Introduction

Swiftly packing together bundles of newly-laundered linen for shipment to a nearby hotel, Samantha is a model of efficiency and purpose.[1] Seeing the energy with which she manages Lamp Community's large industrial laundry, cheerfully singing to herself while scheduling the day's deliveries, it's hard to imagine the person she describes of four years ago. "I was trouble back then," she says of her years on the streets. "And it took a long time for me to see that. I mean, even when I started working here, I messed up *a lot.*"

Samantha's transformation began slowly, when she started hanging out at the Day Center operated by Lamp Community, a nonprofit organization that offers a comprehensive array of supportive housing and service options to people living with mental illness in Los Angeles' Skid Row neighborhood. Mentally ill, illiterate and prostituting herself to sustain her crack addiction, Samantha's previous efforts to change her life had ended abruptly in failure. Sometimes her disruptive (and often psychotic) behavior won her a quick exit from substance abuse treatment programs or faith-based missions. Other times, her own fear of "not measuring up" to the demands of service providers led her to sabotage any chances for improving her life.

At Lamp Community, however, Samantha finally found people willing to accept her for who she was. "They didn't judge me," she remembers, "I was a wreck, but they made me feel like a human being for the first time in a long while." Staff at Lamp Community didn't make any demands on Samantha the first few weeks she was there. They just listened to her tell them what *she* thought she needed to do. They provided a lot of support, some positive reinforcement and let her know about the bevy of service options they offered. After a couple of false starts, Samantha began to address her mental illness with medication. Slowly, she reduced the frequency of her crack binges. After a few months, she began working occasionally at one of Lamp Community's businesses. All of these businesses (and many of Lamp Community's program positions) are staffed by the organization's program participants, who are known as "members."

Lamp Community was able to help her achieve this where other service providers could not by employing an innovative service approach that permeates every program in the organization. Lamp Community members and staff refer to it simply as "The Community Model."

The Community Model is a comprehensive method of service provision that has helped thousands of homeless people with mental illness achieve residential stability and an improved quality of life. Employing harm reduction service strategies in a safe, flexible and non-hierarchical environment, the Community Model allows people to tailor their own paths to recovery and wellbeing.

[1] Some names have been changed to protect members' privacy.

The Community Model has proven particularly effective at serving dually-diagnosed individuals and other members of the vulnerable and difficult-to-engage chronically homeless population. A prototype for the federal "Safe Havens" program, the Community Model's success also helped shape the federal government's recent "Collaborative Grant to Help End Chronic Homelessness" initiative. Over the years, the Community Model has been adapted and replicated by other nonprofit providers, most recently by the OPCC (formerly Ocean Park Community Center) network of shelters and services in nearby Santa Monica.

Samantha now knows this history well. She's the first to say that the service philosophy of the Community Model made it possible for her to become a full-time manager of Lamp's laundry service, with a salary that allows her to have an apartment of her own in South L.A. And like most longtime members of Lamp Community, she's become invested not only in her own success, but in the success of her peers and the larger community around her. It's the secret of Lamp Community's effectiveness. "I'm where I am today because a lot of people stood behind me and said I could do it. Now, I try to do the same thing for others who need that kind of helping hand."

1. History of the Manual

In 2001, The California Endowment launched a three-year, $24 million initiative to gain greater understanding of the barriers that limit access to effective mental health services and find ways to break through those barriers. In response, Shelter Partnership, Inc., in collaboration with Lamp Community, OPCC, and the RAND Corporation, developed a proposal to showcase one of the most successful and imaginative approaches to engaging homeless persons with mental illness in the nation, the Community Model, developed by Lamp Community in Los Angeles over the past two decades. The proposal was one of 46 grants awarded statewide by The California Endowment that year.

The resulting collaborative established many goals, including the replication of the Community Model through the establishment of a Safe Haven for chronically homeless and disabled people in Santa Monica. Another primary aim of the grant was the wide dissemination of information on the model's components and characteristics. To achieve this, the collaborative set out to demonstrate to other innovative Southern California mental health and homeless service organizations how to implement this model in their own communities. This manual is one of the primary components of the training and education portion of the grant.

The manual attempts to explain the philosophy and structure of the Community Model to demonstrate how it engages chronically homeless persons with mental illness more effectively than more traditional mental health and housing programs. It also embodies the lessons learned from the collaborative's experiences during the last three years in adapting and using this model in a suburban community on the west side of Los Angeles.

2. Using This Manual

This manual is intended to assist service providers and policymakers to incorporate the Community Model approach into their programs for chronically homeless people. It complements the Community Model Training Institutes that the collaboration hopes to continue to offer on a periodic basis. It is hoped that the manual will be useful both as a book read from start to finish, as well as a reference guide on specific issues regarding services to homeless people with mental illness.

The content of the manual is based upon observations, interviews, focus groups and surveys with the staff and members of Lamp Community and OPCC, as well as Safe Haven providers across the nation. The manual is organized into five sections, with appendices:

- ***Introduction:*** *How to use this manual, questions and answers concerning the Community Model, and a brief history of its implementation.*
- ***Part One:*** *An overview of the principles underlying harm reduction and community, and a review of the characteristics of the Community Model.*
- ***Part Two:*** *A review of the service and housing components of the Community Model and issues specific to their operation and staffing.*
- ***Part Three:*** *"How to Build Community," a detailed discussion of strategies to incorporate the Community Model philosophy into housing and service delivery.*
- ***Part Four:*** *An overview of the Community Model's strategies to expand employment opportunities for members.*
- ***Part Five:*** *Concrete issues related to developing a Community Model program, including siting, physical configuration of program space and funding resources.*
- ***Appendices:*** *Listings of resources for training, technical assistance and funding, as well as a detailed narrative describing the establishment of a Safe Haven program in Santa Monica, California.*

3. "What is the Community Model?" and Other Questions

What is the Community Model?
The Community Model is *both* an overarching service philosophy of **harm reduction** and **community-building** *and* a comprehensive menu of specific **housing, service and support components:**

- **Harm Reduction:** The Community Model's service philosophy is rooted in the principles of "harm reduction," a set of practical intervention strategies that reduce the negative consequences of drug use and mental illness. Rather than focusing solely on stopping the use of drugs and alcohol, harm reduction emphasizes improving an individual's quality of life, health and wellbeing. By offering addicted persons the option of first adopting methods of *safer use* and *managed use* before attempting complete *abstinence*, harm reduction often reaches people who have not responded to other treatment approaches.

- **Community Building:** In keeping with the tenets of harm reduction, the Community Model services are always offered on a voluntary basis. This non-coercive service philosophy is bolstered by an equal emphasis on building "community." Individuals are encouraged to explore their strengths and see how they can contribute to a larger community. By providing a safe, non-judgmental and loosely-structured environment, the Community Model empowers people to support each other as they improve their health and life conditions.

- **Housing, Service and Support Components:** The Community Model's commitment to empowering the individuals it serves determines not only *how* services are provided but also *which* service components are essential to the overall success of the program. Program components are there to facilitate accessibility, stability and personal development, including:
    - **Accessibility:** Outreach and drop-in components, along with informal socialization opportunities (dining, safe areas to gather), ensure that services are readily accessible to all.
    - **Stability:** An array of temporary, transitional and permanent housing options provide residential stability. Offering a wide range of places and ways to live is crucial to reaching as many people in need as possible.
    - **Personal Development:** Case management advocacy, support groups, employment opportunities and other supports enable individuals to help themselves grow as members of a larger community.

Who is served by the Community Model?
The Community Model is designed to serve homeless single adults with mental illness. The voluntary nature of services has made the Community Model especially effective at reaching dually-diagnosed persons, chronically homeless people and other individuals with special needs who have not been successfully engaged by other programs. The

Community Model has *not* been used to serve homeless families and offers only basic referral services to homeless people without severe and persistent mental illnesses.

What are the goals of the Community Model?
The primary goal of the Community Model is to improve the residential stability of homeless people. Quite simply, it *ends* people's homelessness, without imposing overly restrictive requirements on behavior and program participation. The Community Model achieves this by creating a lifelong community where people can improve their health and general wellbeing in a variety of residential settings.

For some, achieving residential stability may mean fully independent living in a private apartment. But for many of the formerly homeless, dually-diagnosed individuals served by the Community Model, this may be an unrealistic objective. Others need living options that offer more structure and support. Some Community Model "members" (program participants) choose to live in a respite shelter of congregate sleeping alcoves or shared single room occupancy (SRO) units; others reside in "transitional" housing of semi-private cubicles. Many maintain permanent efficiency apartments in "independent housing" supported by on-site services. All housing options provide varying levels of supportive services and allow residents to remain as long as they choose.

By focusing first on providing a homeless person with mental illness a safe, stable and tolerant place to live, the Community Model answers that person's most urgent need, housing (as it would most likely be articulated by the homeless individual). Once individuals are confident that their immediate crises have been resolved, they are more able (and likely) to work on other aspects of their lives that threaten their wellbeing. Only then does the Community Model help them to address mental health, substance use, employment and other barriers to greater independence.

Is the Community Model successful? How is success measured?
Lamp Community's use of the Community Model has helped end the homelessness of thousands of individuals during the past two decades. Two years after placement, approximately 70% of Lamp Community's members remain stably housed in independent housing, transitional housing or the respite shelter, an extremely high rate of success for this challenging population. This is all the more impressive because most people served by Lamp Community have repeatedly failed to complete other programs.

While almost all of the participants in the Community Model experience an improvement in their health and wellbeing and a decrease in psychiatric instability and substance use, these goals are secondary to the primary goal of achieving residential stability. Once they are stabilized in housing, these other positive outcomes naturally follow. As a result, participants increase their independence, socialization and even employability, while reducing their dependence on expensive systems of emergency care, including psychiatric and medical hospitals, the criminal justice system and emergency shelters.

Lamp Community's development and use of the Community Model has been repeatedly recognized as an innovative program that reaches some of the most challenging to engage individuals within the homeless population. It received HUD's Community Service Excellence Award, was cited as a model by the California State Governor and is one of a handful of agencies being studied by a nationwide HUD best practices research project.

4. A Brief History of the Community Model

Skid Row

On any given night, an estimated 700,000 people are homeless in the United States.[2] As many as 84,000 of them reside each night in Los Angeles County, one of the metropolitan areas hardest hit by homelessness.[3] Unlike most cities, Los Angeles' homeless population is heavily concentrated in the city's beach communities and a 40-block area east of Downtown L.A. known as Skid Row.

Surrounded by the city's railyards, public transportation terminals, wholesale food markets and the downtown business district, Skid Row has offered inexpensive accommodations to low-wage workers and down-on-their-luck individuals for over 80 years. Zoning laws and other municipal policies have helped preserve the area as a valuable source of affordable housing stock. But these efforts have also helped concentrate poverty in the area, along with a plethora of service programs meant to assist individuals to escape their impoverished circumstances.

With the advent of widespread homelessness in the early 1980s, and the increasingly severe shortage of affordable housing in the Los Angeles area, the neighborhood became a magnet for homeless single adults. The crowded sidewalks of Skid Row now provide sleeping space each night for thousands of homeless individuals who cannot gain entry to the district's more than 7,000 beds in single room occupancy (SRO) hotels, missions and shelters. The resulting blend of substance abuse, ill health and crime is a grim spectacle that remains unnoticed or ignored by most of the metropolitan area's residents.

New arrivals to Skid Row who are motivated and resourceful can often negotiate their way into treatment programs and other services that may help them rebuild their lives. Others, addicted but capable, may survive by selling drugs and single cigarettes, or engaging in other marginal and often illegal pursuits. Many cycle in and out of shelters, rooming houses, hospitals and jails for years.

Homelessness and Mental Illness

A particularly vulnerable segment of the Skid Row population is comprised of homeless individuals living with mental illness. Nationwide, approximately 25% of all homeless single adults have severe mental illness. More than half of these also struggle with secondary diagnoses of substance addiction, developmental disabilities, HIV/AIDS or other health problems.[4] With few of the social skills necessary to develop relationships to "make it" on the streets, and less adept at negotiating barriers to treatment and services, members of this segment of the homeless population are more likely to experience regular crises and remain homeless for extended periods of time.

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[2] National Law Center on Homelessness and Poverty, "Out of Sight - Out of Mind? A Report on Anti-Homeless Laws, Litigation, and Alternatives in 50 United States Cities," 1999.

[3] Shelter Partnership, Inc, "The Number of Homeless People in Los Angeles City and County, July 1993 to June 1994," 1995.

[4] Koegel, Paul, et al. "The Causes of Homelessness," in Homelessness in America, 1996, Oryx Press.

Faith-based missions and other traditional service providers on Skid Row are sometimes able to serve homeless people with mental illness. But more often, these providers are unable to meet this challenging population's complicated needs. Their staff often lacks training in mental health issues. Strict behavioral requirements and rigid programming make participation difficult for people with mental illness. Services are often fragmented; negotiating the system often requires more motivation than this group can initially muster.

These barriers are especially problematic when a mentally ill individual also has problems with addiction. Traditional housing and service programs for individuals with substance addictions are usually based on the "Minnesota Model," a therapeutic community treatment approach that begins with a primary goal of abstinence and sobriety.[5] This model has proven effective for a substantial minority of addicted persons, although a significant percentage of program participants do not respond to its treatment regimen.[6] This is especially true for homeless individuals with mental illness. Often, drug use helps alleviate their mental health symptoms – often referred to as "self-medicating." In these cases, sobriety is often not their first priority. By imposing a rigid hierarchy of goals where sobriety is the first goal, many programs lack the flexibility to address the special needs of this population.

In addition, traditional mental health and housing programs often require sobriety and the use of psychotropic medications as a condition of access to housing and services. Faced with this daunting choice, many homeless individuals choose to remain on the streets rather than risk failure in a high-pressure program. Unable to engage these individuals on the terms dictated by the program, staff members often refer to this population as "service resistant."

The Los Angeles Men's Place

Recognizing the enormous gap in services for homeless individuals with mental illness, Mollie Lowery left her position as Executive Director of Ocean Park Community Center (now simply called OPCC) in 1985, joining with local community activist Frank Rice to find a way to serve the homeless mentally ill population living on Skid Row more effectively. Says Lowery, "We believed that people with mental illness could – and would – come in to a place if they felt it was meeting their needs. I didn't for a minute believe that mentally-ill folks were out there on the street because they didn't have enough sense to come in out of the cold. They were out there because they didn't see any other options."

In June 1985, Lowery and Rice opened the Los Angeles Men's Place (LAMP), a "Day Center" that provided homeless people with mental illness a safe and clean space that met their basic survival needs: food, clothing, hot showers, toilets, advocacy and other services. It focused on reaching out to homeless people on the streets, building their trust

[5] Anderson, DJ. Origins of the Minnesota Model of Addiction Treatment. Journal of Addictive Diseases. 18(1):107-114, 1999.
[6] Gerlach, R. Acceptance & Abstinence? The International Journal on Drug Policy. 3(2):83-6, 1992.

and engaging them in on-going support. While the staff had few resources to offer at this time, demand for their assistance was unremitting: homeless people with mental illness in the area quickly recognized that at LAMP, somebody was finally providing a place where they felt welcome. Instead of "patients" or "clients," they were referred to as "guests," (and more recently, "members"). Instead of set programs and strict standards of behavior, they themselves were encouraged to determine the nature and pace of their recovery plans.

After the LAMP Day Center had operated successfully for a year, an overnight encampment took root in front of the building. Each night, up to twenty members were sleeping outside LAMP's doors, insisting that it was safer and friendlier to sleep on the sidewalk there than in the local mission beds. In response, LAMP began providing respite shelter services in March 1987, clearing out the Day Center every evening so that beds could be laid out for eighteen members at night. Staff quickly realized that the beds not only satisfied an urgent need for the people they served; the stability and continuation of contact afforded by the shelter also made services more accessible and effective.

The Community Model

With few precedents to follow, LAMP staff had to develop their own methods to respond effectively to the complex needs of the population, by providing a safe and non-judgmental environment where people could develop solutions to their problems that were practical and workable *for them*. Thus were born the beginnings of the Community Model, a practical and now comprehensive service philosophy that has since helped make services more effective and more responsive to the needs of homeless people with mental illness across the country.

It wasn't always easy, and the next steps were never obvious. During the first two years of operation, for instance, LAMP pushed sobriety and banned individuals with obvious addiction problems. It soon became clear, however, that many of the people coming to LAMP were dually-diagnosed with both mental illness and substance addiction. LAMP first responded to this problem with referrals to existing drug and alcohol treatment programs. But these more traditional programs were unable to address all of the needs of the dually-diagnosed population. For example, at the time many abstinence-oriented substance addiction interventions did not allow the use of any psychotropic medications. LAMP found that their members' mental illness made them unwelcome in most substance abuse treatment programs, and their addictions often masked their mental illnesses. As a result, they rarely received help except emergency services in times of crisis caused by their mental health or addiction problems.

It was clear that LAMP's Community Model had to become more flexible to be effective. If the point was to engage people who were not being served by other programs, then LAMP's services *had* to become more tolerant and less judgmental. Consequently, LAMP began to develop its own drug recovery services based on the precepts of harm reduction. LAMP's addiction services now offer a broad spectrum of recovery interventions in loosely-structured, informal settings, offering members help with

everything from reducing the most harmful effects of their drug use to supporting them to achieve total abstinence.

The Need for Housing
LAMP had always helped its members to find and retain housing with local nonprofit housing developers like the Skid Row Housing Trust. But in the late 1980s, it became clear that without better access to a variety of housing options, and the stability this housing engendered, LAMP's members could not achieve their full potential. The organization first attempted to develop permanent and independent housing by leasing a building in Santa Monica, 15 miles away from downtown Los Angeles. But because of the distance, a dearth of community support and a lack of public transportation at that time, many people living in the Santa Monica building returned to the Skid Row area within the year.

While disappointed that the placements did not stick, LAMP staff realized that the rhetoric it espoused about the importance of "building community" was actually being confirmed by this wholesale return. Embracing its members' affirmation of the community it had created, LAMP redirected its housing efforts to the Skid Row neighborhood. In the ensuing years, the agency has developed Lamp Village, a 48-unit transitional (but not time-limited) housing program, and Lamp Lodge, a 50-unit permanent housing program. It also collaborates with local community-based housing development organizations to provide housing-based supportive services, and master leases about 50 residential hotel units in the neighborhood.

Member-Operated Businesses and Employment Opportunities
To further empower members and provide the local neighborhood with resources, the organization, now known as Lamp Community, has developed an array of services over the past decade that includes three member-operated businesses: 1) a linen service that provides laundry service for local hotels, missions, and shelters; 2) public showers and toilets that provide a vital service to the homeless people on Skid Row; and 3) a coin-operated laundromat. In addition, Lamp Community creates extensive opportunities for current and former members to work as staff in all of the organization's programs.

After almost twenty years, the Community Model now offers Lamp Community's members a complete range of housing, services and employment opportunities, sustained by an extraordinarily supportive community of peers. The success of the Community Model has helped demonstrate the validity and effectiveness of the harm reduction approach to serving the homeless mentally-ill population, and has helped inspire the creation of similar, federally-funded "Safe Havens" around the country.

The OPCC Community Model and Safe Haven
The recent collaboration between OPCC, Lamp Community, Shelter Partnership and the RAND Corporation replicates the Community Model in a Safe Haven being established by OPCC in Santa Monica, CA.

Transferring the lessons learned on Skid Row to create a fully-realized, comprehensive program in Santa Monica has been a challenge for OPCC, the lead agency on the project. Community concerns, especially around siting, along with questions of funding, organizational culture, staff training and other issues have all helped the groups involved to understand even more clearly what is entailed in developing and operating a program for homeless mentally-ill persons based on the Community Model. "The Community Model is a product of many years of experience, experiment, and continual re-evaluation," says Lowery. "It doesn't happen overnight."

The collaboration's replication experience has helped inform the creation of this manual. The lessons learned from both the two-decade development of the Community Model on Skid Row and the more recent replication and siting efforts in Santa Monica are described herein. With the dedication of the provider community, it is our hope that this manual will allow other groups seeking to make their services more responsive to the needs of homeless mentally ill persons and other chronically homeless populations.

Ruth Schwartz, the Executive Director of Shelter Partnership, Inc, recounts the thinking that led to the Community Model collaborative: "In 2001, The California Endowment, the largest health care foundation in California, requested proposals for 'Special Opportunities in Mental Health Funding.' Mollie Lowery and I immediately knew it was the opportunity we had been hoping for – to evaluate, replicate and train others in the hugely successful Lamp Community Model. And we knew that OPCC in Santa Monica would be the perfect partner, because of the great need of the population there and OPCC's similar and progressive service delivery paradigm."