PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

Date: June 15, 2023

To: Steven Sheets, Chief Executive Officer
Kristin Damron, Program Director

From: Vanessa Gonzalez, BA
Nicole Eastin, BS
AHCCCS Fidelity Reviewers

Method

On May 16 – 18, 2023, Vanessa Gonzalez and Nicole Eastin completed a review of the Southwest Behavioral and Health Services (SBHS) Permanent Supportive Housing Program (PSH). This review is intended to provide specific feedback in the development of your agency's PSH services in an effort to improve the overall quality of behavioral health services in the Central Region of Arizona.

SBHS offers a range of services, including outpatient mental health treatment and psychiatric services, residential housing, and in-home and supported housing services. Since the last review SBHS combined the PSH Link and the In-Home programs. The In-Home/Transitional PSH team now consists of Behavioral Health Professionals that assist with intakes and treatment planning as well as provides therapy services within the PSH program, and Community Behavioral Health Specialists that provide only PSH services.

Due to the system structure of separate treatment providers, information gathered at the Southwest Network Saguaro and Lifewell Windsor clinics were included in the review as sample referral sources. However, some data obtained reflects services provided by other partner clinics, as well.

This review was conducted remotely, using videoconferencing or telephone to interview staff and members.

The individuals served through the agency are referred to as "*clients*" or "*members*", but for the purpose of this report, the term "tenant" or "member" will be used.

During the fidelity review, reviewers participated in the following activities:

- Interview with the In-Home PSH Services Program Director.
- Interview with five Community Behavioral Health Specialists from the In-Home PSH program.

- Interview with the SWBH Community Resilience Vice President and Program Director.
- Group interviews with three Case Managers from Southwest Network Saguaro clinic, and five Case Managers from Lifewell Windsor clinic.
- Interviews with four members that are participating in the In-Home PSH program.
- Review of agency documents including intake procedures, policies and procedures, eligibility criteria, In-Home staff job descriptions, *In-Home Flyer*, *In-Home Handbook*, program description, organizational structure, member leases and safety inspection documents, team meeting notes, and program rules.
- Review of 10 randomly selected member records, including charts of interviewed members/tenants.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) PSH Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing (PSH) model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the PSH model along 7 dimensions: Choice of Housing; Functional Separation of Housing and Services; Decent, Safe and Affordable Housing; Housing Integration; Right of Tenants, Access of Housing; and Flexible, Voluntary Services. The PSH Fidelity Scale has 23 program-specific items. Most items are rated on a 4-point scale, ranging from 1 (meaning *not implemented*) to 4 (meaning *fully implemented*). Seven items (1.1a, 1.2a, 2.1a, 2.1b, 3.2a, 5.1b, and 6.1b) rate on a 4-point scale with 2.5 indicating partial implementation. Four items (1.1b,5.1a, 7.1a, and 7.1b) allow only a score of 4 or 1, indicating that the dimension has either been implemented or not implemented.

The PSH Fidelity Scale was completed following the review. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The agency demonstrated strengths in the following program areas:

- The In-Home PSH tenants had a choice of unit based on data provided and interviewee reports. Tenants select units in the communities where they want to live. Tenants can live with whom they choose. Service staff do not hold keys to tenants' residences.
- The In-Home PSH staff and clinical teams do not have a role in property management functions, nor do landlords play a role in provision of support services.
- Based on data provided, the majority of housed PSH members pay 30% or less of their income toward housing costs.
- The PSH program supports members in obtaining scattered site housing that is well integrated throughout the community.
- At the time of review, In-Home program staff carry caseloads within the optimum range of 15 members or fewer.

The following are some areas that will benefit from focused quality improvement:

- The agency lacks ability to maintain copies of current leases and Housing Quality Standards (HQS) reports. Develop a reliable practice for collecting and maintaining copies of tenants' current leases and HQS documentation to readily access to effectively support and advocate on behalf of tenants for safe and affordable housing.
- Clinical teams were not aware of PSH service provisions available to support members, nor were Housing Specialist positions filled. Clinical teams and service providers would benefit from a shared understanding of *Housing First* principles so that members expressing a need for housing are assisted in obtaining housing that aligns with their preferences. Clinical teams would benefit from awareness of

PSH service provisions available to support members and then share that information regarding such provision with members.

- PSH participants have limited opportunity to provide feedback to program design and delivery. Develop additional strategies to solicit and incorporate member input on program design and service provision.
- Not all members, nor clinical team staff, were aware the PSH program provides 24/7 services. Ensure members and clinic staff are aware of availability after hours.

PSH FIDELITY SCALE

Item #	Item	Rating	Rating Rationale	Recommendations
Dimension 1 Choice of Housing				
1.1 Housing Options				
1.1.a	Extent to which tenants choose among types of housing (e.g., clean and sober cooperative living, private landlord apartment)	1, 2.5 or 4 2.5	Some restrictions to tenant choice of housing type exists at the clinic level. Neither clinic that participated in the review had a Housing Specialist on staff. Staff interviewed at one clinic shared an understanding that it is member preference when choosing the type of housing desired and a referral for PSH services is made. At the other clinic, interviews indicated some clinic staff seek treatment settings or staffed residences for those with substance use disorders or those determined not able to live on their own, rather than independent housing. In addition, staff indicated members need an income, or a voucher, to be referred to the PSH program. PSH staff reported advocating on the member's behalf when the clinical team suggests a housing type contrary to the member's living goal. One member record showed the clinical team recommending a higher level of care despite the member's goal of independent living. PSH staff assisted the member with searching and securing independent living. Members interviewed reported being supported by the PSH program in their choice of housing type. One member reported challenges in garnering support from their clinical team for their	• The agency and system partner have a responsibility to educate and inform clinic staff that members only need to express a desire for safe and affordable housing to be referred. • Clinics continue to lack understanding of service provisions available to members enrolled in PSH services. Educate and inform referral sources, i.e., behavioral health clinics, of the enhanced services available to members referred to this specific program.

			housing type choice and was referred to the PSH program to assist.	
1.1.b	Extent to which tenants have choice of unit within the housing model. For example, within apartment programs, tenants are offered a choice of units	1 or 4 4	Clinic and PSH staff interviewed stated that members are allowed choice in the units that are offered. Examples included preferences identified of a first-floor apartment. In one record reviewed, the member was requesting a first-floor apartment, and since one wasn't yet available, the member opted for a second-floor apartment until a first-floor unit becomes available.	
1.1.c	Extent to which tenants can wait for the unit of their choice without losing their place on eligibility lists	1 – 4 4	PSH staff reported there is no waitlist for PSH services. PSH staff interviewed reported there is no risk of members being discharged from the program when they decline a housing option. Staff reported members with vouchers have 90 days to secure housing and that there are exceptions for members to obtain an extension. Staff reported six-month extensions have been granted to voucher holders due to the climate of the housing market. There was no evidence in records reviewed or documents provided that indicated a voucher would be terminated or a member would lose their place in line due to closure with the PSH program. Members interviewed indicated they were able to live in a different apartment or group home until there was availability of the unit they wanted such as desiring a complex with an elevator. Members reported the PSH staff being very helpful at making sure members get housing where desired.	
1.2 Choice of Living Arrangements				

1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 4	Clinic and PSH staff interviewed stated tenants have the final decision about the composition of their household. Members interviewed reported the ability to decide to live alone, with a roommate, children, or family. Staff also informed that members must report additional members of their household when applying to the housing subsidy to be considered, and that clinical teams and PSH staff do not provide insight or approval when requests are made to the voucher holder. A new tool being utilized by members, and PSH agencies, is an Arizona State University roommate match database. PSH staff said if a member finds a roommate match, the PSH program will assist both the member and the match with finding a place they want to live. Data reflected 14% of members are in settings where there may be program control over housing composition, i.e., behavioral health residential facilities.	
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to which housing management providers do not have any authority or formal role in providing social services	1, 2.5, or 4 4	Based on interviews with clinic staff, PSH staff, and members, property managers do not have any role in providing clinical or social services to tenants. PSH staff reported speaking with landlords if issues arise at the request of the tenant.	
2.1.b	Extent to which service providers do	1, 2.5, or 4	According to interviews conducted, service providers do not have any responsibility for housing management functions. Clinic and PSH	

	not have any responsibility for housing management functions	4	staff denied collecting rent, serving evictions, and are not tasked to report lease violations. There was no evidence of staff having responsibility for housing management functions in documents provided or in records reviewed.	
2.1.c	Extent to which social and clinical service providers are based off site (not at the housing units)	1 – 4 4	Clinic and PSH staff reported that social service offices are based off-site and are not located in complexes where members of the program reside. According to the data collection, 14% of tenants reside in settings that may have staff available. Tenants interviewed reported receiving services through assigned integrated clinics and through other providers off site from their residences.	
Dimension 3 **Decent, Safe and Affordable Housing**				
3.1 Housing Affordability				
3.1.a	Extent to which tenants pay a reasonable amount of their income for housing	1 – 4 4	Clinic and PSH staff interviewed reported members are paying 50 – 70%, or higher, of their income toward rent. Some member leases include utilities. Members interviewed reported paying 80 - 90% of their income toward rent. Several members shared the difficulty they face living on social security and the inability to apply for a rental voucher since they are not considered homeless. Members did report PSH staff assisting with obtaining food boxes, resume writing and employment support, and working on a budget to offset income to rent ratio. Based on rent to income data provided for 87 housed members, members of the program are paying an average of 29% of their income toward rent. Nearly 26% of housed members receive a housing subsidy.	
3.2 Safety and Quality				

3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 1	Data provided to reviewers showed the PSH program has less than 25% current and passing Housing Quality Standards (HQS) inspections on record for housed members. PSH staff reported members that do not hold housing subsidy vouchers do not receive HQS inspections. PSH staff reported they do assist members in market rate housing walkthroughs, prior to lease signing, when requested. Additionally, PSH staff encourage members to look for items upon moving in that would be on the HQS inspection list and do their best to educate members on housing inspection items.	• Work to ensure that all tenants are housed in units that meet HQS, not just tenants that have a rental subsidy. Some programs have trained staff that conduct HQS inspections for the PSH program.
Dimension 4 **4.1 Housing Integration**				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 4	Based on housing data provided, and reports from clinic and PSH staff, 100% of housed tenants within the PSH program live in units that are integrated within their communities. Few members are housed in units that have been set aside for people meeting disability-related eligibility criteria.	
Dimension 5 **Rights of Tenancy**				
5.1 Tenant Rights				
5.1.a	Extent to which tenants have legal rights to the housing unit	1 or 4 1	PSH staff interviewed reported that members have full rights of tenancy, particularly those living in independent settings and members that have copies of their lease. PSH staff attempt to obtain copies of leases from members, however, report being unsuccessful all the time, especially when trying to get a lease from a rental voucher administrator. PSH staff reported members living with family and friends do not generate their own leases for the members.	• PSH programs obtain and maintain current copies of leases for 90%, or more, of housed members. Ideally, PSH programs accompany members during new lease signings and lease-ups. Work with members to support them during these times, consequently obtaining a copy of the lease to be used later as a reference when educating tenants on their rights and

			According to data provided, 39% of members had a lease on file with the PSH agency at the time of the review. Of eight housed members, records reviewed did not indicate PSH attendance during member lease signing. One member interviewed reported PSH staff assisting in the lease signing process as they were at an inpatient setting and did not want to lose the opportunity to obtain the apartment.	responsibilities with the intent to prevent evictions and maintain stable housing. • Continue efforts to educate members, and their family and friends with whom they reside, of the benefits and protections the written housing agreement may offer. Living with family does not guarantee rights of tenancy. • Consider tracking leases and term end dates so that PSH staff can proactively plan with tenants to renew their lease, explore other options, and to understand the conditions of the lease if converted to month-to-month.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions	1, 2.5, or 4 4	Most members reside in settings where tenancy is not contingent on adhering to program rules or treatment. Housed members interviewed reported only being required to follow rules on their individual leases and that there were no special requirements or program rules. Based on housing data provided, a small number of housed members reside in staffed transitional or treatment settings where tenancy is contingent on treatment participation or program rules.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1 – 4 3	PSH staff interviewed confirmed practicing a *Housing First* approach and that there are no PSH program entry requirements other than a referral from clinic staff. PSH staff reported that members can self-refer to the program, and the PSH program will coordinate with members' clinical teams to obtain a referral packet.	• PSH staff and system partners should collaborate with clinic staff to increase understanding of the *Housing First* model and how PSH supports that. Assessing members' needs would be an appropriate measure if the purpose were to identify skills and services needed to support the member in being successful in living

			Staff at one referring clinic interviewed were not aware of what the *Housing First Approach* was and reported members do have to show some type of readiness before getting a PSH referral from the clinic. One case manager did not have knowledge about PSH service provisions. The other clinic staff interviewed practiced the *Housing First Approach.* All records reviewed showed referrals being made in a timely manner from clinic staff recommending the service and there were no readiness requirements. All members interviewed said they did not have to demonstrate readiness in order to get a PSH referral.	independently. Members only need to express a desire for safe and affordable housing to be referred to PSH programs.
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 2.5	Per interviews at one clinic, PSH services are available to members that request support based on individualized needs. Staff at the other clinic reported that most stable members are prioritized for PSH referrals. PSH staff interviewed indicated they do not have a waitlist for PSH services and identified treating every member equally. In the event the agency needed to move to a waitlist, they would prioritize homeless individuals, members with expiring vouchers, and those with evictions. The PSH program does not require the Vulnerability Index Service Priority Decision Assistance Tool (VI-SPDAT) as part of the referral process. The PSH program *In-Home Flyer* identifies areas the program can assist members with but does not identify a priority population.	• System partners should ensure that clinic staff assisting members with accessing permanent supportive housing and services across all provider clinics have a common and accurate understanding of eligibility and prioritization. Lack of accurate information may result in members being dissuaded from pursuing housing or feeling frustrated with the results.
6.2 Privacy				
6.2.a	Extent to which tenants control	1 – 4 4	Members interviewed reported having privacy in units and that staff do not enter without permission. PSH staff and clinic staff do not hold	

	staff entry into the unit		copies of tenant keys and confirmed that members control entry and have privacy in their units. About 14% of housed members are in settings where staff affiliated with the residence may have varying levels of access, including halfway houses, and residential programs.	
Dimension 7 Flexible, Voluntary Services				
7.1 Exploration of tenant preferences				
7.1.a	Extent to which tenants choose the type of services they want at program entry	1 or 4 4	Clinic staff interviewed reported members can choose the services they want at program entry and that members are the authors of their service plan with the help of clinic staff. Members interviewed stated they have a choice of goals and services they want and need at the clinic level. Clinic records reviewed had evidence of service plans with general housing goals in addition to specific PSH service goals. Not all goals in service plans were written in the member's voice, and one did not have a housing goal listed.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 4	Staff interviewed at both clinics said service plans are completed at intake and they usually update them annually. PSH staff and clinic staff said members can modify their service plan whenever they want. Members interviewed reported being able to modify their service plan whenever they want to add or change a service. One member interviewed reported adding a transportation goal to their service plan. A barrier identified by clinic staff was scheduling a time to adjust the service plan and the coordination. PSH staff advised it can be difficult to get services added to service plans at the clinic for members, so they advocate on the member's behalf.	
7.2 Service Options				

7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 4	In-Home staff can assist members with affordable housing search, budgeting and daily living skills, community integration activities, resource identification and access, problem solving, and coping skills. Upon intake with the PSH program, members develop treatment goals according to their needs, strengths, abilities, and preferences. Of the records reviewed, service plans with the PSH provider were written in the members' voice, based on individual needs and objectives. Staff reported members can choose from housing search support, independent living skill (ILS) services, budget work, and more, as part of their service plan. PSH staff reported that members on the Navigator level of service with their clinic can receive PSH services.	
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 3	The PSH team reported updating member service plans quarterly and invite members' clinical teams to the meeting. PSH staff reported members can stay on as a PSH member as long as they would like, and they can participate in other services the agency offers. According to records reviewed, it appears members are discharged shortly after securing housing. In some records reviewed, members were referred to the SBHS counseling services prior to closure with the PSH program. Members interviewed were unaware of additional services that could be provided by the PSH team after housing was secured. One member reported that they were scheduled with PSH staff to discharge from services but would continue receiving counseling services. The member reported their understanding of PSH services as the only goal is to get persons housed and then	• Evaluate aspects of what appears to be an expectation of time limited services, i.e., graduation after members are housed. PSH programs should include services to support members to attain and *retain* housing at their preferred intensity. PSH programs are designed for those with the most significant challenges to housing stability and retention and who often need long-term service and supports.

			close services and was aware of the opportunity to re-enroll in services should they need.	
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 2	The program has attempted to restart the peer feedback group since the pandemic, however no PSH members have attended. PSH staff reported revisiting the group every few months. The agency offers a non-PSH specific semi-annual survey to members to gather input and satisfaction with services. PSH staff reported members can complete with staff or access the survey through a link or mail the survey at any time to provide feedback. Members also have the opportunity to utilize the agency's suggestion box located at the main office or call the PSH Director or Risk Management Department directly to report dissatisfaction or provide feedback. PSH staff affirmed that persons with direct lived experience of psychiatric recovery are part of the PSH team. Members interviewed reported that during the quarterly individual service planning meetings staff solicit feedback on the services the program offers and indicated the ability to talk directly to staff or the PSH Director to provide suggestions or to report dissatisfaction with services.	• Explore additional ways to solicit and incorporate member input on program design and service provision. For example, options to facilitate member/tenant forums so that members can voice their concerns and desires for program design, participate in quality management, or other processes that impact service design and provision. • Consider revising the agency satisfaction survey to include housing specific items. Consultation with other PSH providers on survey formats may be helpful.
7.4 Quality and Adequacy of Services				
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 4	All PSH staff interviewed reported a caseload of 15 members or fewer. Of the 14 PSH staff providing services to members/tenants, caseloads ranged from two to fifteen, and compromised a mix of members determined with a serious mental illness or general mental health.	
7.4.b	Behavioral health services are team based	1 – 4 3	PSH staff reported inviting clinic staff to the member intake and service plan update meetings for input on service planning. The PSH service plan is sent to the clinical teams to review and sign	• Ideally, all behavioral health services are provided by an integrated team. Due to the current structure of the system with separate service providers, this is not

			when clinic staff are unable to attend. Clinic staff reported they do not seek input from staff at the PSH provider when service plans are updated at the clinic level. Per interviews with the PSH provider and clinical team staff, a desire for increased communication and collaboration between the PSH provider and clinic staff was identified. Based on records reviewed, evidence of PSH staff sharing agency service plans with case managers and coordination of care was located. PSH and clinic records showed several instances of communication documented including phone calls and emails coordinating member care. One member record showed PSH staff coordinating care with both the member's clinical team and a peer run agency the member was attending to ensure all parties and the member were working toward the same goals.	possible. Consider scheduling regular planning sessions between the PSH provider, clinic staff, and the member to coordinate member care. Soliciting input and sharing updated service plans and other documentation is encouraged if an integrated health record and integrated team cannot be implemented.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 2	According to PSH staff, the program offers supportive services 24 hours a day seven days a week. Staff interviewed reported the PSH program hours are 7 – 6pm, Monday – Friday. PSH staff reported staff are available 24/7, with staff rotating the on-call responsibilities weekly on a voluntary basis. Staff reported rarely receiving after-hours calls to assist members. Staff reported that clinical teams also offer after-hour services and members seem to reach out first to their clinics and general crisis lines. PSH staff do not adjust their hours to accommodate members after hours or on the weekends, but reported accommodating members early in the morning for members that are employed and have the same hours as the PSH program. PSH staff reported the	• Ensure all members are informed of PSH staff on-call availability. Consider including the hours of PSH staff availability and how to contact PSH staff after hours in the *In-Home Brochure* and/or *In-Home Handbook*. Members in the PSH program should be able to contact the program's on-call staff member as a primary resource in the event of a crisis. PSH staff may be better positioned to respond to and support members in the community, including outside of regular business hours, than staff from general crisis lines.

			after-hours number is a part of their voicemail script on agency cell phones. Clinic staff and some members interviewed were unaware of the PSH teams' ability to provide after-hours services to members.	

PSH FIDELITY SCALE SCORE SHEET

1. Choice of Housing	Range	Score
1.1.a: Tenants have choice of type of housing	1,2.5,4	2.5
1.1.b: Real choice of housing unit	1,4	4
1.1.c: Tenant can wait without losing their place in line	1-4	4
1.2.a: Tenants have control over composition of household	1,2.5,4	4
Average Score for Dimension		3.63
2. Functional Separation of Housing and Services		
2.1.a: Extent to which housing management providers do not have any authority or formal role in providing social services	1,2.5,4	4
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	4
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	4
Average Score for Dimension		4
3. Decent, Safe and Affordable Housing		
3.1.a: Extent to which tenants pay a reasonable amount of their income for housing	1-4	4
3.2.a: Whether housing meets HUD's Housing Quality Standards	1,2.5,4	1
Average Score for Dimension		2.50
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	4
Average Score for Dimension		4
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the	1,4	1

housing unit		
5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	4
Average Score for Dimension		2.50
6. Access to Housing		
6.1.a: Extent to which tenants are required to demonstrate housing readiness to gain access to housing units	1-4	3
6.1.b: Extent to which tenants with obstacles to housing stability have priority	1,2.5,4	2.5
6.2.a: Extent to which tenants control staff entry into the unit	1-4	4
Average Score for Dimension		3.17
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	4
7.1.b: Extent to which tenants have the opportunity to modify services selection	1,4	4
7.2.a: Extent to which tenants are able to choose the services they receive	1-4	4
7.2.b: Extend to which services can be changed to meet the tenants' changing needs and preferences	1-4	3
7.3.a: Extent to which services are consumer driven	1-4	2
7.4.a: Extent to which services are provided with optimum caseload sizes	1-4	4
7.4.b: Behavioral health services are team based	1-4	3
7.4.c: Extent to which services are provided 24 hours, 7 days a week	1-4	2
Average Score for Dimension		3.25
Total Score		23.05

Highest Possible Score		28