue life goals (71%), but did not impact the majority (77%) of residents’ ability to get or keep a job.



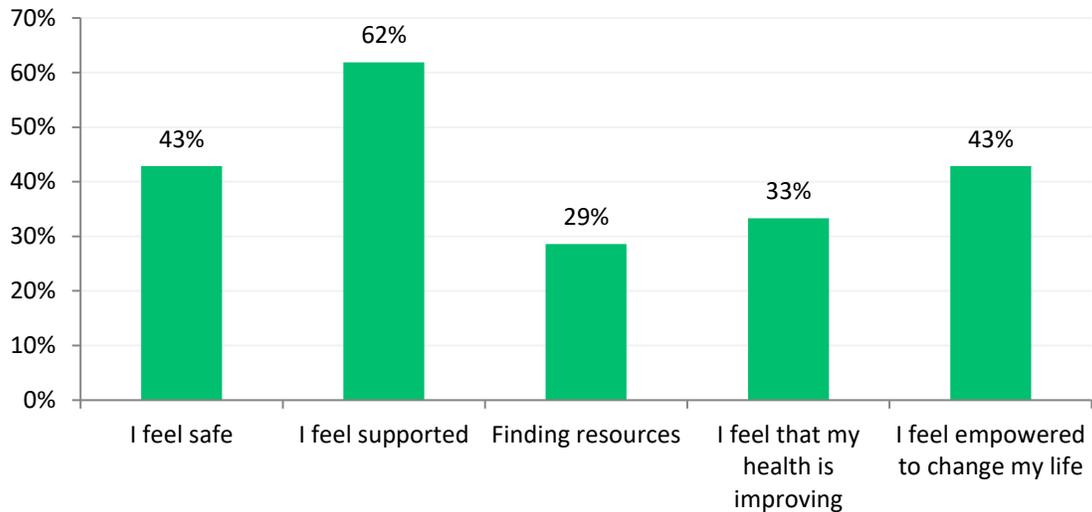


Supportive housing programs could be improved if... (Choose ONE)		
Answer Choices	Responses	
They have shorter waitlists	15%	2
There were more programs	38%	5
They offered supportive housing in other locations	54%	7
Other (please specify)		8
	Answered	13
	Skipped	14

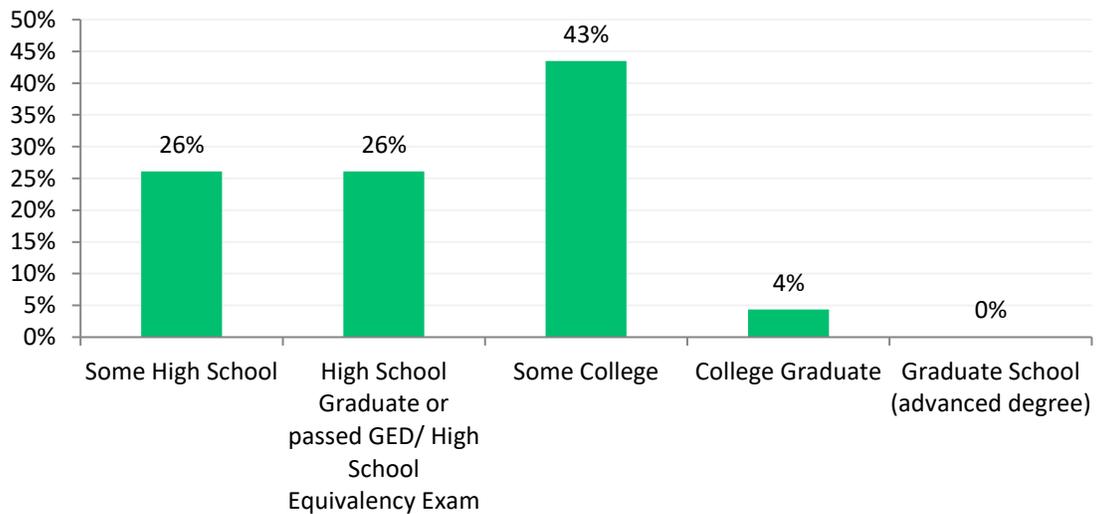
**Supportive housing programs could be improved if...*

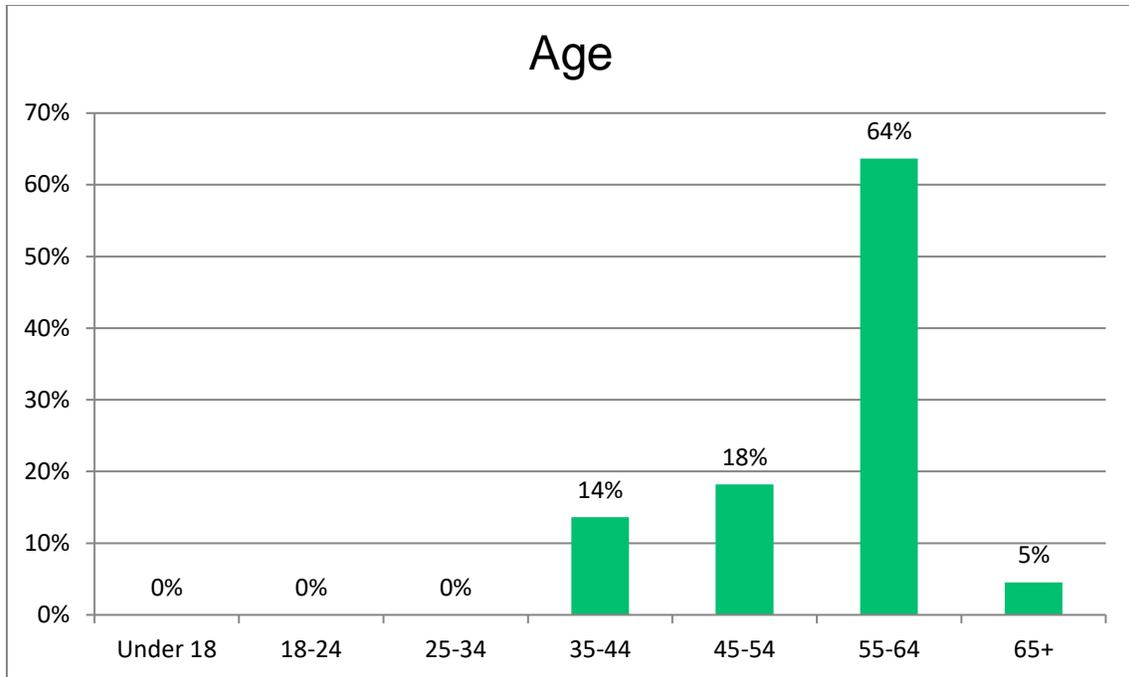
- It could provide emergency housing
- There was senior citizen housing
- It had support groups that offer jobs and communication skills
- There were more case managers
- All of the above
- If people were informed about the available programs and supports earlier in their recovery - I wasn't informed until 2017

Describe what you like most about your supportive housing program?



Which of the following best describes your level of education?





Your Ethnic, Racial, Cultural Background:		
Answer Choices	Responses	
Asian/Pacific Islander	0%	0
Black or African American	33%	8
Hispanic/Latino	4%	1
White/Caucasian	63%	15
American Indian or Alaska Native	0%	0
Other (please specify)		0
	Answered	24
	Skipped	3

Gender		
Answer Choices	Responses	
Female	62%	16
Male	38%	10
Other (please specify)		0
	Answered	26
	Skipped	1

COMPARISON DATA

These numbers are self-reported by the agencies.*

	InterCommunity	Chrysalis	CHR-Enfield	CHR-Manchester	CMHA
DMHAS Funding	100%	100%	100%	100%	100%
Capacity	18	517 total	14	20	88
Estimated unduplicated client count (FY 17-18)	20	21 in Hartford	18	21	88
Full Time Employees	1.25	18 across all programs	1	1	5
Part Time Employees	0	0	0	2	0
Peer Support Staff	0	0	0	1	0

Please note that the original formula of \$9,500 per year per client has decreased to \$7,500 per year per client. The cost of living adjustment (COLA) is additional.