Looking Forward: Rhode Island Opportunities for Community Integration

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Executive Summary

Access to safe, decent affordable housing for people with disabilities has been identified as a key social determinant of health — and like many states, Rhode Island has begun implementing initiatives and strategies to promote housing that is integrated in the community, together with supports that help people sustain their community housing. Rhode Island Housing and Mortgage Finance Corporation (RIHousing) partnered with the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals hiring the Technical Assistance Collaborative (TAC) to facilitate a planning process that would help the state better understand the housing and housing-related services needs of people with intellectual/developmental disabilities (I/DD), serious mental illness (SMI), and substance use disorders (SUDs). The resulting recommendations, summarized below, are presented in this report. As a secondary focus of this report, TAC was also asked to consider the housing and service needs of people leaving the Rhode Island Department of Corrections system.

1. Systems-Level Recommendations

Recommendation 1A: Infuse all programs that serve Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (DBHDDH) clients with the principles and practices of Housing First, permanent supportive housing (PSH), and supported employment.

Recommendation 1B: Convene a state inter-agency task force to develop and implement an action plan to increase independent integrated housing opportunities and essential housing stabilization and tenancy support services.

2. Housing Recommendations

Recommendation 2A: Increase investment in housing and resources targeted to people with disabilities.

Recommendation 2B: Apply for upcoming Housing and Urban Development (HUD) Mainstream vouchers.

Recommendation 2C: Review increased incentives to maximize existing resources under the amended Qualified Allocation Plan (QAP).

Recommendation 2D: Target new PSH resources to individuals transitioning from Mental Health Psychiatric Rehabilitation Residences (MHPRRs) in order to create flow within this continuum, and to individuals with developmental disabilities in order to reduce reliance on group home settings.

Recommendation 2E: Repurpose existing MHPRRs based on planned openings to meet the needs of targeted populations.

Recommendation 2F: Pilot a housing program to transition people with behavioral health needs from jails and prisons to community-based housing.

3. Housing-Related Services Recommendations

Persons with Serious Mental Illness and Substance Use Disorders

Recommendation 3A: Integrate housing and tenancy support services into Assertive Community Treatment (ACT), Integrated Health Homes (IHH), and peer specialist services.

Recommendation 3B: Create a housing specialization within the certified peer recovery specialist role or as a separate service for individuals with SUDs who are not eligible for ACT or IHH.

Recommendation 3C: Conduct an analysis of ACT and IHH services to assess 1) frequency and intensity of service delivery, and 2) type of service activities and interventions provided.

Recommendation 3D: Conduct an analysis to determine how many of those who leave SUD recovery housing need PSH in order to attain successful tenancy and continued recovery.

Recommendation 3E: Establish housing goals at the point of admission to Eleanor Slater Hospital to drive treatment activities and the discharge planning process.

Recommendation 3F: Conduct staff training specific to housing and tenancy support services.

Recommendation 3G: Target new Home Stabilization services to individuals who are most in need and who are ineligible for other community-based services.

Recommendation 3H: In partnership with the Executive Office of Health and Human Services (EOHHS) and Medicaid, work with the state's primary managed care organizations and accountable care organizations to authorize housing-related services, more ACT and IHH teams, and the addition of housing specialists to ACT, IHH, peer support, and peer recovery teams.

Persons with Intellectual/Developmental Disabilities

Recommendation 3I: Create movement from residential to shared living arrangements by conducting outreach to individuals who want to move into supported housing and who are not in need of higher-intensity supports and services. Create additional opportunities for shared living and increase outreach to those interested in voucher-based PSH options.

Recommendation 3J: Fund new positions to deliver in-home housing-related services under the Home Stabilization benefit for adults with I/DD who want to move into voucher-based PSH units.

Recommendation 3K: Explore sustainable funding and financing mechanisms to create a family peer specialist service position focused on helping families explore options for more independent levels of housing over time.

Persons Leaving Jails/Prisons with Unstable Housing Options

Recommendation 3L: Develop systems to enhance data on persons entering DOC who are homeless, persons leaving DOC who are homeless, and persons leaving DOC with potential housing instability.

Background and Policy Framework

Plan Overview

Under Governor Gina Raimondo's leadership, Rhode Island has been engaging in activities to better understand the housing and housing-related service needs of people with disabilities and other special needs. Rhode Island Housing and Mortgage Finance Corporation (RIHousing) and the Rhode Island Department of Behavioral Health, Developmental Disabilities and Hospitals (BHDDH), engaged in strategic planning between January and June 2020 to identify and develop strategies that promote integrated community living options for people served by the state. The Technical Assistance Collaborative (TAC) was hired to facilitate the analysis, planning process and development of the strategic recommendations in this report.

This report offers an analysis of housing and housing-related services that are currently available to support Rhode Islanders living with disabilities and other special needs. The report identifies opportunities to expand affordable housing and housing-related services, and to utilize them more effectively. Barriers and gaps are also presented, with strategies to address these issues. Recommended strategies for Rhode Island to support the ability of individuals to live successfully in integrated, community-based settings are presented in the last section.

Several agencies within EOHHS were involved in this planning:

- The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)
- The Department of Children, Youth and Families (DCYF)
- The Department of Health (DOH)
- The Department of Human Services (DHS)

The planning process also involved staff from RIHousing and the Rhode Island Department of Corrections (DOC).

TAC interviewed stakeholders including state agency staff, family members of consumers, and providers. In formulating its recommendations, TAC further drew on information from Rhode Island reports, key informant interviews, and national best practices and policies.

National Housing Policy Context

Housing Is a Social Determinant of Health

State Medicaid and disability agencies are increasingly focused on the need to get and keep people housed as a way to improve outcomes and reduce health care expenditures. The evidence is extensive demonstrating a direct relationship between housing interventions and health outcomes within low-income and otherwise vulnerable populations.[1] An increasing number of studies show that providing housing supports to persons with high needs yields a reduction in health care costs and a net increase in savings. In addition, offering health care services along with housing supports can lead to improved health outcomes. Medicaid and state agencies across the country have recognized the benefits of housing-related services and have paid attention to studies showing that partnerships among health care, service, and housing providers have improved health outcomes in specific high-needs populations.

The Americans with Disabilities Act and *Olmstead*

Access to integrated, community-based housing is an important policy direction under the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's 1999 *Olmstead* decision, which held that the unjustified segregation of people with disabilities violates Title II of the ADA.[2] States have an "integration mandate" to serve people with disabilities in the most integrated setting possible, and strategies to address community living options are essential to this requirement.

States have historically relied on congregate group residential settings for persons with disabilities. A range of congregate settings often exists in states, with varying degrees of oversight, size, and quality — from well-run group homes to large, segregated sites. Depending on the state, large congregate facilities may be known as boarding homes, residential care facilities, assisted living facilities, adult care homes, or rooming houses. Some characteristics are common in these large segregated sites: Most of the residents have disabilities, residents hold few to no tenancy rights, strict program requirements are in place, staffing is limited, and oversight is minimal resulting in poor environmental conditions.

As a way to help states plan integrated housing strategies, the U.S. Department of Justice (DOJ) issued a statement in 2011 that included definitions of both integrated and segregated settings. These definitions are often used by states in planning their housing strategies as they seek to provide a range of treatment and independent living options that meet the unique needs of persons living with disabilities. The DOJ definitions are:

> "**Integrated settings** are located in mainstream society; offer access to community activities and opportunities at times, frequencies and with persons of an individual's choosing; afford individuals choice in their daily life activities; and, provide individuals with disabilities the opportunity to interact with non-disabled persons to the fullest extent possible. Evidence-based practices that provide scattered-site housing with supportive services are examples of integrated settings."

[1] Taylor, L., Coyle, C., Ndumele, C., Rogan, E., et al. (2015). Leveraging the social determinants of health: What works? Prepared for the Blue Cross Blue Shield of Massachusetts Foundation. Yale Global Health Leaderships Institute.

[2] Olmstead v. L.C., 527 U.S. 581 (1999).

"By contrast, **segregated settings** often have qualities of an institutional nature. Segregated settings include, but are not limited to: (1) congregate settings populated exclusively or primarily with individuals with disabilities; (2) congregate settings characterized by regimentation in daily activities, lack of privacy or autonomy, policies limiting visitors, or limits on individuals' ability to engage freely in community activities and to manage their own activities of daily living; or (3) settings that provide for daytime activities primarily with other individuals with disabilities."[3]

Best Practices

As states have worked to implement community-integrated housing for people with disabilities and other special needs, several models of housing with supportive services have emerged as best practices. These models each have a research base that demonstrates positive outcomes, including improved clinical outcomes, increased tenure in the community, increased employment, decreased inpatient and emergency department use, cost effectiveness, and individual satisfaction.

Housing First

Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions or barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness, rather than to address predetermined treatment goals established prior to permanent housing entry.[4]

Permanent supportive housing

Permanent supportive housing (PSH) is a nationally proven model for housing vulnerable populations including those with serious mental illness (SMI) and/or substance use disorders (SUDs), and people who have experienced homelessness for long periods of time.

While PSH policy and practice have evolved over time in many states and programs, commonly accepted tenets of PSH include:

- Consumers/tenants have all the rights and responsibilities of tenancy.
- Housing is not subject to time limitations other than lease requirements.
- Leases are renewable if compliance with standard lease terms and property rules is maintained.
- Neither support service compliance nor following treatment plans is a condition of accessing housing or maintaining tenancy. However, support services are offered to promote independent living and help consumers find, get, and keep housing.
- Chosen support services are client-driven, individually tailored, and flexible — and are primarily provided in the consumer's home.
- Ongoing, regular communication must occur between service providers, property managers, and tenants to ensure that tenants remain successfully housed by resolving any difficulties and preventing eviction.

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[3] U.S. Department of Justice Civil Rights Division (2011). Statement of the Department of Justice on enforcement of the integration mandate of Title II of the Americans with Disabilities Act and Olmstead v. L.C. *https://www.ada.gov/olmstead/q&a_olmstead.htm*

[4] U.S. Department of Housing and Urban Development. Housing First Permanent Supportive Housing Brief. *https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf*

PSH can be *site-based*, meaning all the residents of the building are consumers of the program, or *scattered site* throughout a larger building or neighborhood. Both models require rental assistance or operating subsidies to make the units affordable.

Rapid re-housing

Rapid re-housing (RRH) is a newer model of permanent housing that provides short-term rental assistance and supportive services to help people obtain housing quickly, become more self-sufficient, and remain housed once the short-term rental assistance and services are completed.

Integrated and independent affordable housing

Integrated and independent affordable housing typically refers to units set aside in an affordable housing development for people with disabilities or other special needs populations.

Recovery housing

Recovery housing provides a stable, home-like residential setting in which skills vital for sustaining recovery from SUDs are learned and practiced.

Shared housing or shared living

Shared housing can maximize housing resources and increase overall housing stability. This model has been used to serve different populations including individuals with intellectual/developmental disabilities (I/DD), SMI, and substance use histories, and formerly homeless individuals including homeless Veterans. While models vary, in general two or more unrelated individuals share a housing unit with private bedrooms but shared common areas. The model is promoted in high-cost housing markets to address affordability issues but may also be encouraged to reduce isolation and facilitate service delivery.

Reentry housing and services

Transitional housing and case management services for high-risk people leaving correctional facilities reduce recidivism. These housing models are designed to address the needs of individuals in the correctional system who are eligible for parole or probation, but who are unable to locate appropriate housing. Both affordable housing and community-based supports necessary for independent living are provided.

Rhode Island's Policy Context

Many individuals who are served by Rhode Island state agencies either need or already rely on affordable housing options and housing-related services to support their ability to live in integrated, community-based settings. Based on interviews with stakeholders and a review of available data, there are not enough community-based affordable housing resources for individuals with disabilities and other special needs through the current combination of state and federal resources.

Housing Options in Rhode Island

Several reports have identified the need to expand affordable housing options in Rhode Island, particularly for persons with disabilities and other special needs.

HousingWorks RI's *2019 Housing Fact Book* documents the overall lack of affordability for both homeowners and renters in the state. According to the report, based on the average two-bedroom rent in 2018, a household earning the state's median renter household income could not affordably rent in any Rhode Island city or town.[5] The report further outlines that making 10 percent of every city or town's housing stock qualify as low-and-moderate income, a goal outlined in Rhode Island State Law 45-5342, has only been attained in six of the state's thirty-nine communities.[6]

For people living with disabilities, available data shows a story that is even more dire. According to TAC's *Priced Out* database, in 2020 a Rhode Islander with a disability receives SSI benefits equal to $823 per month, or 20.6 percent of the state's average area median income. Statewide, a person with a disability living on SSI would have to pay 98 percent of their monthly income to rent an efficiency unit, or 111 percent of their monthly income for a one-bedroom unit.[7]

The Rhode Island Commission for Health Advocacy and Equity Legislative Report 2020 states that "No community in Rhode Island has enough low- to moderate-income housing units relative to the estimated number of income-eligible households, and most communities have less than one low- to moderate-income housing unit for every five income-eligible households."[8]

Best Practices and Medicaid

Medicaid and managed care factor significantly in the funding and design of housing-related services in Rhode Island. Over 317,000 residents, representing approximately 90 percent of Medicaid recipients in the state, are enrolled in managed care. This includes persons with behavioral health and other disability diagnoses such as I/DD, SMI, and SUDs.

Governor Raimondo's "Working to Reinvent Medicaid" group, in collaboration with other agencies, set strategic goals to focus on improving service integration and other social determinants of health, including housing.[9] Two of the strategic goals in EOHHS's Medicaid managed care plan focus on improving health outcomes for Rhode Islanders on Medicaid by orienting the health care delivery system to:

- Respond to upstream social determinants of health to address health-related social needs and consider community factors that impact population health, *with an emphasis on housing and homelessness*, and

[5] 2019 Housing Fact Book | HousingWorks RI @ RWU, *https://www.housingworksri.org/Portals/0/Uploads/Documents/2019%20Pages/HFB2019_compressed.pdf*, p. 9.

[6] Ibid, p. 14.

[7] Technical Assistance Collaborative, Inc., Priced Out Report, *http://www.tacinc.org/knowledge-resources/priced-out-v2/*

[8] Rhode Island Commission for Health Advocacy and Equity (2020). Rhode Island Commission for Health Advocacy and Equity legislative report, p. 10. *https://health.ri.gov/publications/reports/2020CommissionForHealthAdvocacyAndEquityLegislative.pdf*

[9] State of Rhode Island Executive Office of Health and Human Services (undated). State of Rhode Island Medicaid program managed care strategic goals overview. Retrieved on 7/14/2020 from: *https://files.constantcontact.com/9309e48c001/b857e0c1-14ff-4fe1-b870-2a468ed64cab.pdf*, p. 2.

- Meet the unique needs of seniors, people with disabilities, and those in need of long-term services and supports in a way that prioritizes choice and *empowers individuals to remain in the community*.

Findings from a 2015 Truven Health Analytics report, focused on a review of the state's behavioral health care system, include evidence of the need for additional housing-related services for those served by Medicaid:

> "The rate of homelessness among those served by the Rhode Island mental health system was higher than the national average (5% versus 3.3%). Yet, only 2.6 percent of individuals with serious mental illness served by the Rhode Island mental health system received supportive housing."[10]

Truven's recommendation related to these findings was for the state to shift its "financing and provision of services away from high cost and intensive and reactive services toward evidenced based services that facilitate patient-centered, community based, recovery oriented and coordinated care" efforts.[11]

Implications of COVID-19

While this strategic planning effort began before the coronavirus had impacted communities across the United States, it is impossible to ignore either the immediate impact of the virus on Rhode Island or the long-term implications it may have on housing and services for the state's most vulnerable populations.

Early on, the state convened a leadership team to coordinate responses to the coronavirus. This team includes representatives from the Office of Housing and Community Development; RIHousing; the Department of Health; the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDHH); and RI Coalition for the Homeless. This leadership team has received technical assistance from representatives of the Centers for Disease Control (CDC) and from TAC in our role as a HUD-funded technical assistance provider, and has coordinated closely with the governor's office, the state's 211 system, the Rhode Island Office of Veterans Services, the City of Providence, and others.

Early lessons may continue to foster an interest in creating community-based, integrated, non-congregate housing settings. In addition to adding a new lens to this review, the coronavirus also required the attention of key stakeholders and state leaders to work to prevent the spread of the virus and to address the immediate impact of COVID-19 on the state. This meant that TAC was unable to access all potential data or to complete all planned interviews. While this information would have provided valuable guidance, the analysis and recommendations in this report nevertheless remain relevant. The response to the virus rightfully took priority during the completion period of this plan, but key leaders were involved in forming it and have expressed their commitment to work on systems change for housing and related services in the long term.

[10] Truven Health Analytics (2015). Rhode Island Behavioral Health Project: Final report. Retrieved on 7/13/2020 from http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Truven%20Rhode%20Island%20Behavioral%20Health%20Final%20Report%209%2015%202015.pdf, p. 5.

[11] Ibid, p. 4.

Environmental Scan

TAC performed an environmental scan to better understand the unique challenges that Rhode Island experiences in meeting the affordable housing and housing-related services needs of people living with disabilities and those with other special needs. A multidisciplinary team of TAC consultants with expertise in behavioral health and affordable housing systems gathered information and data to inform this plan, using the following methods:

- Conducting phone and in-person meetings with leaders at RIHousing and BHDDH
- Conducting in-person and telephone key informant interviews and small focus groups with housing partners, service providers, and other stakeholders
- Reviewing data provided by housing agencies and BHDDH staff
- Reviewing publicly available reports and documents

Lists of interviewees and documents reviewed can be found in Appendices A and B, respectively.

Several overarching themes emerged:

Housing Themes

- The lack of safe, affordable housing located near the services that persons with I/DD, SMI, and SUD need
- A desire to shift the behavioral health system from housing options of higher intensity to PSH options

Housing-Related Services Themes

- Concern that some Assertive Community Treatment (ACT) and integrated health home (IHH) services are currently not provided at a frequency or intensity needed to support individuals living in independent, integrated housing.
- Concern that ACT and IHH do not emphasize or provide enough skill development in areas necessary for successful tenancy (e.g. behaviors related to adhering to terms of a lease, being a good neighbor, household upkeep, establishing friendships and support networks, seeking assistance when needed).
- The need to tailor and design housing-related supports (1115 Home Stabilization services) to the specific needs of different populations who will be eligible for the service (those with I/DD, SMI, or SUD).
- Concern that provider staffing shortages have created gaps in services, including case management, for behavioral health populations.

Analysis of Rhode Island's Affordable Housing System for People with Disabilities and Other Special Needs

TAC reviewed the array of affordable housing and supportive housing resources currently available in Rhode Island to better understand existing pathways and operations and to identify potential opportunities and linkages. We found a myriad of affordable housing opportunities in Rhode Island, identified several existing strengths and opportunities, and identified barriers and system gaps to address in order to increase housing opportunities.

Organization of Housing Resources and Programs in Rhode Island

As in other states, housing policy, programs, funding, development, and oversight in Rhode Island are organized by different state and local governmental agencies, private landlords, and nonprofit service providers. In Rhode Island, three statewide entities oversee the planning and production of affordable housing. In addition, BHDDH funds and administers housing programs for persons with mental illness, SUDs, and developmental disabilities.

The Housing Resources Commission (HRC) was created by legislation in 1998 to be the state's planning and policy, standards, and programs agency for housing issues. Established under Rhode Island General Law 42-128 and the RI Housing Resources Act of 1998, the HRC is composed of 28 members, representing a wide range of constituents. "The mission of the HRC is to ensure that all Rhode Islanders have access to safe and affordable housing. The broad, inclusive membership of the Commission assures all stakeholders in the housing field are working together to create strong neighborhoods, improving the economic climate of our State."[12]

In addition to the HRC's planning and oversight role, RIHousing and the Office of Housing and Community Development (OHCD) together administer the federal and state resources for the creation of new affordable housing, PSH, and emergency housing. RIHousing is a self-sustaining public agency of the State of Rhode Island that provides low-interest loans, grants, education, advocacy, and consumer counseling to help customers rent, buy, and retain their homes. RIHousing administers the Low-Income Housing Tax Credit program, the HOME program, the HUD Section 811 program, and the state's allocation from the National Housing Trust Fund. In addition, Rhode Island has 26 public housing agencies which together provide over 9400 public housing units and close to 11,000 Housing Choice Vouchers.

This complex network of affordable housing responsibility can result in fragmented planning. For example, planning and funding of programs to prevent and end homelessness fall to two different state agencies. OHCD administers the federal Emergency Solutions Grant (ESG) program and the State Rental Assistance Program, while RIHousing is the lead agency for the state's Continuum of Care (CoC) program and directly administers CoC-funded rental assistance programs. While much of this work is coordinated at the HRC and CoC levels, the different funders mean multiple contracts, often with the same providers.

[12] State of Rhode Island Office of Housing and Community Development (undated). Housing Resources Commission. Retrieved from on 7/13/2020 from: *http://ohcd.ri.gov/hrc/*

Since the CoC and ESG programs are focused on populations that meet the strict HUD definition of homelessness, these systems of housing are unable to engage those at risk of homelessness, experiencing housing instability, or at risk of institutionalization. As a result, the true need of underserved populations may not be fully known, and planning and allocation of resources may not be being conducted in an efficient, coordinated manner.

Overview of Housing for Persons Living with Mental Illness and Substance Use Disorders

Residential Services – Mental Health Psychiatric Rehabilitation Residences

BHDDH provides a continuum of residential services through its Mental Health Psychiatric Rehabilitation Residences (MHPRRs). These programs provide care for individuals who require increased structure due to their chronic mental illness and may meet the standard for a group home level of care: Individuals must have a serious and persistent mental illness and be unable to live in a less restrictive setting in the community. BHDDH contracts with nine providers for a total of 421 MHPRR beds on a four-level continuum.

Level 1 MHPRR programs are the most independent settings on the continuum. Two providers operate three MHPRR Level 1 programs. These are single or shared living apartment settings, comprising a total of 33 beds. The number of beds per program ranges from 10 to 12. Providers receive a per diem rate of $85 per resident. Eligible individuals may receive ACT and/or IHH services while residing in these programs.

Level 2 MHPRR settings are supervised apartments and may be clustered within a single building or complex. Four providers operate eight program locations with a total of 105 beds across the state. The number of beds per program ranges from eight to sixteen. Staff are available 24 hours a day, 7 days a week, but not always on-site. Some program models may include a staff office within the building or complex, while other programs have off-site program offices with staff spending designated hours on-site or visiting residents by arrangement. Providers receive a per diem rate of $125 per resident. Eligible individuals may also receive ACT and/or IHH services while residing in these programs.

Level 3 MHPRRs are group homes. These are single-site, group living settings. Nine providers operate 23 group homes for a total of 261 beds. Individual program capacity ranges from seven to sixteen beds. Providers receive a per diem rate of $125 per person. Group homes provide on-site staffing available 24 hours a day, 7 days a week.

There is only one Level 4 MHPRR program in Rhode Island, called Central Street House. This 16-bed program is a residential rehabilitation program for individuals with dual diagnoses of serious mental illness and SUD or other complex conditions.

See Table 1 below for a summary of MHPRR levels.

Table 1 - Mental Health Psychiatric Rehabilitation Residences

MHPRR-BHDDH Level	Description	Reimbursement	Number of Beds
Level 1	Supportive Housing model	$85/day per diem	33
Level 2	Supervised Apartments	$125/day per diem	105
Level 3	Group Home	$125/day per diem	261
Level 4	Central House — specialized residential rehabilitation program for Dual Diagnosed individuals	$175/day per diem	16
Total Beds = 415			

BHDDH licenses a wide array of providers delivering the following services:

- Inpatient and outpatient detoxification
- Outpatient services including therapy
- Counseling and intensive outpatient programs
- Medication-assisted treatment
- Centers of Excellence: specialty centers within licensed agencies that use evidence-based practices and provide treatment and care coordination to individuals with moderate to severe opioid use disorder

Additionally, BHDDH licenses a total of 280 residential substance abuse treatment beds in 11 programs. These programs are aligned with the American Society of Addiction Medicine levels of care and most are clinically managed at Levels III.1, III.3, or III.5 (low, medium, and high intensity residential rehabilitation treatment). These licensed programs are treatment-oriented and are not considered housing.

As noted, due to the coronavirus, TAC was unable to complete an analysis of individuals leaving residential treatment programs in need of housing and tenancy supports to maintain their recovery. However, interviews with key stakeholders and a review of documents reveal that the primary housing resource available after residential treatment is recovery housing. Other housing resources include private market housing and affordable and subsidized housing.

Substance Use Disorder Recovery Housing

Recovery housing provides a stable, home-like residential setting in which skills vital for sustaining recovery from addiction are learned and practiced. BHDDH does not have oversight of recovery houses, and most, if not all, of these settings are privately owned. BHDDH does not license recovery houses as providers or facilities. Rhode Island Communities for Addiction Recovery Efforts (RICARES) is the agency responsible for the certification of recovery residences. Certification is a voluntary process; however, it is required in order to receive referrals and state funds. BHDDH does provide funding for room and board for up to 12 months for levels 2 and 3 of recovery housing (see below), using a tiered model in which funding decreases over time spent in the housing.

Recovery houses are certified according to the National Alliance for Recovery Residences (NARR) levels of care for on-site support. Rhode Island has all four levels. Oxford Housing is considered Level 1, a peer-run sober living model, which is a relatively new model to Rhode Island. There is interest in expanding this option. NARR Levels 2 and 3 include on-site support, which usually includes a person in recovery who lives in the house and functions as an on-site manager or senior resident. This is not a clinical position but focuses on household management and operational support. Residential Treatment is the highest level of NARR recovery housing (Level 4). This level of housing looks more like a facility, and treatment is provided by clinical staff with services available 24/7.

According to the RICARES website, there are 46 certified recovery houses. There are 37 recovery houses for men, of which 36 are Level 2 and one is Level 3. There are nine recovery houses for women, of which six are Level 2 and three are Level 3. According to staff at BHDDH, recovery houses include specialty housing for parents with children, Veterans, and individuals identifying as LGBTQ.

To support individuals' transition from recovery housing to independent housing, BHDDH has partnered with the Department of Labor and Training for employment assistance to individuals experiencing long-term unemployment due to behavioral health disorders. An "Employment First" approach is adopted to prepare and support individuals to access affordable housing upon exit.

Inquiries and referrals for state funding for certified recovery housing are managed through BH Link — the statewide behavioral health facility designed to offer innovative crisis intervention services and connect people in crisis to ongoing treatment and care. Among other services provided, this entity triages individuals seeking substance use treatment and manages referrals and a waitlist for recovery housing. According to BH Link, there is a waitlist to access state funding for recovery housing, and hundreds of calls come in weekly from people inquiring into the availability of this funding and wanting to know their place on the waitlist, though many are repeat calls.

See Table 2 for an overview of SUD recovery housing levels.

Table 2 - SUD Recovery Houses

BHDDH Level	NARR Description	BHDDH Payment
Level 1 Oxford House	Peer-run	Self-pay
Level 2 Men only – 37 houses Women only – 6 houses	Onsite house manager or senior resident	$20/day for first 6 months; 75%/day for months 7-9; 50% or $10/day for months 10-12; $0/day after the first year
Level 3 Men only – 1 house Women only – 3 houses	Onsite house manager or senior resident	
Level 4 Specialty housing include parents with children, individuals identifying as LBGTQ, and Veterans	Residential treatment	Medicaid reimbursement

Housing Gaps for Persons Living with Mental Illness and Substance Use Disorders

Rhode Island lacks a statewide PSH model for individuals with behavioral health conditions who do not meet the homeless eligibility criteria for HUD's Continuum of Care (CoC) program. Without access to affordable housing paired with flexible and responsive services, individuals are left with only the option of moving into more restrictive settings that may not be their choice. Long waitlists for subsidized housing limit the affordable housing options available to individuals who rely solely on state and federal income entitlement programs (e.g. SSI, SSDI). Individuals leaving recovery housing who have criminal records face additional challenges when applying for affordable housing.

This absence of such a PSH model has impeded movement through the MHPRR continuum so that individuals in institutions who may require this type of setting in order to be discharged have no available placement at discharge. More importantly, this lack of PSH has caused programs originally intended as transitional and treatment-oriented, to become instead more like permanent housing placements.

Overview of Waiver Housing and Housing-Related Services for Persons with Intellectual and Developmental Disabilities

Housing and housing-related support and services for persons with I/DD under the states' 1115 waiver were designed together in this tiered system, therefore both will be described in this section. In the January 2019 extension of the State's 1115 Demonstration Global Waiver, BHDDH describes its tiered system of housing and services options for persons with I/DD. There are five housing categories for adults with I/DD within the 1115 demonstration waiver: 1) living with family or a caregiver; 2) shared living arrangements (SLAs) which allows a maximum of two individuals to live together; 3) community support residences; 4) group homes; 5) and independent living, such as in an apartment, some but not all of which are voucher-funded. The array of services across housing settings includes:

- Integrated community-based support (CBS)
- Community-based day (CBD) support, employment services, and respite for adults living at home with family or with another caregiver
- CBS, CBD, employment support services, and access to overnight supports for individuals residing in community support residences
- CBD and respite for individuals residing in SLAs; and CBD and traditional residential support services for those residing in group homes.

All individuals may also receive professional support services, case management, and non-emergency medical transportation. These housing categories and available supports and services are organized in tiers intended to provide a choice in housing/living settings along with a set of services that meet the person's unique needs and circumstances along a continuum of care. Individuals are presented with housing and services choices based upon their assessed level of care in the least restrictive setting possible based upon their needs. Table 3 below shows an overview of the housing tiers and services/supports provided under the 1115 waiver.

In addition to the supports described, the 1115 waiver extension added assistive technology as a benefit for all covered under the waiver including persons with I/DD. Those within any tier can utilize waiver funding to purchase assistive technology. While assistive technology was written in the 1115 waiver, it was done so with little funding support. The Division of Developmental Disabilities sees the addition of assistive technology as critical in helping more individuals to live independently in the community. The availability of assistive technologies in people's homes has the potential to reduce reliance on traditional services while providing the support that is needed. The COVID-19 pandemic has forced the increased use of technology (telephonic and telehealth services) to ensure continuity of services, so significant groundwork has been laid in this area. While waiver funds may be utilized to purchase assistive technologies and services such as remote monitoring, additional funding is needed at the BHDDH level to fully fund I/DD providers to offer more robust remote monitoring and telehealth models of care. Along with assistive technology, as noted in previous sections of this plan, the waiver extension approval also includes Home Stabilization services which, once rolled out and designed, will also be available to persons with I/DD.

Table 3: I/DD Housing and Services Tiers Under the Rhode Island 1115 Demonstration Global Waiver

Tiers	Housing Options	Available Supports
Tier A — Mild Needs	• Living with Family/Caregiver • Independent Living • Community Support Residence • Shared Living • Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/or Day Supports • Transportation
Tier B — Moderate Needs	• Living with a family/caregiver • Independent Living • Shared Living • Group Home	• Access to overnight support services • Integrated Employment supports • Integrated Community and/Day Supports • Transportation
Tier C — Significant Needs	• Living with a family/caregiver • Independent Living • Shared Living • Community Support Residence • Group Home	• Community Residential Support or access to overnight support services • Integrated Employment supports • Integrated Community and/Day Supports • Transportation

Over time, BHDDH has placed a greater emphasis on home- and community-based services for adults with I/DD and in the design of the 1115 waiver. In the 2019 demonstration waiver extension, the state notes that it is committed to expanding access to community-based supports and housing choices for adults with I/DD to promote community inclusion and independence. Institutional level of support services would be available only to those who are in need of the highest level of care and clinical supports that institutions provide. Due to the restrictive nature of institutional programs/facilities, consideration is only given under extenuating circumstances where there are no other housing options that would provide the required 24-hour skilled care.

Gaps in Housing for Persons Living with Intellectual and Developmental Disabilities

Accessible Housing

The array of housing options for individuals with I/DD is not expansive enough to meet the needs of all individuals with I/DD. Those interviewed noted that there are not enough accessible housing options, including group homes, independent apartments, and SLAs, for individuals with I/DD who also have co-occurring physical disabilities (such as cerebral palsy) across the state. There is some funding available through the Access to Independence program, a collaboration between RIHousing and BHDDH, which assists with making home modifications for families and caregivers of people with developmental

disabilities. However, there are limitations on how, and in which settings, these funds can be used for ramps, lifts, bathroom modifications, and other equipment purchases.

Group Homes

Interviewees stated that there are gaps in the array of housing options. Since the state seeks to avoid institutional placements, individuals with intensive behavioral and physical service needs are usually placed in specialized group homes. Those interviewed noted a need for additional housing that is accessible by those with I/DD who have significant co-occurring physical disabilities. In addition, there are not enough skilled and well-trained provider staff or enough community support residences for people with significant clinical needs who require some staffing but do not require staff 24 hours a day, 7 days a week. Interviewees stated that provider staff often lack the knowledge and resources to help residents who are ready to move to more independent housing models, such as shared living, which contributes to minimal movement within the residential system and less clinically appropriate placements for those in need. In addition, interviewees suggested that persons often stay in group homes for long periods of time because not all providers are well-trained in teaching skills toward independence. It was noted that training funds were previously available via BHDDH for staff development but that this funding has not been available in recent years. Interviewees also stated that providers receive higher rates of reimbursement for those in group homes versus other housing options, and therefore may be financially incentivized to keep individuals in group homes. BHDDH interviewees note that initiatives have begun to work closely with providers to ensure that group home placements are being carefully considered based upon need. The Department also continues to ensure that group home residences are compliant with the Home and Community Based Services (HCBS) Final Rule setting standards to have fewer residents in group homes (four to five persons per home).

Living with Family and Shared Living Arrangements

In general, there was concern that Rhode Islanders have been slow to adopt shared living as a housing option for adults with I/DD. This contributes to a gap in utilization of the full array of housing options such as SLAs, making it difficult for adults with I/DD to move out of their family home if they do not need the level of care that a group home provides. Interviewees expressed concern that as parents age, the lack of sufficient viable housing options for their adult children makes it difficult to plan for the future. Interviewees suggested the need to allow for innovative ways to support individuals in existing housing models and to expand the number of housing options. One option would be to increase the number of SLA host homes and allow more flexible service package funding to provide services to multiple residents by one provider (versus having separate providers for each resident). BHDDH's Division of Developmental Disabilities has recently changed the SLA regulations to authorize additional support services in SLAs when needed. Efforts by the Division include increasing the number of SLAs over the past three years with plans to continue this trend, connecting or matching individuals who may want to live together in an SLA and working to increase the number of roommates in SLAs who share a direct support worker. For individuals who could live independently, but perhaps not alone, the Division facilitates roommate arrangements when appropriate. For example, two individuals could live in the same home with an SLA provider, and receive personalized services according to their needs. These situations also allow for maximization of service resources. Continuing these activities will be important in increasing housing options and continuing to create flow from living with family into SLAs for those who don't need the group home level of care.

Individuals in the developmental disability system typically do not move out of group homes into less restrictive settings such as independent living. Historically, the system was not set up to encourage independence and growth. Only in the past few years has this has become a focal point of discussion

and a part of targeted initiatives of the Division of Development Disabilities (DDD) as described above. However, one challenge facing SLA providers is access to affordable housing to accommodate shared living arrangements. SLA regulations do not allow for the lease to be in the name of an individual with I/DD, and instead must be in a service provider's name. Another obstacle is that some providers who are eager to enter into these arrangements and provide services to a person living with them, do not live in settings with adequate space or the needed number of bedrooms. Additionally, interested provider incomes, while often low, often exceed the thresholds for eligibility for affordable housing.

Another challenge noted by interviewees at DDD is that aging parents whose adult child with I/DD has lived at home or in group homes for a long time are often reluctant to consider more independent options such as SLAs. There is obvious concern for what will happen when they are no longer able to care for their adult child, or they pass away. An option being explored is having the family as a unit move into the assisted living setting. This way, at the time of a parent's passing, as long as the person with a disability meets eligibility requirements they could stay in this setting where they will have lived for some time and where they have established social connections and routines. Many assisted living facilities have levels of care that allow for greater independence with shared dining. These types of arrangements may be appropriate in cases where parents and adult children do not wish to explore SLAs or independent apartments but want to continue to live together as a family with services and supports tailored to their levels of independence both for parents and their children. This contrasts with the situation of younger parents with an adult child with disabilities living at home and receiving services. These parents seem more willing to consider independent options such as SLAs or independent living with supports and to plan for future needs well in advance. The work of the Division to continue to balance choice along with offering less restrictive housing options will be key in creating flow from congregate type settings or living at home with family, to more independent housing options.

Independent Living/Section 8 and Other HUD-Sponsored Housing

Specific data on the numbers of adults with I/DD living in Section 8 or other HUD-sponsored PSH settings was not available at the time that this report was written, however I/DD provider interviewees highlighted the need for additional HUD units that are truly affordable and accessible for this population. Interviews highlighted a gap in available first-floor units accessible to individuals with I/DD who had co-occurring physical disabilities or limitations. Providers interviewed noted that bottlenecks between higher levels of care and group homes are due to a general shortage in affordable accessible units that meet the specific needs of persons they serve, such as public forms of transportation and proximity to services and supports such as day programs or supported employment providers.

In summary, based upon our analysis of documents and interviews, there are several key issues for Rhode Island to address or continue to address in the area of housing for persons with I/DD:

- Additional SLAs and independent living/PSH options with supports are needed to help adults with I/DD and other complex needs live in the community.
- While some funding exists for home modifications, generally the array of housing options and funding is not adequate to meet the accessibility needs of those with both I/DD and physical disabilities or limitations.

    - More HUD units are needed that are affordable, accessible, and located near supports and services used by persons with I/DD.

- Work should continue with group home providers to ensure that placements reflect individuals' level of need and to evaluate whether current residents' needs match the group home level of care.

Overview of Housing for People Experiencing Homelessness

As mentioned above, Rhode Island has one statewide Continuum of Care (CoC) to carry out the planning and programming of housing for people experiencing homelessness. According to HUD, the purpose of the CoC program is to:

> Promote community-wide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effective utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.[13]

In 2019, the Rhode Island CoC (RI CoC) was awarded over $7.66 million to support 39 projects including PSH, rapid re-housing (RRH), Homeless Management Information Systems (HMIS), Coordinated Entry, and CoC planning initiatives.

According to the RI CoC's 2019 housing inventory count (HIC), there are 1,518 PSH beds including 212 family units with 655 beds and an additional 863 units for individuals. These units represent a mix of independent housing supported with project- or site-based rental assistance; scattered site tenant- and sponsor-based units; and shared living congregate housing. Supportive services provided in these PSH units vary, including case management, substance use counseling, food, transportation, and assistance with activities of daily living. The number of PSH units in the CoC has stayed relatively constant with 1,506 PSH beds reported in 2015. According to the 2010 HIC, the number of PSH beds at that time was 1,321. Some of the increase from 2010 to 2019 represents the conversion of transitional housing units to PSH units.

The CoC has also worked to create RRH units. Rapid re-housing programs provide short-term rental assistance and supportive services to help people obtain housing quickly, increase their self-sufficiency, and remain housed once the short-term rental assistance and services are completed. As of 2019, Rhode Island had 50 RRH family units with 181 beds, and 78 units for individual adults.

A new model being introduced in Rhode Island is to facilitate the movement of formerly homeless families and individuals out of PSH and RRH units into long-term affordable housing. Sometimes referred to as "move up" or "moving on," these programs are intended to help individuals and families who no longer need the services aligned with PSH to move out of these PSH units into long-term affordable housing. This movement would then free up units for homeless individuals and families to move out of homeless shelters or unsheltered settings. RIHousing is working with New Lease, a nonprofit organization based in Massachusetts, to persuade private owners of HUD multifamily housing to

[13] "What Is the Purpose of the CoC Program?" retrieved from HUD Exchange on April 28, 2020: *https://www.hudexchange.info/faqs/1544/what-is-the-purpose-of-the-coc-program/*

establish a homeless preference in their developments, and to facilitate the referral of PSH and RRH residents into those units. To date, New Lease has engaged owners of seven to ten properties to participate in the program and is in the process of establishing the referral protocols which will come through Rhode Island's coordinated entry system.[14]

Gaps in Housing for People Experiencing Homelessness

The overall lack of affordable housing has a tremendous impact on people experiencing homelessness. Recent point-in-time homeless counts and data from the state's coordinated entry system indicate that demand for housing far outpaces the supply. In addition, once residents are stabilized in their PSH units, many are unable to leave the service-enriched housing since there are limited affordable housing options. The efforts of New Lease and RI Housing's Move-Up initiative will address some of the issues of people being "stuck" in PSH.

While RI has prioritized the availability of permanent housing for people experiencing homelessness, progress is limited by the lack of available resources. Between 2019 and 2020 the state saw a slight increase of 20 beds in all its permanent housing categories which includes permanent supportive housing, other permanent housing, and rapid rehousing. The largest increase was in RRH beds with a 52% increase from 259 beds to 394 beds in the past year. The number of PSH units declined from 1,518 beds in 2019 to 1,237 beds in 2020. This is partly due to the limited availability of CoC funds for new housing. Each year the RI CoC can compete for limited "bonus" funding that is not sufficient to meet the overall need for permanent housing units. To meet the larger need, additional non-CoC resources will be needed.

Gaps in Housing for People Leaving Jails and Prisons

It is challenging to find accurate data from either the Rhode Island HMIS or from the DOC on the number of people who leave jails and prisons and go to emergency shelters either immediately or soon after. However, national data indicates that a "revolving door" routinely exists between the homeless shelter system and jails/prisons. Nationally, formerly incarcerated people are almost 10 times more likely to be homeless than the general public. In addition, national research indicates that up to 15 percent of incarcerated people experience homelessness in the year before admission to prison. Furthermore, studies of homeless shelters nationally find that many formerly incarcerated people rely on shelters after their release. According to RI HMIS, there were over 145 entries into emergency shelter from jail or prison between March 2019 and March 2020. People leaving jail and prison are generally not eligible for HUD-funded permanent housing programs and Rhode Island itself does not fund any transitional housing for people leaving incarceration. The DOC works with all inmates to gauge their housing options prior to leaving a facility but these options often change either at the last minute or soon after release, a situation also backed up by national data.

[14] Rhode Island Homelessness, Coordinated Entry, *https://www.rihomeless.org/coordinated-entry*.

Affordable Housing Strengths and Opportunities for Persons Living with Disabilities and Other Special Needs

RIHousing provides low-interest loans, grants, education, advocacy, and consumer counseling to help customers rent, buy, and retain their homes. RIHousing administers the Low-Income Housing Tax Credit program, the HOME program, and the state's allocation from the National Housing Trust Fund.

- **The HOME Program** is a federal block grant that provides $3,475,044 to the state for the creation of rental housing for households earning 80 percent of Area Median Income (AMI) or less.

- **Workforce Housing Initiative Pilot** has $7,000,000 to support the development of rental housing for those earning up to 120 percent of AMI.

- **National Housing Trust Fund** provides $3,000,000 to Rhode Island based on a formula to create rental housing for households earning 30 to 50 percent of AMI.

- **The Thresholds Program, administered by RIHousing on behalf of BHDDH, has historically** made funds available annual for capital funding to increase the supply of housing for people with SMI, SUDs, and developmental disabilities. These funds are dependent upon the budget approval process and have ranged over the years from $1.2 million to $200,000. The funds come from state general operating revenue and by statute are limited to construction only.

- **The HUD 811 Project Rental Assistance (PRA)** program provided funding for this integrated affordable housing model. In short, 28 states and District of Columbia successfully competed for 811 PRA resources, allowing them to administer project-based rental assistance in Low Income Housing Tax Credit (LIHTC) developments that set aside no more than 25 percent of their units for people with disabilities. The model requires a partnership between a state's housing finance agency and its Medicaid and human services agencies to ensure that program participants receive the support they need to obtain and maintain their housing. RIHousing administers the 811 PRA program. Other models of integrated affordable housing include tenant-based rental assistance that allows recipients to identify an eligible unit in the community and receive the rental assistance to help pay the rent on that unit.

- **9% LIHTC** credits provide over $3,200,000 to support the financing of new rental housing for households earning less than 80 percent of AMI, and typically between 50 and 60 percent of AMI.

In 2018, RIHousing spent $139 million to finance the rehabilitation or new construction of 773 affordable rental units. RIHousing also administers programs that aim to preserve existing affordable housing including the Capital Magnet Fund, the Preservation Revitalization Deferred Loan Program, the Preservation Loan Fund, 4% Low Income Housing Tax Credits, and taxable and tax-exempt mortgages.

RIHousing is the Collaborative Applicant for the RICoC, which receives over $7 million from HUD to finance over 35 programs including 28 PSH and 7 RRH programs. A complete list of the 2019 CoC awards can be found at: *https://files.hudexchange.info/resources/documents/2019-rhode-island-coc-grants.pdf*. As the Collaborative Applicant for the RI CoC, RIHousing oversees its annual funding competition and its

processes and planning; RIHousing is also the direct recipient of over $3 million in CoC funding that is operationalized through subcontracts with eight to ten nonprofit organizations.

RIHousing administers the **Road Home Program**, an initiative funded by RIHousing's own revenues, which provides sponsor-based rental assistance in which a provider agency entered into a lease with a private landlord and sublet the unit to eligible households. This program provides a temporary housing subsidy. Funding for the program has been reduced in order to focus RIHousing revenues on other priorities.

Another program funded by RIHousing revenues is the **Neighborhood Opportunities Program**. Originally funded at six to seven million dollars per year, the program sought to cover operating deficits in eligible affordable housing units. In lieu of using RIHousing revenues, many of the subsidized units now receive project-based rental assistance.

The **Office of Housing and Community Development (OHCD)** provides financial and operational support for all housing programs administered by the Housing Resources Commission, including a rental assistance program which will provide housing to homeless individuals and families through nonprofit homeless service providers. OHCD's Community Development branch administers the federal Community Development Block Grant (CDBG) program, and related programs. OHCD also administers the state's federal Emergency Solutions Grant (ESG) program which funds emergency shelters and homelessness prevention programs.

OHCD operates the state **Rental Assistance Program (RAP)** which provides 24 months of rental assistance to chronically homeless persons through a network of nonprofit organizations, many of which also operate CoC-funded programs. RAP, which is funded by the real estate conveyance tax, provides tenant-based rental assistance to homeless persons referred through the RICoC coordinated entry system.

OHCD also manages an annual allocation of just under $700,000 in ESG funding to support shelter operations, RRH programs, and related services.

Other types of projects supported by OHCD include:

- Development of affordable housing opportunities, rental and homeownership, throughout Rhode Island; Rehabilitation of homes occupied by low- and moderate- income households, eliminating health and safety code violations
- Investment in projects, such as infrastructure improvements, designed to help the state recover from presidentially-declared disasters, including the floods of 2010 and Hurricane Sandy
- Support of job training programs, such as culinary education, for unemployed and underemployed persons
- Provision of rental subsidies, to transition persons experiencing homelessness into permanent housing
- Revitalization of distressed neighborhoods through concentrated investments in housing, infrastructure, and public facilities
- Support of lead-based paint hazard reductions in residential structures

In addition to these statewide entities, Rhode Island benefits from 26 public housing agencies (PHAs) which administer over 10,000 Housing Choice Vouchers (HCVs) and over 9,400 units of public housing. The HCV program allows recipients to cover the rent of an eligible unit in the community. In addition to

HUD's general HCVs, there are targeted voucher programs, accessed through a competitive process, that provide rental assistance to non-elderly persons with disabilities. Three Rhode Island PHAs and two nonprofit organizations have been successful in obtaining these specialized Mainstream vouchers. See Table 4 below.

Table 4: Public Housing Agencies

PHA	City	Mainstream Vouchers	Date Awarded
Gateway HealthCare	Pawtucket	**75**	
Kent County Mental Health Center	Warwick	**75**	
North Providence Housing Authority	North Providence	**25**	
Pawtucket Housing Authority	Pawtucket	**95**	
Providence Housing Authority	Providence	**50**	

Gaps in Non-targeted Affordable Housing for Persons with Disabilities and Other Special Needs

Rhode Island has made progress in creating affordable housing for its residents. While the state has some innovative housing development programs, only the 811 PRA program and the low-budget Thresholds program specifically target non-homeless people with disabilities and other special needs. The CoC program and State Rental Assistance Program create permanent housing for people experiencing homelessness who often have co-occurring disabilities; however, the narrow eligibility criteria for these programs makes it impossible for people with disabilities who are not homeless, but who are nevertheless in need of more independent housing, to access these units.

The New Lease program will, hopefully, address the problem of people in PSH being unable to move to more independent housing. The Move-up Initiative can also be replicated across many of the State's PHAs to facilitate access to their HCVs. Similar opportunities are needed to assist people with disabilities to move from more service-intense treatment programs to independent, community-based housing.

Analysis of Rhode Island's Housing-Related Services for Persons with Disabilities and Other Special Needs

Organization of Services and Programs in Rhode Island

Within EOHHS, there are several departments and divisions with responsibility for specific target populations. BHDDH serves Rhode Islanders who live with mental illness, substance use disorders, and developmental disabilities by maintaining a system of high-quality, safe, and coordinated care across a full continuum of services. BHDDH promotes the health, safety, and well-being of all Rhode Islanders by developing policies and programs that address developmental disabilities, mental illness, addiction, and recovery.

> "The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals is responsible for running a responsive, caring, and efficient system of person-centered services for individuals with mental health and substance use disorders and intellectual and developmental disabilities. Wellness, recovery, and parity are the themes the agency uses to combat stigma and to move closer to an inclusive society. The Department works to create safe, affordable, integrated services for all Rhode Islanders, while collaborating with community partners to be champions of the people who need assistance in a timely, efficient, and effective manner. This also means building capacity and ensuring every door is the right door for care, while simultaneously working to make sure there is parity and that health care is equitable."[15]

An Organizational Overview

Per RI General Law Title 40.1, the director of BHDDH is empowered as the State Mental Health Authority and as the Co-Single State Authority for Substance Abuse within EOHHS for the purposes of determining the Maintenance of Effort for substance abuse education, prevention, and treatment programs. The co-designation is a result of the state's consolidation of Medicaid behavioral health funding. Policy, planning, and oversight of substance abuse education, prevention, and treatment as well as, the licensing of behavioral health care, developmental disabilities, and traumatic brain injury programs for the State of Rhode Island is under the auspices of the Department.

BHDDH has six licensed community mental health centers (CMHCs), which along with one other community mental health organization that provides specialty mental health services (Fellowship Health Resources, Inc.) form a statewide, fully integrated mental health delivery system of community mental health organizations, providing a comprehensive range of services to clients with SMI and SUD. The six CMHOs serve as designated providers of IHH services and Assertive Community Treatment (ACT). Each CMHO is responsible for establishing an integrated service network statewide for coordinating service provision with specific regional areas of responsibility. CMHCs have agreements, memorandums of understanding, and linkages that specify requirements for coordinating comprehensive care with other

[15] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (undated). Our mission, vision and strategic plan. Retrieved on 7/13/2020 from: https://bhddh.ri.gov/about/mission.php

health care providers, inpatient settings, and long-term care settings. This arrangement facilitates a managed care emphasis on addressing each person's primary medical and specialty physical health care and behavioral health needs in order to reduce health care costs, hospital admissions, and emergency department visits.

BHDDH is responsible for planning, funding, and overseeing a community system of services and supports for adults with developmental disabilities. The Department funds a statewide network of community-based services and supports for Rhode Islanders living with intellectual and developmental disabilities. These services (as more fully described in "Overview of Waiver Housing and Related Services for Persons with I/DD") are available through community provider agencies or on a self-directed basis. The Division ensures access to available resources in response to the unique needs of each person served, and supports opportunities for meaningful roles in the community for people living with developmental disabilities, including employment at competitive wages. There is work being done to achieve the terms of a 2014 federal consent decree to assist individuals in obtaining integrated employment and integrated community day services. The Department supports person-centered planning for all individuals who want to receive services. Individuals and families create a service plan matched to their unique interests and goals. BHDDH promotes human rights and protects the health and safety of adults living with intellectual and developmental disabilities through quality improvement initiatives and the licensing and oversight of service providers.

Community-based Services for Individuals with Behavioral Health Conditions

Integrated Health Home and Assertive Community Treatment Services

The goals of IHH and ACT services are to address more effectively the complex needs of persons with serious mental illness and co-occurring chronic conditions. Based on level of functioning, individuals may qualify for both IHH and ACT services. BHDDH estimates that approximately 10 percent of its service recipients with SMI who are eligible for IHH will also qualify for ACT team services.[16]

Integrated Health Home

Rhode Island's integrated health home is built upon the evidence-based practices of the patient-centered medical home model. IHH coordinates care for persons with SMI and builds linkages with and among behavioral health care providers; primary care; specialty medical providers; and community and social supports.

IHH care is provided to individuals in the community by a team of professional and paraprofessional mental health staff in accordance with an approved treatment plan to ensure each member's stability, improved medical outcomes, and reduced reliance on more restrictive services such as hospital emergency departments, inpatient medical-surgical admission, and psychiatric care. IHH teams coordinate care and ensure that medically necessary interventions are provided to help the member manage the symptoms of their illness. The IHH team assists the member, their providers, and their natural community supports to address social determinants affecting the member's health and well-being. Members receive assistance accessing medical, social, educational, and vocational services, as necessary.

[16] State of Rhode Island Executive Office of Health and Human Services (2018). 5/29/2018 Public notice of proposed amendment to Rhode Island Medicaid State Plan. Retrieved on 7/13/2020 from: *http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/1115Waiver/IHHACT-PublicNotice5.29.18.pdf*

The goals of IHH and ACT are to more effectively address the complex needs of persons with serious mental illness and co-occurring chronic conditions.

Assertive Community Treatment

ACT is a comprehensive and complementary set of services designed to meet all of an individual's behavioral health care needs in a community setting. A multidisciplinary team provides the member enrolled in ACT with mental health outpatient services, care coordination, peer support, psychopharmacology, SUD counseling, vocational training, and care management, with the goal of increasing community tenure. ACT is not a linkage or brokerage case management program that connects individuals to mental health, housing, or rehabilitation programs — that is the role of the IHH staff layered onto the ACT teams.

The ACT team delivers integrated clinical treatment, rehabilitation, and other supportive services in community locations. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for members. ACT teams are available to provide necessary services 24 hours a day, seven days a week, 365 days a year.

Research has shown that ACT services are successful in achieving outcomes and increasing community tenure for individuals with SMI and complex needs. Rhode Island's IHH provides for ACT services for those identified to be in need, as established in a standardized level of care/functionality assessment. Members are eligible for ACT if they have a DLA score of 3.0 or under. ACT programs will be reviewed by BHDDH using the Tool for Measurement of Assertive Community Treatment (TMACT) fidelity scale. EOHHS, through a collaboration with managed care organizations and BHDDH, will monitor the clients receiving ACT as a subset of the IHH population.[17]

Peer Support Services

Peer support services are specialized, therapeutic interactions between certified peer recovery specialists (current or former consumers of behavioral health services trained to offer support and assistance to those in the recovery and community-integration process) and individuals in the process of recovery. This Medicaid-reimbursable service is designed to promote empowerment, self-determination, understanding, coping skills, and resiliency through mentoring and service coordination supports.

Certified peer recovery specialists work in a wide range of settings including community mental health centers, behavioral health programs, substance use treatment facilities, peer-run organizations, community-based organizations, emergency departments, courts, homeless shelters, and outreach programs, and are certified by the Rhode Island Certification Board.[18]

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[17] State of Rhode Island Executive Office of Health and Human Services (2018). 5/29/2018 Public notice of proposed amendment to Rhode Island Medicaid State Plan. Retrieved on 7/13/2020 from: *http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/1115Waiver/IHHACT-PublicNotice5.29.18.pdf*

[18] State of Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (undated). Certification, training and licensure. Retrieved on 7/14/2020 from: *https://bhddh.ri.gov/mh/certification_training.php*

Peer recovery specialists provide essential nonclinical support to individuals with behavioral health disorders. Required services include interventions that promote socialization, long-term recovery, wellness, self-advocacy, and healthy living skills through education, coaching, navigating, and mentoring. These categories of service activities align with those of tenancy support services.

Housing-Related Service Gaps for Individuals with Behavioral Health Conditions

Intensity and Frequency of IHH and ACT Services

While supporting community tenure and assisting with daily living skills are activities provided by ACT and IHH teams, these services are primarily clinical in nature and emphasize coordinating and providing health care treatment and supporting continued recovery. Within the behavioral health service system, there are no designated housing and tenancy support services available at this time; or those services that do support individuals in community settings are not available with the frequency and intensity often needed to ensure successful transition and ongoing tenancy. This was a common concern expressed during stakeholder interviews. Interviewees noted that IHH and ACT services are not currently provided with the frequency or intensity necessary to adequately support someone living independently in the community; nor do these services focus on developing and strengthening skills necessary for successful tenancy.

Prior to the movement of compensation for services into managed care, ACT required a minimum of four hours of contact per month. Based on a number of factors, including team size, staff estimated productivity, and available work hours per year, BHDDH has estimated that ACT clients should receive approximately 8 hours of contact per month, on average. While BHDDH does receive encounter data, it is difficult to determine the actual average number of hours of ACT services delivered due to concerns about the reliability and validity of claims data from the Medicaid Management Information System.

IHH has a specified team size for staff and clients. Based on a previous iteration of BHDDH's Health Program, it is estimated that IHH clients should receive three hours of contact per month, on average. It is likely that some individuals receive more than the minimum amount of service contacts. To adequately meet the needs of individuals living in independent community living settings, both ACT and IHH services must be robust, responsive, and flexible.

Research on PSH and Housing First models consistently finds that individuals with serious and persistent mental illness are able to live independently when services are available with the flexibility, frequency, and intensity necessary according to the individual's changing needs. The transition to independent living and early tenancy phases often requires frequent, sometimes daily contact. As individuals settle into their new home, services can be titrated.

Services Provided to Individuals in Recovery Housing

For many individuals, the support available through the community of residents living together in a recovery house meets their needs and allows them to further progress in their recovery. However, others may have needs greater than a therapeutic community and on-site recovery house manager or senior resident can adequately address. One stakeholder expressed concern for individuals who require assistance to take daily prescribed medications. This level of assistance, and behaviors or issues that may arise from not taking medications consistently, may result in the person having to leave the

recovery house. This stakeholder did not specify the type of medications (e.g. for physical or behavioral health condition).

Workforce Training

Additionally, ACT and IHH staff, peer specialists, recovery coaches, and other staff responsible for assisting individuals to live independently may lack the expertise and knowledge necessary to help navigate complex housing eligibility and application processes; identify and teach skills specific to pre-tenancy, move-in, and on-going tenancy; and establish successful partnerships with landlords and property managers.

Additional Community-Based Services for Individuals with Intellectual and Developmental Disabilities

In addition to the 1115 waiver services/supports that are offered through the adult developmental disability system (as described in the previous section of this report), individuals with I/DD who are eligible for the Medicaid Long-Term Services and Supports (LTSS) program have access to a variety of other home- and community-based services that support living in the community:

The **Independent Provider (IP)** program is a self-directed option for people living in their homes who meet the criteria for Medicaid LTSS but need fewer services. Services available include homemaker and personal care. The IP program allows individuals to choose their personal care aide, control their service schedules, and receive case management and assistance with personal care coordination.

RIte@Home is a Shared Living program through EOHHS. This service is for individuals who cannot live alone and who require considerable assistance with activities of daily living. The caregivers who provide services to individuals must go through one of two intermediaries who help to oversee contracted caregivers.

Personal Choice is another self-directed service that allows individuals to hire and manage personal caretakers who assist with daily living activities including bathing, dressing, and home-related activities. Typical services include personal care assistance, environmental modifications, specialized medical equipment, assistive devices, Meals on Wheels, and emergency response systems.

Program for All Inclusive Care for the Elderly (PACE) is a program that allows elders, including older persons with I/DD, to remain in the community for as long as possible. PACE contracts with health care professionals and other agencies to provide needed care. For individuals with the greatest need, PACE offers skilled nursing care.

Housing-Related Services Gaps for Individuals with Intellectual and Developmental Disabilities

Case Management

BHDDH case managers focus on person-centered planning for each individual regarding their housing and services goals. However, turnover due to retirements in case management staff have recently created gaps in planning for both longer-term housing services and moving to more independent levels of housing. When interviewees were asked how the upcoming 1115 waiver Home Stabilization services should be designed for persons with I/DD, they noted that providers and case managers performing this function will need to be well-trained to tailor their approaches carefully to engage each individual in a way that works for them.

Training Needs and Shortages in the Workforce

Interviewees stated that additional training of the workforce to meet the needs of persons with I/DD is critical. In particular, more training is needed for care for those with I/DD and co-occurring complex physical disabilities along with the development of more specialty housing that can meet this population's needs. Interviewees also advocated for increased wages for those staff working with this population, once they are trained. As noted in the housing gaps discussion section of this plan, persons with I/DD in group homes tend to remain there for long periods of time and not all group home providers may be teaching skills for individuals to live independently. Training funds were previously available via BHDDH for staff development but this funding has not been available in recent years. BHDDH regulations and certification standards ensure providers are trained on the basics in topics such as behavioral supports and supported employment. More in-depth training beyond this is at the discretion of providers. Exploring standardized trainings across providers related to skill-building toward independence could be further explored at the provider level to support movement from more restrictive to less restrictive settings with supports.

Family-to-Family Support/Family Navigation

Parents are also in need of additional family peer supports to help identify resources in times when their adult child's behaviors or physical care needs may become harder to manage at home. Interviewees were not aware of any additional family resources or services, such as family peer navigators/specialists, within the developmental disability system for people who have adult children with I/DD and co-occurring diagnoses. The Center for START (Systemic, Therapeutic, Assessment, Resources, and Treatment) Services at the University of New Hampshire was recently contracted by BHDDH to conduct a study of Rhode Island services gaps. The START model is designed to help serve persons with I/DD and co-occurring behavioral health conditions and their families, and is aimed at improving the lives of persons with I/DD and their families through services and evidence-based practice recommendations. The Center for START has also formed a learning community made up of a variety of stakeholders, including families/parents, in order to learn from one another and assess what services gaps exist, including potential gaps in family peer supports.

Assistive Technology

As noted earlier in the I/DD services and housing overview, the 1115 global waiver allows those in each tier to purchase assistive technologies. However, funding is currently limited to providers to support a full array of remote monitoring functions using these technologies. Currently, I/DD agency providers are only able to provide 24/7 emergency supports. Recognizing a gap in technology supports, BHDDH is currently exploring funding for more enhanced use of technology such as additional telephonic supports

and telehealth. Interviewees at BHDDH noted that the Division of Developmental Disabilities has had success in setting up some remote technologies to serve persons with I/DD during the COVID-19 pandemic. Leveraging the lessons learned and successful use of technology with persons with I/DD during the pandemic, and exploring future funding options to continue the use of technology, particularly for those who choose independent housing or SLAs, will be important in supporting individuals to live in the community.

Based upon our analysis of documents and interviews, there are several key issues for Rhode Island to address in the area of housing-related supports and services for persons with I/DD. These include:

- Exploring resources for additional training and guidance on how to teach independent living skills so that individuals can live independently. Such trainings could include those sponsored by the American Network of Community Options and Resources (ANCOR).
- Exploring gaps in peer supports by examining the findings from the Center for START Services learning community and systems analysis to examine gaps for family services and consider funding for family peer support positions.
- Address the need for further funding in assistive technology and for provider agencies to expand the use of assistive technology models.

Recommendations

1. Systems Level Recommendations

Based upon the analysis above, TAC recommends the following steps the state may take at a systems or Department level to help increase access to permanent supportive housing (PSH) and its related services.

Recommendation 1A: Infuse all programs that serve Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) clients with the principles and practices of Housing First, permanent supportive housing, and Supported Employment.

Housing options that promote true community integration, and opportunities to explore and gain employment, together form the foundation for living a full and meaningful life in the community and for positive long-term recovery outcomes. Individuals are more likely to remain engaged in treatment and recovery-oriented services when those services support the attainment of valued life roles. Integrated housing options and employment are key domains on which all services can be based. To ensure this focus, TAC recommends that all Rhode Islanders receiving community-based services establish, as part of their Personal Care Plan, a housing goal that identifies their preferred living setting and service activity objectives to attain this goal. This housing goal identifies and addresses interventions based on a strengths and needs assessment that directly relates to obtaining and maintaining housing.

A person's aspirations for where they want to live and how they want to contribute should also form the foundation for their individualized, recovery-oriented care plan. This involves establishing the long-term goals for housing and employment and then taking steps that lead directly toward the person's goals — regardless of perceived or real readiness. This represents a shift away from a linear

model of service delivery in which a person's symptoms and behaviors must first become stabilized as a person progresses through a series of services that lead to the actual desired goal.

Shifting focus to life in the community does not negate a stepwise approach for some individuals for whom this may be suitable and effective.

Recommendation 1B: Convene a state inter-agency task force to develop and implement an action plan to increase independent integrated housing opportunities and essential housing stabilization and tenancy support services.

Building on established collaborative inter-agency partnerships strengthened by the collective response to COVID-19, Rhode Island should convene a time-limited working group or task force that will create a plan for increased independent integrated housing opportunities and housing stabilization and tenancy support services to support individuals in accessing and maintaining community-based housing of their choice. At a minimum, members should include leaders from BHDDH, the Executive Office of Health and Human Services (EOHHS), and the Rhode Island Housing and Mortgage Finance Corporation (RIHousing). As part of this planning process, focus groups can be conducted to obtain input from key community providers including, but not limited to:

- The state's three primary managed care organizations (United, Neighborhood Health, and Tufts)
- Representatives from each of the accountable care organizations responsible for providing services to individuals served by BHDDH
- Provider trade and leadership organizations
- Peer recovery leadership
- Realtor associations
- Representatives from Eleanor Slater Hospital and other state-run facilities
- Representatives from nursing facilities and assisted living facilities whose residents include persons with serious mental illness (SMI) and intellectual/developmental disabilities (I/DD) who could be targeted for transition to the community
- Family members and clients of BHDDH services and residential programs

2. Housing Recommendations

In order to meet the demand for affordable, community-based housing, it is important to expand on existing practices and to introduce new housing opportunities for consumers of BHDDH services.

Recommendation 2A: Increase investment in housing and resources targeted to people with disabilities.

Governor Gina Raimondo's 2021 budget prioritized the development and preservation of affordable housing including the creation of a housing bond bill that would provide a dedicated source of revenue to increase the supply of affordable housing. The governor's budget included $7.9 million annually in permanent funding for the construction of affordable housing, paid for by an increase in the real estate conveyance tax on properties valued at more than $500,000. State officials estimate that the new tax would generate enough money to create 250 affordable homes for low- and

moderate-income residents each year. In addition, the governor's proposed budget called for a $25 million housing bond to support the development and rehabilitation of affordable housing. Hopefully, the state legislature will approve these housing initiatives proposed by Governor Raimondo. Once this happens, in order to expand housing for consumers of BHDDH, it is recommended that program rules require set-asides in housing funded by the new initiatives for BHDDH consumers. If one out of every ten units funded by the real estate conveyance tax were dedicated to BHDDH, about 25 new units of affordable housing would be made available. Another 80 units could be created out of the housing bond resources assuming the same set-aside.
The Road Home program provided valuable short-term rental assistance for BHDDH consumers, people experiencing homelessness, and other low-income residents. The program was funded through RIHousing revenues and is financially unsustainable for the organization so funding has been limited. To fill some of the gap created by the reduced budget for the Road Home program, it is recommended that the state develop a pilot rental assistance program funded out of state operating funds targeted to BHDDH consumers. With an estimated rent of $900 for a one-bedroom unit[19], in a program serving individuals receiving a monthly SSI payment of $733 and requiring a 30-percent payment toward rent, the annual rent for an individual would be just over $9,000 per year including necessary administrative fees. A pilot state-funded rental assistance program could serve ten individuals with a commitment of $90,000 or 50 individuals with $450,000 or 100 individuals with an annual budget of $900,000. The pilot program could be operated by several local public housing agencies with an emphasis on those administering Mainstream vouchers. Such state-funded rental assistance can be considered a bridge to more permanent subsidies including Housing Choice Vouchers, Mainstream vouchers, and nonelderly disabled vouchers, or to Department of Housing and Urban Development (HUD) 811 Project Rental Assistance (PRA) units.

Recommendation 2B: Apply for upcoming HUD Mainstream vouchers.

It is anticipated that there will be another Notice of Funding Availability (NOFA) for Mainstream vouchers. In 2019, the Pawtucket Housing Authority was the only public housing agency (PHA) in Rhode Island to receive an award of 20 Mainstream vouchers. While it is not known if other PHAs applied for the Mainstream vouchers in 2019, an effort to encourage all eligible PHAs to apply for the next round could yield considerable resources. The 2019 application required a demonstration of partnership between human service organizations and the applying PHA. BHDDH and RIHousing could bring all PHAs together to review the next NOFA's requirements, align service and referral resources accordingly, and support all PHAs to submit applications. In neighboring Massachusetts, 18 PHAs were awarded a total of 753 vouchers, and in Connecticut, 6 PHAs were awarded 231 vouchers.

Recommendation 2C: Review increased incentives to maximize existing resources under the amended Qualified Allocation Plan (QAP).

Getting owners of Low Income Housing Tax Credit (LIHTC) developments to participate in the HUD 811 PRA program can be challenging. RIHousing has amended its QAP to include additional incentives for LIHTC applicants to participate in the 811 PRA program. This report encourages

[19] HUD Office of Policy and Development Research, Fair Market Rents, https://www.huduser.gov/portal/datasets/fmr.html

RIHousing to review the success of these additional incentives and be prepared to include additional ones in the next QAP to continue to maximize 811 PRA resources.

Recommendation 2D: Target new PSH resources to individuals transitioning from Mental Health Psychiatric Rehabilitation Residences (MHPRRs) in order to create flow within this continuum, and to individuals with developmental disabilities in order to reduce reliance on group home settings.

At the time of data collection for this plan, BHDDH had identified 45 individuals for transition from MHPRR programs to independent housing with essential community-based services aimed at supporting successful tenancy. Additionally, a goal of BHDDH is to reduce reliance on group homes for individuals with developmental disabilities. BHDDH can create a detailed plan that transitions individuals from these two groups to new PSH resources should they become available. Simultaneous planning can take place as vacancies become available in MHPRR programs to repurpose some of these programs for current special needs populations if that is deemed an appropriate reconfiguration of resources. Currently there are many people with serious mental illness stuck in hospitals who need this resource, as well as patients from Eleanor Slater Hospital who need community placement. It should be noted that many of these facilities, as with the developmental disability group homes, are owned by the state and require significant capital investments to restore and maintain — such expenses are not built into rates, therefore many of these facilities are in disrepair.

Recommendation 2E: Reconfigure existing MHPRRs based on planned openings to meet the needs of targeted populations.

Develop and implement a plan to reconfigure programs within the existing MHPRR residential continuum to meet the specialized needs of individuals currently unable to move to a less restrictive setting due to lack of available services. Identify priorities such as young adults aging out of the foster care system, and individuals with criminal histories and forensic backgrounds who with structure and support could live in community settings. While it may be tempting to direct new housing and services resources towards developing/expanding supervised and supported residential programs, it is proposed instead to access program vacancies that can be created by transitioning people from MHPRR beds to PSH or other more independent housing should these opportunities become available. This link helps ensure that service-enriched housing is available for those who most need it and that more community-based housing is available to graduates of these programs.

Recommendation 2F: Pilot a housing program to transition people with behavioral health needs from prison to community-based housing.

Rhode Island does not currently have a housing program to help people leaving incarceration transition to the community. Creating a pilot program that would provide housing assistance and supportive services to people leaving jails/prisons with no stable housing would provide the state with an opportunity to measure the success of such an intervention on an initial small scale. Connecticut's REACH program (see Recommendation 2F) provides scattered site transitional housing and case management services to high-risk individuals transitioning into the community from the correctional system. REACH provides a housing subsidy, support in locating housing, and intensive case management for four to six months. Additional services include: referrals to mental health and other treatment providers; vocational supports; educational opportunities; and transportation assistance.

3. Housing-Related Services Recommendations

Service-related recommendations are organized as they pertain to the populations served by BHDDH.

Persons with Behavioral Health Conditions (SMI and SUD)

Recommendation 3A: Integrate housing and tenancy support services into Assertive Community Treatment (ACT), Integrated Health Homes (IHH), and peer specialist services.

To support a housing policy that promotes individual choice and community integration, it is essential that individuals have access to flexible, responsive, and housing-focused services. It is recommended that BHDDH establish housing and tenancy support as an integral component of ACT, IHH, and peer support specialist services. One model used by some states is to add a housing specialist position to ACT teams. This staff member is trained and holds the knowledge and expertise necessary to navigate the complexities of housing systems, establishes relationships with local landlords and property managers, and is knowledgeable about housing eligibility and application requirements. A similar position could be added to the IHH teams. In this way, available resources would be maximized, reducing overlap in services for some individuals (e.g. one individual receiving both ACT and IHH services).

Recommendation 3B: Create a housing specialization within the certified peer recovery specialist role or as a separate service for individuals with SUDs who are not eligible for ACT or IHH.

BHDDH has been exploring the option of creating a housing navigator role to help individuals with SUDs only to access available housing resources. This position can be developed as a new service or integrated as a specialty within the existing Certified Peer Recovery Specialist role. This specialist can initiate services with the individuals who are still in residential treatment to identify housing and support needs upon discharge, and with individuals first entering recovery housing to help them identify housing upon exiting recovery housing.

Recommendation 3C: Conduct an analysis of ACT and IHH services to assess 1) frequency and intensity of service delivery, and 2) type of service activities and interventions provided.

Research has consistently demonstrated that individuals with complex behavioral health conditions and challenging behaviors can live independently in the community when adequate and relevant services are available. Pre-tenancy and move-in phases of PSH often require more intense and frequent services which can be titrated once a person settles into their new home and establishes routines and social supports. Then, throughout the ongoing tenancy, an individual's changing needs require services that are responsive and flexible. Individuals need assistance to develop skills directly related to tenancy and community living, including addressing needs related to potential loneliness and boredom.

Some stakeholders expressed concerns that as currently provided, neither ACT nor IHH is adequate to support hard-to-serve individuals in more independent housing. This contributes to an overreliance on supervised congregate settings.

As part of this analysis, determine if expansion of ACT or IHH is needed, as well as specialty teams such as FACT — Forensic Assertive Community Treatment. This model, as implemented in other states, includes a liaison with the Department of Corrections who has expertise in helping individuals address barriers to community living as a result of criminal histories. Another option is to set a realistic rate for the Housing Stabilization code that was approved by Medicaid (see Recommendation 3G for more information).

Recommendation 3D: Conduct an analysis to determine how many of those who leave SUD recovery housing need PSH in order to attain successful tenancy and continued recovery.

Many individuals who enter recovery housing need affordable housing upon exiting, yet may not need PSH. Other individuals leaving recovery housing may need PSH, yet not be eligible for ACT or IHH services. Both groups can be prioritized for the new Home Stabilization service, offering the support needed to assist them in finding and settling into independent living.

Recommendation 3E: Establish housing goals at the point of admission to Eleanor Slater Hospital to drive treatment activities and the discharge planning process.

BHDDH recently began the process of assisting individuals with applying for all eligible housing as part of the discharge planning process. Establishing long-term housing goals at the point of admission can serve to guide treatment and rehabilitation activities while in the hospital, and highlights that if MHPRR programs are considered, these settings are intended as transitional in nature and should directly lead to the desired housing goal. As individuals wait for access to affordable housing, MHPRR programs can focus on developing skills for further recovery and independent living. BHDDH and providers are working collaboratively with RI Housing to connect with housing providers and establish essential relationships and partnerships.

Recommendation 3F: Conduct staff training specific to housing and tenancy support services.

Develop and implement a training program specific to housing and tenancy support services. All staff designated as housing or home stabilization specialists will be required to complete this training program. Recommended topics should include: overview of the various housing options, eligibility criteria, and housing application processes; establishing relationships with landlords and property managers; conducting a housing needs assessment; assisting individuals to navigate the housing search and application process; arranging for successful move-in; and essential skill and support development for ongoing tenancy.

Recommendation 3G: Target new Home Stabilization services to individuals who are most in need and who are ineligible for other community-based services.

Given the importance of services to help people find, get, and keep housing within the PSH model, the Centers for Medicare and Medicaid Services (CMS) stated in its June 26, 2015 Bulletin that "research has demonstrated successful community integration for individuals in need of long term

services and supports (LTSS) that receive housing-related services"[20] and described how states may add housing-related activities as covered services in Medicaid state plan amendments and other CMS waivers and demonstrations as follows:

- **Individual Housing Transition Services** – which include activities leading up to a move to PSH, such as identifying housing needs and barriers, development of a housing support plan, assisting with housing applications, identifying resources to cover one-time move-in expenses (i.e. security deposits and furniture), ensuring the housing is safe, assisting with the move itself and developing a housing support crisis plan.

- **Individual Housing and Tenancy Sustaining Services** – which include early identification of problems that may jeopardize housing, education on the rights and responsibilities of tenants and landlords, coaching on development of the relationship and resolving disputes with landlords or other tenants, linking the person to community resources, assisting in the housing recertification process, regularly updating the person's crisis plan, and other supports as needed.

Rhode Island has included PSH and housing-related services in recent efforts to infuse them into its state systems. The Rhode Island EOHHHS has included a set of Home Stabilization Services in the latest 1115 amendment known as the Rhode Island Comprehensive Demonstration.[21] The stabilization services in the demonstration are defined as follows:

- **Home Find Services** are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for their own living expenses.

- **Home Tenancy Services** are designed to ensure timely access to appropriate, high-quality services for individuals who require support to establish or maintain a home, with the goal of promoting successful community living and reducing unnecessary institutionalization, addressing social determinants of health, and promoting a person-centered, holistic approach to care.

These services were approved by CMS in 2015[22] but the design and provision of these services are currently being developed by the state and are not yet available. The current rate that was proposed is too low to be financially viable for agencies to provide the services. When these services are developed and launched, and an appropriate rate is approved, they will be available to the populations served by BHDDH including adults with I/DD, SMI, and SUD.

[20] Centers for Medicaid and CHIP Services (2015). CMCS informational bulletin: Coverage of housing-related activities and services for individuals with disabilities. https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/CIB-06-26-2015.pdf

[21] Centers for Medicare and Medicaid Waiver List for the State of Rhode Island (January 1, 2019 through December 31, 2023). Retrieved on 7/14/2020 from: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/FINAL%20RI%20STCs%20w.Tech%20Corrections_11.19.19.pdf

[22] Letter from Danielle Daly and Angela Garner of the Centers for Medicare & Medicaid Services State Demonstrations Group (2020). *https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ri/ri-global-consumer-choice-compact-ca.pdf*

Rhode Island is encouraged to maximize this new resource through strategic implementation that leverages existing resources to target those who are most in need and who are ineligible for other community-based services.

Options to consider include prioritizing access and/or length of access to the new Home Stabilization services for those not eligible for other community services. If ACT, IHH, Waiver and peer specialist services include housing and tenancy support as part of their package, this new service could be a needed resource for individuals not eligible for other services.

If the Home Stabilization service will be implemented in a way that layers it with existing services, then it is recommended that BHDDH build on its earlier state-funded model of this service. A Critical Time Intervention (CTI) approach was followed so that the home stabilization service provided the initial home-finding and move-in support and then provided a warm handoff to the involved provider for ongoing service.

Recommendation 3H: In partnership with EOHHS and Medicaid, work with the state's primary managed care organizations and accountable care organizations to authorize housing-related services, more ACT and IHH teams, and the addition of housing specialists to ACT, IHH, peer support, and peer recovery teams.

The managed care and accountable care organizations have an interest in recognizing the importance of housing in health outcomes given the proven cost savings associated with evidence-based models such as PSH and Housing First. Medicaid should set forth clear contractual expectations with managed care and accountable care organizations to authorize and pay for housing-related services. In partnership with EOHHS and Medicaid, the managed care and accountable care organizations should consider how to use available resources to pay for housing-related services and develop reimbursement strategies to encourage providers to deliver quality and effective housing and tenancy support services. They should also establish clear requirements for network Community Behavioral Health Organizations related to housing and tenancy services, including intended outcomes.

Persons with I/DD

Recommendation 3I: Continue to create movement from residential group homes to shared living arrangements (SLAs) by continuing work to outreach to individuals who want to move into supported housing and who are not in need of higher intensity supports and services. Create additional opportunities for shared living and increase outreach to those interested in voucher-based PSH options.

BHDDH's current strategic plan includes activities designed to increase access to and additional flow from one residential setting to another for adults with I/DD. A few of these long-term strategic goals include:

- Reducing the number of those living in group homes
- Continuing to increase the number of shared living arrangement (SLA) sites and the number of providers who can support persons with more complex behavioral, medical, and behavioral health care needs in SLAs and non-group home settings

- Identifying a targeted number of persons each year who could move to shared living arrangements and matching persons who may want to live together in SLAs
- Exploring the expansion of assistive technologies to provide remote monitoring services and telehealth for persons who live in SLAs or voucher-sponsored housing, and leveraging successes and lessons learned from the use of assistive technology to support individuals during the COVID-19 crisis

In addition to these strategies, outreach to individuals who would be interested in exploring voucher-based housing options, such as with set-asides noted above, is an important step. Creating more movement in residential settings for those with I/DD over time will help the system of care become more integrated and less restrictive with less intensive support services.

Recommendation 3J: Fund new positions to deliver in-home housing-related services under the Home Stabilization benefit for adults with I/DD who want to move into voucher-based PSH units.

Collaborate with I/DD service providers to create positions that specifically help persons with I/DD with pre-tenancy and tenancy-sustaining supports under the upcoming Home Stabilization 1115 benefit. Training these staff on how to help people apply for and obtain housing will be an important step in ensuring that this service will meet the needs of this population.

Recommendation 3K: Explore sustainable funding and financing mechanisms to create a family peer specialist service position focused on helping families explore options for more independent levels of housing or other supports needed while adult children are living at home with family.

Examine the findings from the START Center's assessment of family support services that may be missing from the I/DD system and explore short-term funding opportunities while exploring sustainable funding for Family Peer Specialist services through block grants or other state plan funding. These types of services are needed to help families learn about long-term service options for their children and to connect them with supports while they are planning toward moving their children to more independent settings as parent caregivers age.

Recommendation 3L: Develop systems to enhance data on persons entering DOC who are homeless, persons leaving DOC who are homeless, and persons leaving DOC with potential housing stability.

A working group made up of staff from Rhode Island Coalition for the Homeless, which oversees the state's Homeless Management Information System (HMIS),, and appropriate staff from DOC and DBHDD, can find ways to share data and enhance the collection of information on persons living with behavioral health issues who are discharged from DOC. This will make it possible to identify those most at risk of becoming homeless or returning to homelessness. The group will determine data needs, collect and analyze data, and report on the extent of the "revolving door" in Rhode Island as a first step in developing targeted homeless prevention strategies and transition to community opportunities.

Conclusion

This plan will help Rhode Island to further develop existing strategies and implement new ones that can improve access for persons served by BHDDH to a variety of housing options and housing-related supports.

Strengths of the state's current housing and services system include:

- A desire to shift the behavioral health system from housing options of higher intensity to PSH options
- Current strategic plans and Medicaid initiatives supported by Governor Raimondo that recognize housing as a social determinant of health and housing-related services as a vehicle to reduce costs and improve health outcomes for BHDDH populations over time
- A strong foundation for evidence-based practices and programs including ACT and IHH teams and a continuum of services and housing options for persons with SMI, SUD, and I/DD to draw upon to move the system forward.

Gaps and challenges related to improving access to PSH and related services include:

- The lack of safe, affordable housing located near the services that persons with I/DD, SMI, and SUD need.
- Concern that ACT and IHH services are currently not provided at the frequency or intensity needed to support individuals living in independent, integrated housing. Additionally, these services do not emphasize or provide skill development in areas necessary for successful tenancy (e.g. behaviors related to adhering to terms of a lease, being a good neighbor, household upkeep, establishing friendships and support networks, seeking assistance when needed). This needs to be investigated using reliable data that may not be available in the MMIS system.
- The need to tailor and design housing-related supports (1115 Home Stabilization services) to the specific needs of different populations that will be eligible for the service (people with I/DD, SMI, and SUD).
- Provider staffing shortages have created service gaps for the behavioral health populations, including in case management.

Implementing the system, housing, and housing-related services recommendations as outlined in this report will help the state to further act on its commitment to provide housing in settings of lower intensity with an array of services that are appropriate to people's needs and desires, and to implement housing-related services that will help the BHDDH population to obtain and sustain housing.

Appendix A: Key Informant and Group Interviews

- Linda Mahoney - Administrator of Behavioral Health and Substance Use Disorder Programs – 2/13/20
- Caitlin Frumerie – Rhode Island Coalition for the Homeless - 2/14/20
- Debra Langevin and Susan Jewel – The Autism Project (Lifespan) – 2/27/20
- Substance Use and Mental Health Leadership Coalition Meeting – 2/28/20
- Community Provider Network Meeting (ID/DD provider Leadership) – 3/5/20
- DBHDDH Behavioral Health Leadership Team Meeting – 3/9/20
- Brenda Clement - HousingWorks RI at Roger Williams University – 3/10/20
- Heather Mincey, Assistant Director and Joanie Martell, Director for Residential Programs with the Division of Developmental Disabilities - 5/27/20
- Jessica Mowry and Elizabeth Bioteau, RI Housing

Appendix B: Data and Documents Reviewed

Documents

- Application to Participate in the Section 223 Demonstration Program State of Rhode Island – October 2016
- Request to Extend the Rhode Island Comprehensive Section 1115 Demonstration Waiver – July 11, 2018
- Rhode Island Behavioral Health System Block Grant – 2019
- Rhode Island Uniform Application for Substance Abuse Prevention and Treatment and Community Mental Health Services Block Grant - FY 2018/2019
- State of Rhode Island Executive Order – Establishing the Working Group for Healthcare Innovation – July 20, 2015
- State of Rhode Island Executive Office of Health and Human Services – Public Notice of Proposed Amendment to Rhode Island Medicaid State Plan – IHH and ACT Integration – May 29, 2018.
- State of Rhode Island Executive Office of Health and Human Services - Public Notice of Rhode Island COVID-19 1115 Demonstration Waiver Request – 3/27/2020
- Rhode Island PATH Grant Application – 2018
- The Evolution of Family Navigation in Rhode Island – Presentation by the Rhode Island Autism Project – Data from 2004 to 2007
- RI HMIS Data
- RI DoC Data
- Rhode Island Housing Scan – 2019 Developed by Technical Assistance Collaborative