Outreach, Engagement and Service Delivery

4

CHAPTER

Outreach, Engagement, and Service Delivery

By Mary E. Walachy and Jerome Ray

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

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

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

Mary E. Walachy, M.S.W., is the Executive Director, and Jerome Ray is the Director of Homeless Services at the Mental Health Association of Greater Springfield, Inc., in Springfield, Massachusetts.

Specific Criteria for a Safe Haven Facility

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

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

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

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

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

Outreach

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

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

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

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

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

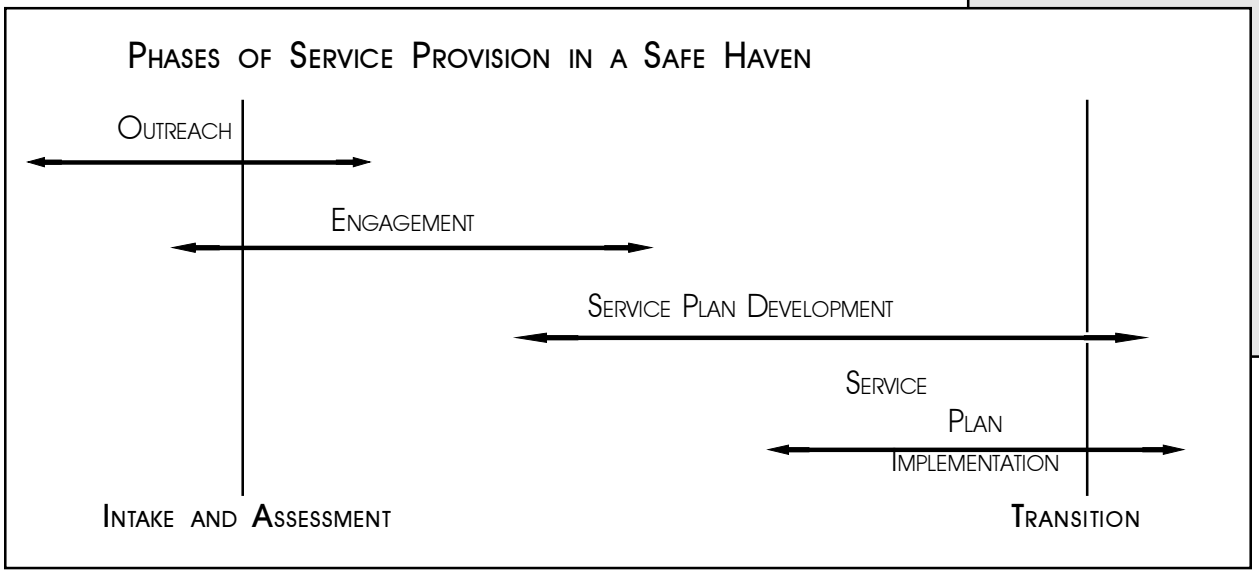
Another approach is to consider only a part of the Safe Haven's capacity as open to referral placements from other providers in the community. The balance of the capacity might be committed to residents secured through the Safe Haven's outreach efforts. The Pathfinder Program relies on direct referrals from the local Department of Mental Health for six of its 12 beds, while the remaining six beds are available for open referrals from the community. Pathfinder does not have an outreach team, but does engage in outreach to the area's homeless population by providing a small-scale meals program on site for prospective participants. They also have a social club offering several programs for the homeless mentally ill and for those who also have problems with substance abuse.

The more engaged the resident has become, the greater the level of trust, and the greater the likelihood that the resident will consider and accept additional benefits of the Safe Haven experience.

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

A report on a cris
incident should incl

1) natu
event
sons
involv
2) prec
factors;
3) the c
tervent
4) inform



Carol, a story of successful engagement

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

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

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

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

Engagement

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

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

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

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

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

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

Intake/Assessment

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Service Delivery

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

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

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

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

- Health Care for the Homeless nurses were already familiar with the guests and the continuity had practical value;
- it prevented the overuse of already overworked in-house nurses; and
- the contract represented an excellent opportunity to form a collaborative relationship with another area provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This plan should be considered a part of the resident's information within the Safe Haven's records. The Safe Haven should give consideration to whether any aspect of the plan should be released or shared with other service providers. Resident consent to such release must be worked out. This consideration is fundamental because each service provider with whom the resident interacts may also be developing a treatment plan. An ability for these providers to discuss the degree of consistency or to resolve conflicts in the plans is precluded if there is no consent to release.

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

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

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

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

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

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

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

Conclusions/Recommendations

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

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

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

Recommendations for Exemplary Practice

- Provide a continuum of services, including outreach and health care, beginning on the streets and continuing until housing is obtained.
- Ensure that the target population is served by being a portal of entry to services for a population that may be difficult or resistant to engagement.
- Engagement and service delivery must retain the expectation that the resident will advance to more permanent housing with appropriate supports.
- Adequate numbers of trained staff are critical to effective operations.
- An individualistic approach is needed to focus on the special needs that set this population apart from those able to utilize existing shelters.
- Engagement should be woven into all aspects of the Safe Havens environment.
- Operate social clubs on site.
- Provide transitional employment programs on site.

The authors wish to acknowledge Walter Leginski, Chief of the Homeless Programs Branch of the Center of Mental Health Services, who contributed to the service delivery section. They also wish to acknowledge David Picard, Director of Harbor House; Dave Weisberg, Assistant Director at Pathfinder; and Brian Fournier, Program Supervisor at Safe Havens. These individuals gave generously of their time and provided many valuable observations, which reinforced and extended our experiences at MHA.