III. How To Build Community

What does it mean to "build community?" Many Community Model members say it's the way the program helps them develop supportive relationships with staff and other members. They repeatedly refer to the program as being "like a family." They appreciate that the program "doesn't make you feel like you're being judged." For many members, being surrounded by an understanding, supportive community of peers and helpers allowed them to succeed where they would have failed in other programs.

Program staff say that the supportive "family feeling" of the Community Model is no accident, but the result of a continual, conscious effort to make the people they serve feel welcome and respected. One program director puts it simply: "We don't yell or order people around." Establishing trusting relationships and nurturing the strengths of community members requires additional effort and time. But when a network of mutual supports is combined with a tolerant atmosphere, services become more accessible, more appealing and more effective.

So how does an organization achieve this ideal? The preceding chapter described the fundamental principles and underlying characteristics that guide service delivery in the Community Model. This chapter explores concrete strategies to integrate these concepts into new or existing programs, including:

1. **Redefining Success**
2. **Leadership and Flattening the Hierarchy**
3. **Making Services Supportive and More Tolerant**
4. **Expanding Choice and Flexibility**
5. **Integrating Services and Increasing Access**

The chapter also provides specific information on other important issues related to the Community Model, including:

6. **Training and Supervision**
7. **Responding to Relapse and Decompensation**
8. **Dealing with Violence and Other Disruptions**
9. **Adopting the Community Model**
10. **Implementing the Community Model – One Provider's Experience**

1. Redefining Success

Most social service programs require participants to take predetermined steps toward fixed goals on a schedule imposed by the program. Helping program participants achieve one standard set of objectives makes measuring "success" and "failure" in these programs fairly straightforward. For example:

- Most substance abuse treatment programs make sobriety the defining goal of every participant's treatment plan – the length of time each client is clean and sober is simple to measure and easily understood by funders.
- Employment programs likewise use job placements and length of time employed to measure their success and justify their programs.
- Recently, pressure from funding agencies has forced many homeless shelters to begin tracking how many people they place into permanent housing each year, in an effort to refocus their mission from providing emergency lodging to ending homelessness.

The Community Model, on the other hand, assists members to establish their own personal goals and develop strategies to achieve these objectives at a self-determined pace. This open-ended method presents difficulties when trying to evaluate the program's effectiveness, for a number of reasons:

- The provider must be ready to help members address a variety of barriers to residential stability, from addiction and homelessness to social isolation and unemployment. The milestones for each differ substantially.
- Members establish widely disparate personal goals, from ambitious ventures like total sobriety or full-time employment, to more modest achievements like maintaining good hygiene or just showing up every other day. All of these goals are equally valid, but difficult to compare or quantify.
- Each member will work toward these goals at his or her own pace. Some members will choose *not* to address some issues that affect their ability to live independently.
- While members may achieve or miss milestones, an individual's progress in the program is solely a relative measurement; "failure" is not a recognized outcome in the Community Model.

All of these factors make it difficult to aggregate data in order to evaluate the effectiveness of the Community Model program as a whole.

Further complicating matters, the Community Model serves perhaps the most challenging segment of the homeless population: chronically homeless single adults with mental illness and dual diagnoses. These folks are precisely the individuals who cannot gain access to more mainstream programs – in part because the performance measurements used to evaluate these programs necessitate screening out people less apt to succeed in them. Employment programs will face difficulties fulfilling the ambitious job placement

and retention benchmarks they are required to meet if they take on too many individuals who are homeless, mentally ill and have other substantial barriers to employment. In contrast, the Community Model selects participants in exactly the opposite way, by welcoming primarily individuals who have failed in (or been failed by) other, less flexible, programs.

Nevertheless, Community Model programs must be held to some standard of success. They need to have the capacity to measure their programs' performance, both to guide the continual improvement necessary for any effective program, and to convince government, funders and the public of the model's value. They also need to find ways to help members measure their individual progress as they work toward their goals.

Lamp Community has responded to these challenges by creating performance measurements that focus on the *relative* improvement achieved by members. These measurements apply to both the progress of each individual and of the aggregate performance of each program.

- **Measuring Individual Progress** – Members work with their advocates (case managers) to set individually-tailored personal goals. While these goals may include ambitious undertakings such as compliance with a new psychotropic medication regimen, they mostly consist of small steps toward more independent living. "For some people, just trusting us enough to walk into the drop-in center is a major success," says Shannon Murray, Lamp Community's Deputy Director. Each week, a member meets with his or her advocate to set new personal goals and review progress on previously agreed upon objectives. Members' progress is measured on a relative basis – tracked solely within the context of the individualized plan they have developed with their advocates. If a member is not ready to start tracking continuous sobriety, the advocate may instead agree to note how many days he or she didn't imbibe that week. And if that is too daunting a goal at that time, the two may instead agree to first track how many groups the member attends each week.

- **Measuring Program Performance** – To assess the overall effectiveness of the Community Model program, Lamp Community has implemented a performance measurement tool that measures individual's progress, while still accounting for the disparate levels of functioning of members. Developed in conjunction with the California State government's "Integrated Services for Homeless Adults With Serious Mental Illness" program, Lamp Community's evaluation instrument begins by establishing a baseline with each member when she is first engaged by the program. The baseline reviews the individual's recent employment and education history and interactions with such public systems as hospitals, jails and prisons over the year preceding arrival at Lamp Community. While this self-reported data hardly tells a person's entire story, together the information can do much to gauge the individual's relative independence and level of functioning over the previous year. By comparing this baseline data to information tracked during an individual's participation in Lamp Community programs, the

individual's relative improvement (or deterioration) can be easily assessed. Data collected includes:

- **Number of Days Homeless**
- **Number of Days Hospitalized for Medical Reasons**
- **Number of Days Hospitalized/Institutionalized for Psychiatric Reasons**
- **Number of Days Incarcerated**
- **Number of Days Employed**
- **Number of Days Enrolled in Educational Activities**

Collecting these types of data achieves a number of objectives:

- By not concentrating on collecting information on sobriety, medication compliance and program attendance, the Community Model allows members themselves to determine the course of their treatment, rather than having the program impose a predetermined solution upon them.
- The data collected instead tends to reflect the objectives most often voiced by members: staying out of the hospital, staying out of jail or finding a permanent home.
- The data measures the frequency of the interventions most likely to require significant public expenditures. As the Community Model reduces its members' need for these interventions, the social and economic benefits of the program become clear. The data confirms the many individual success stories, while also providing a compelling cost-benefit analysis.

When service providers contemplate adopting the Community Model, they sometimes voice concerns that harm reduction may foster complacency among the people they serve. After all, sobriety is difficult enough to achieve even when all participants in a program are focused on this goal. If drug use by participants is tolerated, what will motivate others trying to stay clean? When a program boasts a high level of tolerance and emphasizes choice, is it really just enabling participants to continue destructive behaviors?

"Of course, our goal is to help members become as independent as possible," says Shannon Murray, the Lamp Community Clinical Director. "But if you set goals too high, people fail, and then everybody feels terrible." Shannon is quick to point out that most of Lamp Community's members "failed" other programs' unrealistic expectations. So why not try a new approach? "When you encourage someone to set lots of small, realistic goals, there's a good chance they're going to succeed. And when they do, they start thinking, 'Hey, I *can* do this,' and they get motivated for bigger challenges. Once they have a few successes under their belts, the sky's the limit."

But won't some program participants just take advantage of Community Model lodgings without working on the issues that brought them there in the first place? Paul Alderson, the Chronic Homelessness Initiative Director, doesn't see this happening at Lamp Community. "We may employ a softer, less punitive approach, but we're not going to let you alone. If a member is doing drugs in his room, we might say that's okay, but someone is always going to be coming at the person with new alternatives until we reach him somehow." Mollie Lowery agrees. "If you're in a Lamp program, you've got to be working toward *something*. If you can't meet the goals you set for yourself, we'll revisit your plan, but you've got to keep trying. People usually respond to that kind of support by renewing their efforts."

Lamp Community continues to refine its data collection activities. For instance, not all homelessness is the same: spending many months on the street usually indicates a higher level of instability than an extended stay at a transitional housing program. By separately tracking street homelessness and nights spent in shelter and other facilities, a clearer picture of a member's previous residential instability emerges.

Other categories of useful information that could be tracked include enrollment in entitlement programs, or renewed contact with family members. Finally, efforts to confirm self-reporting with information from public agencies would make the baseline information more accurate, although confidentiality issues and staff time constraints must be addressed to achieve this.

2. Leadership and Flattening the Hierarchy

Practitioners of the Community Model are quick to contrast the program's egalitarian management approach with other programs' more hierarchical organizational structures. They say that by "flattening the hierarchy," the Community Model encourages staff collaboration and increases opportunities for members to take leading roles in their recovery and rehabilitation.

To be sure, with only two levels of management between the executive director (the deputy director and the program directors) and front-line staff, Lamp Community is aggressively democratic compared to most nonprofit service providers. But the program's egalitarian emphasis doesn't come naturally. It must be cultivated through the example of the executive director's everyday interactions with staff and members. Paradoxically, the "non-hierarchical" Community Model requires a strong, deliberate and self-aware leader more than most other programs do.

Of course, every nonprofit organization can benefit from sound leadership. There are, however, some actions and attributes a leader can adopt that are particularly important to a successful Community Model program. Lamp Community management staff say the following activities and leadership qualities are necessary for directing the effective operation of the Community Model:

- **Attention to Internal Operations** – The Executive Director of a Community Model program must be prepared to spend time managing actual service delivery as well as external affairs. As the nonprofit sector becomes larger and more complex, much more of the typical executive director's time and energy is spent on fundraising, community and media relations, public policy issues and strategic planning. While these concerns must be addressed, the Community Model executive director should also remain engaged in the day-to-day operations of the program.

- **Constant Presence** – Engagement in day-to-day operations requires maintaining a continual availability to both members and staff on the front lines. The

Executive Director exemplifies the Community Model's ideals of accessibility and support by spending a great deal of time outside of the office and in the field:

- The executive director "models" the tolerant behavior that staff (and members) must adopt to be effective.
- Externally, he or she consistently articulates the Community Model, dispelling misperceptions and building valuable relationships.
- He or she demonstrates inclusive, nonjudgmental language in all settings.
- The executive director's daily schedule is loose enough to permit impromptu meetings and unscripted interactions and more relaxed conversations with members and staff.
- Formal reporting to the executive director by management staff is supplemented and sometimes replaced by more casual interactions and collaborations at the program sites.
- An open office policy permits anyone – staff and members – to approach the executive director to discuss issues important to them.

- **Flattened Management Structure** – To further facilitate close contact with "the front lines," Lamp Community's program directors report to the executive director via the deputy director or in some cases, directly. The deputy director provides guidance and clinical support to program directors and staff, supplementing the executive director's supervision. There are no assistant program directors, only direct service delivery staff in each program: mostly advocates, peer advocates (members and former members) and a couple of positions (social worker, nurse) that are slightly higher in stature than these entry level slots.

  The relative lack of hierarchy of the Community Model ensures that the executive director is able to maintain contact with program staff. By cultivating an ongoing dialogue between decision-makers and line staff, program management becomes more democratic, collaborative, responsive and transparent. The resulting reduction in administrative support is compensated for with an array of meetings, cross-trainings and employee exchanges

Making the time to "be there in every way" for members and staff is not easy, and may not come naturally to some managers. For Mollie Lowery, the founder and Executive Director of Lamp Community, this compassionate approach appears to be an extension of her personality. "You always get a hug when you see Mollie," says Robert, a longtime resident of Lamp Lodge, a 50-room permanent supportive housing residence. It's clear that Robert has learned from Mollie's example – he gives her two more hugs, as well as hugs for everyone else in the building's courtyard, before returning to his room with a smile.

By modeling supportive behavior, Mollie sets in motion a cascade of encouragement and support, from staff to tenant, tenant to tenant and back to staff. But her tactile methods are not for everybody. "We think we're as supportive as Lamp," laughs Lou Anne White, OPCC's Safe Haven Director, "But I just can't hug that many people every day. We let our members know we're with them in other ways." OPCC's success supports Lou Anne's contention, but Robert would probably advocate for more hugs, not less.

between programs. Some staff say that the absence of assistant program directors can put added pressure on program directors; there's no one immediately able to step into the position in case of illness or other absence. But most agree that the ready availability of the executive director and deputy director to line staff make up for this occasional disadvantage.

- **Boundary Spanning** – Just as the executive director must attend to both external and internal concerns, he or she must also balance administrative management responsibilities with the creative work of leading a community. Paul Alderson, the Chronic Homelessness Initiative Director, says "it's a right brain/left brain kind of thing. It's a struggle for one person to mesh the operational, structural and administrative duties of running a comprehensive program with the fuzzier, less tangible responsibilities of building a community. It takes a special person to be that kind of 'boundary spanner.'"

  To Paul, the focus of the Community Model differs from other programs he has supervised because, instead of managing an organizational structure that works toward set goals and benchmarks, program leadership must cultivate an entire culture. This culture creates an environment that provides the support and direction that members need to help themselves. Working without clearly-defined or standardized objectives can be disorienting for management. But developing a culture of support can help many individuals succeed over the long term.

- **Incorporating Societal Change** – More than one Lamp Community staff member observed that one of the factors that makes Mollie Lowery an effective leader is the way that she demonstrates how daily activities and interactions within the program relate to the larger goal of changing society. Making societal change an explicit goal drives the Community Model program design in innovative ways. It provides a context that helps members understand the hardships they encounter and the central role they play in overcoming those barriers. And attaching a greater meaning to the work at hand helps boost morale among staff. Most important, focusing on societal change increases the impact of this relatively small program, helping to spread the Community Model's innovative solutions to the problems of homelessness, mental illness and poverty in the United States. This manual is just one result of the Community Model's efforts to effect change beyond the immediate scope of the program and its members.

3. Making Services Supportive and More Tolerant

Creating a Supportive Atmosphere

Like all programs serving homeless people, the Community Model strives to be "supportive." All too often, supportive is a catch-all phrase used to describe any service provided by agencies serving homeless people. But to Community Model staff, it describes a particular approach that allows members to define the types of services they

will receive and how these services will be delivered. Staff's role is to elicit participants' wants and needs, provide constructive responses and alternatives, and then support participants' efforts to achieve their goals.

"It takes longer to do it this way," says Lou Anne White, OPCC Safe Haven Director, "but people need to have input on how they get services. We ask them all the time, in groups and one-on-one. A lot of times, especially in the beginning, they'll just go, 'you guys decide,' but that's not good enough. You have to be persistent and get them involved in decisions if you want to help them achieve real change for the long-term."

Supportive Helping Behaviors

Verbal	**Non-Verbal**
Supportive	Good eye contact
Is non-judgmental	Sitting close (but not too close)
Non-confrontational	Calm tone of voice
Calls member by first name	Occasional smiling
Interprets and clarifies to check message	Nodding of head
Summarizes to assure "on the same page"	Positive facial animation
Uses verbal reinforcers ("I see," "yes," "mmm")	Normal rate of speech
Asks open-ended questions	Attentive listening

Unhelpful Behaviors

Forceful advice ("you should do," "I think you")	No eye contact, closing eyes
Preaching	Sitting far apart
Placating	Sneering, frowning, scowling
Blaming	Yawning
Cajoling	Yelling, shaking pointed finger
Extensive probing (using "why" a lot)	Fidgeting
Directing, demanding	Rolling eyes, huffing
Talking too slow or too fast	Squinting

Promoting Tolerance

Another key to the Community Model's effectiveness is its high tolerance of behaviors not always accepted in other social contexts. The tolerant attitude modeled by both staff and members allows the program to engage homeless individuals with mental illness that other programs have been unable to reach. Some of the ways services can be made more supportive and tolerant include:

- **Allow time and space for "just hangin' out"** – Homeless people with mental illness usually appreciate the structure a program can give to lives that have become all too disordered, but most (especially those living on the streets and in public spaces) will respond negatively to too much structure, too fast. Most appreciate having a considerable amount of private time when they won't have to maintain "normal" appearances. Formal interactions like intake interviews and referral assistance are essential, but they should be supplemented with periods in

which members can have casual, brief conversations to provide opportunities for building trust with both staff and other members.

- **Be aware of how you converse with members** – Community Model staff and members engage in adult-to-adult interactions, not doctor-patient or parent-child relationships. Be on a first-name basis. Steer clear from clinical or medical language and jargon. Avoid instructing or giving advice, unless asked. Be readily available.

- **Focus on strengths, not disabilities –** Allow the member to articulate his or her needs – ask open-ended questions and avoid assuming information. Don't try to establish a relationship by talking about a person's substance abuse or other problems. At the same time, don't ignore obvious signs of addiction or go along with the individual's delusions; acknowledge them without disparaging them. Eventually, the person will be ready to talk about and address such issues.

- **Recognize your own beliefs and how they affect your relationships** – Differences in deeply held values and beliefs can interfere with building a trusting relationship. Try to understand where your values are likely to diverge from those of the people you serve. Some Community Model staff find that participating in therapy helps them understand their own motivations and how these affect the way they relate to members.

> "Everybody brings their own 'stuff' – moral values, preferences, dislikes – into a helping relationship," says Paul Alderson. "You've got to realize when your stuff is getting mixed up with their stuff. If you recognize when your idea of the 'right' way to do something is undermining the approach a member has chosen, you'll be able to adjust. You end up being a lot more helpful to that person."

- **Empower members to help each other –** A program that establishes trust and provides support through hundreds of casual, nonjudgmental interactions requires a lot of unstructured time. Staff cannot do all this work by themselves. Members must be enlisted in the effort to create a program culture where their intuitive impulses to support each other are channeled into constructive, supportive relationships. Members' capacity to support each other can be developed both in informal interactions and through therapeutic group work.

- **Maximize job opportunities for members and former members** – Hiring people who have experienced homelessness, addiction and untreated mental illness into advocate, peer advocate and other positions makes it easier for the program to establish trust and credibility with all participants. It helps facilitate mutual support networks and provides inspiring role models to members. Hired members must be well-trained and adequately supervised to minimize conflicts and inappropriate interactions.

- **Review incidents and events with staff and members** – Every few days in any social service program, some event occurs that elicits strong reactions among staff and program participants. It may be a participant's personal achievement, such as moving into a new apartment; it might be an argument or an altercation between members; it could be a birthday celebration or a member's death. All of these events can touch the lives of members and staff in a variety of unpredictable ways; sometimes they precipitate crises and relapses, other times they instigate positive improvement in someone's life. Community Model staff can use these events to initiate constructive discussions about what happened and why, and how members (and staff) feel about themselves, others and the program. Formal and informal debriefings can prompt positive change and reduce bad feelings.

Tolerating Relapses and Other Setbacks

In addition to making services more inviting, exhibiting tolerance means permitting members to continue participating in the program despite relapses and other setbacks. It's the social service equivalent of unconditional love, a logical tactic for maintaining the participation of people who essentially have no other service alternatives.

High tolerance does not equal a lack of consequences, however. Members who consistently fail to comply with the service plans they developed are presented with alternatives – leaving the program for a day or two, moving from a transitional housing cubicle to a respite shelter bed, or spending some time in a more structured residential treatment facility. But these options are presented and discussed with the member as a series of choices he faces, not punishments. Thus, the conventional response – rebelling against authority – is not as readily available; the member is instead left to decide what course of action he will choose.

Members play a significant role in creating and maintaining the supportive community of the Community Model. They have primary responsibility for teaching new members the program's basic rules of behavior. They also familiarize new members with the many resources offered by the Community Model. Some Lamp Community members are particularly adept at distracting a member craving drugs on a stressful day. Others provide companionship to members fighting depression. Some members have learned how to enforce the program rules against violence, by keeping an eye on those with a propensity for aggression and working with staff to deescalate violent situations. "Working next to Lamp Village, I see it all the time," says Michelle Yu, Director of Development. "Members develop a sense of ownership in the Community Model. They become much more likely to help other community members meet their goals."

Being tolerant of bizarre behavior and failures to comply with service plans requires patience on the part of staff (and fellow members). Staff just has to remember that recovery and progress toward goals is entirely the responsibility of the member. Staff's role is limited to assisting the member to achieve those goals and to ensure that other members are negatively affected as little as possible. In the long run, the program has a better chance of helping a member succeed by remaining available rather than by alienating him or her.

4. Expanding Choice and Flexibility

The Community Model offers flexible services and supports that address almost all of the needs of homeless people with mental illness and/or dual diagnoses. Members choose which services and supports they would like to receive and determine how they will use them. Simply by giving homeless people a choice in their treatment, housing and program participation, the Community Model empowers its members. As a result, members become more invested in achieving positive outcomes when pursuing their goals.

Of course, the Community Model has to balance members' ability to choose with the equally important needs of other members and of the program itself. If every participant was given free rein to engage in illegal activities, threaten staff and impose on other members, the program would quickly lose its effectiveness. So how does Lamp Community define and maintain the line between keeping a semblance of order and maximizing member choice?

When an individual enters a Lamp Community program, she must observe three simple, non-negotiable rules:

- No violence (including credible threats of immediate violence)
- No theft
- No on-site substance use (although this rule is not enforced in independent housing)

Members who break these rules face sanctions:

- In the case of violence, they may be asked to leave the program site, for as little as a few hours to as long as an entire week. If serious bodily harm is inflicted they most likely will face arrest.
- Theft is harder to deal with, as it can be difficult to identify the thief. The individual at fault may have to leave the program for a few days, sometimes going to another placement within Lamp Community.
- Drinking or using drugs at a program site may merit a few hours' to a day's suspension from a program. In some cases, a warning may be issued on a first offense; repeated infractions usually result in a transfer to another program or a longer break from Community Model participation.
- Rules are enforced on a case-by-case basis by program directors, though staff must balance flexible responses with avoiding the appearance of favoritism. Members are judged against the standards which can be reasonably expected of them. People with different levels of functioning must meet different standards.

The Community Model's responses to drinking and the use of illegal substances vary most widely, depending on the program:

- Members in the **drop-in center and respite shelter programs** are afforded the most latitude: they tend to be newly enrolled in the Community Model, or are more experienced members who have had particular difficulty addressing their addictions. On-site use will result in a program suspension of a day or less. If they arrive at the program drunk or high, they are allowed in as long as they remain quiet and unobtrusive. In some cases, they may be asked to go directly to their shelter beds. Any restrictions that are imposed are based on behavior, not on the substance use itself.
- Members who have chosen to live in **transitional housing** follow personal service plans they developed with the assistance of their advocates. These plans usually identify reducing or ending substance use as one of many goals. The transitional housing program offers residents more structure to help achieve this objective: many opt for drug testing and an initial period of being restricted to the building. On-site substance use may result in a return to the respite shelter, or enrollment in an even more structured residential treatment program. Or it may merely provide an opportunity for residents to talk about the process of relapse and recovery and renew their commitment to their original goals.
- **Independent housing** residents are focused on maintaining their residential stability; often, this includes a commitment to sobriety or reduced substance use. As long as they are not disruptive to other residents, however, they may choose to use in the privacy of their rooms. Once again, rules address negative behaviors linked to substance use, not the substance use itself.
- **Member-operated businesses** sternly prohibit substance use on the job. Inebriated or high members are sent home, although their positions are held until they are ready once again to try to abstain from substance use during work hours.

"It's up to the member to decide how much structure or sobriety they can handle, but it's not a free-for-all," says Clinical Director Shannon Murray. "For the program to work, there have to be consequences. People have to learn how to act in the world. We're not helping them if we let them use mental illness as an excuse, because they won't get that consideration in the real world. The trick is to provide a safe, supportive environment where they get lots of second chances."

Guests voluntarily participate in these programs to help them reach their individual health management goals. Depending on the service plans they develop and the programs in which they participate, they agree to follow additional restrictions to the three basic rules. If they violate the rules they accepted, they will be held accountable. And at any time, the member may choose to go to a setting that requires less structure or to rework her service plan.

"Many programs for homeless people have adopted harm reduction language," observes Mollie Lowery. "Most of them just use this language to get people to work toward the

program's goal – becoming clean and sober. If that's not the individual's goal, then that's not harm reduction."

By emphasizing member choice and flexibility, the Community Model empowers people to make their own decisions about the way they want to live. More often than not, they choose to stop or reduce their drug and alcohol use. And because they have made that decision themselves, they are more invested in achieving a positive outcome. Their chances of succeeding increase accordingly.

Some of the ways the Community Model increases program flexibility and encourages member choice include:

- **Allow members to choose groups** – Members residing in the respite shelter must attend the morning meeting. Beyond that, they are free to choose which therapeutic and social groups they want to attend, and how often they will attend them. Members in transitional housing are expected to attend two groups per week; which ones they choose is up to them.
- **Offer a wide range of groups and activities** – The opportunity to choose is only valid if there are a number of options to choose from. Lamp Community offers many different groups by allowing members from all programs to participate, increasing the number of participants. They can choose from women's groups, men's groups, living with HIV/AIDS, Activities of Daily Living, anger management, good health, job search support, veteran's group, mothers of children in foster care, current events discussions and many others. In addition, many other activities are offered to members, from art classes and music groups to field trips and cultural events.
- **"De-clinicize" groups** – Instead of offering a weekly group on substance abuse issues, the provider can hold a forum for people to talk about "keeping healthy." The same issues can be raised and addressed, but participants won't feel stigmatized or defined by their disabilities.
- **Options must be readily available** – Programs, shelter, housing and activities need to be immediately or quickly accessible to encourage and facilitate participation. It isn't really a choice if people face weeks of waiting to get what they have decided they need.
- **Don't "schedule recovery"** – The Community Model avoids time constraints and deadlines for "full recovery." Recovery is rarely a linear process. Expectations that a person will move on to the next "stage" by a certain time can encourage failure and disengagement from the program.
- **Housing is not dependent on program participation** – Except for violating rules against violence and illegal activities, a member's choices and level of participation in treatment and other program activities cannot be allowed to jeopardize his or her housing situation.
- **De-emphasize hierarchies of independence** – The Community Model is not a linear continuum in which people progress to ever greater levels of independence or drop out. It is instead a set of equally valid housing and program options. People do not fail or go backward from one program to another. There are no

fixed paths to recovery. Only personal choices. As one member remarked, "I don't want to be ordered. I want to have a choice. This place gives you the choice to get started again."

- **Increase member input through once-a-morning meetings** – Every morning, staff and members meet in each program to share information on activities and events in the community. In addition to going over available resources, members have a chance to discuss what is going on within the program. Everything from interpersonal dynamics to house rules are discussed. Members decide how they want the program to operate, and how it can best serve them.
- **Increase member input by hiring former members and maintaining peer advocate positions** – Blurring the boundaries between staff and members is a great way to empower members and ensure that their needs will be met in a way they believe is effective.
- **Counter ingrained attitudes of shame and disappointment** – Traditional attitudes toward sobriety and drug use are deep-rooted among service providers and members. Despite the Community Model's efforts to destigmatize disabilities, members will often feel ashamed or guilty when they fail to maintain sobriety. As one member admitted, "When Mollie saw that I was using again I felt really bad that I let her down." The Community Model tries to accentuate the positive achievements of individuals and deemphasize setbacks.

The Community Model preaches "member choice" and empowering program participants. But don't members often make bad choices? What is the role of support staff in helping people make the very personal choices that help improve the quality of their lives? Patricia Lopez, Director of the Respite Shelter, says that just by facilitating discussion, staff can trust members to make the choices that are best for them.

She mentions a recent morning meeting at the shelter. "Quite a few members staying at the shelter wanted to be able to watch TV whenever they wanted to [Right now it doesn't go on before 3 pm and is turned off at 10 pm]. "So we talked about it." Discussion at the shelter residents' meeting explored why the TV was only on for a few hours an evening. Some residents mentioned the value of being able to get a good night's sleep; others talked about the importance of holding group meetings in the shelter area. Some residents said they didn't want the TV on all the time. "We were willing to change the rules, but first, we put it back on them. We asked questions and listened to almost an hour of discussion. In the end, the residents decided that the TV hours could be changed, but nobody wanted to make the change anymore. After evaluating all the options, the shelter residents ended up leaving the TV schedule alone."

5. Integrating Programs and Increasing Access

Over the past decade, most service providers have worked with all levels of government to create what is often called a "continuum of care" for homeless individuals. This service continuum helps homeless people move through a linear progression of programs that facilitate gradually increasing levels of independence. It acknowledges that many homeless people will not require all the steps in this progression: some may not need treatment; some will go directly into independent housing. The continuum of care expects that, in some instances, people will not be able to comply with a program and may have to return to a previous program level.

This continuum of services has helped thousands of homeless people return to housing and stability. But thousands more remain homeless. Traditional outreach programs and drop-in centers cannot engage them; shelters frighten them; the eligibility standards and participation requirements of transitional programs make it difficult for them to qualify or meet expectations. When an individual fails during one step of the process, he or she often is alienated from all assistance and falls through the gaps between programs, homeless once again.

Most individuals unserved by the continuum have mental illness or dual diagnoses. Most have been homeless for extended periods of time. These are precisely the individuals served by the Community Model. "The Community Model works because our people aren't expected to comply with the program. Instead, the program and service wrap around them," says Paul Alderson. "It's person-centered treatment. It's breaking out of the traditional system of segmented services and bringing everything homeless people need within reach."

The Community Model differs from more traditional homeless services by eliminating (as much as possible) the gaps between its services and programs. Services (and individual service plans) are integrated. Members are able to gain access to whatever services they believe they need quickly and seamlessly. The Community Model:

- emphasizes a unified culture across all of its programs
- facilitates communication between staff of different programs
- eases members' transitions from one program to another

Breaking down segmentation and barriers between programs requires continual reexamination of program administration, rules and protocols. Here are some of the strategies that Lamp Community employs to integrate its programs and increase members' access to services:

Increasing Access:

- **Street Outreach** – Like many programs serving homeless people, Lamp Community operates a street outreach team that initiates contact with and engages homeless people living in public spaces. Teams of two people walk the area, although a van is also available to the team. Because of the concentration of homelessness in the Skid Row neighborhood, most new members arrive at the drop-in center on their own, through word of mouth.
- **Geographic Proximity** – Locating all of Lamp Community's programs within blocks of each other also facilitates interaction between program members and staffs. This proximity is one way cultural differences are limited between programs. It also allows members to receive services available at other programs almost instantaneously, and permits those seeking services multiple points of entry.
- **Regular Schedules –** Providing services, assistance, meals, activities and social events on a regularly scheduled basis encourages homeless individuals

to rely on Lamp Community for many of their needs, the first step toward long term engagement with the program.

- **Ready Responsiveness** – When working with homeless individuals with mental illness, it is important to be able to react quickly to requests for assistance. Often, a person may be open to taking steps toward a goal one day, then refuse services the next. You never know when someone will be ready to enter detox, start taking medication or move into housing. Improving your ability to facilitate placements at any time will increase the chances for success. One program director goes so far as to carry a handcart full of application papers and resource manuals whenever he travels between program sites, in case he meets a member he has been attempting to place into housing or otherwise engage into services.

Integrating Programs:

- **Lots of meetings** – Communication between staff of Lamp Community's different programs is fostered through a meeting regimen that may appear excessive compared to most service programs.
    - Each program's staff and members meet first thing every weekday morning.
    - Program directors then meet together each day with the Executive Director and Deputy Director and overnight staff to share information about the day-to-day operations of each program component.
    - Program directors have one-on-one meetings with each staff member once per week.
    - All staff meetings occur once every quarter.

  Often, staff members from one program will attend the daily meeting of another component, both to better understand the program, and to discuss the progress of members they both serve.
- **Self-Conscious Reflection** – Program director meetings not only cover program needs, administrative issues and the progress of individual members. They also provide a forum for discussing Lamp Community's culture. These meetings allow management staff to develop consistent policies and approaches across programs. They tease out inter-program conflicts, employee rivalries and differences in service provision. More than any other activity, these frank, sometimes contentious discussions help ensure that all programs are using the same strategies to work toward the same goals.
- **Cross-Training Between Programs** – From time to time, a Lamp Community program will take on employees from other programs and train them in their procedures and activities.
- **Employee Exchange** – Employee understanding of other programs is further encouraged through the temporary exchange of employees between two programs. For example, a drop-in center employee may work for a few days during the month at a Lamp Community housing program to get a better grasp of the skills required of their members to succeed in housing.
- **Attendance at Group Events** – Lamp Community encourages all members and staff to attend group gatherings held at each of the program facilities.

Professional relationships, trust and friendships are nurtured through informal and celebratory gatherings, like holiday and birthday parties, outings and advocacy events.

- **Including Members and Non-Social Work Staff** – Members, former members and support staff all help build community. Sometimes the person working the front desk or cleaning up the kitchen can make the best assessment of a member's needs and state of mind. Keeping open lines of communications between these workers and members and the social work staff helps the program respond more quickly and effectively.

"At Lamp, everyone knows George," smiles George Rivera, a longtime member and employee of Lamp Community. "I have credibility because I know what people are going through. They know they can talk to me and I'm not going to scold them. I use more of a smooth approach. I say, 'If you're using, be safe and don't share needles.' Sometimes they feel guilty. They'll start crying. I tell them that it's okay, we can start again tomorrow."
"When I first started working here, I'd get frustrated when people would start using again. I felt it too much. I had to set boundaries, so I started working nights. But even when I'm working janitorial, I'm still an advocate. Because I'm here all the time – nights, weekends – I got a much better idea of what's going on. I let Patricia, the program director, know who needs help. Usually, I know before anyone who needs to be hospitalized. I love this place. I make it my business to make sure it runs smoothly."

Facilitating Transitions

When guests experience significant changes in their lives, they often reassess the goals they have set for themselves. Being released from jail or prison, suffering an incident of abuse, overdosing on drugs or some other cataclysmic event may cause a member to reevaluate their present life circumstances. As a result, they may choose to utilize other services and housing offered within the Community Model. A resident of the respite shelter may decide to move to transitional housing and attempt to stay sober. A transitional housing resident may rededicate himself to maintaining sobriety and choose to work part-time in a member-operated business.

Crises offer an opportunity for more intense engagement, but only if the program is ready to respond. Programs attempt to maintain some excess capacity in order to react quickly to these openings, though high demand for shelter beds and housing units can make this difficult. In some instances, the shelter can operate a bed above capacity, or a housing program can rent an additional room from other housing providers.

Often, during crises the individual's bond with the community is strengthened. Cheryl Emmons, Director of the Lamp Village Transitional Housing program, observes, "When members in need see that their advocate and other members are around when no one else is, they learn something about Lamp. It may become a turning point in their relationship with the community." During these times, staff and members are able to show – rather than just talk about – the existence of a real, supportive and caring community.

A transition from one Lamp Community housing or service program to another can be initiated either by the member or his or her advocate. Usually, it is the member who

expresses a desire for more independence and privacy, or perhaps for more participation and structure. If the advocate believes the member is capable of handling more independence, however, he or she will not hesitate to broach the subject with the member. In some cases, staff will allow a member to reside in a new type of housing on a trial basis. The advocate will observe how the member is utilizing the room, cubicle or bed. With the advocate's support and some luck, the member will adjust to the new setting and thrive. If the new residence is not a good fit, the advocate will help the member return to the previous setting or try another housing option. After a brief transition period, a newly-settled member will get a new advocate, although the former advocate will continue to keep in touch and be available as a resource.

6. Training and Supervision

Most people in the social services field have some intuitive understanding of what it takes to assist people to become more independent. But this intuition must be augmented with extensive professional and practical training. The goals of training are twofold: one, to impart the techniques and strategies of helping people overcome barriers to independence, and two, to understand the personal dynamics of the relationship between the provider and the recipient of this assistance.

And training in itself is not enough. To be effective, direct service provision staff needs ongoing supervision that models essential behaviors, closely monitors performance and provides constructive feedback. While few would disagree that supervision is necessary, the lack of supervisory capacity is probably the most common weakness in the typical social service agency. Supervisors need training, too.

The Community Model depends on classroom training of some of the basic concepts of social work. Every worker must understand the causes and complications associated with identification, overidentification, disidentification, personalization, transference, countertransference and other dynamics of social service relationships.

But the Community Model also uses practical, on-the-job training to initiate employees into its community-oriented, less clinical, approach to service delivery. "Training begins on day one here," says Paul Alderson. "We have to challenge people at their foundations. Usually, the more educated they are, the harder it is to do. People don't realize how our own personal biases and beliefs can get in the way of helping others set and pursue the goals they need to achieve."

It can be difficult for workers used to mainstream social service delivery to accept some of the precepts of a harm reduction program like the Community Model. If a worker believes that a homeless person can overcome homelessness only by achieving sobriety, he will not be effective serving a person unwilling to attempt abstinence. The worker's professional, cultural or religious beliefs may prevent him or her from establishing trust with those who do not share those viewpoints.

Lamp Community has always emphasized communication between staff and departments. When Lamp collaborated with other area providers to secure a federal grant to "help end chronic homelessness," the program they developed together used the Community Model approach. This meant that there would be lots of opportunities for workers and programs to coordinate their efforts -- in other words, a lot of meetings.

For example, Lamp Community's Collaboration Grant staff participates in the following weekly meetings:

- Lamp Community staff morning planning meeting (3 days/week)
- Executive Team Meeting w/ top management of all participating agencies
- Quality Assurance multi-agency case management staff case reviews
- Integrated Service Team (line staff & staff/programs linked to initiative)
- One-on-one supervision meetings (management & front line staff)
- Clinical supervision (clinical director and program director)
- "The Ladybug Picnic" (program directors of participating agencies)

The "ending chronic homelessness" grant is the most extensive collaboration with other providers Lamp Community has ever attempted. "We decided to do it because we wanted to spread the culture of the Community Model to other agencies at the same time we improved ourselves learning from their approaches," says Paul Alderson, who is responsible for the program. "It requires even more meetings than we have within Lamp, which is saying a lot. Just the same, we can't give any of them up. They've all evolved from our needs."

"You have to make it safe enough that people are willing to question themselves," adds Mollie Lowery. "I ask people to write down why they do this work, then think of times that your motivations interfered with your ability to help someone. Often we find that our own values get in the way. You have to figure out in what way did your beliefs make you ineffective."

Training

- 2 weeks of initial, closely supervised, on-the-job training
- Crisis Intervention, a 2-day course offered by Los Angeles County Department of Mental Health (LADMH)
- De-escalation Techniques
- Harm Reduction Strategies (1 day at Lamp & 2 days at LADMH)
- Working with Severely Mentally Ill People (LADMH)
- HIV/AIDS Training
- Ethics, Confidentiality and Professional Standards
- Cross Trainings between different Community Model programs once/month

Supervision

- Program Directors meet with their staffs for two hours once per week
- Deputy Director meets with Program Directors twice per month
- Executive Director and Administrative Staff meet with Program Directors twice/month

- Program Directors hold 1-on-1 meetings with each staff member once per week
- Entire Lamp Community staff holds "town hall" meeting once a month
- Clinical Supervision
- Staff Retreats
- Dramatherapy Workshops

The availability of training resources and approaches to supervision vary among agencies and geographic areas. Every agency's management must decide what the most effective approach is for their organization. For the sake of comparison, the following is an overview of the training modules and supervisory activities used by Lamp Community. Some training is provided by Lamp Community staff, while other components are provided by offsite agencies; supervision can vary from program to program within the organization.

7. Responding to Violence, Relapse, Decompensation and Medical Issues

Serving homeless people who have severe mental illnesses, addictions and physical disabilities can be a challenge. Implementing the Community Model's unusually tolerant approach to these problems may intimidate agencies that have not served this population before. Or they may be skeptical that anything but a program that requires abstinence and compulsory medication can be effective. Here are answers to some commonly asked questions:

What does it mean to treat substance abuse and mental illness as a public health issue (as opposed to a matter for law enforcement)? What are the responsibilities and legal ramifications for the provider?

Addiction to drugs and alcohol is a problem for tens of millions of Americans. Millions more suffer from severe mental illnesses. Criminalizing some of these addictions and the negative behaviors caused by mental illness has led to an explosion of the incarcerated population, without producing a discernible drop in drug use or serious mental illness. Treatment focused on abstinence has enabled many people to recover from the disability of addiction, while leaving many unresponsive to mainstream treatment modalities. Thousands of people are ineligible for, or are unable to comply with, many treatment programs for addiction and mental illness. Homeless people are especially vulnerable to criminal punishment for drug use because they are impoverished and live in public spaces.

The Community Model attempts to help those who have not responded to or been offered treatment for mental illness and substance abuse. To engage people who have not been reached by traditional mental health and addiction programs, the Community Model employs harm reduction strategies that accept that illegal drug use will sometimes occur.

Implementing the following guidelines will help protect the provider's reputation, legal standing and relations with the community:

- Do not permit recreational drug and alcohol use on the program premises. This rule should be enforced vigorously, although responses and sanctions should address the addiction, rather than punishing the individual.
    - When residents live in private rooms, efforts to build trust and independence usually outweigh the value of interfering with an individual's private activities. If substance use is quiet and private, and does not impinge on a resident's ability to live independently, it should be treated like substance use by people of independent means.
    - Instead, address the negative behaviors sometimes associated with substance abuse. Drug dealing, violence, loan sharking and harassment are just some of the actionable behaviors that require a quick response from law enforcement. This limits interventions to instances where the substance use is clearly destructive to the fabric of the community.
- Make a specific effort to ensure that substance use immediately around the program site is not out of line with the expectations of the neighborhood. In Skid Row, illegal drug use is rampant in public places. Around Lamp Community program sites, drug use is comparatively tame. In an affluent neighborhood, expectations for appropriate behavior may preclude even hanging out in front of the program, much less using drugs outside the door.

What do you do when severe drug or alcohol use or untreated mental illness is causing an individual substantial harm?

Addiction and mental illness can cause some people to hurt themselves in terrible ways. Every program must do all it can to mitigate the grave physical effects of such abuse. But in almost all cases, these efforts must be undertaken with the voluntary participation of the individual in question. Except in instances where harm is clearly imminent, making a subjective judgment to intervene against the will of an individual is ill-advised and, in some cases, illegal. Such intervention will probably interfere with your ability to assist an individual effectively in the long run.

In most states, the only clear criterion for intervening to stop a person's self-destructive behavior is when that individual is an immediate danger to himself or others. By law, a person can be involuntarily hospitalized *only* if he or she meets this definition. But a licensed psychiatrist is the only person who can make this decision, and in most cases it must be seconded by an attending psychiatrist at the hospital, to ensure that the decision is a valid one. People are considered a danger to themselves or others when:

- The individual has made a clear and credible statement that she will harm herself; a method is identified and/or readily available; and the individual has a

history of such behavior, or clearly believes she has a reason to engage in such behavior.
- The individual has made a clear and credible statement that he will harm someone else. He has a weapon available to them and is exhibiting violent tendencies, or has a history of violent tendencies.
- When he is so physically incapacitated that he cannot protect himself from the elements, harm from others, or a medical condition that will soon threaten his life.
- In almost all cases of involuntary hospitalizations, police will be involved and will have a say in whether the individual is committed. In these instances, make sure you have a mental health history for the individual and can clearly document the individual's mental illness in order to make a credible case for hospitalization.

Patricia Lopez, Lamp Community's Respite Shelter Director, tries to avoid involuntary hospitalizations as much as possible. "If a person has benefits, we try to do a voluntary hospitalization. Sometimes, it's difficult to convince someone to go along with that. But if you can calm him down and you've built up the level of trust between you, you can usually avoid an involuntary commitment." It is difficult to voluntarily hospitalize an individual without benefits in California. In cases in which voluntary hospitalization is not an option, Lamp Community must depend on the Los Angeles County Hospital Emergency Room or the Psychiatric Emergency Team (PET) to make an involuntary hospitalization.

What are proper and effective responses to relapse or decompensation?

When someone shows up inebriated or high to a shelter or transitional housing program, he or she should be allowed to enter the premises. If the individual is not disruptive, they can engage in quiet activities, although interaction with staff or other members should be kept to a minimum. Usually, it is best to have them go to their bed or room and sleep it off. "Even when people are high, they can still act appropriately," says Shannon Murray. However, it is not productive to discuss the individual's addiction problem with him or her at this time. A time the next day should be found to follow up while the incident is still fresh in everyone's minds.

Peer support and input is critical when discussing incidents of substance use, so that the discussion does not become a battle between the provider and the individual. In some instances, the person will immediately rededicate him or herself to her service plan. In others, the advocate and the individual may decide that she is better served in a more structured residential treatment facility, or in a less structured program within the Community Model.

Shannon Murray recalls one member who had just been released from prison to Lamp Village transitional housing. "He went from the most structured environment – prison – to the much less structured environment at Lamp." Despite an addiction to heroin, the individual did well in the program – for a while. "But he started using again because he

was immersed in the Skid Row milieu. After four relapses, he decided he needed the structure of a therapeutic community, so we helped him enter one. Lamp Community can't be everything to everybody, after all." Murray points out that people can be sober but not be "in recovery." "They need to dry out and get some stability before they can start working on recovery. It's about changing a person's way of thinking, and sometimes you can't do that when you're still on Skid Row." When this person graduates from residential treatment in a few more months, Lamp Community will be ready to offer him an independent apartment if he's interested.

During crises caused by inebriation or decompensation, longtime members play almost as important a role as staff. They "talk each other down," and encourage one another to refocus on reality, defusing paranoid delusions and other barriers to functioning. Without security guards around, this approach often works. It doesn't end the decompensation, but calming people down allows clinicians to resume working with the individual constructively.

How do you deal with chronic health issues? What are your alternatives?

Many homeless people arrive at a Community Model program with chronic health issues, from HIV/AIDS to infirmities associated with aging. Neither Lamp Community nor OPCC have much in the way of medical services, making individuals with medical problems one of their greatest challenges.

A Community Model program must try to be accessible to everyone, but every now and then someone with dangerous health issues will seek shelter. If you are unable to accommodate their medical needs, it is important to conclude that as early as possible. Depending on the extent of the disability or illness, placement into a hospital or a skilled nursing facility may be appropriate.

In the Los Angeles area, individuals receiving SSI can be placed into a skilled nursing facility within two to three days. Individuals without benefits, however, must seek admission to a hospital through the emergency room, which in Los Angeles, can take more than a day. Though they are reluctant to accept homeless people for more than a few days at a time, hospitals are better able to place people into a skilled nursing facility within a reasonable time. After being discharged from the hospital, however, it is more difficult for an individual to gain entry to a skilled nursing facility. Entering into a Memorandum of Understanding (MOU) with such a facility can provide you with a dependable option for people with serious physical disabilities.

How do you respond to violence and disruptions? Are there ways to minimize incidents?

Although the Community Model seeks to "decriminalize" certain behaviors, it is important to develop a positive relationship with local law enforcement. Lamp Community offers ongoing training modules for local police officers on all aspects of homelessness and how to work with homeless people. The training includes one day at the Police Academy and half a day in focus groups at Lamp Community. Police officers' response is surprisingly positive when they get a chance to meet people and observe a program at work.

By not having uniformed security guards, tensions are deescalated. Members step in to assist others to fit in with the precepts of the program, with an emphasis on no violence. Open settings for the programs also help minimize violence. Employing de-escalation techniques, like allowing a distressed member to have an escape route at all times during conversation; having those conversations in open areas; speaking in low tones and other tactics are all valid.

8. Addressing Concerns about the Community Model

The preceding chapters offer an array of actions and strategies to help a service provider establish a new Community Model program or adapt the Community Model service philosophy to its existing programs. As they use these tools to implement the Community Model, providers must also take steps to educate, reassure and win the support of staff, board members, funders and even program participants.

Some of these stakeholders will question the effectiveness of a program that does not enforce total abstinence. Others will have concerns about the mechanics of operating a program in which some participants may regularly use substances, while others are trying to maintain their sobriety. Some will be skeptical that participants can maintain housing, employment or psychiatric stability without completely abstaining from drugs and alcohol.

In short, stakeholders are asking, "Why adopt the Community Model?" Why risk it? Their concerns are not unreasonable. But placing the Community Model in the larger context of homeless service provision and your agency's mission can help assuage their apprehensions:

- **The Community Model serves homeless people with mental illness and dual diagnoses who have not been assisted by other programs** – Survey the people you plan to serve. How many have been helped by existing substance abuse treatment programs? Some will say that a program may have once helped them, but they are now once again using. Many more will talk about being repeatedly kicked out of programs, or not being accepted in the first place. The Community Model doesn't supplant other treatment options, it supplements them, giving

people who have failed or been failed by other programs a new way to succeed. In short, nothing else has worked for them, so why not try a new approach?

- **The Community Model's emphasis on choice is more effective than not serving people at all –** If homeless people with mental illness and dual diagnoses are not being served by existing programs, how will a new program engage them? By empowering participants to direct the course of their treatment, issues related to authority and personal autonomy are put aside. Often, individuals are "difficult to engage" because they are preoccupied with power struggles with institutions and authority. By requiring an individual to work on self-improvement without dictating the terms of that very personal enterprise, individuals who are paranoid, distrustful or just plain discouraged are no longer faced with one of their major barriers to participation – a long-held perception that they are not allowed choices. Mollie Lowery points out that programs can only be effective if the people they serve agree to accept assistance. The onus is on the provider to figure out what type of assistance they will accept – then provide it. "When you say you 'treat people where they're at,' you have to mean it. If someone is sick and cold, but he doesn't want to come inside because he doesn't want to stop using immediately, I could leave him on the park bench. But if I did, I'm not being very effective, am I?"

- **The Community Model may be the service philosophy closest to the original intent of your agency's mission** – Most programs serving homeless people began with the intent of ending people's homelessness. To achieve this, many shelters and residential programs began to offer an array of services – from addiction treatment and mental health services to job training – that helped people become more independent. Somewhere along the way, these tools intended to help people achieve residential stability became ends in themselves, usurping the programs' original mission of returning homeless people to permanent housing. It is true that some people are so incapacitated by mental illness and addiction that they need to be stabilized before being placed in permanent housing. But it is also true that an increasing number of studies argue for a "housing first" strategy whenever possible. Programs serving homeless people with mental illness and dual diagnoses that place them into permanent housing first and then provide services and support to them there achieve higher rates of long-term residential stability than programs that withhold permanent housing until sobriety and psychiatric stability are achieved.[1] A recent study found that a "housing first" program had a housing retention rate of approximately 80%, a rate that presents a profound challenge to clinical assumptions held by many housing providers who characterize chronically homeless people as "not housing ready."[2] If a program's

[1] Carol Siegel, et al, "Comparison of Housing Alternatives for Severely Mentally Ill Persons in New York City," SAMHSA 2004.
[2] Sam Tsemberis, PhD, Leyla Gulcur, PhD, and Maria Nakae, BA., "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis," American Journal of Public Health, April 2004, Vol 94, No.4.

goal is to re-house people unserved by existing programs, the Community Model's more tolerant, "housing first" approach is an effective option.

Practitioners, funders and other stakeholders will have other questions about the Community Model. Some of the most common questions asked include:

What do we mean by "lifelong community?" Isn't such an open-ended commitment enabling?

The "lifelong community" provided by the Community Model offers an indefinite duration of support for members for as long as they believe they need that support. There are no program "graduates." Instead, individuals newly-arrived at the drop-in center participate alongside members who have resided for years in transitional housing or independent housing. More experienced members provide stability for newer members.

Longtime Community Model residents may choose to join newcomers in continuing to receive the more formal supports offered: participation in groups, ongoing case management, psychiatric consultations and help with referrals to other services, as necessary. But longtime members are more likely to rely on the decidedly informal supports offered by the Community Model: they come to the drop-in center and other program gathering places for meals, art classes, answers to an occasional question and simple companionship. Some may have ascended to one of the many jobs available to Community Model members.

Members' extended – yes, even lifelong – connection to the Community Model program does not equal stasis, however. Staff and members are always encouraging – and expecting – their fellow members to continue to work towards their goals. When a member achieves one goal, he or she will quickly set a new one.

There is plenty of time and space for "hanging out" in the Community Model, but the camaraderie made possible by these casual interactions serves a purpose. Staff and members keep track of each other in a non-threatening, casual environment where gentle interventions are possible. Surprisingly, members are often more likely to show up at the program when things are going badly for them as when they're doing well. They know someone will be there ready to help them.

Doesn't offering lifelong services become expensive?

The Community Model serves people with multiple barriers to independent living. By definition, they will most likely require care and support, in one form or another, for the rest of their lives. One landmark study found that when this care is provided in hospital emergency rooms, psychiatric institutions and correctional facilities, it costs an average of more than $40,000 a year per individual in major U.S. cities. If the individual is instead sustained by placement into subsidized housing with on-site supportive services, these costs are reduced by 40% per year per unit created. The study found that savings

achieved by supportive housing pay for all but $995 of the annual cost of constructing, operating and providing services to these units.[3]

Individuals with similar disabilities who live in a Lamp Community residence – the respite shelter, transitional housing and even independent housing – cost considerably less to subsidize than most supportive housing. Most of Lamp Community's programs provide housing and services for less than $10,000 per year per member. This is a result of Lamp Community's considerable cost efficiencies, including:

- Streamlined management staff
- Many duties are performed by members, peer advocates and former members
- Programs and sites share staff
- Some housing units are cubicles
- There is no security staff.

To be successful, does the Community Model require a concentrated catchment area like Skid Row?

Certainly, the concentration of extreme poverty in Skid Row has shaped the nature of Lamp Community's service delivery. Very few programs for homeless people have so many living right outside their doors, and hardly any can site all of their program locations within walking distance of each other.

But Skid Row preceded Lamp Community by decades. The provider has merely responded to the environment that existed. While having sites closely situated helps the program keep in contact with its members, the lack of affordable housing outside of the district keeps people tied to an area teeming with rampant drug use and other impediments to independence. The provision of "lifelong community" is in part a necessity borne of geographic limitations.

The Community Model can thrive beyond these boundaries, however. The replication by OPCC in Santa Monica covers a much larger area. OPCC has responded by incorporating more transportation support, including working with the City of Santa Monica to reroute the public bus lines. Lamp Community is also expanding. The agency now provides supportive services to residents of affordable housing developed by A Community of Friends on the other side of Downtown Los Angeles. These new enterprises demonstrate that as long as members can move easily between program sites, the Community Model can operate effectively.

What services should be provided by the Community Model? What services should be delivered by other agencies?

Every provider must decide, and constantly reevaluate, which services and supports should be delivered directly by the agency itself, and which should be left to other

[3] Culhane et al, "The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals," Corporation for Supportive Housing, May 2001.

government and nonprofit providers. For example, many programs serving homeless people living on the streets directly provide basic medical services, both to answer an important need and as a way to engage hard-to-reach individuals. In San Francisco, medical services are often provided on-site in supportive residences through an arrangement with the County Health Department. On the other hand, Lamp Community provides an extremely comprehensive array of services, yet chooses to allow its members to continue to receive all medical care off-site from nearby medical providers

It is important to know what your agency's strengths are, and which services your management staff is capable of supervising well. Look also at what other providers in your catchment area offer – and what services are not available to people in your neighborhood. Establishing links to services in other agency's programs, through memoranda of understanding or contracts, can make each other more effective, and increase the number of people you can serve.

9. Implementing the Community Model: One Provider's Experience

Depending on the organization's culture, management will face challenges when implementing what for some will be a major change in service philosophy. Management and direct service staff will question aspects of the Community Model that differ from the way they currently deliver services. Funders and board members may be concerned about how the change will affect the organization's efficacy. Program participants and the public may also have questions about the Community Model program.

The leaders of OPCC faced a number of challenges when they first considered adopting the Community Model service philosophy to operate a new Safe Haven program in their community. OPCC's experience implementing and embracing the Community Model offers some lessons to other providers.

In some ways, OPCC had built-in advantages implementing the Community Model. Most obviously, Lamp Community founder Mollie Lowery had served as OPCC's executive director in the early 1980s. And after forty years of providing services to low-income and homeless adults and children, OPCC shared many of the same principles that provide the foundation for the Community Model:

- Like Lamp Community, OPCC serves homeless people living on the streets and in public spaces with a drop-in center.
- OPCC also operates a comprehensive transitional program for homeless women with mental illness.
- And like Lamp Community, OPCC seeks to provide services that are client-centered, voluntary, flexible and focused on empowering people to rebuild their lives. Management is diverse and actively encourages program graduates to obtain employment in the agency and participate in the organization's governance.

Despite the conspicuous similarities between the two organizations, however, substantial differences quickly became apparent. Somewhat surprisingly, OPCC management found that many of the differences they discovered actually argued for the adoption of a Community Model program. John Maceri, OPCC's Executive Director, began to think that implementing the Community Model would revitalize OPCC and help the organization focus again on its original mission:

> I think we had become too comfortable with our current program designs. We were very focused on "measurable outcomes." There is increasing pressure from funders to demonstrate success that can be counted and reported and, as a result, we had drifted away from a nonlinear approach to service delivery. Moving people through the "continuum of care" – from emergency shelter to transitional programs and on to permanent housing – became the only achievement worth measuring. As important as it was, and still is, getting credit for housing placements took priority over acknowledging the dozens of incremental improvements our clients were making along the way. Product was becoming more important than process. While we subscribed to a nonlinear philosophy of service delivery, we were practicing a very linear model in the pursuit of a narrowly-defined "success."

John makes clear that he believes the solution to ending homelessness is permanent housing. And he agrees that funders are entitled to expect that their money will produce outcomes that improve the quality of people's lives. But he does believe that OPCC's programs needed to expand their definition of success:

> The quality of an individual's life can be improved simply by taking a shower regularly. It's not particularly earth shattering – especially when compared to securing an apartment – but it is an important step toward regaining self-esteem. We acknowledged those steps, but we forgot to celebrate them. We were becoming so focused on the end result that we diminished the client's journey.

Despite operating a network of effective and diverse programs, OPCC staff had long been frustrated by their inability to offer comprehensive assistance to homeless men with mental illness. OPCC had a comprehensive program for homeless women with mental illness that took into account their many barriers to independence. But men with the same barriers had difficulty complying with the eligibility criteria and participation requirements of programs serving less disabled homeless people.

Presented with an opportunity (and possible funding) to expand its services for homeless men with mental illness, OPCC's senior management team spent over a year considering different program models and discussing how a new program would fit with the agency's other services. Early on, the team focused on creating a "Safe Haven," as defined by the U.S. Department of Housing and Urban Development. OPCC management knew that they needed to establish a program that explicitly served people who were not served by existing programs. Although Lamp Community was one of the prototypes for the Safe Haven program, the funding does not require providers to follow the Community Model

service philosophy. OPCC management had to weigh the benefits of the Community Model's inclusive and supportive services against possible resistance to its harm reduction philosophy from OPCC staff and the community.

> The staff went through a kind of evolution around the project. There was apprehension about many things. Would it drain our resources? Who would supervise it? Where would we site it? How would it fit with our other programs? How would we measure success? We had some very animated conversations about it. It brought up a variety of issues for individuals on the team. After sifting through all of them, we finally reached consensus that the Safe Haven was an important and valuable addition to OPCC that we could all support.

John and the OPCC management team agree that they were able to attain consensus because they observed the following principles:

- **Have honest discussions about how you define success:** Staff members in the same program often have diverse opinions about what constitutes a successful outcome. Staff members who are in recovery themselves usually define success as total abstinence from drugs and alcohol; they may view anything less as unacceptable. Staff in transitional housing programs may define success as placement into permanent housing, while access center staff may consider someone who shows up every day for the sack lunch program a success. Talking through these differences reminds staff that the people they serve have different needs depending on their circumstances. Says John, "'One size fits all' doesn't work for homeless people, especially those with mental illness. Our own biases about what constitutes 'success' can get in the way of understanding what people need and how programs can be structured to meet those needs."

- **Come to a common understanding about the goals of the program** – The Community Model can't work without a shared foundation of values and practices. Management and line staff must agree on how flexible the organization will be about sobriety and program requirements. Management needs to develop consensus on measurement criteria both with staff and funders.

- **Make sure staff has a forum where they can honestly express their concerns about the Safe Haven and/or the Community Model** – Not everyone will embrace the Community Model program and its principles. Resistance may be based on a misunderstanding of how the program operates. At OPCC, one staff member said he "didn't like the fact that we weren't holding clients accountable in the Safe Haven program." Safe Haven participants were in fact being held accountable, but his definition of "accountable" differed from that of the program. This was not uncommon at OPCC, an agency that employs many of its program graduates, a policy that offers advantages as well as challenges. Staff can be extremely empathetic, but often judgmental: they overcame tough life circumstances and pulled their lives together, so why can't everyone else do the same? Some staff will never accept harm reduction as a legitimate strategy and

will not be able to work in a Community Model program. On the other hand, OPCC's experience is that empathy usually wins out when staff have the opportunity to talk honestly about their fears and concerns.

- **Just because everyone has the same information doesn't mean that they have the same understanding** – Often, people can attend the same meeting, hear the same information and come to completely different conclusions. We all have life experiences, biases, attention spans and moods that can greatly influence our opinions and conclusions. It may require many conversations reviewing the same information before a group can achieve consensus. Staff needs time to digest information and ask questions. They will rarely come to a complete understanding after just one presentation.

- **Patience is a necessity during the planning process** – Staff cannot be forced to embrace the Community Model. For some, the Community Model philosophy is so different from their core values that they will never implement the program properly. Even staff open to the language of harm reduction will require time to fully understand and implement the Community Model. They will need the support of key stakeholders, from line staff to supervisors to executive management, to make the program successful. The stresses involved in program development, siting battles, funding challenges and the ongoing day-to-day operations provide many opportunities for staff to lose sight of why we do this work. The journey is as important as the destination, even if it takes awhile to get there.