INTRODUCTION

Safe Havens serve as refuge for people who are homeless and have a serious mental illness. Safe Havens provide more than shelter. They close the gap in housing and services available for those homeless individuals who, perhaps because of their illness, have refused help or have been denied or removed from other homeless programs.

In 1992, amendments to the Stewart B. McKinney Homeless Assistance Act included a provision for the creation of Safe Havens. According to Title IV, Subtitle D of the McKinney Act:

> A safe haven is a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who are on the street and have been unable or unwilling to participate in supportive services.

The McKinney Act specified several characteristics of Safe Haven facilities:

- 24-hour residence for eligible persons who may reside for an unspecified duration;

- private or semiprivate accommodations;

- overnight occupancy limited to 25 persons;

- low-demand services and referrals; and

- supportive services to eligible persons who are not residents on a drop-in basis.

Safe Havens encourage residents to go beyond just finding shelter. This is done by creating a housing environment that is safe, sanitary, flexible and stable, and which places no treatment participation demands on residents, but has high expectations for residents. These expectations specifically include that the resident will transition from unsafe and unstable street life to a permanent housing situation and that re-engagement with treatment services will occur. Because these expectations are introduced non-intrusively and as the resident is ready, the phrase "low demand" is often used to characterize Safe Haven housing.

According to *Outcasts on Main Street*, the Report of the Federal Task Force on Homelessness and Severe Mental Illness, which was the impetus for creating the program, this transition period is necessary "to achieve relative stability and to permit professional staff to adequately assess clients' long-term needs and prospects. The skills needed for survival on the streets (such as the need to mistrust strangers and use hostility as a defense) differ greatly from those needed for accommodation indoors. Before they are ready and able to adhere to rules and program requirements, many people with severe mental illnesses need not only shelter from the harshness of street living, but time to reflect and learn to trust helpers."

The McKinney Act lays the groundwork for Safe Havens but does not offer specific guidance on issues ranging from staffing and site design to rules and outreach. This Tool Kit has been developed to guide communities and project sponsors to create effective Safe Havens. It is written by people who have developed and/or operated Safe Havens and mental health consumers have critiqued their ideas. The Kit includes eight chapters covering the key issues surrounding the creation of Safe Havens, as follows:

Continuum of Care. Chapter 1 discusses how Safe Havens can fit into a local Continuum of Care approach to alleviate homelessness, an approach that focuses on a local community creating a network of housing and services that lead to permanent housing. Safe Havens figure prominently in this continuum.

Planning, Designing, Siting and Financing Safe Haven Housing. Chapter 2 focuses on establishing the physical aspects of a Safe Haven project with an emphasis on good planning and design. The chapter also covers cost preparations and choosing the best housing situation and location.

The Challenge and Opportunity of NIMBY. Chapter 3 discusses overcoming the effects of the NIMBY (Not In My Back Yard) syndrome and offers suggestions to help new programs to address this issue.

Program Issues: Outreach, Engagement and Service Delivery. Chapter 4 uses examples and recommendations for exemplary practices from three established Safe Havens to offer direction in these crucial program issues.

Crisis Management. Chapter 5 will help Safe Haven staff recognize, anticipate and prepare for crisis within their programs. It suggests five tenents of crisis management to guide a program's response to emergency situations.

Program Rules and Expectations. Chapter 6 discusses making effective house rules, dealing with infractions, and protecting residents' rights. It includes a special section on rules regarding sexual activity and drug use.

Staffing Issues. Chapter 7 reviews staffing patterns and makes suggestions for staff background, qualifications, and training. This chapter also addresses issues concerning outreach staff, consultants, volunteers, students, space and the facility.

Transitions from Safe Havens. Chapter 8 presents ideas to help residents prepare for their eventual departure from a Safe Haven to a more permanent living situation. It indicates that preparations begin at the earliest stage.

DEVELOPMENT OF THE SAFE HAVEN TOOL KIT

This Tool Kit is based on information gathered at a meeting, "Developing and Operating Safe Haven Programs," held in Washington D.C. in April 1997. The meeting was sponsored by the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services and the Office of Special Needs Assistance Programs, Office of Community Planning and Development within the U.S. Department of Housing and Urban Development.

The meeting convened experts in the fields of housing, homelessness and mental illness, and Safe Haven staff from across the United States. The format purposefully included participation by mental health consumers on each topic. Federal representatives from CMHS and HUD worked with the group members to begin to create a consensus on the issues and exemplary practices included in this Tool Kit.

Six papers were prepared for review at the CMHS/HUD meeting. Participants responded to the subject material and then the papers were developed to reflect the consensus of the group. These papers account for six of the Tool Kit's eight chapters. The remaining two chapters, on NIMBY and Crisis Management, were added in light of the participants' expressed need to address these important issues in this guidebook.

It is hoped that this collection of information will inspire communities to open Safe Havens for homeless people with serious mental illness who are unwilling or unable to leave the streets.

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The Continuum of Care

CHAPTER

THE CONTINUUM OF CARE

BY ANN O'HARA

During the past several years, the federal government has developed a comprehensive, coordinated and flexible approach to assist affordable housing, community development, and homelessness activities at the state and local levels. Through the U.S. Department of Housing and Urban Development's (HUD) Consolidated Plan process, local and state officials can identify and prioritize needs and resources, and develop strategies and action plans for the investment of federal housing and community development funds. Building from the Consolidated Plan, states and communities are also implementing HUD's Continuum of Care approach to alleviate homelessness - an approach that fosters a community-based and comprehensive response to meeting the different and frequently complex needs of homeless people. A Safe Haven can be an important element in a community's Continuum of Care.

The Continuum of Care approach arose from evidence that previous homeless assistance efforts had produced a patchwork of homeless assistance projects and programs that often had little or no relationship to one another. The lack of a systematic approach left significant gaps in homeless services, despite the best intentions of dedicated advocates and providers. In many communities, the special needs of some homeless subpopulation groups were often unmet or only partially addressed.

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This situation certainly applied to homeless persons with a mental illness or co-occurring substance use disorder. Often the most visible, yet the hardest to reach homeless population, the opportunities for these individuals to move beyond homelessness are reduced by the very nature of their disability, which disrupts their judgment, motivation, and social skills. Because of their complex needs and frequent resistance to both mental health and/or homeless services, a comprehensive and flexible array of specialized services and supports must be readily available to assist them.

The Continuum of Care approach has given states and localities a framework and resources to address the complex needs of homeless people with a mental illness or a co-occurring disorder, as well as other priority needs. The Continuum of Care approach helps communities plan for and provide a balance of emergency, transitional, and permanent housing and service resources. McKinney funding and other resources can then be targeted to develop new housing and service options that must be available within a seamless and comprehensive system to alleviate homelessness.

> The lack of systematic approach left significant gaps in homeless service, despite the best intentions of dedicated advocates and providers.

THE CONTINUUM OF CARE FOR HOMELESS PEOPLE WITH MENTAL ILLNESS INCLUDES:

- Assertive outreach, engagement and assessment activities to establish trust and to assist in meeting basic human survival needs;

- Immediate access to a low-demand and safe alternative to the streets and access to an integrated system of services and supports;

- Transitional housing with appropriate supportive services;

- Permanent supportive housing.

THE SAFE HAVEN AND THE CONTINUUM OF CARE SYSTEM

Safe Havens were authorized by Congress to fill a critical gap identified within the Continuum of Care system for homeless people with a mental illness or co-occurring disorder. The Federal Task Force on Homelessness and Severe Mental Illness, which was convened by the Interagency Council on the Homeless, proposed the concept of a Safe Haven in its report *Outcasts on Main Street* published in 1992. *Outcasts on Main Street* documented what many homeless advocates and service providers knew from experience – that the unique needs of many homeless people with mental illness living on the streets frequently couldn't be addressed by the outreach and emergency shelter programs that serve the general homeless population. The Task Force proposed a national strategy and specific action steps designed to end homelessness among people with mental illness, including Safe Havens.

In 1994, HUD's Supportive Housing Program (SHP) was expanded to include the development and operation of Safe Havens targeted exclusively to the most difficult to reach people who are homeless and who have a mental illness. Safe Havens serve as a portal of entry to the homeless and mental health service systems. They offer an array of basic services and supports and access to more traditional housing and service options.

OUTCASTS ON MAIN STREET

"Safe Havens can accommodate homeless mentally ill persons coming from shelters or emergency rooms (when hospitalization is not required) as well as those coming directly from the street. They offer a relatively stable and secure environment for people not yet willing to participate in more mainstream housing options -- both temporary and permanent -- for homeless individuals."

Defining and Prioritizing The Need for a Safe Haven

As new and potential Safe Haven projects are considered across the country, the purpose of the Safe Haven within the Continuum of Care system must be clearly defined and understood. The mission of a Safe Haven is to serve hard-to-reach homeless persons with severe mental illness who are on the streets and have been unwilling or unable to participate in supportive services. This Safe Haven mission statement clearly defines what Congress intended the Safe Haven target population to be. It is <u>not</u> a program for homeless people who can be easily engaged in mental health services and who are ready for residential settings, such as group homes, permanent supportive housing, or independent living. It is not a hospital diversion program, nor is it a hospital discharge program for persons at-risk of homelessness. And, although the length of stay is not defined, it is not permanent housing.

> **A community needs to consider several other factors when determining the relative priority for a Safe Haven:**
>
> - Because it is transitional in nature, a Safe Haven will serve more individuals over the course of a year than its capacity at any point in time.
>
> - Some people who are homeless and who have a mental illness may continue to be resistant to any services after a Safe Haven is made available to them.
>
> - In order to maximize the use of a Safe Haven within the Continuum of Care system, "next step" programs are needed for Safe Haven participants ready to move to transitional or permanent supportive housing.

The Continuum of Care process can assess and quantify a community's need for a Safe Haven through a variety of sources. The homeless component of the local government's Consolidated Plan should contain an estimate of the number of homeless persons with a mental illness, as well as information on the

> **The mission of a Safe Haven is to serve hard-to-reach homeless persons with severe mental illness who are on the streets and have been unwilling or unable to participate in supportive services.**

number of persons living in places not designed for human habitation. Using these estimates as a basis, more specific needs data can be obtained from a street census conducted by outreach workers, from hospital emergency room staff, from detox and substance abuse service facilities, emergency shelters, homeless drop-in centers, and other programs serving homeless persons who have a mental illness.

Preconditions for Developing Safe Havens within the Continuum of Care

The available literature as well as interviews with Safe Haven sponsors point to a number of factors that are key to developing successful Safe Havens within the Continuum of Care system. Ideally, Safe Haven projects should:

- Be developed in communities where there are sufficient numbers of hard-to-reach homeless individuals with mental illness to ensure a high ranking with the Continuum of Care process. By design, Safe Haven projects should periodically accommodate new residents and assist current residents to move on to more permanent housing. This design means a significant number of potential program participants should be identified as needing the services of a Safe Haven.

- Have a clear strategy for leveraging resources that can be used in combination with SHP funding for Safe Haven's development, operations, and supportive services.

- Have a sponsor who brings expertise and experience with homeless people with a mental illness and a strong track record in the community. These factors become critical when seeking political and community support and when siting the program.

- Seek some political and community support for the project when developing the project concept, which can later be leveraged into broader support as the project proceeds into development.

- Include formerly homeless peer counselors who can overcome barriers to outreach and engagement that often prevent homeless people with a mental illness from taking the initial step toward services and treatment.

- Encourage the empowerment of Safe Haven's residents by giving them an opportunity to participate in the operation of the facility.

- Have a readily available network of "next step" transitional and permanent housing options within the Continuum of Care system.

IT IS UNLIKELY THAT ANY SAFE HAVEN WILL HAVE ALL OF THE ABOVE IN PLACE. HOWEVER, FOUR BASIC ELEMENTS ARE ESSENTIAL:

1. Knowledge and understanding of the needs of the target population and how they are, or are not, currently being met within the Continuum of Care system.

2. An experienced sponsor with a good track record who can "sell" the project and operate it effectively.

3. Linkage with the public mental health system or community-based mental health service providers.

4. Realistic strategies for leveraging the housing and service resources needed by Safe Haven residents, particularly "next step" resources for mental health and supportive housing.

WHAT IS THE SAFE HAVEN PROGRAM ACTUALLY LIKE?

Safe Havens are designed with consideration to the specialized needs of individuals with a mental illness, who have been living on the streets or who occasionally use emergency shelters. A Safe Haven provides a highly supportive environment where an individual can rest, feel safe, and where there are no immediate service demands.

Safe Havens are small (limited to 25 overnight residents), readily accessible (open 24 hours a day, seven days a week) and low demand (residents are not required to participate in treatment programs). There are no time limits for Safe Havens, although the goal is to assist residents to move on to other transitional or permanent supportive housing. This non-intrusive, low-demand environment can help homeless people with a mental illness re-establish trust and to eventually re-engage in needed treatment and services.

Safe Haven facilities are designed with these goals in mind, by offering either private or semi-private accommodations along with common use of kitchen facilities, dining rooms and bathrooms. In addition to residential facilities, the Safe Haven may also provide assertive outreach and other supportive services, such as food, clothing, bathroom and laundry facilities, health and mental health care, to eligible persons who are not residents on a drop-in basis.

WHAT LINKAGES HELP A SAFE HAVEN FIT INTO THE CONTINUUM OF CARE SYSTEM?

To fulfill its purpose as a portal of entry within the Continuum of Care system, the Safe Haven must be linked to *all* other components of the Continuum of Care system that are needed by homeless people with a mental illness. The flexibility of the program permits many of these services (i.e. assertive street outreach services, drop-in centers, emergency residential services, health, mental health, and substance abuse services) to be funded through HUD's Supportive Housing Program. However, to avoid unnecessary overlap and duplication of effort, Safe Havens must develop link-

ages whenever possible with other Continuum of Care programs, such as the Supportive Housing Program, the Shelter Plus Care Program and HUD's Section 8 Program.

Because of their unique role as the system's entry point, Safe Havens must be maximized for their intended purpose. Therefore, the "essential" next step resources of transitional, permanent supportive housing, and independent living that are appropriate for people with mental illness, must be identified and readily available to Safe Haven residents. Once a Safe Haven is open, movement within the system becomes essential for both the homeless individual with a mental illness who is living on the streets and who needs the services of a Safe Haven, and for current Safe Haven residents who are ready to take the next steps toward community re-integration.

LINKING WITH OUTREACH REFERRAL NETWORKS AND STRATEGIES FOR SAFE HAVENS

Targeted outreach and engagement activities, which can be funded as SHP supportive services, are critical components of the Safe Haven. Safe Havens may have their own outreach staff and/or may rely on referrals from existing programs in their community, including the McKinney-funded Projects for Assistance and Transition from Homeless (PATH) program. Along with outreach activities, it is also important to educate the police and people working at local shelters, meal programs and hospitals about the availability of the Safe Haven and the process for making referrals.

The basic services and supports provided by Safe Haven drop-in centers are integral components to outreach and engagement strategies. By offering the essentials of life such as food, clothing, laundry, storage and basic health care, drop-in centers become "portals of entry" to the program by establishing a point of contact from which trust can build. When based at the drop-in center, outreach staff can remain in contact with homeless persons as they make their transition from the streets to the residential component of the Safe Haven.

Although many Safe Havens have co-located a drop-in center exclusively for people with a mental illness

on-site, other innovative outreach and referral strategies can be developed in conjunction with the Safe Haven residential program. For example, successful outreach/referral and drop-in center programs already operating within the Continuum of Care system might be augmented to accommodate the specific needs of people with a mental illness, thus avoiding duplication of capacity. The Safe Havens project in Columbus, Ohio, is now pursuing this strategy after having difficulty siting a new facility that includes both a drop-in center as well as supportive housing at a single site.

LINKING WITH PUBLIC MENTAL HEALTH SYSTEM RESOURCES

One of Safe Haven's long-term goals is to give every Safe Haven resident better access to the mainstream network of community-based mental health services. Making this transition is essential if the resources of the Safe Haven are to be maintained for their transitional purpose. Ideally the community mental health system is involved in the initial planning and development of the Safe Haven so that linkage to mainstream mental health system resources can be addressed during project development.

In Houston, the Safe Haven was conceptualized and sponsored by the mental health system to address the needs of a specific population of their consumers who cycled repeatedly from the streets to jails and shelters. The Harris County, Texas, Mental Health/Mental Retardation Authority acts as the single point of accountability for all mental health consumers in the area, and has developed a number of successful programs serving homeless and formerly homeless consumers. The agency's commitment to this population will facilitate access to mainstream mental health programs when Safe Haven residents are ready. Next step transitional and permanent housing resources will also be available through McKinney-funded SHP and Shelter Plus Care Program and through state supportive housing resources controlled by the Harris County Authority.

Some sponsors have succeeded in identifying sufficient mental health service resources within the Continuum of Care to begin developing a Safe Haven without support or funding from the agency that controls the purse strings. These Safe Havens may confront problems later when trying to transition program participants into mainstream mental health housing and

supportive service programs. The lack of public support from county or local mental health authorities could make it difficult to leverage the political and community support needed during the siting process. Safe Havens initiated without the initial support of the public mental health funding system may also have difficulty leveraging commitments of this funding "after the fact."

Interviews with a number of Safe Haven sponsors in this situation appear to indicate a potential correlation between the public mental health system's previous commitment to other supported housing programs, and their interest in financially supporting a Safe Haven project. For example, a Safe Haven sponsor in the Midwest reports that the county mental health board has shown little interest in and contributed no funding for the project. This mental health board, which ultimately controls all mental health service funding, has had no involvement with any HUD McKinney housing programs, although the community's Consolidated Plan states that more than 1,000 homeless people with a mental illness are in need of supportive housing in the region. Fortunately, a community mental health center administering the McKinney SHP transitional housing and Shelter Plus Care programs has agreed to provide supportive services for the project and will help link program participants to permanent supportive housing resources.

Linking with Substance Abuse and Health Care Services

The availability of substance abuse services, particularly ancillary detox and short-term "holding" programs, are essential for Safe Haven participants. Hard-to-reach homeless persons with mental illness frequently need access to primary health care to address medical emergencies as well as chronic and complex medical and dental problems. During the outreach and engagement process, entitlements such as Medicaid may not be in place to pay for these services. Safe Haven sponsors have looked both within and beyond the Continuum of Care system to identify and plug into networks that can provide these services.

In Boston, Safe Haven residents will have access to new specialized 28-day detox and early recovery services that were added to the Continuum of Care system in 1996. Advocates for homeless people

worked closely with the Massachusetts Legislature for over a year to obtain this funding targeted specifically for homeless substance abuse services within the state Department of Public Health's budget. Staff from this program, which is co-located within Boston's public emergency shelter system, are trained and supervised by mental health professionals who are also certified in addiction services.

> ## Safe Havens initiated without the initial support of the public mental health funding system may also have difficulty leveraging commitments of this funding "after the fact."

Health Care for the Homeless programs are providing valuable primary health care services to many Safe Havens across the country. Freestanding medical and dental clinics, and community-based health centers have also volunteered to provide free care for Safe Havens residents in several communities. In New Haven, Connecticut, the Safe Havens sponsor has affiliated with the local Visiting Nurse Association, which will provide an on-site team for initial health screenings and physical examinations.

Linking with Managed Care

The term "managed care" refers to a set of principles and technologies used to ensure that the most applicable clinical care is provided in a cost-efficient manner. In recent years, states have increasingly looked to see how the principles and technologies of managed care can be applied to Medicaid and non-Medicaid services, including those funded by state mental health, health, and substance abuse agencies. In these states, the implementation of managed care may have significant implications for programs within the Continuum of Care system.

In many cases, the impetus for embracing managed care comes from governors, Medicaid directors, and managed care organizations who may be seeking

opportunities within managed care for cost savings as well as improvement in access and quality of care. At this point in time, it is unclear what impact managed care technologies will have on specialized housing and supportive services programs targeted to serve homeless persons with a mental illness. One of the opportunities provided by managed care is that it allows public mental health systems more flexibility to move away from traditional financing models and toward more nontraditional approaches, such as those offered in a Safe Haven.

However, few national managed care organizations have had experience with either Medicaid recipi-ents or homeless persons with severe disabilities. These organizations may not understand the value or scope of services that are offered within Continuum of Care systems, since they go beyond traditional inpatient and outpatient services. To preserve funding for these programs in a managed care environment, managed care organizations will need to understand how the success of programs within the Continuum of Care system is directly related to keeping people out of more costly settings such as inpatient care.

Planning, Designing, Siting and Financing Safe Haven Housing

CHAPTER 2

PLANNING, DESIGNING, SITING AND FINANCING SAFE HAVEN HOUSING

BY DAVID PORTERFIELD

This chapter is intended to assist agencies and organizations seeking to plan Safe Havens with the process of thinking through the many complex issues associated with establishing a successful program. Planning a program that combines both housing and services can be overwhelmingly complex and sometimes unmanageable. By providing examples as well as ideas, this chapter intends to illustrate successful approaches to the problems associated with developing Safe Haven housing.

A review of existing Safe Havens reveals that problems associated with siting and financing the housing have caused delays in program start-up for many groups. However, the time line for program start-up can be met−or at least delays can be minimized−through careful planning and continued monitoring of the project during the early stages.

This section discusses the planning, financing and development of the "bricks and mortar" component of a Safe Haven. Because these three activities− planning, financing and developing−are linked and interrelated, they are

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best considered together.

PLANNING

One of the most important aspects of establishing a Safe Haven is its initial planning. On a macro level, the planning process begins with the development of the community's Continuum of Care. When done properly, the Continuum of Care is developed through identification and analysis of:
- the needs of the homeless population,
- the existing resources available to meet those needs, and
- the gaps in resources and services in the particular community.

The gaps are then prioritized and specific programs are designed and implemented to fill them. Questions about whether a Safe Haven is needed or feasible and how it may fit into a community's Continuum of Care are covered in detail in the previous chapter.

The same approach employed in developing the Continuum of Care should be used in planning the specific program elements, including the establishment of a Safe Haven. However, the planning required at the program development level must be much more detailed. It is an iterative process requiring continued refinement as more detailed information becomes known.

1. Identify and quantify need. The first step is to identify and quantify the needs the Safe Haven is intended to meet. What is the intended capacity of the Safe Haven? What kinds of services will the intended residents need to overcome their situations? What rate of turnover is anticipated? (The turnover rate is, at least in part, dependent upon the capacity of other aspects of the Continuum of Care, such as access to permanent supportive housing opportunities. It will also be dependent upon the nature of the anticipated future residents, their abilities and the effectiveness of the supportive services provided to them.)

2. Inventory resources. An inventory of community resources available to meet the needs of the target population is also essential in planning for a Safe Haven. This accounting should extend beyond those resources identified in the formal Continuum of Care to include resources such as existing housing stock, supportive services programs and potential partners who might help provide such things to support and supplement the efforts of the Safe Haven. Once resources have been identified, those in control of the resources must be approached and asked for commitments to the Safe Haven. The Safe Haven sponsor must also gather specific information about costs and availability of housing in the community, costs of operating the housing (for example, rent, utilities and security) and costs of the supplies needed to operate the program.

3. Prepare budgets. The next step in planning for Safe Haven housing is to use the information collected to prepare the project budgets. Under the application process required by the Department of Housing and Urban Development (HUD) for their funding of a Safe Haven, applicants must submit budgets that identify the costs of the program, the number of individuals served and so on. It is recommended that the HUD application forms be viewed as summary information. The Safe Haven sponsor should develop more detailed budgets indicating the cost of establishing and operating the program over time. Budgets should account for one-time costs as well as operating costs such as meals, transportation and furnishings.

REHABILITATED, ACQUIRED OR DEVELOPED HOUSING UNITS

If housing units are going to be rehabilitated, acquired or developed, the housing portion of the Safe Haven budget may require two different budgets. The program will need a development or capital budget and an operating budget.

The development budget identifies the costs of acquiring or producing the housing and the anticipated sources of funds to pay for it. Items such as the purchase cost of a building and the cost of any necessary building improvements should be included in this budget, along with a number of "soft" costs associated with carrying out such a project including: professional fees (architectural, legal, accounting); the cost of construction financing; zoning, building and other permits; etc. Quite often, because of the need to keep the ongoing operating costs low, the developer must utilize several sources of subsidy funding to reduce the amount of money that needs to be borrowed under a mortgage. Generally speaking, the greater the number of sources of funding, the higher the soft costs will be and the more complex and risky the project will become.

For these reasons, it is important to have access to people experienced in the development process. The operating budget for a project that is developed and owned should include detailed breakouts for expenses such as maintenance, repayment of long-term debt and property management costs. The operating budget must be balanced against the anticipated income the housing will generate (such as rent payments made by occupants, income provided by the Safe Haven and other operating subsidies, if any).

COST PREPARATIONS

The development and operating budgets are interactive. Costs incurred in developing the project will affect the income needed to support the project when it becomes operational. For example, development debt, such as a first mortgage, shows up in the operating budget as a debt service cost. In addition, many of the costs contained in the operating budget (e.g., leasing costs) will change over time, and such changes need to be accounted for during the budget preparation stage.

Program policy choices, such as whether Safe Haven residents will be asked to pay rent, are reflected in the budgets as well.[1] In general, these factors should be modeled using a variety of assumptions ranging from "best-case" to "worst-case" scenarios. This practice, sometimes called project sensitivity testing, often reveals weak points in the financial viability of the program and can be helpful in creating contingency plans for possible funding shortfalls.

As planning for a Safe Haven continues, programmatic and financial "gaps" in the resources available to the project will become more evident. Program planners must continue to refine the budgets to ensure that they will fit the needs of the community within the limits of the available resources.

DESIGN

The underlying design, philosophy and values of a Safe Haven will have a direct impact on the kind of housing the program will seek. For example, if Safe Haven designers have determined that a centralized "all under one roof" approach will be most effective in pro-

viding services to Safe Haven residents, they will need to identify a facility with adequate space. If, on the other hand, a more home-like environment with drop-in services is desirable, then the housing type and location will be very different. The local real estate or rental housing market will also have a direct impact on the types of housing that are feasible within a Safe Haven budget. These same factors will help shape the way in which the housing is financed. Thus, it is critical that Safe Haven planners work through the overall program design and program "values" before considering financing options for the Safe Haven housing.

The housing needed to operate a Safe Haven can be accessed in a number of ways. These include utilizing an existing and already owned facility, leasing existing housing units, and developing and operating new housing designed and built specifically for the needs of a Safe Haven. During the planning process, Safe Haven designers must seek to determine which approach or approaches will be most effective and most practical in their particular community. Although program planners may already own or control existing housing that is consistent with program values, this is the exception rather than the rule. For more on facility design, please see Chapter 7.

LEASING EXISTING RENTAL HOUSING

Leasing existing housing is usually the least complicated and often the least expensive approach to securing housing for a Safe Haven. Leasing offers the potential for greater flexibility and variety in housing, and if a scattered-site model is being used, leasing can lead to variety in locations as well.

When leasing is contemplated, it may have a limiting effect on the overall scale of the project, or it may limit the number of project units possible in any one location. For example, the housing stock in some communities consists largely of single-family homes and duplexes, which can potentially affect the "economy of scale" of a Safe Haven. On the other hand, this same kind of housing stock can lead to the creation of settings that are more home-like and less institutional than might be possible in higher density housing situations.

A number of precautions can be taken in a leasing situation to protect a Safe Haven. Using an attorney to assist with lease negotiations is strongly recommended.

Seeking a long-term lease or obtaining an option to purchase the property helps guard against having to move the program unexpectedly. A thorough inspection of the property by a certified building inspector is also essential. In addition, the lease should clearly identify the landlord as being responsible for maintaining all major building systems.

When negotiating for leased space, it is important to resolve all property and liability insurance questions and to make sure the landlord has the legal authority to enter into a lease with an agency or a unit of government rather than an individual. Some housing units have underlying financing that may prohibit such arrangements.

Legal advice and adequate time are essential to successful negotiation of a lease between a landlord and a Safe Haven operator. All potential problems associated with such a lease must be resolved before the lease is signed.

DEVELOPING AND OWNING HOUSING

If the type or location of housing the Safe Haven needs is not available through leasing, developing housing may be preferable or even necessary. Housing development is complex, risky and time consuming. It requires specialized training and established working relationships with a variety of actors and agencies. Thus, Safe Haven operators should examine all possible alternatives carefully before taking on the task of developing and managing the housing themselves.

Information about community housing costs and vacancy rates, which should have been compiled during the planning phase, can help program planners determine whether development of housing is advisable.

Because the development (or redevelopment) of housing specifically for a Safe Haven requires such a significant investment of both time and capital, it should only be undertaken within the context of long-term community and human service systems planning. Developing housing for a Safe Haven is advisable if the community demonstrates the willingness to make a long-term investment in the "institutional infrastructure" needed to sustain operation of the Safe Haven over time.

Once the decision to develop the housing has been made, program operators must examine the various ways of making the project happen. One way is to collaborate with an existing housing development organization for production of the housing units. Some such collaborations are done on a "turnkey" basis, with the developer owning the housing during construction and transferring the title to the Safe Haven upon completion. In other cases, the Safe Haven program may own the housing throughout the development process, but contract with a developer for construction and possibly management of the completed units. It is also possible for the developer to retain ownership and management of the completed housing units, leasing them to the Safe Haven. This last arrangement is helpful because it separates the roles of land-

LEASES AND SAFE HAVENS

The Milwaukee County Safe Haven is one example of a Safe Haven that leases property. The Milwaukee County program chose to lease existing units for several reasons. First, the Milwaukee County Mental Health Division, which sponsored the Safe Haven, had a goal of providing highly integrated housing settings for the Safe Haven residents. Input from mental health consumers indicated that home-like settings in a variety of locations (e.g., north side and south side) would be most comfortable for potential residents from those neighborhoods. In addition, the housing stock in Milwaukee County consists primarily of duplexes, which meshed well with the scattered-site, low-density model envisioned by Safe Haven planners. To implement its program, Milwaukee County approached nonprofit neighborhood organizations who owned and operated affordable rental housing and negotiated leases in four locations that provided the desired settings while also keeping within the program budget.

lord and service provider, reducing the conflicts of interest that might otherwise occur.

Collaborating with an existing development organization can often "leverage" additional resources (for example, grants, subsidies, debt financing and equity) that may not be available to the Safe Haven operators on their own. With these additional resources, more Safe Haven grant funds can be used to serve additional residents or broaden the scope of services available.

SUPPORTIVE HOUSING PROGRAM

Ultimately, whether Safe Haven housing is leased or owned by the Safe Haven operators, paying for the housing with HUD Supportive Housing Program (SHP) funding requires planning the program to be in compliance with the SHP's regulations. For leased housing, SHP provides a three-year commitment for housing costs with the possibility of renewal grants. Safe Haven planners need to project future sources of operating funding to pay housing costs beyond this three-year commitment.

HUD requires a 20-year use restriction on housing purchased and/or developed for the Safe Haven that often requires a long-term commitment of the Safe Haven operators to the operating budget of the facility itself. Projects that cannot demonstrate long-term solvency are not viewed favorably by most funding sources. A successful track record and evidence of diversified funding for the program will mitigate this situation.

FINANCING

The expense of developing an intensive 24-hour residential service program could be a deterrent to the development of Safe Havens in some communities. However, the development of a Safe Haven can be more feasible and cost-effective if sponsors can successfully combine HUD SHP funds with other networks and resources for funding key housing and service components.

Up to $400,000 in HUD SHP funding is potentially available for acquisition, rehabilitation or new construction, but a cash match from the applicant is also required. This cash match can be financed; however,

debt service cannot be paid out of SHP operating funds. A portion of the operating costs and the cost of supportive services can also be covered by SHP funds. To complete the funding package, leveraged resources can be provided from both within the existing Continuum of Care system, as well as from "mainstream" housing and supportive service programs.

Leveraging other resources and funding networks is critically important for Safe Haven sponsors because:

- Cash resources are essential to meet SHP match requirements if acquisition, rehabilitation or new construction activities are planned.

- Funding for the Safe Haven provided by the mainstream public mental health funding network is concrete evidence of "buy in" by officials who make policy for the system and control the purse strings. This "buy in" will be important for the long-term viability of the Safe Haven as a component of the mental health service system.

- Many hard to reach homeless persons with a mental illness will also have other co-occurring disabilities such as substance abuse, AIDS, or other physical disabilities. Supportive services for these disabilities may be difficult to access for a treatment-resistant homeless population with intensive service needs, but could be essential for a Safe Haven resident.

- Resources leveraged from other homeless programs -- such as outreach services, social and recreational services, meals programs, and housing -- can promote collaboration across the Continuum of Care system and avoid unnecessary duplication of effort.

- Connections to other community resources, such as those targeted for employment, public service, and the media, can build and maintain public support for the Safe Haven as a valued community program.

Most communities that may need a Safe Haven have existing federal, state, local, and private resources for housing and supportive services that can be used in conjunction with HUD SHP funds. Identifying and aggregating these "leveraged" resources into a seam-

less system that meets the needs of Safe Haven residents begins during the project's conceptualization stages and becomes an ongoing part of operations. Several sources for potential funds can be approached in an effort to secure the capital match funds required by SHP. For example, Safe Haven sponsors in Houston and Boston received commitments of Community Development Block Grant funds administered by local government. Emergency Shelter Grant funds provided capital match for the Honolulu Safe Haven. In Ohio, the Ohio Department of Mental Health capital bond program ensured that matching funds were available for two Safe Havens in Cleveland and Columbus. The Lowell, Massachusetts, Safe Haven operates in a building that was already owned by the mental health system. Other possible sources of SHP matching funds are HUD's HOME program, state or local capital funding programs for transitional housing, and private fund raising.

Safe Haven sponsors should also seek private support for their programs whenever possible. Private resources from foundations, the business community, local churches, and individual donors provide critical financial and community support, particularly during project development. This type of support can help convince local officials or neighborhood groups to lend their support for the project and help to address NIMBY problems if they occur.

The Safe Haven in Lowell, Massachusetts, has opened up a network to the community by operating a bakery within a local indoor farmer's market. Safe Haven residents can take advantage of the program to learn valuable job skills and to re-engage in community activities. Twice a week, Safe Haven residents also set up shop to sell the bakery's goods in several of Lowell's elderly housing buildings, which has helped the Safe Haven residents to reconnect and give something back to the community. The Lowell program has also been promoted on the local cable television access channel.

The Houston Safe Haven is exploring an affiliation with the University of Texas's Houston Recovery Campus, an innovative program being developed for people recovering from substance abuse. In Boston, Safe Haven residents will have some meals regularly provided by members of the Newbury Street Church where the program will be sited. Other Safe Haven sponsors are also actively exploring ways in which church groups can

help with fund raising and provide regular volunteer services that can augment core supportive services funded by the Supportive Housing Program.

DEVELOPMENT

Assembling a competent development team is critical to ensuring that a Safe Haven development project is feasible and proceeds on time. Some Safe Haven planners have all the technical expertise needed for housing development under one roof, but most need to locate community partners experienced in housing development and management to serve on the development team. Team members are likely to be found in nonprofit housing organizations, housing authorities, private development firms and local property management companies. Partners experienced in designing and providing supportive, community-based services may also be needed. Examples of such partners could include other homeless service providers, community mental health agencies and consumer groups. Consumers should be an integral part of the team. Infor-

ESTABLISHING A DEVELOPMENT TEAM

The Milwaukee Safe Haven program established a diverse development team with the following membership and responsibilities.

1. Representatives of the mental health system coordinated the design and implementation of services with direct input from mental health consumers who had previously experienced homelessness.

2. Representatives of the public housing authority provided overall coordination and acted as fiscal agents.

3. The Wisconsin Partnership for Housing Development, a nonprofit intermediary organization, provided technical assistance for both service system design and identification and leasing of housing for the Safe Haven.

4. Nonprofit housing organizations developed the housing units and leased them to the Safe Haven.

mation gathered from consumers through surveys and focus groups should also be used during the planning process.

Working with a skilled development team allows Safe Haven operators to concentrate on the things they do best—designing and delivering quality services. While establishing a good development team may seem overly complex, the effort will pay off in the creation of higher quality and more cost-effective programs.

Utilizing a development team effectively requires skillful coordination, especially during the start-up phase of the program. To ensure coordination, it is important to identify a skilled project manager who is experienced in managing complex projects involving multiple actors. The project manager must clearly understand the goals and underlying values of the project and must be given the authority to take the steps necessary to keep the project on track.

It is often beneficial for Safe Haven planners to obtain technical assistance in assembling a project development team with the necessary expertise in affordable housing development and management and the capacity to develop and manage Safe Haven housing as well. Local, state, regional and national agencies involved in supporting nonprofit housing development are possible sources of such assistance. The cost of their services can frequently be covered under contracts they hold with HUD or other funding sources.

Choosing a Safe Haven Location

Determining the optimal location for a Safe Haven can be difficult. Several important siting considerations are outlined below:

- *The housing used for the Safe Haven should strive to fit within the context of the community.* Safe Haven housing must be acceptable to both the future residents and the surrounding community. Information gained in consumer surveys and focus groups should be applied to siting decisions. In addition, Safe Haven housing should physically match the housing type and scale of the surrounding neighborhood. This consideration is especially important in new construction or substantial rehabilitation projects.

- *Location directly affects costs and choices*

may be limited by the budget. The ideal housing location may simply be out of reach of the Safe Haven budget. Knowing the local real estate market and working with a real estate professional who understands and supports program objectives can simplify the search for potential sites. Local public agencies such as the community planning and development department or the public housing authority may also be helpful in siting the Safe Haven.

- *Site must fit the local planning framework and zoning requirements.* Safe Haven planners should work with local zoning and community-planning officials to ensure that the planned Safe Haven fits within the planned development and zoning parameters for the area. Securing the support of local elected officials and agency administrators early in the process is essential to keeping the Safe Haven development on schedule. Safe Haven planners may need the assistance of someone familiar with local officials and political processes to help develop the necessary working relationships.

- *Access to supportive services, community services and transportation must be considered.* Safe Haven residents generally need ready access to community services such as shopping, transportation and health care. A working knowledge of the neighborhoods in the community is essential to identifying locations that can support the needs of a Safe Haven.

- *Location should strive to meet the needs of a potentially diverse population of residents.* Depending on the scale of the program, Safe Haven housing should strive to meet the needs and preferences of many different individuals. This may mean that multiple sites in a variety of settings will be needed to allow consumers to make the choices that will meet their needs.

Structure and Space Considerations

Potential Safe Haven operators often wonder whether their existing space or other readily accessible space can meet the objectives of the Safe Haven in addition to meeting other organizational objectives. The comments below may

help such agencies determine whether the locations being considered truly offer effective solutions to the space needs of the Safe Haven housing.

The importance of designing Safe Haven housing and program components around the people the Safe Haven intends to serve cannot be overstated. Agencies are often tempted to design Safe Haven housing arrangements around their existing facilities, disregarding or skipping entirely the planning and information gathering steps and proceeding directly to the bricks and mortar development. Short-circuiting the planning process in this way is dangerous and can result in the creation of a Safe Haven that does not meet the needs of the consumers.

Although it takes more time, evaluating any proposed Safe Haven site in terms of the market information gathered during the consumer housing preference study is essential. Safe Haven planners must continually ask themselves: "Does this proposed location meet the defined needs of its future occupants as identified in our market surveys?" Only sites that yield a positive answer to that question are likely to meet the needs of the program over time.

Using an existing structure versus a new structure. Existing structures are frequently more cost-effective and easier to develop, and they tend to be located closer to essential services. They can often be brought on line more quickly as well. But existing structures are limited by their current configurations; they may not be easily conformed to the housing design considered most desirable for the Safe Haven.

New construction or substantial rehabilitation are often more expensive initially. They also require more planning time and involve higher risk. But new or substantially rehabilitated space can be designed from the ground up to include all of the features desired in a Safe Haven such as better security, a compatible floor plan, higher energy efficiency and greater comfort. On the other hand, new construction and substantial rehabilitation usually involve purchase of the property, which limits the number of sites available and makes future relocation less feasible.

NOTE:

[1] The issue of charging rent can raise complex legal and administrative questions related to real estate law and benefit eligibility. Paying rent is not possible for most people who initially move into a Safe Haven. However, over the course of several months new residents may be assisted in becoming eligible for income, such as SSI. Qualified legal assistance should be utilized in making such program design decisions.

Sharing space with another program and/or using the Safe Haven as a drop-in center. From a planning, design and siting perspective, having a Safe Haven share space with other programs can add complexity to the site identification process. Zoning and licensing issues may be more complicated as well.

The easiest, and perhaps best, shared facility situation might be to combine a Safe Haven with a related service, such as an emergency shelter, but this will work only if the resulting Safe Haven housing meets the needs of the consumers who will live in it. A clear

The importance of designing Safe Haven housing and program components around the people the Safe Haven intends to serve cannot be overstated.

distinction needs to be drawn between the Safe Haven and the emergency shelter. The potential Safe Haven residents are likely to be people who have rejected the emergency shelter as an option.

Using the Safe Haven site as a drop-in center for homeless people can help to create outreach and engagement opportunities, but may also result in a more disruptive setting for the residents of the Safe Haven. Adding the drop-in feature may limit the number of potential sites, increase neighborhood opposition and increase security and staffing needs as well. (Please refer to Chapter 6, pages 66-67, for more ideas on building designs)

Properly conceptualized and implemented, the Safe Haven can provide local Continuum of Care systems with an effective approach to engage and serve a difficult to reach homeless subpopulation. By offering a refuge from the streets, a low-demand approach, and appropriate services and supports that are readily available, Safe Havens can make a meaningful contribution in eliminating homelessness among people with a mental illness. A Safe Haven is more than a place, however; it is a "metaphor" for community support systems. As such, the public mental health system and other housing and service providers within the Continuum of Care system will have much to learn from the implementation of Safe Havens.

The Challenge and Opportunity
of NIMBY

CHAPTER

THE CHALLENGE AND OPPORTUNITY OF NIMBY

BY ED DEBERRI

The so-called NIMBY (Not In My Back Yard) syndrome, and its cousin BANANA (Build Absolutely Nothing Anywhere Near Anything), present both a formidable challenge and a wonderful opportunity to potential developers and operators of Safe Havens. The challenge is obvious: the successful siting of the Safe Haven facility. The opportunity is subtle, but significant: the administration of the project even from its initial planning stages in a way that embodies the core principles of a Safe Haven, namely respect for human dignity, perseverance, and hope.

Most supportive housing projects in general, and Safe Havens in particular, face opposition from NIMBY forces. A 1997 survey of Safe Haven developers found that siting was their chief concern. NIMBY's impact on Safe Havens is consequential. NIMBY can increase costs, cause starting delays of more than six months to a year, and necessitate site changes. In some cases, potential developers have lost funding and had to cancel plans for a Safe Haven due to an inability to site the facility successfully.

This potential adversity, though, can be a blessing in disguise for Safe Haven developers. NIMBY forces developers to plan thoroughly, design the facility and program thoughtfully, educate wisely, and act deliberately. NIMBY necessitates that agency administrators and consultants reach out to and treat their future communities and neighbors in the same way they

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expect their outreach workers to reach out to and treat potential residents: with patience, respect for their dignity, and establishing trust. Safe Haven developers, like Safe Haven line staff, need discipline, perseverance, and a sense of humor. There is more to the analogy. When a resident is in a crisis and is dangerous to self or others, staff can, as a last resort, invoke available provisions of law to effectuate a commitment. So too, when NIMBY forces threaten the very existence of a Safe Haven, project developers can – and should – use every legal means to achieve siting. Every person, no matter how long homeless or how seriously mentally ill, has a basic right to live in a community. Safe Haven developers have both the privilege and responsibility to uphold this right.

Legal means, however, should be a last resort. Most Safe Haven operators have not had to utilize lawsuits or other legal action to site their projects. This chapter sketches seven steps successful Safe Haven siters have taken to open the doors of their programs. Only the last step needs to be taken hand-in-hand with lawyers.

SEVEN STEPS TO ADDRESS NIMBY ISSUES

1. Know the likely concerns and anticipate potential opposition

2. Plan thoroughly

3. In siting and design, keep NIMBY concerns in mind

4. Community outreach and education

5. Adopt and implement a "good neighbor" policy

6. Cultivate and utilize "non-traditional" allies

7. Develop a legal strategy . . . just in case

STEP ONE: KNOW THE LIKELY CONCERNS AND ANTICIPATE POTENTIAL OPPOSITION

It is imperative that Safe Haven developers become very familiar with who their potential opponents may be and what arguments, reasoning, and tactics they may employ. Once Safe Haven developers have identified potential sites, they should consult with developers of other supportive or low-income housing projects in these neighborhoods. Developers can learn a great deal from the experience of their predecessors about the individuals and organizations that are likely to oppose the project, what strategy and tactics have worked in the past for developers and what has not, and which persons in the neighborhood are "in the know" and may be counted on for support. As potential opponents are identified, Safe Haven developers can begin to develop plans to address their concerns.

Potential opponents are unique to each given situation; most arguments likely to be expressed in opposition to the siting of a Safe Haven are not. Some are generic to any type of supportive housing, others are geared more to the character of a Safe Haven. The most common reasons that neighbors and other community members have used to object to a Safe Haven are:

- I don't want a bunch of people who haven't been able to take care of themselves around my home.

- This Safe Haven won't be safe for me or my children. These people have mental illnesses, so they are likely to be dangerous.

- This project will lower the value of my property; first a homeless shelter, next this neighborhood will become a ghetto.

- These people will not fit into the neighborhood. Since they are homeless, they will loiter, will be disheveled, will panhandle, and will act antisocially.

- The neighborhood will become overcrowded with all these new people and traffic will increase.

- You say that your funding is guaranteed for only three years. What happens after that? How do I know that you won't just abandon the place, and then we'll have to deal with a vacant building?

The majority of these objections contain at least a nugget of legitimate concern. Safe Haven developers must be prepared to address and honor what is legitimate in these arguments while, at the same time, dispelling any fears and misconceptions. The following steps provide some guidance for these tasks.

Step Two: Plan Thoroughly

Good planning for a Safe Haven encompasses more than just house rules and transition options. Just as effective planning was necessary for a Safe Haven to be included in a community's Continuum of Care, so it is needed for the Safe Haven to achieve successful siting.

A comprehensive plan for responding to potential NIMBY issues identifies and builds on knowledge of potential supporters and opponents, and their interests and concerns. It features an inclusive community education and outreach strategy (Step Four) and takes into account likely scenarios and possibilities. It outlines the way the Safe Haven developer will secure the support of the media and political leaders. The siting plan is proactive and anticipates and sketches responses to potential objections. The Safe Haven developer should have a well-developed strategy. Every action the developer takes to anticipate and respond to potential NIMBY concerns, including a list of community meetings and a record of telephone calls, should be documented.

> Just as effective planning was necessary for a Safe Haven to be included in a community's Continuum of Care, so it is needed for the Safe Haven to achieve successful siting.

Excellent financial planning is as valuable for addressing NIMBY concerns as it is for a Safe Haven to be included in a Continuum of Care or to operate effectively. Concerns about the financial viability of a Safe Haven are legitimate for both potential residents and potential neighbors. Some supportive housing programs have had to close due to lack of funds, and their closure, in addition to harming the

residents, has also impacted the neighborhood. An unkempt, vacant building is a safety hazard that detracts from a neighborhood's vitality. Safe Haven developers should not depend solely on a Supportive Housing Program grant for Safe Haven financing. They will need to cobble together funding from other sources – and assure the neighbors they are doing so. Some potential funding sources, described more completely in the Continuum of Care chapter, may include PATH funds, Medicaid reimbursements, state mental health or housing funding, Community Reinvestment Act contributions from financial institutions, and grants from local Business Improvement Districts to name a few potential sources.

Step Three: In Siting and Design, Keep NIMBY Concerns In Mind

In the previous chapter, David Porterfield describes how a Safe Haven can be designed to promote resident dignity and support the objective of a successful transition. The design of a Safe Haven can also anticipate and respond to NIMBY-related concerns.

In choosing a site, the Safe Haven developer must understand and be prepared to address every relevant licensing requirement and zoning regulation. One way to deal with these requirements is to avoid them. The developer of a Safe Haven in Eugene, Oregon, chose to locate the facility in an unincorporated area where many of these requirements do not exist. Developers of Safe Havens in Milwaukee, Wisconsin, and Montgomery County, Maryland, chose to develop lower density, scattered site programs in which many prohibitive zoning regulations were inapplicable. Since zoning regulations are an arrow in many a NIMBY quiver, these developers used a tactic that rendered the regulations moot.

Landscaping and other outdoor design features can allay fears (most of which are stereotypical and unfounded) about residents being a visual detraction in the neighborhood. By the very nature of a Safe Haven, residents would have no reason to wait in line or loiter. Many Safe Haven residents do, though, like to exercise, recreate, or smoke outside. An attractive courtyard or backyard, landscaped in such a way to enhance resident privacy and comfort, will not disrupt a neighborhood. A well-designed and maintained entrance will boost resident self-esteem and not diminish property values.

The Safe Haven in Springfield, Massachusetts, is located in an historic building that was once the jewel of its neighborhood. When the Safe Haven developers acquired it, the building had become run down. The developers were able to restore its beauty, thus enhancing the neighborhood.

A final design-related NIMBY caution is for developers to consider what they call these projects. By calling the "drop-in center" an "activity center," Safe Haven developers in Honolulu changed the connotation of the program (without altering its essence), and alleviated many potential concerns.

STEP FOUR: OUTREACH TO AND EDUCATE THE COMMUNITY

Community outreach and education is critical. This step gives the Safe Haven developer the opportunity to be proactive, establish credibility, and listen to and address community concerns. If a developer reaches out and educates effectively, then the NIMBY concerns should be addressed and the Safe Haven should be sited.

The first stage in outreach and education is with the immediate neighbors of the proposed Safe Haven site. The developers will need to spend a great deal of time with these neighbors, getting to know their interests and concerns, and helping the neighbors to learn about their mission and the programs they operate. Taking the neighbors on a tour of the other programs they operate and introducing them to the neighbors of these sites can be very effective. Providing the neighbors with a contact person who will be immediately responsive to expressed concerns is also very important. Instituting a "Good Neighbor Policy" (see Step Five) is another effective action.

Once the immediate neighbors have agreed to work with (or at least not oppose) the developers, they can proceed with the next stage which includes distributing a community education packet, forming a neighborhood advisory council, and holding a series of community meetings in the neighborhood. The education packet would include material which illustrates the experience of the Safe Haven developer (and operator, if two different organizations), describes the Safe Haven philosophy and program, outlines the good neighbor policy, and defuses likely NIMBY concerns. The packet should be professional, easy-to-read, and invite neighbors and community members to become involved in the Safe Haven.

A well-designed, well-planned Safe Haven that offers an excellent low-demand program and features qualified staff will not lower property values.

Several Safe Havens have found that forming a Neighborhood or Community Advisory Council has been beneficial in achieving siting. This council is composed of neighborhood leaders, church members, local merchants, and other interested parties. Such a council not only lines up support for the Safe Haven, it also provides an excellent mechanism for the Safe Haven developer to remain aware of neighborhood opinion. A council enables the developer to learn which rumors, if any, may be circulating about the Safe Haven and what may be the most effective ways to dispel them. The council can become the ears of the Safe Haven.

Another facet of community education and outreach is neighborhood or community meetings. Veterans of siting battles advise Safe Haven developers to schedule a series of meetings with an established agenda for the series set in advance. A Safe Haven in Chicago found a series of meetings to be essential. A series allowed both the neighborhood and the developers to commit to working together over a period of time. It demonstrated the intention of the developers to take the concerns of the community seriously and to respond to them. In the first two meetings, the neighbors were able to express their fears and concerns. The developers were able to listen and respond, and their responsiveness enabled the development of enough of a relationship and the creation of sufficient trust for the neighbors to work with them in a non-adversarial way. The developers report that the series of meetings was difficult and time-consuming and the relationship was and is by no means perfect, but without the meetings the Safe Haven probably would not be open.

Two additional approaches that Safe Haven developers have found helpful are having mental health consumers and family members with ties to the neighborhood voluntarily speak to concerned individuals or groups. This interaction, which has to be completely voluntary on the part of the consumer or family member, can personalize the Safe Haven, debunk stigma, and defuse tension. A local National Association of Mental Illness chapter, or other family or consumer group, might serve as a resource.

The other approach is for Safe Haven developers to address from the beginning the myth of lower property values. Several studies have found that only in approximately one of every 15 cases does a supportive housing project lower property values in a neighborhood (see *Building Inclusive Community* in the Additional Resources section at the end of this chapter). A well-designed, well-planned Safe Haven that offers an excellent low-demand program and features qualified staff will not lower property values.

Step Five: Adopt and Implement a "Good Neighbor" Policy

It is essential for both good relationships and the integrity of the Safe Haven itself that project developers honor the legitimate concerns of future neighbors and the community. Having fears about a Safe Haven does not necessarily make a neighbor a Grinch or a Scrooge. In many cases, and for a variety of reasons, low income or supportive housing projects have not been an asset to a neighborhood or community.

The first element of a "Good Neighbor" policy is having a designated staff contact who will respond promptly to legitimate concerns, both during siting and after move-in. This contact can help to establish developer credibility. A second element is for staff (and residents if it would be helpful to the residents) to maintain the property by making sure that any litter is picked up, the sidewalks swept, snow removed promptly, and the facility is kept attractive. Good neighbors also do things such as take out the trash of elderly neighbors and watch the property of neighbors who are away on vacation. A final element is for Safe Haven staff to participate in neighborhood associations and attend neighborhood meetings. In these ways, Safe Havens will continue to engender trust and establish credibility.

The Safe Haven in Burlington, Vermont, was a good neighbor by having an open house for neighbors the weekend before its first residents moved in. Having the neighbors over for cake and punch gave them the opportunity to meet the program staff and took some of the mystery out of what would go on in the building.

Step Six: Cultivate and Utilize "Nontraditional" Allies

Several Safe Havens have found significant support in their siting quests from sources that have not usually championed agencies that offer services to people who are homeless and who have serious mental illnesses. These sources include downtown merchants and others in the business community, realtors, and the police. Cultivating relationships with these entities in the planning and community outreach stages (and continuing them in the operational stage) can ease Safe Haven siting and enhance the program itself.

The Safe Haven in San Diego formed a close relationship with the local business community. Developers achieved this support by explaining how the Safe Haven would be able to offer assistance to the population about whom the businesses were most concerned. Developers in Honolulu used testimony from political and business leaders in Santa Monica, California, to convince their own political and business leaders to support the Safe Haven. A realtor in Parkersburg, West Virginia, provided significant assistance to the developers there in finding a location for their Safe Haven and easing community concerns about possible negative impact. In each of these three cases, these nontraditional alliances proved decisive in the successful siting of the Safe Haven.

Step Seven: Develop a Legal Strategy . . . Just in Case

Unfortunately, there have been instances in which Safe Haven developers have found that a competent attorney is just as important to a program's success as a visionary executive director, a caring outreach worker, or a skilled case manager. While legal difficulties do not arise in every instance, Safe Haven developers would be prudent to involve lawyers from the beginning to develop a legal component to the siting strategy. These means are utilized only as a last resort, in some cases they have proven necessary.

While much of the legal and litigation strategies focus on state and local laws and regulations and the unique situation of the Safe Haven to be sited, two federal laws may be applicable. The Fair Housing Act and the American with Disabilities Act have been used successfully by proponents of supportive housing to repel NIMBY forces and achieve site control. Citing provisions in one or the other piece of legislation, various courts have found NIMBY-inspired zoning regulations to be discriminatory. For more information on applicable case law, readers may contact the Bazelon Center for Mental Health Law [(202) 467-5730], the National Law Center on Homelessness and Poverty [(202) 638-2535], or HomeBase [(415) 788-7961].

Siting a Safe Haven facility can be even more challenging than operating a Safe Haven. Frequently, NIMBY-inspired forces will be present, and occasionally they will be especially persistent and aggressive. Developers can take heart that dozens of Safe Havens, through comprehensive planning and effective community outreach, have been sited in every region of the United States. Safe Haven developers can learn from these successes. Anticipating and responding to NIMBY is essential. Safe Havens are an exceptionally effective way of reaching some of our most vulnerable citizens. Project developers owe their potential residents their wisest and most dedicated effort.

For Additional Information:

Advisory Commission on Regulatory Barriers to Affordable Housing. "Not in My Back Yard: Removing Barriers to Affordable Housing." Washington, D.C., 1991.

Beggs, M. OK In My Backyard: Issues and Rights in Housing for the Mentally Ill. San Francisco, CA: San Francisco Study Center, 1993.

HomeBase. "Building Inclusive Community: Tools to Create Support for Affordable Housing." San Francisco, CA, 1996.

Outreach, Engagement and Service Delivery

CHAPTER 4

OUTREACH, ENGAGEMENT, AND SERVICE DELIVERY

BY MARY E. WALACHY AND JEROME RAY

When the Federal Task Force on Homelessness and Severe Mental Illness recommended the development of Safe Havens to better serve a special group of homeless persons with mental illness who had difficulty accepting housing and services, it sounded like a good idea. But would it work?

In 1992, the Federal Task Force released a report titled, *Outcasts on Main Street.* The report clearly articulated the general design parameters for the operation of Safe Havens, including that programs should be small, low demand, have no required length of stay, and have high staff-to-client ratios. A concept was born from these recommendations − "provide a safe and decent residential alternative for homeless people with severe mental illness who need time to adjust to life off the streets and to develop a willingness to accept services." From this concept emerged a feasible Safe Havens design that reflected a true understanding of the needs of the population that it was intended to serve.

In his 1993 paper, "Housing Homeless People with Severe Mental Illness: Why Safe Havens?" Frank R. Lipton, M.D., responded to the Task Force's report. He stated that "the report does not specifically address the issues of length of stay, (although it says in passing that people can stay as long as they wish) rules governing the management of substance abuse, criminal activity, violence, treatment with psychotropic medications, [and] refusal to participate. Other crucial operation questions need to be answered."

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	SPECIFIC CRITERIA FOR A SAFE HAVEN FACILITY
	• 24-hour residence for eligible persons who may reside for an unspecified duration;
	• private or semi-private accommodations;
	• a small, highly supportive environment where an individual can rest, feel safe and be subject to few demands;
	• limited overnight occupancy to no more than 25 persons;
	• a non-intrusive, low-demand environment in which to slowly build trust;
	• talented employees -- both professional and non-professional -- and competitive salaries.

Such questions, and many others, must be considered by those who wish to provide Safe Havens. Although it will take more implementation experience and research to provide definitive answers, it is possible to reflect on the experiences of existing providers to begin the initial dialog on outreach, engagement, and service delivery in Safe Havens.

This chapter is intended to assist potential or current Safe Haven operators to examine crucial program issues based on the successful experience of three New England Safe Havens: the Mental Health Association (MHA) of Greater Springfield, Inc.'s Safe Havens Program in Springfield, Massachusetts; the Pathfinder Program, Inc. in Lowell, Massachusetts; and Harbor Home, Inc. in Nashua, New Hampshire.

The information discussed will include descriptions of the ways MHA has addressed key program issues such as outreach, intake and assessment and service plan development and implementation. MHA's successful outcomes are compared to the Pathfinder Program and the Harbor Home Program, which describe similar successes through different approaches.

Following a discussion of program issues, the chapter will include recommendations for exemplary practice as identified by the above mentioned participants.

OUTREACH

Safe Havens may conduct outreach to prospective residents with their own staff or may rely on referrals from outreach staff from other homeless service programs. Regardless of the arrangement, it is imperative that everyone involved in the outreach process understands, accepts and embraces the mission of the Safe Haven to serve the most difficult-to-serve consumers. The mission of a project can be compromised at both the outreach and intake phases by individuals who are either unwilling or unable to recruit and/or serve this target population.

MHA's outreach efforts are conducted by an in-house outreach team of two Shelter Specialists and one Outreach Counselor. This team is the main referral source for the program. Through daily street outreach to local parks, bus stations and river fronts, as well as visits to city soup kitchens, shelters (family and single), and other social service agencies such as food pantries or the welfare office, staff can identify individuals meeting the criteria for placement.

The MHA Outreach Team's expertise with the area's homeless population dates back to 1984, when few services existed for people who were homeless. Many of the contemporary services in Springfield, especially services targeting homeless mentally ill

persons, came about at least in part from the information gathered by this outreach team. The MHA application to HUD for a Safe Haven have at its genesis the needs assessment of the hard-to-engage homeless mentally ill candidates identified by the outreach team. The local Department of Mental Health (DMH) officials recognize the MHA Outreach Team as the most authoritative source in determining need and short-term eligibility for services for this target population. As a result, MHA's Safe Haven maintains control over the referral process, unlike most programs that receive DMH support dollars. MHA's project staff has identified that their ability to have total control over who enters the program ensures compliance with the project mission.

Outside organizations and individuals, such as DMH, city officials, and churches, may refer or suggest that someone be considered for placement. MHA makes the final decision based on its Safe Havens criteria. While this works well in MHA's case, we recognize the model does not fit with every continuum of care plan. Other communities may find that referrals into the program are effective and negotiate these arrangements as a part of its continuum of care approach. An affiliation or agreement with area providers of outreach services can accomplish the task. For example, Harbor Homes relies on external outreach efforts to identify prospective participants, including local mental health clinics and other health care providers that are familiar with the target population. A close working relationship in which all parties understand the program and its mission can prove successful.

Another approach is to consider only a part of the Safe Haven's capacity as open to referral placements from other providers in the community. The balance of the capacity might be committed to residents secured through the Safe Haven's outreach efforts. The Pathfinder Program relies on direct referrals from the local Department of Mental Health for six of its 12 beds, while the remaining six beds are available for open referrals
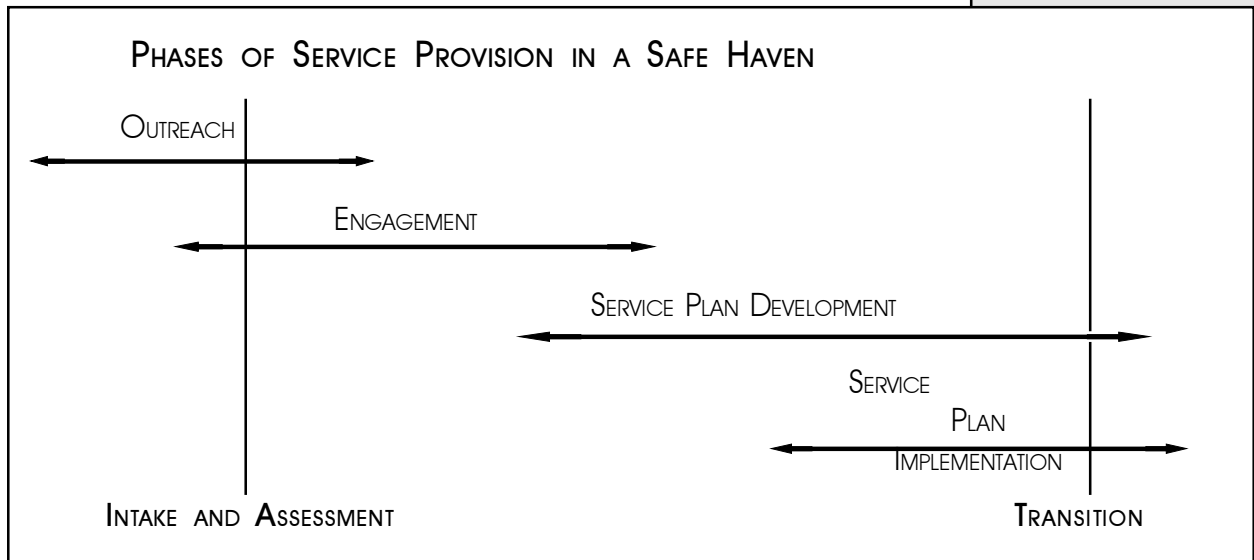
The more engaged the resident has become, the greater the level of trust, and the greater the likelihood that the resident will consider and accept additional benefits of the Safe Haven experience.

from the community. Pathfinder does not have an outreach team, but does engage in outreach to the area's homeless population by providing a small-scale meals program on site for prospective participants. They also have a social club offering several programs for the homeless mentally ill and for those who also have problems with substance abuse.

Given that all three Safe Havens offer some degree of "drop-in" activities, this is an approach worth considering as an outreach and engagement technique. Such drop-in opportunities allow prospective participants a first hand op-

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Phases of Service Provision in a Safe Haven

Outreach

Engagement

Service Plan Development

Service

Plan

Implementation

Intake and Assessment

Transition

Carol, a story of successful engagement

Carol (not her real name), a long-term resident at the MHA Safe Havens, provides a clear case for consistent, supportive, and individualized contact. Carol, 60, became homeless when the rooming house she lived in was sold and boarded up. Carol was too symptomatic to understand the eviction process and spent several weeks wandering the streets and sleeping in abandoned buildings. Carol would use the soup kitchen she was familiar with but refused shelter.

Once the outreach team learned of her homeless status they began daily contact, including offering shelter, and the Safe Haven. One night, after her stop at the soup kitchen, Carol entered the emergency overnight shelter and was directed to the women's dormitory. It was crowded and chaotic – Carol walked out. The shelter specialist who was on-site caught up to her and reminded her of the Safe Havens option, even showing her a photo of the house. Carol accepted the offer.

Carol merely spent the night at Safe Havens. She left very early in the morning and didn't return until late that night, but she returned. She barely made eye contact and had virtually no verbal exchange. Safe Havens staff and outside providers made a point of "being around" when Carol came and left, always offering opportunities for her to feel welcome -- the sharing of birthday cake with other guests and staff, and joining in a Christmas celebration, are notable examples. After several months, Carol came to participate in special events in the house and dramatically increased her interaction with staff and other providers, especially the nurse. Carol still participates only selectively in mental health services and still eats many of her meals away from the site, but as this case illustrates, with patience and a focus on engagement, progress can be made.

portunity to view the program and to talk with others who have taken advantage of the project without committing to the program themselves.

Engagement

Engagement in the context of Safe Havens refers to establishing interest and encouraging involvement. The Safe Haven must help the resident establish an interest in services that might be of benefit in the move toward permanent housing. Once such a disposition has begun, engagement continues to help the resident to become involved with at least some of these services. It is a process that may begin before the individual becomes a resident, but is most active with those who are residents of the Safe Haven.

MHA's Safe Havens experience validates the importance of engagement for any subsequent service. Therefore, every aspect of the day-to-day program operations has engagement as a focal point. Meal planning, cooking, cleaning and entertainment are just a few examples of opportunities staff have to engage residents. The more engaged the resident has become, the greater the level of trust, and the greater the likelihood that the resident will consider and accept additional benefits of the Safe Haven experience.

The time period during which engagement occurs must be fluid. It is probably best to think of it as a continuing process as staff and residents interact. Harbor House stresses that engagement is a priority for the first two to four weeks and is ongoing afterward. At Pathfinder,

post-intake engagement for the initial cohort of residents was less of an issue because the 12 residents were all identified before the start of the program and took part in the planning and actual setup of the site. The lesson here is a reminder that engagement may also begin to occur before the individual becomes a resident of the Safe Haven.

A consistent experience for Safe Havens is that even the most isolated residents show progress when consistent, individualized contact is part of the daily routine. A critical dimension of engagement is the absence of any aspect of coercion. Both the symptomatology residents may show and past experiences with treatment systems that have led them to be distrustful underscore that coercion must be minimized for successful engagement.

Engagement for any resident is an individualized process that cannot be timed or predicted. Its hallmarks are the absence of coercion, patience, finding non-obtrusive ways of meeting resident's needs, and offering routines that help the resident to feel safe and included.

Intake/Assessment

Intake requirements are kept to a minimum at MHA's Safe Havens program to remain true to the ideals of the Safe Havens model, which was designed purposely to be as nonthreatening as possible. In many cases it is understood that for many of the potential residents, it's their inability to get through the intake process at traditional shelters that make them candidates for Safe Havens.

Intake and assessment is also a continuing process for the Safe Haven. One aspect of it that is time-specific is whether the Safe Haven placement is right for that individual, i.e., the entry decision. However, other aspects of intake and assessment, especially the accumulation of other needed information on the resident, is accomplished in an informal manner. This aspect of intake and assessment is usually protracted, overlaps with engagement, and may begin at a time prior to the individual's entrance into the program. MHA staff, many of whom have worked in the homeless community for many years, frequently interact with prospective guests or regularly communicate with other service providers, thereby creating an information base that reduces the need for an intrusive intake process.

Both Pathfinder and Harbor House expressed a need to have a reasonable understanding of the individual's needs, including psychiatric history, prior to placement in the program. Of particular concern in determining whether the Safe Haven is the right opportunity for the person is the issue of violence. The three Safe Haven providers all agree that the assessment of risk was the primary, if not the only, absolute assessment that needs to occur prior to occupancy. Potential violence must be evaluated prior to placement in order to preserve the health and safety of the potential guest, other residents, and staff. Such an assess-

> ### Potential violence must be evaluated prior to placement in order to preserve the health and safety of the potential guest, other residents, and staff.

ment is a profoundly difficult one to make in dealing with psychiatric issues, but Safe Haven operators need to do their best.

The origins of an assessment are unimportant. Accuracy is far more critical. In addition, the assessment does not need to be written. Among some of the options to consider are:

A face-to-face professional assessment. A risk assessment of this nature can be difficult to obtain, especially if the person under consideration has an untreated, severe mental illness and little is known about how the symptoms will manifest themselves. In addition, some potential residents may be actively symptomatic and unable to answer questions that might help with the assessment.

Observation. Through the process of outreach or the person's attendance at drop-in activities, staff may have occasion to observe how the individual interacts. Dealing with anger, stress, and negotiating interpersonally are all instances when we demonstrate what emotional resources we use in day-to-day situations. These occasions provide staff with opportunities to assess whether the placement would be a wise one.

Third-party advice. In some cases the person may be well-known by an outreach team or the referral source, and the necessary information can be gathered from them. Of course, all considerations about confidentiality

Confidentiality considerations may be governed by provider-specific guidelines, legal precedents at the state level, or ad-hoc agreements can be developed as part of the continuum of care process.

A few other considerations regarding intake and assessment are worth noting:

Medications and injectibles. Staff experience strongly supports the importance of requesting prospective guests to place any medications or sharp objects they may have in a locked area before they can enter the program.

Co-occurring disorders. Statistics compiled by MHA's outreach team reveal that over 29% of all eligible homeless adults present symptoms of co-occurring disorders (substance abuse and mental illness). To prohibit guests with substance abuse histories from occupancy would exclude a significant portion of the target population. Substance abuse disorders present a concern for intake in that the guest must agree to follow house rules regarding substance use. In most cases, these house rules will prohibit alcohol or nonprescription drug use on the premises, and they usually are formulated or supported by the residents.

Substance use. This also presents a concern for the ongoing assessment of the resident's needs and the development of expectations for subsequent engagement into treatment. The determination of the level or degree of substance abuse and the potential for such disorders to mask or mimic mental illness may take some time. A lot can be learned and evaluated during the engagement phase. Less manifest aspects of substance use in the resident's life may appear over time.

Labels. Many prospective Safe Haven residents face a common problem of being labeled as "troublemakers", or worse, by other providers in the community with which they have had contact. For example, they may have been banned from some shelter programs because of their symptoms or viewed by providers as using services excessively or inappropriately. The unique features of Safe Havens programs, including professionally trained staff, ensure that prospective guests receive fair consideration. The prospective resident with a nega-tive history or labels should be allowed full opportunity to explain previous circumstances, if such explanation is deemed to be appropriate or needed.

For the intake and assessment functions of the Safe Haven to be effectively completed, it is important for the Safe Haven to have collaborations with other providers, to participate actively in the continuum of care configuration for the community, and to be willing to gather and to use information that helps with these functions in a flexible and ongoing way. The important point is that the Safe Haven is trying to eliminate the barriers that have kept the individual from re-engaging with needed services.

SERVICE DELIVERY

The entire field of community mental health struggles with the appropriateness of linking residential and treatment/support services for persons with serious mental illnesses. The Safe Haven inescapably combines both the provision of housing and the provision of services that will benefit the resident. Other chapters have addressed characteristics of the Safe Haven as a housing program. It is more difficult to characterize the nature of the support and encouragement the resident receives as part of the services that are delivered in this housing.

A substantial amount of the services the resident receives will probably occur off-site, i.e., outside of the actual Safe Haven. Many of these services are characterized by the specialty skills that are necessary for the service and include things like medical and dental treatment, substance abuse counseling, psychotherapy, and psychotropic medication monitoring. Most Safe Havens include these services in the list of what is available to their residents. The choice of whether the agency provides them itself, in-house or off-site, depends largely upon what the operating agency already provides within their own service system. Multi-service providers who add a Safe Haven to their service array may be able to provide these services within the auspice of one organization.

However, the decision to contract for services may be driven by considerations other than specialty or prior experience. For instance, MHA chose to obtain nursing services from the Health Care for the Homeless grantee in Springfield. Frequently, their nurses

were already providing services to the consumer at other shelters, the soup kitchens or, in many cases, in the streets. Continuity in the established relationship between a nurse and a homeless man or woman who is unable or unwilling to accept many services, can be the key to acceptance of necessary services once in Safe Havens. Although MHA had psychiatric nursing services available in-house, it chose to subcontract the service. Some of the reasons may help other Safe Havens to consider their options. Specifically,

- Health Care for the Homeless nurses were already familiar with the guests and the continuity had practical value;

- it prevented the overuse of already overworked in-house nurses; and

- the contract represented an excellent opportunity to form a collaborative relationship with another area provider.

More subtle for the Safe Haven to consider is the nature of activities in the Safe Haven that are intended to encourage, assist, and support the resident so that the goal of the Safe Haven is fulfilled, i.e., for the resident to become actively linked with treatments and able to move on to other housing. Other chapters contain information that contributes to the accomplishment of this goal. The nature of the Safe Haven housing itself can contribute to stabilization and communicate role expectations about interactions with others, as well as hope for the future. These aspects can have real impacts on behavior. The rules of the Safe Haven, noted in Chapter 7, protect the resident's general welfare, convey expectations for conduct in housing, and reinforce the notion that responsible behavior considers impacts on others. And, perhaps, most critical, managing crises deals directly with how symptoms and their consequences can be addressed within a Safe Haven (see Chapter 5).

However, on a day-to-day basis, staff and residents interact in a way that must also contribute to the Safe Haven's goal. The process is so individualized that documenting it seems elusive. From some of the operational Safe Havens, we can accumulate experiences that contribute to this unique residential culture. In many ways, the service program is a continuation of the engagement process to which the Safe Haven adds a unique type of case management-flexible, open-ended, and non-assertive, but characterized by establishing a relationship with the resident, identifying needs, and seeing if those needs can be met.

Some considerations for how to keep demands from being intrusive while encouraging the resident to re-engage, might include the following:

1. Establish and maintain trust. The atmosphere established by staff must reinforce feelings of safety and security. In turn, this inspires trust in the resident and confidence to face change.

Readiness for change is individualized and not always linear. Staff must have great tolerance for this personal unpredictability and be nonjudgmental about it, particularly if relapse or regression occurs.

2. Use engagement to identify needs. Participation, however minor, in the rhythms of everyday life in the Safe Haven--meals, chores, socializing--has clinical significance and gives the resident experience with responsibility and housing skills. Such participation should be offered, not demanded, and modeled by staff and other residents. Achieving this participation is often the gateway to subsequent progress.

Staff participation with the resident, by observation, conversation, and activity, is key to accumulating an understanding of the resident's needs. It is the basis for helping the resident with insights about his/her needs. As needs are identified and agreed to by the resident, he/she is better positioned to participate in formulating a plan for addressing those needs.

Most Safe Havens see themselves first as housing, and secondarily as treatment or service settings. Although sensitive to the clinical issues in residents, they do not function as traditional therapeutic psychiatric, psychological, or social work programs. Thus, this aspect of services within a Safe Haven setting must be thought of as a needs identification, not as directed to helping the resident with the resolution of problems or symptoms.

3. Assist with awareness of services and supports. Information about available services and supports should be open and accessible for residents. As they ask about services or read postings, these are opportunities to address any concerns they may have

about the experiences itself, their rights, costs, locations, etc. Opportunities should be identified and offered for any services within the Safe Haven, such as group and individual sessions. Many of these services within the Safe Haven probably will not have clinical content (skill training, legal service, or explaining a benefit). But they give the resident positive experiences with being a service recipient.

4. Formulate a Safe Haven plan. As events unfold, each resident should be encouraged and supported in developing a plan for his or her Safe Haven experience. In a treatment setting, these are often referred to as treatment plans, even when they include more support services than treatment. But this seems too weighty a label for the plan within the Safe Haven.

Through self-insight and staff ascription, the resident will begin to identify specific needs he or she has. Some of these will be around their future housing status, some may be related to recurring problems in their life such as mental health difficulties or substance use that they become more willing to address, and some may be about things they need to function more independently in the community (e.g., job skills, socialization opportunities, etc.). The resident should be encouraged to agree to have these needs documented, as the beginning of a Safe Haven plan.

A plan can begin to take shape as the resident is also encouraged to think about how these needs can be met. Information can be provided on the range of services within the Safe Haven and elsewhere in the community that relate to meeting a need. As the resident agrees to try out some of these services, this should be documented as part of the plan.

The plan should be flexible so it can be updated and expanded as the resident is ready and so revisions help the resident avoid feelings of failure if a part of the plan does not work out. Staff can help the resident set realistic expectations for meeting the needs, such as how many activities are attempted at once, whether community resources are available, what types of outcomes the resident might expect, and over what time period.

This plan should be considered a part of the resident's information within the Safe Haven's records. The Safe Haven should give consideration to whether any aspect of the plan should be released or shared with other service providers. Resident consent to such release must be worked out. This

consideration is fundamental because each service provider with whom the resident interacts may also be developing a treatment plan. An ability for these providers to discuss the degree of consistency or to resolve conflicts in the plans is precluded if there is no consent to release.

5. Assist with a service linkage. As a Safe Haven "care" plan unfolds, representatives of the Safe Haven must be willing to help the resident link with the identified services. For most Safe Havens, this will be a role that the staff fulfill. However, it is also possible that these steps could be fulfilled by a party outside the Safe Haven to which the resident has been linked. Many staff will be familiar with aspects of case management that require brokering--locating and calling providers, representing the resident, and arranging for appointments. Such brokering is required at this stage.

Another dimension of brokering may involve helping the resident get to the service. This may involve reminders that an appointment is coming up, helping the resident think through the logistics (when to get up, lead time to get there, any special preparations, etc.), arranging transportation, and possibly going with the resident, especially to the first appointments.

Periodically, the resident should be encouraged to reflect on how things are going, whether the service is meeting the identified need, if he/she likes the service providers and what they offer, if they listen to and respect the resident, or whether there is progress.

The Safe Haven staff may also find that a part of the plan includes implementing goals set by these other providers. Most obvious will be a goal in which the resident wants to stay with another provider's treatment regimen and it involves behaviors that occur in the Safe Haven. The Safe Haven is not expected to duplicate or develop special skills, but rather help the resident implement steps they may have agreed to around taking a medication, acquiring a skill, staying on a particular schedule, etc.

If such a care plan can be achieved, the Safe Haven will have accomplished a primary goal of assisting the resident to re-establish contact with treatment providers. Change should be evident in the resident's behavior in such areas as optimism, involvement with at least a minimum degree of service receipt, some stabilization of symptoms, and a willingness to consider setting and

attaining goals. The goal of helping the resident advance to other housing is addressed in Chapter 6 -- Transitions from Safe Havens.

Special recognition should be given to the role of peers before leaving the issue of the service program. Peer involvement has had a tremendous impact at the three Safe Haven sites surveyed. Pre-employment training and social clubs saw the greatest level of peer-directed activities. Harbor Homes and Pathfinder both have in-house social clubs and TEPs (Transitional Employment Programs) and MHA has an affiliation with the Lighthouse Program, a local, DMH-funded clubhouse, for both of these services. The Lighthouse received a grant to work with people who are homeless and mentally ill, to provide skills training and job placement. A peer advocate was included in the grant to do outreach to the homeless community and one of the sites frequented is a Safe Haven. The combination of peer involvement and other specialized features of Safe Havens has produced better than expected results, with improved service integration and increased linkages to the more traditional service delivery system at all three sites.

CONCLUSIONS/RECOMMENDATIONS

In the opening section, we asked whether the concept of a Safe Haven worked in the real world. Our conclusion is that it *does*. When HUD included Safe Havens in the Supportive Housing Program funding announcement, NOFA, it gained the immediate interest of homeless providers because of the obvious gap in the continuum of care it addressed. The straightforward concept and the program guidelines that were unambiguously outlined in the application made the initial decision to operate a Safe Havens an easy one. Doubts about implementing the program specifics were eased because the providers' own experience had shown that without the special features, the target population remained disengaged from services and unsheltered for long periods.

The three Safe Havens discussed in this chapter attribute their success (as evidenced by rare vacancies and the stated need for next-step housing) to each program's ability to remain focused on the unique needs of this population. An effective outreach model must be in place at the beginning to ensure that the most needy individuals receive services. Once in the program, engagement must be woven into all aspects of the Safe Havens environment. The program should have the means to nurture greater self-sufficiency, support the resident to re-engage with treatments and supports, and focus on next-step housing. Affiliation agreements with other providers in the local continuum of care promote these goals. Extensive collaboration and contact with outside providers to capture their expertise not only ensures quality services, but promotes a community-wide commitment to the program.

These Safe Havens serve each city's most vulnerable and visible mentally ill individuals. These programs have dramatically reduced their plight and provide a desirable alternative to the inappropriate and costly incarcerations and hospitalizations that has been the usual method of treatment. The ability and willingness to serve each city's most needy men and women in a dignified and effective manner benefits the entire community, thus enhancing their opportunities in the future.

RECOMMENDATIONS FOR EXEMPLARY PRACTICE

- Provide a continuum of services, including outreach and health care, beginning on the streets and continuing until housing is obtained.

- Ensure that the target population is served by being a portal of entry to services for a population that may be difficult or resistant to engagement.

- Engagement and service delivery must retain the expectation that the resident will advance to more permanent housing with appropriate supports.

- Adequate numbers of trained staff are critical to effective operations.

- An individualistic approach is needed to focus on the special needs that set this population apart from those able to utilize existing shelters.

- Engagement should be woven into all aspects of the Safe Havens environment.

- Operate social clubs on site.

- Provide transitional employment programs on site.

Crisis Management

CRISIS MANAGEMENT

BY JAIMIE PAGE

Crises will occur in Safe Havens. Crises may occur inside the Safe Haven facility, in its immediate neighborhood, or in the community-at-large. Types of potential crises include:
- threatening behavior,
- dangerousness to self or others,
- medical emergencies,
- missing persons,
- outsiders attempting to victimize a Safe Haven resident, and
- fires and natural disasters.

Effective Safe Havens anticipate and prepare for crises. These programs develop crisis management procedures and train staff to respond efficiently and calmly. Effective crisis management reduces potential harm to residents, staff, community members, and property. It also minimizes the potentially traumatic effects of crises on Safe Haven residents.

This chapter suggests five tenets of crisis management to guide a program's response to emergency situations. It then describes several potential crises and effective responses. The chapter also contains a scenario of a crisis common to Safe Havens and outlines immediate, secondary, and follow-up responses.

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- Prevention is key.
- Interventions are always client-centered.
- Interventions balance consistency with flexibility.
- Safe Havens are committed to residents for "the long haul."
- Staff need to know when and how to get help.

1. Prevention is key. Many crises that could potentially develop in Safe Havens can be prevented or minimized. Not only can Safe Havens and staff anticipate and take action to prevent general crises, but they can also identify and address potential crises that could occur with individual residents.

Staff, for example, will observe that one resident who has organic deficits as well as chronic mental illness is prone to smoking in his room and sometimes drops his cigarette without knowing it. The resident may not be able to follow the standard "rule" of no smoking in rooms, and staff will need to take a more proactive approach. The response could include more vigilant monitoring of the resident's room, having him check his cigarettes at the front desk, or having him smoke with staff accompaniment.

Another resident may have a behavioral "red flag" of further escalation once he/she begins to think that others are "part of a plot" to control his/her mind and body. Effective responses include assigning staff to more intensive one-on-one interaction, considering additional medications as needed in addition to any regular medications he/she may be taking, keeping other residents at a distance, and preparing to intervene quickly should an incident arise.

2. Interventions are always client-centered. The resident's individual care plan identifies potential problems and lists appropriate interventions that will be effective and caring. Safe Havens support the dignity, respect, self-esteem, and greatest possible self-determination of any resident affected by an intervention.

As program staff and the individual resident collaborate to develop the resident's care plan, a case manager may ask the resident, "If you should start to get angry when you think people are plotting against you, what can we do together to keep you and everyone else safe?" While full participation on the part of the resident will not always be possible, many residents can suggest and ordinarily should know of specific interventions identified in the plan. The plan will also assist residents to develop their capacity to manage crises to the greatest extent possible. Prior identification and discussion is usually less surprising and traumatic for residents. In time, through use of this approach, many residents will begin to expect certain responses to specific behaviors. These expectations will function as safety mechanisms for all involved parties.

Although physical restraint of residents by staff is almost never appropriate, involuntary transport to emergency rooms for involuntary psychiatric evaluations is an intervention that many Safe Havens will probably use in a few instances. Prior to initiating this response, staff must determine that such an intervention is in the best interest of the resident and that the resident will benefit from it. This type of intervention is often traumatic for the resident, as well as for other residents who witness it. Questions about the trustworthiness of the Safe Haven and its staff can frequently arise among residents. An effective intervention will address these concerns and usually include debriefings after public incidents. A major goal of the residents' debriefing is to increase feelings of safety and security.

3. Interventions balance consistency with flexibility. Staff should be consistent with each resident. For example, staff working with the resident who has difficulty managing his smoking should carry out the intervention of keeping his cigarettes at the front desk and accompanying him while smoking. Otherwise, the variation of interventions may confuse or frustrate the resident, and the risk of fire will increase.

The appropriateness of a particular type of intervention, however, varies depending on the specific situation of an individual resident. For example, a woman who was frequently victimized on the street has recently moved into the Safe Haven after a particularly long

period of outreach to her. Upon moving in, this new resident is gently informed of the need to keep the Safe Haven safe by smoking only in a designated area. If she doesn't remember this "rule" initially, staff will be more lenient and flexible because they want to continue to engage her with less intrusion and structure so as to avoid her return to the streets.

What is appropriate for one resident may be counterproductive or damaging for another. Fairness does not become an issue because the Safe Haven neither makes nor advertises generic interventions to specific behaviors. If one resident would question why he has to turn in his cigarettes while another resident does not, staff can respond in a manner appropriate to the resident by saying that each resident's care plan is different and that confidentiality and privacy requirements prohibit staff from discussing another resident's care plan.

Effective responses not only defuse the particular situation, but also contribute to a safer environment for residents and staff.

4. Safe Havens are committed to residents for "the long haul." Once a person is identified as a potential Safe Haven resident, the program is committed to the person during all phases of treatment: engagement, treatment, crisis intervention, transition, and follow-up. For a resident who has experienced a crisis, **the time period after the crisis is critical**. Residents can often feel embarrassed, remorseful, in need of support, and ambivalent about returning to the Safe Haven. They may wonder how they will be received. Outreach may need to take place following a crisis. These intensive engagement efforts may occur in hospitals, jails, the streets, a crisis shelter, or other locations appropriate to the resident's situation. Even in cases in which the resident is transferred to another facility or to a state hospital, the Safe Haven staff can contribute to a smooth transition.

5. Staff need to know when and how to get help. A comprehensive manual containing up-to-date policies, procedures, and referral information, as well as on-going staff training in de-escalation, medical triage, and crisis management is essential. Program operators must ensure that staff are sufficiently trained and that the necessary supports are in place. Crises are easier to manage when staff feel competent and supported.

POTENTIAL CRISES AND RESPONSES

When dealing with crises, there is a need for immediate, secondary, and follow-up responses. Effective responses not only defuse the particular situation, but also contribute to a safer environment for residents and staff. In a crisis, the first staff member to respond usually becomes the crisis manager and directs other staff and residents. Staff should observe and "size up" the situation before taking action. While there is often more than one correct way to respond, drills can help staff develop and practice appropriate responses.

Threatening/escalated behavior is the most common crisis that a Safe Haven will face. This type of behavior includes: raising of one's voice, yelling or screaming, subtle or veiled threats, cursing, increased psychomotor activity, irritability, accusations, intrusions, and gestures or positioning with or without objects that suggest throwing or hitting. It has several possible causes: a mental illness; response to being close to others after having been isolated; interaction between two or more people with untreated mental illness; substance abuse, adjustment to new structures and routines; and perceptions of intrusion by staff and other residents. Threatening behavior may pose a danger to other residents or staff.

In cases of threatening behavior, staff need to attempt to calm the resident through body language, a soft, low voice, and comforting, empathic language. De-escalation may also include attempts to distract the resident; persuade the resident to leave the area or ask the persons causing the behavior to leave; request the person who is "bothering" the resident to leave the immediate vicinity for a time; or address the escalated resident's perceived needs.

If de-escalation does not work, staff need to get help. Safe Havens should have a code system that alerts staff to a crisis. With a code system, a staff member would announce via intercom or in another way, "Code One in the dining room." Staff would know that there is a crisis in the dining room.

If a particular staff person is the target of the escalation, he or she should ordinarily leave the immediate vicinity once another staff member arrives. Only one staff member should ordinarily talk to the escalated resident. With sufficient staff, a "show of support" is often useful. It may allow the resident to submit without losing face.

Staff, however, should look for signs that the resident is escalating even more due to the increased number of staff. In that case, the extra staff should remove themselves from the resident's view, but be close enough to respond if needed. The crisis manager will direct staff according to the resident's response. In cases where danger is clear and imminent, the crisis manager should ensure that 911 is telephoned immediately.

A secondary response would be gently guiding other residents who witnessed the crisis to a different area and assuring them of their safety. One follow-up response would be debriefing sessions, one with the residents and another with the staff. A few staff members may want to avoid the debriefing because it may be misperceived as a process of criticizing each other's interventions. When debriefing is done collegially, however, it builds the Safe Haven team and assists staff to develop insight and skills. Other follow-up responses include communicating the incident via progress notes, shift reports, or other means, and reviewing the escalated resident's care plan. A report on a crisis incident should include: 1) nature of the event and persons involved; 2) precipitating factors; 3) the chosen intervention; 4) information/alternatives/choices given the resident; 5) staff response; and 6) suggestions for responses to any future situation.

Dangerousness to self is another common crisis. A number of Safe Havens have experienced that, as residents begin to take medications regularly or as they continue to live in Safe Havens, their symptoms may begin to dissipate. During this time, residents may begin to realize where they are, what they've been doing, and what or whom they have lost. By not

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- the chosen intervention;

- information/alternatives/choices given the resident;

- staff response; and

- suggestions for responses to any future situations.

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allowing weapons in the facility and by having staff monitor usage of medications and other potentially harmful substances or instruments, a Safe Haven can reduce opportunities for this crisis.

Staff generally should accompany the resident back to the Safe Haven upon discharge and ensure a smooth transition and welcome home.

On-going suicide assessment and a plan for intervention will be critical elements in the care plans of more than a few residents. While "suicide rounds" are generally inappropriate for Safe Havens, the Safe Haven and its staff need to be sensitive to the condition of residents in this situation. If program staff observes symptoms indicating an increased risk of suicide, it may increase staff monitoring and support, relay information to the resident's psychiatrist for a medication adjustment, or refer the resident to a crisis shelter or program.

If the resident is at high risk for self-harm, staff may need to attempt to persuade the resident to enter a hospital for a psychiatric evaluation. Obviously, a voluntary admission is preferable to an involuntary one. If a voluntary admission does not take place, the Safe Haven may have to initiate an order for involuntary transport. Ordinarily, staff should wait to tell the resident about the order until the transporting authorities have arrived in order to reduce risk of the resident fleeing the facility. When the authorities arrive, staff should assure the resident that they care about the resident and that a staff member will visit them at the hospital. Safe Haven clinical staff or the resident's psychiatric care provider will communicate pertinent information to the hospital.

Prior to visiting a resident, Safe Haven staff will inquire of the resident if he or she needs any clothing or personal items, and then will bring the requested items. This kindness expresses to the resident the staff's commitment and esteem. Prior to discharge, the appropriate Safe Haven staff member will consult with the resident, hospital staff, and the care plan team to update the resident's care plan. Staff generally should accompany the resident back to Safe Haven upon discharge and ensure a smooth transition and welcome home.

Medical Emergencies are also likely to occur. A Code One and immediate call to 911 is warranted for any of the following:

- loss of consciousness;
- seizures lasting more than one minute or any seizure for a person without a history of seizures;
- choking;
- deep lacerations;
- significant bleeding;
- appearance of confusion or significant personality change;
- severe numbness or tingling in or inability to move extremities;
- difficult breathing; or
- fainting.

If a Safe Haven has 24-hour on-call medical consultation, staff should call and receive direction for the following: inability to urinate or incontinence in a resident who usually does not have this problem, vomiting blood (looks like black coffee grounds), blood in their stool (looks like black tar), burns, severe abdominal pain, copious diarrhea and vomiting, allergic reactions to food/medication, sudden appearance of rash, or resident eats or drinks something not meant for consumption. If medical consultation is not available, staff should help the resident seek emergency treatment. The general rule is to err on the side of safety.

If medical consultation is not available, staff should help the resident seek emergency treatment. The general rule is to err on the side of safety.

During a medical crisis, staff should attempt to distract other residents away from the immediate area of the crisis and advise them that an ambulance is on the way. If residents witness an incident, a debriefing meeting should take place. Communication is critical in emergency situations: communication between Safe Haven staff, administration, and collateral staff; communication of medical history and information to emergency and hospital staff; and receiving information from hospital staff on the course of treatment and discharge. After the emergency, the resident's care plan may need to be adjusted.

Safe Havens may also experience a **missing person** crisis. Occasionally, a Safe Haven resident may "disappear" for one or several days. This situation becomes a crisis when any of the following occur:

- The resident does not usually leave unannounced and is missing for an unusually long period of time;
- The resident does not return to pick up checks, food stamps, other entitlements, or allowances;
- Collateral contacts, including family, have not seen the resident;
- The resident has left important belongings behind;
- The resident needs to take medication for pressing health reasons.

In this type of situation, staff usually will contact hospitals, jails, police, diversion teams, crisis shelters, emergency shelters, and the coroner's office. Staff may also increase outreach efforts and collaborate with other outreach and social service providers in attempting to locate the resident. The Safe Haven may also "get the word out" on the street that it is looking for the resident, if this approach would be in the resident's best interest. The Safe Haven could also contact an agency that specializes in locating missing persons.

An outsider attempting to **victimize a resident** is another type of crisis. This problem will vary depending on the location of a Safe Haven. Many Safe Havens are located in urban neighborhoods, which persons who are homeless frequent. Many, if not most, Safe Haven residents have been victimized on the streets or in shelters. Predatory behavior and abuses of persons who are homeless and who have serious mental illnesses can include threat of or actual physical or sexual assault; financial abuse; persuasion of residents to use illegal substances to provide more income to dealers; and "setting up" residents to handle illegal drugs or drug-related money. Predators may be subtle about these activities and lead residents to believe that they are not in any danger by associating with them.

One prevention is to only allow approved visitors into Safe Haven facilities. Another is to have a single, monitored, and secure point of entry. A Safe Haven that has a drop-in center or in which screening or intake for services take place in the hours of operation should be sure to limit entrance to the residential areas of the facility.

A Crisis and A Response

The Scenario:

A resident, John, hears voices that command him to hit another resident, Sarah, because she has planted a microchip in his brain so that the enemy can track him. Sarah gets a black eye.

Immediate Responses:

1. The staff member who witnesses the incident or who arrives at the scene first calls a Code One. Other staff respond.

2. The first staff member:
   a. in view of other staff, asks John to come with her to a different location, to "cool off;"
   b. assigns a second staff member to accompany Sarah to another area to calm her and assess her injury; and
   c. assigns a third staff member to assist and debrief other residents.

3. Based on John's care plan and staff assessment of the situation, staff request John to seek a voluntary psychiatric evaluation. John agrees and a staff member accompanies him to the hospital.

4. Staff administer appropriate first aid to Sarah and offer her the option of additional medical attention.

Secondary Responses:

1. Staff communicate relevant information on John to the appropriate hospital personnel.

2. Staff continue to comfort Sarah and assist her to process the incident.

3. Staff debrief the other residents who witnessed the issue.

4. Staff record and communicate information on this incident to other staff as appropriate.

5. Staff debrief the incident in a staff meeting.

Follow-up Responses:

1. Staff visit John in the hospital and work with him, hospital personnel, and care plan team to revise his care plan. Staff accompany John back to the Safe Haven upon discharge.

2. Staff prepare Sarah for John's return by listening to her concerns and assuring her that staff believes that John is safe. (It is my experience that residents are very forgiving of each other's "incidents.")

3. Staff and residents warmly greet John upon his return and reassure him that he is welcome.

4. Staff monitor John and Sarah, their interactions, and other residents' response to John.

5. Staff praise positive behavior. If new medication seems to be a key factor in improved behavior, staff point out this benefit to John.

– Jaimie Page

As a Safe Haven limits visitors and educates residents about issues of safety, predators may view staff as a threat, and staff may be at risk. If a non-resident enters the Safe Haven and escalates for whatever reason, staff should attempt to de-escalate the individual with the goal of having the individual leave. If this does not work, a Code One should be called and 911 contacted.

All staff should be aware of any particular outside person who may pose a threat to residents or staff. The Safe Haven should have a set plan for responding to predictable incidents. For example, a resident has been harassed by a man about her entitlement checks. He comes to the Safe Haven on the day she receives her check and asks for her. If she is not there, or if staff are unwilling or unable to locate her for him, he escalates.

An immediate response may be for the person at the front desk to call for assistance as soon as the individual approaches and to have all staff present collectively inform him that they will not get the resident for him at that time or in the future. Secondary responses include informing the resident that the man is not an approved visitor. Staff may also accompany the resident on errands around the neighborhood to send a message that the staff are watching out for the resident. (While this approach may seem intrusive, residents are usually thankful for intervention because they often may have difficulties in setting boundaries themselves.) Follow-up responses may include seeking a court injunction against the outsider and addressing safety issues in house meetings or in the resident's care plan.

A **fire or natural disaster**, while unusual, is another type of crisis. The Safe Haven should make sure that there are complete and accurate safety policies and procedures, posted routes of exit, visible and accessible fire extinguishers, first-aid kits, and other necessary supplies.

The risk of fire is greater in Safe Havens for several reasons. Many residents smoke and may not be familiar with the risk of fire indoors. A few may smoke and have residual substances related to inhalant use on or near them. Others may have difficulty remembering to put their cigarettes out and inadvertently drop them. Still others may not be able to remember the "rule" of only smoking in designated areas and smoke in their rooms, where it is not easy for staff to monitor their smoking.

Preventative measures include education, reminders, and staff monitoring of the Safe Haven building. Some Safe Havens have designated smoking areas in or outside the facility. Staff can discuss fire safety in house meetings and conduct monthly or quarterly fire drills with residents. Notice of the drill will reduce any anxiety around it. One-on-one education can take place with those who refuse to participate as well as those who are frightened by the drill process. Staff should verbally announce a fire drill rather than pulling the fire alarm.

Safe Havens should expect that crises will occur, prevent them whenever possible, and intervene in an effective and client-centered manner.

Sometimes a resident will pull a fire alarm. At these times, staff need to conduct a fire evacuation for all persons in the building, rule out a fire, and then immediately deactivate the alarm. Staff will also need to calm the residents, notify the fire department (if there is no automatic notification system), and address the behavior of the resident who pulled the alarm.

Certain areas of the country are more prone to natural disasters than others. These disasters may include hurricanes, tornadoes, and earthquakes. Depending on the area and the prevalence of such disasters, staff may conduct drills or resident education sessions. If there are community drills where the Safe Haven is located, staff should prepare residents.

In conclusion, Safe Havens should expect that crises will occur, prevent them whenever possible, and intervene in an effective and client-centered manner. Programs should provide staff with the training, structure, and support to handle crises. Effective crisis management can enable Safe Havens programs to serve residents even more compassionately and successfully.

Program Rules and Expectations

CHAPTER

6

PROGRAM RULES AND EXPECTATIONS

BY SALLY ERICKSON AND JAIMIE PAGE

Rules in Safe Havens promote transition, safety, cleanliness, and privacy. Most Safe Haven residents have been unable to adhere to the strict rules of shelters and in other housing settings. Rules should not set up residents for failure and should be presented in a manner that is least intrusive and punitive. Safe Havens vary in size, scope of service, functioning level of clients, and access to available services in the community. Rules will reflect the individual Safe Haven and the community in which it exists. Generally, the fewer and simpler the rules, the better for the residents and for the program.

FIVE PRINCIPLES OF EFFECTIVE RULES

1. Rules should reward positive behavior.

2. Consequences should be explained and enforceable.

3. Rules should relate to living situations.

4. Rules provide opportunities for engagement.

5. Rules provide a safety net for residents.

Sally Erickson is the Project Director for Mental Help Hawaii at Safe Haven Honolulu in Honolulu, Hawaii. Jaimie Page is coordinator of the Health Care for the Homeless Project at Kalihi-Palama Health Center in Honolulu, Hawaii.

1. Rules should reward positive behavior. Whenever possible, Safe Havens should reward residents for positive behavior rather than punish for negative behavior. The use of rewards promotes an overall engagement strategy that has proven to be more successful than the use of punitive measures. For example, staff can reward a resident with poor grooming habits for attempts to improve hygiene with a manicure, gift certificate, or simply offer positive feedback when she does shower and change clothes, rather than deny her services because she is malodorous. This resident would probably seek services elsewhere – or not at all – if treated punitively.

2. Consequences should be explained and enforceable. If a consequence for inappropriate behavior is needed, it should be one that the resident might expect ahead of time and it should be enforceable. Consequences should generally be relatively minor for the first infraction, with more serious consequences for additional infractions. For example, if a resident aggressively tries to promote substance use among other residents, staff might ask the resident to leave the building for a period of time. Staff might help the resident gain insight into harmful effects of drugs to himself and others. Staff might also require that this resident not communicate with particularly vulnerable residents. Over time, the program might require participation in appropriate substance abuse treatment for the resident to continue to stay at the Safe Haven. If the resident continues to pose a threat to other residents after a series of interventions, he will usually be asked to leave permanently, with services and referrals offered at a different location or program. The extent to which Safe Havens are willing to try different interventions to alleviate behavioral problems varies from program to program.

3. Rules should relate to future living situations. House rules should be tied to the behaviors that future housemates or landlords might expect. Safe Havens can use rules to instill hope for and progression toward more independent living. For example, if residents squabble over the television channel selection or dining room seating arrangements, staff can assist them to use communication and problem-solving skills to resolve the issues. Staff can use these opportunities to point out that problems may occur in the future and residents will need to learn ways to resolve them. The program should provide residents with the opportunity to deal with issues themselves whenever possible.

4. Rules provide opportunities for engagement. Safe Havens can use rules to facilitate discussions with residents around issues of safety, cleanliness, and privacy. Every interaction with residents provides an opportunity for engagement and teaching. Programs can emphasize harm reduction rather than strict adherence to a behavioral expectation. This approach will enable staff to teach about safe sex, substance use, and similar issues. For example, if a resident is found in another resident's room in a sexual situation, staff can use the opportunity to address issues like safe sex practices, positive relationships, communication and assertion skills, and the effects one's behavior might have on another person. If a resident arrives at Safe Haven intoxicated and/or high, the staff might allow the resident to enter as long as she is calm, or enter to sleep, and address substance abuse issues later when the resident is sober.

> Safe Havens can use rules to instill hope for and progression toward more independent living.

5. Rules provide a safety net for residents. It is critical to the well being of the residents that a Safe Haven be truly safe. Many residents lack social and communication skills, and rules, such as those prohibiting guests in the building and residents in other residents' rooms, allow for a safety net. The resident can fall back on "the rule" and feel less pressured by peers or situations. When a rule is violated and safety threatened, staff should intervene immediately.

COMMUNICATING RULES TO RESIDENTS

Rules should be presented in a simple, positive, and culturally appropriate manner so that residents can understand them regardless of their current mental status or language ability. Rules can be communicated to residents in a variety of ways. Outreach staff can begin to go over rules and expectations with potential residents before they move in. As part of a move-in orientation process, residents read or hear the rules again, and acknowledge by signature that they understand them. The orientation paperwork, however, should be kept to a minimum to avoid a sense of formality and intrusion. Within the building, resi-

dents can get visual reminders of the rules by viewing them posted on bulletin boards, in their rooms, in common areas, etc. Verbal reminders also help. This can be done on a one-to-one basis by residential and/or case management staff; during house meetings; and on a more formal basis, such as in conferences with staff during discussions of rule infractions. When appropriate, and whenever possible, residents participate in their own goal-setting and planning ("treatment plan," "care plan," etc.). During these discussions, residents receive feedback regarding rules, how they're doing with them, and what kind of consequences they can expect should there be further infractions.

Different levels of rules at some Safe Havens may require different responses. Infractions of rules addressing safety, such as violence or possession or use of weapons, will result in an immediate and more consistent type of response. It's helpful to start with general house rules and then get more specific with individual residents on a case-by-case basis. Language other than "rules" may be used, such as "house customs," "goals" or "rights and responsibilities." General rules that pertain to issues of safety, cleanliness, and privacy might be presented in the following format.

"Please help keep Safe Haven"

RESPECTFUL, by not swearing, stealing, or pressuring anyone (this includes sexual pressure);

PEACEFUL, by not bringing in weapons, fighting, or hurting anyone;

CLEAN, by not eating in rooms or smoking in the building, and by keeping yourself and your room clean;

SUBSTANCE FREE, by not bringing drugs, alcohol, or paraphernalia into the building;

SAFE & PRIVATE, by not bringing guests into the building, or having other residents in your room;

FAIR, by limiting phone calls to five minutes; and

NEIGHBORLY, by not hanging out in front of the building or littering.

(House rules from Safe Haven Honolulu)

RESPONDING TO RULE INFRACTIONS

The degree of flexibility with rules will vary from region to region due to the availability of programs and services. In areas where a Safe Haven is the only resource for the targeted population, rules may need to be more flexible to provide a safe home to a broader group of people with more diverse needs. In locations where there is a broader spectrum of services, a Safe Haven can be less flexible, accept a more limited group of people, and refer people with complicated needs to a more appropriate setting. Furthermore, in areas with colder climates, the development of rules and consequences for infractions will need to reflect the weather. For example, at Safe Haven Honolulu, a resident may be asked to leave the building for four or more hours when a particular rule is broken. However, this may not be possible in New York in winter. Staff in colder climates need to be more creative and/or careful when establishing consequences to enforce rules.

Safe Haven rules should be flexible, because what is beneficial for one resident may be counterproductive for another resident.

The general approach to rule infractions and subsequent intervention is based on the value placed on a reward rather than punishment philosophy, as mentioned. Many Safe Haven staff members have worked in psychiatric institutions, hospitals, and other programs that tend to be consequence and control-oriented. Safe Haven residents have typically failed in these programs. Therefore, staff are encouraged to be creative, to acknowledge client strengths, to incorporate client goals and ideas into interventions, and use a reward philosophy whenever possible.

Exemplary outreach staff typically spend months engaging clients with the use of positive regard, incentive items and services, working with client-perceived needs, using effective communication, and letting the client determine the pace when possible. These strategies must continue when the same client moves into a Safe Haven, and must be valued and implemented by all staff.

Safe Haven rules should be flexible, because what is beneficial for one resident may be counterproductive or harmful for another resident. At Safe Haven Honolulu,

for example, a woman who had been assaulted on the streets for several years finally feels comfortable enough to move in. Staff will be more lenient with her, initially, about rule infractions, such as smoking in the building. The intent is to be able to continue to engage her with less of a sense of staff intrusion and program structure, thus preventing her return to the streets. However, there should be consistency with individual clients.

There should be different levels of intervention if a resident violates a rule. They are listed here in the order of serious to minor infractions.

Immediate response. If there's a need for immediate attention, on-site staff respond to emergencies: voluntary admission to a psychiatric or substance abuse facility; involuntary transportation via the legal system to hospital emergency rooms, 911 calls (police, fire, ambulance), asking a resident to leave the building for a period of time to cool off, using other de-escalation techniques, etc. These involve issues of immediate safety like medical/psychiatric/physical building emergencies.

Unscheduled/Urgent Care Plan Team response. Safe Havens should have Care Plan Teams for each resident that consult with each other as to the appropriate response when learning of an infraction of a moderate to serious nature. (At Safe Haven Honolulu, the Care Plan Team is comprised of a psychiatrist, psychiatric nurse, medical nurse, residential coordinator, clinic coordinator, rehabilitation specialist, as well as the case manager and residential assistant assigned to each resident.) At Safe Haven Honolulu, a resident who has a problem with inhalants and who smokes, accidentally started a small fire in her room. The Care Plan team consulted and came up with the following plan: the resident must turn in her cigarettes at the front desk, and may only smoke outside. Staff would also confiscate paint-laden purses/clothing, etc., to avoid further fire hazards and part of her allowance is contingent upon maintaining ongoing, supportive substance abuse counseling.

Scheduled Care Plan Team response. When events can wait until the scheduled Care Plan Team meeting, staff and, whenever possible, the resident come up with a plan to address patterns of rule violations. This usually begins with the least intrusive, yet safe, intervention and gets more stringent as the pattern continues.

The team along with the resident may develop a "standing order" for particular infractions. If a resident can expect a consequence the enforcement of that consequence is more likely to be successful and may help to deter the behavior in the future. For example, a resident knows ahead of time that every time he throws a plate of food in the dining room, he'll be asked to leave the building for four hours.

RESIDENT RIGHTS

The following rights should be incorporated into any Safe Haven:

- Right to participate in goal-setting, treatment planning, monitoring, and discharge planning.

- Right to voice concerns.

- Right to participate in decisions regarding medications.

- Right to refuse medication and to refuse to participate in "therapeutic treatment" or activities.

- Right to choose health care providers.

- Right to dignity and respect.

Tenant rights. Tenant rights are an issue that may be more of a concern if residents pay rent. Some Safe Havens do not charge rent, while others charge one-third of a resident's income (if he or she has an income) and/or a nominal program service fee. Most existing Safe Havens do not incorporate tenant rights because of the difficulty associated with the eviction process and other potential legal entanglements. Basic Accommodations, in Canton, Ohio, incorporates tenant rights because they underscore the program's emphasis on the universal rules of rental housing. They use a standard lease as well as a housing plan that is adapted to meet Safe Haven needs.

Tenants are required to meet three obligations to: (1) respect neighbors, (2) respect property, and (3) pay rent on time. Infractions of these tenant obligations result in a landlord-tenant-based response rather than a treatment-based response, including restitution for damage, tenant council discussions, and referral to support persons who might assist with further damage prevention. This includes building staff, a case manager, or a community support provider.

Areas of Concern: Rules Regarding Sexual Activity and Drug Use

Sexual Activity. Most Safe Havens do not allow residents to engage in sexual activity, to exhibit "public displays of affection," or allow guests of either gender in their room. One reason for this is that many residents, both male and female, have been victims of sexual abuse or assault. A Safe Haven in Madison, Wisconsin, states that 100% of their female residents have been sexually assaulted and many male residents have sexual boundary issues.

Safe Haven Honolulu was initially less stringent on sexual activity, so as to promote residents' self-determination. However, when females were observed disassociating when someone was fondling them, and when these same women began to decompensate as a result, they changed this policy. Safe Haven Springfield does not allow sexual activity because of the inability to monitor issues of consent and degrees of trauma. Both Safe Haven Springfield and Safe Haven Honolulu feel that if a couple wants to engage in sexual activity, staff may want to evaluate whether or not one or both are ready for independent living. NOVA/Safe Haven in Phoenix reports that while there is some truth to the statement that disallowing sex on site is "just moving it," some residents are not capable of giving informed consent. Residents, whether male or female, who have difficulty setting limits with others, have the support of knowing this rule is in place and they will not be "strong-armed" while at the facility.

Alcohol and drugs. Because they receive government funding, Safe Havens cannot allow any illegal drugs on the premises. While alcohol consumption is legal, most Safe Havens do not allow alcohol use on site because of the large percentage of residents who are dually diagnosed with substance use issues. Some Safe Havens feel that it is acceptable for residents to use substances and remain in the program, as long as it is not on site. Safe Haven Honolulu and NOVA/Safe Haven in Phoenix allow intoxicated individuals to enter the building as long as they are calm. Safe Haven Springfield allows intoxicated residents to enter, but assesses for risk and may refer the individual to a detox facility or emergency room. Safe Haven Madison does not allow anyone in the house who is drunk or high. If they show up in this condition, they are referred to a detox facility.

Safe Havens need to consider whether they will be a "dry," "damp," or "wet" facility. While Safe Havens do not assist or support residents in using alcohol or illegal drugs, some may have chosen to work with their residents toward a better understanding of their substance use and toward abstinence or reduced use and dependence. When Safe Havens have adopted such an approach with their residents, a consistent set of principles emerges for working with the resident:

- a non-judgmental and respectful approach;

- helping residents to identify harmful effects of drug and alcohol use and the benefits of decreasing and/or ceasing use;

- exploring alternate patterns of use;

- praising small successes;

- developing flexible plans that address substance abuse issues.

Since many Safe Haven residents do not have insight into the harm of their drug use, Safe Havens should further investigate the use of a "Motivational Interviewing" or "Stages of Change" approach to working with clients. Safe Havens may want to consider training in these models for all residential staff, rather than having one designated substance abuse counselor. Within Safe Havens, the emphasis is on safety rather than a limited focus on violation of rules or laws.

Expectations for a Safe Haven

Expectations appropriate for a Safe Haven include a belief in the clients' capability and that all citizens must have the opportunity to live in, participate with, and contribute to their communities. Expectations of clients vary because client capabilities, needs, and level of trust varies. Expectations should be individualized and based on initial and on-going Care Plans that involve long-term and short-term goals, measurable objectives, and staff interventions. Specific expectations include that:

- clients will move into permanent housing after stabilizing, or if ascertained that a different setting is in the clients best interest, a successful referral will be made;

- the residents' level of insight into their health and mental health needs will improve;

- symptoms will improve, and

- most residents will be able to live fulfilled, safe, and empowered lives within the community.

Over time, Safe Haven residents should have the opportunity to progress and to gradually learn community re-entry skills, including:

- good grooming and hygiene

- communication skills

- anger management skills

- social skills

- laundry/household maintenance skills

- dealing with mental illness, including: diagnosis, symptoms, medication and side effects, "red flags," how to get help when they need it, and how to gain peer support

- to set and monitor goals for themselves

- how to negotiate the public transportation system

- what recreational activities they enjoy and can feel comfortable with

- budgeting skills

Participation in activities is encouraged and reinforced, but not required. As residents progress toward independent living, they should be given opportunities to initiate and participate in activities like cooking, shopping, budgeting, planning social activities, etc. When residents are ready and interested, referrals to activity programs such as a "clubhouse"-type model can be made.

Expectations for Residents

Residents can expect a program to provide a positive, safe environment by:
- giving honest, fair, and respectful treatment;
- developing a sense of trust;
- being flexible;
- advocating on the residents' behalf;
- offering fun, meaningful and inexpensive activities both within the program and out in the community;
- ensuring their safety; and
- respecting their privacy.

Residents can expect that Safe Haven staff will treat them with unconditional respect, and help them exercise power and self-determination by involving residents in decision making and in the monitoring of services and treatment. Staff allow residents to set the pace of their progression. Therefore, standard limits for task completion are avoided.

Safe Haven staff are expected to help with clothing, toiletry items, mail and phone services, showers, laundry, etc. They are expected to provide healthy food and assist with the provision of special diets, culturally appropriate foods, and special requests. Staff are also expected to monitor resident's physical and mental health and offer assistance and care accordingly.

Finally, residents can expect that they will be assisted in living a fulfilled and high-quality life, however they define this, through staff providing teaching, support, optimism, and encouragement. Staff will also be expected to assist residents with: independent housing whenever possible, outpatient mental health care, quality health care, meaningful activities and relationships outside of the "homeless mentally ill" service-provider network, while providing effective and comprehensive individualized services.

ATMOSPHERE OF EXPECTATION

Before residents move in, the outreach workers, case manager, or whomever is the referral source, should let the client know that Safe Haven is transitional and that they will be expected to move on when they're ready.

- When they are first engaged and move in, residents are given time to settle in and get into the routine of taking care of themselves with the goal of independent living.

- Staff must be oriented to an atmosphere of expectations (specific interventions as they relate to goals and expectations are written into a resident's Care Plan).

- Residents meet regularly, on an informal basis, with assigned staff. Together, the staff and residents explore progress in completing various tasks.

- Promote upbeat, lively, fun atmosphere...using humor to motivate people.

At Safe Haven Honolulu, residential assistants on each shift are assigned four to five residents. Depending on that resident's Care Plan, they may work with them on cleaning their room, doing laundry, attending Narcotics Anonymous meetings, participating in rehabilitation/recreational activities, etc.

ATMOSPHERE OF TRUST

The key to a Safe Haven promoting an atmosphere of trust is engagement. Engagement strategies start at outreach, and carry over into residency. With a sense of trust, clients and residents are more likely to try new ideas, to listen to encouraging words, to feel secure, to try medicine, and to start developing relationships with other people.

Starting with outreach, residents are able to make a connection with a familiar face. In some settings, outreach staff also work within the Safe Haven building, so there is already one identified staff person that the client has known for a period of time. Outreach staff can also provide valuable referrals because they are already linked to clients who are more likely to try Safe Haven if they are referred by someone they trust.

As stated previously, specific engagement strategies that work include:

- treating people with positive regard
- working with their perceived needs
- providing incentive items and services
- letting clients set the pace whenever possible, and
- communicating effectively

Active listening on the part of Safe Haven staff will also promote a sense of trust. This can be accomplished by listening to concerns, complaints, ideas, suggestions, and by encouraging residents one-on-one and in group discussions. Staff can foster trust by demonstrating values of honesty, respect, and fairness in all facets of interaction.

Staff will find that if they de-emphasize mental illness initially, never force medication, and include residents in decision-making about their medication (and start them on a low-dose strategy), clients will be more trustful. Mental health issues can be addressed slowly and gradually as a resident's insight into his or her mental illness increases.

Finally, by respecting clients' privacy and personal space, staff will be viewed as trustworthy. This includes respecting private mail and phone calls, knocking on doors, not entering without permission (unless there is concern or a case of emergency); not being overly intrusive, and by backing off when clients don't want to talk or engage.

RESIDENT ROLE IN DEVELOPING AND APPLYING PROGRAM RULES

Philosophy. Residents should be involved in rule development from helping to set and monitor rules to resolving some issues on their own. This reflects the Safe Haven values/mission: Safe Havens need to be flexible, adaptable to resident's changing needs, and open to programmatic improvement through change efforts. If something doesn't work or make sense, change it. Residents are asked to participate in the ongoing development and monitoring of rules. It facilitates their ownership of the rules and increases the likelihood of success. In several Safe Havens, residents propose tougher rules for themselves and for each other than those developed by the staff. Staff will

need to moderate discussions with residents and may need to advocate and hold firm to more liberal guidelines.

Monitoring mechanisms. These can include, but are not limited to: weekly residents' meetings; a house policy council; peer monitoring in which residents monitor each other and advocate for each other once they feel a sense of pride/ownership; a suggestion box; Care Plans; and individual discussions.

FACILITY DESIGN

The design of a facility can support effective monitoring of rules and create a safe environment.

Site selection. Many Safe Havens may not have the luxury of selecting their site -- either the location or the specific building -- and may encounter significant community-based obstacles in their efforts to do so. They may not be able to afford major renovations, or not be allowed to do them because they are in a lease rather than ownership situation. Many Safe Havens may need to make the building work for them either permanently or until renovation monies can be secured.

Safe Havens need to be flexible, adaptable to resident's changing needs, and open to programmatic improvement through change efforts.

Safe Haven Honolulu, located in an urban setting, is several blocks from downtown Honolulu's drug and prostitution activities. The location is excellent for engaging clients in the area, but the proximity to such a high drug area can be detrimental for them in the long run as they attempt to become clean and sober.

Safe Haven Honolulu is a three-story, historic building with 25 individual rooms on two residential floors. The main floor holds the screening room/case management office, reception area, dining and activity area, kitchen, and clinic. Office and storage space, a smoking lounge, and meeting area are located on the residential floors, main floor and basement. An additional two rooms are used for clients in need of one-on-one supervision or respite services.

SPECIFIC BUILDING ISSUES

Facility design should support compliance with rules. Some of the specific building issues that can support rule compliance include: front desk/monitoring, gender-separated quarters, a communications system, private space, and safety mechanisms.

Front desk/monitoring. When guests and clients first enter Safe Haven, they are warmly greeted at the front desk. Safe Havens with private rooms may consider having residents pick up their room key at the front desk and turn it in when they leave. Some clients, as part of their Care Plan, may need to empty their pockets or leave their bag at the front desk. Cigarettes and quarters for laundry may be distributed here.

The front desk should be staffed by trained residential personnel who can intervene when clients enter and leave. They may suggest that a client change soiled clothes or put on shoes. If a client needs encouragement to avoid dangerous activity, like drugs, prostitution, or socializing with known predators, the staff member may try to distract him or her with a card game or some other activity, or at least indicate the hope to see the client return.

Gender-separated floors. Some Safe Haven clients have difficulties with boundaries. Many female clients have been victimized by men and are afraid of them. Separating genders can help clients learn how to set boundaries.

A communication system. There should be a simple, reliable in-house communication system, particularly with a way to signal other staff when help is needed in a certain part of the building. Safe Haven Honolulu calls a "code one" over intercom speakers in the phones.

Private space. Private rooms are more desirable than shared rooms. At Safe Haven Honolulu, private rooms are an advantage for clients who are paranoid or have difficulty setting limits with others. They may also occasionally need to yell at their voices or perform certain rituals that make them feel safer, and they can do this in the privacy of their room. Private spaces should never be searched without the knowledge and participation of the residents.

Safety mechanisms. The following safety mechanisms should be considered when designing a Safe Haven facility.

- Limit building entry to one monitored area to ensure that those entering the building are clients.

- Room checks should occur at regular intervals. Safe Haven Honolulu residential staff knock on doors three times per day, at mealtimes. If the person does not answer, staff announce themselves and open the door.

- Residents are told upon move-in that staff will turn off lights or radios if a resident is out of his/her room.

- Buildings should be locked at nighttime. This is safer in some urban neighborhoods. Staff can use their keys and open the door for residents.

- Staff offices should be dispersed throughout the building. This is a passive way to monitor occasional unpredictable client behavior and helps staff blend in with residents.

- Depending on the acuity level of clients, some Safe Havens may consider using security mirrors, "hospital" door hinges, Plexiglas instead of glass and other safety devices. As this can be costly, changeover can occur as things are broken and are being replaced, or a few "safe" rooms may be set aside for clients who need them. Whenever possible, creative, homelike alternatives should be used, rather than bars. For example, a window box makes exiting through the window less compelling.

- The exterior of the building should fit in with the neighborhood. There should be places for clients to sit that are not directly in front of the building, to avoid giving neighbors the idea that the project is a "magnet." Many programs have an inviting atrium or lounge where clients can sit, as well as outdoor or indoor smoking areas.

OTHER DESIRABLE FEATURES

1. Qualified staff and non-hierarchical staffing. (i.e., a team-based approach).

2. Comprehensive staff training, such as, de-escalation, dual diagnosis, involuntary psychiatric evaluations, etc.

3. Staff support and/or clinical consultation in dealing with difficult clients.

4. On-call staff in case of medical/psychiatric emergencies.

5. Resident leaders.

6. Good relationship with neighbors.

7. Community presence.

8. An investment on the part of local business people, consumers, and service providers, such as an advisory council or board.

9. Collaboration between service providers: emergency shelters, mental health centers and agencies, and hospitals.

10. The involvement of consumers on an Advisory Council and on staff.

11. A broad spectrum of permanent supportive housing in the community.

12. A communicated sense that Safe Haven is a home rather than a shelter or institution.

SUMMARY

Safe Havens will need to have a set of house rules to promote resident and staff safety and a sense of expectation that will result in a smooth transition into permanent housing. Program rules can make or break the success of a Safe Haven. If rules are too strict, clients who have been chronically homeless and have a serious mental illness are unlikely to succeed. By presenting simple, positive rules and allowing for flexibility and a respectful response to infractions, staff can significantly help residents progress during their stay at Safe Haven.

Staffing Issues

CHAPTER 7

STAFFING ISSUES

BY SHARAN LONDON

The Safe Haven's low demand environment for residents can create a high demand and high stress environment for staff. Staff members have the challenge of maximizing benefits for the most difficult to engage homeless persons. This can lead to burnout – which can be prevented, or at least ameliorated, by focusing on staffing issues. Remembering and recognizing how far residents have come in the program helps staff focus on the positives and not be burdened with the negatives.

STAFFING PATTERNS

Staffing patterns vary at Safe Havens. They, of course, are influenced by the program's funding and any requirements the funding agency may have. A program design is also impacted by the available staff, their skills, and the division of responsibilities among staff members.

In Safe Havens, positions and staffing levels vary around the country. Some programs may have a program manager, case managers and case aides, while others combine job responsibilities so that all of the major elements of each position are covered. All staff act cooperatively, sharing information to maximize the benefit to the client.

Sharan London is the Executive Director of the Montgomery County Coalition for the Homeless, Inc. in Rockville, Maryland.

Program manager. The program manager or program director is usually responsible for the administrative functions associated with a Safe Haven. This person may be responsible for other programs within a larger organization or may be hired solely to run the Safe Haven. A program manager may not have the responsibility for the program's finances if the Safe Haven is managed by a larger organization that has overall fiduciary responsibility.

Program managers have administrative and programmatic oversight of the Safe Haven. They have operational, reporting, and staffing responsibilities – recruiting, hiring, supervising and terminating staff. A manager needs to have the ability to successfully carry out programmatic and administrative duties.

Case managers. An in-house case management staff can offer a program many benefits. A case aide can handle many of the daily activities, but the case manager is charged with the development and implementation of an ongoing treatment and transition plan for the Safe Haven resident. The case manager can interact with other agencies and service providers and act as the advocate for the clients as they attempt to negotiate the web of services. The case manager can be the resource specialist for entitlements, day programs, treatment alternatives and housing. In addition, they can act as the intermediary with psychiatrists or other mental health service providers, assist in filling prescriptions, and help clients with transportation to appointments. The on-site case manager can also help provide double coverage during the day, an important consideration when clients may need to be transported, when a crisis occurs, or when other staff are off-site.

Case aides. Staff charged with the everyday interaction with residents vary in background as well as title. Whether they are called case aides, shelter workers, residential assistants or community integration specialists, people in these line staff positions are the ones who oversee the activities of daily living in the Safe Haven. Some Safe Havens include these positions as well as extensive funding for case management. Where Safe Havens do not have on-site case managers, the role of the case aides is expanded, and the case aides act as advocates for the residents with outside agencies and perform some of the functions of a case manager. Many Safe Havens recognize that case aides have a very important role. Case aides regularly and con-

tinuously interact with residents and, therefore, often have the most intense relationships with them. Case aides often share meals with residents and help them with their medications. These kinds of activities provide opportunities in which residents are more likely to give feedback on the program. The level of intimacy that is created in that day-to-day living environment may lead to the development of the trust relationships that are so vital to the success of a Safe Haven. Also, case aides often lead house meetings that allow clients to address ongoing issues relating to the management and maintenance of the Safe Haven.

Case aides are also often responsible for the routine maintenance of the facility, including supervision of the cooking and cleaning. However, resources dictate how shopping and general maintenance are performed. Some programs rely heavily on donated meals that are prepared and delivered to the site. Other programs expect residents to cook for themselves or for the group. Some sites have the staff prepare meals for the entire population. Maintenance can be performed by contract, and the responsibility for making those contacts fall to either the program manager or the staff person on-site.

Staff coverage. All Safe Havens need to have 24-hour staff coverage, but programs have the liberty to adjust supplementary staff to specific needs. Most programs do not have double coverage, but many programs expressed an interest in increasing their available staff.

- In Maryland, the Montgomery County Coalition for the Homeless doubles staff coverage during day hours but not at night; Safe Haven Honolulu has double coverage on all shifts.

- In Morristown, New Jersey, the Morris Shelter has 24-hour coverage by one male and one female staff member – this arrangement helps protect the program from potential sexual harassment charges in a direct, but costly, way.

Safe Havens do not have a universal requirement that staff must remain awake overnight, but it is a common practice. Several facilities have live-in residential managers who are not required to stay awake overnight, but who are obligated to respond to any emergencies that may arise.

All Safe Haven staff members are expected to offer support to residents and should always be available to residents in distress. Sometimes, the mere presence of a staff person provides this service. No matter how casual the interaction with a resident is, each program manager, case manager, or residential assistant is responsible for modeling appropriate behavior. Opportunities regularly occur to respectfully educate residents about the activities of daily living.

STAFF BACKGROUND AND QUALIFICATIONS

A person's ability to understand and adapt to the Safe Haven philosophy is the paramount consideration during hiring. Most of the Safe Haven design is non-traditional, and the employee's open-mindedness and flexibility to adapt are often the greatest indications of his or her chances of success. For example, a social worker trained in a traditional academic setting, where the emphasis is on being proactive and causing change, may find it difficult to allow a Safe Haven resident time until he or she is ready to engage.

A similarity in values seems to provide the cohesion needed in a good staff and the supportive environment that leads to success for the residents. At the very least, the staff in the programs should reflect the ethnic, racial and sexual diversity of the population served by the Safe Haven. It is imperative that the manager successfully transmits the values and philosophy of the program and that all employees understand and implement those values.

The background, experiences and qualifications of persons filling program positions vary within each Safe Haven environment. Based on the staffing pattern, the responsibility of any of these positions may be expanded so most positions have an educational requirement of a bachelor's degree, such as in social work or psychology. This requirement may be seen as a way to assure a minimum level of understanding about mental health issues.

In some cases, however, an advanced degree may not be as important as experience in the delivery of human service and a personal value system that is in concert with the Safe Haven's philosophy. Many programs have successfully hired employees who are formerly homeless, in recovery, or consumers of mental health services. Consumers of mental health and addiction services, as well as formerly homeless persons, can increase the ability of the staff to relate to the clients because they "speak the same language" and may share experiences. However, before hiring, some length of "clean time" or period of recovery should be required to avoid stressing an employee and causing a situation that may lead to relapse. Also, those who do not have formal mental health education may need additional training, education and supervision. Finally, while it is important to hire consumers, it is just as important not to label them as "consumer staff."

The hiring process serves as a screening tool. It is during this time that an employer gets a sense of the applicant's value system, flexibility, adaptability, and other qualities. Dialogue with open-ended questions and asking the applicant to respond to "how would you handle this" scenarios are good ways to learn about how the applicant may react to the Safe Haven environment. Interviews tend to be stressful, so it may be helpful to allow the applicant to meet some clients in an informal setting. Also, it may be useful to ask a person to work on a temporary, hourly basis to assess his or her skills over a 60- to 90-day probationary period, allowing the employer time to evaluate an employee's abilities.

STAFF TRAINING

The unique qualities of the Safe Haven philosophy make staff training very important. Training serves the dual purpose of teaching staff to work with residents and making staff feel more secure in a Safe Haven environment.

Some Safe Haven-specific training elements are:
- Low-demand, high expectation approach
- Life on the street
- Stable, secure, highly supportive environment
- Portal of entry concept
- Continuum of Care
- Transition to permanent or permanent supportive housing

A Safe Haven operates outside the traditional psychiatric models. Accordingly, the process and outcome may differ from an employee's past experience. Staff

will be asked to operate and respond in a manner that may be unfamiliar to them. Staff needs to understand and envelop this philosophy. Residents are not medicated into compliance, so staff need to handle their feelings of not having total control. They also have to learn to redefine success for this population because, for Safe Haven residents, success may not be permanent housing right away.

Some mental health-specific training elements are:

- Recognizing signs of mental illness
- Suggestions for dealing with behaviors
- Medication usage and disposal
- Knowing medication names, expected outcomes, and side effects
- Signs of decompensation
- Techniques for de-escalating violence
- Dual diagnosis

Training on dual diagnosis is important because many residents of Safe Havens are dually diagnosed. For staff that approach their work from a recovery perspective, the training explains how a client's mental illness may preclude his or her participation in traditional support groups such as AA or NA.

Staff may be apprehensive in working with homeless people who come directly from life on the streets. Residents needed certain behaviors to cope while on the street, and the staff need to understand where the residents are coming from. Staff members that can recognize, handle, and diffuse crisis can increase safety for themselves and for clients.

Some training elements specifically for staff members dealing with life on the streets residents are:

- CPR and first aid
- Preventing disease transmission
- Intervention strategies and when it's appropriate to use them (see Chapter 5)
- Need for staff and client boundaries, how to set them, and how to ensure that they are respected

Resource manuals and training manuals are used in many Safe Havens to give staff clear directions to follow when problems may occur, which is especially important due to the low-demand nature of programs. They should know the steps to be followed when resolving problem behaviors or managing a crisis.

Employee manuals that explain personnel policies should be complemented by an operating manual that includes policies and procedures in the operation of the facility. Personnel policies should include protocol on client confidentiality, use of client funds, sexual harassment concerning clients and staff relationships, and for a drug-free workplace and an employee assistance program.

Staff also need to know about community resources. As information is compiled about various community programs, it should be presented to the staff as well. Staff should be able to access those resources or, at the very least, know where to find information.

STAFF SUPPORT AND SUPERVISION

Continuing support of staff is imperative. Staff meetings and case reviews should allow all staff to provide input and to see that their contribution is valued. Sharing information about experiences with clients gives staff the chance to see how residents are interacting with other staff, to see what techniques may be working best with each client, and to work as a team to develop expectations for that person. Sharing frustrations and brainstorming solutions allows staff to acknowledge the tensions of the job and potentially decrease burnout. Also, staff meetings are a great forum to recognize successes by clients as well as staff.

Remembering and recognizing how far people have come in the program helps the staff to focus on the positives and not be burdened with the negatives.

Individual meetings between staff and the supervisor allows the program manager to work with each employee. During weekly sessions, a staff member can raise issues and the supervisor can give feedback on his/her performance. These meetings also allow the supervisor to educate individual staff about the Safe Haven philosophy and its practical application.

Regularly scheduled meetings of all staff encourage employees to save noncritical issues for the weekly meeting, which can empower staff to resolve noncrisis issues on their own and keep the supervisor

out of the day-to-day conflicts. The program manager can use the time to provide additional education about psychiatric issues as well.

Program managers or directors may supervise the direct service staff, but it is imperative that they are also given this opportunity for supervision themselves. If program managers are not responsible to another more senior staff person in the Safe Haven or parent organization, it is important to build in this type of support. When no direct supervisor is available, it may be necessary to use mental health consultants, such as psychiatrists, to allow program managers the same support.

> **Program managers or directors may supervise the direct service staff, but it is imperative that they are also given this opportunity for supervision themselves.**

Managers have to continually work to minimize turnover and burnout by educating the staff about stress reduction. When staff members can achieve balance in and out of the workplace they are better able to function as employees. It is incumbent upon the manager to encourage and model that balance. This may require a greater number of leave days or flexible scheduling that acknowledges the extra hours often required of the positions. Appropriate use of compensatory time and responsible scheduling may also decrease burnout. Staff retreats and celebrations are important to continually energize the staff.

It is imperative to acknowledge the individual and collective contributions of all employees. Staff who have worked in the delivery of human services generally have some idea of the scope of their responsibility and the level of intensity. For employees who are in recovery, it may be useful to make attendance at meetings part of their job duties. The on-call nature of positions needs to be clarified to allow employees to take leave time when needed and it is important that awake time is compensated in facilities where overnight staff sleep, but can be awakened in the middle of the night.

OTHER CONSIDERATIONS

Outreach staff. Outreach is an essential component of Safe Havens because the program serves homeless persons living on the streets. In cases where the Safe Haven provides community outreach, staffing patterns have to reflect the need for someone on the streets. This function can be performed by existing staff with accommodations made for the need to be out of the facility during certain hours. Again, the performance of this role is often a function of the funding and other resources available within a community. For example, if a community has a well-established outreach mechanism, it may not be to the advantage of the Safe Haven to employ someone solely for that purpose. Using existing resources has the additional benefit of fostering cooperative arrangements with other service providers.

Consultants. Some Safe Havens grants include clauses concerning the use of outside consultants for supportive services. The use of consultants ranges from the provision of somatic medical care, psychiatric coverage for medication monitoring, consultations and group and individual therapy, case management services, vocational training and counseling, psychiatric rehabilitation services and job placement and coaching. Consultants can be utilized as funds become available and when the services to be provided are not considered for full-time employees. If funds were available, it is possible to incorporate some of these consulting positions into regular staffing patterns.

Volunteers. Volunteers are used in varying degrees within existing programs. While the use of volunteers instead of staff is not recommended, they can be used to supplement staff. Volunteers can help provide transportation, food, or clerical support. Volunteer boards are important for fund raising and community relations. The support of local communities, congregations or service organizations often eases the establishment of a Safe Haven. Volunteers with experience in the mental health field can provide much needed services that would not otherwise be available.

Students. Student interns are another potential source of additional coverage. The facility may be located near a school with a graduate program in either psychology or social work where students are often required to intern. Without having to pay even a stipend, the program has access to an additional

employee. Similarly, programs such as AmeriCorps or church-sponsored volunteer programs can be a good resource for staff at a reduced rate.

Space. Many Safe Havens are located in existing facilities, and changing the interior design may not be feasible. Safe Havens should assure handicap access to facilities. Many program directors recognized the need for private office space that can be locked – allowing for the storage of medication and confidential files and for a private meeting space. Private space is especially important because programs often maintain logs on clients and may be trying to secure services that require discussing private and confidential client information. One facility accommodates not just the Safe Haven administrative staff, but also the parent organization staff. This sharing of space provides additional staff for coverage, if needed, and gives clients an opportunity to interact with other community members.

Facility. The facility does not have to have a staff kitchen or bedroom, but at a minimum should include space for staff to store personal belongings that are needed for job performance. Unless the program employs residential managers who expect their own room in exchange for salary, a private bedroom does not seem reasonable. Most programs indicated that their overnight staff does not sleep anyway and the presence of a bed may be too enticing. If sleeping is allowed, a pull-out sofa can be used as an office furnishing and can provide a place for staff to rest or sleep.

The staffing patterns and physical space of existing Safe Havens are as varied as the locations. What may be considered exemplary staffing patterns and practices for one site may not be realistic for another. The Safe Havens philosophy is the common thread among all of the programs and should be referred to by all programs when deciding how to handle these issues.

Transitions From Safe Havens

CHAPTER

TRANSITIONS FROM SAFE HAVENS

BY ANDREA WHITE, CHRIS KIRK, AND SUZANNE WAGNER

Safe Havens offer a residence to people with mental illness who have been unwilling or unable to participate in other housing and services. The initial goal of the Safe Haven is to engage residents in living in the Safe Haven; the ultimate goal is to facilitate access to permanent housing.

Safe Havens must hold these two goals in balance. The engagement process, service program, policies and procedures, staffing patterns, and building design must be developed with both goals in mind. This chapter describes an approach to facilitate the transition of hard-to-engage homeless people with serious and persistent mental illness who are living in Safe Havens to other housing settings. Examples have been drawn from Safe Havens operating in Philadelphia, Chicago, Honolulu, New York, and Burlington, Vermont.

THE LOW DEMAND MODEL AND TRANSITIONS

Low demand does not mean low expectations. The resident has a choice to engage and, therefore, the low demand model promotes a resident sense of autonomy, responsibility, and perception of himself or herself as having control over and being able to take action to positively influence his or her life.

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The involvement of the residents is critical in empowering them to exert control over the process of accessing housing. The length of stay at the Safe Haven is determined by the time it takes for each individual to complete the tasks necessary to access housing. There is no predetermined, standard time frame. For a successful transition, residents must have sufficient time to complete the tasks, develop the skills, and achieve the confidence necessary to move out of the Safe Haven.

DEVELOPING LINKAGES

The ultimate goal of Safe Havens is to transition residents to the next stage of housing and all actions must be designed to achieve this goal. Programs need to ask two questions: (1) Where will Safe Haven residents move? (2) How can the program facilitate the transition?

> In Philadelphia, Project H.O.M.E.'s Safe Haven regularly uses the sponsor organization's own supportive housing, as well as a range of other community options including Department of Veteran Affairs' sites, subsidized housing, other organizations' supportive housing, and some market rate housing.

An important first step for a Safe Haven is to establish linkages with other providers in the local Continuum of Care. Some communities, particularly large urban areas, may have a well-developed stock of supportive housing that includes a range of models serving a variety of needs. Smaller communities may need to rely on creative alternatives, such as developing relationships with for-profit landlords and developing their own supportive housing that meets the needs of their clientele. No matter how extensive or limited the local Continuum of Care, it is critical to identify and/or develop long-term and more permanent housing options for Safe Haven residents as the Safe Haven is being designed.

> Safe Haven Honolulu is overcoming limited housing options in its community. Existing mental health housing is "high demand" and often unappealing to Safe Haven residents. Boarding homes are not safe. The Continuum of Care in Hawaii is still in development.

As an immediate alternative, the program is locating private landlords who will rent apartments that people can share and afford. Safe Haven Honolulu staff provide on-going support and case management to the residents once they are in these apartments. The program has also started a consortium of service providers to advocate for more housing options, particularly for people with co-occurring substance abuse disorders and those with medical needs.

CREATING A CULTURE OF TRANSITION

Safe Havens strive to create a culture that supports movement into more permanent housing. The establishment of such a culture depends upon the clear definition, communication, and regular reinforcement of the goal of obtaining permanent housing. As soon as it is reasonable in this low-demand model, residents entering the Safe Haven for the first time should learn about the goal and be told that staff will assist them to move toward it at their own pace. This establishes clear expectations for the staff and program. For a successful transition, each group, case management service and activity should promote the resident's ability to obtain and maintain permanent housing.

Safe Havens strive to create a culture that supports movement into more permanent housing.

For example, discussions in a cooking class can focus on the menu planning and meal preparation skills residents will need when they have their own homes. A conflict between two residents can provide an opportunity to highlight and teach conflict resolution skills that residents will be able to use when they move on.

A culture that supports transition is also facilitated by building a system of rewards. Safe Havens can host public celebrations for residents who are moving into a new home and present a "move-in package" of personal items or household items for the new setting. Additional public acknowledgment can occur in groups or community meetings. Former residents who are successful in their new homes can be invited back to describe their experiences.

THE INDIVIDUAL HOUSING PLAN

Once a resident is aware of the available housing options, he/she can begin to develop an individualized housing plan. An assessment tool – which indexes the resident's stability, medical status, daily and community living skills, motivation to obtain housing, substance use, entitlement status and housing history – is useful. The assessment tool captures the resident's current level of readiness and indicates areas where additional skills are needed for the resident to be successful in a permanent supportive housing setting. This tool may also be used throughout to reflect the strengths and skills Safe Haven residents have developed that will serve them in accessing and maintaining a permanent living situation. (See Appendix A for more information.)

Having identified these skills and resources, the Safe Haven then must provide the residents with the opportunity to build and practice these skills and/or obtain additional resources. The program design must include these services: entitlement assistance, money/medication management, assistance in reducing and/or managing the symptoms of mental illness, training in the skills of daily living, training in interpersonal skills and conflict resolution, and substance abuse services.

Entitlements advocacy and budgeting skills are two services identified as crucial by the Safe Havens we interviewed. Having enough money to meet

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The Safe Haven design must include these services:

- Entitlement assistance

- Money/medication management

- Assistance in reducing and/or managing the symptoms of mental illness

- Training in the skills of daily living

- Training in interpersonal skills and conflict resolution

- Substance abuse services

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basic living expenses helps people feel more secure and enables them to see housing as a real possibility. Also, obviously, without some form of income, the resident will not be able to pay rent in the new housing setting. Establishing a savings account while in the Safe Haven enables a resident to start budgeting and planning for a new home and the furnishings he/she will want and need.

In developing individual housing plans, providers take into consideration the resident's housing preferences in regard to neighborhood, level of supervision, need for privacy etc. (See Appendix B for "Housing Preference Questions for Residents.") Exploring the resident's housing preferences is critical. It sends the message that the staff member sees the process and decision-making around the housing choice as mutual. It also provides residents with the opportunity to feel a sense of power and control over their lives and provides valuable information about their expectations. Then the staff member can narrow the housing search efforts to conform to the resident's stated preferences and can work with the resident to clarify his/her preferences.

In developing the plan, the staff member also should explore the resident's housing history and try to identify and raise awareness about any patterns between housing choice and homelessness. For example, a person might have become homeless because she did not take her medication and stopped paying her rent. This can indicate to the staff member and resident that a setting with medication supervision may be more helpful. It is also useful to identify components of the Safe Haven that have worked well for the resident. Has the resident enjoyed the opportunities for socialization, participated and learned from groups, and taken advantage of the meals that have been provided? If so, it is likely that the resident will continue to benefit from a setting that provides similar services.

A HOUSING GROUP

Central to the process of assisting residents to transition to permanent housing is providing information to residents about the various housing models. One of the most effective methods is a Housing Group, which provides a regular public forum to engage Safe Haven residents in the discussion about housing. It also creates an opportunity for residents to motivate and educate one another. A group can facilitate

the process of peer support, as residents are often more amenable to information and suggestions from peers than they are from staff. Sometimes residents will even question each other's housing choice and stimulate thinking about the realities of these choices. However, as some residents are not comfortable in groups, some of this education will need to be done individually.

> Curriculum for the Center for Urban Community Services, Transitional Living Community's weekly housing group includes: a presentation of one housing model per session detailing level of privacy, services offered, level of supervision, house rules, expectations of tenants, etc.; the displaying of photographs of actual residences where residents could move; tours of different housing options; preparation for and practicing the housing interview; budgeting workshops to help residents plan and save for needed furniture and other household items; and discussions with former residents who have made a successful transition

Housing Focused on Transition

The physical design of the Safe Haven can be used to support residents' ability to achieve the goal of accessing housing. A clean, safe and well-designed Safe Haven can provide a powerful incentive to seek permanent housing. Living in such a setting raises residents' expectations for what is possible in permanent housing. Taking time with the design shows respect for the residents, who will then be more likely to believe that safe decent housing is a possibility. Safe Havens, which avoid an institutional feel in design and decoration and provide a more home-like setting, will be more appealing to residents. Involving residents in decorating the facility can prepare them for moving into and decorating their own homes, as well as empowering residents to think of the Safe Haven as their temporary home.

Since safety is a factor influencing whether people are willing to enter a Safe Haven, as well as one of the barriers people often identify about permanent housing, the Safe Haven must be vigilant in creating and enforcing safety and security standards that prevent hazardous conditions and prevent and contain psychiatric, medical and other emergencies which threaten the safety of the residents. For a more in-depth discussion of this point, please refer to Chapter 7 -- Program Rules and Expectations.

OVERCOMING OBSTACLES TO THE TRANSITION

In helping people to access housing, numerous obstacles may need to be overcome. Service providers must be aware of possible obstacles, and the Safe Haven's activities must be designed to surmount them. Obstacles include the lack of affordable, safe housing and housing models for people with special needs. A major obstacle may be a resident's ineligibility for entitlements due to immigration status, diagnosis (such as a person with a primary diagnosis of substance abuse is no longer eligible to receive Supplemental Security Income benefits), or because government assistance has been cut or eliminated.

> **THE FIVE KEYS TO MAKING SUCCESSFUL TRANSITIONS:**
>
> 1. Identify affordable housing
>
> 2. Understand housing needs
>
> 3. Develop trust
>
> 4. Match the resident with a housing option
>
> 5. Address psychiatric stability

1. Identify affordable housing. Some barriers can only be overcome through the creation of housing that is more flexible and caters to the needs of Safe Haven residents. Several Safe Havens are themselves helping to create more housing options. The strategy used by Safe Haven Honolulu -- joining with other providers to advocate for more housing -- has proven effective. Coalitions of providers are more likely to be heard than an individual agency advocating alone. Safe Haven providers can contribute up-to-date, firsthand knowledge of the housing needs of homeless people with mental illness and important gaps in the continuum of care. This information makes Safe Haven an invaluable and critical resource for planning and collaboration.

2. Understand housing needs. Miscommunication between a staff member and resident over housing needs occurs frequently. It is common for residents who are unfamiliar with the process of accessing permanent housing to refuse to consider any other option than residing in their own apartment. This kind of statement by a resident should be explored by the staff member to better understand its meaning. The staff member can ask the resident to articulate what the type of housing he prefers symbolizes to him. For example, a resident who wants his own apartment may see this choice as evidence that he is getting better and is no longer in need of psychiatric or supportive services. Another resident might not feel comfortable around other people and needs private space with a door that can be locked. By exploring the meaning of the housing preference, the staff member can determine how best to assist the resident to meet subsequent housing needs.

> It is most important that the worker and program allow residents time to build trust and to feel safe in the relationship.

For many Safe Haven residents, issues of freedom are paramount in their housing preferences. Staff members should help these residents to find settings that accommodates these preferences. Again, it is critical that staff explore exactly what "freedom" means to each resident. Is it freedom to come and go as one pleases? Is it the freedom not to have to attend a day program? Once staff understand the meaning of freedom to the individual, settings that accommodate these needs can be sought. In some cases, the resident may be more willing to consider a supportive residence if he sees it as an intermediate step toward a more independent living situation.

The staff member will want to link the proposed option to the resident's aspirations. For example, if a resident has expressed a desire to find part-time work, the staff member might point out the advantage of living in a residence that has vocational training and/or some type of employment program. A preference for a housing option that requires a great deal of independence also presents an opportunity to help the resident see the need to improve skills. For example, if a resident who wants to live in a particular residence has poor hygiene and lice, she might be motivated to bathe and delouse to gain access to the housing.

3. Develop trust. Another frequent obstacle is a lack of trust in the staff member or in the Safe Haven itself. It takes time for people to share personal information with others, and it can be a particularly lengthy process with people who may be guarded because of mental illness or because they have had negative experiences when they have trusted service providers in the past. It is most important that the worker and program allow residents time to build trust and to feel safe in the relationship. The most effective means of overcoming this obstacle is to make consistent, regular outreach efforts while allowing residents to control the length and content of the interactions.

It may be necessary for program staff to spend long periods of time with some residents engaging in non-threatening activities, such as watching television or eating together so that they can begin to tolerate the staff member's presence. Staff members can also look for opportunities to respond to the residents' needs for clothing, food, or physical comfort. The staff member should always follow-up on tasks they have undertaken to build the resident's trust. Finally, staff should also learn about the residents' interests and draw them into discussion around these topics.

4. Match the resident with a housing option. Active substance abuse can be a particularly difficult obstacle. Most housing providers require that applicants have a period of documented abstinence before allowing them to move into the residence. Safe Haven staff can address substance abuse by exploring with the resident what he is gaining from use. People with mental illness use substances for a variety of reasons that include the need to medicate their psychoses or secondary symptoms, the desire to feel normal, and the increased ability to socialize. Having identified the adaptive functions of the drug, the staff member can help the resident to find less destructive replacements. These might include a medication change or new socialization opportunities.

Simultaneously, staff must also elicit any negative consequences the resident may be experiencing as a result of the drug use. Again, there is a wide range of possible consequences. It is critical that the staff member understand the consequences that are meaningful to the resident. For example, a resident may not like it that she cannot access her preferred housing option because she smokes marijuana. Another resident may dislike being sick with a hangover every morning. Staff should help residents to explore any negative consequences in a nonjudgmental and nonconfrontational manner, so that the residents do not feel so threatened that they cut themselves off from the staff.

Residents can feel much more secure about moving if they know they will continue to have contact with the Safe Haven.

Some housing options may not require total abstinence from alcohol and other drugs, but consequences of use that may interfere with meeting tenancy obligations will need to be addressed. We have found two theories to be especially useful in negotiating this barrier: Prochaska and DiClemente's Stages of Change[1] and Miller and Rollnick's Motivational Interviewing[2]. The first provides a schema for assessing resident's readiness to change problem behavior and suggests interventions that are effective at each stage. For example, if a resident is unwilling even to discuss any negative consequences of substance use, it is of little use to give them a list of AA meetings in the area. It might be more effective to point out that the resident has been coughing a lot or seems tired all the time. This may raise awareness of the negative consequences of the use and could increase motivation for change. Miller and Rollnick provide specific tools to help motivate residents to address problems particularly when they are ambivalent about change.

5. Address psychiatric ability. Active psychoses in a resident can also delay the transition. Currently, most of the debilitating psychotic symptoms that would make it impossible for a person to live in supportive housing can be managed with appropriate medication. The task is to help the resident to see *a need* to take medication and then to adhere to a prescribed medication regime.

A resident who is so severely psychotic that he is in danger of hurting himself or others may need to be hospitalized. A hospitalization often presents an opportunity to stabilize a person on medication and to possibly house them directly upon discharge. For less psychotic residents, staff will need to rely on engagement practices and form a relationship with the resident that can provide the context for discussing the need for medication and other treatment.

In helping a resident to accept psychiatric treatment, the staff member will need to destigmatize and normalize the mental illness; have frank and ongoing discussions about the resident's illness to heighten awareness about it; explore the resident's fears, feelings and history of treatment; and help the resident to connect her goals and/or other needs to obtaining psychiatric treatment. The staff member may also act as a liaison between the psychiatrist and resident by accompanying her to the clinic, encouraging her to talk to the psychiatrist about the benefits and side effects of the medication, interpreting the psychiatrist's instructions, closely monitoring the resident's reactions and responses to the medication, and by helping the resident to advocate for any needed changes. The staff member will also want to help the resident to identify any positive changes related to the medication. People do not have to be symptom-free to live in supportive housing. The focus should be on reducing or eliminating those symptoms that interfere with the person's ability to access and maintain housing.

SUPPORT THROUGH THE TRANSITION

The successful placement of residents from the Safe Haven to permanent housing requires that the program provide support to residents through the transition period. Stress management groups and other strategies to help residents manage anxiety about change can be used. Staff should also anticipate that some residents will have fears about failing. Staff can provide opportunities for residents to discuss these fears, offer assistance and strategies to manage these feelings, and help residents to develop a plan to get support once they are in the new setting. For many residents, knowing they have the option to return to the Safe Haven if the new setting does not work helps to relieve anxiety. Additionally, "failures" can be re-framed as learning opportunities that will help residents learn more about their housing needs and preferences.

Staff also need to be alert to the process of termination and anticipate feelings, such as sadness and anger, in the face of transition. The staff member's task is to help the resident talk about their grief over leaving the staff, friends or community to which they have become attached. It is important for residents to give voice to their fears about moving from a setting in which they have felt safe and "at home," to an unknown setting where everything and everyone may be new.

Additionally, tangible supports that can be put in place to assist a resident in the transition include touring the new neighborhood to learn where to shop, identifying goals that continue after moving into housing and providing follow-up support for a period after the individual has left the Safe Haven. Residents can feel much more secure about moving if they know they will continue to have contact with the Safe Haven.

Safe Havens have developed a variety of mechanisms to follow up with residents who have made the transition. Programs differ depending on available staff and where people move. Follow-up can be an informal process in which the former residents visit the Safe Haven for support and help, as in the Project H.O.M.E. Safe Haven. In the model developed by The Howard Center for Human Services residents are linked with case managers from a community-based agency as soon as they arrive at the Safe Haven. This case manager continues to work with them after they transition. Staff from Safe Haven Honolulu visit residents in their new homes once they have moved and provide ongoing case management services.

Residents will almost surely experience some anxiety over making the transition to permanent housing. They may fear of losing what they have gained in the Safe Haven and what they will encounter in a new setting. The resident may need time and opportunity to grieve the loss of relationships and sense of safety they have gained in the Safe Haven. They will also need to discuss any specific fears they have of the new setting, so that staff and peers can help to problem-solve about how to manage them. The continual focus on housing as the goal of the Safe Haven will mitigate some of this anxiety as the residents are continually reminded that the Safe Haven is a means to an end and the focus is on planning for the future. Additionally, it is helpful for residents to focus on the skills and strengths they have developed in the Safe Haven and to identify how these skills and strengths will assist them in managing the transition into their new living situation.

> . . . the Safe Haven is a means to an end and the focus is on planning for the future.

The paradox of an effective Safe Haven is also its greatest strength: In creating a warm, accepting, engaging environment where residents feel respected and secure, the Safe Haven will be creating an environment that residents will not want to leave. Without such an environment, however, residents cannot gain a sense that safe, secure housing is possible. That is, they must experience it to know that it is real and that they are entitled to it. A resident we knew once said that she would miss everyone when she moved, but that being a part of something there made her believe she could be part of something again. She said she was not scared to move, but was able to see this as a good thing. She believed she would be an asset to her new home, and so did we.

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Appendices

Appendix A

Areas of Assessment
for Housing Placement

This assessment is adapted from documents used by the Center for Urban Community Services in New York.

I.   PSYCHIATRIC FUNCTIONING

- Current mental status:

- History of high-risk behaviors:

- Treatment attitudes and understanding of illness:

- History of hospitalizations:

- Judgment, impulse control, memory and concentration:

- History of treatment and use of psychotropic medications:

II.   MEDICAL STATUS

- Unmanaged, undiagnosed, or contagious illness:

- How independent is applicant in obtaining medical help?

- Special needs, for example, diet, medication:

- HIV status:

III.   ACTIVITIES OF DAILY LIVING SKILLS

- Ability and motivation to improve skills:

- Hygiene, housekeeping and cleaning one's living space:

- Shopping, cooking and maintaining a proper diet:

- Budgeting and prioritizing needs and activities:

- Household knowledge and safety:

IV. COMMUNITY LIVING SKILLS

- Communicating or interacting in public:

- Accessing other systems/keeping appointments: IM, MH, SS:

- Traveling, banking, using the post office, library and other community services:

- Discriminating danger/asserting and protecting oneself:

V. MOTIVATION TO OBTAIN HOUSING

- Applicant's current living situation:

- Feelings and fears that affect motivation:

- Attitude and behavior toward and throughout the placement process:

VI. SUBSTANCE USE/ABUSE

- Signs and symptoms of current use:

- Consequences of use:

- History of use:

- History of treatment:

- Applicant's assessment of the impact of substance use on his/her life:

VII. ENTITLEMENT STATUS

- Current Status:

- Barriers to obtaining entitlements:

VIII. SOCIAL SKILLS AND NEEDS

- Need or desire for interaction with family, friends and partners:

- Privacy Needs:

- Level of comfort in groups, both formal and informal:

- Does the applicant's belief system or behavior affect social functioning?

IX. HOUSING HISTORY AND PATTERNS

- Causes of homelessness:

- Long-term institutionalization (e.g., hospital, shelter):

- Unserviced housing:

- Serviced or supportive housing:

- Family or significant others:

X. APPLICANT PREFERENCES

APPENDIX B
HOUSING PREFERENCE QUESTIONS
FOR APPLICANTS

These descriptors can guide discussion with applicants of special housing preferences and needs when filling out the accompanying worksheet. This list of descriptors is adapted from documents used by the Center for Urban Community Services in New York.

I.   NUMBER OF ROOMMATES

- Would you share an apartment if you had your own room?
- Do you like having some company where you live?
- Have you lived by yourself before?
- Do you get lonely?

II.   MEALS PROVIDED/COOKING FACILITIES

- Would you prefer having your own kitchen? Shared kitchen? Cafeteria?
- Do you like to cook? How often -- every day, three times a day?
- Do you mind cleaning up after cooking?

III.   LAUNDRY/LINENS PROVIDED/CLEAN OWN ROOM

- Would you like to have help with some of these responsibilities?

IV.   SHARED/OWN BATHROOM

- Is a shared bathroom in the hall acceptable?
- Would a bathroom shared only with one or two other people be alright?

V.   LOCATION

- Neighborhood, borough?
- What features are important (such as shopping, libraries, transportation, well-lit areas, etc.?)

VI.   CURFEWS

- How do you feel about these policies?
- Does it make you feel safer to know the door is locked as night?

VII.   VISITOR POLICY

- Do you want to have overnight guests? How often?
- How do you feel about having your guests screened?
- Do you like knowing that other people's guests are screened?

VIII.   PETS

- Do you currently have a pet that you wish to keep?

IX.   LEVEL OF SAFETY/SECURITY

- What is important to you?
- Will you be going out a lot?
- Will you be going out on your own or with roommates or friends?

X.   SOCIAL SERVICE STAFF ON SITE

- Do you like having someone to talk to or be available any time of the day or night?
- Would you like to live in a place that has no staff on site and have staff visit you instead?

XI.   SOBRIETY

- How do you feel about being in a setting where people may be using drugs or alcohol?
- Is a community that strongly supports sobriety important to you?

XII.   GROUPS/DAY PROGRAM

- Would you like to have access to in-house groups?
- How do you feel about mandatory attendance at groups?
- Do you like the idea of having staff sponsored activities, like trips and movies?

XIII.   MONEY MANAGEMENT

- Would you like to have help safekeeping or managing your finances?

XIV.   MIX OF PEOPLE IN FACILITY

- Do you prefer living with all women (or men), or younger people, etc?
- Would you like to live with different people than you do now?

APPLICANT'S HOUSING PREFERENCES WORKSHEET

Use this worksheet to help develop your strategy for housing by clarifying goals and acceptable options. List relevant issues in a column under each heading.

Name: _____   Date: _____

Where I am now:
(ex. Share bath w/ 40 people)

What I really want:
(ex. Private bath w/ tub)

What I would accept:
(ex. Share bath w/ 2 or 3 people)

FOR MORE INFORMATION

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