**White Paper**

**Safe Haven Model Development Executive Summary, Assessment, and Recommendations**

**March 4, 2012**

**Background**

In July 2010, and under the leadership and direction of the VA National Center on Homelessness among Veterans, the U.S. Department of Veterans Affairs (VA) National Homeless Program Office funded four Safe Haven model development projects. A Safe Haven is a 24-hour/7-days-a-week, community-based early recovery model of supportive housing that serves hard-to-reach homeless individuals with severe mental illness who are on the street and have been unable or unwilling to participate in traditional treatment and supportive services. As noted in the U.S. Department of Housing and Urban Development (HUD) Safe Haven Toolkit, Safe Havens encourage residents to go beyond just finding shelter. This is accomplished by creating a housing environment that is safe, sanitary, flexible, and stable. In addition, these programs place no treatment participation demands on residents, but have high expectations for residents: the resident will transition from unsafe and unstable street life to permanent housing and re-engage with treatment services. Because these expectations are introduced non-intrusively and as the resident is ready, the phrase “low demand” is often used to characterize Safe Haven housing.

Funding for the VA Safe Haven model development project was designated to develop and implement a Safe Haven model that could be replicated throughout the VA, broadening our homeless continuum of care. Safe Havens provide street outreach and community-based residential services to hard-to-reach Veterans with mental illness and substance use problems who are experiencing homelessness. The small facilities, typically 25 beds or fewer, provide a low-demand, non-intrusive environment, designed to re-establish trust and re-engage the homeless Veteran in treatment services and permanent housing options.

Safe Havens were initially authorized by the McKinney-Vento Act of 1994 with funding provided by HUD’s Permanent Supportive Housing Program. The primary mission of the first funded programs was to target dually diagnosed chronically homeless individuals who were ineffectively served by traditional homeless programs. HUD initially funded about 300 programs. The *2010 Annual Homeless Assessment Report to Congress* (AHAR) indicated that there are only 128 Safe Havens providing a total of only 2,199 year-round beds (HUD, 2011).

The Safe Haven model does not require sobriety or full compliance with treatment for admission or continued stay in the program. Many individuals experiencing homelessness cannot be fully compliant with traditional requirements and consequently have repeated failures resulting in chronic homelessness. Safe Havens attempt to reverse that trend by continuously engaging the Veteran using state-of-the art, evidence-based therapies, but do not discharge the Veteran for noncompliance or relapse. The primary focus of the Veteran’s care in a Safe Haven program is housing stability and service engagement.

In FY 2009 VA launched an initiative to end homelessness among Veterans within five years. This initiative necessitated that VA re-examine its programs to serve homeless Veterans and also launch many new programs and initiatives to accomplish the objective of ending homelessness among Veterans. It was soon evident that there was a large population of chronically homeless Veterans who would require specialized programs to assist in ending their homelessness. Chronically homeless Veterans have very high rates of mental illness and substance use problems with multiple treatment failures, and often are reluctant or resistant to cooperate with additional treatment or rehabilitation that requires sobriety, staying clean or full cooperation with a treatment regimen. As noted previously, many cannot or will not comply with requirements of traditional programs. To reach Veterans with these problems requires programs that utilize a low demand approach. Data collected through the VA's Specialized Homeless Programs indicate that 37% (15,301) of the Veterans accessing VA Homeless Programs in FY 2011 were chronically homeless. The Safe Haven model development initiative was one of several initiatives launched to address and assess the effectiveness of new strategies to address the special needs of chronically homeless Veterans. Low demand programs like Safe Havens and the VA’s new Housing First program are necessary to reach and provide services to the many chronically homeless Veterans whose needs frequently cannot be met by traditional homeless programs that require sobriety and compliance with treatment.

**Literature Review**

Safe Havens provide an effective link between street homelessness and permanent supportive housing. The Ward Family Foundation (2005) conducted a national survey of 79 Safe Havens. This review indicated that Safe Havens effectively engage and retain residents, with over half of residents successfully transitioning into some type of permanent housing program. More specifically, approximately 30% of those leaving the Safe Havens exited to affordable permanent housing with both subsidy and supports (permanent supported housing), 13% exited to affordable permanent housing with subsidy but without supports, and 7% went to affordable permanent housing with neither subsidy nor supports. Although most (72%) of the Safe Havens reported that they did not impose any time limit on length of stay, the average length of stay was only 262 days.

Other large-scale studies also support the effectiveness of offering housing services using a low-demand approach. Schinka, Casey, Kasprow, and Rosenheck (2011) recently published findings from a large-scale study examining whether sobriety at program entry affected outcomes among Veterans in VA Grant and Per Diem transitional housing programs. Data included information from 3,188 Veteran records representing 1,250 housing programs that required sobriety and 1,938 programs that did not. Study outcomes were length of stay, program completion, and recidivism for homelessness, housing status, and employment status. Results indicated that sobriety on program entry was not a critical variable in predicting outcomes.

Leff and colleagues (2009) conducted a large-scale meta-analysis of 44 housing programs serving 13,436 individuals. They categorized each program into one of four types: 1) residential care and treatment, 2) residential continuum, 3) permanent supported housing, and 4) non-model housing. The first two models were considered high-demand housing programs, and low-demand programs were classified under the permanent supported housing model. Non-model programs consisted of arrangements with individuals living on the streets, using shelters, or residing in housing that is described simply as part of “treatment as usual.” Although all three housing models achieved significantly greater housing stability than non-model housing programs, low-demand programs out-performed the other program types with regard to reduction in hospitalization and consumer satisfaction.

Researchers at the University of Michigan’s Center for Local, State, and Urban Policy published a Policy Report that reviewed the literature on housing and housing arrangements for homeless populations (Gerber, Haradon, & Phinney, 2008). The report cites 65 articles and/or technical reports. With regard to low-demand housing models, the report concluded that, compared to traditional housing programs that require abstinence and treatment compliance, low-demand programs demonstrate comparable outcomes pertaining to substance use and participation in mental health services.

**Site Status**

The four Safe Haven programs funded through the VA are located in Bay Pines, FL; Bronx, NY; Bedford, MA; and Philadelphia, PA. All of the programs except one, Philadelphia, are now fully operational. Two of the programs have operated at full capacity for one year and have small waiting lists. Over 60% of discharges from the operational programs have had positive outcomes, with the majority moving to permanent supportive housing.

**Assessment and Lessons Learned**

Early data from the programs’ approximate six months of operation indicate that more than one-half of the 139 Veterans participating in the program had positive outcomes of becoming permanently housed or engaging in additional rehabilitative care. Even those who did not have positive housing outcomes were often engaged in needed treatment, and some returned to the facilities after leaving prematurely, reflecting a core value of Safe Haven programs: keeping chronically homeless individuals engaged to achieve housing stability. Although there are limited studies of Safe Haven models, the programs usually achieve a benchmark of slightly better than 50% achieving long-term housing stability. Although this benchmark appears to be low, Safe Haven programs serve the most chronically homeless, hard-to-serve individuals.

Two of the four sites selected for Safe Havens quickly became operational by using sole source contracts with highly experienced Safe Haven providers. The two sites that utilized a competitive contracting process took approximately a year to become operational. Sole source contracting should be utilized whenever possible and permissible to avoid delays in developing operational programs.

Research from the 11-site, multi-agency Collaborative Initiative to Help End Chronic Homelessness (CICH) indicates that staff often require ongoing support and training to adapt to the nuances of implementing a low-demand approach (Olivet, McGraw, Grandin, & Bassuk, 2010). As such, the VA National Center on Homelessness among Veterans provided a two-day training program on the Safe Haven model for both VA staff and community providers who participated in the model development project. The training included both clinical and administrative issues of management of a Safe Haven and participants indicated that the training was both helpful and useful.

The Center has utilized the Safe Haven Tool Kit Manual, *Developing and Operating Safe Haven Programs*, developed by HUD and the Substance Abuse and Mental Health Services Administration (SAMSHA) as a guide for both VA and community providers. This tool kit has been very helpful for the VA and provider staff managing the Safe Havens. A copy of the manual is attached.

Traditionally, VA’s homeless programs require sobriety and compliance with treatment for admission and continued stay. These requirements leave many Veterans with chronic homelessness experiencing repeated treatment and housing failures with limited or no access to programs that can assist them in leaving the streets. Our data on the two operational programs reveal that there is significant demand for low-demand approaches and that many of the current residents had few options for homeless services and treatment prior to their admission to the Safe Haven. Thus they were relegated to shelter programs.

Lastly, HUD funded Safe Havens as a permanent housing model as part of their Permanent Supportive Housing Program. Our Safe Haven sites were funded utilizing Health Care for Homeless Veteran (HCHV) contract funds. This program provides contract funds for transitional residential treatment of homeless Veterans with an expected stay of up to six months and an allowable six-month extension when clinically indicated. Our review of the HUD-funded programs revealed that the majority of individuals entering these programs stayed less than a year before moving on to other permanent housing alternatives. After one year of operation, less than one-half of the Veterans in VA Safe Haven programs have required extensions beyond six months.

**Fidelity Reviews of the Operational Safe Haven Programs**

Researchers with the National Center conducted fidelity visits with the two operational VA Safe Havens (i.e., Bay Pines and Bronx). These visits occurred approximately six months after each program began operating: the Bay Pines fidelity review occurred on May 16, 2011, and the Bronx review was conducted on June 16, 2011. Activities for each review included: 1) conducting interviews with VA and Safe Haven staff, 2) touring the facilities, 3) reviewing program materials, and 4) observing program activities.

Overall, preliminary findings indicate that both the Bay Pines and Bronx Safe Havens demonstrated a very high degree of faithfulness to the Safe Haven principles. Central to the Safe Haven model of care, neither site has implemented sobriety requirements for admission to or continued stay in the program.

The fidelity reviews found minor differences between the two sites. For instance, the Bay Pines site routinely utilizes breathalyzers and occasionally implements urine drug screens, whereas the Bronx site does not implement these procedures. If Veterans are determined to be intoxicated (based on observation at the Bronx facility, and based on testing and observation at Bay Pines), both sites require Veterans to sober up in a designated area within the facility before returning to their rooms. This area is referred to as the “Safe Room” in Bay Pines and called the “Sober Lounge” at the Bronx program. Once sober, Veterans at Bay Pines are required to sign a Substance Abuse Acknowledgment Form, while the Bronx program does not have such a procedure.

Similar to a therapeutic community approach, the Bay Pines program utilizes a chore list in which Veterans are expected to sign up for and perform routine chores as part of their care. Veterans in the Bronx program are not expected to perform any chores. The two facilities also differ in their medication management practices: Bay Pines manages all medications for Veterans, including over the counter medications, while the Bronx program performs medication management services when clinically indicated.

**Performance Metrics**

As with all specialized homeless programs operated by the VA, Safe Havens are required to complete a standard set of information—at entry and exit—for each Veteran accessing Safe Havens. Safe Haven Coordinators enter data in VA’s Homeless Operations Management and Evaluation System (HOMES). (See Attachment B for a copy of the data collection instruments.) The goal of these data collection activities is to measure the extent to which the programs meet established objectives, including the following:

* Target chronically homeless Veterans diagnosed with co-occurring disorders;
* Increase Veterans’ housing stability;
* Improve Veterans’ outcomes related to alcohol, drug, mental health, medical, social/vocational, and family problems; and
* Increase Veterans income and benefits.

Specific performance metrics in line with the objectives listed above include the following:

* Targeting – Veterans entering Safe Haven who are chronically homeless and diagnosed with mental illness, substance abuse, or co-occurring disorders or who were living in places not meant for human habitation.
* Outcomes – Increase in housing stability, income and benefits, improvement in living situation, and follow-up treatment for identified problem areas (alcohol, drug, mental health, medical, social, vocational, family problems).

**Data from Operational Programs**

During FY 2011, 139 Veterans were admitted to the Safe Havens located in Bay Pines and the Bronx. Basic demographics indicate that these Veterans had characteristics consistent with a difficult-to-serve population: the majority were chronically homeless (68%); spent the majority of the 30 days prior to program entry homeless or in treatment (80%); were unemployed, disabled, or retired (70%); and had problems related to alcohol (92%), drugs (69%), mental health (97%), and medical issues (79%).

On average, Veterans stayed at the Safe Havens for 115 days. While approximately half (48%) were discharged following successful completion of the program, an additional 39% left the programs by their own decision. Only 5% of Safe Haven residents were asked to leave the program due to rule violations. Following program discharge, nearly half (47%) of Veterans were in a housed situation while 23% were either homeless or living in an unknown location and 16% were receiving inpatient or residential treatment.

At discharge, 56% of Veterans were receiving or had pending applications for VA benefits and 35% for non-VA benefits; due to limitations with the data it is unclear whether these applications for benefits were made during the Veterans’ tenure in the program. Service linkages with VA and non-VA providers were in place for most of the Veterans following discharge: 60% for alcohol treatment, 41% for drug treatment, 67% for mental health treatment, and 66% for medical treatment.

**Recommendations for Future Safe Haven Development**

VA has fewer options for chronically homeless Veterans who are unable to achieve sobriety, stay clean, or comply with treatment. For the chronically homeless Veteran who repeatedly has failed in traditional programs, these requirements are “a bridge too far.” These Veterans frequently cannot be reached and served in VA’s traditional homeless programs. Development of low-demand approaches as provided in Safe Havens and Housing First approaches are necessary for VA to end homelessness for all Veterans in five years. Early program results support expansion of Safe Haven programs and it is recommended that VA expand the program to at least 20 additional sites.

**Selection Criteria for Development of New Safe Havens:**

Facilities that have a chronic homeless Veteran population of more than 400 in their local metropolitan area as defined in the latest cumulative data from the National Center on Homelessness among Veterans should consider development of a Safe Haven. Please see Attachment A for facility data on chronically homeless Veterans.

In addition, facilities that have high rates of chronically homeless Veterans with very limited resources to serve this population, and have specified a need in their five year plan to end homelessness among Veterans may consider development of a Safe Haven program.

**Start up and Funding of New Safe Haven Programs:**

The average per diem cost of operating a Safe Haven ranges from $80 to $120 per day. The cost of operating a 25-bed Safe Haven facility at 85% occupancy with a per diem cost of $100 is $730,000 per year.

There are two options to establish and fund new Safe Haven programs. First, new Safe Haven programs can be funded by utilizing HCHV contract funding. A formal request to the VHA Homeless Program Office to utilize HCHV funds for this purpose must be submitted with an agreement to participate in monitoring, regularly scheduled calls, and technical assistance established by the VA National Center on Homelessness among Veterans.

Second, it may also be possible to establish a New Safe Haven program as an existing component to an established Grant and Per Diem (GPD) project. It should be noted that GPD Providers must operate a ‘safe and sober’ environment by regulation; therefore, to establish a Safe Haven component to an existing GPD project, providers must satisfy this requirement through program design and staffing. The GPD provider would be expected to submit a scope change to create a low demand component consistent with the technical assistance provided for Safe Havens to the GPD national office. The scope changes must be submitted with collaborative support from the local GPD liaison. In addition, the GPD provider must agree to meet the staffing requirements detailed in the section on staffing and guidance for establishing new programs, agree to and present a plan to utilize a low demand approach as detailed in the HUD/SAMSHA Technical Assistance Guide for Safe Havens, and participate in technical assistance and in the regularly scheduled calls provided by the VA National Center on Homelessness among Veterans.

Safe Haven programs must meet the residential occupancy requirements of the National Fire Protection Association Life Safety Code and both the GPD and HCHV programs require inspection by VA staff. In addition, some facilities may require structural adaptation to provide private or semi-private accommodations for the residents. Private and semi-private accommodations are recommended for Safe Haven residents.

**Staffing Requirements for Safe Havens**

Safe Haven providers are required to have 24-hour staffing with a desired staffing ratio on all shifts of 1 to 15. Case managers should be available on all day shifts seven days per week. Safe Haven providers are encouraged to utilize peer support staff to augment outreach activities, transportation services, housing specialist services, and other services where utilization of a formerly homeless Veteran peer may be especially beneficial to enhancing the care of chronically homeless Veterans.

Each Safe Haven program should have a VA liaison, usually a clinical social worker, who coordinates admissions, and primary, mental health, and substance abuse care from VHA with the provider.

**Relationship with Other VHA Homeless Programs**

Safe Haven Programs should be fully integrated with other VHA homeless programs and the full range of primary, mental health, and substance abuse treatment programs of the local VA medical center. The Safe Haven offers a unique opportunity to provide an immediate response to the chronically homeless Veteran’s homelessness and provide stable housing without requiring sobriety or compliance with treatment, a barrier that often prevents access to other homeless programs. However, even though compliance with treatment and sobriety should not be conditions of admission or continued stay, case management activities with the Veteran should be directed to encourage the Veteran utilizing Safe Haven services to accept VHA clinical and homeless services.

Safe Haven residents who are able to stay stably housed should be offered the opportunity to transition to permanent supported housing programs like HUD-VASH. Transitioning to low-demand permanent programs like the Housing First Program is ideal and should be offered when Housing First Programs are available.

**General Guidance for VA Facilities Establishing New Safe Haven Programs**

VA facilities planning to establish a Safe Haven Program should recruit experienced Safe Haven providers or providers that are committed to establishing a low-demand model. Smaller sites that do not exceed a total of 30 homeless Veterans are preferred. Sites must also be able to accommodate women Veterans and provide a safe environment that supports their security and well-being.

VA facilities are encouraged to utilize sole source contracts whenever possible to activate the facilities in a timely manner. There are very limited numbers of Safe Haven providers in most cities, making sole source contracting the preferred contracting method when permissible.

Facilities should utilize training and technical assistance for both VA and Safe Haven provider staff that is provided by the VA National Center on Homelessness among Veterans. Many homeless staff have been trained in traditional models of care and need additional training to acquire the expertise required by this model. This includes training on striking the very important balance of maintaining a low demand environment and maintaining a safe environment for residents and staff and developing appropriate provider policies to support that balance.

It is recommended that facilities establishing Safe Havens utilize the fidelity reviews offered by the VA National Center on Homelessness among Veterans; Studies of existing programs indicate that there is a program drift toward traditional homeless program modeling that reduces the intent and effectiveness of the Safe Haven model.

All facilities establishing Safe Haven programs should utilize the HUD/SAMSHA Safe Haven Tool Kit Manual and additional VA policy guidance, approved at the departmental level. These documents are available on the VA National Center on Homelessness among Veterans share point site.

Facilities establishing Safe Haven programs are required to target admission of chronically homeless Veterans with severe mental illness and chronic substance abuse problems who have been clinically assessed to require a low-demand environment to end their homelessness. The targets can be expanded to include Veterans with medical problems or multiple homeless program failures if resources are available locally.

**Special Note:**

Although it may be possible for some GPD Programs to provide a low demand Safe Haven program within the existing funding offered by the GPD program, it is recognized that other GPD programs would require enhanced funding to provide the appropriate environment and staffing necessary for a Safe Haven. It is recommended that a legislative proposal be introduced to allow VA to provide the additional funding for staffing and environment requirements of a Safe Haven and make it possible for other GPD programs to provide low demand Safe Haven programs.

**References**

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