The American Psychiatric Association has two annual meetings, a May meeting for its entire membership and an October meeting for psychiatrists working in public mental health. In 2005 the theme of the entire October conference was recovery (perhaps casting into doubt the idea that psychiatrists are far behind everyone else). I participated in several workshops and symposia as well as a large Recovery Celebration organized by the Irwin Foundation that, for the first time anyone could remember, featured numerous psychiatrists and consumers side by side, without boundaries, as speakers, educational entertainers, vendors, and audience members.

One of the workshops I presented, alongside Shannon Legere, the director of the program, described how we use our Homeless Assistance Program as a welcoming entrance for the other Village programs, an innovative "intake process." We wrote this intending it to be a few page handout to accompany our presentation. It grew and grew as we found more "essential" practical details we had to include until it reached its present, rather lengthy state.

This paper really is only for readers who want a lot of "nuts and bolts." I included it nonetheless, because I think it's important to realize that recovery does permeate everything about a program. It's not just about the values. Recovery includes also programming, staffing, structure, and funding. A successful transformation is incredibly detailed and thoughtful.

Creating a Welcoming Program (with Shannon Legere, LCSW) (2005)

Mental health programs around the nation are attempting to transform themselves to achieve the vision of a recovery based mental health system outlined in the President's Commission Report. In contrast to a good diagnosis forming the backbone of an illness based system, having good relationships with the people we're serving forms the backbone of a recovery based system. Therefore, many programs have begun focusing on improving their welcoming. As first steps, welcoming can be improved through attitudinal changes of the staff, improving intake procedures, and reducing barriers to care. At the Village in Long Beach, California, the Mental Health Association has gone well beyond these first steps, creating a highly sophisticated, comprehensive welcoming program.

Beginning about twenty years ago as a small store front and an outreach van carrying lunches to the streets we have evolved into a complex and highly integrated program. We welcome hundreds of people who are homeless, incarcerated, or institutionalized, helping them begin their process of recovery. This lengthy paper will describe our program services, structure, values, staffing, and funding. We hope it will be useful to planners, program directors, staff, and consumers looking for detailed guidance to build their own welcoming programs

Services:

MHA Mental Health America of Los Angeles

Engagement itself is the main service we offer. Although many of the people we work with have received large amounts of mental health services (some are even referred from "high utilizer" lists) the vast majority have never really felt welcomed anywhere or engaged in any treatment or recovery process. Our "engagement" services include:

- Street outreach – Staff meet homeless people in the community, (under bridges, along the river bed, in the alleys), bringing services to them such as sack lunches, blankets, use of a cell phone. The main objective is to build a trusting relationship by literally starting "where they are at." It often requires consistent ongoing contact over long periods to effectively build rapport. These people may be referred to us by neighbors, police, or most often, other homeless people.

- Jail outreach – Staff go into the county jail, engaging with inmates identified as having mental health issues, informing them of our services, exploring goals, housing plans, criminal history and figuring out if they are a good match for or program. If the inmate and we decide this is a good service match, we arrange to pick up the inmate once discharged, often housing them. We may also go to court with the inmate prior to release to inform the judge of voluntary participation in our program.

- Hospital and Institutional Outreach – Staff use discharge planners at local psychiatric hospitals and other institutions (IMDs) to connect to inpatients who are in need of follow up psychiatric care, intensive case management supports, have no permanent housing plans and are unlikely to be able to coordinate services on their own.

- Phone "system navigator" - One staff is identified to respond to all incoming inquiry, information and referral calls. They provide information, triage calls, and shepherd people into our HAP program or into other community services. This service is far beyond the normal phone referral lists. We may spend hours with providers, consumers, or families on the phone over months, or even arrange walk-in consultations or outreach visits, to make sure they are connected to what they need wherever that is.

- Charity Services – We provide showers, laundry facilities, phone usage, bus tokens, small amounts of cash, mail services, bus tickets to return home, lockers, sack lunches and hot meals, hygiene supplies and basic first aid, all with little requirements and no time limit on participation.

- Drop in Center and Smoking Garden – We provide an unstructured, high tolerance environment for people to hang out in and have a safe place to spend time off the streets with few behavior-based rules, and no time limit for hanging out. These serve as a "sanctuary."

- Drop in Center walk in support services – Staff provide immediate problem solving, case management, and emotional support. Almost all of people we see experience their problems as a crisis. This doesn't force us to always be in a "crisis response" mode. Instead of immediately taking over people's lives to rescue them we continue to focus on relationship building and ongoing collaborative problem solving so they don't have to have lives of continuous crisis.

Psychiatric engagement and medications are easily accessible, but are not "emergency services."

- "Supported" referrals to other services – Staff assist with obtaining appointments or detailed information about the services someone is being referred to and provide transportation to the referral either through cash, bus tokens or even by staff driving them. We often call or visit to follow up with referrals and to give emotional support.

- Attitude Adjustment meeting – We run a daily, open, early morning group meeting, based on a Dual Recovery Anonymous format that also has influences from Native American spirituality and healing, incorporating whatever issues participants in the meeting bring up. This is very popular because people feel listened to, accepted, and welcomed.

- Benefits Advocacy – Staff provide benefits information and advocacy, support people in completing forms, making, arriving to and, at times, even sitting through appointments at various offices, and assist in appeals processes as needed. Our psychiatrist fills out eligibility forms and dictates lengthy, usually successful, SSI reports.

- Re-documentation – Staff assist with getting birth certificates, ID, social security cards, VA discharge verification and or any other form to help identify someone, often paying for them.

- Day Labor Employment– We provide jobs in the community for one hour to one day of work that people get paid for on that same day. Only basic skills are needed for these non-specialized jobs (for example, landscaping, cleaning up a construction site, moving furniture, setting up a bingo hall, etc.). We don't require any formal identification to participate in day labor. Work is distributed amongst any interested people who are homeless and have some mental illness. It is intended as a re-introduction to work, not as a long term primary source of income or employment.

- Drop in Center employment – Homeless people are, paid to help run our drop-in center with staff support (distributing clothes, showers, laundry, and mail, and giving staff clerical support). This is an opportunity for responsibility, having purpose and creating a new role, other than "homeless" or "mentally ill person" and preparation for community employment (Complete job applications, formal identification documents, and interviews are required to get hired. They receive a pay check every two weeks, and have to comply with our employee regulations to avoid getting fired). Work is for up to six months, and averages 10 to 20 hours per week.

- Motel vouchers – We have a very limited number of housing vouchers at a reduced cost for local motels. We use them selectivelyfor very vulnerable people (especially families with small children), as charity to engage with very reluctant people, or as a co-payment to subsidize the financial contribution the member can make toward housing while they're working towards being able to afford their own housing.

Many people who come to us asking for help are really asking for charity not treatment. Charity is getting something that will improve their life without them having to do anything or change themselves, whereas, treatment is help to change themselves to improve their lives. If we offer them treatment, instead of charity, they typically will reject it and accuse us of not being helpful. Instead of blaming them for being treatment resistant, our program integrates "crisis" services, engagement and charity services. It is rare to see even two of these functions integrated, although the vast majority of people need all three together.

We have found that for many people engagement is a prolonged and disjointed process. We sometimes have to maintain contact with people for years, while they leave and come back, wander around the country, or are reincarcerated. Rather than consider each contact as a separate "failed" episode of service, opening and closing cases over and over again, we take a very long term view, seeing each contact as one piece of a larger engagement strategy.

Despite our best efforts a few people appear to be "persistently unengageable," but they are only identifiable in retrospect. We are consistently surprised at how many people we think will never be engaged eventually "come around" if we don't give up on them. There are also a few people who are too violent, destructive, stealing, or predatory to be included in our program. We maintain safety by creating a shared responsibility, "community watch," culture that is much more effective than the usual segregating and restricting, "us vs. them" culture. Therefore, we are able to safely be much more tolerant and inclusive than other programs. In general, if we can't include someone, neither can society at large, and they are soon incarcerated. This doesn't usually strike us as "inappropriate jailing of the mentally ill." Society needs to be safe. We do not generally initiate coercive treatment proactively for either of these groups of "failures".

In the same way that traditional mental health systems prescribe certain services based upon people's diagnosis and case management / rehabilitation needs, our recovery based agency bases our treatment and quality of life services upon people's recovery stage and quality of life goals. Keep in mind that every service is designed to help the person grow into the next stage. Everything is "transitional" but rarely strictly "time limited." Transitions can be gradual and some staff will work with consumers in multiple stages moving forwards alongside them as they progress.

To help conceptualize recovery based services it is useful to divide people into three recovery based groups: "Unengaged," "Engaged, but not self-coordinating", and "Self-responsible". People who are "unengaged" generally do not collaborate in their recovery. They might refuse all treatment, come in irregularly during crises, only want charity and entitlements but not treatment, or be brought into treatment repeatedly or involuntarily for being dangerous or disruptive. People who are "engaged, but poorly self-coordinating" might want to collaborate in their recovery, but have trouble coordinating the services they need. They may miss appointments, take medications poorly, abuse substances, or have poor skills or support. They need someone to help coordinate their services. People who are "self-responsible" not only collaborate in their recovery, they can coordinate it.

The three groups are not dependent entirely on consumer traits. System traits, primarily "engageability" and "directability," also affect who is in which group. For example, years ago there were many people who wouldn't go to a local mental health clinic to make appointments and get medications, but, but who were willing to come to our Homeless Assistance Program. When we hired a part time psychiatrist and started handing out pills at our drop-in center most of them wanted to take pills. They weren't really "medication resistant." They were "clinic resistant." When we changed the "engageability" of psychiatric services, many of them changed from "unengaged" to "engaged, but poorly self-coordinating." Similarly, it is far easier for consumers to coordinate their own services if they are available at one site in an integrated services program, instead of scattered in several separate systems.

Here is a listing of our services broken down by program area and recovery stage. Not all of these services are offered in our welcoming program, though most are. Typically, as someone moves from "unengaged" to "engaged, but not self-coordinating" we will move them from our Outreach and Engagement team to either our Fast Track team, our Transitional Age Youth team, or one of our long term Neighborhood teams, and when they move from "engaged, but not self-coordinating" to "self-responsible", we move them to our Wellness Center, our local CMHC outpatient clinic, or to the private sector.

Employment:

- Unengaged: day labor, "work for a day – house for a day"
- Engaged, but not self-coordinating: agency businesses, supported employment including job development and coaching, group placements, supported mental health employment
- Self-responsible: non-disclosure competitive employment job development, competitive mental health employment

Housing:

- Unengaged: vouchers, SRO hotels, family support
- Engaged, but not self-coordinating: Board and Care, drug treatment programs, sober living, supported housing, master leases, IHSS, family support
- Self-responsible: independent living

Finances:

- Unengaged: small grants and loans, GR (welfare) and state disability application, SSI/SSDI application and documentation
- Engaged, but not self-coordinating: SSI/SSDI "interim funding", rental subsidies, SSI/SSDI payee, grants and loans, agency savings accounts,
- Self-responsible: grants and loans, community bank accounts

Substance Abuse:

- Unengaged: harm reduction, motivational interviewing, DDA meetings, referrals

- Engaged, but not self-coordinating: harm reduction, motivational interviewing, DDA meetings, drug treatment and detox programs, sober living, 12 step work
- Self-responsible: relapse prevention, ongoing 12 step work, giving back

Therapy:

- Unengaged: engagement, empathy, crisis, drop-in groups, "one session psychotherapy"
- Engaged, but not self-coordinating: supportive, in vivo skill building, "corrective emotional experiences", drop-in groups
- Self-responsible: appointment based focused individual or group therapy, self-help (including creating WRAP, advanced directives)

Medication:

- Unengaged: med exploration, med trials, high flexibility and accessibility
- Engaged, but not self-coordinating: med management, long acting injections, high flexibility and accessibility
- Self-responsible: self- management, regular appointments

Social:

- Unengaged: "accepting" environment in the program, peer outreach, staff organized activities
- Engaged, but not self-coordinating: peer networking, supported socialization
- Self-responsible: community development and integration

Education:

- Unengaged: exposure
- Engaged, but not self-coordinating: supported education, agency classes
- Self-responsible: career development

Crisis response:

- Unengaged: outreach, crisis walk-in, meet practical needs while engaging, collaborate with coercive services (police PET teams, ER, hospital, jail MH) diverting when possible
- Engaged, but not self-coordinating: home visits, crisis walk-in, 24 hour emergency hotline, peer run warm line, coordinate support services in the community, "life coaches"
- Self-responsible: peer support, peer run warm line, coordinate natural supports in the community, utilize self-directed crisis plans (WRAP, advanced directives)

Program designers may notice that their programs have some of these services only available in certain forms, so that they're forced to mismatch recovery stage and service, or that they only have some of these services, in which case they're unlikely to promote successful outcomes in the areas they're missing. It is possible to collaborate with other agencies to provide more services, but usually not with "Unengaged" people, only when facilitated by a case manager with "Engaged, but not self-coordinating"

people, and independently coordinated by the consumer using referrals only with "Self-responsible" people.

People are usually in the same stage for every service they're receiving, because their stage reflects how far they've come in recovery, not how far they've pursued any particular goal area. These stages are not intended to be used as prerequisites for each other. People should use whatever stage's services they're in at the time. Some people may resist moving on even when they are able.

These aren't the only services possible to offer. This is just a list of what we've tried at the Village. We had an interesting conversation with a woman in a planning workshop trying to apply these recovery planning stages to assist the battered Hispanic women she works with (Unengaged – collocate a mental health worker and a recovered peer at the church where these woman come to talk to the priest and at the ER where they come for medical treatment for their beatings; Engaged but not self-coordinating – have a mental health worker stick with these woman in a motivational interviewing approach when they return to their men and, when they're ready, walk alongside them through the steps necessary to escape the abuse and recover; Self-Responsible – have a work sheet of the steps to take and the resources available and a recovered peer to offer support along the way.)

Structure:

Our program structure continually evolves with changes in funding, staffing needs, program goals and services needs in the community, but our overall philosophy of staffing and delivering recovery services remains consistent. All pieces of our structure overlap, supporting our overall goals and culture. Our current structure consists of four programs:

- Outreach : street outreach, jail outreach, hospital and institutional outreach

  This is the literal process of "meeting people where they are at." Outreach brings services to the fringes of society, connecting to the hopeless, those too sick to recognize they need help, and those unable to navigate traditional "clinic style" mental health treatment. Outreach occurs everywhere in the community where homeless people reside, under bridges, in the river bed, behind abandoned buildings and at parks. There are no time limits placed in the engagement process. The only rules are that it is a consistent activity and we move at their pace. Services brought to the street include the tangible such as a blanket, sack lunch, bus tokens, and motel voucher for the night. It also includes the intangible such as a consistent friendly face, a non-judgmental approach, an empathic ear and a hopeful person.

- Drop in Center : phone "system navigator", charity services, drop in center and smoking garden, walk in support services, "supported" referrals to other services, attitude adjustment meeting, benefits advocacy, re-documentation, drop in center employment, and motel vouchers

  People can walk in off the streets without a referral or appointment and have a welcoming and safe place to spend the day off the streets as well as connect with services and resources. Our target population is the homeless with mental illness. However, anyone homeless can walk in

and receive basic services, information, and referrals to the appropriate resources. The idea is that homeless people need welcoming environments in which to begin accessing services, no matter what their issues are.

Formal intakes are not required to receive services nor is there a time limit by which an intake gets completed on someone. We've had people for years who just come and use the shower and we might only know them as "river bed Joe" and know nothing else about their life. That's moving at the member's pace. If and when a formal intake is completed with the Personal Service Coordinator (PSC) and the member, it is simple, doesn't require verification of provided information, and is used as another tool to continue the engagement process.

Members can choose who they want to work with. No formal assigned case loads exist.

Members can remain in the Drop in Center level of service indefinitely, while PSCs make repeated proactive attempts to engage them in further recovery services. The Drop in Center serves as the entry point into our Village programs, and as one point of access for homeless services in the City of Long Beach.

- Fast Track Case Management: Intensive case management, benefits assistance, re-documentation, vocational rehabilitation (job training sites and job development), supported education, supported housing, motel vouchers, transitional housing subsidies, shelter plus vouchers, substance abuse treatment including access to a dual diagnosis residential treatment program, payee services and financial planning services, supported medical treatment, ongoing psychiatric care including medication management services, family preservation and dependency support, community integration and supported social services

Fast Tack is the first formal case management team people are triaged onto from the Drop in Center if they are determined to have severe mental illness, are homeless or at risk of homelessness, repeated hospitalization or incarcerations for non-violent offenses, and are in need of intensive support services and are sufficiently engaged to benefit from the services. These are often people that traditional mental health treatment didn't work for. Fast Track continues the engagement process the Drop in Center and Street Outreach staff began to avoid drop outs.

The idea of the Fast Track Team is to remove people rapidly from homelessness, provide an individualized range of intensive supports and move people back into the community with newly learned skills, ongoing entitlements, and "natural" supports so they need less intensive psychiatric and case management supports. Our recovery oriented services are highly individualized and based upon people developing their own goals. The sign on the wall says, "Remember – Fast Track is time- limited! So get a job, an apartment and have a dream come true……… before you hit the road."

An evaluation of the continued level of supports a member needs to move toward self sufficiency and recovery is made at the one year mark. They may "graduate" into non mental health services, the local CMHC, the Wellness Center, private mental health care or even no services at all depending on how far they have recovered. Graduation occurs if a member has been able to return to the community and is self responsible demonstrated by living independently, managing their own money, employed and/or has some social network, can make and keep their own medical, psychiatric and other appointments and is able to overall function without intensive support and guidance. If, on the other hand, they need continued intensive supports, they are transitioned into one of our longer term Village Neighborhood teams.

The member is an active participant in this "moving on" process. Members may get comfortable in Fast Track and struggle with the idea of "graduating," but they are continually encouraged and guided by staff to prepare and take the risk of trying life without intensive supports. Members can return if their life falls apart, and they are in need of intensive supports once again. We have built this into the program because the process of recovery is not always linear but fluctuates with each individual. Having members know that they could come back if needed allows them to take more of a risk and try life on their own. They can also "stop by" informally after they leave to "keep in touch."

- Safe Haven: long term housing subsidies, intensive case management

This program is new for us. We started it in the summer of 2005. Safe Haven is a HUD program that provides permanent housing to chronically homeless individuals with minimal requirements. Our program design is highly innovative, the only one of its kind in the City of Los Angeles and possibly in the country according to HUD. Chronic homelessness has a specific HUD definition: Being homeless on the streets or in uninhabitable places for one year or more; or having four episodes of homelessness in three years.

We are using this program as an alternative to Fast Track targeting the "hard to engage" chronically homeless and those with no income or General Relief as their only source of income, even if their mental health diagnosis is unclear. By HUD rules, mental health treatment is not even a requirement for participation in the program and if desired must be provided by some other program (often the Drop in center).

This program is a "housing first" model with minimal requirements for members. For example, members are placed in community housing the minute they decide they want it with only a one page "guest agreement" that states that you are a guest and here are the basic behavioral guidelines we ask you to follow if you want to live here, (e.g. no overnight guests, no destruction of apartment property) instead of the usual HUD inspection and formal one year lease agreement.

Our design consists of housing phases through which members move through. The first apartment offered is located in a ten unit building, with an on site manager available for overnight problem solving. Once a member is able to remain stably housed at this level we then move them into scattered site units. Hopefully, after a year they will be able to pay for their own housing either through entitlements or employment, the third phase. The idea of phases creates a sense of linear movement through the housing continuum, however, there is built in flexibility so members can move back and forth as needed. Movement through phases is based on learning good housing behaviors (e.g. not being disruptive in your living environment, having guests over with out getting complaints from neighbors, keeping things clean and well cared for, becoming self-supporting, paying the bills, getting along with the landlord, etc.) There is no set time limit for moving through the housing phases and becoming self responsible, and we do recognize for some members in this program self responsibility may take many years to achieve. Overall, the more flow we are able to create the more people we can serve overall and get off the street.

High support is provided to the members in housing, with multiple visits per day and sometimes all day long support is provided. The program recognizes the challenge it might be for someone to transition from long time street living into housing, therefore all the support services are highly individualized

Values:

It's important to focus not just on what's done, but also how it's done. The values behind the practices are crucial. Some values, like consumer inclusion, hope, empowerment, choice, self-determination, pursuing quality of life goals, experiencing non-patient roles, and individualization of services are important throughout treatment and some are more important in certain stages of recovery.

Unengaged:

- There's "No Wrong Door": People shouldn't be expected to understand our system design well enough to go to the right place for what they need themselves. Every entry into the system ought to lead to every service and it's the responsibility of whoever greets them as they come in the door to get them successfully to the right place.

- Everyone is welcoming: Too often we focus on our tasks of gate keeping and rationing, before we make new people feel welcome. If new people are seen as unwelcome additional burdens by staff they are unlikely to greet them with open arms.

- Create a "counterculture of acceptance": Most people with serious mental illnesses (and/or substance abuse) experience a lot of rejection from our community. To be helpful our programs need to accept people that outsiders may not. This is not to say we should tolerate being abused or injured, but many people need a sanctuary of sorts, a place to let down their walls and work on recovering.

- A good treatment is built on a good relationship: Use everything possible to build relationships including charity (e.g. listening, respecting, doing things for people, self-disclosure, sharing non-treatment time and activities).

Engaged, but not self-coordinating:

- Support, don't care-take: Staff are often needed intensively to facilitate people getting services and their needs met. This is done with the person not for them while teaching them the skills to be able to think it through themselves and do it themselves. People will often prefer things being done for them, but that doesn't promote self-responsibility and recovery.
- Services are mobile: Their lives, their problems, and their goals are in the community not in our offices, so we need to be out there too. Build skills by doing things together where they need to be done, not by talking about how they're done in the office.
- Services are accessible: These people have serious problems coordinating things, including our appointments. The needed flexibility usually requires a team working together so there's a better chance someone is available
- Integrate services into a "one-stop shop": Having personal relationships with multiple service staff makes it more likely they'll actually access the services they need.
- Be a "no fail" program: Instead of rejecting people or taking over their lives when they do things wrong, focus on how they can learn from their missteps and what changes they need to make. Instead of closing their case when they don't show up, do assertive re-engagement. Go out and find them.

Self-responsible:

- Create natural, community supports and roles: It's important to work ourselves out of a job. We want to help people find friends to support them, to find places to belong besides with us, to have more meaningful roles in their lives than being good patients.
- Promote self-help: We should teach people skills to manage a variety of symptoms and to get their needs met and connect them to other people in recovery who can support each other.
- Encourage people to "give back": No longer should they be just "consumers" of services. They can give back to our programs and to others in need. They can be role models bringing hope to others. Some even pursue mental health employment.
- Encourage mental health advocacy: Not everyone will want to promote the recovery movement or even disclose their illnesses outside our programs, but those who chose to can have a profound impact on stigma and the community's perception of mental illnesses.

- Create “graduation” rituals and services: It’s important to have a positive exit from the system (even for people who continue to take medications), but there are serious personal issues for both the people taking the risk of moving on and for the caring staff they leave behind that need to be addressed. We need to remember that full recovery is far more common, and far more realistic, than we imagine.

Our traditional system creates very little flow and as a result our case loads go up and up and we have to rely on increasingly draconian rationing to keep ourselves afloat. A recovery system with its pervasive emphasis on growth and movement forwards can create much more flow. This helps both by moving people to higher levels where they do more for themselves and by “graduating” people. Flow and rationing are inversely related. The more flow we create the less rationing we need. The less flow we create the more rationing we need. While it may be easier to give a man a fish than teach him to fish, only the teaching creates self sufficiency and flow.

An experienced psychiatrist well versed in recovery, who worked at our program as a locum tenems said that the thing he learned most was not to take so much responsibility for people. He didn’t realize how much he was still being the father taking responsibility for their lives, and that wasn’t really being respectful of them. He needed to learn to do more negotiating and planning and less telling people what to do. He also said that when he returned for a second stint a few months later, he was very surprised how well the people were doing he’d engaged the first time. At most programs, at best, they would’ve “settled in” after three months, but with us that wasn’t the goal. They’d been aggressively pursuing goals throughout and as a result had achieved a great deal.

When all is said and done we will only build these programs, incorporate these values, and create flow if we believe recovery is possible. That’s what makes this is a recovery based-system.

Staffing:

We give special attention to who we employ to achieve all this. We deliberately employ staff who come from various educational, spiritual and life experiences backgrounds. Together we form both a multidisciplinary and “multiexperiential” team capable of creating a welcoming and safe environment for many people society rejects. We employ many people who are living examples of the power of recovery and are impressive spreaders of hope.

We approach cultural competency by hiring a staff that is culturally diverse and can relate directly to cultural issues instead of learning them from a training session. Staff diversity extends not only to ethnic issues, but also to age, parenting experience, poverty experiences, spiritual beliefs, etc. We also help people connect to culturally specialized agencies in our community.

Our Drop in Center is staffed with a mix of people with life experience and formal education. This mixing of staff within one program brings about a balance, allowing us to view situations and problem solve in a holistic way. We have created a culture of acceptance and recovery within our team and are able to model this to our members.

Currently in our HAP program we employ 15 staff total including 1 psychiatrist, 1 nurse practitioner, 2 social workers. The rest of the staff either have Bachelor's degrees, not necessarily in social work or human services, or have no higher education at all. Five of our staff have direct life experiences with homelessness, recovery form substance abuse and/or mental illness. Many of the rest also have some experiences with mental health and substance abuse or have been recipients of other social welfare programs at some point in their life.

We find that most skills (from motivational interviewing, street or institutional outreach and engagement, to completing an intake and psychosocial assessment) can be taught. However some staff, because of their life experiences, have strengths in areas that are difficult to teach (street credibility, being in recovery form substance abuse, taking psychiatric medications, being a victim of abuse). When matching these experiences to job function we find natural leaders emerge in certain areas and then teach them whatever else they need to know.

For example, street outreach is an activity where engagement skills and techniques can be taught, but street credibility is innate. One of our street outreach workers was homeless for many years, is in recovery from both mental illness and substance abuse and is very attuned to his Native American heritage. Even though he wears large turquoise rings on each finger, elaborate jewelry around his neck and fancy shoes when on street outreach, he is able to naturally connect with people often the first time they meet. He has street credibility. He uses his life experiences to engage with people on the streets and uses his culture as a way to help people heal. He does things like, takes a currently homeless person on outreach with him to outreach to others, brings members to Pow Wow's or sweat lodges, all for engagement and healing purposes.

This type of job matching by innate ability and life skills may seem obvious but it's an important point, especially when creating a program that includes engagement services.

On the other hand, we've expanded our professionals' roles. For example, we need to have a psychiatrist that is willing to engage in activities outside of the normal psychiatrist role. To provide psychiatric services in this type environment our psychiatrist needs to engage with people outside of a formal appointments, be willing to talk about things other than just pills or symptoms, be able to create a safe psychological space to talk about deeply emotional matters amidst the chaos of an unstructured Drop in Center environment, and be willing to provide some case management support and create plans with the PSCs.

These examples are not to say that only people with life experiences in homelessness or mental illness are best at these jobs, but instead this reflects our attempt to create a recovery oriented environment, rich in diversity and choices.

Staff work as a "team" in delivering integrated services. Even though there are separate functions, staff are trained as "generalists", being able to provide a range of services within the recovery scope of practice. Everyone is good at engagement, benefits assistance, problem solving, emotional support, substance abuse treatment and housing assistance. This generalist function also occurs within the team

in that all staff are expected to be able to help all members. We don't create artificial barriers to services by saying "you're not on my case load so I can't help you." Instead we share "case loads" and offer support as needed to anyone, reinforcing our integrated services and team culture.

We also try to be an integrated "one stop shop." For example, instead of referring a person to another agency for a non-mental health related issue, because "we don't provide that", all staff are able to provide some level of information, care and resources for almost any issue. If we don't know the answer we then work along side the member to figure how to best get their needs met

Constant and open communication within the team is required to create a welcoming, safe, recovery oriented environment. Our communication processes are facilitated through both informal and formal methods. Formally we have team meetings and a team decision making process. Informally have an open community working environment which allows us communicate on a regular basis, to teach through modeling, and encourage a culture of emotional validation and processing.

Our formal methods of communication include specific task and process oriented meetings. We have a daily morning meeting (30 minutes), to assign tasks of the day, make sure there is appropriate coverage in the building, and to briefly discuss and create a plan to respond to any crisis or outreaches from the day prior. Also this meeting is a time for our psychiatrist to share information about the new evaluations from the day before. This information is not about diagnosis and treatment plan but about a history of this person's life, how they got to be homeless and at our door steps today, and how the team can help this person get off the streets permanently or achieve any other goal. We consider the special emotional needs they have and try to anticipate barriers to engagement. The plan also includes identifying which staff would be the best match to work with this person based on their needs and goals.

Formal team meetings also occur one time weekly. The purpose is to discuss program issues, specific members, problem solve, share successes, create transition and triage plans, and process feelings as needed. Member related decisions and program related decisions are made within the team. Staff are expected to consult with each other instead of having to make decisions independently. Neither the team leader nor the psychiatrist has the final word; instead it is the collective team that is making the decision.

Informal communication becomes very important to building and maintaining our culture as well as for staff training. We replace the traditional "case presentations" or "clinical supervision" with "working along side of" each other and modeling. This often requires an expansion of roles, especially for those in specialized or leadership roles. For example, the psychiatrist may provide some case management problem solving and support along side of a PSC, or the team director may work street outreach for the day. This learning and "working along side of" promotes team building, promotes staff growth and learning as an on-going, two-sided process and helps to flatten the hierarchy, opening up channels of communication.

We work in an open community environment, with little built out office space or walls separating members from staff. Staff sit in clusters; Drop in Center staff and Street Outreach staff sit together and Safe haven and Fast Track staff sit together. The team director and psychiatrist also sit in this open space and tend to move back and forth between the two clusters. This facilitates team building and communication, provides a variety of opportunities for members to engage and connect emotionally with us, and creates a place of safety for both members and staff.

We have very few “private conversations” with each other. Instead we openly discuss feelings, process issues, give feedback and problem solve collectively. Conversations are overheard, interactions are observed and we have a heightened awareness of our surroundings because of this open environment. At any given time several staff will be aware of what is going with any particular member as well as with each other. We can get emotionally closer to our members than we’re “supposed” to, and let them “under our skin” because we have the rest of the team “watching our back” and keeping us safe. We maintain a high level of ethics without normal boundaries, barriers, and sharp role definitions. We preserve confidentiality the same way AA or group therapy does. We share within our group, but not with outsiders.

Funding:

The needed services are so varied that it is rare for one funding source to pay for everything that’s needed. Unfortunately, that means that administrators have to combine multiple funding sources (e.g. MediCal/Medicaid, HUD, PATH, city) with multiple accountability requirements to create the integrated services people really need. (My image is of an old fashioned TV with lots of tangled wires plugged in the back all to get the whole package one good cable can give.) The challenge to the administration of this patchwork funding is to deliver services that feel seamless to members moving through the system (for example, from Outreach to Drop-in-Center to Fast Track) and to not complicate the program staff’s documentation requirements so much that they are overwhelmed and spend more time on paperwork than with people. What works for us is to combine funds that are compatible, fill gaps in already existing services, and thereby fund a seamless progression of services (street outreach to case management). Staff deliver integrated services while being allocated to multiple funding sources. For example one staff member is 80% funded for case management and supportive services and 20% funded for street outreach. Therefore the people he meets on the street are then able to continue working with him on creating a case management plan, instead of being passed off once the person moves from street outreach to the Drop-in-Center. This streamlines the process for the staff and member and provides continuity in care.

What funding streams we use has varied over the years depending on availability, the demands of the funding stream upon both the people we serve and our staff, our ability to integrate it into existing programs, the values and flexibility of the funders, and our ability to communicate with them. We do not pursue every source of funding, but only those that will enhance our program without overly burdening it. Here is a representative list, including some advantages and challenges of each. Your funding streams will, of course, be different, but this section can give you some idea of how we evaluate funding streams and how hard this really is.

Housing and Urban Development (HUD) – We have a Supportive Housing Program grant (SHP), subcontracted out to HAP from the City of Long Beach, the HUD direct grantee. These funds are used to provide supportive services only (SSO) to homeless people in our Drop in Center. These include case management, program supplies to operate the drop in center and psychiatric services. Our Safe Haven is also a HUD project but funding is for leasing of apartments and staff supportive services. No program supplies for members, psychiatric evaluations or medications are funded by the Safe Haven project. Our SSO project is a three year grant, beginning in 1997, with continual renewals since then. Our Safe Haven grant is also for three years. We are in our first year.

Advantages:

- Current grant term 3 years (although HUD is moving toward one year grant terms). Longer grant terms allow you more time to spend the money and make adjustments to your program and budget without the "have to hurry up and spend the money by the end of the year" syndrome.
- Renewal rate is high. If we successfully meet their goals and use funds appropriately the chances of renewal are high.
- Good funding source if want to start up homeless services.

Challenges:

- Double bureaucracy. We do not direct contract with HUD. Instead we contract with the City of Long Beach. Therefore we have to follow both the City and HUD rules. This leaves little room for compromise and being creative in implementation of projects. Program decision making takes a long time, often have to get regional and sometimes federal HUD approval prior to the City allowing minor program changes.
- HUD is heavy on the administration side requiring extensive annual reports, monthly financials, and written justification for any program changes. However, grants typically only pay 1-5% administrative overhead. HUD also requires elaborate time keeping procedures.
- HUD does not fund 100% of anything, so you must have a cash match. Depending on the type of program HUD funds between 75-80% of a program.
- However, combining HUD funds with other funding is difficult. HUD is often more restrictive than other sources. Therefore, all documentation and charts must be designed to satisfy a HUD audit. For example, HUD requires written verification of "homelessness" by staff and member, has specific definitions of "homelessness" and " chronic homelessness," and only wants reporting and documentation on HUD funded activities in your program. These idiosyncratic rules become challenging for staff when they are allocated across funding sources. You have to be very clear of what HUD will and will not pay for.

City of Long Beach, Social Service Grant - Community Block Grant funds supporting street outreach services.

Advantages

- Has virtually no documentation requirements for staff
- Grant reporting minimal
- Funds can be used as cash match for HUD

Challenges

- Many competitors for available CDBG from the City
- Only pays for .75% of one outreach worker at this time
- Grant application long and time consuming for the amount of money received

Emergency Food and Shelter Program (FEMA) – provides motel voucher money.

Advantages

- Few requirements to apply and receive this money
- Only funding stream for motel vouchers

Challenges

- Amount of funds available fluctuates each year so our award amount also fluctuates. Some years we have very little motel voucher money other years we have lots.
- Funds for vouchers can't be used to subside someone in a motel (they pay and portion and we pay the difference). Vouchers can only pay the bill in full and for not longer than 30 days.

MediCal – used to fund our Fast Track Program and a large portion of the Village Neighborhood teams.

Advantages

- Additional income on top of our county of Los Angeles Department of Mental Health AB2034 contract for wrap around mental health services. (AB2034 funds are a special state program for serving homeless and jail diversion people with severe mental illnesses available only in some counties in California. They require substantial "MediCal matches.")
- High ceiling of spending with MediCal dollars

Challenges

- Not often used in homeless programs because most of our population are not on Medical.
- The services MediCal pays for are medically based and not rehabilitative based.
- Charting is a challenge because the documentation must reflect “medical necessity” service not rehabilitative value. Often what we practice and document feel like two separate activities. Requires intensive and on-going staff training.
- Low reimbursement rate (average .50 cents on the dollar)

PATH (People Assisting the Homeless) - State funds passed through the Los Angeles County Department of Mental Health. Provides funding for outreach, drop in center and engagement services.

Advantages

- Minimal and easy staff documentation
- Broad array of services provided, fills in many of the gaps

Challenges

- Yearly amount fluctuates
- Funds are tied to billing units of service

Additional Grants- Extra projects we take on, often one year grants that benefit our members in some way (e.g.) deposit funds to move into housing, funding for furniture.

Advantages

- One time funds, quick to spend, often have fewer requirements because the funds just need to be spent.
- Provides some extra flexibility with projects we can “try on” for a year without having to make a long term commitment.

Challenges

- Hiring for a one time grant. Most people don’t want a job for just one year.
- Grant implementation is not always convenient or well thought out by the funder. It may require lots of extra effort on the programs part to make the grant successful
- Being flexible enough in your program so that funding/ grants can come and go with out drastically changing or eliminating some important service

Charitable Donations - Individuals and groups often donate modest amounts of money, clothes, food, etc. to our program

Advantages

- Limited if any restrictions on how to make use of the donations, including cash
- The items donated are often those which are not covered or limitedly covered by our funding (for example, clothing, hygiene supplies, household items for those moving into a new apartment, or money for housing deposits).
- Allows creativity to enhance or add services to our existing program. (For example, with a nursing student association donation we purchased backpacks, filled them with basic first aid supplies and our nursing students use them while they're working street outreach.)

Challenges

- Donations are inconsistent, often increasing seasonally with school projects or holiday giving.
- Soliciting donations on a regular basis
- Storage space may be an issue especially for furniture and household items and at holiday time. (Although sorting, storing and distributing donated items makes a good temporary job for our members.)

Concluding Remarks

In medieval Europe villages were often surrounded by large walls and guard towers to stay safe (not unlike many mental health programs today). The front gate was particularly vulnerable because it had to be both welcoming and protective, so it often had the most elaborate structure. A common approach was to have two sets of fortified gates with a walled area in between them for welcoming strangers, getting to know them, doing business with them, and deciding whether to allow them entrance into the village proper, all while they were being observed and guarded. This area was called the barbican. (No, our standard lobbies do not function as barbicans. Our lobbies, while often observed and guarded, are outside the walls. Staff don't venture out into them and you can only get help if you can get past them.) A well run barbican kept new people coming to the village enriching it while keeping everyone safe. A well run welcoming center engages people into mental health services and gets them on their road to recovery.

"Welcome to the Village."