Relationship of VCBH to Housing

- VCBH co-develops and coordinates appropriate housing for people living with mentally illness;
- VCBH partners with builders, property management companies, landlords & service providers;
- VCBH utilizes a variety of different funding sources to provide housing resources;
- VCBH employs “housing first” model;
- VCBH delivers evidence based services to clients.
Barriers to Housing for Homeless & Mentally Ill

- Rent is too high
  - Average monthly rent in Ventura County in 2020 is $2037*
- Lack of housing stock (vacancy rate currently less than 4%)
- Lack of supportive housing (NIMBYs, cost, politics)
- Lack of variety of housing (Board & Care / RCFEs)
- Mental illness makes finding & keeping a home challenging
- Stigma & unrealistic expectations of homeless & mentally ill – changing the meaning of success

* CA Housing Partnership 2020 Affordable Housing Needs Report
### Ventura County Area Median Income (AMI)

**Effective April 1, 2020 – The AMI for Ventura County for Single Household is $79,100**

<table>
<thead>
<tr>
<th>Person</th>
<th>30% Median (Extremely Low Income)</th>
<th>50% Median (Very Low Income)</th>
<th>80% Median (Low Income)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Person</td>
<td>$23,700</td>
<td>$39,550</td>
<td>$63,250</td>
</tr>
<tr>
<td>2 Person</td>
<td>$27,100</td>
<td>$45,200</td>
<td>$72,300</td>
</tr>
<tr>
<td>3 Person</td>
<td>$30,500</td>
<td>$50,850</td>
<td>$81,350</td>
</tr>
<tr>
<td>4 Person</td>
<td>$33,850</td>
<td>$56,450</td>
<td>$90,350</td>
</tr>
</tbody>
</table>

**Sample Salaries for Ventura County (salary.com)**

- Dental Hygienist: $80,000 per year
- High School Teacher: $71,000 per year
- Social Worker: $70,000 per year
- Police Officer: $60,000 per year
- Park Ranger: $41,000 per year
- Auto Mechanic: $18.30 per hour

**According to CA Housing Partnership 2020 Report on Housing for Ventura County, a household must have an income if $39.17 per hour or $81,473.60 annually in order to afford the average monthly rent of $2,037.**

Ventura County Behavioral Health
The behaviors and histories of VCBH clients coupled with the tremendous scarcity and high cost of housing in Ventura County create many challenges to successfully placing clients into appropriate housing and then keeping them there.

- 14 community based and governmental organizations in Ventura County providing a variety permanent supportive housing (PSH) options. Each has their own wait list, eligibility & application.
- VCBH manages about 250 units of PSH, including project based, tenant based & adult residential care. Some but not all of the PSH projects managed by VCBH require a referral from the County’s Coordinated Entry System (CES).
- All new funding for housing requires CES.
- Current wait list for non-CES VCBH housing is 10 years.
- VCBH clients are eligible to apply to the other 14 organizations for housing.
Clients engage with VCBH clinics for mental health treatment. All housing resources are accessed through the clinics via the treatment teams and the case manager.
Coordinated Entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. Fair and equal access means that people can easily access the coordinated entry process, whether in person, by phone, or some other method, and that the process for accessing help is well known.
How to Apply for Supportive Housing in Ventura County:
Ventura County CES:

Screening - Initial Contact with Customer

Pre-Screening

- Customer contacts for services
- Verbal ROI? over phone
- If refuses entry into HMIS, serve client and document outside HMIS

Client Eligibility Determination

- Homeless or at risk?
  - Yes
  - Collect data using assessment
  - Identity client housing need(s)
  - Run eligibility in HMIS
  - Potentially eligible?
    - Yes
    - Housing, Trans, or MHT
    - Referral
    - No
    - Referred to 211/other
    - Make referral for other service(s)

Program Determination

- Provides customer with referral information
- Informs customer of next steps & docs needed
- No
- Referral

Pathways to Home Project Care Manager

- Service transaction in HMIS
- City or region of person? (Yes/No)
- Number of MOHIST CalWORKST
- Service transaction in HMIS

HMS System

Ventura County Behavioral Health

9
And then...
Wait! There is more...
And finally...
Ventura County CES:

- Participant agency must pay into HMIS;
- Pathways to Home case conferencing;
- **All about the match**;
- No supportive services plan;
- VISPDT can be manipulated;
- Not always timely;
- No landlord engagement;
- No follow-up required.
New Method – Evidence Based Practice
Successfully housing someone with mental illness begins with appropriate placement.

**Phase I** has 4 steps as follows:

1) Entry into HMIS. A score of 10 or more on VISPDRT = referral to CES;
2) Completion of a Housing First Checklist;
3) Completion of evidence based assessment Milestones of Recovery Scale (MORS) to determine appropriate level of care;
4) Once housing is identified, Case Manager reviews SAMHSA’s evidence based “Tools for Tenants” with client.
Evidence Based Housing First Checklist

Compliance with Housing First principles as defined by the United States Interagency Council on Homelessness:
https://www.usich.gov/tools-for-action/housing-first-checklist/

1) Are applicants allowed to enter the program without income?
2) Are applicants allowed to enter the program even if they aren’t “clean and sober” or “treatment compliant”?
3) Are applicants allowed to enter the program even if they have criminal justice system involvement?
4) Are service and treatment plans voluntary, such that tenants cannot be evicted for not following through?
The MORS is evidence based practice that determines a consumer’s:

• **LEVEL OF RISK** (likelihood of harmful behavior & co-occurring disorders)

• **LEVEL OF ENGAGEMENT** (connection w/VCBH treatment team)

• **LEVEL OF SKILLS & SUPPORTS** (level of support needed to live safely in the community)

A score of 6 & above indicates client readiness for PSH.
A score of less than 6 results in a referral to treatment and/or Adult Residential Facility.
*There is a different MORS for older adults.*
SAMHSA’s Evidence Based Tool Kit for PSH

https://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4509
During the first month of being housed, the Case Manager will check in with clients at their new home once per week to review at minimum the following:

<table>
<thead>
<tr>
<th>WK1</th>
<th>WK2</th>
<th>WK3</th>
<th>WK4</th>
<th>New Tenant On-Boarding Weekly Review</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phone #s for assistance with unit, CM, RISE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Property rules – what is not allowed</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phone #s for CM, clinic and RISE</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Transportation resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Life skills (cleaning, hygiene, budgeting, shopping, cooking, etc...)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Participation in community events</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Assistance with benefits (EBT, SSI, Medi-Cal, etc...)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Disaster preparedness and emergency exit information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Substance use treatment or other health needs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ask client if they have questions or concerns</td>
</tr>
</tbody>
</table>
Supportive services & treatment are voluntary.

- Client refuses services once housed
- Attempt to conduct & document scheduled on-boarding visits (outreach)
- Notify property management to contact clinic if problems arise
- On-boarding fails & client decompensates
- ACT intervention by clinical team to address symptoms
- If housing status is threatened, contact VCBH Housing Manager
Assertive Community Treatment (ACT)

ACT programs rely on multidisciplinary teams of professionals with expertise in psychiatry, nursing, social work and substance abuse treatment, and employment counseling. A small staff-to-patient ratio allows for individualized and comprehensive care.

What would Rhonda do?
Phase III: On-Going Supportive Services

- Encourages regular interaction w/CM
- Supports client’s social ties to community
- Fosters sense of belonging
- Promotes peer support activities
- Creates opportunities for modeling positive norms
- ACTIVELY COMBATS ISOLATION
Establishing rapport with property managers & landlords is crucial to successful housing retention. Building a relationship will ensure:

- VCBH is notified right away if there is a problem
- Creates opportunity to educate about Housing First
- Supports consistency with issuing lease violations
- Provides opportunity for other PSH tenants
- On-going clarification of roles and responsibilities
- Allows for discussions around reasonable accommodation
Phase V: Evaluation

Some of the things we look at when measuring outcomes for evidence based practices in PSH:

• Time in PSH *measured in months*
• Symptom relief & over-all well being *measured by an improved MORS score*
• Socialization & integration into the community *as measured by none or reduced lease violations/complaints*
• Satisfactory personal care & independent living skills *as measured by observation & reduced need or frequency of services.*
# Phase V: Evaluation

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Focus Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathways to Home Screening Assessment</td>
<td>Client Demographics</td>
</tr>
<tr>
<td>Vulnerability Index-Service Prioritization</td>
<td>History of housing, risks, etc.</td>
</tr>
<tr>
<td>Decision</td>
<td></td>
</tr>
<tr>
<td>Time in PSH</td>
<td># of individuals housed &amp; time housed</td>
</tr>
<tr>
<td>Socialization &amp; integration</td>
<td>Less violations/complaints, etc.</td>
</tr>
<tr>
<td>Personal &amp; independent living</td>
<td>Observation &amp; reduced frequency of services</td>
</tr>
<tr>
<td>MORS*</td>
<td>Level of recovery</td>
</tr>
<tr>
<td>Behavior and Symptoms Identification Scale-24 *</td>
<td>Behavior &amp; symptoms</td>
</tr>
<tr>
<td>Treatment Perception Survey*</td>
<td>Treatment satisfaction</td>
</tr>
</tbody>
</table>

*VCBH Outcome Assessments
THANK YOU!

QUESTIONS?