Supportive Housing Meeting

12-17-14

NAHRO/Governors Budget Update: NAHRO is asking for $150 million for HIF Funds as everyone was disappointed with the $50 million in the Governor's budget. NAHRO is asking for everyone to go and lobby the legislators to up the amount the Governor has projected.

Sobering Center (Social Detox): Grand Forks experiences approximately 40 admits per month to the emergency room for social detox…costing thousands of dollars. The Sobering Center is being head up by the Blue Ribbon Commission.

Presenters: Staff from SEHSC (Jeff McKinnon, Kristy Rhen) Dakota Foundation Staff (Missy Mahnahan and Kandia Qual)

Jeff talked about there being an initial proposal for a FT LAC from the HSC and a FT case manager. The legislation did not support this. Staff now outreach and bridge to services at SEHSC. He talked about touring San Marco in Duluth. They tried to model the Cooper House after the San Marco Center in Duluth but quickly realized they needed to tweak the plan because they couldn't support the staffing piece. He talked about services being "piece meal" at first and that SEHSC staff are not currently imbedded at Cooper House. They talked of promises being made to the community that were not able to be upheld due to funding issues.

The model that Cooper House using is Housing First Permanent Supportive Housing. This model meets all the requirements for Housing First. They are contracted through human services, secondary they are supported through the housing authority and the nurse is funded through another entity.

Lessons: Shore up staffing as it affects who you can serve. "You can't ½ a** it." They talked of initially wanting and trying to serve the "highest of the highest level of needs" at first and that that is not possible with the staffing that is available or may be available in the new facility. The group will need to decide what population they want to serve. Ie chronic homeless, persons in IDDT, etc. What model will we follow? SAMHSA has some toolkits for Permanent Supportive Housing (PSH) that are good. Cooper is a Housing First/PSH project/highbred model which utilizes the harm reduction model as well. They talked about the kind of staff that work best. Ie someone that buys into this model, someone that does not adhere to sobriety is the only way versus harm reduction.

They mentioned that we need to decide on what kind of staffing is going to be there as this will dictate who you will serve and wrap services around. It was suggested that if you have a vision don't deviate from it because it will just cause more hiccups along the way. Make sure to lock down staff from the very beginning and get their commitments to the project.

Another lesson learned is that community providers got upset when the people served wasn't who they initially said they would serve. The more legwork done up front the better, because community

providers will ask what is in it for them and you need to be prepared to answer them. Data collection from pre-admission to Cooper House will speak volumes with community providers especially when they are measured against post-admission data. Community providers want to know how this saves them money as Cooper House is expensive to run.

Choose your staff very carefully. They talked a lot about preparing clinician for this population. Ie "homeless when living in an apartment." They talked about the homeless culture ie not used to structure, having a place, having rules, etc. Having a "housing case manager" would be ideal. Need staff with "thick skin." Not staff that see things in black and white and believe abstinence is the only way.

Staff are Mental Health Technicians with MHT training, training in social detox, therapeutic intervention, IDDT, Motivational Interviewing, policies and procedures. What would be ideal would to have a case manager on staff if you can swing the salary.

Needs to be a balance of empathy and accountability

They have monthly cleanliness inspections with leniency to what cleanliness means…it just needs to be a safe environment. They have encountered bed bugs in the facility. They have a contract with an extermination company and housing pays the fee for that because the housing authority owns the building.

Work with Dakota Foundation thru a contract.

Generally Missy is there during the day and one other staff. One on at night with staff available for calls.

Recommended policies and procedures be set ahead of time ie what staff will and won't do, transport clients? Etc?

Cooper House has a limit to the amount of alcohol a resident can bring in each day. They did decrease daily alcohol limit from (1000ml/day of hard liquor or 1 case of beer) to (500ml/day of hard liquor or 1 case of beer).

Talked about collecting data pre and post residency. Ie if you identify a target audience you could start collecting data on hospitalizations, ambulance rides, law enforcement encounters, etc. Scott Steenerson (PD Liaison) was able to gather the PD data as well as their local hospitals. Used IDDT levels of care as well.

Eide Bailey did an Impact Study for them.

Have on sight food bank at times, churches coming in to cook meals

Need to have a good rapport with local PD and perhaps have a contact such as neighborhood resource officer etc.

SEHSC does have staff AD outreach case manager and Case aides going out

Keep a log and have incident reports that Melissa reviews each morning and contacts involved staff to make a plan