Housing Tenancy Support Toolkit

For Community Support Teams

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part of the UNC Center for Excellence in Community Mental Health

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Introduction

Welcome to the Housing Tenancy Support Toolkit for Community Support Teams! In 2022, the North Carolina Department of Health and Human Services (NCDHHS) contracted with the Technical Assistance Collaborative (TAC) and the University of North Carolina Center for Excellence in Community Mental Health to provide coaching and training to Community Support Team (CST) providers serving individuals in Transitions to Community Living. As part of this effort, we have developed this toolkit to help CST providers effectively support individuals receiving services. Our primary focus is on enhancing tenancy support services for individuals participating in TCL. However, we hope this toolkit will be beneficial to providers of tenancy support services through other programs as well, such as Assertive Community Treatment and tailored care management. The insights and resources you will find in this document can help you gain a foundational understanding of CSTs, TCL, and tenancy supports. Fillable templates and forms in the appendices can be used to enhance CST infrastructure and provide effective services.

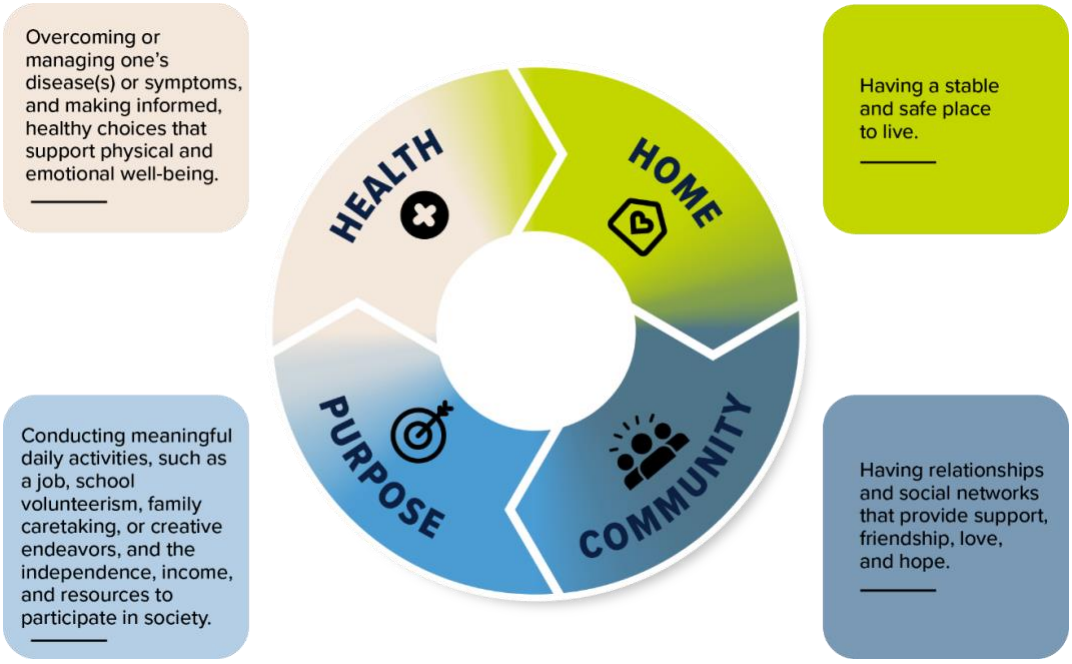
Common Definitions

Recovery

The Four Major Dimensions of Recovery (SAMHSA)

The Substance Abuse and Mental Health Administration (SAMHSA) defines recovery as a process through which people improve wellness, increase independence and autonomy, and create a fulfilling existence. SAMHSA's four dimensions of recovery — health, home, purpose, and community — offer a dynamic approach to achieving these goals (SAMHSA, 2024.). The role of CST is to provide the support that allows people to achieve recovery on their own terms.

Figure 1: Four Dimensions of Recovery



Recovery-Oriented Language

The language providers use when talking to and about the individuals they serve matters immensely. Creating shared language is essential to effective communication and common understanding. In all documentation and communication methods, it is critical to use recovery-oriented language to describe the services provided, the challenges individuals receiving services face, and the successes they achieve. Recovery-oriented language is "person-centered," describing an individual's behavioral health conditions as part of their larger self; nobody should be defined by this single aspect of their life. The language used about individuals receiving services often reflects implicit or explicit biases or beliefs about those individuals — so to fully embrace recovery-oriented practice, it is imperative not only to examine language but to regularly question your own biases and adjust your perspective.

Table 1: Making the Shift to Recovery-Oriented Terminology

Commonly used term: "This person…	Recovery-oriented language: "This person…
…is schizophrenic, mentally ill"	…is diagnosed with schizophrenia; has mental illness"
…is paranoid, delusional"	…has symptoms of paranoia, is experiencing delusions"
…is non-compliant or resistant"	…exhibits difficulty taking prescribed medication or is not following the recommended treatment; is choosing not to take medications currently"
…is decompensating"	…has experienced an increase in symptoms"
…is homeless"	…is experiencing homelessness"
…has limited insight"	…is focusing on x, y, z instead"
…is low-functioning"	…is experiencing a difficult time with x, y, z"

Additional Resources on Recovery-Oriented Language

- *Recovery-Oriented Language Guide: Words Matter* (Mental Health Coordinating Council)
- A Guide to the Use of Recovery-Oriented Language in Service Planning, Documentation, and Correspondence (Mental Health America – Allegheny County)

Psychiatric Rehabilitation

A core element of the CST service array is the provision of psychiatric rehabilitation. As defined by the U.S. Psychiatric Rehabilitation Association, *"Psychiatric rehabilitation services are collaborative, person-directed, and individualized. These services are an essential element of the health care and human services spectrum and should be evidence-based. They focus on helping individuals develop skills and access resources needed to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice."*[1]

Figure 2: Psychiatric Rehabilitation Principles

[1] Psychiatric Rehabilitation Association (n.d.). About PRA.

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Transitions to Community Living

Olmstead & The History of TCL

In August 2012, the U.S. Department of Justice entered into an agreement with the state of North Carolina to resolve allegations that the state had failed to serve individuals with disabilities in the most integrated setting to appropriately meet their needs, as required by the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973. The agreement is referred to as the NC *Olmstead* settlement, as it was based on the 1999 Supreme Court ruling relating to Title II of the ADA, also known as the *Olmstead* decision. The *Olmstead* decision affirmed that people with disabilities have a qualified right to receive state-funded supports and services in the community rather than in institutions. The NC *Olmstead* settlement was specifically directed toward individuals with serious mental illness (SMI) who reside in or are at risk of residing in adult care homes. Learn more on the NCDHHS Transitions to Community Living website.

What Is Transitions to Community Living?

As part of its *Olmstead* settlement, the State of North Carolina developed the Transitions to Community Living (TCL) initiative for adults who live with SMI or serious and persistent mental illness (SPMI). TCL ensures that eligible individuals who reside or are at risk of residing in an adult care home have the choice to live and work in their communities. Across the state, Local Management Entities/Managed Care Organizations (LME/MCOs) work with provider agencies to deliver education, transition/tenancy support, and community-based services to eligible individuals. TCL provides rental subsidies and ongoing tenancy support services to help participants live successfully in their own homes.

TCL Housing Guidelines

The primary emphasis of the NC *Olmstead* settlement is on transitioning individuals to supportive housing in their community of choice. The TCL Housing Guidelines provide a blueprint for implementing, funding, and operationalizing the housing component of the *Olmstead* settlement. Housing subsidies, types of housing, and other benefits available to TCL participants are all covered in detail in this toolkit.

TCL Eligibility and Access

Since TCL is based on the state's *Olmstead* settlement agreement, it has specific eligibility criteria. Individuals with SMI/SPMI who are currently living in larger adult care homes (ACHs) and individuals discharged from state psychiatric hospitals are identified by the state. While the top priority is to transition individuals living in ACHs to the community, the next priority is to divert individuals with SMI/SPMI from entering an ACH in the first place, and instead to give them the choice of where they want to live. To this end, a referral for TCL screening should be submitted for every person who seeks admission to an ACH. The referral can be completed by the individual or by others acting on their behalf.

The "Referral Screening Verification Process" (RSVP) is completed online, and is then sent to the LME/MCOs to confirm whether an individual has an SMI/SPMI and verify Medicaid status and income, in order to determine their eligibility for TCL.

In addition to the DHHS TCL website, each LME/MCO has a dedicated web page that provides the specifics of its own TCL enrollment processes.

Table 2: LME/MCO Transitions to Community Living Webpages

LME/MCO TCL Web Pages

- Alliance Health
- Partners Health Management
- Trillium Health Resources
- Vaya Health

Additional Resources on Transitions to Community Living

- Transitions to Community Living (NCDHHS)
- Transition to Community Living Housing Guidelines (NCDHHS)
- RSVP Online Portal (Emphasys Housing Locator) and RSVP Fact Sheet (NCDHHS)
- Settlement Agreement with Department of Justice (NCDHHS)
- LME-MCO Directory (NCDHHS)

Tenancy Supports and CST Service Delivery

Housing Tenancy Supports

Permanent supportive housing (PSH) is a nationally recognized, evidence-based practice that combines permanent, deeply affordable rental housing with voluntary and flexible community-based services. PSH supports people who have serious and long-term disabilities — such as mental illnesses, developmental disabilities, physical disabilities, substance use disorders, and chronic health conditions — in accessing and maintaining stable housing in the community of their choice. PSH is a cost-effective solution to addressing the needs of vulnerable people with disabilities who are homeless, institutionalized, or at greatest risk of these conditions.[2] [3] [4]

Voluntary, flexible, community-based services, including tenancy supports, are individualized to meet the needs of the participant and assist them in living independently and maintaining success within the community of their choosing. These services should be recovery-oriented and grounded in psychiatric rehabilitation principles (see above). Successful tenancy support services balance housing *success* and housing *satisfaction*. Success in housing means being able to meet the terms and conditions of the lease (e.g., paying rent on time, ensuring upkeep of the unit, alerting landlord to concerns, etc.), while satisfaction means that the housing has met the tenant's personal needs for safety, comfort, and inclusion in the broader community (see Appendix A: Permanent Supportive Housing Cheat Sheet.)

Three Phases of Tenancy Support Services

1. **Pre-tenancy**: These services begin when a person expresses interest in obtaining an apartment, regardless of their current living situation (in an ACH, psychiatric hospital, another long-term care facility, or experiencing homelessness). The pre-tenancy focus is on accessing housing and preparing to maintain that housing. The service provider and recipient work collaboratively to identify the recipient's housing preferences, strengths, needs, and desires; begin obtaining benefits and entitlements; and formulate plans to help the recipient both obtain and maintain independent housing in the community.

[2] Jacob, V., Chattopadhyay, S. K., Attipoe-Dorcoo, S., Peng, Y., Hahn, R. A., Finnie, R., Cobb, J., Cuellar, A. E., Emmons, K. M., & Remington, P. L. (2022). Permanent supportive housing with Housing First: Findings from a community guide systematic economic review. *American Journal of Preventive Medicine*, *62*(3), e188–e201.

[3] Peng, Y., Hahn, R. A., Finnie, R. K. C., Cobb, J., Williams, S. P., Fielding, J. E., Johnson, R. L., Montgomery, A. E., Schwartz, A. F., Muntaner, C., Garrison, V. H., Jean-Francois, B., Truman, B. I., Fullilove, M. T., & Community Preventive Services Task Force (2020). Permanent supportive housing with Housing First to reduce homelessness and promote health among homeless populations with disability: A community guide systematic review. *Journal of Public Health Management and Practice*, *26*(5): 404–411.

[4] Rog, D. J., Marshall, T., Dougherty, R. H., George, P., Daniels, A. S., Ghose, S. S., & Delphin-Rittmon, M. E. (2014). Permanent supportive housing: Assessing the evidence. *Psychiatric Services (Washington, D.C.)*, *65*(3), 287–294.

2. **Move-in:** This phase begins with the signing of a lease and ends when the person has settled into their home and adjusted to the new neighborhood; thus the timeframe will vary. This transition can be both exciting and stressful. Services in this phase are focused on managing the details of moving, ensuring the unit is ready, and supporting the individual emotionally and physically with the transition. (See Appendix B for a sample move-in checklist).
3. **Ongoing tenancy:** These services assist the recipient in meeting the conditions of their lease (success) and enjoying successful tenancy and community inclusion (satisfaction). Services continue to spread beyond immediate housing needs to support long-term goals, needs, and desires as well as enhancing support systems (see below).

Specific tasks should be planned for and accomplished in each of these phases. For a more detailed version of the lists below in the context of a Framework for Providing Tenancy Support, see Appendix A.

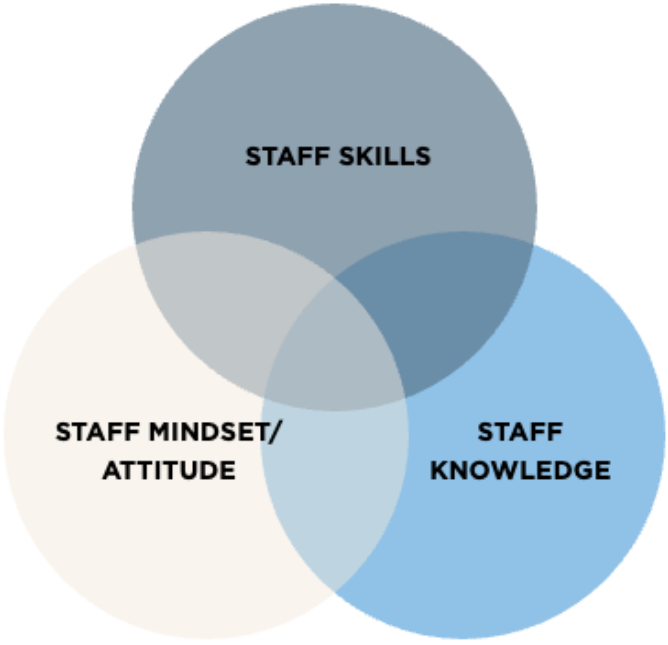
Table 3: Tenancy Support Activities

Pre-tenancy	Move-in	Ongoing Tenancy
•Relationship-building •Applying for benefits/entitlements •Housing eligibility & application •Assessing & addressing housing barriers •Understanding the role of the tenant •Pre-planning for support needs once living in housing •Housing search •Selecting a unit	•Update assessment, goals, and crisis plan •Arrangement for move •Assisting with utility setup & security deposits •Support with packing & unpacking •Ensuring unit is ready for move-in •Initial adjustment to new home & neighborhood •Providing increased support during transition	•Sustained, successful tenancy •Skill-building to promote competence, confidence, and self-sufficiency •Enhance personal satisfaction through relationships, employment, education •Assessing both tenant and setting for changes during every visit •Adjusting the type, intensity, & duration of services based on needs •Accessing social and recreational activities •Service linkage and connection

Providing Effective Tenancy Support Services

Providing effective tenancy support services requires a combination of certain skills, knowledge, and attitudes from the service provider. The provider agency should ensure that staff members are trained in, and utilizing, the capacities shown below. Supervision of service providers should include community observation and feedback to enhance provision of services (see Supervision of Tenancy Supports).

Figure 3: Skills, Knowledge, & Attitudes for Successful Tenancy Support



STAFF SKILLS
- Motivational Interviewing
- Cognitive Techniques/CBT Educational Teaching
- Harm Reduction
- Psychiatric Rehab Interventions

STAFF KNOWLEDGE OF
- Housing Knowledge: Housing Rights, Fair Housing Laws
- Community Resources
- Entitlement Programs

STAFF MINDSET/ATTITUDE
- Evaluate your biases
- Unconditional Positive Regard
- Genuine Curiosity
- Solution Oriented Focus
- Recovery-Oriented

Additional Resources on Tenancy Support Services

- Permanent Supportive Housing: Evaluating Your Program (SAMHSA)
- Permanent Supportive Housing: Tools for Tenants (SAMHSA)

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Landlord Engagement

Developing relationships with landlords is crucial for providing services to individuals served by the CST. Whether or not a service user is participating in TCL, reliable partnerships with landlords can help you identify challenges or concerns before they escalate; address issues so as to prevent tenancy loss; expedite a relocation process; and ultimately prevent homelessness. Strong partnerships and effective services can also encourage landlords to work with your team in the future.

Landlords often prioritize tenants who pay rent on time, maintain the property, live harmoniously in the neighborhood, and stay long-term. They typically employ criminal background checks, rental history verification, credit history, landlord references, and income verification to assess potential renters' ability to meet the lease requirements. It's essential for individuals seeking housing to disclose relevant information up front, so that they can explain or update any discrepancies found during screening. CST staff can also support the potential resident in writing a mitigation letter (Appendix C) or in applying for a reasonable accommodation (Appendix D) that would help them meet the terms of the lease. In certain cases, landlords may be willing to adjust their requirements if the tenant receives regular support from a program; they may also be legally required to make accommodations for the resident under the Fair Housing Act (see Fair Housing).

Providers can create marketing materials about their agency's services, highlighting the role of a designated contact person to minimize confusion and streamline communication if an incident occurs. These materials should also emphasize the specific benefits of working with the agency. Providers can create marketing materials about their agency's services, highlighting the role of a designated streamline communication if an incident occurs. Providers can create marketing materials about their contact person to minimize confusion and agency's services, highlighting the role of a designated contact person to minimize confusion and streamline communication if an incident occurs.

Benefits to Landlords of Collaborating with Community Support Teams

- Access to a dedicated support person/team to address challenges.
- Prompt response within a business day.
- Provision of "good tenant" skills training and hands-on tenancy support.
- Assistance with relocation and eviction prevention if problems cannot be resolved.
- A consistent flow of tenant referrals from the agency, reducing the need to advertise vacancies.
- Potential participation in an annual recognition event and positive media exposure.

For individuals in TCL or other voucher-based programs, additional incentives for landlords may include:

- Majority of the rent paid by the LME/MCO or voucher program.
- Higher deposit for "higher risk" tenants.
- Risk mitigation funding for damages

These materials should also emphasize the specific benefits of working with the agency. To find landlord partners, providers can cold call local landlords, ask for referrals from existing partners, reach out to realtors, or organize networking events. It is crucial to maintain an organized database of landlord partnerships and housing opportunities, which can be as simple as a spreadsheet containing contact information, property details, tenant screening flexibility, smoking or pet policies, and accepted subsidies or programs (see Landlord Tracker in Appendix E). Providers may work in partnership with their LME/MCO regarding landlord engagement, especially during pre-tenancy and the initial move in; however, it is important for service providers to maintain their own working relationships and regularly engage with their landlord partners. This demonstrates good customer service and creates opportunities to mitigate situations that jeopardize ongoing tenancy. It also ensures that the provider remains top-of-mind when landlords have available properties.

Additional Resources on Landlord Engagement

- Landlord Recruitment and Retention (Connecticut Coalition to End Homelessness)
- Landlord Engagement: Reset Your Community's Critical Partnerships during COVID-19 (HUD Exchange)
- The Landlord Engagement Toolkit: A Guide to Working with Landlords in Housing First Programs (Ministry of Employment and Social Development of Canada)
- Landlord Relationships (CSH)
- Effective Landlord Engagement Strategies (Technical Assistance Collaborative)

Housing Rights

The Federal Fair Housing Act prohibits the denial of housing, or discrimination in housing, based on a person's membership in a protected class. There are seven federally protected classes:

1. Race (any race)
2. Color (any color)
3. Religion (any religion or no religion)
4. National Origin (any nationality)
5. Sex (include gender, gender identity, and sexual orientation)
6. Familial Status
7. Disability [5]

Fair Housing Laws

- Federal Fair Housing Act
- N.C Fair Housing Act
- Civil Rights Act of 1866
- Title IV of Civil Rights Act of 1964
- Americans with Disabilities Act
- Section 504 of the Rehabilitation Act of 1973

In addition, North Carolina also has an eighth protected class, Affordable Housing, which states that zoning regulations may not prohibit the development of low-income or affordable housing.

Reasonable Accommodations

The Fair Housing Act requires housing providers to take steps to allow persons with a disability equal opportunity to live in the property with the same access as any resident. Two requests can be made:

- Reasonable Accommodation: A change in rule, policy, or procedure that is necessary because of the person's disability and that would provide them full and equal use and enjoyment of the housing.
- Reasonable Modification: Structural changes made to units or common areas to afford a person with a disability the full use and enjoyment of the dwelling.

[5] Under fair housing law, a disability is a physical or mental impairment that substantially limits one or more major life activities; having a history of such an impairment; or being perceived as having such an impairment (whether or not they have that impairment) and includes individuals associated with the person with the disability. Under this definition, mental health conditions are considered a disability. Alcoholism and former drug use are covered but *active illicit* substance use is not covered under the disability term. It should be noted for providers that many individuals in TCL have co-occurring disorders and it is necessary to evaluate the reason for the accommodation. (i.e., is the underlying behavior or need related to a mental health condition or substance use?).

Table 4: Reasonable Accommodations vs. Reasonable Modifications

Reasonable Accommodations	Reasonable Modifications
• Rent is due on the first of the month, but a reasonable accommodation could be requested to allow a resident who receives their SSI/SSDI payment later in the month to pay rent later. • No pets are allowed on the property, but a reasonable accommodation could be requested to allow a service or assistance animal for a resident with a disability. • Applications must be completed in person, but a reasonable accommodation could be requested to allow someone to virtually complete the process if they were not able to be onsite due to their disability. • Usually, a resident is terminated for poor housekeeping habits; however, a reasonable accommodation could be requested to allow the tenant more time to comply with the terms of the lease and declutter. • Typically, there is a fee for early termination of a lease, but a reasonable accommodation could be requested to waive the fee if the resident is transferring to another unit or building because the unit exacerbates their disability.	• Lowering the countertops for a tenant who uses a wheelchair • Installing a shower bar for a tenant who has difficulty with mobility • Installing a ramp into the entrance of the building to make it accessible to a tenant with a wheelchair • Installing sound-proofing panels to decrease the noise that exacerbates a tenant's disability • Widening the doorway to allow better access

Requesting Accommodation

Reasonable accommodations can be requested at any time during the housing process (from application through pending eviction) by the resident, a family member, or a service provider on behalf of the resident. Requests can come in any form; however, *it is best to submit the request in writing*. Requests should explicitly state that a reasonable accommodation is being requested; depending on the disability, you may also need to submit a verification of disability. You do not need to disclose specifics regarding the disability but only how the accommodation is related to the disability. After the request is submitted, the landlord has a certain amount of time to respond (usually two weeks); lack of response within that period can be construed as a "constructive denial" of the request. This should be an interactive process. A checklist for submitting a request as well as an example of an accommodation request letter can be found in Appendix D.

Resources

More comprehensive information about reasonable accommodations can be found on the official ADA website. The NC Fair Housing Project of Legal Aid North Carolina has additional resources regarding fair housing laws, applications, and processes as well as trainings and recordings.

Housing Access and Placements

Voucher Programs

Listed below are nine important rental assistance programs available in North Carolina. Appendix G provides a side-by-side comparison of these voucher programs.

1. The Housing Choice Voucher (HCV) program
2. Special Purpose vouchers such as: [6]
    - Emergency Housing Vouchers
    - Mainstream Vouchers
    - HUD-Veteran Affairs Supportive Housing (HUD-VASH)
    - Emergency Solutions Grant Rapid Re-Housing (ESG-RRH)
    - Continuum of Care Rental Assistance[7] (CoC-RA)
    - Supportive Services for Veteran Families (SSVF)
    - Key Rental Assistance (Key)
    - Transitions to Community Living (TCL)

U.S. Department of Housing and Urban Development Continuums of Care

A Continuum of Care, or CoC, is a coordinated system of support that provides a range of services to individuals experiencing homelessness in every community. It involves a centralized system through which individuals experiencing homelessness can access resources and receive appropriate assistance based on their needs. These resources include emergency shelters, transitional housing, supportive services, and other programs aimed at preventing and ending homelessness. The CoC is often made up of a variety of service providers and government agencies in a given geographic area, and is one of the main vehicles through which individuals experiencing homelessness or housing instability can access housing services.

Coordinated Entry is a process within the CoC to connect people efficiently and effectively to housing and services. Coordinated entry typically involves standardized assessments to determine a household's level of vulnerability and prioritization for housing assistance. This approach helps streamline the intake process, reduces duplication of services, and ensures that those in greatest need receive assistance in a timely manner. It also facilitates coordination and collaboration among service providers, allowing for the efficient allocation of resources and a holistic approach to addressing homelessness in a community.

[6] Non-exhaustive list of Special Purpose Vouchers. Local public housing agencies may have additional types of Special Purpose Vouchers such as Family Unification Program (FUP), Foster Youth Independence (FYI), and/or Non-Elderly Disabled (NED).

[7] Formerly known as Shelter Plus Care

CST provider agencies are encouraged to become active members of their CoC to more effectively serve their clients who are experiencing homelessness. As a CoC member, the CST can refer eligible clients to the coordinated entry system for housing placement. *Note that individuals often must meet the HUD definition of homelessness to be served by a CoC.* Being a member of the CoC can also help CSTs form partnerships with local homeless services agencies that may be able to assist with emergency housing solutions or other housing or service opportunities not offered through the CoC.

The U.S. Department of Housing and Urban Development (HUD) maintains an updated list of Local North Carolina Contacts that can help you connect with your local CoC.

Additional Resources on Continuums of Care

- CoC Program Toolkit (HUD Exchange)
- Coordinated Entry - Core Elements (HUD Exchange)
- Introductory Guide to the Continuum of Care (HUD Exchange)
- Introduction to Coordinated Entry and HMIS (HUD Exchange)

Community Inclusion

Practices that support community inclusion give everyone, regardless of their abilities, the same opportunity to engage in a full range of community activities so that everyone is valued for their uniqueness in a welcoming and embracing environment. Community inclusion integrates individuals with disabilities into the community, allowing them to interact with individuals without disabilities as much as possible; providing opportunities to live, work, and play; and giving people a choice in whom they socialize with and what their activities of leisure will be.

Community inclusion creates opportunities for people with disabilities to associate with people and develop relationships outside of the health system. The ways people participate in the community are self-directed and individualized — each person drives the process of determining how, when, and where they want to participate and incorporate dignity of risk. In this approach, providers neither encourage nor require people to participate in an activity or in their community in a specific way, especially if it is something that is not meaningful to them; likewise, providers do not discourage anyone from participating on the basis of their symptom level, the perceived severity of their disability, or because they haven't tried the activity before.

Community inclusion focuses on multiple domains and areas of participation, including:

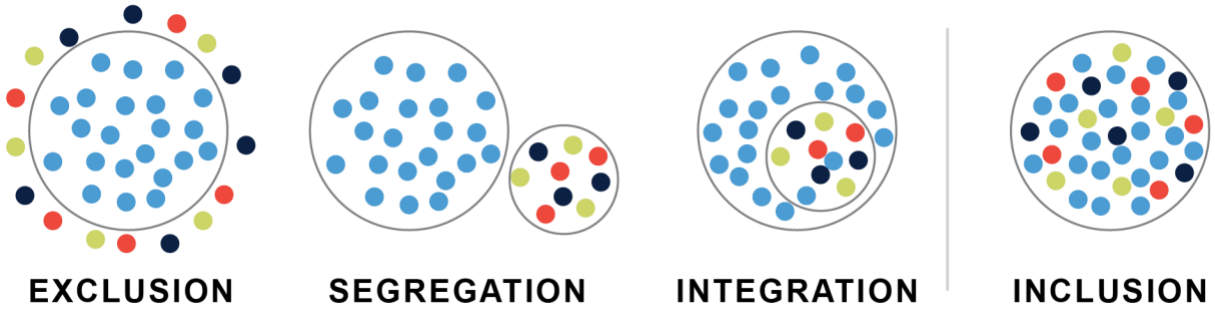
- Employment
- School
- Housing
- Dating/marriage
- Parenting
- Leisure/recreation
- Spirituality/religion
- Civic engagement
- Friendships and social relationship

As social creatures, we all participate in our communities in ways that influence our well-being. In the "whole person" recovery model, community inclusion is an integral piece of the CST's work helping individuals to achieve their recovery goals. People have the right to live in a community of their choosing. By focusing on participation in multiple life domains, CSTs help people become less isolated and enhance their wellness and recovery. Reducing isolation has been shown to improve overall health and wellbeing.[8] A person who decreases their isolation becomes engaged in more physical activity, has enhanced cognitive functioning, and experiences greater happiness and less loneliness, changes that can lead to better health behaviors (less depression, better sleep, better general health); decreased mortality risk; and decreased chronic stress and cardiovascular disease.[9]

[8] Evans, M., & Fisher, E. B. (2022). Social isolation and mental health: The role of nondirective and directive social support. *Community Mental Health Journal*, *58*(1), 20–40.

[9] National Institute on Aging (2021). Loneliness and social isolation — tips for staying connected.

Figure 4: Visual Representation of Community Inclusion



Source: Mental Health America & the Temple University Collaborative of Individuals with Psychiatric Disabilities (2015). Behavioral health managed care entities: Important partners in promoting community inclusion.

CSTs can promote community inclusion by adopting and using these 11 "fundamentals of community inclusion," paraphrased here from *Well Together – A Blueprint for Community Inclusion: Fundamental Concepts, Theoretical Frameworks and Evidence*.[10]

1. Community inclusion is important.
2. Community inclusion applies to everyone who experiences a disability, regardless of the "status" of their disability.
3. Community inclusion requires seeing 'the person,' not 'the patient.'
4. Self-determination and dignity of risk are critical.
5. Multiple domains of mainstream life should be sought.
6. Seek participation that is more like everyone else.
7. Use technology, natural supports, and peer support.
8. Providing support to family and other natural supports promotes community integration.
9. Environmental barriers must be identified and addressed.
10. Maximize the use of mainstream community resources.
11. Need to establish welcoming communities.

Additional Resources on Community Inclusion

- Temple University Collaborative on Community Inclusion
- Strategies for helping someone identify areas of community inclusion (TU Collaborative)
- Managing Risk in Community Inclusion (TU Collaborative)
- Loneliness and Mental Health: What Helps…And What to Do if it Doesn't (University College London & King's College London)

[10] Salzer, J., & Baron, R. (2016). *Well together – A blueprint for community inclusion: Fundamental concepts, theoretical frameworks and evidence*. Melbourne, Australia: Wellways Australia Limited.

Individual Placement and Support

Individual Placement and Support - Supportive Employment (IPS/SE) is the only evidence-based practice of supported employment for people with mental illness. IPS/SE provides wraparound employment services and prioritizes integration with behavioral health. Individualized job search and support plans focused on competitive employment, clinical guidance, access to benefits counseling, and long-term supports make IPS/SE a unique and highly successful employment service. Worldwide research in both rural and urban settings demonstrates that IPS/SE is often two to three times as successful as traditional models of supportive employment.[11] [12]

Employment is a vital component of behavioral health recovery.[13] [14] A meaningful job in an integrated setting gives people a sense of purpose and value. Research has also demonstrated that people with mental illness who are employed experience improved self-esteem and financial security, a reduction in psychiatric symptoms, reduction in substance use, and less social isolation.[15] [16] [17] Most people with mental illness *want* to work, but need supports to manage the job search process and understand how their benefits might be impacted by returning to work.

IPS/SE in North Carolina

IPS/SE is available in many counties in North Carolina and is highly effective in helping people return to work or school as part of their overall wellness goals. Work "readiness," previous work history, and

[11] Bond, G. R., Drake, R. E., & Campbell, K. (2016). Effectiveness of individual placement and support supported employment for young adults. *Early Intervention in Psychiatry*, *10*(4), 300–307.

[12] Marshall, T., Goldberg, R. W., Braude, L., Dougherty, R. H., Daniels, A. S., Ghose, S. S., George, P., & Delphin-Rittmon, M. E. (2014). Supported employment: Assessing the evidence. *Psychiatric Services (Washington, D.C.)*, *65*(1), 16–23.

[13] Substance Abuse and Mental Health Services Administration (2021). Substance use disorders recovery with a focus on employment and education. HHS Publication No. PEP21-PL-Guide-6. Rockville, MD: National Mental Health and Substance Use Policy Laboratory.

[14] Dunn, E. C., Wewiorski, N. J., & Rogers, E. S. (2008). The meaning and importance of employment to people in recovery from serious mental illness: Results of a qualitative study. *Psychiatric Rehabilitation Journal*, *32*(1), 59–62.

[15] Bond, G. R., Drake, R. E., & Becker, D. R. (2020). An update on Individual Placement and Support. *World Psychiatry, 19*, 390-391

[16] Gibbons, B., & Salkever, D. (2019). Working with a severe mental illness: Estimating the causal effects of employment on mental health status and total mental health costs. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(3).

[17] Wallstroem, I. G., Pedersen, P., Christensen, T. N., Hellström, L., Bojesen, A. B., Stenager, E., White, S., Mueser, K. T., Bejerholm, U., van Busschbach, J. T., Michon, H., & Eplov, L. F. (2021). A systematic review of Individual Placement and Support, employment, and personal and clinical recovery. *Psychiatric Services (Washington, D.C.)*, *72*(9), 1040–1047.

treatment status are not factors in whether or not someone can work with an IPS/SE team. IPS/SE is an employment first approach and is based on the belief that everyone who wants to work should be able to do so. In North Carolina, the only eligibility criteria a person must meet for IPS services are:

- They are at least 16 years old.
- They have a mental health diagnosis.
- They want to work.

If someone you support is interested in receiving IPS services, you can do one of the following:

- Contact your LME/MCO for agencies that provide IPS services near you.
- Contact the UNC Institute for Best Practices or use the Institute's interactive online map to find IPS teams that serve your area.

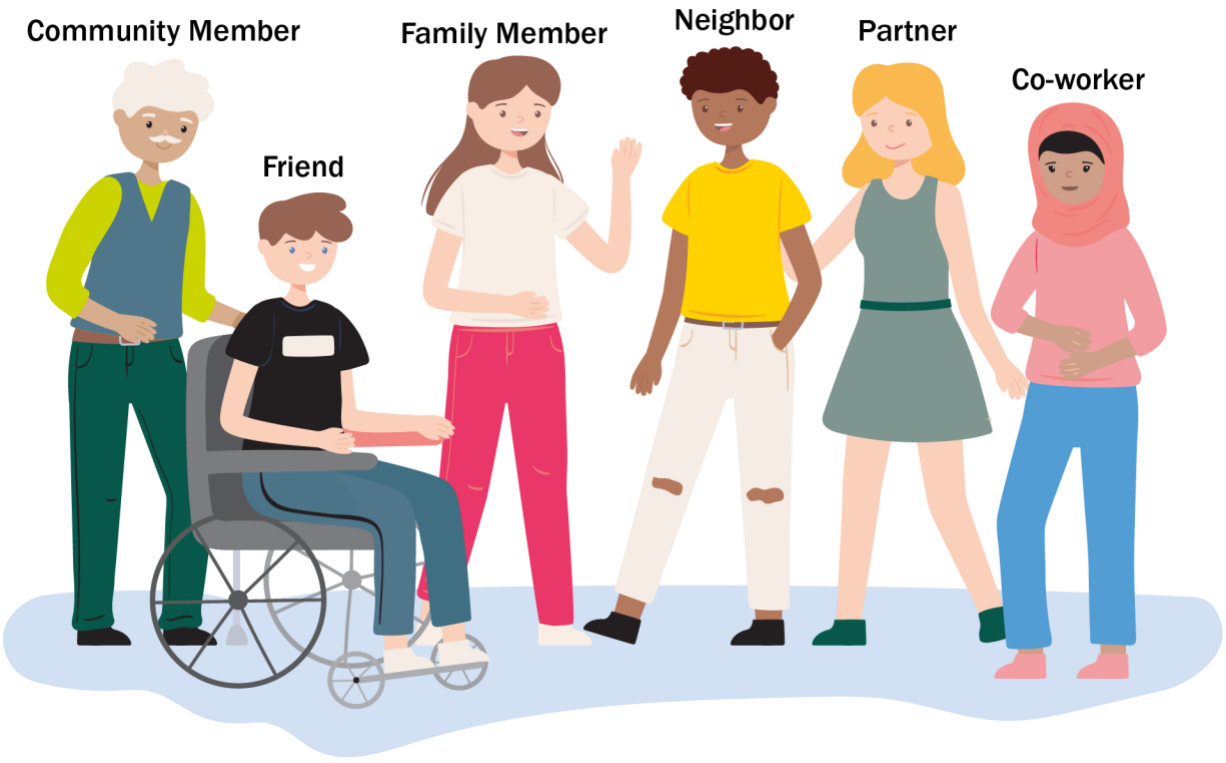
Additional Resources on Individual Placement and Support

- Employment Discovery Tip Sheet (UNC Institute for Best Practices)
- Individual Placement & Support fact sheet (NCDHHS)
- International IPS Learning Community

Utilization of Natural Supports

Natural supports are the personal associations and relationships that people develop in their habitual environments (family, school, work, community, etc.) and that enhance the quality and security of their lives.[18] These ordinary relationships, in contrast to formal, paid, professional supports (like the CST), are developed organically and are generally mutually beneficial. Simply stated, these are the people we have fun with, hang out with, look forward to seeing, and regularly connect with in our daily lives. Often such relationships are built on a shared history, interest, or activity; they create the love, care, connection, and acceptance that help in tough times and that make people feel connected to something bigger than themselves. It is vital for CST staff to support service recipients in enhancing natural supports, while also understanding that it's typical for these relationships to change, evolve, and even dissolve throughout the life cycle. Forming and growing relationships with natural supports takes time and effort, but maintaining these relationships can enhance the quality and security of life for CST service recipients. It is important for CST staff and service recipients to continually re-evaluate who is important to this person and how the CST can help continuously enhance this support network.

Figure 5: Natural Supports



[18] UPenn Collaborative on Community Integration (n.d.). Natural supports.

Common Natural Supports [19]

- Family members
- Coaches
- Coworkers
- Friends
- Librarians
- Bus drivers
- Romantic partners
- Teachers
- Barbers, hair stylists
- Neighbors
- Faith community members
- Letter carriers

Engaging Natural Supports

Natural supports complement and enhance the work of formal support systems like the CST. Natural supports foster empowerment, independence, and growth. They reduce the need for formal support services and enhance life engagement and satisfaction. They promote sustainability and ensure continuity of support during transitions within treatment provider agencies (e.g., staff turnover, discharging from CST). Guided by the individual's preferences, CST providers can foster, strengthen, and enrich people's natural supports by helping them to:[20]

- Identify and expand interests and hobbies, and enhance social skills, community opportunities, and relationships by joining clubs, volunteering, and participating in community events
- Re-establish relationships with family, friends, or others with whom relationships may have been disconnected.
- Find a job, possibly by connecting with IPS.
- Coordinate with natural supports to help provide practical assistance.

Identifying Supports

By asking these questions, CST providers can help service recipients identify and engage with some natural supports:[21]

- Who are the most important people in your life? What do you value about your relationship with them?
- Who is the first person that you want to tell when you have good news (or bad news) to share?
- Who gives you advice or help when you have a problem?

[19] UPenn Collaborative on Community Integration (n.d.). Natural supports.

[20] UPenn Collaborative on Community Integration (n.d.). Natural supports.

[21] Some of these questions were taken/adapted from the Change Collaborative's Natural Support Practice Framework.

- Who shares your past with you or knows your life story?
- When you think about the people in your life, who would you like to know more deeply? Who do you think understands you best?
- Who worries about you when you are really struggling?
- Who do you see with you as you think about your future?
- Who in your life do you admire and wish you spent more time with?

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Utilization of Peer Support Services

Definition and Core Competencies

The practice of employing people with lived experience (i.e., peer support specialists), has gained momentum with funders, policymakers, and practitioners since Medicaid funding began reimbursing for peer support in 1999. Since that time and with the expansion of additional funding mechanisms, peer supporters have been added to behavioral health, emergency department, crisis, substance use, criminal justice, domestic violence, HIV+, housing, and numerous other systems.[22] [23] This trend is supported by research demonstrating the effectiveness of peer support in enhancing empowerment, hope, quality of life, and life satisfaction while reducing hospitalizations, self-stigma, mental-health-related costs, and the use of inpatient services.

Peer support appears simple, but without appropriate organizational and supervisory training it is vulnerable to being co-opted into case management, transportation services, or quasi-clinical services, rendering it ineffective. Supervisors are frequently unprepared to recruit, employ, supervise, mentor, and support the professional development of peer supporters, based on their scope of practice and competencies.

Peer Support: Definition, Scope, and Competencies

The simplest definition of peer support is the use of personal shared experience to establish mutual relationships that include mentoring and sharing of resources and information. Peer support includes a variety of activities and interactions between people who share similar experiences of being diagnosed with mental health conditions, substance use disorders, or both.[24] SAMHSA has drafted core competencies for peer support services that are recovery-oriented, person-centered, voluntary, relationship-focused, and trauma-informed.

History of Peer Support

Understanding the roots of peer support is critical to valuing and effectively utilizing a peer workforce in systems and organizations. Peer support services emerged from a disability and civil rights movement called the Consumer/Survivor/Ex-Patient (C/S/X) movement that began in the 1970s when former psychiatric patients began organizing for rights, protection, and humanity of people labeled with mental illness and against harmful practices such as forced treatment, segregation, forced drugging, restraint, and confinement by treatment providers. Today, as organizations become interested in employing peer workers, their understanding of this history is of utmost importance as the role of change agent within the agency — influencing policy and practice both in and out of services, and advancing social justice — remains integral to effective peer support.

[22] U.S. Government Accountability Office (2020). Substance use disorder — Medicaid coverage of peer support services for adults.

[23] KFF (2022). Medicaid behavioral health services: Peer support services.

[24] SAMHSA (n.d.). Peer support.

Effective peer support requires some fundamental components for the organization, including:

- **Shared Experience.** In peer support, shared experience means that the peer support specialist's lived experience is similar to that of the service recipient they are working with. To achieve these matchups, an agency must consider the individuals its program serves and seek peer supporters with shared experience. Not all experience is the same, so if your agency is serving people experiencing first episode psychosis, shared experience would be peer supporters who have experienced psychosis; if they are supporting people re-entering the community from jails or prisons, a peer supporter with shared experience is someone who has been incarcerated; and if your organization helps people experiencing homelessness to navigate housing systems, you should seek peer support specialists who have also been unhoused.
- **Role of Peer Support**. In addition to serving as a change agent for a shift toward healing, recovery-based services and practices, a peer supporter offers four primary types of support with affiliated tools, illustrated in the table below.

Table 5: Types of Peer Support

Type of Peer Support	Description	Tools
Emotional Support	Empathy, concern, and caring to improve identity, self-esteem, worldview, confidence building, voice and choice	Sharing personal recovery story, connection to self-help resources, participating in groups together (NA/AA, Double Trouble, etc.), emotional support — listening, not judging
Informational	Share knowledge and information	8 Dimensions of Wellness, navigating systems, Wellness Recovery Action Plans (WRAP), Illness Management and Recovery, Whole Health Action Management (WHAM)
Instrumental	Assistance with accomplishing tasks, skill-building	Problem-solving, self-advocacy, Wellness Self-Management, accompanying people, supported decision making
Affiliational	Assistance connecting with people to promote relationships, sense of belonging	Recovery communities, family, friends, social opportunities, faith connections

Peer Support in North Carolina

North Carolina's peer support specialists are trained in fundamental competencies and have a Code of Ethics to guide their work. Certification is required, and includes a state-approved peer support

curriculum consisting of 50 hours plus an additional 20 hours of training related to the peer support role. Visit the web page of the NC Certified Peer Support Specialist program for current information about training, certification, and recertification. The state has outlined nine domains with fifty affiliated competencies for certified peer support specialists that span commitment to personal recovery, peer relationships, systems competencies, ethics and boundaries, substance use, trauma-informed practices, service member support, and cultural competencies.

Supervision and Support for Peer Support Specialists

Supervisors should be well trained in the scope, practice, competencies, ethics, workforce development, and supervision of the peer workforce. For this model to succeed, supervisors must value the expertise of the peer supporter as different from that of clinically trained staff, but equally important. This perspective requires supervisors to consider peer support specialists not as former service recipients, but rather as professional colleagues with a specialized role and skills within the service and team — and reduces the risk that peer supporters will be assigned inappropriate duties as case managers, monitors, "moles" for the team, drivers, medication counters and transporters, phone operators, paraprofessionals, or mini-clinicians. While peer supporters may have some similar tasks to those of a case manager, such as helping people to schedule appointments, they are not simply case managers. If a peer support specialist has Qualified Practitioner status or even licensure, it is important to discuss their role on the team. If they are serving in the capacity of a peer supporter, their work should be considered through that lens, not as a Qualified Practitioner, Licensed Clinical Addiction Specialist, case manager, or similar clinical role, and their supervision should be provided as a peer supporter. (See Supervision Section for more details.)

Additional Resources on Peer Support Services

- North Carolina Certified Peer Support Specialist Program (NCCPSS): Certification
- NCCPSS: Training Core Concepts
- NCCPSS: Code of Ethics
- *The Provider's Handbook on Developing & Implementing Peer Roles* (Lyn Legere Consulting)
- National Practice Guidelines for Peer Specialists and Supervisors (National Association of Peer Supporters

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Documentation of Tenancy Supports

Documentation is a critical part of providing excellent community-based mental health services. Proper and thorough documentation is required for CSTs to stay in compliance with state and federal laws and to allow for services to be billed, and also ensures helps ensure that the services provided are necessary, effective, and in line with the recipient's needs, goals, and required care.

The person-centered plans (PCPs), crisis plans, and service notes that CSTs complete are meant to capture the essence of service recipients' goals, their plans for emergency situations, and their progress toward their short-term and long-term goals. Good documentation reflects that the work being done by the CST is in line both with best practices and with the individual's choice. This documentation is also a means to describe to other providers the type of support the team has given and the individual's progress toward their goals. There should be a "golden thread" consistent throughout documentation. The golden thread concept describes the connectivity that should exist between the individual's diagnosis, their person-centered plan, and their ongoing progress notes. There should be a clear link between services provided and the individual's goals as identified in their service plan. (See Appendix A for a visual representation.)

Person-Centered Planning

The most important part of a PCP is that it is based on the service recipient's stated goals. The Administration for Community Living's National Center for Advancing Person-Centered Practices and Systems states that person-centered planning is "a way to learn about the choices and interests that make up a person's idea of a good life — and to identify the supports (paid and unpaid) needed to achieve that life." Person-centered planning in the context of a CST is led by the person for whom the plan is written, with facilitation support from a CST staff member. CSTs should prioritize the following five areas to support a fully person-centered planning process[25]:

1. *Strengths-Based, Culturally Informed, Whole-Person-Focused*: Based on the belief that people can grow, change, and realize personally valued goals, the facilitator skillfully uses person-centered tools to support goal discovery, visioning, and self-direction. The facilitator helps the individual discover or rediscover themselves as a whole person with strengths and interests beyond their disability or diagnosis.
2. *Cultivating Connections Inside the System and Out:* Linkages with both paid (professional) and unpaid (natural) supports, and awareness of systems the individual can access. This actively involves family caregivers and other supporters to collaboratively develop and implement the person-centered plan in accordance with the preferences of the person.

[25] Tondora, J., Croft, B., Kardell, Y., Camacho-Gonsalves, T., & Kwak, M. (2020). *Five competency domains for staff who facilitate person-centered planning*. Cambridge, MA: National Center on Advancing Person-Centered Practices and Systems.

3. *Rights, Choice, and Control:* Relationships and planning activities are based on respect and on the assumption that people are capable of and have the right to control decisions that impact their lives. It requires an understanding of the concepts of dignity of risk and the right to fail and provides basic education about one's rights in services and supports people to advocate for themselves and/or have others advocate for them when appropriate and desired.

4. *Partnership, Teamwork, Communication, and Facilitation:* Ensures the primary focus remains on respecting the priorities and perspective of the person. The conversation follows the person's lead; the person is never "talked about" as if they are not in the room, and conversations and questions are directed to their attention. The facilitator ensures that they are on the "same page" as the person and regularly checks in to be sure they are capturing the information correctly and to see if the person has any questions or clarifications in the plan. The facilitator should maintain focus on the person's desired life goals and outcomes.

> All people have the right to live, love, work, learn, play, and pursue their dreams in their community. Person-centered planning is a highly individualized process designed to respond to the expressed needs/desires of the individual."
>
> – NCDHHS Person-Centered Planning Guide

5. *Documentation, Implementation, and Monitoring:* Actively includes the person's strengths, interests, and talents in their plan and its implementation. The person is provided a copy of the plan, which is a "living document," revised as needed based on the person's preferences and evolving situation. The plan should include goal statements in language that is clear and accessible while capturing what is important to the person in their own words wherever possible. The CST team should ensure that services are delivered both in accordance with the person's preferences and as specified in the plan. If there are discrepancies, the plan should be revisited with the individual to ensure services are meeting their needs and desired goals.

In November 2022, North Carolina issued official guidance on person-centered planning, including expectations on both format and content for PCPs. The work of the CST is to document how its services — both in the office and in the community — support the service recipient in achieving their stated goals through evidence-based interventions and assistance in connecting to their natural supports, community, and resources.

The person-centered plan must include:

- Assessment of life domains
    - Daily Living
    - Employment
    - Community Living
    - Safety and Security
    - Healthy Living
    - Social and Spirituality
    - Citizenship and Advocacy
    - Any other areas of importance to the person
- Action Plan with the service recipient's long-term goal, short-term goals, and interventions or the action steps to be taken to achieve these goals.

- Short-term goals help the person move closer to achieving their long-term goals and reflect concrete changes in functioning/skills/activities that are meaningful to the person and are proof they are making progress. These are written in SMART format (see Appendix K).
- Long-term goals are oriented toward quality-of-life priorities and not only the management of health conditions and symptoms (e.g., I want to finish school, get back to church, see my grandkids, get a car, etc.)
- Interventions reflect how all team members contribute to help the service recipient achieve their goals. Interventions are specific tasks the provider and recipient agree on, with details about who does what, when, and why to help the person achieve their goals.

- Enhanced Crisis Intervention Plan (see below)
- Signature page

Additional Resources for Documentation of Tenancy Supports

- *Five Competency Domains for Staff Who Facilitate Person-Centered Planning* (National Center for Advancing Person-Centered Practices and Systems)
- Person-Centered Planning (NCDHHS)
- PCP Training — Frequently Asked Questions (NCDHHS)
- How to Write a SMART Goal
- SMART Goal Planning for Behavioral Health (Beacon Health Options)

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Crisis Planning

It is critical for service providers to understand not only the technical aspects of writing a crisis plan, but *why* a crisis plan is an essential wellness tool and *how* to help a person to develop an effective plan. Like any other emergency preparedness document, such as a fire safety and evacuation plan, a crisis plan provides detailed instructions on how to prevent a situation from escalating. In this case, the goal is 1) to stop a challenging situation or triggering event from escalating into a mental health emergency, and 2) to be prepared in case a mental health emergency does develop.

NCDHHS provides a crisis plan template; in addition, we offer a three-step process below that can guide CST staff through completing a crisis plan and supporting a service recipient in developing their own crisis plan with provider support. This three-step framework can help CST staff collaborate with service recipients to ensure they have taken appropriate steps to identify, mitigate, and intervene. (An example of this crisis planning framework can be found in Appendix H.)

Predict: Understanding the type of situations that can "trigger" or activate a crisis and lead to a negative outcome (such as a safety risk, hospitalization, or incarceration) is important. Predicting a crisis requires information such as:

- Events, triggers, situations, people, sounds, anniversaries, times, days, months that have resulted in a mental health symptom escalation or crisis in the past. Examples could include:
  - "Every year the week before the anniversary of my mother's death is very difficult for me and I have ended up in the hospital the last three years."
  - "On Sundays I feel isolated and alone and have cut myself to cope."
  - "Being in crowded places with a lot of noise overwhelms and confuses me and I need to get out of there quickly."

Allow the person to identify:

- What it feels like inside their body when they are activated or triggered (early warning signs)
- What it looks like to others when they are activated or triggered (warning signs)

It's important for people to recognize their distress as early as possible so they can engage in practices that soothe or distract them, help them work through the distress, or connect them with others to prevent a trigger from becoming a crisis and a crisis from becoming an emergency. It's equally important that the person's support team, which may include family, friends, and service providers, learn to recognize such signs as early as possible so they can offer support.

Prevent: When a triggering event occurs, preventing a mental health crisis requires a combination of skills, support, activities, and resources. A crisis plan should include:

- People the person can connect with, places they can go, and activities that help them soothe themselves and work through distress
- Contact information for the people and places that are accessible to them
- Having activities on hand that they can pick up and try

- Information about what helps and what harms the person during a crisis

Plan: The planning section of the crisis plan is the who, what, when, and how of crisis/emergency response for the service recipient. The plan should address these questions:

- How and when will the people supporting the individual decide that they need to activate mobile crisis, call 988, or go to a hospital emergency department?
- If the person requires that type of help, who will call and what will the person say?
- If the person has a psychiatric advance directive, where is it located?

In case the person does have to go to the hospital, the plan should specify their hospital of preference and any hospitals they do *not* wish to go to. This allows the person to have autonomy in decision-making processes, even if they are not able to make those decisions during the emergency event. These steps can reduce trauma and ensure the individual's preferences are followed to the extent possible.

All of this information can be included in the crisis planning template which may be downloaded from the NCDHHS "Person-Centered Planning" page.

Person-Centered Progress Notes

Providers use progress notes to capture the ongoing interventions and services they deliver. Each interaction with a service recipient should be documented, with the notes focused on how the interaction supported progress toward the goals laid out in the Action Plan. Progress notes should describe not only the situation or circumstances for the visit, but also the interventions used, the response of the individual, and the impact of the interaction on their overall goals.

Progress Notes Required Elements

- Name of service recipient — should appear on each page of the progress notes
- Service record identification number — should appear on each page of the progress notes
- Date of service provision
- Name of service provided
- Type of contact (face-to-face, phone)
- Place of service provision
- Purpose of contact as it relates to PCP goals
- Description of the intervention provided (must accurately reflect treatment for the duration of time indicated)
- Duration of service, amount of time spent performing the intervention
- Assessment of the effectiveness of the intervention and its effect on progress towards the individual's goals
- Date, signature, and credentials or job title of the staff member who provided the service

When documenting services, CST staff should use recovery-oriented language, i.e., language that is respectful, non-judgmental, clear and understandable, trauma-informed, and strengths-based. Progress notes should be accurate descriptions of what occurred, avoiding interpretations, assumptions, or judgements. When documenting services, CST staff members should be sensitive to and respectful of the language, thoughts, customs, beliefs, and values of the service recipient's racial, ethnic, religious, or social group. When documenting, keep in mind that a service recipient may request to review their progress notes.

Review of Documentation

Regular review of the documentation is a critical component of providing excellent CST services. There are unique requirements for each type of required CST documentation. These requirements, best practices, and also the spirit of these documents are very clearly outlined by the guidance the state has provided in the form of training on PCPs and Enhanced Crisis Intervention Plans. Regular reviews of each PCP involve ensuring that, at a minimum, it clearly summarizes the stated goals of the service recipient, includes SMART goals, uses recovery-oriented language, and shows coordination with other providers.

It isn't enough to simply review each CST required document on its own. It is important to view the service recipient's record as a whole and ensure a clear link between the individual's vision and goals for their life, the content of their PCP, their Enhanced Crisis Intervention Plan, and ongoing services the CST provides as documented in progress notes. All methods of documentation utilized as part of CST service delivery should be customized and individualized for the person receiving services, and not copy/pasted; should avoid use of excessive clinical language or jargon; and should be written with, for the benefit of, and in all ways accessible to the person receiving services. (See Appendix H for a Sample Documentation Review Template.)

The entire package of documentation should be reviewed on a regular basis. Most agencies have a quality assurance professional who reviews documentation, but it is recommended that the CST also spend time reviewing documentation to ensure it gives an accurate picture of the work taking place with each person served and truly aligns with their recovery goals. (See Appendix H for templates that can be used to audit progress notes.)

Additional Resources on Crisis Planning

- Progress Note (SIRP Format)
- Records Management and Documentation Manual (NCDHHS)

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Supervision of Tenancy Supports

The ultimate goal of supervision is to help workers provide service recipients with the best possible services.[26] To accomplish this goal, supervisors provide a combination of administration, education, and support.[27] Trauma-informed supervision is a critical tool to prevent burnout, secondary trauma, and compassion fatigue among supervisees. Trauma-informed supervision buffers the impacts of demanding work by offering workers empathy, support, and care. Supervision is typically viewed as a partnership between a supervisor and supervisee in which the supervisor supports, coaches, delegates, and directs the supervisee.[28]

Clinical supervision for CST staff is provided by a Team Lead who has knowledge, skills, and abilities relevant to the population served. The Team Lead monitors the delivery of CST services to ensure that interventions are provided effectively to help the recipient rebuild community, daily living, personal, social, and specific tenancy skills, including obtaining and maintaining their own housing, developing natural supports, managing their illness, and reducing crises. (See the CST service definition.)

It is important to prioritize regularly scheduled, dedicated time to meet with each staff member on the team for formal supervision. Frequency and structure of supervision is dependent upon the staff's skill set, scope of practice, and role on the team, and is based on their supervision plan. Supervision is ideally provided in person, either one-on-one or in a group setting. At times it may be necessary to schedule additional supervision sessions, particularly if there are significant needs in one area, so that supervision sessions do not become overly focused on that one area. Keep records of supervision meetings as a reference for topics and strategies discussed. These notes should be available to both the supervisor and the supervisee. (Two templates for documenting supervision can be found in Appendix M).

In addition to formal supervision, the Team Lead should be available for impromptu supervision with all members of the team, as needed. Having an open-door policy where staff can meet with the Team Lead (whether in person or over the phone) outside of scheduled times demonstrates that the Team Lead is there to provide support to the staff when it is needed. Supervisors can work with team members to create infrastructure and protocols to balance when immediate or impromptu supervision is necessary versus when situations can wait for formal supervisions.

[26] Edwards, J. K., & Chen, M.-W. (1999). Strength-based supervision: Frameworks, current practice, and future directions: A Wu-Wei Method. *The Family Journal, 7*(4), 349-357.

[27] Tsui, M. (2005). *Social work supervision: Context and concepts*. Thousand Oaks, London; New Delhi: Sage

[28] Pennsylvania Coalition Against Rape (n. d.). *A guide to trauma-informed supervision*.

Supervision of Services

Supervisory Competencies

There are many different supervision models, and it is important for supervisors to find the best fit for themselves, their staff, and the setting. Here are two different models of clinical supervision for consideration:

1. Reflective Supervision: In reflective supervision, the supervisor and supervisee ask basic questions when analyzing a situation: What happened, what did the supervisee think or feel, what sense of the situation did the supervisee make of the situation, what did they do, and what can/will the supervisee do if the situation arises again? Learn more from these resources on reflective supervision by the Administration for Children and Families and the Share Collaborative.
2. Developmental Supervision: Developmental supervision assumes that staff members' personal and professional growth are developmental, and that the supervisor "meets the supervisee where they are at" with developmentally appropriate supervision. Typically, developmental supervision is more structured and didactic in the early stages and becomes more collaborative as the supervisee develops more skill, confidence, and clinical judgement.

A supervisor must be familiar with the skills, scope of practice, codes of ethics, and professional standards for all professional roles on the team — peer support, Qualified Professional, therapist, substance abuse professional, etc. The supervisor must also have the skills, knowledge, and abilities most relevant to the population and age served by the team. The supervisor should use evidence-based practice models to promote staff development, professional and ethical standards, program development and quality assurance, performance evaluation, and must also attend to administrative duties.

A supervisor will likely need additional training outside of CST service definition requirements to have competency in all disciplines employed by the team and to be an effective supervisor. An effective supervisor is self-aware, practices regular self-care, provides constructive and specific feedback on an ongoing basis, is supportive, asks thoughtful questions, discusses service recipients' needs and intervention strategies as a teaching tool; is an active listener; avoids making assumptions; and is empathetic, dedicated, attentive, and supportive.

Feedback for supervisees should address factual knowledge, general counseling skills, skills specific to a recovery orientation, clinical judgment skills, interpersonal attributes, and multicultural competency. Conversely, a supervisor should regularly be requesting feedback from supervisees on their supervision as it is being provided, in order to improve the alliance between the supervisor and the supervisee.

Figure 6: Principles of Good Feedback

Source: University of Alberta Health Sciences Council

Team Meeting

The Team Lead facilitates a weekly face-to-face team meeting to ensure that planned support interventions are provided; to allow CST staff to briefly discuss the status of all service recipients; to problem-solve emerging issues; and to plan approaches to intervene and prevent crises.[29] The Team Lead should balance the timing and structure of these meetings to ensure that enough clinical information is communicated for coworkers to understand each service recipient's goals and progress, while also making sure that meetings are timely and concise.

The meeting should be structured in such a way that staff share information related to the visits that occurred in the week prior to the meeting. A service recipient contact log can help; this is a tool for the team to use and is meant to be a snapshot of the work done with a specific individual. It is often

[29] North Carolina Department of Health & Human Services (2020). State-funded Community Support Team.

organized by individual, with each person on the caseload having their own log, and is updated month by month. (See Appendix J for team meeting templates.)

The majority of the time in the meeting should be dedicated to discussing the clinical needs of service recipients, with administrative updates given as needed. For example, the agenda for a meeting could be:

1. Administrative (team, agency, LME/MCO, or state) updates
2. Review of contact log with a focus on discussion of any clinical concerns

   Someone on the team facilitates roll call of each service recipient on the caseload (this can be done alphabetically or in whatever order the team prefers). If a person did not have any visits that week, the reason should be explored, and a plan created for next week. If there was contact with the person, the staff shares a brief overview of the visit (status of the person, interventions delivered, responses, barriers to interaction, other successes/challenges) and briefly discusses next steps and needs.
3. Clinical Consultation

   As needed for service recipients with complex needs, specific time can be set aside during team meeting for an "in-depth" analysis of the individual's needs, goals, and interventions supported to date. This fosters team collaboration to more specifically support the service recipient, and allows team members to review practices and enhance their clinical strategies. (A sample clinical consultation form can be found in Appendix O)

Community-Based Observation of Services

Community-based observation and mentoring is a vital part of the supervision process that should take place on a regular basis (monthly to quarterly depending on the needs of the staff member) to allow the supervisor to observe the supervisee delivering services in the community. These occasions are sometimes an opportunity for the supervisor to support service recipients with complex needs or to demonstrate interventions to the supervisee in a teaching role. Time should be scheduled after the community mentoring to check in and provide feedback to the supervisee about what was observed. Due to the nature of the work, this formal check-in can occur in the vehicle after a visit (assuming supervisee and supervisor are alone) or in another space compliant with the Health Insurance Portability and Accountability Act (HIPAA), but in either case, the feedback should be documented. (See Appendix N for a sample community observation form.)

One-on-One Supervision

One-on-one or individual supervision is defined as one supervisor and one supervisee meeting together for supervision. This is done ideally in-person, in a location with privacy, and includes the formal and impromptu meetings that occur between supervisor and supervisee. Due to the nature of CSTs, there may be times when supervision is provided virtually or over the phone, but concerted efforts should be taken to ensure that face-to-face supervision occurs monthly.

Supervision of Peer Support Staff

North Carolina Certified Peer Support Specialists are essential parts of CSTs. Peer support specialists are people living in recovery with mental illness and/or substance use disorders who provide support to others who can benefit from their lived experiences. The NC Certified Peer Support Specialist Program

ensures that its graduates meet a set of requirements to provide support to individuals with mental health or substance use disorders. Peer support specialists guide and encourage individuals to take responsibility for and actively participate in their own recovery, model the recovery process, promote self-advocacy, and assist in decision-making and self-determination. They are fully integrated members of the CST and, like other team members, benefit from supportive supervision.

Supervisors play a key role in the successful integration of peer workers in the workplace. The purpose of supervision is to help the peer support specialist to be resourceful and effective in performing work duties and in fulfilling the requirements and duties of the position, including administrative, educative, supportive, and supervisory roles. An effective supervisor will help the peer support specialist draw on personal experience and focus on developing relevant skills to meet the job requirements while remaining focused on the needs and preferences of the person served.

SAMSHA outlines the following priorities for supervision of peer support specialists: [30]

- Supervisors must understand peer roles and practices.
- Supervisors must have a recovery orientation and model recovery-oriented practices.
- Supervisors support the development of the unique knowledge and skills needed for peer support practice.
- Supervisors recognize the connections between behavioral health conditions and trauma, health disparities, and social inequity.
- Supervisors use strengths-based supervision.
- Supervisors provide a space to address ethical and boundary issues.
- Supervisors advocate for the integration of peer workers in the workplace.

Since a peer support specialist is a person in recovery, health or mental health challenges may affect their performance of work responsibilities. Due to workplace boundaries and privacy concerns, it is important that the supervisor not address the issues personally, but rather follow company/agency policy and refer the staff member to an employee assistance program or other outside service.

Additional Resources for Community Support Team Supervision

- Supervision of Peer Workers (SAMHSA)
- Supervisor Guide: Peer Support Whole Health and Wellness (Georgia Mental Health Consumer Network)
- A Guide to Trauma-Informed Supervision (Pennsylvania Coalition Against Rape)
- Clinical Supervision and Professional Development of the Substance Abuse Counselor: A Treatment Improvement Protocol (SAMHSA)
- Supervisory working alliance inventory (SWAI) – Supervisee (*Journal of Counseling Psychology)*

[30] Substance Abuse and Mental Health Services Administration (n.d.). Supervision of peer workers: Bringing Recovery Supports to Scale Technical Assistance Center strategy (PowerPoint slide deck).

Wrap-Up

The purpose of this toolkit is to provide foundational information for CST providers who are working with TCL members to promote and enhance tenancy. However, the toolkit provides the infrastructure for effective tenancy supports beyond the TCL program. It is based on lessons learned during CST coaching and support offered by TAC and UNC from 2022 to 2024. It is our hope that this resource will be part of agency onboarding across the state, and be included in training in order to ensure that staff are well-versed in the foundational components of both CST and tenancy support. The appendices below offer samples, fillable templates, and additional resources that may be helpful for CST providers.

Appendices A – O: Forms, Templates, Trackers, and Other Resources

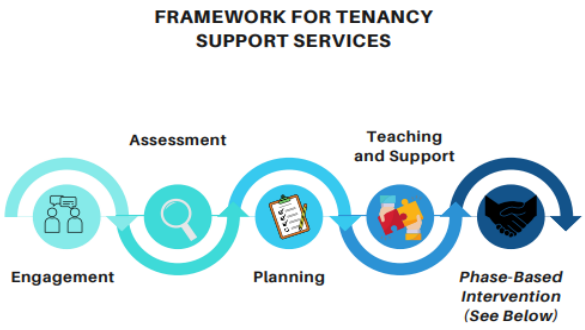
Appendix A: Permanent Supportive Housing "Cheat Sheet"

Phases of Permanent Supportive Housing

1. Pre-tenancy services center on accessing housing.
2. Move-in services focus on the actual move into the PSH unit, and on helping household members settle into their new home.
3. Ongoing tenancy services continue to assist people in meeting the conditions of their lease and enjoying successful tenancy.

Framework for Providing Tenancy Support

This framework should be utilized to enhance tenancy support services throughout the three phases of permanent supportive housing:



1. Engagement
2. Assessment
3. Planning
4. Teaching and Support
5. Phase-Based Interventions

Phase-Based Interventions

Pre-Tenancy	Move-In Phase	Ongoing Tenancy
Develop rapport and partnership	Continue building rapport	Strengthen rapport and partnership
Explain voucher subsidy and service eligibility, and help with these as needed	Update assessment and housing-focused plan	Continually assess and update housing-focused plan

Pre-Tenancy	Move-In Phase	Ongoing Tenancy
Help tenant understand the role and responsibilities of being a tenant	Continue to provide education on the roles, responsibilities, and rights of a tenant	Support skill-building to enhance competency and self-sufficiency in managing apartment
Conduct biopsychosocial and housing assessments to evaluate strengths and preferences as well as needs and barriers related to housing tenancy (see "Pre-Tenancy Assessment" below)	Assist with utility setup and obtaining furniture and household items	Access social and recreational opportunities (community resources, libraries, employment, church, sports, etc.)
Develop an initial housing-related service plan (planning for security deposits, obtaining identification, etc.)	Assist with utility access (heat, phone, etc.)	Pursue employment and educational opportunities
Plan for support and service needs and create plans to mitigate any housing barriers	Arrange for the move	Engage with existing supports and create new natural supports
Conduct the housing "search" and select a unit	Provide support with packing/unpacking	Intervene early in housing-related issues
Complete housing applications and maintain momentum and motivation while awaiting approval	Get oriented to new neighborhood and community resources	Advocate with landlords

Pre-Tenancy Housing Assessment

Pre-tenancy interventions set the stage for successful ongoing tenancy. Assessment is necessary to build on strengths and past experiences, and may indicate needs that will be part of the next phases of supported tenancy. In order to create a plan that will support housing tenure, these are some areas to explore through assessment (this is not a complete list):

Housing-specific knowledge that the person has or needs	Skills and resources needed to choose, obtain, and maintain housing (do not make assumptions; be prepared to teach needed skills)	Tenancy selection barriers and landlord screening barriers
Housing retention barriers (see below)	Personal preferences that can enhance satisfaction or hinder sustainability	Opportunities to promote choice

Potential Barriers to Evaluate and Mitigate

Fear of change; comfort with current living situation	Low or no income, benefits, or employment
No history of independent living; negative experience of independent living	Need for financial literacy skills
History of loss of tenancy	Supportive services and resource needs
Outstanding arrears (utilities, etc.)	Inability to understand or meet conditions of the lease
Health needs (mental health, medical, substance use, medication, etc.)	History of not wanting or using housing supports; “system” trauma

Assessment Questions to Ask Throughout the PSH Process

In every phase of PSH, staff should continue to assess the needs of both the tenant and the residence. Here are some questions that can be considered at each phase in the process:

Tenant	Residence
• Is the person disengaged or hard to reach? Are your visits with them growing shorter? • Is there evidence that the person is stressed or overwhelmed, or that their symptoms changing? • Is there evidence of use of tobacco, alcohol, or other substances? • What are the person's goals? Is there a disconnect between their words and their actions? • Are they demonstrating the skills to set up and sustain the home on their own? • Is there a lack of follow-through on appointments? (If so, explore the goals again and ensure that the visits are beneficial to the person, helping them work on their goals)	• Is the person preparing to pack/unpack their belongings? • Are there signs that the tenant is not staying in the unit? • Are there signs that other people are staying in the unit? • Are there health and safety issues (e.g., candles, signs of smoking in the unit, signs of bugs/mice, drug paraphernalia in the unit)? • Is there evidence of missing medications, or of medications piling up in the apartment? • Is the person making progress personalizing the space, adding their own touch to the unit)? • Are there signs that the person is having trouble cleaning and maintaining the unit on their own? • Are there broken items in the apartment or things that are not working? • Are there food and supplies in the apartment to meet basic needs?

Planning to Intervention: The Golden Thread

The overall aim of the PSH process is for the participant to experience success and satisfaction in their new home. Each phase has a specific objective and unique tasks to accomplish. As the person progresses through the process from housing search to move-in to ongoing tenancy, the assessment and housing goals should be updated accordingly. The person-centered plan (PCP) should be individualized and flexible, reflecting the changing interventions and activities in each phase as well as the ongoing assessment of the person and the setting. The PCP should guide interventions and documentation for every encounter.

Training and Support

Tenancy skill building examples (not a complete list):

- Education on responsibilities of tenancy
- Learning strategies to being a good neighbor: being aware of how one's actions can affect one's neighbors
- Enhancing social skills to interact with neighbors, landlords, building managers, transportation personnel
- Finding and accessing community resources; teaching *in vivo* where the person will be (gym, library, bus, etc.)
- Occupancy: only the person on the lease can reside in the unit
- Paying rent, understanding the subsidy, and general financial literacy
- Maintaining the apartment: understanding and meeting cleanliness standards, inspection expectations, safety in the unit, managing repairs and requesting maintenance
- Enhancing activities of daily living and solidifying apartment upkeep skills
- Strengthening advocacy skills to engage with landlords, doctors, family, etc.
- Honing wellness skills (exercise, sleep hygiene, nutrition, self-care, recognizing when to ask for help)
- Continued crisis planning and re-evaluation of Wellness Recovery Action Plans in order to support individuals in identifying and mitigating potential crises
- Support with navigation of housing system and assisting with setting up utilities
- Enhancing natural supports and fostering community inclusion and participation in meaningful activities (community events, social and recreational activities)
- Orientation to new neighborhood (e.g., bus routes) and increasing comfort with independently accessing resources

Ways for Staff to Enhance Tenancy Support

Motivational Interviewing can help to elicit behavior change, explore, and resolve ambivalence and evoke motivation.

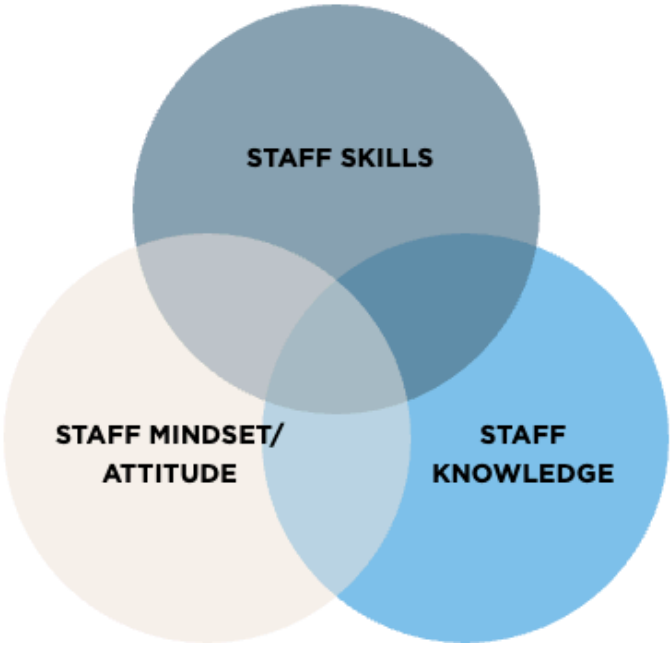
Behavioral Techniques/Interventions include modeling, role-playing, behavioral tailoring, and relapse prevention.

Educational Teaching Strategies allow a provider to teach skills using patience, repetition, *in vivo* practice, and adult learning models.

Cognitive Behavioral Therapy (CBT) is a technique used to help individuals recognize and change limiting cognitive patterns and related behaviors.

Harm Reduction focuses on finding alternative activities that are less harmful and/or reduce the risk of eviction.

Trauma-Informed Care is based on understanding the effects of trauma and the Adverse Childhood Experiences (ACEs) Study, building resilience.



STAFF SKILLS
- Motivational Interviewing
- Cognitive Techniques/CBT Educational Teaching
- Harm Reduction
- Psychiatric Rehab Interventions

STAFF KNOWLEDGE OF
- Housing Knowledge: Housing Rights, Fair Housing Laws
- Community Resources
- Entitlement Programs

STAFF MINDSET/ATTITUDE
- Evaluate your biases
- Unconditional Positive Regard
- Genuine Curiosity
- Solution Oriented Focus
- Recovery-Oriented

Appendix B: Sample Move-in Checklist

Person Needs to Know (Intervention: Provide information and education)	Person Needs to Be Able to Do (Intervention: Develop and strengthen skills)	Person Needs to Have (Intervention: Develop or acquire a resource or provide support)
• Location of needed and desired community resources (public transportation, shopping, recreation, services, worship, etc.) • How to access resources for moving and move-in costs • Terms and conditions of lease • Expectations of tenancy (what the landlord expects) • Rights of tenancy (what the tenant is entitled to) • Emergency contact numbers (who to call, when, why, and what to expect)	• Agree to terms and sign lease • Pack and unpack belongings • Maintain schedule of appointments and services • Self-care skills for illness management, stress • Recognize when in need of support, e.g., increase in symptoms, feeling anxious, lonely, etc. • Recognize need for maintenance request • Seek help if needed • Keep apartment reasonably clean • Follow terms of the lease (noise level, guests, where to take trash, pay rent on time) • Use public or other transportation • Interact with neighbors in a friendly manner • Use all appliances (stove, laundry, sink and tub, etc.) • Planning daily activities	• Money for security deposit • Money to pay for any back due utility bills (if applicable) • Income to pay tenant portion of rent • Assistance with actual move (friends, truck, movers, etc.) • Basic furniture (bed, dresser, kitchen table, couch/chair for living room) • Household supplies • Crisis Support Plan • Increased support

Appendix C:
Sample Mitigation Letter

[Agency Letterhead]

Date

Housing Entity Contact Information
c/o Housing Case Manager name if known
Their Address
Their City, State, Zip Code
Their Email Address

Re: Appeal of CORI-Related Housing Denial **[Client's Housing Authority Case #]**

To Whom it May Concern;

I/Organization write/s to advocate on behalf of [**Client Name, Client's Housing Authority Case #**]'s placement in permanent housing through the [**Housing Entity**]. We understand that he/she/they has/have been denied based on his/her/their past involvement with the criminal legal system. [**I/Organization Name**] have been working with [**Client Name**] for the past [**number of months/years**] and feel they have made substantial progress towards building a life in recovery. I/Organization feel that many of their past offenses were related to their [**behavioral health/substance use/being unhoused, etc.**] for which they are now receiving support through our organization. Some of the steps [**Client Name**] has taken include:

Examples:

- Participation in Community Support Team services
- Completion of a behavioral health or substance use program
- Adherence to treatment plans
- Participation in counseling or social service programs
- Positive contributions to the community
- Completion of probation or adherence to requirements.

Furthermore, it has been [**number of months/years]** since [**Client Name**] has had any interaction with the criminal legal system. With support, [**Client Name**] can be a successful tenant. Your consideration is appreciated.

Sincerely,

[Signature]

Your Name and Credentials or Organization's Name

Your Address
Your City, State, and Zip Code
Your Email Address

Appendix D: Reasonable Accommodation (RA) Checklist and Sample Letter[1]

RA Checklist

Reset Form

When completing a reasonable accommodation letter, it is best practice to complete the request in writing so there is documented proof of the request. The following items should be included in the request:

☐ Explain your relationship to the person with a disability.

☐ Specifically state that the person has a disability.

- ✓ You do not need to state the specific disability or disclose any diagnosis. (The landlord may request proof of disability but even then, you do not need to disclose the specific disability.)
- ✓ Focus on any substantial limitations to major life activities.

☐ Specifically state that you are requesting a reasonable accommodation.

☐ Explain why the reasonable accommodation is necessary and how it is related to the disability.

- ✓ How will the accommodation support the person?

☐ Ask for a response by a certain date.

- ✓ By law, landlord is required to respond within a reasonable time frame and a lack of response is considered a denial.

☐ Make sure the letter is signed and dated, with contact information for a response.

[1] Adapted from NC Legal Aid Fair Housing Training

RA Sample Letter

[Your Name]
[Your Address]
[Your City, State, Zip Code]
[Date of the letter]

[Name of Apartment Manager/Housing Authority/Landlord]
[Housing Complex]
[Address]
[City, State, Zip Code]

Dear [Apartment Manager/Housing Authority/Landlord]:

I am [applying to become a tenant] at [address]. Although you have a no pets policy, my [your physician, psychiatrist] has prescribed me an assistance animal to help me cope with the functional limitations I experience that are directly related to my disability, and to enhance my abilliy to live independently and to fully use and enjoy the rental unit you own and/or administer.

I am requesting that you modify your no pets policy to permit me to have the assistance animal recommended by my physician as a reasonable accommodation under the Fair Housing Act.

Attached please find documentation from my [your professional (physician, psychiatrist)] of my disability and the functional limitations I experience as a result, as well as a prescription for an assistance animal to help me cope with my disability. The animal need not be certified or trained to perform this service for me.

Please reply in writing regarding this request for an accommodation within 10 business days. Thank you for your consideration and I look forward to receiving your reply.

Sincerely

[Your Signature]
[Your Name]

Appendix E: Landlord Tracker

Reset Form

Property Information

Name of Property: _____

Address of property, apartment complex, or leasing agency: _____ County: _____

Type of property: ☐ Section 8 ☐ Private ☐ Other _____

Property Manager/Landlord Information

Name of Contact: _____ Phone number: _____

Website (if applicable): _____

How were they contacted? ☐ In Person ☐ Via Telephone ☐ Internet ☐ Other _____

Date(s) of contact? From: _____ To: _____

Application Requirements

Application Details: ☐ Paper ☐ Online ☐ Fee Rent Pricing:_____

Criminal history policy: _____ Eviction/broken lease policy: _____

Allows smoking? ☐ Yes ☐ No Other information learned: _____

Name of property	Address of property, apartment complex, or leasing agency	County	Type of property (e.g., Section 8, private, etc.)	Property manager's or landlord's name	Phone number	Website (if applicable)	How contacted? (e.g., in person, via telephone, internet, etc.)	Date(s) of contact	Application details (paper, online, fee)	Criminal history policy	Eviction/ broken lease policy	Allows smoking? (Y/N)	Rent pricing	Other information learned

Reset Form

Appendix F: Housing Tracker

Reset Form

Individual's Name

Income:	$ _____	Need an accessible unit?	☐ Yes ☐ No
Rent budget	$ _____	Able to use stairs?	☐ Yes ☐ No
TCL recipient?	☐ Yes ☐ No	Open to roommate?	☐ Yes ☐ No
Has housing voucher?	☐ Yes ☐ No	Close to bus stop?	☐ Yes ☐ No
In targeted housing?	☐ Yes ☐ No	Close to community resources?	☐ Yes ☐ No
Desired location:	_____		

Apartment Details

Apartment name	Apartment address	Apartment contact (phone/email)	Manager's name	Date applied	Waitlist timeline	Section 8 (y/n)	Targeted (y/n)	TCL (y/n)	Income-based (y/n)	Market rent	Other details
						Choose	Choose	Choose	Choose		
						Choose	Choose	Choose	Choose		
						Choose	Choose	Choose	Choose		
						Choose	Choose	Choose	Choose		
						Choose	Choose	Choose	Choose		

Appendix G: Voucher Program Basics

PROGRAM BASICS	*HCV*	*EHV*	*Mainstream*	*ESG-RRH*	*CoC-RA*	*SSVF*	*HUD-VASH*	*Key*	*TCLV*
Type of Rental Assistance	Tenant-based, can be project-based	Tenant-based special purpose HCV, cannot be project-based	Tenant-based, special purpose HCV, can be project-based	Tenant-based	Tenant-based	Tenant-based	Tenant- or (occasionally) project-based	Project-based	Tenant-based
Funding	U.S. Dept. of Housing and Urban Development (HUD) allocates to public housing agencies (PHAs)	HUD allocates based on a formula directly to PHAs that opt in	HUD allocates directly to PHAs. PHAs must apply for Mainstream vouchers	HUD distributes block grant to cities and states, which then award grants to Continuum of Care (CoC) applicants	HUD awards competitive funding to CoCs	U.S. Dept. of Veterans Affairs (VA) awards grants to supportive services nonprofits	HUD and VA allocate to PHAs and VA medical centers (VAMCs)	State revenue – Recurring item in NC Dept. of Health and Human Services (NC DHHS) budget	State revenue – Recurring item in NC DHHS budget
Target Population	Individuals & families with low incomes (PHAs may set preferences locally)	Individuals and families who are homeless; at risk of homelessness; fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; were recently homeless; or have a high risk of housing instability	Non-elderly persons with disabilities	Individuals/families experiencing homelessness as defined by Category 1 ("literally homeless") in HUD's Homeless Definition Rule or Category 4 ("fleeing or attempting to flee domestic violence with no other residence")	Individuals/families experiencing homelessness as defined by Categories 1, 2 ("imminent risk of homelessness"), 3 ("homeless under other Federal statutes"), or 4 For permanent supportive housing, at least one household member must have a disability	Veteran households who are literally homeless or imminently at risk of literal homelessness	Veterans experiencing homelessness as defined by Category 1 or 2 Priority for those who are chronically homeless with severe mental illness or dependent children	People with disabilities with low incomes	People with disabilities addressed under the 2012 *Olmstead* settlement with low incomes

Appendix H: Template for the Review of Person-Centered Documentation

Reset Form

Life Domains

Daily Life and Employment What a person does as part of everyday life – school, employment, volunteering, communication, routines, and life skills.	**Community Living** Where and how someone lives – housing and living options, community access, transportation, home adaptation and modification.
Safety and Security Staying safe and secure – finances, emergencies, relationships, neighborhood, well-being, decision making supports, legal rights, and issues.	**Healthy Living** Managing and accessing health care and staying well – medical, mental health, behavioral, alcohol, tobacco and other drug use, medication management, life span development, exercise, wellness, and nutrition
Social and Spirituality Building/strengthening friendships and relationships, leisure activities, personal networks, community inclusion, natural supports, cultural beliefs, and faith community.	**Citizenship and Advocacy** Building valued roles, understanding personal rights, making choices, sexual orientation, self-identification, setting goals, assuming responsibility and driving how one's own life is lived.

Source: "Person-Centered Planning," NCDHHS

Person-Centered Plan Review

- ☐ Evidence of assessment in all 6 domains in each treatment plan (See above)
- ☐ Evidence of the individual's voice in the treatment plan, including direct quotations
- ☐ Goal statements include direct quotes from the individual
- ☐ Natural supports are identified and incorporated into planning (if specified concern is that there are no natural supports, then plan include opportunities to enhance natural supports)
- ☐ The objectives are linked to goals
- ☐ There are target dates on the objectives
- ☐ Treatment goals change with each plan revision
- ☐ Plan specifies what the individual will do, and what team will do, including specification of interventions

☐ Readable for the individual receiving services

☐ Specific to intensity needed

☐ Community-based planning (includes plans/interventions to connect the individual to the community.)

☐ Includes coordination with other service providers if applicable (Primary care, Individual Placement & Support (IPS), peer support services, etc.)

☐ Evidence that services are culturally relevant

☐ Evidence that IPS or vocational rehab was explored and incorporated into plan if individual expressed interest; if not, evidence that goals are revisited/employment desire re-assessed

Is there evidence that the plan has been regularly updated to reflect the changing needs of the individual? ☐ Yes ☐ No

Please explain:

Are the goals self-directed? ☐ Yes ☐ No

Please explain:

Is the Plan SMART (specific, measurable, achievable, relevant, and time-bound)? ☐ Yes ☐ No

Please explain:

Is the language person-centered? ☐ Yes ☐ No

Please explain:

Provide examples of the specific language and how it could be more person-centered:

Does the plan actively use the strengths of the individual? ☐ Yes ☐ No

Please explain:

Provide examples of how the plan could better incorporate strengths:

Crisis Plan Review

- ☐ Individualized (i.e. includes specific strategies, strengths, quotes, and individual's supports are included in the plan)
- ☐ The plan identifies triggers, warning signs, and red flags of crisis and how to respond at each stage
- ☐ The plan is driven by the individual (includes quotes and the person's identified contacts and supports)
- ☐ Includes access to provider's 24-hour crisis service
- ☐ Identifies opportunities to enhance wellness and engage in mitigation
- ☐ Involves strategies to decrease the likelihood of hospitalization or incarceration
- ☐ A copy has been given to the individual

Progress Notes Review

- ☐ The specific goal/objective being addressed during the engagement (what was the intended outcome)
- ☐ Description of intervention/service provided (what staff did)
- ☐ Description of individual's response and actions as part of the service delivery
- ☐ An assessment of effectiveness of the service activity (what happened, or did not happen, as a result of the service activity)
- ☐ Progress achieved toward identified housing goal and objectives

- ☐ If outcome was not achieved, description of what occurred instead
- ☐ Notes include the date, frequency (how often) and duration (how much time was spent) of each service
- ☐ Services delivered to individuals can be directly tied to the person-centered plan or tenancy support services
- ☐ Plan for the next visit with date, and action steps for staff and participant, and specific follow-ups

- ☐ Evidence of utilization of evidence-based practices (Motivational Interviewing, harm reduction, progressive engagement, etc.)
- ☐ Notes are written in recovery-oriented and person-centered language.
- ☐ Notes reflect the strengths of the individual

Notes documented here:

Overall:

What are the strengths in documentation?

How could the documentation be changed to be more person-centered?

Appendix I: Chart Audit Forms

Reset Form

Overall Chart Review

- ☑ Level of intensity of service needs is documented clearly in service notes and PCP.
- ☑ Authorization is obtained for service level required based on level of intensity of services.
- ☑ Staff have assessed and identified if there are needed services that are not currently available/offered.
- ☐ Services provided are evidence based.
- ☐ Services are recovery focused.
- ☐ Services are community-based.
- ☐ Services are flexible and based on the individual's level of need or their request.
- ☐ Services are flexible and based on the individual's level of need or their request.
- ☐ Services are unique to the individual.
- ☐ Individual is supported in forming social relationships and supports of their own choosing.
- ☐ Services are delivered consistent with the service definition.
- ☑ For individuals moving into Supportive Housing (SH), or who have exited SH but may move back to SH, their primary provider is or will provide the necessary pre-tenancy, move-in and post tenancy services to enable the individual to live successfully in the community.
- ☑ Services provided are evidence-based practices.
- ☑ If the individual is considering or requesting a housing slot or moving into housing, their PCP includes a housing goal with specific objectives and tasks.

PCP is/includes…

- ☑ Individualized - includes individual's voice, strengths, realities, goals
- ☑ Individual's selected goals - interventions and content supports progress toward these goals whether or not specific community resources exist.
- ☑ Readable for the individual

- ☑ Specific to the intensity needed
- ☑ Recovery-focused
- ☑ Community based — includes plans/interventions to connect the individual in/to the community
- ☑ Regularly updated to reflect change in goals
- ☐ Updated at each phase in tenancy
- ☐ Evidence of translation services being offered if the individual does not speak English
- ☐ Includes staff participating in providing the interventions
- ☐ Is implemented by a QP and includes coordination with other service providers if applicable (primary care, IPS, peer support services, etc.)
- ☐ A copy has been given to the individual
- ☐ Plan is readable for the individual
- ☐ The plan involves strategies to decrease likelihood of hospitalization or incarceration
- ☐ The plan includes specific community-based strategies for crisis support
- ☐ Includes access to provider's 24-hour crisis service

Supported Employment

- ☐ Individual expressed interested in employment and was referred to IPS or VR services

Community-Based Mental Health

- ☐ Provider has identified the appropriate level of services based on the individual's need
- ☐ Provider has made a services authorization request that is adequate and appropriate for the service type and intensity level that matches the individual's needs

Appendix J:
Team Meeting Template

Reset Form

Team Meeting Agenda

Date of Meeting: _____ Facilitator: _____

Start Time: _____ Attendees: _____

End Time: _____

Agenda

1. Team Building Exercise
2. Administrative Updates/Needs
3. Team Successes/Celebrations
4. Critical Incidents to Address (Use Template Below)

Tenant/ Service Recipient	Staff	Event Type (Crisis Call, Hospitalization, Incarceration, etc)	Intervention	Resolution/Outcome

5. New Referrals
6. Roll Call from previous week (Roll call should cover: individual's goals and updates; recent interventions; current supports and needs; community engagement activities; employment and housing updates; pressing medical and behavioral health needs; identified concerns/ potential crisis factors; current intervention effectiveness)

Tenant / Service Recipient	Staff	Auth/Hrs LEFT	Successes/Concerns	Recommendations

Tenant / Service Recipient	Staff	Auth/Hrs LEFT	Successes/Concerns	Recommendations

7. Additional Team Needs/Asks

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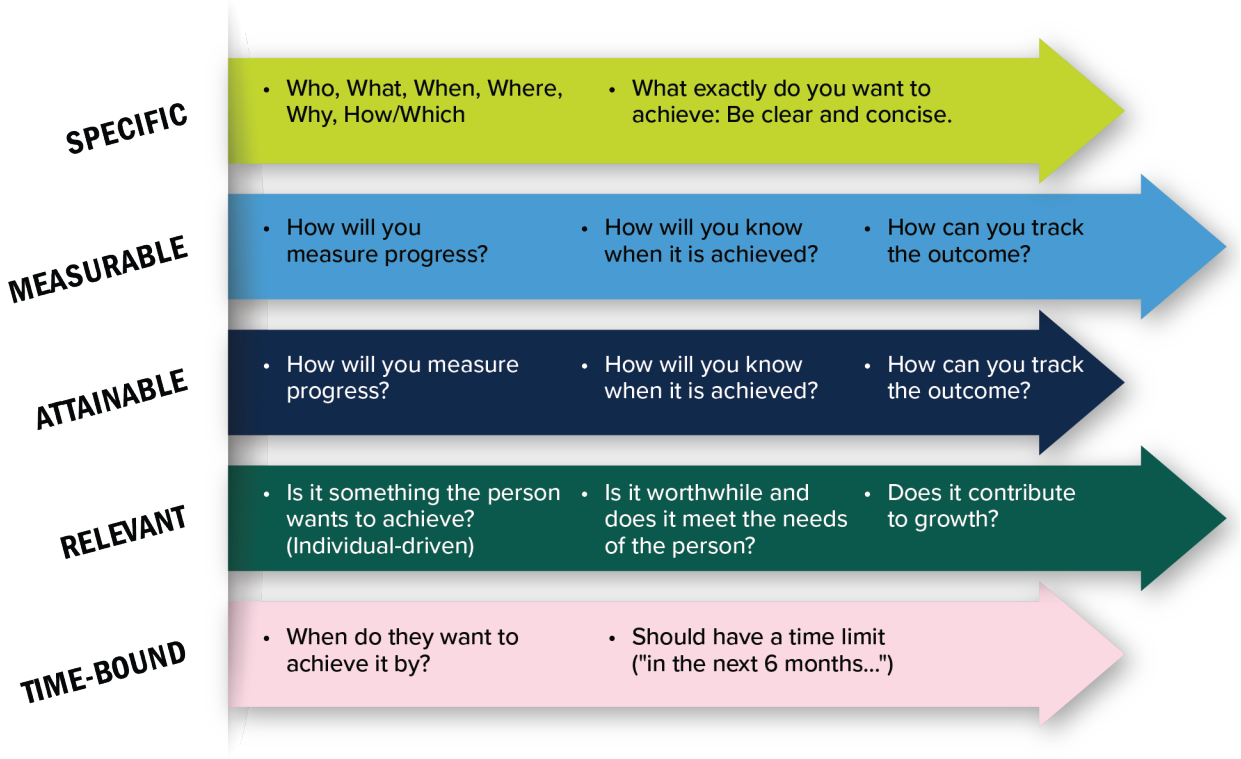
Appendix K: SMART Goals



Appendix L: Supervision Contract

Reset Form

Supervisory Conditions

This document serves as a description of the supervision partnership between:

_____ and _____

Supervisor name, credentials, title — Supervisee name, credentials, title

Frequency: ☐ Weekly ☐ Bi-Weekly ☐ Other: _____

Day: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Time:

From: _____ am / pm To: _____ am / pm

Location: _____ Alternate Location: _____

Supervisor Responsibilities

- Ensure that supervision occurs on a regular basis as detailed above.
- Provide a private space that is free of interruptions.
- Be supportive, encouraging, and respectful.
- Maintain accurate and clear records of supervision via the supervision log.
- Ensure that a supervision agreement is negotiated and decided upon annually.

Supervisee Responsibilities

- Attend supervision regularly and on time and participate actively.
- Be prepared by bringing topics for discussion to supervision.
- Ensure a supervision agreement is negotiated and decided upon annually.
- Be accountable for your own supervision and development.

Supervisee Professional Goals

What areas would the supervisee like to focus on for clinical growth?

What supports can the supervisor provide to facilitate growth in these areas?

What training needs has the supervisee identified for this year?

Are there additional needs that the supervisee has currently?

We, the supervisor and supervisee, agree that this supervision is a partnership. What is said during supervision will be kept confidential with the exception of discussion of ongoing cases, or in the instance that someone is being harmed or harming themselves or others. We acknowledge that supervision is a continuous process that will be planned, structured, focused, and private. If one party cannot meet at the agreed-upon time, there is a mutual responsibility to reschedule. By signing, we agree to the

responsibilities outlined in this document. This agreement is valid for one year from the date signed and must be reviewed annually. The supervisor and supervisee both can renegotiate this agreement at any point in time.

_____	_____
Signature of Supervisor:	Date:
_____	_____
Signature of Supervisee:	Date:

Appendix M: Supervision Documentation Form Templates

Template 1

Reset Form

Clinical Supervision

Staff: _____ Start Time: _____

Supervisor: _____ End Time: _____

Date: _____

Topics discussed (Circle all that apply):

Duties & expectations	Comprehensive skills eval	Cases & Assessment	Information & referral
Professionalism	Interagency Collaborations	High Risk issues	Crisis Management
Judgment	Decision making	Progress notes	Termination
Communication skills	Problem solving	Goals & objectives	Diversity issues
Agency Initiatives	Initiative	Treatment planning	Mezzo practice issues
Attitude	Flexibility	Crisis intervention	Macro practice issues
Time management	Self awareness	Practice/intervention skills	Ethical issues
Evaluation Objectives	Accountability	Clinical Skill Building	Other: _____

Comments:

Strengths:

Challenges:

Tasks to be completed by the next supervision session or date specified:

Supervisor Signature: _____

Staff Signature: _____

Template 2

Reset Form

Supervision Notes

Supervisee: _____ Supervisor: _____ Date: _____

Check-in (*Personal highs/lows; how is the work going?; self-care; upcoming time off, etc.*)

Supervisee Agenda Items	Supervisor Agenda Items

Administrative Items (*Include any follow-ups or updates from the last meeting; focus for this week; documentation status; task/project updates; agency/team updates*)

Supervisee Agenda Items	Supervisor Agenda Items

Growth, Development, and Support (*Include any training or support needs; feedback; long-term goals check-in)*

Supervisee Agenda Items	Supervisor Agenda Items

Individual's name	Recent updates/ interventions/ challenges	Provider feelings/reactions, areas for increased knowledge, observations	Follow-up actions to take/possible new strategies	Is documentation complete?
		njkkgk		

Supervisor Signature: _____ Staff Signature: _____

Appendix N: Community Observation Form

Reset Form

This form is designed to support CST Team Leads in providing observation-based feedback to team members following community-based observation and shadowing. This document is meant to be used over the course of an afternoon shadowing a team member to observe "trends" in service delivery and overall use of best practices.

Element of Observation	Not displayed during observation	Infrequently displayed	Consistently displayed	Displayed skilled execution of principle or element	Notes/ Observations
Expressed or showed optimism about person's recovery					
Focused on whole person, not just mental health condition					
Awareness of person's unique identified goals					
Focus of visit is on person's unique identified goals					
Action to honor the person's dignity of risk					
Intervention is catered to the person, different than intervention with other clients (person-specific)					
Evidence of culturally humble practices					
Used preferred names and pronouns					
Focus of the visit is on the person, not the provider					

Element of Observation	Not displayed during observation	Infrequently displayed	Consistently displayed	Displayed skilled execution of principle or element	Notes/ Observations
Staff engaged actively with recipient in order to assess and identify needs					
Provider is performing interventions in line with their credentials and role					
Interaction is warm but clearly professional, vs. overly familiar/close					
Client has been referred to available community resources for needs					
Demonstrated awareness and involvement of person's natural supports					
Used Motivational Interviewing skills					
Used appropriate interventions for housing phase					

Administrative:

Was the worker on time for the visit/meeting?	☑ Yes ☐ No
Was the recipient aware of the visit?	☐ Yes ☑ No
Was the staff member prepared for the visit? (has the appropriate documents, knows the goals, etc.)	☐ Yes ☑ No
Was the note completed in a timely manner?	☑ Yes ☐ No
Does the note reflect the content of the meeting?	☐ Yes ☐ No
Does the note include the required elements of CST?	☐ Yes ☐ No

Summary of community observation:

Appendix O:
Clinical Consultation Form

Reset Form

Case Consultation

Basic demographic information (without identifying details):

Explanation of illness or presenting issue(s) (why is the person here, why now?):

Cultural understanding (focus on how cultural identities/preferences affect recovery and/or treatment preferences; the impact of the person's culture on their life, their understanding of their illness from a cultural context, etc.):

Strengths, preferences, and priorities (personal talents/interests/coping skills as well as natural supports and community connections):

Stage of change readiness and why:

Summary of priority needs/barriers to goal attainment (with a focus on how symptoms/functional impairments are interfering with functioning in community settings):

Hypothesis (central themes, underpinnings, clinical insights, understandings, not a repetition of the data):

Specific questions for consultation:

Treatment recommendations from colleagues (level/intensity of care, with justification based on the above understanding):