



Housing and Justice-Involved

June 26, 2019

Housing Instability Webinar Series

| | | |
|--|------------------------------|--|
| Part 1: The Intersection between Health and Housing | Wednesday, November 14, 2018 | Click here to view webinar |
| Part 2: Navigating the Shelter System | Wednesday, December 12, 2018 | Click here to view webinar |
| Part 3: Permanent and Supportive Housing | Wednesday, January 16, 2019 | Click here to view webinar |
| Part 4: Affordable Housing | Wednesday, January 30, 2019 | Click here to view webinar |
| Part 5: Eviction Prevention | Wednesday, February 20, 2019 | Click here to view webinar |



Developed in partnership
with 1199SEIU Training
and Employment Funds



Upcoming Housing Workshop

Housing and Substance Use

July 2019 – Date TBD

All are welcome to attend.

Limited seating for each workshop.



| Workshop Agenda | Facilitator(s) | Time |
|--|----------------|-------------------|
| Check-In & Introductions | Patricia | 9:00am – 9:10am |
| Overview of Homelessness and the Justice-Involved Population | Bonnie | 9:10am - 9:30am |
| DOHMH Overview of Housing Initiatives & Accessing Supportive Housing | Rebecca | 9:30am – 10:00am |
| Break | All | 10:00am – 10:10am |
| Engagement Strategies & Partnering with Healthcare Systems | Carolyn | 10:10am – 10:30am |
| Q&A / Open Discussion / Case Discussions | All | 10:30am - 10:50am |
| Evaluations | All | 10:50am – 11:00am |

Learning Objectives

Attendees will be able to:

- Describe the prevalence of homelessness among justice-involved individuals
- Learn about DOHMH initiatives to house this population
- Learn about housing programs and how to access them
- Identify strategies on engaging justice-involved individuals around their housing needs

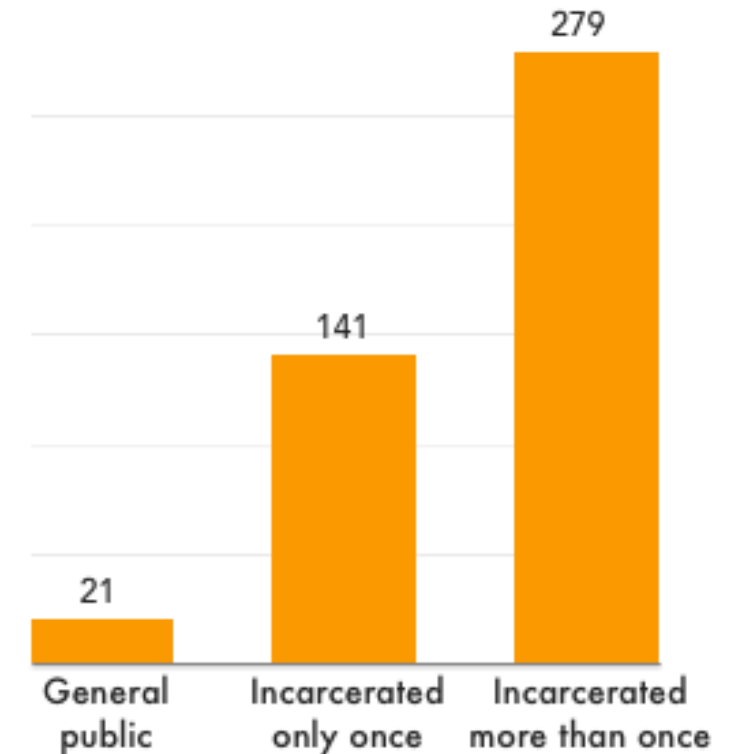


Justice-Involvement and Homelessness

- Formerly incarcerated people are **almost 10 times more likely to be homeless** than the general public¹
- Rates of homelessness are highest for:
 - People who have been incarcerated more than once
 - People recently released from prison
 - People of color and women
- Women are more likely to be homeless than men but men are more likely to be unsheltered homeless

The revolving door of prison contributes to homelessness

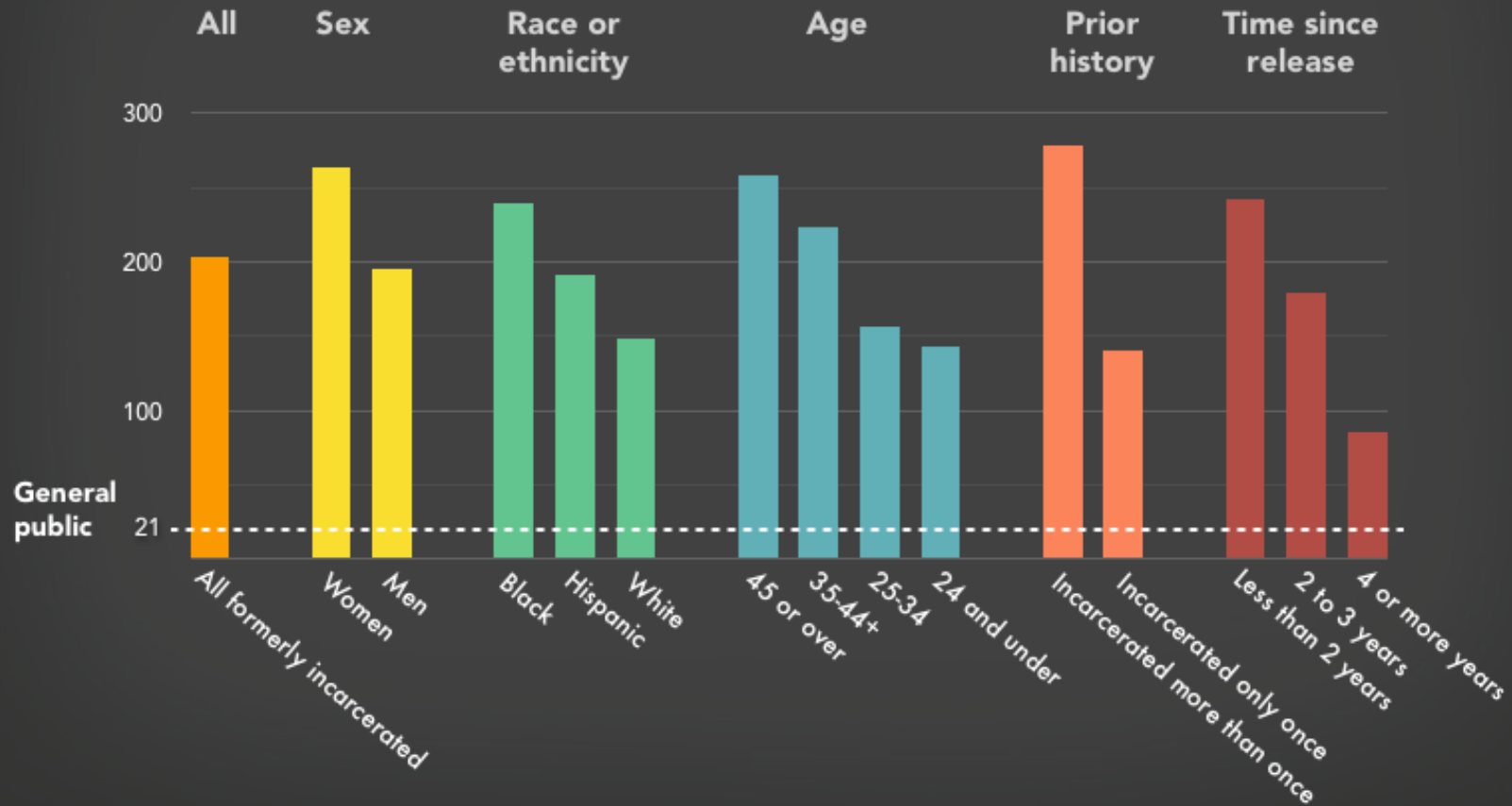
Number of people experiencing homelessness in 2008, per 10,000 population



¹ Nowhere to Go: Homelessness among formerly incarcerated people
<https://www.prisonpolicy.org/reports/housing.html#raceandgender>

Homelessness rates among formerly incarcerated people

Number of homeless per 10,000 formerly incarcerated people in each category, compared to the general public in 2008 (the most recent year data for formerly incarcerated people are available)



PRISON
POLICY INITIATIVE

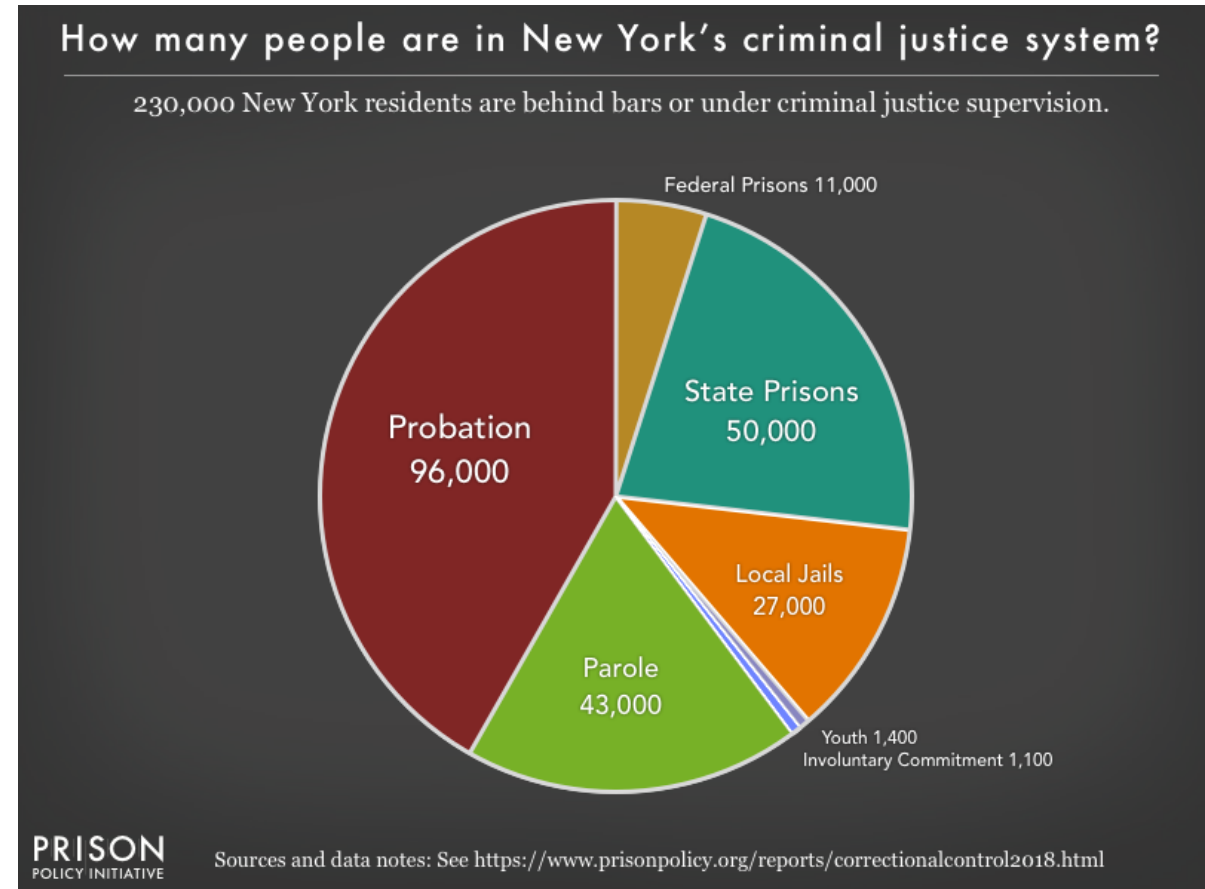
Sources & data notes: <https://www.prisonpolicy.org/reports/housing.html#methodology>

| HOUSING INSECURITY | | |
|--------------------------------|------------------------|--|
| HOMELESSNESS | | |
| Unsheltered Homelessness | Sheltered Homelessness | Marginal Housing |
| Homeless or no fixed residence | Living in a shelter | Living in a rooming house, hotel, or motel |
| 105 per 10,000 | 98 per 10,000 | 367 per 10,000 |

- 203 out of every 10,000 formerly incarcerated people were homeless, nearly three times as many - 570 out of every 10,000 - were housing insecure.
- Hispanics were more likely than people of any other race to live in marginal housing.

Justice-Involvement and Homelessness in NYC

- 230,000 New Yorkers are are of the criminal justice system¹
- **One in five entrants to the shelter** system now comes directly from a State prison, up from one in 10 just four years ago.²
- Individuals with **mental illness return to jail nearly twice as fast** as those charged with similar crimes but who do not have mental illness.³
- People with mental illness are **12.5 times more likely** to die or come into contact with emergency room services in the first few weeks after their release.⁴



1 https://www.prisonpolicy.org/graphs/correctional_control2018/NY_correctional_control_2018.html

2 <https://www.coalitionforthehomeless.org/wp-content/uploads/2018/03/CFHStateoftheHomeless2018.pdf>

3 <http://citylimits.org/2011/10/25/mayors-panel-aims-to-end-the-illness-to-incarceration-pipeline>

4 <http://archive.vera.org/sites/default/files/resources/downloads/treatment-alternatives-to-incarceration.pdf>

Resources

- [Reentry Resource Center: New York](#)
 - [People's Guide to the Consequences of Criminal Proceedings](#)
 - [Housing and Reentry](#)
- Organizations serving those who have been incarcerated:
 - [The Fortune Society](#)
 - [The Osborne Association](#)
 - [CASES](#)
 - [Center for Court Innovation](#)
 - [Legal Services NYC](#)
 - Legal Assistance Hotline is open Monday through Friday from 10am to 4pm.
 - Call 917-661-4500 to speak to an intake officer in any language.

Defining Supportive Housing

Targets households
with barriers

Is affordable

Provides tenants with
leases

Engages tenants in
voluntary services

Coordinates among
key partners

Connects tenants with
community

NYC Coordinated Assessment and Placement System (CAPS)

- CAPS is NYC's initiative to meet the HUD requirement of Coordinated Entry to ensure we are serving the most vulnerable clients and placing them into permanent housing
- Beginning with PSH but intent is to expand to other types of housing
- HRA leading CAPS development in PACTWeb
- Coordinated Assessment Survey is the entry point to CAPS
 - Universal assessment tool to determine potential eligibility for housing and/or rental subsidies
 - Required before beginning 2010e
- Standardized Vulnerability Assessment (SVA) prioritizes people as High, Medium or Low based on Medicaid utilization, systems contacts, and functional impairments

Coordinated Assessment Survey

- Universal assessment tool to determine potential eligibility for housing and/or rental subsidies
- Available to all users of the PACT system
- Required before beginning a 2010e at CHS sites, HASA centers, Street Homeless Solutions outreach teams and DHS single adult assessment and program shelters
- Developing an implementation plan for family shelters, a pilot in DV shelters and including new Rapid Rehousing (RRH) programs

Standardized Vulnerability Assessment (SVA)

| Category/ Vulnerability | Medicaid Service Utilization within the past year | OR | # of System Contact and # of Functional Impairments within 2 years |
|----------------------------|--|----|---|
| High | Top 5% of Medicaid Utilization | | At least 3 System Contacts <u>and</u> 3 Functional Impairments |
| Medium | Between 55% and 95% of Medicaid Utilization | | At least 2 System Contacts <u>and</u> 2 Functional Impairments |
| Low | Below 55% of Medicaid Utilization | | At least 1 System Contact <u>and</u> 1 Functional Impairment or NONE |



Office of Housing Services

Division of Mental Hygiene

Bureau of Mental Health

Rebecca Sievers, MA/MPA

Bureau of Mental Health

Vision: All New Yorkers achieve their desired optimal mental health, so that they can thrive individually, with others, and within their communities.

Mission: To provide services, resources and opportunities that promote mental health and wellness for all New Yorkers by acting early, partnering with communities, and changing the culture around mental health using accurate, data driven information to address disparities that have arisen from long-standing societal injustices.

Values: We encourage the elimination of racial and socioeconomic disparities by:

1. Providing quality, recovery-oriented services that help people meet their needs and goals.
2. Providing linguistically and culturally appropriate services.
3. Promoting autonomy and independence for all people with mental illness

Bureau of Mental Health

- The Bureau of Mental Health is responsible for mental health service delivery to New York City's mental health consumers.
- Through contracting directly with NYC service providers, the Bureau is responsible for developing, procuring, and overseeing over \$200 million of treatment, rehabilitation, housing, care coordination and advocacy programs; and managing the Assisted Outpatient Treatment program.
- Other Initiatives:
 - NYC Well
 - NYC Safe
 - ACT/FACT
 - Mural Arts Program
 - NYC Behavioral Health Tobacco Cessation Center.

Office of Housing Services

- **The Office of Housing Services (OHS) promotes housing solutions for formerly homeless individuals, families and young adults with mental illness and/or substance use disorders. It provides contract oversight to more than 200 permanent single-site and scattered-site supportive housing programs throughout the city.**

The Need for Supportive Housing

- Recovery from a serious mental illness or substance abuse disorders is difficult without safe and reliable housing
- Supportive housing empowers clients and is a vital part of recovery for individuals living with mental illness
- People who are living with a severe mental illness often need:
 - Assistance in accessing safe, affordable housing
 - Support and services that ensure success

Supportive Housing -

Proven Cost-Effective Solution to End Homelessness

- Without a stable place to live and linked support services, many people with SMI cycle between the streets, shelters, jails, hospitals and detox centers
- Thus, it is less costly to provide permanent housing than to expend resources on emergency care and shelter

Supportive Housing in New York

- Licensed SOMH Housing
 - Transitional Living 18-24 Months
 - Congregate or Scattered Site (Apartment Treatment)
 - Supported SRO's
- Non-Licensed Housing (SOMH and DOHMH)
 - Congregate-often integrated with community units
 - Scatter Site-agencies in agreement with private landlords sublease units to formerly homeless tenants.
- Temporary Housing
 - Parachute—short term crisis stabilization

Supportive Housing

- Permanent, affordable housing (both single site buildings and scattered site)
- Tenants have a lease and pay rent (30% of income)
- Services are voluntary
- Mixed populations in buildings

Services Provided in DOHMH Supportive Housing

- Case management
- Educational, vocational and other recovery-oriented services
- Assistance in gaining access to government benefits
- Referrals to medical services, mental health care and treatment for drug and alcohol use
- Recommendations for other needed services, such as legal support

Accessing Housing

- Eligibility Criteria

- Individual or family that is
 - Chronically Homeless
 - Serious Mental Illness (SMI) and/or Substance Use Disorder (SUD)
 - Sub populations of young adults at risk of homelessness

- Application

- HRA 2010e must be completed
 - Contact Center for Urban Community Services (CUCS)
 - (212) 801-3333 - ask for a Housing Consultant
 - <https://www.cucs.org/housing/housing-resource-center/>

- Information and Resources

- [Center for Urban Community Services \(CUCS\)](#)
- [Supportive Housing Network of New York \(SHNNY\)](#)
- [New York City Department of Housing Preservation and Development](#)
- [New York City Department of Homeless Services](#)
- [New York State Homes and Community Renewal](#)

JUSTICE INVOLVED SUPPORTIVE HOUSING (JISH)

JISH is a unique approach to supported housing for individuals who frequently cycle through jail and shelter in NYC

- Need recognized among city agencies providing services
- Use of existing supported housing model (with enhanced services)
- Emphasis on using existing data and cross system collaboration
- Current data

“A Fresh Take on Ending the Jail-to-Street-to-Jail Cycle”

<https://www.themarshallproject.org/2017/05/10/a-fresh-take-on-ending-the-jail-to-street-to-jail-cycle>

The Marshall Project, 5/10/2017

Demonstrated Need

- 2014 Behavioral Health Task Force Findings
 - Need to reduce Jail population
 - Increase in persons with mental illness from 29% - 38%, 7% have serious mental illness
 - Of those most frequently returning, almost all had substance use disorder
 - Recommendations included prevention, treatment and housing
- Hotspotter Study
 - 800 of those who returned the most
 - Older
 - More likely to have SMI, SUD and to experience homelessness
 - Recommendations included supportive housing

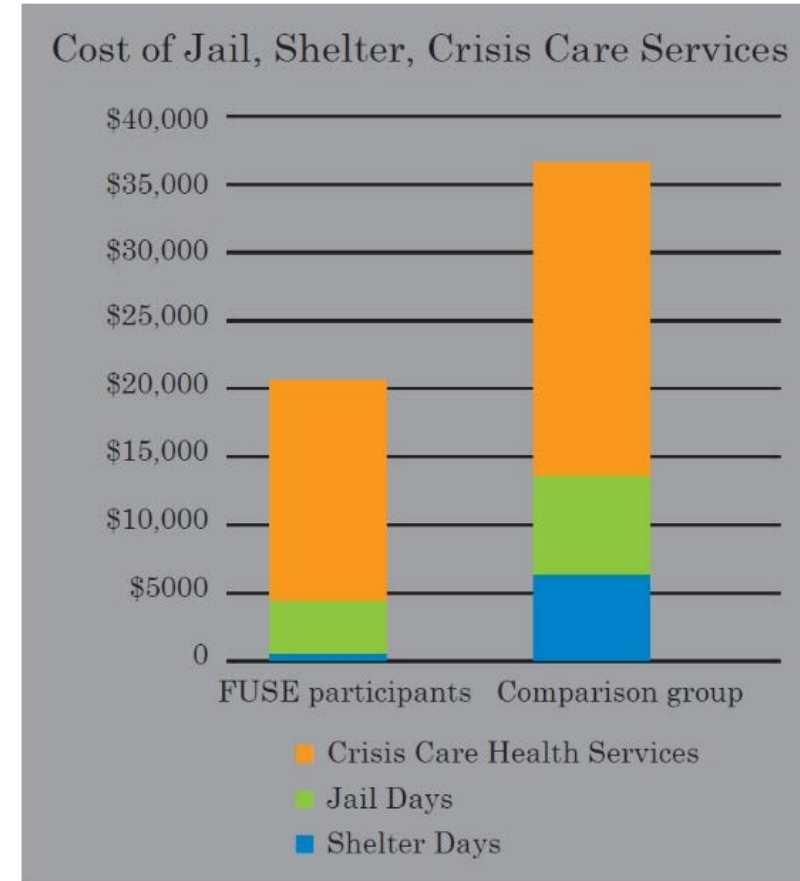
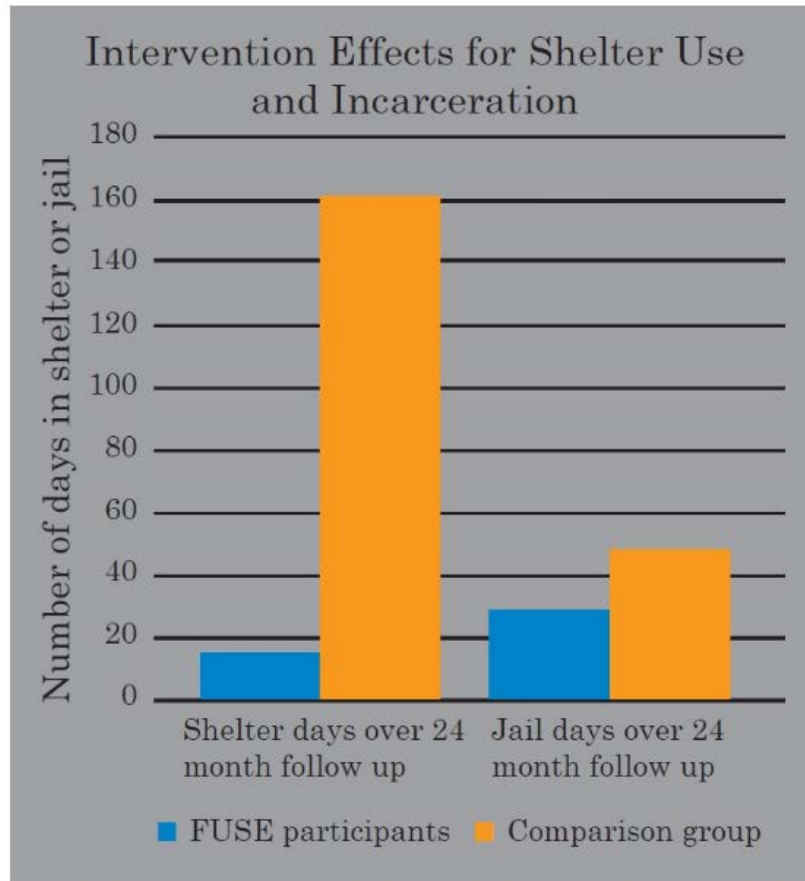
Using an Effective Existing Model

Frequent User Service Enhancement (FUSE)

“... permanent supportive housing as a key component of reentry services for persons with recurring experiences of homelessness and criminal justice involvement will improve their life outcomes, more efficiently utilize public resources, and likely save costs in publicly funded crisis care systems, including emergency medical, mental health and addiction services.”

- Launched by Corporation for Supportive Housing, NYC Dept. of Health and Mental Hygiene, Dept. of Corrections and Dept. of Homeless Services
- Eligibility Criteria: 4 jail stays and 4 shelter stays over 5 years
 - Some additional criteria for individual providers

FUSE Evaluation



Justice Involved Supported Housing (JISH)

Designed to:

- Decrease shelter use
- Decrease jail stays
- Decrease use of emergency and hospital services
- Decrease criminogenic behavior

NOTE: Current JISH is scattered site housing – tenants live independently in the community.

Services assist tenants to:

- Successfully manage their own home and live independently in the community
- Increase problem solving ability to avoid further interaction with the criminal justice system
- Address legal issues
- Improve physical and mental health through linkage to resources in their community
- Increase financial self-sufficiency by connection to employment or educational programs
- Identify personal goals and develop strategies to achieve those goals

JISH Program Snapshot

- Capacity = 120 beds
 - Currently at capacity
- 3 service providers
- Scattered Site Units
- Services are more specific in nature than other SH models
- New RFP will include 90 units Congregate and 60 units Scattered Site

Admission Process – Rapid Housing

- Standard NYC supportive housing eligibility determination process not required
- MOCJ created data match of highest users of jail and shelter
 - 200 individuals randomly selected
 - Referrals are not accepted – individuals must be on the list
 - DOHMH and providers worked with DSS and Correctional Health to locate persons on the list
- Low threshold admission criteria – people do not have to be sober or in treatment
- Must have a mental illness or substance use disorder as evidenced by self report, previous documentation, or screening
- Must be eligible for SSI/SSDI, public assistance or have employment
- NO application process

Current JISH Snapshot

- Demographics

- 83% Male
- 48% 50+ years old, just 1 under 30
- 61% Black, 28% Latino
- 43% less than HS, 38% HS Diploma
- 60% have SUD, 50% of those engaged in services
- 33% have mental health condition, 50% of those in treatment
- 75% engaged in program services

* Data collected in DOHMH Maven System and is from 3d Quarter FY19. Percents are averages across 3 months.

Current JISH Snapshot

- For individuals housed one year or more:
 - 70% have had no overnight hospitalization
 - 60% have had no ER visit
 - 36% have had no arrests
 - 74% have remained in housing

Working with JISH Tenants

- Communicate with the housing program
 - Know who the case manager and program director are
 - Bring housing staff into discharge planning early on
- Recognize the relationship between extensive contact with institutions, institutional and structural racism, and health equity
 - Structural racism and health inequities in the USA: evidence and interventions:
<https://www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2930569-X>
 - Principles of Community Based Behavioral Health Services for Justice Involved Individuals:
<https://store.samhsa.gov/system/files/sma19-5097.pdf>

Engagement strategies

Fortune Society- JISH Program

Techniques

- Introduction - A key element to provide a possible level of comfort for the client.
- Information – Explain the program in detail and allow the client to understand what supportive systems are available through internal referrals and external providers.
- Acceptance – Be inquisitive and ask questions regarding fears of being housed, (ex: “what are some of the concerns with accepting housing?”).
- Assessment – Promoting engagement through thorough assessment and treatment planning.
- Placement - Acclimate the client to his/her new community

Team Approach

- 2 Member team
 - 1 Recovery Specialist
 - 1 Case Manager
- 4 contacts per month
- Referrals to Fortune Society services or outside provider
 - Mental Health Treatment
 - Substance Use Treatment
 - Medical Treatment
 - Single Stop
 - Employment Assistance/ Vocational Training
 - Educational Services

Referral Process

- Identify the clients individual services needs that may require a referral
- Discuss with the client how beneficial the referral would be towards their overall “WELLNESS” (diagnosis, treatment etc.), goals.
- If possibly, identify a referral source, that is in close proximity of the clients community.
- Complete the application process
- Follow-up (status of application, length of process
- In order to maintain a collaborative effort of treatment , build a healthy rapport with the referral source.

Partnering with Health Care Service Providers

- Health Insurance
- Release to consent information
- Discharge Planning with Medical Providers
- Aftercare

Thank you !

Questions and Evaluations