PERMANENT SUPPORTIVE HOUSING (PSH)
FIDELITY REPORT

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To: Sara Marriott, CEO
PSA Behavioral Health Agency

From: T.J. Eggsware
Jeni Serrano
Karen Voyer-Caravona
Georgia Harris
ADHS Fidelity Reviewers
David Lynde
Mimi Windemuller,
Consultants

Method

On October 14-15, 2014, Fidelity Reviewers T.J. Eggsware, Jeni Serrano, Karen Voyer-Caravona, and Georgia Harris, with consultants David Lynde and Mimi Windemuller, completed a review of the PSA Behavioral Health Agency's Permanent Supportive Housing (PSH) Program. This review is intended to provide specific feedback in the development of your agency's Permanent Supportive Housing services, in an effort to improve the overall quality of behavioral health services in Maricopa County. In order to effectively review PSH services within the current behavioral health system, the review process includes evaluating the working collaboration between each PSH provider and referring clinics with whom they work to provide services. For the purposes of this review at PSA, the referring clinics include Choices Townley and PIR Metro. Due to the system structure, issues surrounding the implementation and delivery of PSH services are found at many levels, and therefore, will be noted as such throughout this report.

PSA Behavioral Health Agency (PSA) has provided services in the Phoenix area since 1971. In addition to housing support, services include outpatient counseling, recovery and wellness, and Art Awakenings. PSA's housing support services include three primary programs: In Community, Supportive Living (SL), and Supportive Living Assertive (SLA). PSA considers their Supportive Living Assertive program to most closely align with the concept of Permanent Supportive Housing; therefore, the SLA program was the focus of this fidelity review. PSA also provides services through the Morten Project, serving Title XIX members who are on probation or parole. Referrals to the Morten Project are initiated through probation or parole, which is a different process than referrals to PSA's Supportive Living Assertive homes. PSA staff confirmed that the Morten properties would not be transitioning to the Supportive Living Assertive/Permanent Supportive Housing model until December, 2014. With that in mind, the

Morten Project is not included as part of this review but may be considered for separate review at a later time. It is hoped that this review will facilitate agency changes designed to improve fidelity and that those changes are incorporated in the Morten Project, as well as the SLA program, wherever possible.

The individuals served through the PSA agency are referred to as participants, but for the purpose of this report, the term "tenant" or "member" will be used. The term "housing" in this report, unless specified otherwise, will mean the Supportive Living Assertive/Permanent Supportive Housing arm of the PSA program.

During the site visit, reviewers participated in the following activities:

- Orientation to the housing services provided through PSA.
- Interview with the Permanent Supportive Housing Administrator, interviews with Permanent Supportive Housing Supervisors, and PSA direct service staff.
- Interview with clinic case managers (Choices Townley and PIR Metro).
- Interviews with three members who are participating in the Permanent Supportive Housing program.
- Review of agency documents including intake procedures, eligibility criteria, team coordination and program rules.
- Discussed wait list and criteria with the Regional Behavioral Health Authority (RBHA).
- Review of 10 randomly selected records, including charts of interviewed member/tenants.

The review was conducted using the Substance Abuse and Mental Health Services Administration (SAMHSA) Permanent Supportive Housing Fidelity Scale. This scale assesses how close in implementation a program is to the Permanent Supportive Housing model using specific observational criteria. It is a 23-item scale that assesses the degree of fidelity to the Permanent Supportive Housing model along seven 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 Permanent Supportive Housing 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 Permanent Supportive Housing Fidelity Scale was completed following the visit. A copy of the completed scale with comments is attached as part of this report.

Summary & Key Recommendations

The evidence-based practice of Permanent Supportive Housing appears to be a relatively new concept for staff at PSA and their referring clinics. When fully implemented, Permanent Supportive Housing should allow members to maintain tenancy permanently as long as they meet basic obligations for tenancy in housing. The housing should be safe, private (controlled by the tenant), and integrated in the community. Supports

provided should be meaningful; individualized; flexible; ongoing, if necessary; and voluntary. Supporting a member's housing choice, service options and integration in the community are vital to ensuring people diagnosed with serious mental illness have the same rights and opportunities as other members of the community, including the rights of tenancy. In the PSH model, it is acknowledged the member has the power to choose where, how, and with whom they live rather than being explicitly or implicitly directed by service providers or other external forces. The segregation of individuals diagnosed with a disability is not consistent with the Olmstead Supreme Court decision, decision, and has been seen as a violation of the Americans with Disabilities Act (ADA). During the review, the concept of Housing First was also discussed with staff, and it seemed to be more recognizable than PSH. Housing First is a form of PSH that emphasizes choice, access and flexible, voluntary services and supports, as well as separation of services and housing.

At PSA, in addition to some apartment placement options, a *house model* approach is in place, in which all tenants are diagnosed with a serious mental illness, and services are linked to the residence in a single family structure (a house.). Activities associated with the setting appear to include: staff monitoring, assigned chores, and rules respecting overnight guests that are not created and agreed upon by the residents but imposed by some other entity. This house model does not meet several fidelity requirements for PSH or Housing First, including integration or the separation of services and housing.

The agency demonstrated strengths in the following program areas:

- PSA has a long history of providing a variety of services in Maricopa County, including a historical perspective of how housing support services have developed in the treatment system in prior years.
- In addition to housing support services addressed in this review, PSA offers supports to members in the community, through counseling services, and the Art Awakenings program, a program promoting recovery through creative art expression.
- Leadership staff at PSA appear open to adapting their services to more closely align with the evidence-based practice of Permanent Supportive Housing.
- Leadership staff at PSA stated their agency is member driven, with services that are voluntary, and a program description was provided for their Supportive Living Assertive program outlining the philosophy.
- The interviewed staff at PSA feel supported by their supervisors, take pride in helping individuals make changes, and enjoy the variation of activities their positions provide.
- Tenants pay no more than 30% of income for housing.
- Once they enter the program, members appear to have the ability to provide some input into the services they receive.
- Direct staff caseload sizes fall well below the thresholds identified in the PSH model.

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

It appears past attempts have been made to implement housing supports that are consistent with aspects of the Permanent Supportive Housing model; however, it is clear that implementation efforts have not reached all levels of the system. To achieve the meaningful change necessary to

bring PSH approaches to an effective level will require intentional, coordinated efforts by ADHS, the RBHA, SMI treatment clinics, housing service providers, and members served. Issues that should be addressed across the system include:

- Review of how member choice can be identified and supported at the clinic level, with referrals based primarily on member preferences. (Member choice appears to be constricted at many levels in the system. Research suggests that when housing options are identified based on member preferences and choice; members are more invested in maintaining their residence, possibly engaging in supports.)
- The development of individualized service plans at the clinics, focusing on developing goals *with* the members and not *for* the members (i.e., in the member's words rather than mental health jargon; including documentation and exploration of member preferences).
- Review of the referral process, including the current practice of screening for housing readiness. Readiness screening appears to occur at the clinics as well as through the RBHA.
- Review of the house model and the options to transition from that structure to increased scattered site options.

Although staff noted that they have very recently received some introductory information about the PSH model, further in-depth training of the practice should include:

- Training of service providers at all levels, including staff of SMI treatment clinics, and individuals who make recommendations or guide decisions regarding housing supports (e.g., inpatient treatment providers, psychiatrists, agency management). Training should clearly outline the core concepts of Permanent Supportive Housing, including member choice, integration, and flexible services, with a focus on the definition of "permanent."
- The use of acronyms and terminology can be confusing to even the most system-savvy individual, but when different terms are used for the same type of program it can be especially confusing. It is recommended that the RBHA and Permanent Supportive Housing providers should use consistent terminology across the system. For example, PSA staff report the agency's Supportive Living Assertive program most closely aligns with the PSH model. At the RBHA, the form used to access Supportive Living Assertive housing is the Community Housing Application, but may be referred to as Community Living. PSA also offers Supported Living programs, differentiated from their Supportive Living Assertive program by the permanency of the housing. Clearly differentiating Supportive Living from Permanent Supportive Housing at PSA, and aligning terminology across the system, may help outside providers and members understand the service offered.
- If the term Housing First continues to be used, thorough training of staff would likely result in improved implementation. The system currently does not utilize the Housing First model in which housing is prioritized first, there are no access requirements beyond meeting the requirements of tenancy, and treatment is based on the tenant's choice.
- Members, prospective tenants, or current tenants would benefit from education regarding Permanent Supportive Housing. The SAMHSA Evidence-Based Practices Kit booklet, *Tools for Tenants*, provides a good starting point for system-wide development of educational materials for members.

As a provider, PSA should consider the following issues to enhance the agency's implementation of Permanent Supportive Housing:

- Review of the services provided to ensure that members are offered a full range of choice, including the option to decline services.

- Review of the current house model and how the houses can be adapted to allow for increased tenant choice (e.g., options to continue supports if a tenant moves or moving group activities to a location other than the common living space).
- It is recommended PSA differentiate rules and policies for programs offered through PSA other than the Supportive Living Assertive program, and that these are clearly communicated to tenants. There should be no housing related rules through the service provider governing Permanent Supportive Housing.
- Review of internal policies that imply program adherence is required to remain in housing through the Supportive Living Assertive services. For example, if there are restrictions in the timeframe tenants may have guests, or if specified in leases, that restrictions are consistent with leases for other individuals in the community. In good fidelity Permanent Supportive Housing programs, members are not subjected to rules of tenancy that differ from those normally found in leases signed by renters without an SMI diagnosis.
- Review of how the program addresses situations when members are away from their residence for an extended period (e.g., police report filed if a member is gone from the residence for more than 24 hours; actions that may occur if a tenant is not engaged in services for 72 hours) to ensure the stipulations are consistent with the Arizona Landlord and Tenant Act. From the outside, these practices seem to treat the residence as a “bed” rather than a home, even if the program does not intend that to be the message.
- A careful and purposeful review of the role of the agency and staff in enforcing housing management functions if a member is in violation of their lease. For example, if smoking is prohibited per the lease, should staff contact the housing management agency to report tenants who may be in violation? If non-smoking regulations have been imposed through PSA to tenants in Permanent Supportive Housing, ensure tenants are informed the rule is through the service provider, and not the housing management agency. As currently operated, these practices blur the lines between housing and services and violate the separation principle of Permanent Supportive Housing.

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 **(1)**	Staff at the clinics report interdisciplinary team meetings (i.e., staffings) occur and housing is discussed without members present. Although one staff at the clinics indicated they would prefer members be present during those discussions, it is not clear if this is an approach that is supported by the structure of the system (i.e., focus on "beds" for members without full consideration for member preferences or goals, issues with passes to tour programs for members who are hospitalized). Additionally, when asked about member choice, case management staff provided few options of actual choice, with some noting that members can either chose the housing offered, or be homeless. The RBHA's Community Housing Application prompts whether the applicant (i.e., member) is requesting a "house, apartment or no preference," and preference of location. Due to referral process from clinic to separate providers, member choice is constricted at various points, starting at clinic, and then the RBHA prior to referral received by the provider. Provider placement is based on	• PSA may have limited capacity to act independently to address systematic barriers to fully supporting member choice, but staff at PSA can improve member services by developing relationships with landlords in the community who will work with members and accept vouchers (if provided). This would support a scattered site approach to expand housing options. Further system level intervention will be beneficial to support increased tenant choice in housing.

Item #	Item	Rating	Rating Rationale	Recommendations
			availability, not a variety of options (such as would be found in a scattered site model), and is based on a house model currently at PSA. As a result, tenants are not given a choice of type of housing but are assigned to a type of housing. Real choice is the person telling their supports how, where and with whom they want to live, and being supported, not based on what is available. Members noted during interviews, and documentation referenced goals to move into independent residences. A "choice" between what is available or homelessness is coercive and is not consistent with the spirit of Permanent Supportive Housing.	
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 **(1)**	After referral process, the member may choose to decline the unit offered through the Permanent Supportive Housing provider, and then would go back into the queue maintained through the RBHA, rather than move to the bottom of the list. No scattered site housing or apartments are available through PSA; housing options are based on a house model setting. Tenants are assigned to a unit.	• See comments and recommendations above under 1.1.a.
1.1.c	Extent to which tenants can wait for the unit of their choice	1 – 4 **(2)**	PSA does not manage a waitlist for housing but tracks only referred members who are pending housing. The RBHA manages referrals and the housing waitlist. There appears to be a discrepancy in how the waitlist for housing is	• Housing choice is a central feature of the evidence-based practice of Permanent Supportive Housing programs. In good fidelity Permanent Supportive Housing

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	without losing their place on eligibility lists.		managed. Per RBHA staff, if a member is offered a placement and declines, they are not moved to the back of the waitlist but are flagged as an individual referred and waiting for another referral. The member's status is tracked to include when they were referred and type of setting. However, staff at PSA and the clinics report if a member is offered a placement and declines two to three placements, the RBHA may discontinue further offers. Based on interviews and record reviews, it appears members may be pressured to accept the housing option offered; it is unclear if they are informed they can elect to wait for the unit of their choice without losing their spot on the waitlist. The unit offered is usually not a single apartment in an integrated setting, although that preference was indicated by members , referenced in member record reviewed, and cited by the RBHA as the most requested type of residence.	programs, members can decline housing options that do not reflect their needs and preference without losing their place on a waiting list. • It is recommended that the system explore how and why a discrepancy exists in how the wait list is managed and clarify that issue. All levels of the system must have a shared understanding of how Permanent Supportive Housing is implemented at every point, from referral to move in. • If members can wait for the unit of their choice without losing their place on eligibility lists, then clinic staff need additional training regarding how the waiting list is managed, so they can effectively educate members of their ability to exercise choice.
1.2 Choice of Living Arrangements				

Item #	Item	Rating	Rating Rationale	Recommendations
1.2.a	Extent to which tenants control the composition of their household	1, 2.5, or 4 **(2.5)**	As stated above, member choice is constrained at the referral source due to the structure of the system and a lack of existing scattered site housing options that most closely resemble the Permanent Supportive Housing model. The Community Housing Application prompts if the member is willing to live with roommates, but it is not clear if this preference is a primary consideration. In the PSA housing program, members are offered an individual bedroom in a house with a living space shared by up to three roommates. Bedrooms are private although one member stated that bathroom access is through a roommate's bedroom. Per staff report, the tenants do not get to choose roommates. Tenants must accept a predetermined household.	• The house model is inconsistent with the evidence-based practice of Permanent Supportive Housing. The most obvious solution is to offer more scattered-site apartment options, which was discussed as being in process across the county. Also, a systematic review of the current house model settings, the function they serve, and whether they could be used for other purposes would be beneficial. • PSA may have limited capacity to act independently to address systematic barriers to fully supporting tenant choice in the composition of their households. However, staff at PSA can work on expanding member choice and housing options by developing relationships with landlords in the community who will work with members and accept vouchers (if provided) supporting a scattered site approach. • It is recommended that the agency explore other options for vouchers, beyond current funding streams.
Dimension 2 Functional Separation of Housing and Services				
2.1 Functional Separation				
2.1.a	Extent to	1, 2.5,	Two different housing management agencies	• PSA housing services could be

Item #	Item	Rating	Rating Rationale	Recommendations
	which housing management providers do not have any authority or formal role in providing social services	or 4 **(2.5)**	work with the Supportive Living Assertive properties through PSA. Leases were requested, and a copy was provided for one of the management agencies. It appears the housing management agency and PSA staff have overlapping roles. One housing management agency has a behavioral health arm, and it is unclear if they are also providing services to tenants. This management agency completes monthly inspections, attends meetings, and coordinates with case management. It was further corroborated this management agency has worked with members to maintain safety and health standards. In addition, it is reported that this management agency has staff that enter homes and work on certain tenant skills, including activities to maintain a stable living environment for everyone. This is in contrast to the other housing agency that primarily focuses on leasing.	improved if tenant leases are maintained through PSA. Rights of tenancy must be conveyed in a standard lease consistent in every respect with landlord-tenant law. Additions or subtractions are not permitted. Copies of these leases for every tenant must be maintained on site. • PSA program services will likely improve through the development of Memorandums of Understanding demarcating PSA's role as a service provider, and that of the housing management provider as sole enforcement agent of any leasing stipulations. The housing management agency should have no role in providing services. A clear separation of the duties should be reviewed with PSA staff, housing management agencies, and tenants.
2.1.b	Extent to which service providers do not have any responsibility for housing management functions	1, 2.5, or 4 **(1)**	In one case, a member who entered the PSA housing program did sign a PSA document outlining smoking restrictions and the potential for eviction. It is important to note the form was completed over a year prior to the review, but no redaction or adjustment of the stated policy was subsequently located. Further, it was noted that some staff report infractions of smoking rules to the leasing agent. While some restrictions are increasingly	• It is recommended that PSA maintain copies of leases. Access to the leases and review of those leases by direct care staff will help to delineate the stipulations of the lease and identify violations that can lead to enforcement action or eviction by the housing management agency. It should be clarified that if a tenant engages in a

Item #	Item	Rating	Rating Rationale	Recommendations
			standard to leases found in other types of rental housing, most renters do not have individuals entering their residence inspecting for and reporting infractions to the leasing agent. Staff at PSA report tenants may have guests stay overnight up to three nights a month, but the stipulation was not identified on the lease provided for one of the management agencies. PSA staff members report they "red flag" issues of concern for one of the two housing agencies. There are several areas where housing management and service provision staff have overlapping roles, although the latter do not collect rent, enforce the lease requirements, or handle evictions.	behavior inconsistent with the lease, PSA staff should appropriately engage the member to consider the consequences of the behavior and offer services to address the issue. PSA staff should not, however, be involved in enforcing lease agreements or reporting infractions. Rights of tenancy must be conveyed in a standard lease consistent in every respect with landlord-tenant law. Additions or subtractions are not permitted. Copies of these leases for every tenant must be maintained on site.
2.1.c	Extent to which social and clinical service providers are based off-site (not at the housing units)	1 – 4 **(3)**	The PSA staff interviewed report they work out of the office and conduct individual or group activities at member residences. PSA staff provide medication observation at the administrative building or at residences, although some tenants take medications independently. PSA services are based off site in an office separate from housing management; however, some services may regularly be offered on site. PSA services are. It was not clear if services are brought to the tenants at	• It is recommended the program continue to explore options to expand individualized services based off site, are, that can be brought to the tenants at their request.

Item #	Item	Rating	Rating Rationale	Recommendations
			their request, or imposed by staff while conducting group activities in the homes.	
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)**	Per member, PSA staff, and record review, tenants pay 30% or less of their income for housing costs, with costs ranging from $0 - $204. One clinic case manager reported if a tenant has no income, they are not required to pay rent. Leases were located in member records at the SMI treatment clinics but were not found in the PSA member records.	• It is recommended PSA maintain copies of leases in member records. This will assist PSA staff when developing budgets with tenants, which is a support activity referenced in some records reviewed.
3.2 Safety and Quality				
3.2.a	Whether housing meets HUD's Housing Quality Standards	1, 2.5, or 4 **(1)**	The lease for one of the management agencies provided by PSA indicates the residence meets Housing Quality Standards (HQS). However, copies of inspections were not located in records reviewed, or provided by PSA staff.	• Annual HQS or equivalent inspections should be done at each property, and it is recommended that PSA maintain copies of those inspections and leases in member records.
Dimension 4 4.1 Housing Integration				
4.1 Community Integration				
4.1.a	Extent to which housing units are integrated	1 – 4 **(1)**	PSA staff provides services to members who reside in house model settings, where all tenants are diagnosed with a serious mental illness, an eligibility requirement for tenancy. As a result, the people live in a setting where 76-100% of the tenants meet disability-related eligibility criteria. The house model is similar to residential treatment facilities with services	• It is recommended PSA collaborate with system partners to explore options other than house model settings. • PSA should focus on developing relationships with landlords in the community who will work with members and accept vouchers (if

Item #	Item	Rating	Rating Rationale	Recommendations
			attached to the house. It provides integration only to the extent that houses are located in a residential area. The model does not provide member/tenants the social and community integration that reflect the spirit of integration as intended by the evidenced-based practice model of Permanent Supportive Housing and required by the ADA and Olmstead.	provided) supporting a scattered site approach to expand housing integration.
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)**	Discharge criteria is listed on the program description for the Supportive Living Assertive residences, and includes: "achievement of treatment goals; achievement of maximum benefit from available level of service; no contact with the client for at least 72 hours due to participant disappearance and lack of contact with PNO clinical team or PSA staff" (also referenced on the Consent to Treatment); "needs that exceed services available within the program;" and "loss of Title XIX status" (i.e., Arizona Health Care Cost Containment System eligibility). Clinic staff, staff members at PSA and tenants seem to view the houses as temporary placements as opposed to permanent homes. Members who leave the PSA housing program are viewed as program graduates. PSA seem to define permanence as a significant length of time to resolve identified needs or	• It is recommended PSA maintain copies of all leases in member files in order to support member rights to tenancy in an informed manner. Rights of tenancy must be conveyed in a standard lease consistent in every respect with landlord-tenant law. Additions or subtractions are not permitted. Copies of these leases for every tenant must be maintained on site. • System partners (e.g., SMI treatment clinic staff) and PSA staff would benefit from training regarding the core elements of Permanent Supportive Housing and a Housing First approach, including permanency. Staff appear to have only a superficial familiarity with the Housing First model. Staff seem to understand in a general sense that

Item #	Item	Rating	Rating Rationale	Recommendations
			challenges versus a permanent residence that is the member's own. Some clinic and PSA staff refer to the process required for members to eventually live independently as a step-by-step approach in the levels of support before independent living. This continuum of care approach, in which members move from a higher level of care sequentially to lower levels of care or independence does not support the concept of permanence. There is some discrepancy regarding whether tenants are allowed to have overnight guests. PSA staff report tenants are allowed to have guests a maximum of three nights a month per their lease with one of the housing management agencies. A copy of the lease for the management agency was not provided, and it does not appear the three day stipulation was consistent with landlord tenant requirements related to guests. Whereas, the lease provided for the other management agency indicates the tenant is not allowed excessive lengthy repetitive visitation at the unit or to allow unauthorized persons to live in the dwelling for any length of time. Tenants interviewed report when guests visit they need to produce a copy of their identification, which is inconsistent with the rights of tenancy. One tenant reported the rule was posted the day prior to the interview. The tenants reported they need to obtain	members can decline services but they do not seem to recognize subtle and overt ways in which members may feel coerced in to accepting them. For example, staff report that they conduct independent living groups in the housing sites, making it difficult for members to decline the service. Furthermore, staff refer to members who "graduate" from the housing program, indicating that a continuum of care approach is in place. • It is recommended PSA differentiate rules and policies for other programs offered through PSA from the Supportive Living Assertive program. There should be no rules through the service provider governing Permanent Supportive Housing. • PSA would benefit from review, and revision, of their internal policies that imply program adherence is required to remain in housing through their Supportive Living Assertive services. Preferably, the program would place no additional conditions on tenancy not found in a standard lease. For example, are smoking restrictions or rules

Item #	Item	Rating	Rating Rationale	Recommendations
			permission to have visitors stay overnight, which is also inconsistent with the rights of tenancy. PSA's Policies and Procedure, Transition Planning and Discharge, Section 3.26 indicates "no participant in the Supported Living programs will be discharged solely for being re-hospitalized, when hospitalized for less than 72 hours." If more than 72 hours, it was not clear if a member of the Supportive Living Assertive program could be discharged, or if this only refers to members housed in the identified SL program. The policy does not provide an exception for tenants in the Supportive Living Assertive housing, that tenancy is permanent, and that eviction would only occur as outlined in their lease signed with the housing management agency. It appears tenants can be evicted (i.e., discharged) without due process in some circumstances; as a result, tenants do not have full legal rights of tenancy according to local landlord and tenant laws.	regarding participation in services, specified in leases, consistent with leases for other individuals in the community? If these types of restrictions are in program addendums through the service provider, they should be removed to be consistent with the Permanent Supportive Housing approach. • PSA should review tenant leases for rules regarding overnight guests (e.g., guest can stay no more than three nights per month, ID required). If these types of guest rules are imposed through PSA, it is recommended that PSA eliminate the rule. If the guest rule of three days is specified in leases, the program should review the Arizona Landlord and Tenant Act for guidance, and to determine if the program should advocate with the tenant to adjust the stipulation.
5.1.b	Extent to which tenancy is contingent on compliance with program provisions.	1, 2.5, or 4 **(1)**	There was some indication members must be willing to comply with program rules prior to program entry in order to receive a referral. PSA intake documents include a consent form, which references program rules and responsibilities. However, PSA staff report that members in the Supportive Living Assertive	• PSA program services can be improved by clearly delineating service engagement requirements for the Supportive Living Assertive program. It is recommended PSA differentiate rules and policies for other programs offered through PSA

Item #	Item	Rating	Rating Rationale	Recommendations
			program do not sign off on those rules and responsibilities. The inclusion of the rules and responsibilities on the intake documentation for the housing program seems to imply tenancy is contingent, at least in part, on compliance with program provisions. Additionally, the consent form references transition planning, discharge procedure and the 72-hour contact requirement. The language of other PSA documentation also seems to imply program participation is required to maintain tenancy. For example, the Policies and Procedure, Referral, Screening and Enrollment, Section 3.1 outlines exclusionary criteria, including situations in which members "decline services after continued efforts to engage." PSA's Policies and Procedure, Transition Planning and Discharge, Section 3.26 indicates involuntary discharges could occur if the member "consistently exhibits behaviors which, in the opinion of the treatment team, are incompatible with the program philosophy and structure." The phrasing of the reference seems subjective due to lack of specific examples of member behaviors that could lead to involuntary discharge. In the context of Permanent Supportive Housing by PSA, with the services linked to the house, it appears tenants could be evicted due to undefined behaviors not deemed consistent with the	from the Supportive Living Assertive program. There should be no rules through the service provider governing Permanent Supportive Housing. • As part of PSA's internal review of documentation applicable to the Permanent Supportive Housing component of housing, program administrators should review whether a standard consent for all services offered through the agency is appropriate or should be replaced by a separate consent for Permanent Supportive Housing. Technical assistance or consultation with regulatory agencies will be helpful in resolving that question.

Item #	Item	Rating	Rating Rationale	Recommendations
			program philosophy and structure. PSA Supportive Living Assertive program admission criteria (revised 10/14/14) indicates the requirement of a "reasonable expectation that the participant can be assisted by the treatment modalities provided by the Co-Occurring programs." Lack of a clear definition of how members can reasonably be assisted by treatment modalities seems subjective. As a result of the factors above, it appears program rules require participating in ongoing services, but failure to comply with this requirement does not lead to eviction. However, just because eviction due to lack of participation did not occur, doesn't mitigate the structure that seems to allow the agency to discharge (i.e., evict) a tenant.	
Dimension 6 Access to Housing				
6.1 Access				
6.1.a	Extent to which tenants are required to demonstration housing readiness to gain access to housing units.	1 – 4 **(1)**	In Permanent Supportive Housing, although eligibility criteria (e.g., homelessness) may be considered, preferably no screening of readiness (e.g., stability, medication adherence, and sobriety) would occur. Based on interviews with PSA staff and documentation, it does not appear members are required to demonstrate readiness (e.g., sobriety, adherence to treatment) through a screening process at PSA. Nonetheless, there	• Clinic staff would benefit from training in the referral process, and the differences between residential treatment, Flex Care residences, and Permanent Supportive Housing. • It is not clear if clinic staff use the SPDAT, although use of the form is prompted on the current RBHA's Community Housing Application. The housing administrator for the

Item #	Item	Rating	Rating Rationale	Recommendations
			is evidence of screening prior to the housing services referral. Members are screened at the treatment clinics prior to discussion of all housing options. Access to Permanent Supportive Housing programs is controlled by a level of care assignment, which is based on the member's assessed level of functioning. Due to the primary role the SMI clinical teams play in the assessment process and in determining the type of placement referral that is sent to the RBHA, there is evidence of constriction at the referral source. Clinic staff use the phrase "bed" broadly, in reference to a variety of settings (e.g., residential, housing in the community, supported housing). Clinic staff still use the prior RBHA's assessment document Life Skills Strengths Needs Assessment (LSSNA). The current RBHA's Community Housing Application prompts for completion of the Service Prioritization Decision Assistance Tool (SPDAT), but clinic staff did not reference the tool as part of the referral process for Permanent Supportive Housing. PSA program documents also suggest screenings occur. Per the housing program description, exclusionary criteria include "behaviors which are unresponsive to intervention during the initial clinical contact and the individual requires a higher level of	RBHA should provide education to SMI clinical team staff or other stakeholders (e.g., inpatient providers) regarding the Permanent Supportive Housing model, and required materials to seek the service (e.g., the SPDAT rather than the LSSNA). It is recommended PSA differentiate rules and policies for other programs offered through the agency from the Supportive Living Assertive program. There should be no rules through the service provider governing Permanent Supportive Housing.

Item #	Item	Rating	Rating Rationale	Recommendations
			care and/or is unable to remain safe without increased services indicative of need for a more specialized level of care.”	
6.1.b	Extent to which tenants with obstacles to housing stability have priority	1, 2.5, or 4 **(2.5)**	There is evidence tenants who meet eligibility requirements have equal access to housing. As noted under 1.1.c, certain systemic factors have been identified that may prioritize a member’s access to housing through Permanent Supportive Housing providers. Preferably no readiness criteria would be applied. Although it does not appear members are screened for positive clinical presentation (i.e., stability, sometimes referred to as “creaming”), members appear to be screened in the reverse. Case management teams assess members’ level of independent functioning, and refer members based on what housing option the provider determines will be of most benefit. The team psychiatrist renders the final decision. In the case of members awaiting discharge from inpatient treatment, the inpatient treatment team and psychiatrist also have input into the discharge placement decision. Furthermore, it was not clear if PSA actively seeks tenants who have obstacles to housing. This may be due to the systemic structure in which the clinics send their housing referrals to the RBHA, who manages the waiting list	• This area needs further review to determine if systematic intervention is needed. System housing services will be improved through staff education regarding the Permanent Supportive Housing model, clarification of terminology, and review of screening processes applied. • System partners would benefit from engaging in discussions regarding screening prospective applicants for tenancy related criteria (e.g., ability to pay rent, ability to care for apartment, respect rights of other tenants in the integrated setting, to follow crime free and drug free ordinances), which would generally be allowable, versus screening members based on functional or readiness criteria. The Permanent Supportive Housing model accepts that those with the most obstacles are also those most likely to need engagement and services to successfully live in an integrated community setting. The Housing First model recognizes the central role that stable, safe and affordable

Item #	Item	Rating	Rating Rationale	Recommendations
			upon which all Permanent Supportive Housing providers are represented.	housing with access to a choice of support plays in recovery. • PSA, the RBHA and system partners, when working to build relationships with landlords, may ask for reasonable accommodation to the landlord policies to allow people with disabilities access to the units, such as considering prospective tenants who may have poor tenancy histories.
6.2 Privacy				
6.2.a	Extent to which tenants control staff entry into the unit.	1 – 4 **(1)**	PSA service staff have free access to housing units, including the right to make unannounced visits. Staff report one management agency completes monthly inspections and the other prefers to have someone there when they complete inspections, but they have their own key and can let themselves into the house. Current leases for members in the housing program are not available for both management agencies, so it is not clear if the tenants have full access to their units as outlined in their leases. Members report PSA staff knock when visiting, and the tenants let them into the residence. However, group activities for members occur in the house common areas. It is not clear if the tenants have a choice regarding staff entry to conduct those group activities in the shared	• It is recommended copies of leases be maintained at the service provider. Rights of tenancy must be conveyed in a standard lease consistent in every respect with landlord-tenant law. Additions or subtractions are not permitted. Copies of these leases for every tenant must be maintained on site. • Additionally, the program should revise the program consent to treatment forms for the housing support services, and any addenda developed by the program, to clearly state the tenants have full control of entry to the residence.

Item #	Item	Rating	Rating Rationale	Recommendations
			space of their residence, if they elect not to participate.	
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 **(1)**	Tenants are not the primary authors of their service plans from the referral source. Based on the content of plans reviewed, the identified living situation goals did not appear to be organically developed with members. For example, some plans indicate members want to reside in "24-hour co-occurring residential programs, want to live in community living, or want to live in residential treatment." The use of jargon does not appear to be consistent with goals developed with members in their own words. Clinic staff report the members rarely attend staffings. Even if a member did attend a staffing and voiced their choices, it appears further assessment would be required prior to referral, regardless of the type of service. Clinic staff acknowledge, in situations where the member is hospitalized with acute symptoms, his or her input into the discharge planning process may not be considered reliable, and the clinical and inpatient teams primarily drive decision making. Some individual service plans reviewed included member goals of living independently	• Training is recommended at the SMI treatment clinics to support member choice and a voice in the development of their treatment plans. It may be necessary to assess for need prior to referral to a service. Members have different levels of need, but to the extent possible, member choice should be a driving factor of service provision. • Any new practices put in place to support Permanent Supportive Housing at the provider or system level should outline how, when, what and where member choice is explored and supported.

Item #	Item	Rating	Rating Rationale	Recommendations
			in their own apartment. However, the members were subsequently placed in house model residences, with implied services attached to the housing with other SMI members at PSA. Also, the service plans from referral sources at program entry were not always consistent with service plans developed at PSA. PSA leadership acknowledges the discrepancy, but the program prioritizes member preferences and informs the referring team if there are discrepancies.	
7.1.b	Extent to which tenants have the opportunity to modify service selection	1 or 4 **(4)**	Although there was evidence of constricted member choice in type of services at program entry, once a member enters the program, it appears members have some ability to modify the service plans. Housing treatment plans are developed at the Permanent Supportive Housing provider, and the content of the plans appear to be developed with the members, with some variation in noted goals and objectives. Staff members at PSA voice a strong desire to support member choice of services while in the program. Although, as noted previously, some agency documentation implies participation is required, staff and members did not verbalize those sentiments. The PSA member handbook clearly states the clinician is a partner in plan development, but it is the member's plan.	

Item #	Item	Rating	Rating Rationale	Recommendations
			7.2 Service Options	
7.2.a	Extent to which tenants are able to choose the services they receive	1 – 4 **(2)**	Services (i.e., groups) appear to have implied requirement to remain in housing. Some documentation reviewed indicates members are provided with a list of monthly groups for the month, from which they select those they want to participate. Groups often occur in shared spaces of the houses, and it was not clear if all tenants are in agreement with this arrangement or were even given an opportunity to object. Of activities in the houses, groups tend to outnumber individualized services. Some staff notes indicate the service provided did not relate directly to the person's treatment plan, but were identified by staff as essential to independent living. Additionally, it is not clear if tenants have the option to decline medications or case management, and still retain housing.	• Review the program structure that seems to rely on limited menu of group activities, often conducted in the residence. A menu of options (i.e., group calendar) provided in certain targeted areas does not always relate to individualized plans. PSA members would benefit from more individualized services, selected and driven by the members.
7.2.b	Extent to which services can be changed to meet tenants' changing needs and preferences	1 – 4 **(2)**	Service mix can be adapted in minor ways. The services are attached to the residence at the house, so a choice of no services does not exist. The members must also be associated with a case management service provider to remain a tenant. A challenge in the program structure is the nature of the house models; houses are not integrated and do not fully allow for tenant choice. On page three of the PSA Participant	• If agency documentation is revised to provide clarification regarding the Supportive Living Assertive program description, as recommended above, an addendum to the PSA program handbook, or development of a PSA tenant handbook, will be beneficial outlining exceptions to rules in the handbook for the Supportive Living Assertive services. It is

Item #	Item	Rating	Rating Rationale	Recommendations
			Handbook, a section listed as Supported Living references the goal of member “reintegration” into the community. The handbook also states members are expected “to complete assignments as identified” in their treatment plan and does not differentiate the Supportive Living Assertive or Supportive Living programs. Staff at PSA state the program uses a Housing First approach, but refer to members who have graduated from the housing program (e.g., stepped down, moved in the programs In Community housing, or moved out into their own residence independent of the program). The concept of graduation suggests a continuum of care approach.	recommended PSA differentiate rules and policies for other programs offered through PSA from the Supportive Living Assertive program. There should be no rules through the service provider governing Permanent Supportive Housing. • Staff would benefit from education regarding permanence, and further programmatic review of how graduation is viewed for tenants of the Permanent Supportive Housing program. Further expansion of scattered site, integrated housing, and a move away from house model properties will also allow for additional flexibility.
7.3 Consumer- Driven Services				
7.3.a	Extent to which services are consumer driven	1 – 4 **(2)**	Members have some input into design and provision of services received. For example, one tenant wanted to lose weight, and a walking group was organized. Staff report members can select from a monthly calendar of group activities. PSA staff report they refer to meetings with the members present as Adult Recovery Team meetings, and meetings without the members present as staffings. Staff also report a chore list is used at the homes. Based on documentation, the chores are organized with	• See prior comments regarding member choice under Dimension One, rights of tenancy under Dimension Five, and comments under 7.2.a. • As part of direct staff training, it is recommended to incorporate a review of language used when working with individuals in recovery from substance use.

Item #	Item	Rating	Rating Rationale	Recommendations
			tenants, and staff sign off on completion of the assigned chores. However, although staff directed the chore sheet development and documented member completion of the tasks, there is some indication tenants can negotiate or discuss appropriate completion of household tasks with other tenants. During interviews and in PSA program documents, the concept of co-occurring service provision was stressed. However, the documented language does not support that the concept is understood at all levels. In some records, it was noted the members would remain "clean" from substances. Use of the language does not appear to be consistent with services that are member driven.	
			7.4 Quality and Adequacy of Services	
7.4.a	Extent to which services are provided with optimum caseload sizes	1 – 4 **(4)**	Under good fidelity Permanent Supportive Housing programs, caseloads have no more than 15 tenants to each staff member. At PSA caseloads are considerably below this limit; staff report caseload sizes to be generally three to four members, with a current range of one to three members.	• The assigned caseloads are well below targeted maximum levels. As the program transitions to full Permanent Supportive Housing implementation, and a scattered site model, closely review staff responsibilities and activities to ensure they are trained to effectively meet adjusted expectations. As the program matures in implementing Permanent Supportive Housing services, it is likely caseloads can increase as tenant needs decrease.

Item #	Item	Rating	Rating Rationale	Recommendations
7.4.b	Behavioral health service are team based	1 – 4 **(2)**	Multiple entities are involved in providing member care, and as a result, efforts lack a team approach. Although PSA staff report monthly meetings occur with the Case Management team, individual service providers are primarily responsible for behavioral health services (i.e., Case management, psychiatric services, and nursing services are primarily provided through one of the PNO clinics; housing services are provided through PSA). Additionally, there is some indication of overlapping activities between SMI treatment clinic staff and PSA services. For example, a nursing assessment was completed by PSA, even though the member is treated by a nurse assigned to a SMI treatment clinical team.	• Based on the structure of the system, with separate providers involved primarily for housing services, and other providers for case management and psychiatric services, it may not be possible for PSA to provide services through a team. To the extent possible, PSA should continue efforts to coordinate with the assigned SMI treatment teams. • Thorough training in the Permanent Supportive Housing model could result in more robust coordinated implementation across the system.
7.4.c	Extent to which services are provided 24 hours, 7 days a week	1 – 4 **(3)**	Services are available on a flexible schedule, but not 24 hours a day, seven days a week. Per staff report and documentation, staff is available 16 hours a day.	• PSA should review the program's capacity to provide services 24 hours a day, seven days a week, and the feasibility of such a change.

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	1
1.1.b: Real choice of housing unit	1,4	1
1.1.c: Tenant can wait without losing their place in line	1-4	2
1.2.a: Tenants have control over composition of household	1,2.5,4	2.5
Average Score for Dimension		1.63
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	2.5
2.1.b: Extent to which service providers do not have any responsibility for housing management functions	1,2.5,4	1
2.1.c: Extent to which social and clinical service providers are based off site (not at the housing units)	1-4	3
Average Score for Dimension		2.17
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		2.5
4. Housing Integration		
4.1.a: Extent to which housing units are integrated	1-4	1

Average Score for Dimension		1
5. Rights of Tenancy		
5.1.a: Extent to which tenants have legal rights to the housing unit	1,4	1
5.1.b: Extent to which tenancy is contingent on compliance with program provisions	1,2.5,4	1
Average Score for Dimension		1
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	1
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	1
Average Score for Dimension		1.5
7. Flexible, Voluntary Services		
7.1.a: Extent to which tenants choose the type of services they want at program entry	1,4	1
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	2
7.2.b: Extend to which services can be changed to meet then, tenants' changing needs and preferences.	1-4	2
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	2
7.4.c: Extent to which services are provided 24 hours, 7 days a week.	1-4	3
Average Score for Dimension		2.5
Total Score		12.3
Highest Possible Score		28