Safe Haven Programs

Analysis of Strategies and Operating Practices

July, 2005

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About Ward Family Foundation, Inc.

Ward Family Foundation, Inc. (WFF) was established in January 2001 to assist existing charities improve their effectiveness by implementing best practices. There is a vast network of excellent programs already in place to serve many worthwhile charitable causes. The foundation was inspired by Catholic social teaching which, among other things, recognizes the fundamental right of each human person to life, food, shelter, clothing and medical care. WFF is a 501(c)(3) organization operating as a private operating foundation.

The vision for WFF originated from the personal and business experiences of John L. Ward, the foundation's founder and Chairman of the Board. In 1992, he founded a company to assist businesses improve their operating effectiveness through the use of benchmarking and best practices concepts. Benchmarking is a management tool to help companies remain competitive and become more effective. Best practices are those specific operating practices or philosophies that have been proven to increase effectiveness. WFF wishes to take these proven concepts and practices that have been successfully used in the business world, and apply them to charitable organizations.

WFF would welcome any comments or feedback on this report. While we must respect the privacy of the Safe Haven programs that provided data as part of this study, WFF would welcome an opportunity to facilitate communication among Safe Haven programs, either extant or developing, regarding specific strategies and operating practices detailed in this report.

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Acknowledgements

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We would like to extend our thanks to the Safe Haven providers who participated in a working group that helped in both the design and implementation of this project. Joel Zureick, Steve Friedman, Susan Neth, Mitzy Stewart, Lis Meckenberg, Antoinette Fallon, Kristen Edwards, Alisa Lincoln, Paul Mireles, Julie Gibson and Doris France played an essential role in this process by bringing to light for us the challenges they face in serving the chronically homeless, mentally ill person. They also helped us determine what elements should be included in a Safe Haven evaluation. They demonstrated a clear dedication to serving this population through their willingness to contribute time and effort to the development of this project.

Thanks also go to Mollie Ward for bringing to this project a fresh perspective and creative energies. We appreciate all that she did to pull this project together. Finally, we would like to thank the Safe Haven programs that participated in this study by completing our rather lengthy survey and by being patient in answering follow up questions. Their willingness to participate in this process has provided a useful window into the programs that serve the chronically homeless, mentally ill person.

While we are grateful for the support provided by these individuals, none of them were given an opportunity to review this report in draft and WFF accepts full responsibility for its contents.

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Table of Contents

Executive Summary ……1
General Overview ……11
Accommodations ……12
Filled to Capacity? ……16
Staffing ……19
Neighborhoods ……21
Whom Do Safe Havens Serve?……23
Admissions Criteria……24
Referral Sources ……26
Admissions Procedures……27
Accepting some Residents and Turning Others Away……28
Profile of Residents……30
History of Homelessness of Residents……35
Income and Benefits Sources of Residents……37
Are Safe Havens "Low Demand" Programs?……39
Basic Resident Rights……40
Terminating Residents……41
Daily Life ……43
Length of Stay ……50
Do Safe Havens Play a Unique Role in their Local Communities?……53
Services Available to Residents……57
Partner Agencies……60
Funding Sources……61
HUD-Funded Programs……62
Non-HUD-Funded Programs ……63
Funding Sources: General……64
Largest Funding Sources……66
Effectiveness……68
Indicators of Effectiveness……69
What Next After Safe Havens?……72
Approaches and Philosophies……76
Tracking Former Residents……81
Conclusions about Safe Haven Effectiveness……84
Appendix A: Safe Haven Programs Participating in WFF Study……85

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Executive Summary

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Overview

While conducting a study of emergency and transitional shelter programs (published in July, 2002), several individuals in the policy and research communities with whom we met suggested WFF consider evaluating the Safe Haven program. In an effort to gauge the interest of the Safe Haven community in a study and analysis of that program, WFF hosted two conference calls with a variety of Safe Haven providers and members of the policy and research communities. The idea of conducting a Safe Haven study was strongly endorsed by the approximately 30 people who participated in these calls. The comments made during the conference calls suggested there is a dearth of information on Safe Haven programs, including how they are structured and operate, how they are funded, the nature of their philosophies and their effectiveness at transitioning the chronically homeless, mentally ill person into permanent housing. We hope this study will prove useful to Safe Haven providers as they seek to make changes and improvements to their programs, and to communities that plan to open Safe Havens and want to benefit from the experiences of extant Safe Haven programs as they design and structure their own programs.

We should note that, in this study, a conscious decision was made not to look in any detail at the clinical symptoms of Safe Haven residents and draw any conclusions about the impact the Safe Haven program has on their recovery. WFF's focus was instead on program components and whether conclusions could be drawn about the effectiveness of Safe Havens in moving its residents into permanent housing.

Identifying Participants for the Study

One of the challenges of this project was identifying Safe Haven programs that were appropriate for this study. WFF worked initially with a list of approximately 300 programs. The list consisted of organizations identified by HUD as programs that receive funding under its Supportive Housing Program, some of which have designated themselves as Safe Havens in their grant applications to HUD, as well as programs that have been identified by the private research community. WFF mailed a letter to the organizations on the list describing the WFF study and the reasons for undertaking it. WFF included in its mailing an information form for people to complete and return. The purpose of the form was to determine whether the organizations on the list were in fact Safe Havens, which was defined as "HUD funded or other Safe Haven programs for people who are homeless and have serious mental illnesses (with or without other issues such as substance abuse, HIV, etc.), that attempt to engage or re-engage people in services through a low-demand approach." Twenty-seven of the letters and information forms were returned in the mail as undeliverable. About one-third of the organizations that received the WFF mailing responded by returning completed information forms. Attempts were then made to contact by telephone all other organizations on the list that did not return information forms. All but 47 of the remaining organizations were successfully contacted. WFF mailed the survey to those 47 organizations, some of which did complete and return the survey.

Through this process, WFF was able to identify 118 Safe Haven programs, 79 of which completed and returned surveys. A list of Safe Havens that returned surveys can be found at Appendix A. Safe Havens from all geographic regions of the United States responded to the request for information. While not all programs

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that responded specified the year in which their Safe Haven project opened, the oldest program that did provide this information opened in 1984. Four of the Safe Havens that returned completed surveys were new programs, with one of them not having yet opened its doors.

Compounding the challenge of identifying appropriate programs for this study was the fact that there appears to be a divergence in views over what constitutes a Safe Haven. For example, one organization that was contacted insisted that its program was not a Safe Haven because it offered its residents permanent housing, while other organizations that were contacted house individuals for as long as they choose to remain there and do consider their programs to be Safe Havens. On more than one occasion, an employee of an organization on the original list told WFF that it considered its program to meet the definition of a Safe Haven, while another person in the local community, such as a Continuum of Care representative, disagreed with that assessment. Several organizations returned information forms confirming that they operate Safe Havens, only to contact WFF later after reviewing the actual survey instrument to say that it did not apply to their program. While WFF made every effort to communicate that its study was of programs that house the chronically homeless, mentally ill person, judgments regarding whether programs meet the definition of a Safe Haven were left to the programs themselves. Every survey that was fully completed is included in the WFF analysis.

During this process of contacting organizations, several Safe Haven programs not on the original list heard about the study and contacted WFF to express an interest in participating. In addition, there were nine states for which there were no Safe Havens on the original list. In order to have as comprehensive a list as possible, WFF contacted Continuum of Care representatives in those nine states and confirmed that there were no Safe Havens operating in those states.

Best Practices Analysis

Approach

A best practices analysis is a complicated undertaking for Safe Haven programs. In order to incorporate a benchmarking and best practices analysis into the study, we segregated the participating Safe Haven programs into two benchmark groups. The first benchmark group was comprised of 15 programs with a high referral rate into permanent housing (with or without subsidy and supports) upon exit from the Safe Haven program (this group achieved 85.2% on average, as compared with 41.6% for the remaining 64 programs). We believe that exit to permanent housing is a reasonable measure of success, and therefore refer to this group of 15 Safe Haven programs as the Best Practices Benchmark. The other 64 participating programs were grouped separately for purposes of the analysis that follows, and are referred to as the Overall Benchmark.

The sub-sections that follow present the findings and conclusions that result from this comprehensive benchmarking and best practices analysis.

Basic Program Description

- The Best Practices Benchmark tends to operate a smaller program that is generally at full capacity and focuses more on providing private accommodations.

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- The average Safe Haven program in the Best Practices Benchmark can accommodate 12.3 residents, as compared with 17.3 for the Overall Benchmark.
- The Best Practices Benchmark offers residents a private room (with one resident per room) 80.0% of the time, and a private bathroom 26.7% of the time. This is in contrast with the Overall Benchmark which offers a private room only 59.4% of the time and a private bathroom 7.9% of the time.
- The Best Practices Benchmark is at full capacity 80.0% of the time, whereas the Overall Benchmark is only at full capacity 63.9% of the time.

Admissions Criteria

- Admissions criteria are generally comparable between the two benchmark groups. Several areas of difference were noted and are discussed below.
- The Best Practices Benchmark requires its residents to be "street" homeless more frequently on average (40.0%) than the Overall Benchmark (26.6%).
- The Best Practices Benchmark is more likely to require a diagnosis of severe and persistent mental illness (SPMI) plus a co-occurring diagnosis for admission (26.7%), whereas the Overall Benchmark only requires SPMI plus a co-occurring diagnosis 4.8% of the time.
- The Best Practices Benchmark is more likely to refuse admission to individuals with felony criminal records (13.3% reported this was not acceptable, as compared with an unacceptable response of only 8.1% at the Overall Benchmark) and sexual offender criminal records (66.7% reported this was not acceptable, as compared with an unacceptable response of only 34.4% at the Overall Benchmark).

Admissions Procedures

- While the acceptance rates are comparable between the two benchmark groups, the admissions procedures vary significantly in several key areas.
- At the Best Practices Benchmark, the candidate completes the admission form 66.7% of the time and the referring agency or person only completes the admissions form 20.0% of the time. This is in contrast with the Overall Benchmark where the candidate only completes the admission form 39.1% of the time and the referring agency or person completes it 60.9% of the time.
- At the Best Practices Benchmark, the candidate first visits the program to see if the "fit" is good 73.3% of the time. This contrasts with the Overall Benchmark where the candidate only visits the program 50.0% of the time to see if the "fit" is good.

Length of Stay

- There are some key differences regarding length of stay among the two benchmark groups.
- At the Best Practices Benchmark, 86.7% of the programs have no limit regarding length of stay. This compares with 68.8% for the Overall Benchmark.
- The average length of stay for the Best Practices Benchmark was 296.3 days, as compared with 251.7 days for the Overall Benchmark.

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Profile of Residents

- The demographic characteristics (gender, race and sex) were similar among the two benchmark groups. The history of mental illness was also similar among the benchmark groups.

Daily Life

- The daily and weekly routines vary widely among the two benchmark groups in several key areas.
- At the Best Practices Benchmark, 86.7% offer activities related to behavioral health (12-step meetings, counseling regarding mental health), but residents may choose to attend or not. This compares with 67.2% at the Overall Benchmark.
- At the Best Practices Benchmark, 80.0% of the programs bring in people with different areas of expertise to discuss topics of interest (health, benefit, family). This compares with only 42.2% at the Overall Benchmark.
- At the Best Practices Benchmark, 80.0% of the programs offer activities of general interest (sports night, cooking classes, monthly birthday dinner). This compares with only 46.9% at the Overall Benchmark.
- At the Best Practices Benchmark, 93.3% of the programs make regular opportunities available for residents to participate in program governance (weekly meetings, feedback sessions). This compares with only 70.3% at the Overall Benchmark.
- At the Best Practices Benchmark, 46.7% of residents who have been there longer provide mentoring and positive support to new residents. This compares with only 26.6% at the Overall Benchmark.

Rules and Expectations

- Rules and expectations related to the use of alcohol, illegal substances, violence and criminal activity are similar among the two benchmark groups.
- Regarding rules and expectations in other areas however, there are several key differences.
- At the Best Practices Benchmark, residents are more likely to be given an incentive to do chores (46.7%, verses 26.6% at the Overall Benchmark), rather than being forced to do them (26.7%, verses 43.8% at the Overall Benchmark).

Staffing

- Staffing levels are relatively comparable among the two benchmark groups, although staffing levels at the Best Practices Benchmark are higher.
- On average, the Best Practices Benchmark has approximately .5 full-time staff and .3 part-time staff for every resident. This compared with .4 full-time staff and .2 part-time staff for every resident at the Overall Benchmark.

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Services Available to Residents

- The services available to residents are relatively consistent across the two benchmark groups, although differences exist in several key areas.
- The Best Practices Benchmark is more likely to provide a psychiatrist at the program site (46.7%, as compared with 31.0% at the Overall Benchmark) and to provide treatment and supports for mental illness at the program site (66.7%, as compared with 50.8% at the Overall Benchmark). The Overall Benchmark is more likely to provide these resources off-site or by referral only.
- At the Best Practices Benchmark, 80.0% provide vocational training off-site and have a clear commitment to do so. The Overall Benchmark only provides vocational training off-site 51.6% of the time and is more likely to do so by referral only. A similar comparison exists in the area of job placement assistance.

Funding

- The Best Practices Benchmark accomplished better effectiveness results at a lower operating cost than the Overall Benchmark. The average annual operating budget at the Best Practices Benchmark was $424,222, as compared with $458,960 at the Overall Benchmark.

General Overview of Study

- The average Safe Haven can accommodate 16 residents. Most Safe Havens (88.6%) house residents in a single facility; most (63.3%) offer their residents private rooms.
- Most Safe Havens (67.1%) are always completely full; 19.8% are usually between 75-90% full. Only 10.5% of Safe Havens can usually accommodate a new resident on the day he or she applies.
- Neighborhoods in which Safe Havens operate are most often (62.0%) in a mixed use – residential and commercial – neighborhood.

Whom do Safe Havens Serve?

Admissions Criteria

- The majority of Safe Havens do not require that residents come directly from the streets: only 29.1% of programs reported that “street” homelessness was required for admission.
- Most Safe Havens (89.9%) require their residents to have a diagnosis of severe and persistent mental illness (SPMI) for admission.
- Only 6.5% of Safe Havens require residents to be clean and sober in order to be admitted to their program; 96.2% of Safe Havens will accept people who have a felony criminal record; 68.4% will accept residents with a history of violence against or abuse of children or adults.

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Accepting Some Residents and Turning Others Away

- Most prospective Safe Haven residents gain admission to Safe Haven programs: 46.7% of Safe Havens accept most or all people who approach or are referred to their program; 26.0% accept 3 out of 4 of prospective residents who approach or are referred to them.
- However, when asked for the three most common reasons why people are not admitted to their programs, approximately 64.0% of all Safe Haven programs included one or more of these reasons among their responses: that they will not accept people who are not truly homeless, who do not have a diagnosis of a mental health disorder, who are engaged in other community services, or who have other housing or program options, making it clear the majority of Safe Haven programs serve only those homeless individuals who cannot or will not be served elsewhere.

Profile of Residents

- Most Safe Haven residents are male (58.2%) and between the ages of 35-54 (61.5%). Approximately 92.8% of current Safe Haven residents have a diagnosis of Axis 1 major mental illness (e.g., schizophrenia, bipolar disorder, depression, schizoaffective); 33.3% have a diagnosis of a major mental illness other than Axis 1 (e.g., obsessive compulsive disorder, anxiety disorder).
- Over one-third (36.2%) of Safe Haven residents are reported to be active substance abusers; 36.2% of Safe Haven residents have serious medical conditions such as diabetes, hepatitis, HIV/AIDS, TB, high blood pressure, heart disease, or liver disease
- Approximately 44.7% of current Safe Haven residents were residing in the streets or in abandoned buildings just before they entered the Safe Haven program. Approximately 44.0% of residents had been homeless for 12 months or less; 22.9% had been homeless for 13-24 months.
- Few Safe Haven residents earn income through employment: 11.6% receive income through panhandling, day labor, recycling, etc.; 7.5% and 1.3% of Safe Haven residents earn income through part-time employment and full-time employment, respectively.

Are Safe Havens "Low-Demand" Programs?

Basic Resident Rights

- About one-fourth (24.1%) of Safe Haven programs provide their residents with a standard lease consistent with local landlord tenant law. The majority of programs (58.2%) provide their residents another type of written agreement or service agreement stating their right to stay for a specified period and their obligations related to that stay, such as paying rent and participating in services

Terminating Residents

- Only 1.3% of Safe Haven programs have a policy of not terminating residents for any reason. Common reasons that Safe Havens terminate residents are violence toward other residents (91.1%), violence toward staff (88.6%) and engaging in criminal behavior on-site, unrelated to alcohol or drugs (88.6%). In a number of cases, objectionable behavior must occur repeatedly and be severe before it will lead to termination.

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Daily Life in Safe Havens

- Most Safe Havens offer some structure to daily living of its residents: only 36.7% of Safe Havens have no structure and allow residents to spend time as they like.
- However, only 8.9% of the programs require residents to participate in activities related to behavioral health, and approximately one-third (30.4%) of the programs require residents at least to participate in weekly meetings.
- Safe Havens do, however, typically impose a number of rules on their residents, including a ban the use of alcohol on the premises (94.9%) and verbal abuse of other residents or staff (93.7%).

Length of Stay

- Most Safe Haven programs (72.1%) impose no limit to the length of time that residents may stay in their program. Approximately 22.8% said that they impose a limit but are flexible about whether to enforce it. The average length of stay of residents in all programs is 262.4 days.

Do Safe Havens Play a Unique Role in their Local Communities?

- The greatest difference between Safe Havens and emergency and transitional housing programs in the same community concerns a willingness to take people who abuse substances: 78.5% of Safe Havens will take residents who are active substance abusers; 41.8% of Safe Havens surveyed said that emergency shelters in their community would not take active substance abusers; 48.1% said that transitional housing programs would not take active substance abusers.
- A number of similarities exist among Safe Haven programs and emergency and transitional housing programs in local communities rather than a number of distinct differences. However, WFF believes that further study is needed to draw definitive conclusions about this question.

Services Available to Residents

- Safe Havens tend to offer residents a variety of on-site services, the most common being daily living skills training (89.9%), medications monitoring and dispensing (86.4%) and case management services (76.6%).
- Services most frequently provided to residents off-site, but with a clear commitment on the part of the program providing the service to serve the Safe Haven residents, include visits with a psychiatrist (51.9%) and vocational training (57.1%).

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Funding Sources

- As expected, the vast majority of Safe Havens (85.9%) receive funding from HUD; most of that funding (95.3%) comes from HUD's Supportive Housing Program.
- Half of the Safe Havens (50.6%) receive funds through mental health services funding through state, county or city agency contracts or grants; 44.3% receive funds from service fees paid by clients.
- The average operating budget for Safe Havens is $452,688.

Effectiveness

Indicators of Effectiveness

- The two most important indicators of effectiveness to Safe Havens are where residents go when they leave the program and whether the residents obtained a stable income source, if they did not have one already. Approximately 97.4% of all Safe Havens track these two indicators.

What Next After Safe Havens?

- Slightly over half of Safe Haven residents exit to some kind of permanent housing. Approximately 14.4% return to homelessness, shelters, streets, etc; 11.2% go to unknown destinations, 6.5% go to temporary health institutions and 2.8% go to a criminal justice institution.
- The most common reasons why residents are not able to move into permanent housing are that the residents' condition remains too unstable (64.0%), a lack of housing with the appropriate supports (62.7%), and a lack of subsidies to make housing affordable (58.7%).

Approaches and Philosophies

- Approximately 33.0% of Safe Havens pointed to the low-demand nature of their program in describing the approach or philosophy they see as most important in helping their residents leave homelessness for good.

Tracking Former Residents

- One-third (33.4%) of Safe Havens either have no policy of trying to track residents after they leave the program, or they provided no response to the question about tracking residents; 18.7% said that they try to track residents for 1 – 2 years; 13.3% said that they try to track residents indefinitely.

Conclusions about Safe Haven Effectiveness

- Safe Haven programs appear to be generally effective at retaining residents and keeping them engaged in the program for a significant amount of time, i.e., nine months.
- While slightly over half of Safe Haven residents reportedly go on to some kind of permanent housing, 35.0% of residents return to homelessness, temporary health institutions, criminal justice institutions, or unknown destinations.

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- A number of Safe Haven programs do not pro-actively track residents for any long-term period, i.e., one year or more, once they leave their program. This makes it difficult to draw any long-term conclusions about the impact that many Safe Haven programs have on their residents.
- In many cases, a lack of community resources appears to be to blame for the fact that more Safe Haven residents do not move into permanent housing. Nearly 63.0% of Safe Havens report that a lack of housing in the community with appropriate supports prevents more of their residents from moving into permanent housing, thereby making it clear that Safe Haven programs alone cannot accomplish their principal goal.

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General Overview

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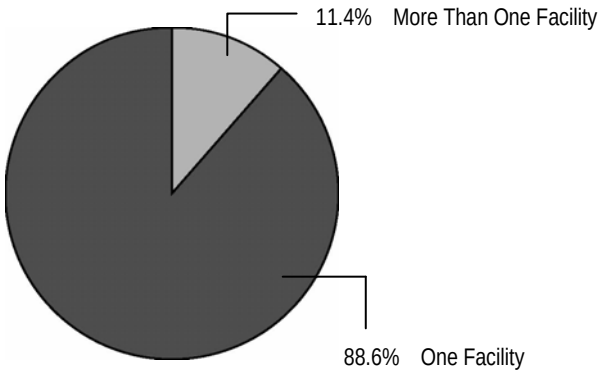
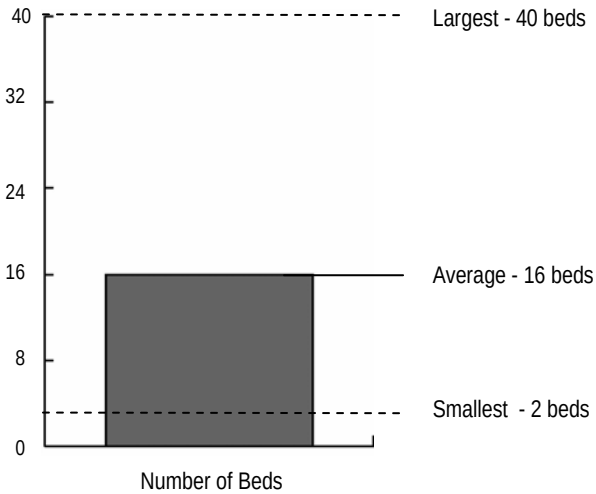
Accommodations

The survey results indicated that Safe Havens have the capacity to house on average 16 residents. Most Safe Havens (88.6%) house residents in a single facility. According to the data received, the largest Safe Haven that serves residents in a single facility can accommodate 40 residents; the Safe Haven that accommodates the least number of residents can house 2 people.

Facilities Configuration



Single Facility Capacity



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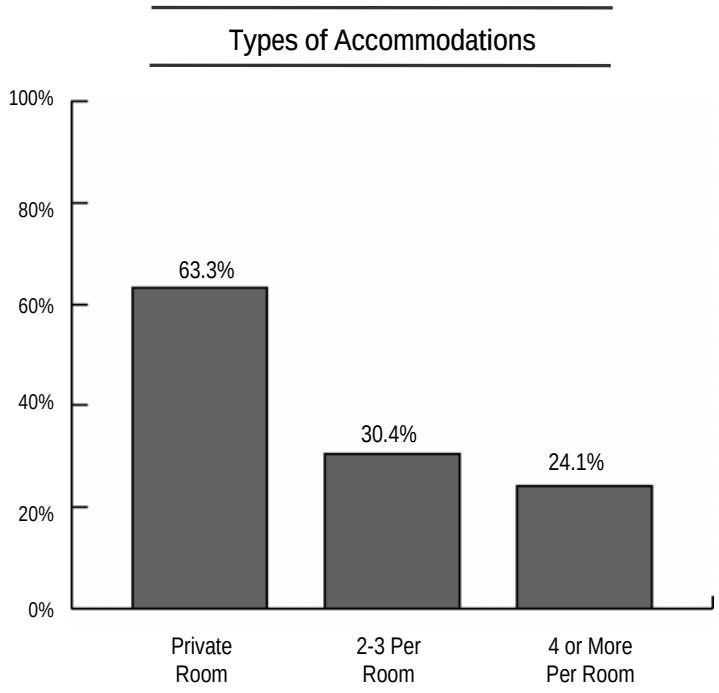
Accommodations (continued)

A number of programs provide more than one type of room for its residents. The majority of respondents (63.3%) reported that their Safe Haven offers residents private rooms. Approximately one-third (30.4%) of the programs provide accommodations that house 2-3 residents per room, while 24.1% house 4 or more residents per room, including dormitory arrangements and large rooms divided by low-wall barriers into individual spaces. One program reported housing 14 residents in three different apartments which are monitored by its staff.



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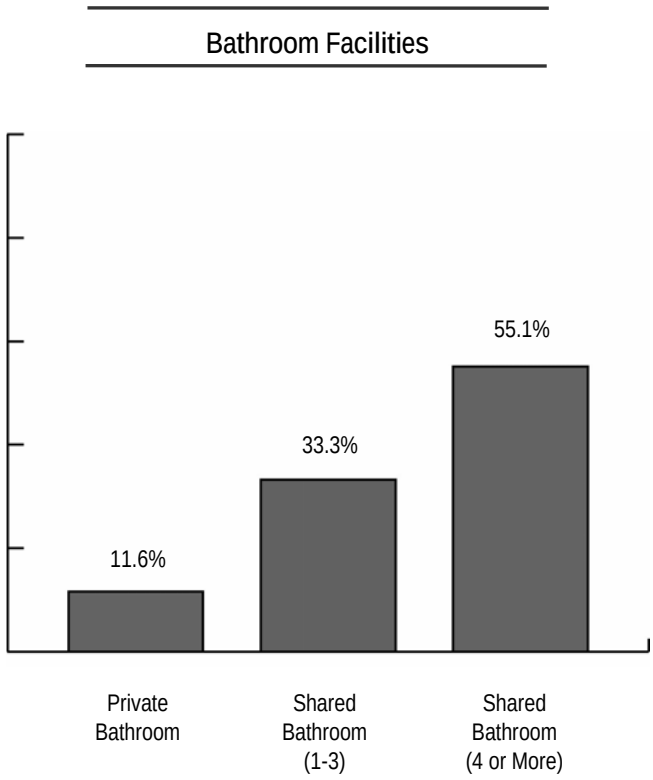
Accommodations (continued)

Over half of the Safe Havens surveyed (55.1%) have bathroom facilities for residents that are shared with 4 or more other people. Approximately 33.3% of the programs reported that residents share bathroom facilities with 1-3 other people. Most programs (55.7%) reported that all or most of their residents share kitchen facilities with other residents. Approximately 38.0% of programs reported that their residents have no access to kitchen facilities. Virtually all (98.7%) respondents indicated their residents have a common space such as a living room or TV room where they can gather and talk with other residents or staff. In most cases (79.8%), Safe Havens have building security 24 hours a day, 7 days a week.



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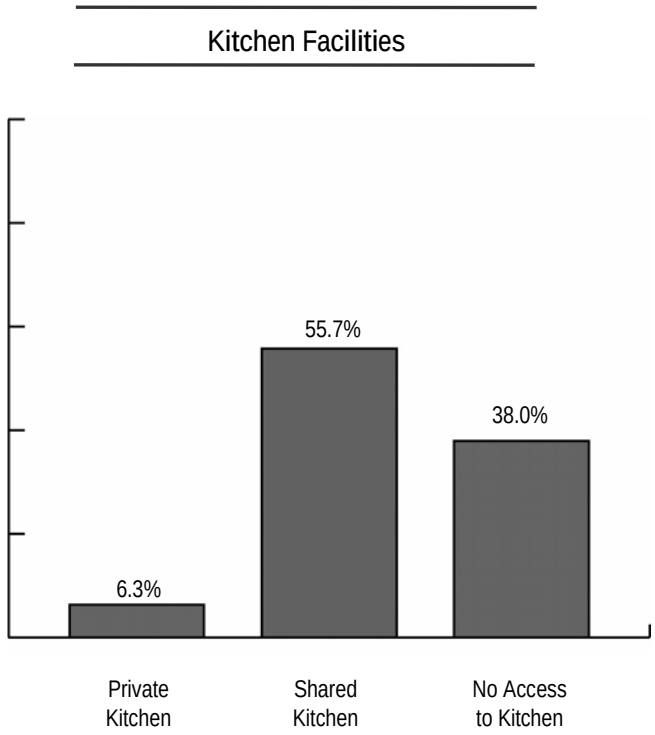
Accommodations (continued)



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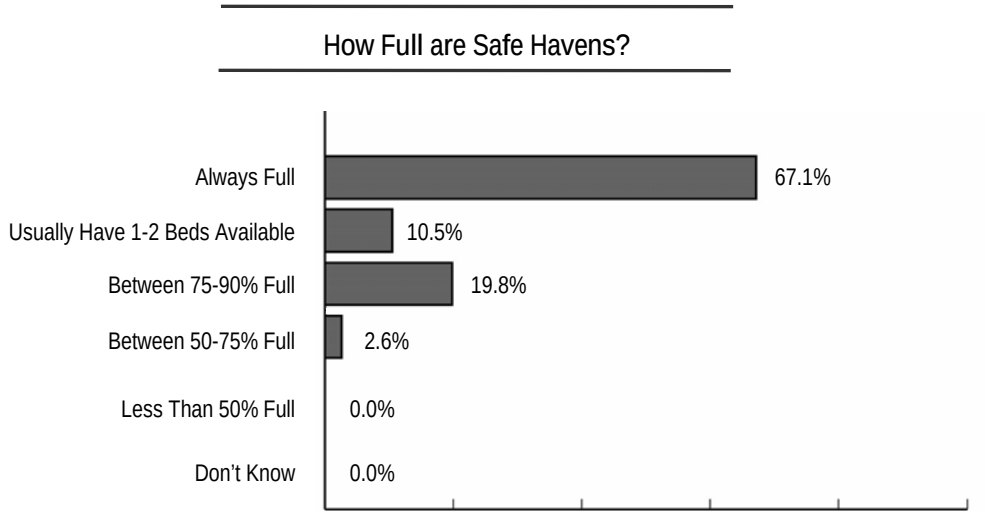
Filled to Capacity?

Most Safe Havens (67.1%) are always completely full and can never take a new resident on the day that he or she applies. Approximately 19.8% reported usually being between 75-90% full. Only 10.5% of the respondents said that they can usually accommodate a new resident on the day that he or she applies. Most respondents (65.8%) indicated they maintain a waitlist for people who want to move into their program. Many programs that reported they had a waiting list were not able to provide a precise answer regarding the length of time people usually have to wait before a bed becomes available. The longest length of time a program reported its wait list to be was 2 years. The shortest wait time reported was 1-3 days. The widest range of wait list time reported by a single program was 6 months – 1 year. Typically, programs that did provide a specific response to this question reported wait list times ranging from several weeks to several months.



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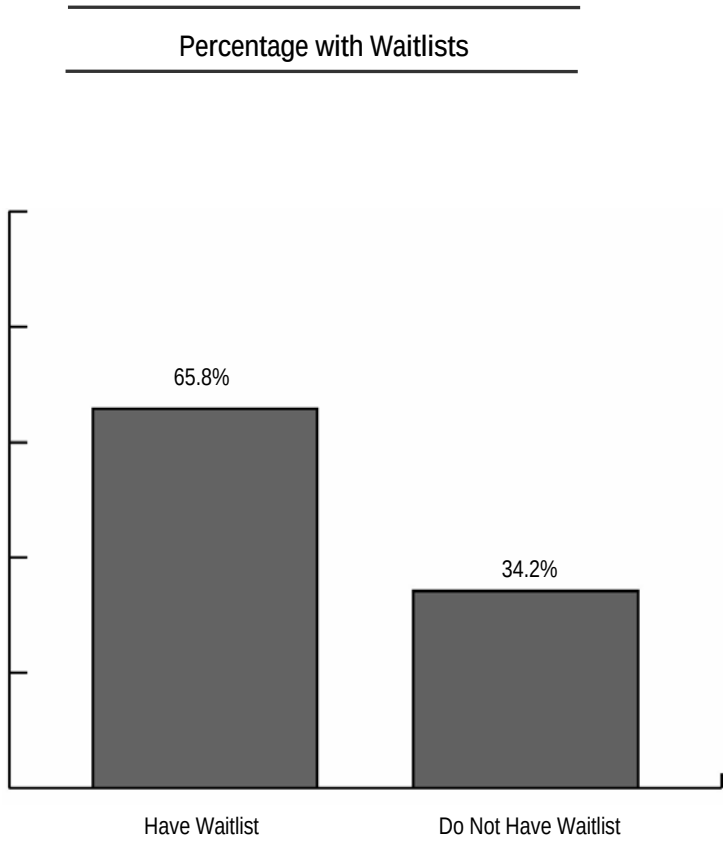
Filled to Capacity? (continued)



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Filled to Capacity? (continued)

One of the reasons cited by several programs in explaining why it was difficult for them to answer questions about the length of time potential clients wait before being admitted to their program relates to how clients are referred to them. One Safe Haven with a wait list reported that more recently referred individuals will often get into their program ahead of other, previously referred, clients because referral sources will continue actively to seek housing for those clients if an immediate bed is unavailable. One program has a referral pool to which it refers when an opening becomes available, but on average, that program has less than one opening each year. Another program reported that it did not maintain a wait list because a separate agency's Outreach Team serves as the Safe Haven's sole referral source. In that case, it generally takes more than 1 week, and on many occasions over 1 month, to place a client due to time needed to gain his or her trust.

One Safe Haven reported that residents are recruited into its program by project staff and mental health outreach workers rather than via self-referral. They follow this approach because the program sees people who seek out the program as generally higher functioning than the Safe Haven target population. In the case of that program, outreach case managers decide based on who are the most vulnerable people. The Safe Haven reprioritizes the list of candidates when they expect that rooms will become available, and candidates at the top of that list are then given an opportunity to move in. Candidates who decline to move in are given 1-3 weeks to consider moving in before the next priority client is offered a room.

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Staffing

Most Safe Havens (88.6%) are staffed 24 hours a day, 7 days a week. Only three programs that are not staffed 24/7 report that the lack of overnight staff makes a difference for the types of people that they are able to accept as residents.

Average Staff Numbers Reported

Description	Averages Reported
Number of full-time staff	7.1
Number of part-time staff	3.6
Number of staff on duty during normal work hours	3.4
Number of staff on duty after work hours on weekdays	1.9
Number of staff on duty on weekends	2

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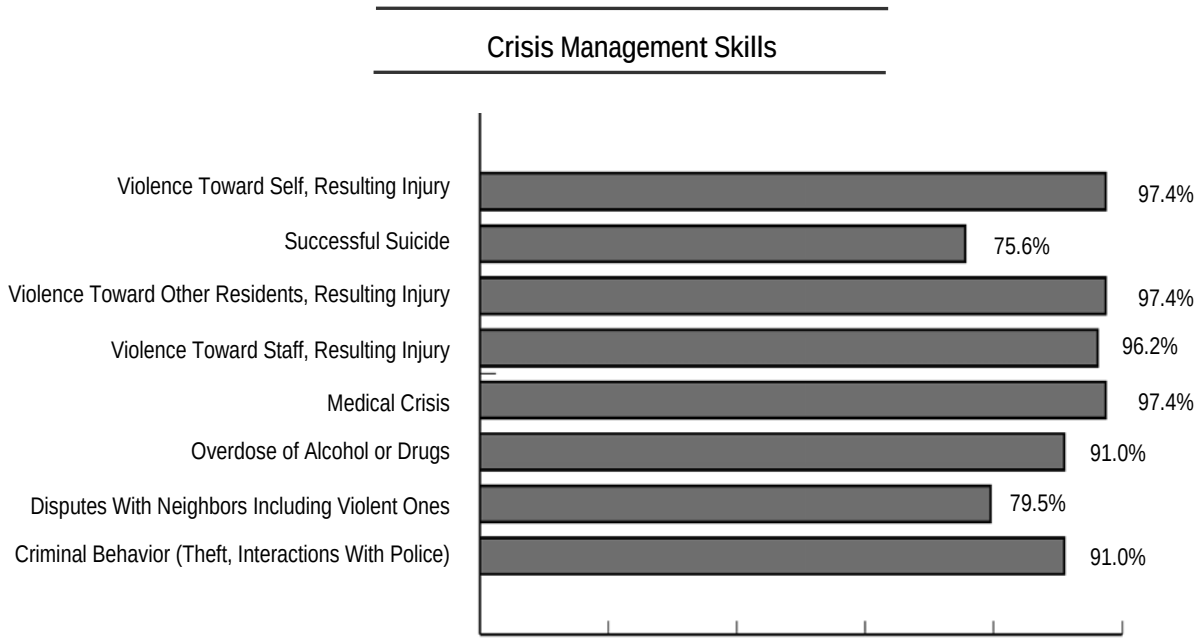
Staffing (continued)

Safe Haven staff must have strong crisis management skills and be prepared to respond to a variety of violent or stressful incidents. In addition to the types of incidents shown in the table below, some respondents included other incidents to which their staff must be prepared to respond, including roommate conflicts and suicide attempts, mental health crises, drug and alcohol-related incidents, delusional behavior on the part of residents that manifests itself in a variety of ways, and weather and building/structure-related crises.



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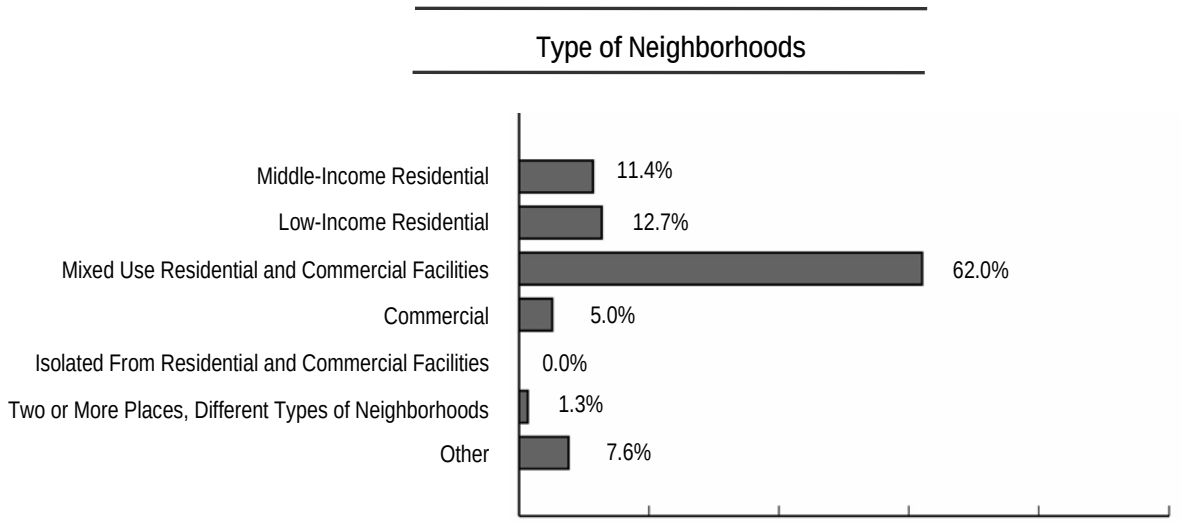
Neighborhoods

Most of the respondents (62.0%) reported that their Safe Haven is in a mixed use - residential and commercial - neighborhood. Roughly equivalent numbers (12.7% and 11.4%) of programs are located in low-income residential and middle-income residential neighborhoods, respectively. Several other answers were provided to the question about neighborhoods in which Safe Havens operate: Skid Row – industrial and SRO hotels and missions, low income neighborhood in the process of successful gentrification, county offices complex outside of town, mixed income/mixed use commercial and residential, and low income but in an area that is being redeveloped by the city. Slightly over half (55.7%) of the programs reported that drug-related crime and other crime is somewhat common in their program's neighborhood. Approximately 31.6% reported that such crime is very common.



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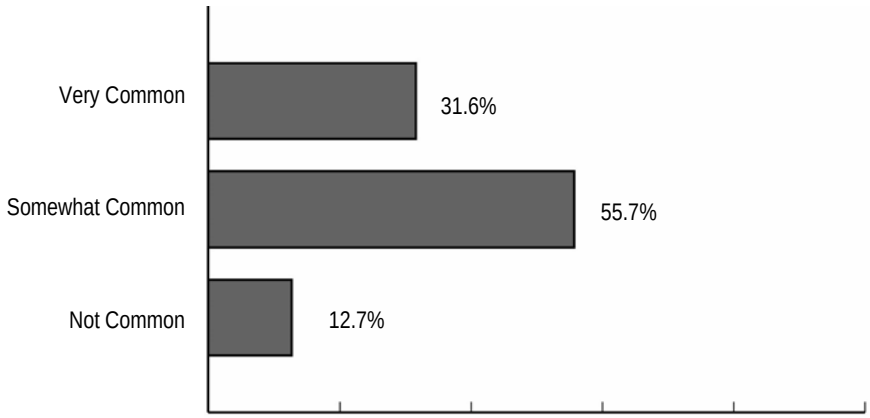
Neighborhoods (continued)

Presence of Drug-Related and Other Crime



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Whom Do Safe Havens Serve?

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Admissions Criteria

The overwhelming majority (93.6%) of respondents indicated that homelessness, defined as "living in a shelter or in a place not typically used for sleeping such as on the street, in a car, in an abandoned building, or in a bus or train station" was required of its residents. One respondent who indicated that homelessness was not required for admission to the program clarified in a follow-up discussion that imminent risk of becoming homeless was sufficient for admission. The majority of respondents do not require residents to come directly from the streets: only 29.1% of the programs reported that "street" homelessness was required, while 67.1% indicated that "street" homelessness was acceptable. Not all programs indicated that a diagnosis of severe and persistent mental illness (SPMI) was required for admission, but a large majority of them (89.9%) said that such a diagnosis was required. Approximately 9.0% of the respondents said that SPMI plus a co-occurring diagnosis (substance abuse or major medical) was required; 91.0% said that it was acceptable.

Most programs indicated that the bar for admission was relatively low in terms of expectations of residents. Only 6.5% indicated that being clean and sober was required. Approximately 19.0% of the programs that completed surveys require residents to be able to participate in developing and carrying out an appropriate treatment plan. On the other hand, only 9.1% said that it was required that residents be inappropriate for, or unwilling to participate in, other treatment programs or supportive services, appearing to indicate that the programs responding to this survey do not necessarily see themselves as the place of last resort for residents.

Similarly, the bar for admission in terms of criminal behavior appears to be relatively low: 96.2% of the respondents said that a felony criminal record was acceptable for residents. Approximately 68.4% said that it was acceptable for residents to have a history of violence against or abuse of children or adults; 59.5% said that a sexual offender criminal record was acceptable.

Several respondents identified other factors that are considered in determining whether to admit a candidate to their Safe Haven program. One program indicated when there is a history of violence, the program will often examine the circumstances and determine if medication has had an impact. In certain cases, that program may require a more extensive history and assessment for screening purposes to ensure that all residents in the Safe Haven are safe. Three programs specified in answering this question that prospective candidates must be chronically homeless in order to gain admission. Another program said that any kind of predatory behavior or overt violence would be cause to exclude someone; another said that persons with a history of arson would not be admitted.

See table to follow. . .

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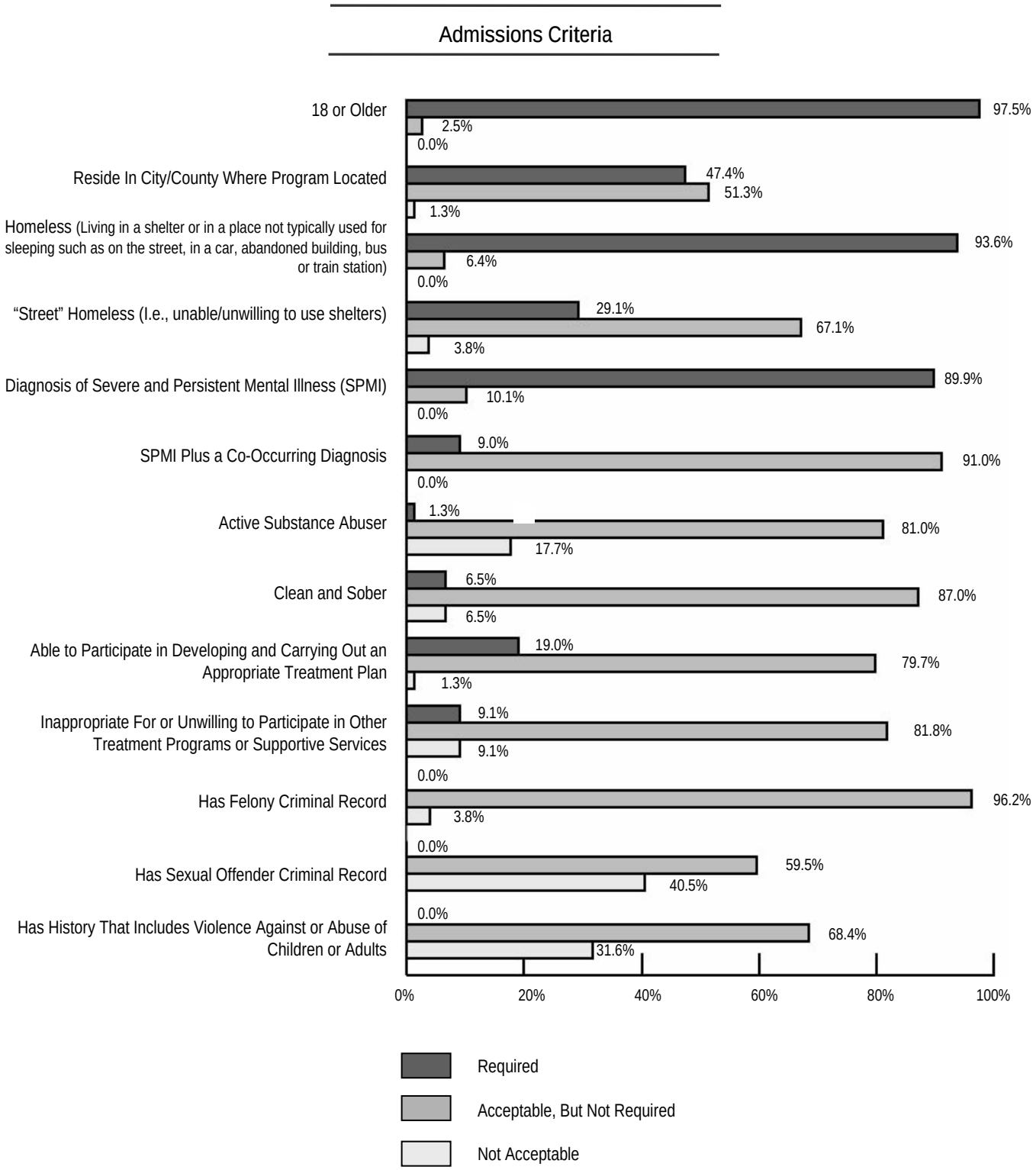
Admissions Criteria (continued)



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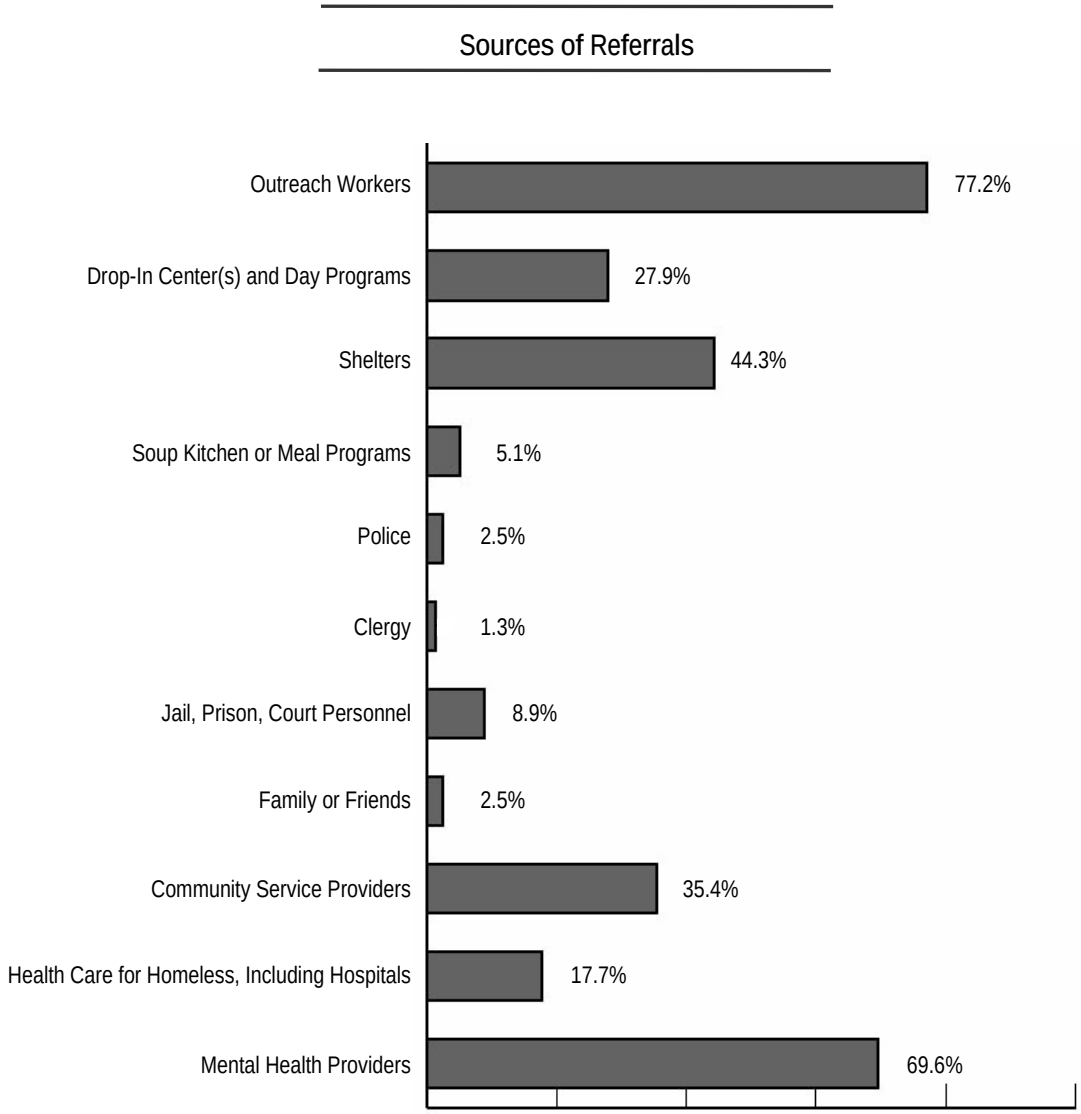
Referral Sources

Most respondents indicated that residents come to their Safe Haven via outreach workers (77.2%) and mental health providers, including psychiatric hospitals (69.6%). Approximately 44.3% reported shelters as one of the most common sources that refers or brings people to their programs.



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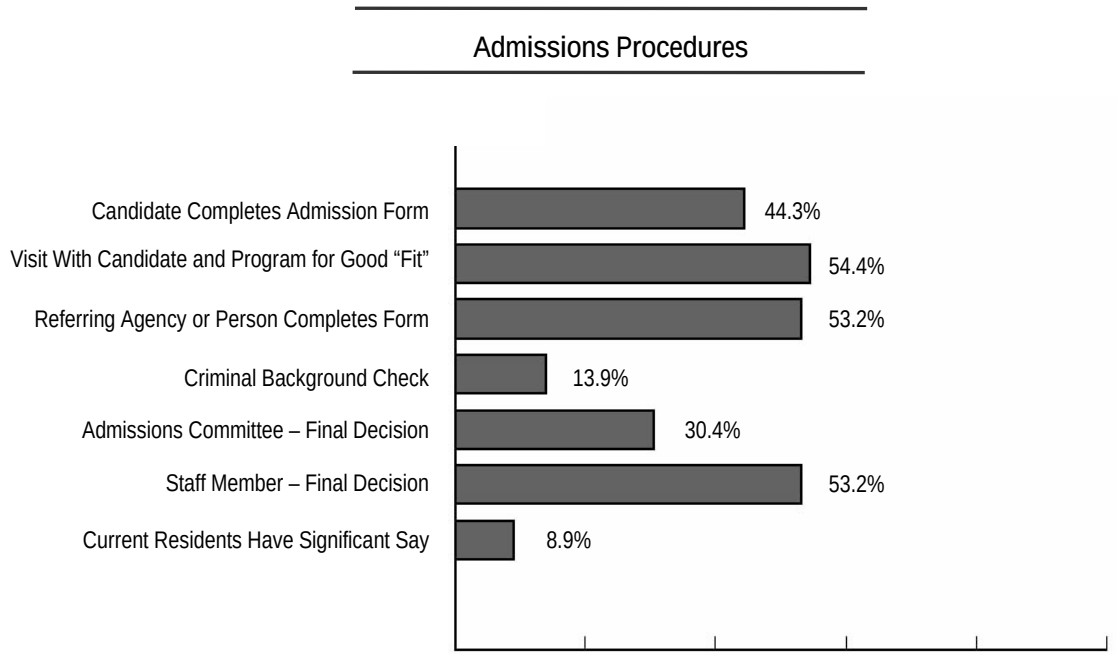
Admissions Procedures

Programs reported a wide variety of admissions procedures, with slightly over half (54.4%) indicating that candidates visit the program in order for both the candidate and the program to see if the "fit" is good.



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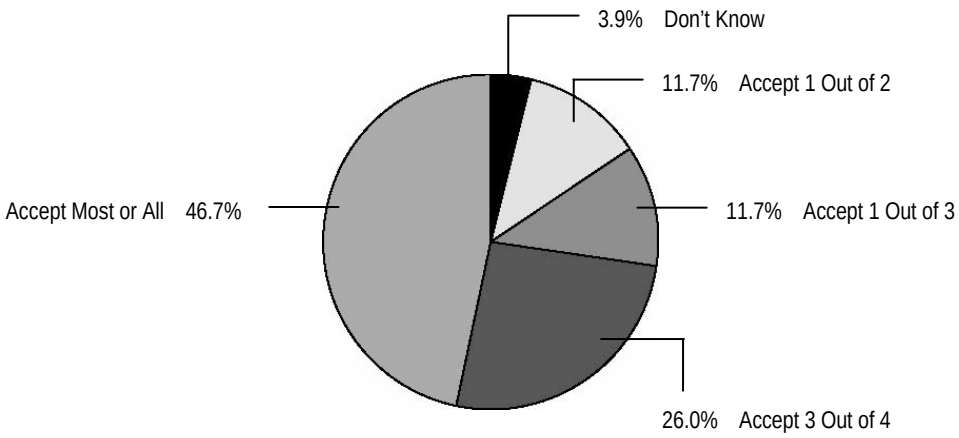
Accepting some Residents and Turning Others Away

Programs that responded to the survey reported that most residents who approach or are referred to their programs are accepted. Slightly less than half (46.7%) of the respondents said that they accept most or all people who approach or are referred to their program; 26.0% reported that they accept 3 out of 4 of prospective residents that approach or are referred to their program.

Acceptance Rate



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Accepting some Residents and Turning Others Away (continued)

The survey asked respondents to list the three most common reasons why people are not admitted to their programs. Looking at all the responses to this question, 35.5% of the reasons provided indicated that people who are not truly homeless, who do not have a diagnosis of a mental health disorder, who are engaged in other community services, or who have other housing or program options, are not admitted (Approximately 64.0% of all Safe Haven programs included one or more of these reasons among their responses. This made it clear the majority of Safe Haven programs serve only these homeless individuals who cannot, or will not, be served elsewhere.) In this context, one program reported that a psychosocial assessment of the individual is first completed by the referring agency to determine eligibility. Another program indicated that homelessness and the presence of disabilities are verified through a Homeless Outreach team. Several programs indicated that individuals who successfully completed traditional shelter programs or who are considered appropriate for other shelter programs are not admitted.

The second most common reason reported among all the reasons provided (14.0%) concerned violent behavior. In these cases, respondents reported that a history of unspecified violent behavior or indications that the prospective client posed a danger to himself or others would be reason to deny admission, A number of respondents (11.0%) reported a variety of unique reasons for denying admission, such as being an illegal alien/not a U.S. citizen, a prior history of conflict with a current resident, being unable to locate the client on the day of admittance or being from out of the county, and being the wrong gender for the apartment vacancy. One program specified that it will not serve a resident more than one time during the same funding contract year; another said that it will not accept repeat guests. Additional unique reasons listed for not accepting people into their programs are that the program suspects the individual may take advantage of other vulnerable adults, the individual has deviant behavior which violates the program's good neighbor policy or has been abusive to staff at other shelters. One program said that it turns people away when they are unwilling to separate from partners or are looking for placement with children. One program that participated in this study provides housing for both mother and children. That program said that it will not accept residents whose children have been removed from custody and for whom Child Protective Services has no reunification plan, or if the mother has more than 2 children or a child over the age of 12.

Active substance abuse was reported by 9.0% of the programs as one of the three most common reasons it denies admission to people. Several respondents (7.5%) pointed to client readiness issues in determining whom to deny admission, including a refusal by the prospective client to accept placement, showing resistance to following procedures, not verbalizing a readiness to change their situation, or indicating no interest in mental health services. An equal number of respondents (7.5%) said they deny admission to people who have physical or medical needs that are too great for the program to accommodate.

In some cases (6.0%), programs are forced to deny admission to people due to lack of space, and 4.5% of programs specified certain kinds of criminal behavior as grounds for denial or admission, including sex offenses, arson, drug trafficking and history of child abuse. Remaining reasons reported are that the prospective client does not meet the program's admission requirement, with no further information provided (3.5%), and the client is too unstable (1.5%).

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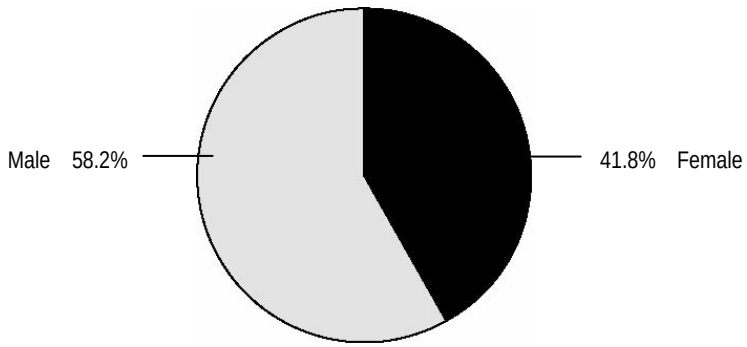
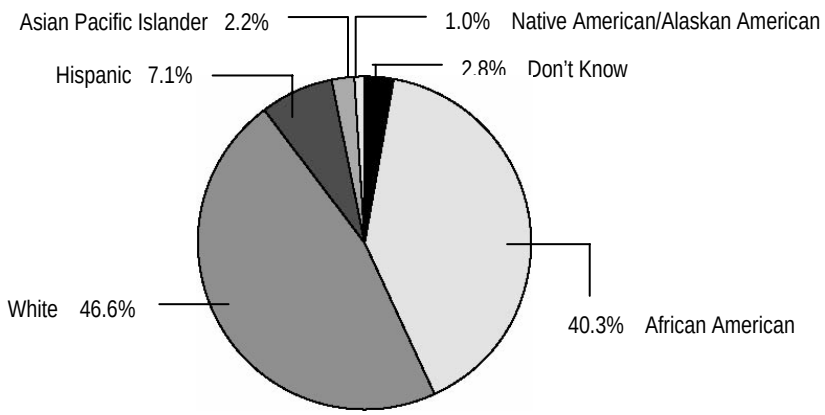
Profile of Residents

Most Safe Haven residents are male (58.2%) and between the ages of 35-54 (61.5%). While most residents were reported to be non-Hispanic whites (46.6%), a large proportion (40.3%) were reported to be African American.

Gender



Race



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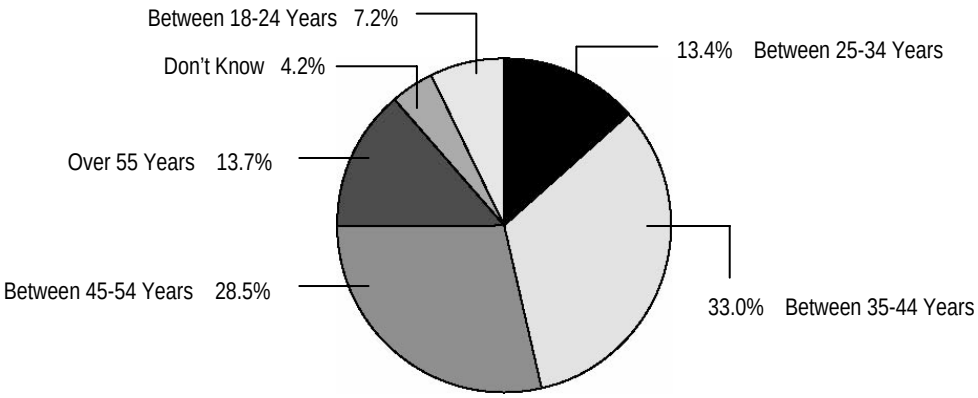
Profile of Residents (continued)

Age



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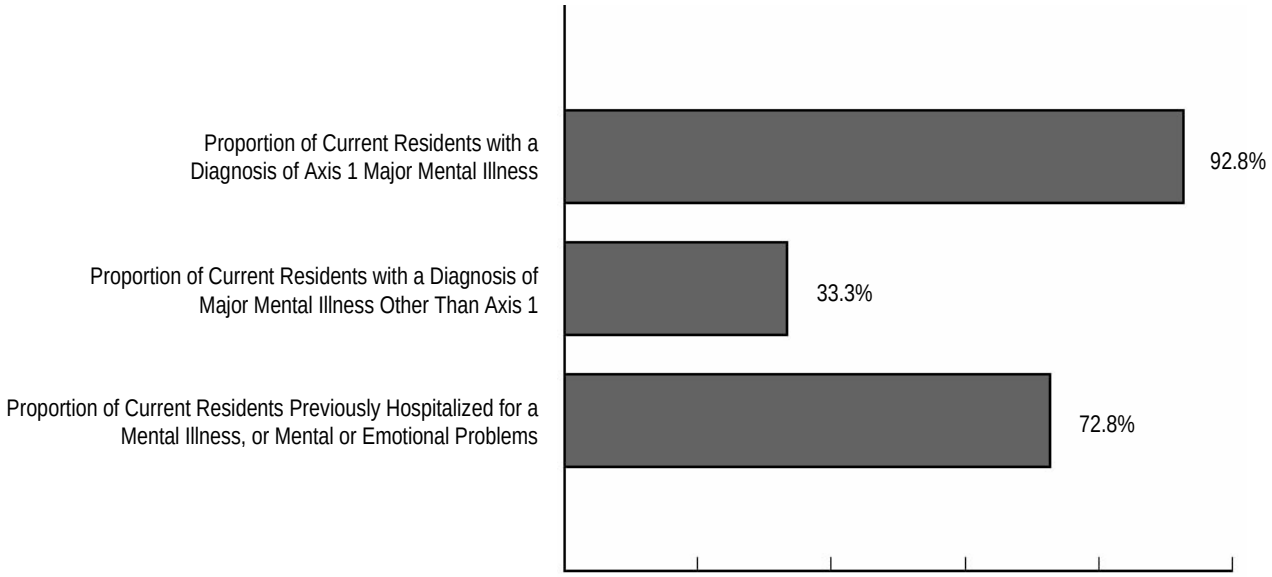
Profile of Residents (continued)

Respondents indicated that 92.8% of current residents have a diagnosis of Axis 1 major mental illness (e.g., schizophrenia, bipolar disorder, depression, schizoaffective), 33.3% have a diagnosis of a major mental illness other than Axis 1 (e.g., obsessive-compulsive disorder, anxiety disorder), and 72.8% of current residents had been hospitalized for a mental illness or mental or emotional problems. Approximately 36.2% of current residents are reported to be active substance abusers, while 36.0% have a history of substance abuse but are not now active substance abusers. Approximately 36.2% of current Safe Haven residents have serious medical conditions such as diabetes, hepatitis, HIV/AIDS, TB, high blood pressure, heart disease, liver disease, etc.

Mental Illness of Residents



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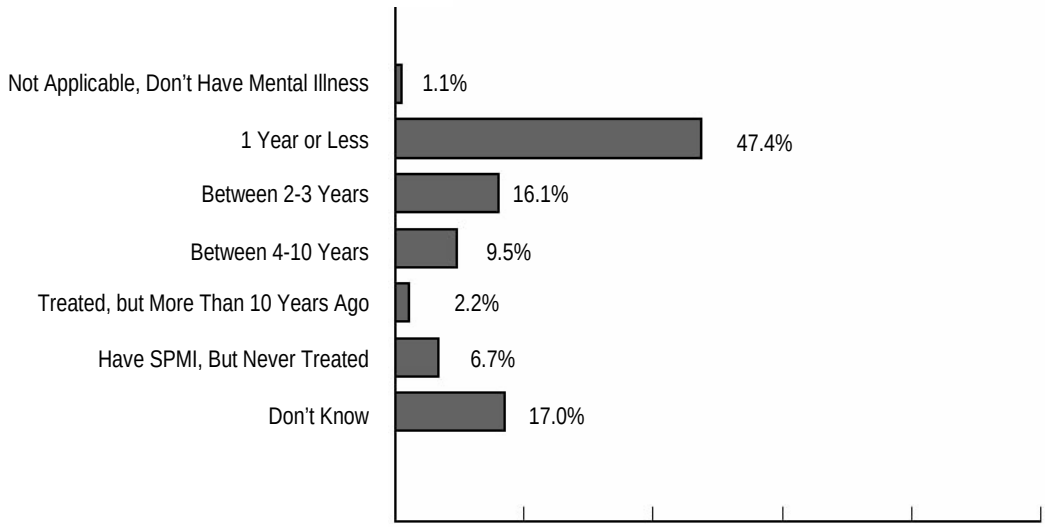
Profile of Residents (continued)

Length of Time Without Treatment for Mental Illness



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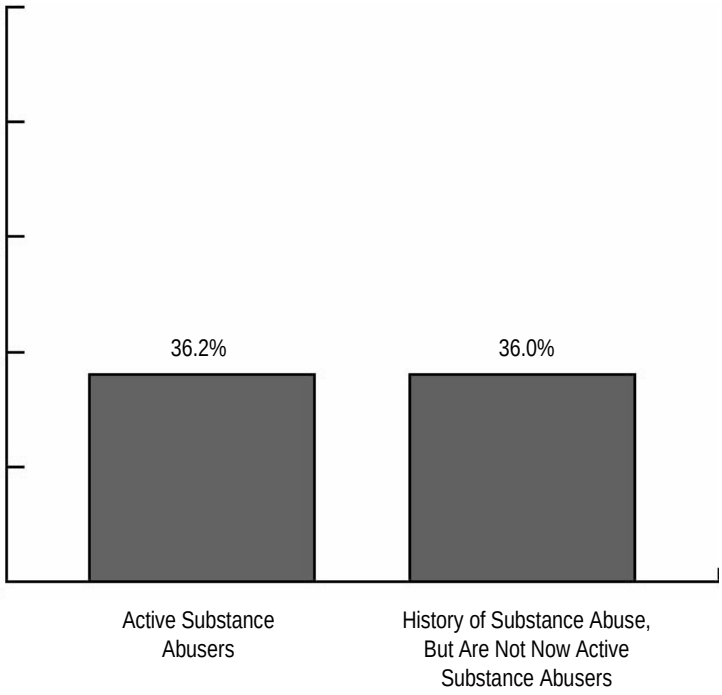
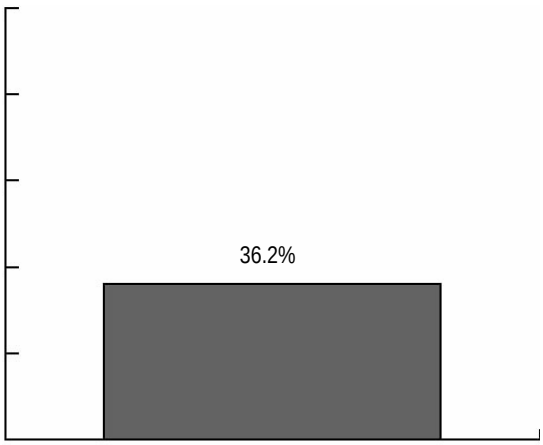
Profile of Residents (continued)

History of Substance Abuse



Proportion of Current Residents with a Serious Medical Condition



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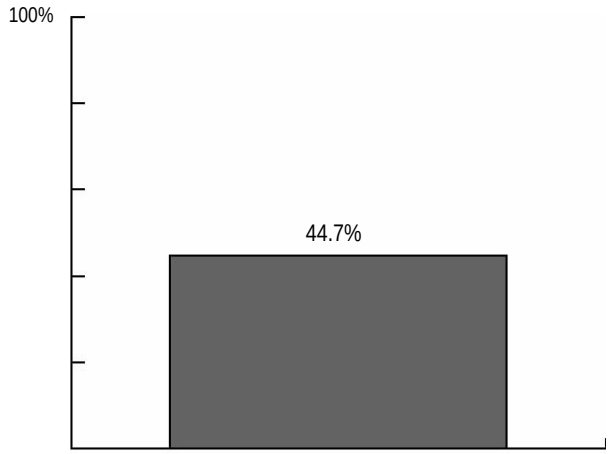
History of Homelessness of Residents

Respondents reported that 44.7% of current residents were residing in the streets or in abandoned buildings just before they entered their programs. Most residents (44.0%) had reportedly been homeless for 12 months or less; 22.9% had been homeless for 13-24 months. The survey attempted to gauge the level of chronic homelessness among Safe Haven residents through a question that asked for the total length of time spent homeless by residents over their lifetimes. This question proved difficult for many programs to answer. Approximately 24.3% of the programs reported that they were unable to answer the question. With that caveat, periods of time spent homeless over a lifetime included on the survey received similar responses. For example, 17.1% had been homeless for 12 months or less; 23.9% had been homeless for 13-24 months; 17.4% had been homeless for five years or more.

Percent Residing in Streets or Abandoned Buildings



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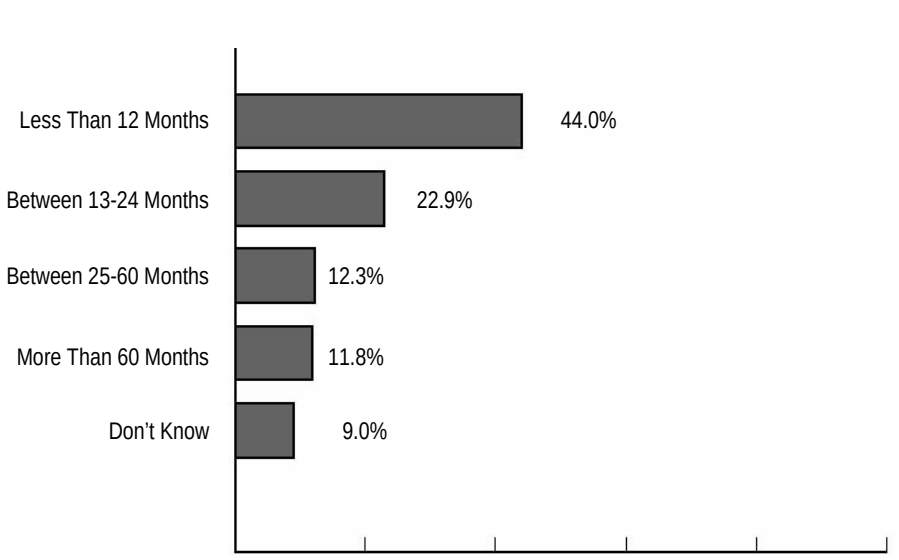
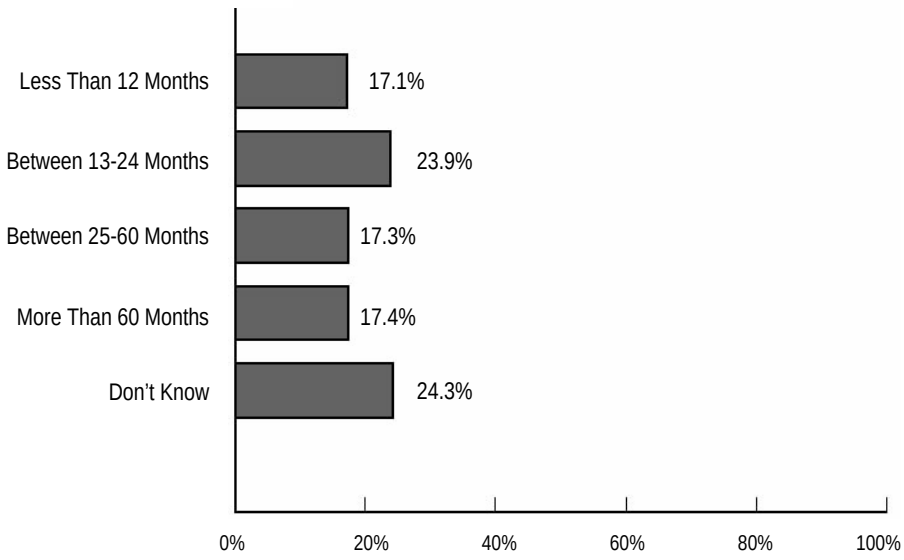
History of Homelessness of Residents (continued)

Length of Homelessness Before Entering Program



Lifetime Length of Homelessness



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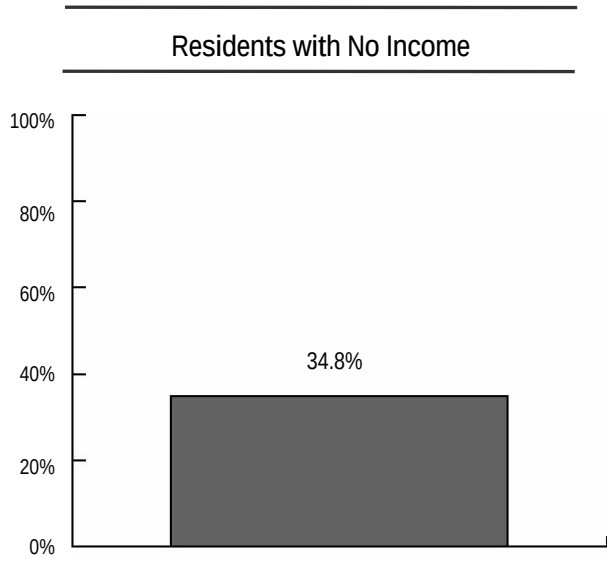
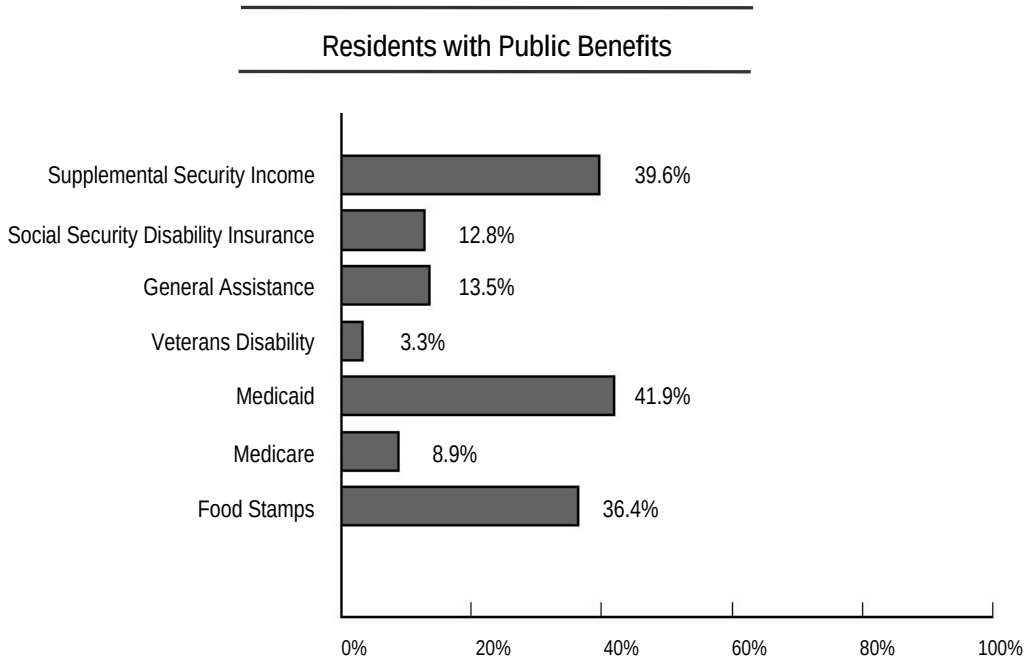
Income and Benefits Sources of Residents

A little over one-third (34.8%) of Safe Haven residents were reported to have no income sources of any kind. Most residents with income sources receive Medicaid (41.9%), while 39.6% receive Supplemental Security Income (SSI). Virtually none of the income of residents is obtained through employment. Approximately 11.6% of the residents reportedly receive income through panhandling, day labor, recycling, etc., while only 7.5% and 1.3% earn income through part-time employment and full-time employment, respectively.





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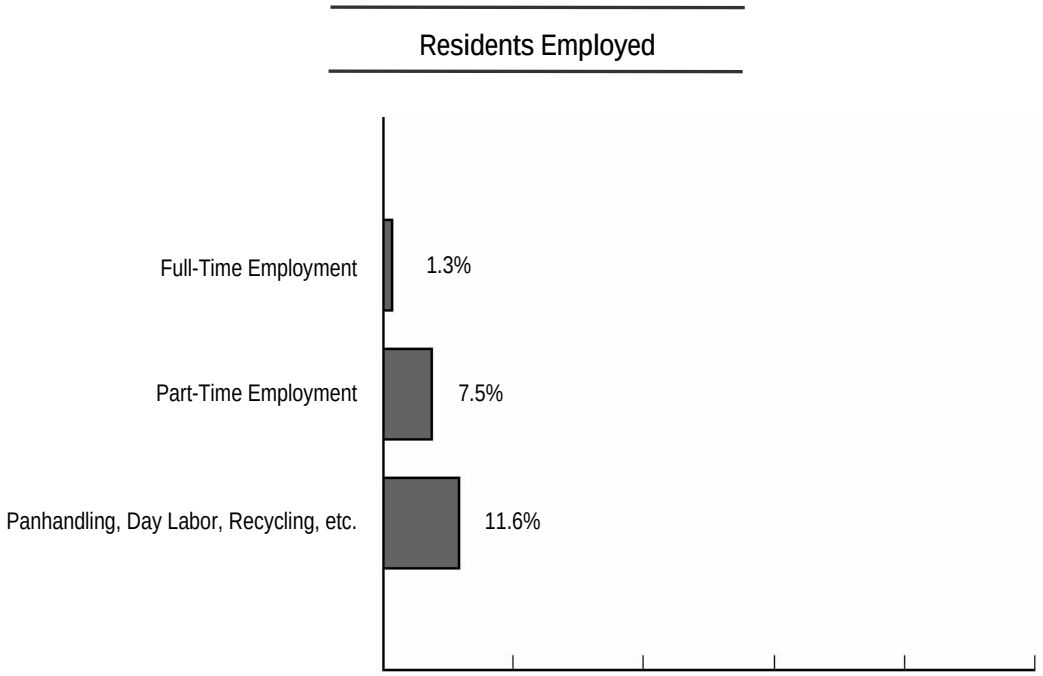
Income and Benefits Sources of Residents (continued)



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Are Safe Havens "Low Demand" Programs?

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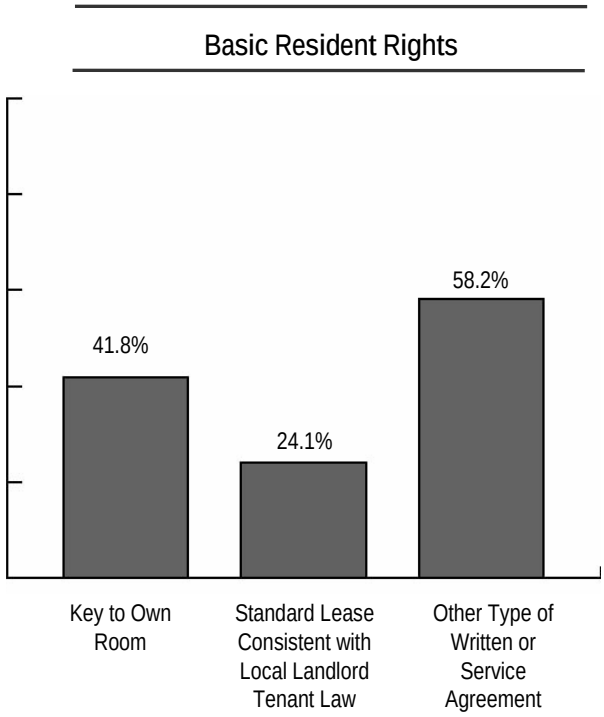
Basic Resident Rights

About one-fourth (24.1%) of the programs reported that their residents hold a standard lease consistent with local landlord tenant law. The majority of respondents (58.2%) indicated they have another type of written agreement or service agreement stating their right to stay for a specified period, and their obligations related to that stay, such as paying rent and participating in services. Approximately 41.8% of respondents reported that their residents have a key to their own room.



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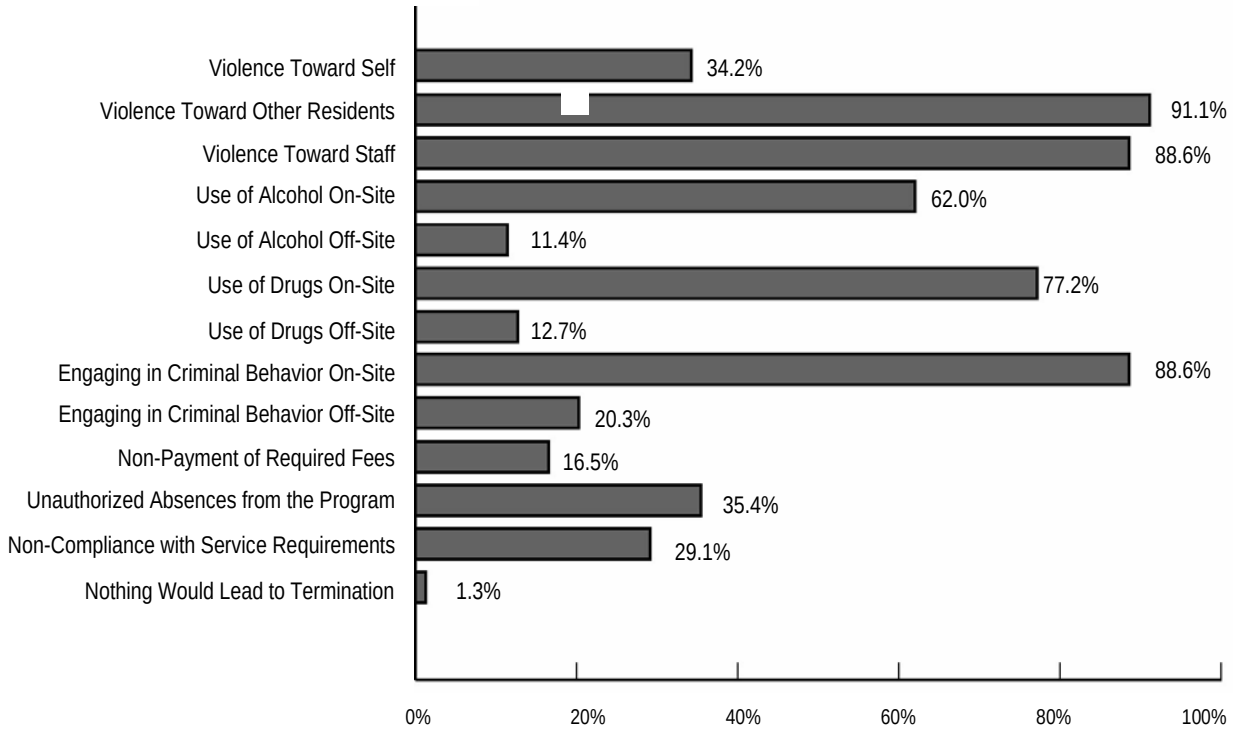
Terminating Residents

Only 1.3% of respondents reported that nothing a resident did would lead to his or her termination. One of the most common reasons cited for terminating a resident (91.1%) was violence toward other residents. Approximately 88.6% said that violence toward staff would cause the program to terminate a resident; 88.6% also said that engaging in criminal behavior on-site, unrelated to alcohol or drugs, was grounds for dismissal. Approximately 77.2% of respondents said that they would terminate a resident for use of drugs on-site; 62.0% said the use of alcohol on-site would lead to termination.

Reasons for Termination



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Terminating Residents (continued)

Many programs, however, sought to clarify their responses and policies on terminating residents by offering additional comment. One program reported that it does not terminate residents, but will ask them to leave for a period of time. Another said that testing positive for drugs or alcohol was cause for residents to leave and then reapply to the program. Three programs specified that violence towards self or others, or criminal behavior, must occur repeatedly before termination will result. One program noted that it rarely terminates anyone and does so only after many chances and when there is a serious concern for the safety of residents and staff. One program clarified that severe violence, apart from normal aggressive behavior experienced, can be reason for dismissal, and given the program's belief in personal accountability and responsibility for persons served and employed, criminal action will be pursued as warranted.

Four programs specified that extended unauthorized absences – more than 7 days in three cases and more than 30 days in one case – could result in dismissal. Four programs specified that when confronted with behaviors that lead to termination, the residents would be linked to higher levels of care such as more intensive mental health care or hospitalization. One respondent noted that a refusal of psychotropic medications after being compliant for an extended period of time could lead to termination. Another said that suicidal clients cannot use their services for 30 days or until a doctor's clearance is provided. Other reasons listed for possible termination were noncompliance after signing an Individual Service Plan, continued persistent substance abuse, distribution of drugs to fellow residents for money, refusing to engage in drug treatment if drugs were creating problems in the milieu, chronic use of alcohol on site and smoking on site.

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Daily Life

A variety of responses were given to questions on the survey that asked about daily life, structure, and rules and expectations of residents at the Safe Havens. Approximately 36.7% reported that their programs had no structure and that residents could spend time as they like. Only 8.9% of respondents said that residents must participate in activities related to behavioral health. However, 70.9% reported that activities are offered related to behavioral health, e.g., 12-step meetings and counseling regarding mental illness (but residents may choose to attend or not). Only one third (30.4%) of the programs require residents to participate at least in weekly meetings. On the other hand, the majority of programs (60.8%) require residents to meet with their case manager on a regular basis.

While the number of required activities at Safe Havens appears to be low, a number of optional activities are reportedly available. Approximately 74.7% of respondents report that residents are afforded regular opportunities to participate in the program's "governance", e.g., residents' council, weekly meetings, and feed back sessions. Approximately 53.2% of the programs offer activities of general interest, e.g., yoga, sports night, monthly birthday dinner and cooking classes. Several respondents provided additional information about the daily and weekly routine for residents of their programs beyond the survey's checklist of potential responses. Several programs noted optional in-house meetings that were part of daily life, including daily living skills training in the areas of hygiene, kitchen and food, and room cleaning. Meetings with case managers to discuss treatment goals are also offered and encouraged. One program offers various groups run by staff to residents on a voluntary basis such as a Women's Group and Activities Group. One program has a Learning Center on-site that is available daily as well as art therapy that is offered weekly.

See table to follow. . .

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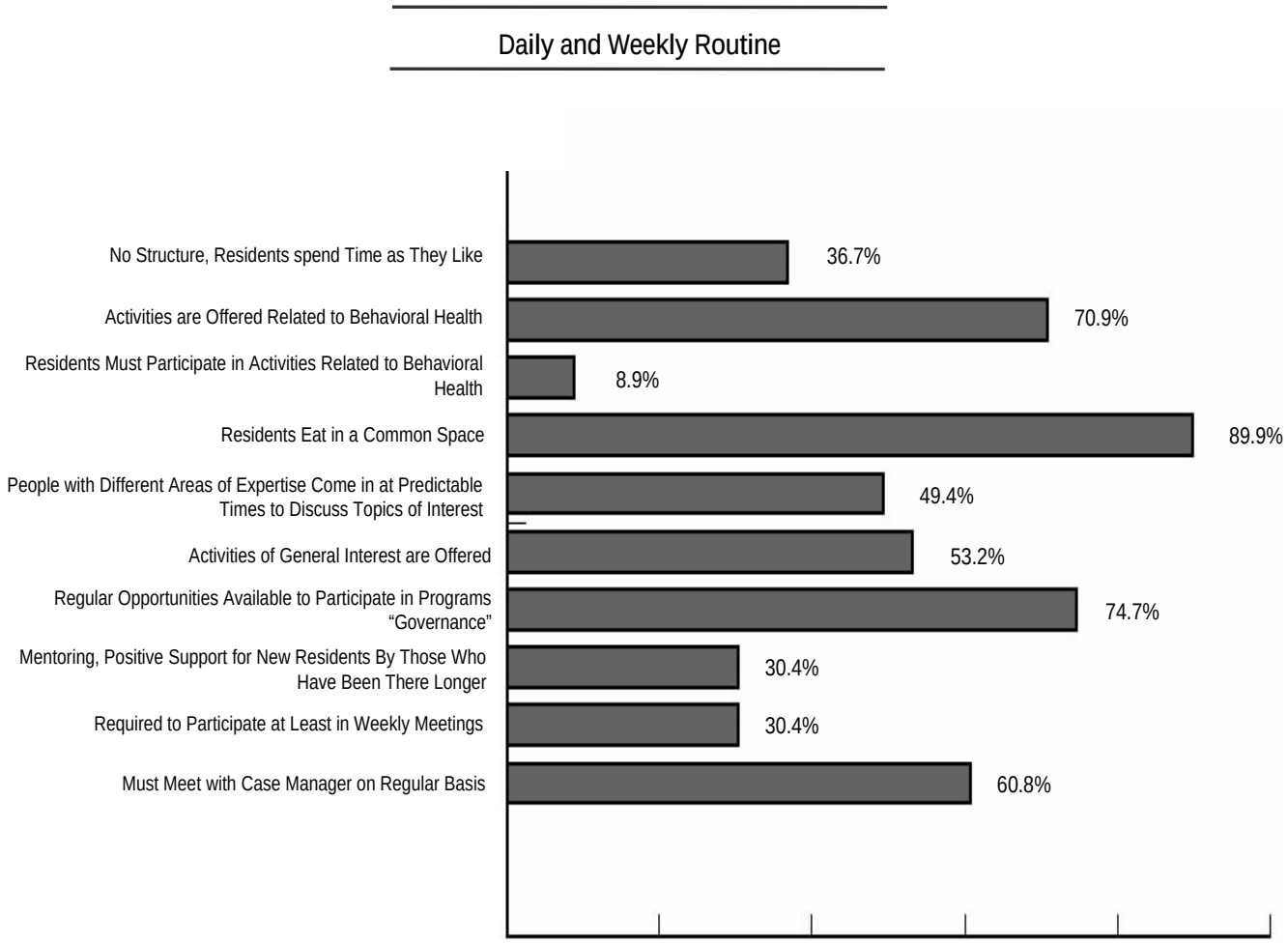
Daily Life (continued)



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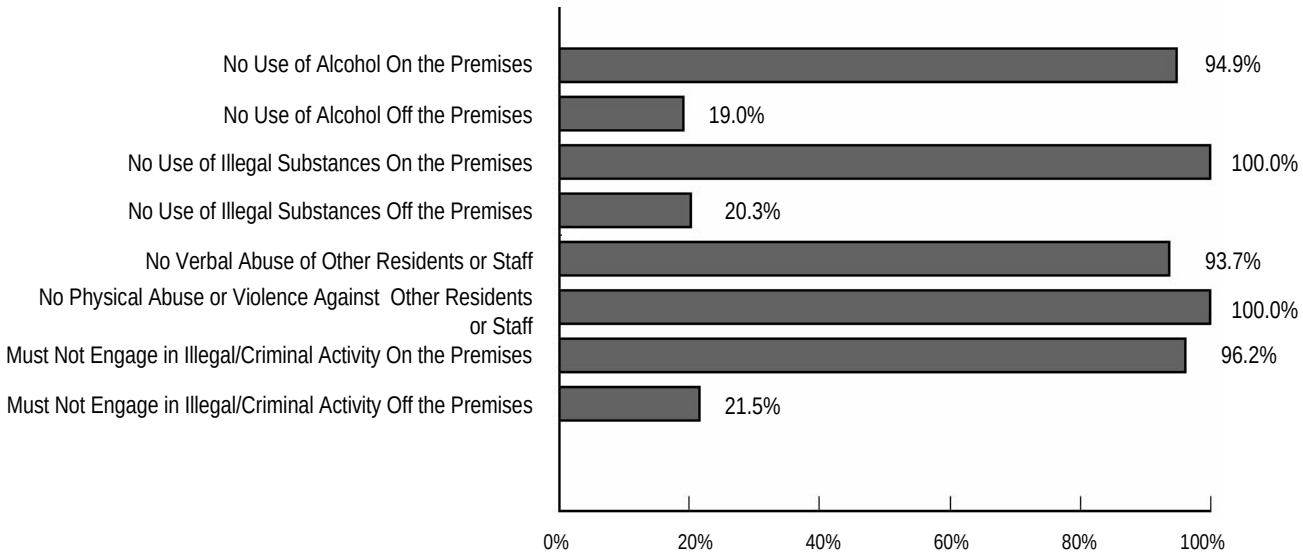
Daily Life (continued)

Many Safe Havens also offer outside activities, with programs linking residents to support services within the community, taking residents on outings in an effort at community integration, weekly trips to museums and other places of interest, and linking residents to volunteer opportunities. One program noted that its residents receive Assertive Community Treatment at home.

With respect to rules and expectations of residents related to the use of alcohol, illegal substances, violence and criminal activity, 100% of the respondents said that their programs ban the use of illegal substances on the premises and physical abuse or violence against other residents or staff. Nearly all respondents (96.2%) indicated their residents must not engage in illegal or criminal activity on the premises. Approximately 94.9% said that residents were not to use alcohol on the premises. Programs also tend to take a negative view of verbal abuse, with 93.7% citing no verbal abuse of other residents or staff among their rules. Other activities banned are pressuring others for sexual favor and stealing. One program said that it will not harbor a known fugitive.

Rules and Expectations
(Alcohol, Illegal Substances, Violence, Criminal Activity)



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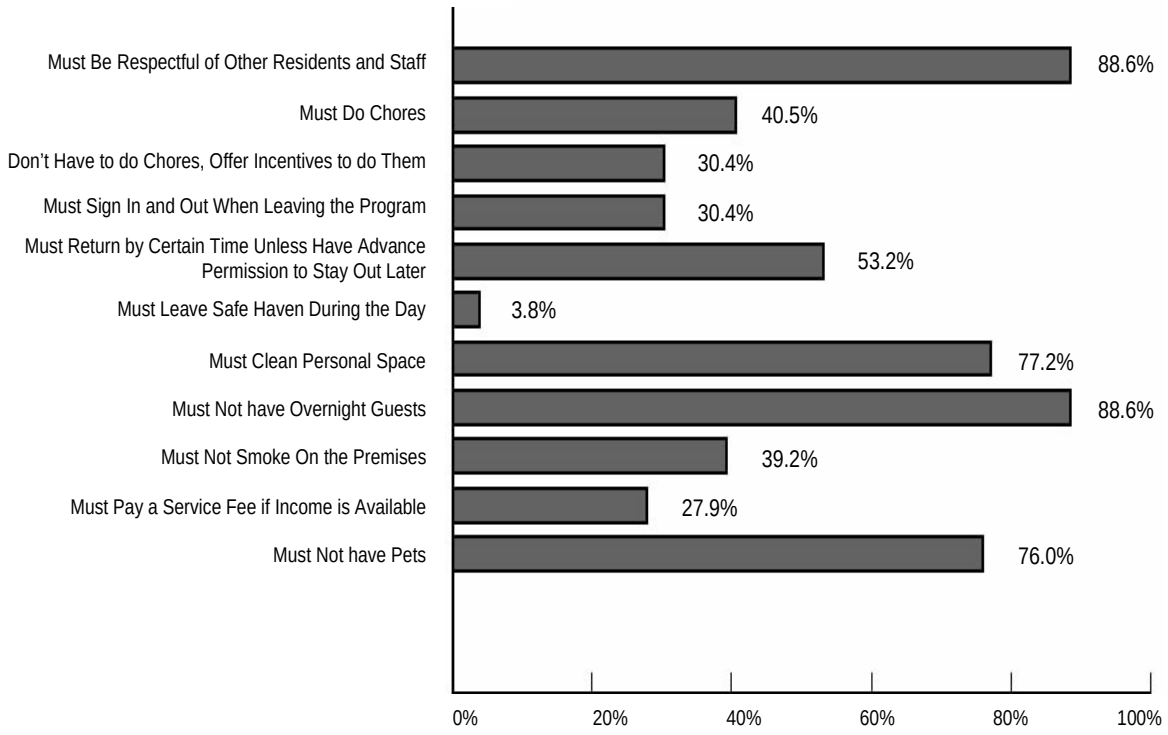
Daily Life (continued)

Respondents also reported a high number of general rules and expectations that apply to residents. Approximately 88.6% said that residents must be respectful of other residents and staff by not having overnight guests. A high percentage of programs (77.2%) require residents to clean their own personal space. Slightly more than half (53.2%) said that residents must return by a certain time unless they have obtained advance permission to stay out later. Other rules and expectations reported by respondents are a requirement that visitors sign in and out, residents must maintain adequate personal Activities of Daily Living (ADL) skills for community living environment and residents are not to borrow or lend money. Four programs specified that smoking could occur only in designated areas. In the case of one program, residents must leave their sleeping quarters during the day but can use a day room, which has a TV, movies, games, puzzles, reading materials, etc. Two programs noted that sexual contact with other guests was prohibited. One program specified "respect yourself, respect others and respect property" as an additional rule beyond those listed; another said that it has behavioral contracts for residents regarding the use of substances, medications, violence, etc. and allows only social therapy animals on-site. Only one program reported having no rules or expectations of residents.

Rules and Expectations
(General)



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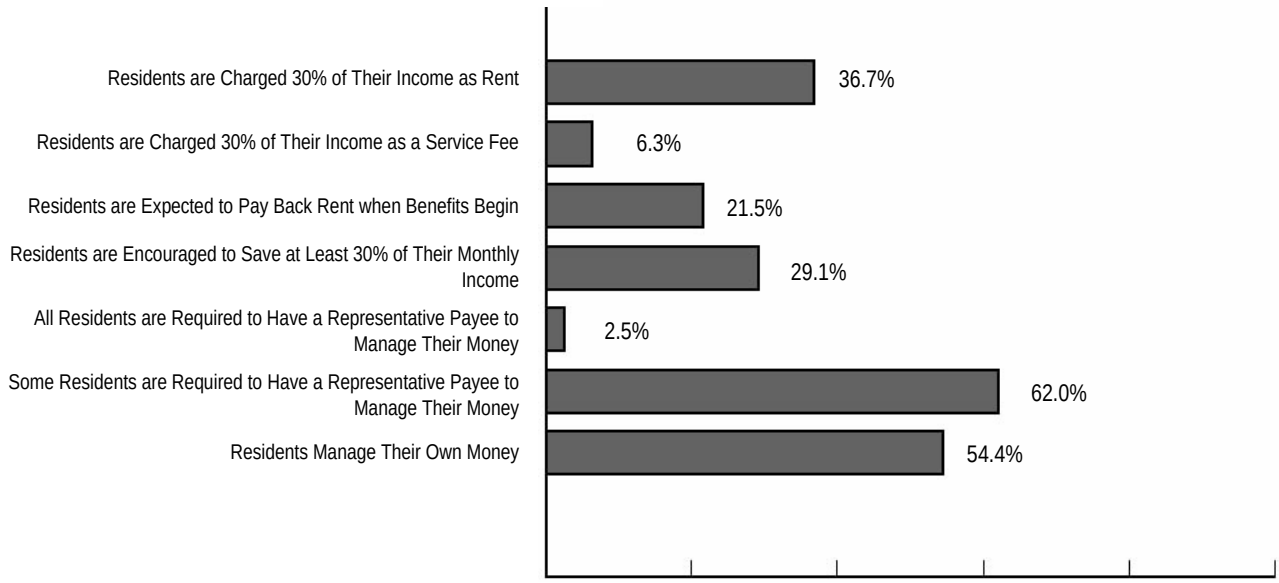
Daily Life (continued)

Finally, with respect to rules and expectations regarding money, 36.7% of respondents said that they charge residents 30% of their income as rent, 29.1% of the programs encourage residents to save at least 30% of their monthly income. Approximately 62.0% said that some residents are required to have a representative payee to manage their money; 54.4% said that residents manage their own money.

Rules and Expectations
(Money)



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Daily Life (continued)

The following lists additional responses as provided by respondents to the survey question regarding money-related rules and expectations:

- Rent is 15% for shared room and 30% for own room.
- Residents do not pay rent.
- Management of money may be referred to resident's physician regarding considering of payee situation if they are not able to reasonably demonstrate responsibility in this area or by history if it is well documented.
- Residents are charged 15% of their income as a service fee.
- Assistance is provided with opening bank accounts and developing a budget.
- Residents must save 75% of income in order to attain housing.
- Residents must pay 66% of their income in facility and service fees.
- Residents purchase their own personal care, toiletry and detergent items.
- Residents pay no rent or fee for services; donations are accepted.
- Clients pay program fees that are equal to their total entitlements less $125 if they have 1 child; $150 if they have 2.
- Residents are expected to pay $85 per month for food costs.
- Residents are encouraged to pay 30% of their income as rent and to pay $85 a month for food. Residents are not discharged if they have income and don't pay for rent or food.
- Residents provide food stamps to defer cost of meals. Must move as soon as housing is available after securing income.
- We are beginning to research possibly charging rent.
- Residents are charged a program fee on a sliding scale (usually around 10-15%, depending on the type of income available).
- Residents are required to save 50% of their monthly income.
- Some residents have representative payees but are not required by the house to do so.
- Residents pay a service fee which is 13% of income in addition to rent.
- Residents with income are required to save all income in excess of legitimate bills and $100 a month spending money, as all basic needs are provided.
- Residents are charged 15% of their income as rent.

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Daily Life (continued)

While there is no agreed definition of the term "low-demand", it appears the majority of programs that responded to this survey operate, what most people could reasonably conclude, are low-demand programs. The vast majority of programs do not require residents to participate in activities related to behavioral health and only one-third of the respondents indicated residents are required to participate in weekly meetings. Where there are requirements, they appear to be aimed primarily at the need to maintain security for residents and staff, such as a broad ban on use of alcohol and illegal substances on the premises and a ban on overnight guests. In the open-ended question on the survey that asked respondents to list the services or aspects of their approach or philosophy that they think are the most important things contributing to their success in helping residents leave homelessness for good, 33.0% of respondents either specifically cited their program's low-demand philosophy or described features of their programs that appeared to indicate a low-demand program. Thus, a number of respondents to this survey clearly regard their programs as low-demand, regardless of how one defines the term.

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Length of Stay

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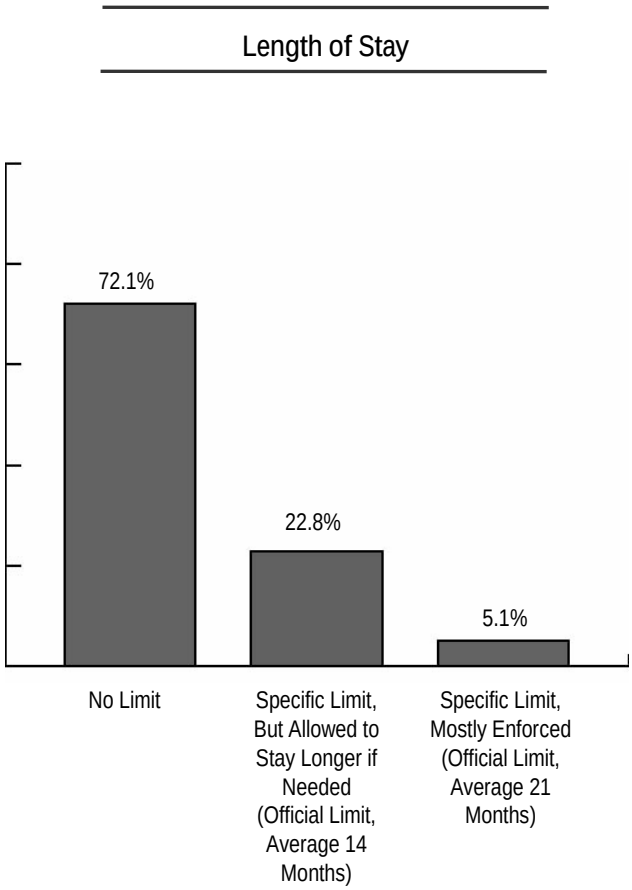
Length of Stay

The majority of respondents (72.1%) reported that they impose no limit to the length of time that residents may stay at their Safe Haven. Approximately 22.8% of the programs said that they have a specific, official limit on length of time residents may stay, with the average length being 14.4 months, but that they will allow residents to stay longer if needed. Only 5.1% of respondents impose a limit on length of stay that is mostly enforced. The average limit that these programs impose is 21 months.



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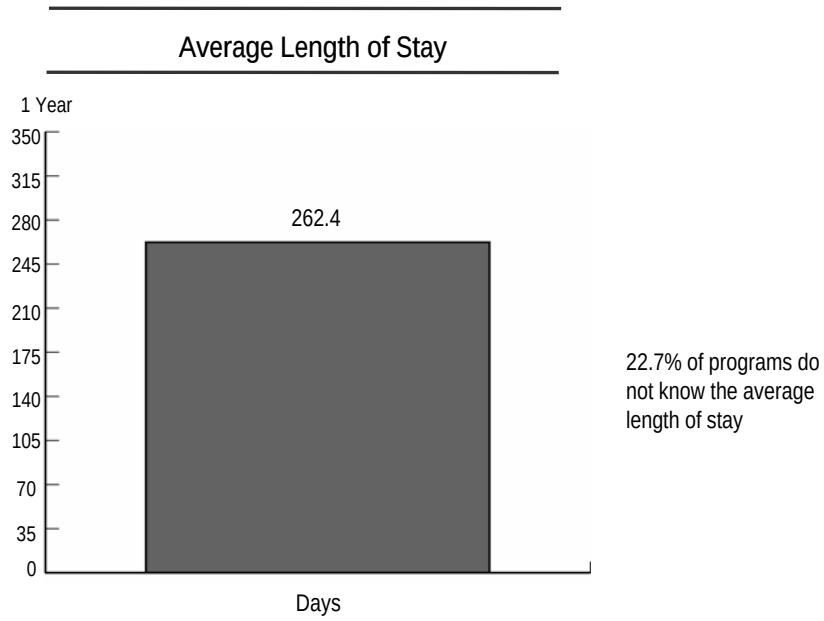
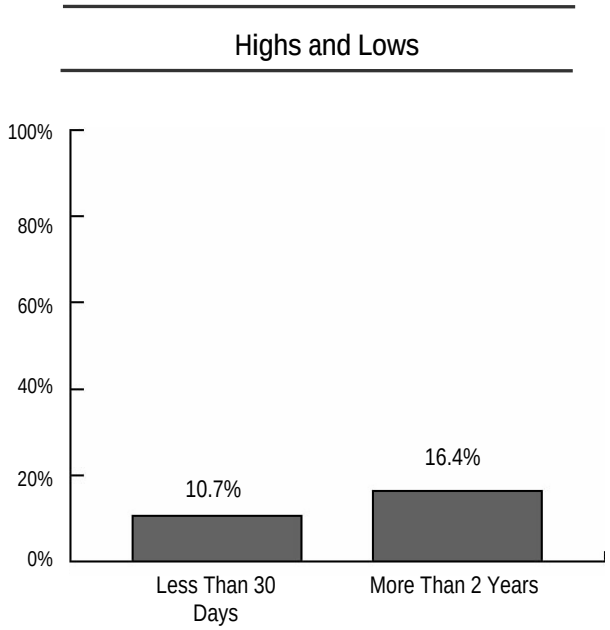
Length of Stay (continued)

The survey asked for the average length of stay of people entering the Safe Haven program. The average length of time that residents reportedly stay in the Safe Haven programs was 262.4 days. However, a fairly large percentage of respondents (22.7%) reported that they did not know the answer to this question. Only 10.7% of residents reportedly stay less than 30 days; 16.4% of residents reportedly stay longer than 2 years.





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Do Safe Havens Play a Unique Role in Their Local Communities?

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Unique Role?

A key question WFF wanted to study was whether Safe Havens serve a group of people that are not being served by other homeless shelters in a particular community. In order to address this issue, the survey included a question that listed 11 characteristics and asked whether each characteristic described the Safe Haven program completing the survey and whether the program differed from emergency and transitional shelters in their communities. The characteristic which reportedly had the greatest difference between Safe Havens and emergency and transitional housing programs was a willingness to take active substance abusers. Approximately 78.5% of respondents said that their Safe Haven program would take residents who were active substance abusers; 41.8% said that this was different from emergency shelters in their community; 48.1% said that it was different from transitional housing programs.

Another characteristic in which answers given indicated a substantial difference between the Safe Haven program and emergency and transitional housing programs was that of imposing no time limits on the length of stay of residents. Approximately 69.6% of respondents said that there are no time limits on residents length of stay (which is slightly less than the 72.2% that reported elsewhere on the survey), 46.8% said that their policy of not imposing time limits was different from both emergency shelters and transitional housing programs in their community. As one might expect, one characteristic listed – offer intensive and/or specialized services – showed a sizable difference between Safe Haven programs and emergency shelters: 70.9% of Safe Havens said that that characteristic was true of their program; 43.0% said that this characteristic was different from emergency shelters in the community. However, only 24.1% of respondents said that the characteristic of offering intensive and/or specialized services was different from transitional housing programs in the community.

See table to follow. . .

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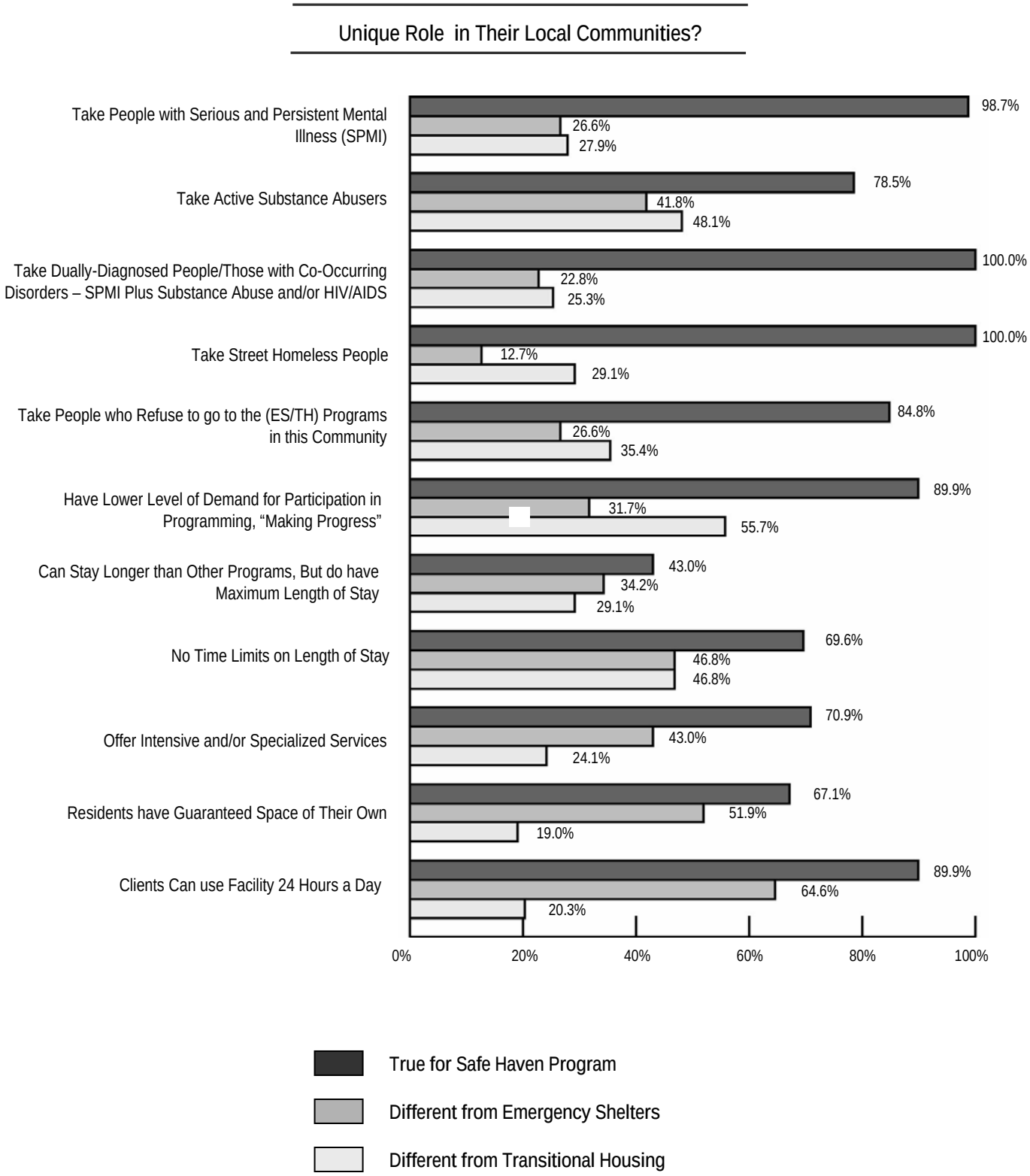
Do Safe Havens Play a Unique Role in Their Local Communities?



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Unique Role? (continued)

The following lists additional clarification as provided by some respondents on the unique aspects of their programs and services, as compared to emergency shelters and transitional housing programs in their communities:

- Residents have access to medications as needed; residents are provided material assistance and transportation vouchers; case management is always available.
- Staff are trained to handle SPMI issues.
- We are more open than the shelters and some transitional programs of taking persons with behavioral problems or who may be perceived as not motivated or non-compliant. Other programs appear stricter and not as open to persons who are actively using substances.
- We work with the chronically homeless.
- We act as an alternative to incarceration for the SPMI in the forensic system.
- We provide medication monitoring.
- We provide 24-hour security.
- Mothers can stay with their children.
- This is not a wet house.
- We use the Housing First model.
- We will take clients who are unable/unwilling to complete intake forms.
- We follow a harm reduction model.

Some programs completing the WFF survey provided additional comments that called into question their degree of knowledge about other shelters in their communities or their ability to answer fully the question about how their Safe Haven differs from emergency shelters and transitional housing programs in their communities. One respondent said that he found the answer complicated to answer in that some emergency shelters and transitional programs may "theoretically offer certain services and share characteristics with Safe Haven programs," but the reality of the situation "may be different, and clients may not have access to these programs." While the data provided would seem to indicate that a number of similarities exist among Safe Haven programs and emergency and transitional housing programs in particular communities, we believe that a careful study of all housing programs for the homeless in particular communities would need to be conducted before definitive conclusions about this question could be drawn.

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Services Available to Residents

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Services Available

The survey listed a number of services and asked respondents to check only one box to report what is the most convenient and reliable way for their residents to get this service. Three choices were provided: 1) at their own program site, regardless of whether a program staff person or someone else actually provides the service, 2) off-site but with a clear commitment to provide the service, i.e., the Safe Haven program has a commitment from the other program (including its own parent program) to serve its residents; or 3) by referral only, i.e., the agency or program to which the Safe Haven program refers its residents for this service has no prior arrangement with its program and no commitment to provide services to its residents.

The survey results indicate that most of the services listed on the survey are provided either at the program site or off-site but with a clear commitment to provide the service. Most programs (89.9%) provide daily living skills training on site. A large percent (86.4%) of respondents reported that medication monitoring and dispensing is provided on-site, with 11.0% reporting that this service is provided off-site but with a clear commitment to provide the service. Case management services are also typically provided on-site: 76.6% reported that residents receive case management services at their own program site; 23.4% said that residents receive case management services off-site but with a clear commitment to provide the service.

Other services that are most frequently provided on-site include budgeting and money management training (71.3%), assistance in accessing entitlements (including housing subsidies) (70.7%), assistance in accessing housing (the actual housing unit) (63.0%), assistance in reuniting with family (68.0%), conflict resolution training (63.4%) and relapse prevention and crisis intervention (60.7%). Slightly over half (53.9%) of respondents provide other treatments or supports for mental illness on-site while 34.4% of respondents said that residents receive such treatments or supports off-site, but with a clear commitment to provide the service.

Services that are most frequently provided off-site but with a clear commitment to provide the service are visits with a psychiatrist (51.9%), 12-step oriented alcohol and drug treatment services (43.6%), vocational training (57.1%), assistance in job placement (50.7%), and representative payee services (57.4%).

Several respondents noted other services that are provided on-site, such as financial and material assistance, medical care, Acudetox-Reki and Reflexology, parenting education, educational services and art therapy. Several programs noted that primary medical care is provided off-site but with a clear commitment to provide the service.

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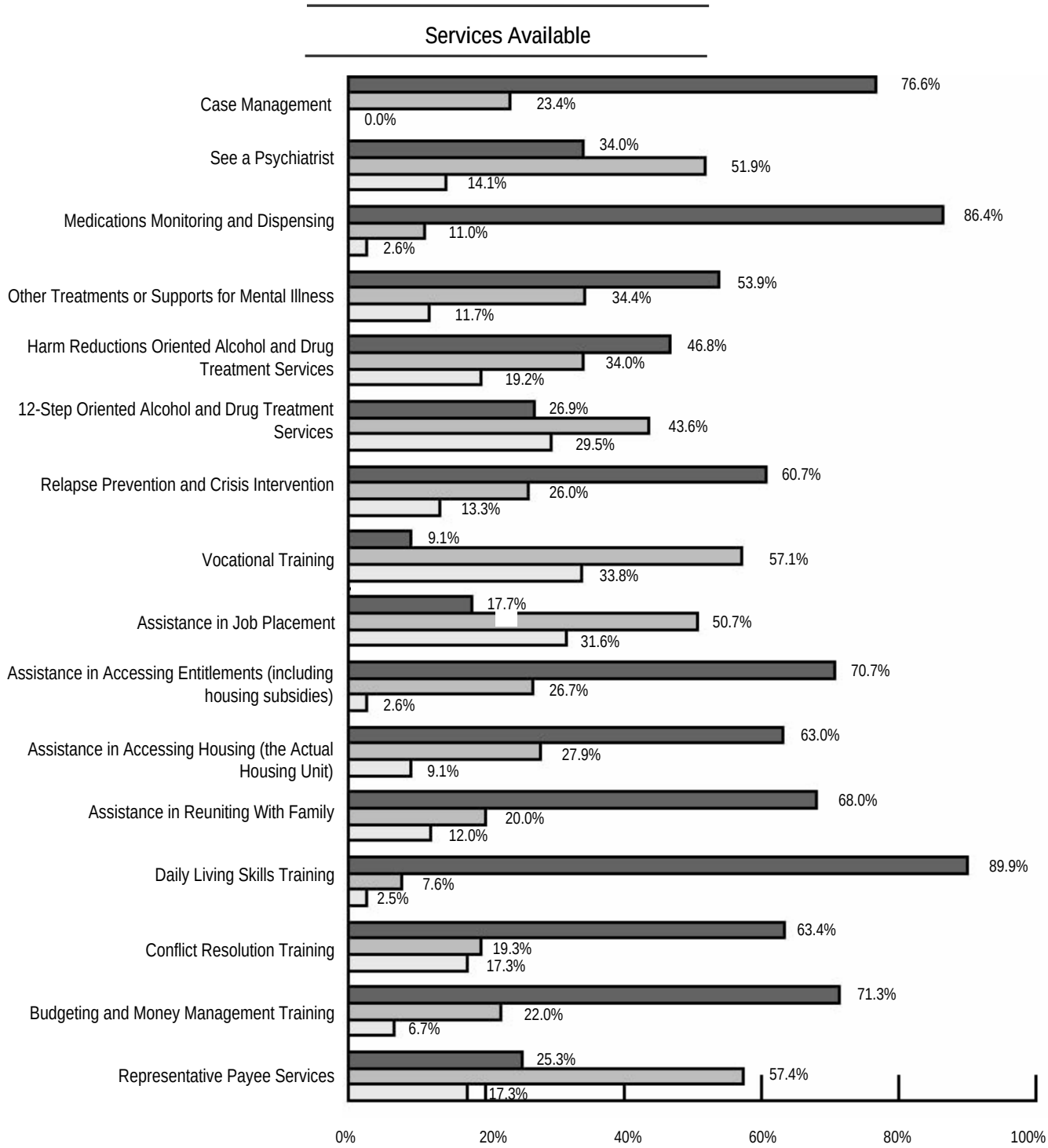
Services Available to Residents



At Program Site (regardless of whether a program staff person or someone else actually provides service)

Off-site, but Clear Commitment (Safe Haven program has a commitment from the other program, including Safe Haven parent program, to serve residents)

By referral only (agency or program to which residents are referred for service has no prior arrangement with Safe Haven program and no commitment to provide services to program residents)

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Partner Agencies

The survey asked respondents to list the three most important agencies with which their program partners to assure that their residents receive the services they need. The table below indicates the type of agency with which the programs responding to this survey partner to provide their residents needed services and the percentage of all programs that partner with this kind of agency:

Type of Safe Haven Partner	% that Partner with this Kind of Agency
Mental Health Center/Agency	96.2%
Hospital/Medical Center/Clinic	54.4%
Public Benefits Agency	38.0%
Social Service Agency	24.1%
Housing Provider/Authority	17.7%
Community agency that provides broad services to the homeless such as outreach and case management services, (includes mobile treatment providers)	13.9%
Home Agency that is equipped to serve Safe Haven residents in a variety of ways including medical, psychiatric and substance abuse services, vocational training and supportive employment	12.7%
Substance Abuse Treatment Programs	8.9%
Payee Services	6.3%
Local Shelter/Drop-In Center	5.1%
Food Pantries/Distribution Centers	3.8%
Vocational Programs	2.5%

Respondents reported that 67% of all services their residents receive are provided by their most important partner agencies.

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Funding Sources

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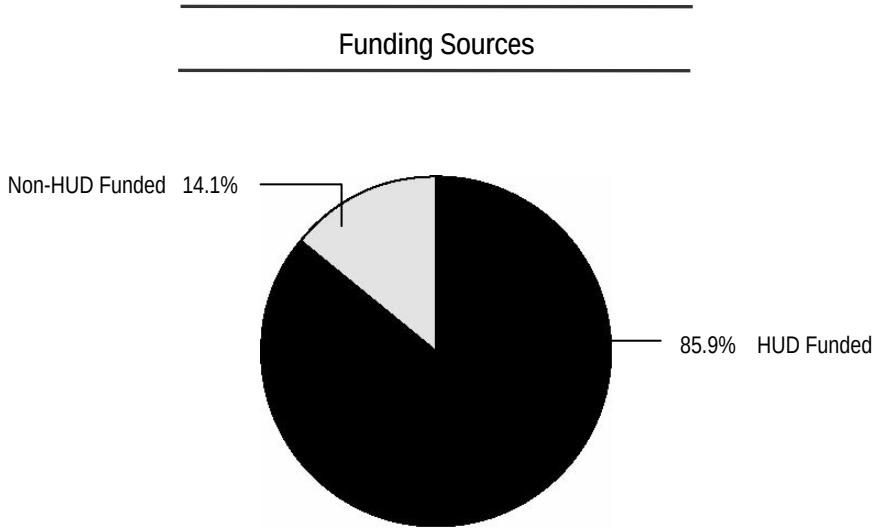
HUD-Funded Programs

As expected, the vast majority of respondents (85.9%) indicated their Safe Haven program is funded by HUD. Approximately 95.3% of the respondents that receive HUD dollars indicated their programs are funded through HUD's Supportive Housing Program. The survey asked that HUD-funded programs report their original award date from HUD and when the program began operation. A large number of responses to this question were not precise enough to allow us to determine with clarity the length of time between the award date and actual start date of the program. Considering only those surveys that gave precise information to this question, i.e., answers that clearly stated the month and year of the award date and the month and year of the program start date, or that otherwise indicated that the award date and program start date were within a single 12 month period, 26 respondents reported an award date and a start date within a 12 month period; 4 programs reported periods of between 12-23 months between the award date and the program start date; 6 reported a period of 24 months or more between the award date and the program start date.



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Non-HUD Funded Programs

The following table indicates the categories of funds received by the 14.1% of respondents that reported receiving no HUD funds. Percentages listed show the total amount of funding from these categories among all of the non-HUD funded programs:

Funding Sources for Non-HUD Funded Programs	Total Amount of Funding from these Categories
Mental health services funding through state, county, or city agency contracts or grants	26.9%
Substance abuse services funding through state, county, or city agency contracts or grants	19.0%
Service fees, rent paid by tenants	11.5%
Physical health services funding through state, county, or city agency contracts or grants	7.7%
State/local general funds	7.7%
Faith congregations	7.7%
SAMHSA	3.9%
United Way or other local combined giving campaign	3.9%
Section 8/Housing Choice vouchers from your local housing authority, whether project or tenant based	3.9%
Medicaid and/or state health insurance plan	3.9%
Other HUD/Housing Funding (Housing and Community Development)	3.9%

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Funding Sources: General

Looking at all the responses to the survey's question regarding specific funding sources, most respondents (77.2%) reported that their programs currently receive funding through HUD's Supportive Housing Program. The next highest reported percentage of funding (50.6%) is currently received through mental health services funding through state, county or city agency contracts or grants. Approximately 44.3% reported currently receiving funds from service fees paid by clients. About one-fourth of respondents reported currently receiving funds from state/local general funds (26.6%), from foundations (25.3%), and from fundraising from individuals (25.3%).

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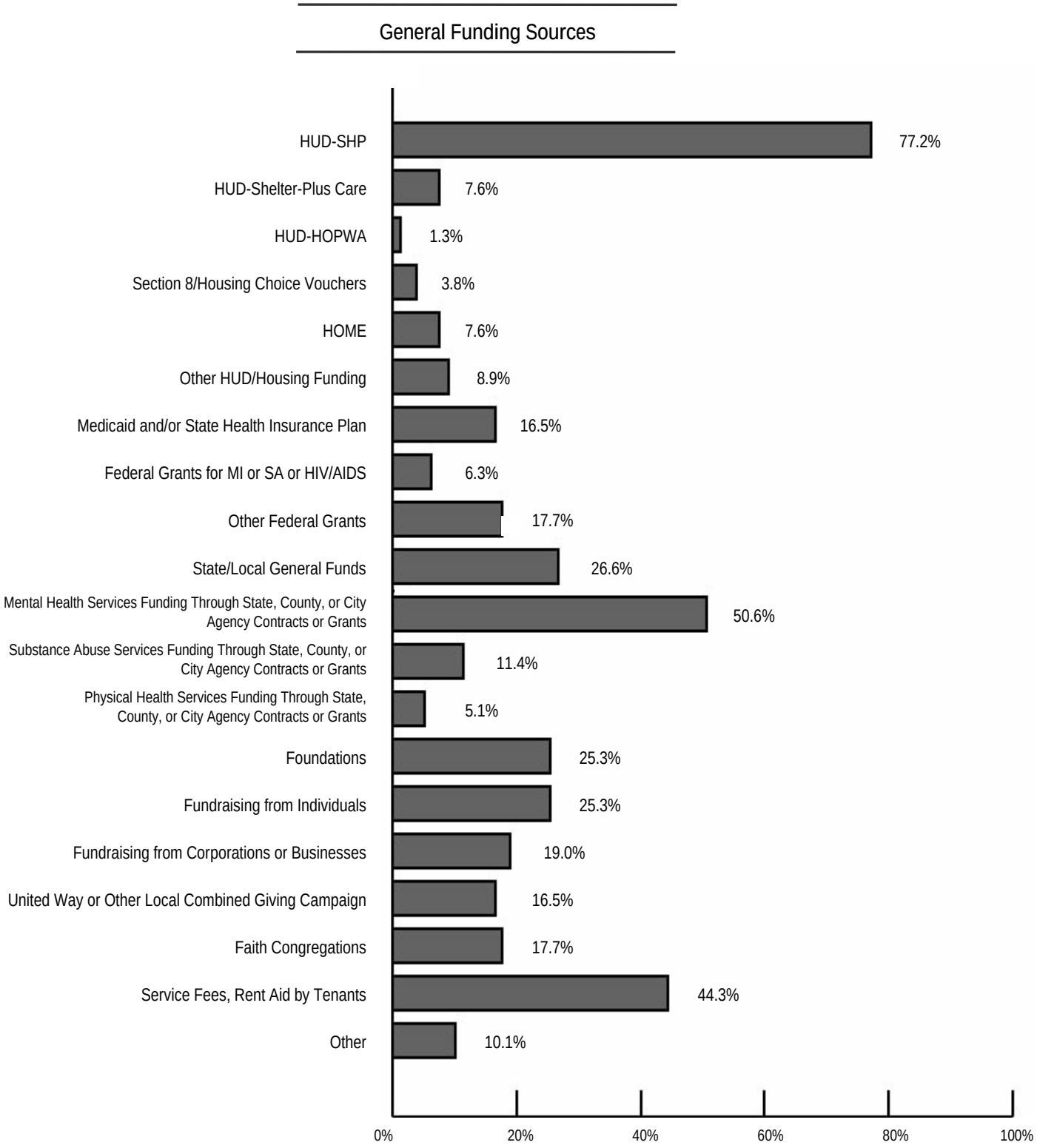
Funding Sources: General (continued)



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Largest Funding Sources

The survey asked respondents to list the three biggest funding sources for the current program year. The categories of funding sources listed and the number of programs that listed that source are detailed below. General categories are listed when no additional information was provided.

Categories of Funding	Number of Programs that Listed this Source
HUD (including HOME Program funds)	69
Local Department of Mental Health and Substance Abuse	27
Service Fees/client rent	16
Foundations	12
Local Human Services Agency	8
Medicaid/State Health Insurance	8
Emergency Shelter Grants/Homeless Shelter Grant	7
County/City Funds	7
SAMHSA (including PATH Funds)	6
Private Donations	5
State Funds	5
Faith Congregations	4
Community Development Block Grant	3
United Way	3
Non-Profit Organization	2
Social Security Administration's Homeless Outreach Projects and Evaluation Award	1
Veterans Administration	1
Own Funds	1
General Assistance	1
McKinney	1
Rent/sublease	1
Local Housing Commission	1
State Realignment and County General Fund	1
Local Medical Center	1
Agency Services	1

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Largest Funding Sources (continued)

Programs reported that 93.3% of their total funding is provided by their three biggest funding sources.

The average operating budget for the current program year for the programs responding to this survey is $452,688.

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Effectiveness

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Indicators of Effectiveness

The survey asked respondents to tell which indicators of effectiveness their program currently tracks, i.e. they keep records of these outcomes. The programs that completed the survey indicated that the two most important indicators of effectiveness were where residents go when they leave the program and whether they obtained a stable income source, if they did not have one already. Approximately 97.4% of all respondents said that they track those two indicators. Other important indicators as reported by the programs were whether the resident was stabilized on psychotropic medications, i.e., the program records both the earlier, unstable condition, and the changed condition (70.5%), and engagement with the program, i.e., the program records the various phases from entry to full engagement (however the program defines it). Approximately 68.0% reported that they track that indicator of effectiveness. Fewer than half of the respondents (46.2%) said that they track whether residents are still stable in housing a significant length of time after leaving their program or the reasons why residents are unable to access permanent housing (46.2%).

See table to follow. . .

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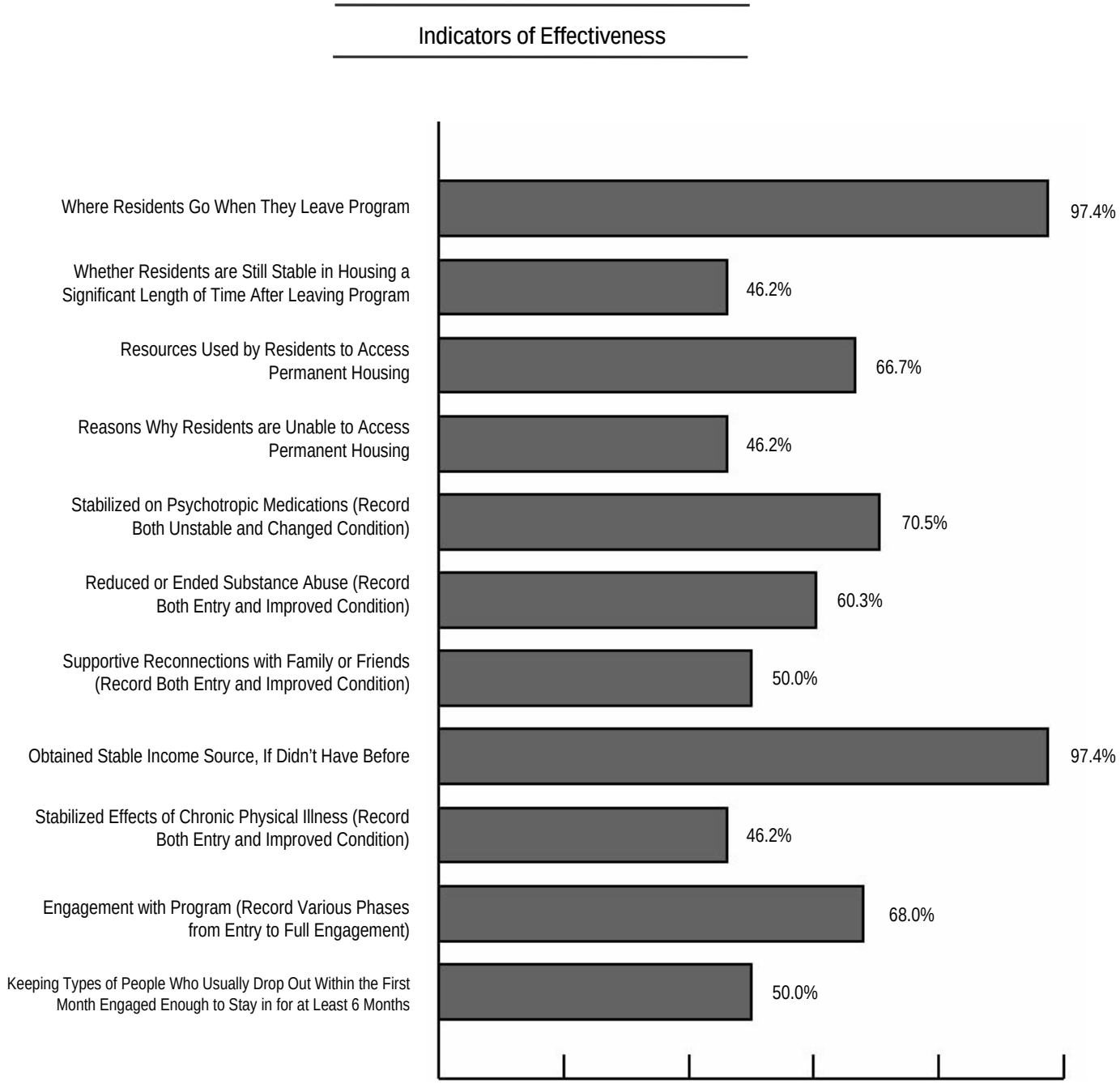
Indicators of Effectiveness (continued)



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Indicators of Effectiveness (continued)

The following are other indicators of effectiveness that the respondents track as detailed on the survey responses:

- Quality of life assessment at time of admission and discharge.
- Improved Life Skills or Daily Living Skills, assessed pre-program and after program for changed condition. Employment or job training participation.
- Number of chronically homeless both admitted into the program and successfully placed into housing. Number of clients referred from forensic systems – intake and placement outcomes.
- Fewer days depressed. Consumer satisfaction.
- Employment outcomes.
- Keeping people engaged enough to stay in the program for 90 days.
- Participation in case management and other services. Participation in mental health treatment.
- Self-determination – involvement with social programs and accessing mainstream services. Financial information – increased income, savings, etc.
- Engagement with mental health services. Employment.
- Level of engagement with residents and staff. Services received from clinical staff, substance abuse, mental health and primary care.

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What Next After Safe Havens?

When residents leave Safe Havens, slightly over half of them exit to some kind of permanent housing. Approximately 30.3% of residents that leave the surveyed programs during any 12-month period were reported to exit to affordable permanent housing with both subsidy and supports (Permanent Supportive Housing). Approximately 12.9% of residents exited to affordable permanent housing with subsidy but without supports; 7.4% went to affordable permanent housing, without subsidy or supports. Of the 5.8% of residents that went to "other" destinations beyond those listed on the survey, one-fourth of them (25.3%) went to stay in some kind of supportive housing, including permanent housing without subsidy but with support, and Single Room Occupancies.

Approximately 14.4% of residents reportedly returned to homelessness, shelter, streets, etc; 11.2% of residents exited to places unknown and 8.7% of residents were reported to reunite with family.

Looking at the 5.8% of residents that went to "other" destinations besides some kind of permanent housing as noted above, 10.7% of those residents went to stay with friends, 12.0% of them went to group homes, assisted living facilities, nursing homes or Adult Family Care Homes, 7.7% went to hotels or motels, and 3.0% received in-patient treatment for substance abuse. One program reported that 25.0% of its former residents were deceased and that only 4 people had left the Safe Haven program in 6 years' time. The remaining "other" responses provided to this survey question were to unspecified locations.

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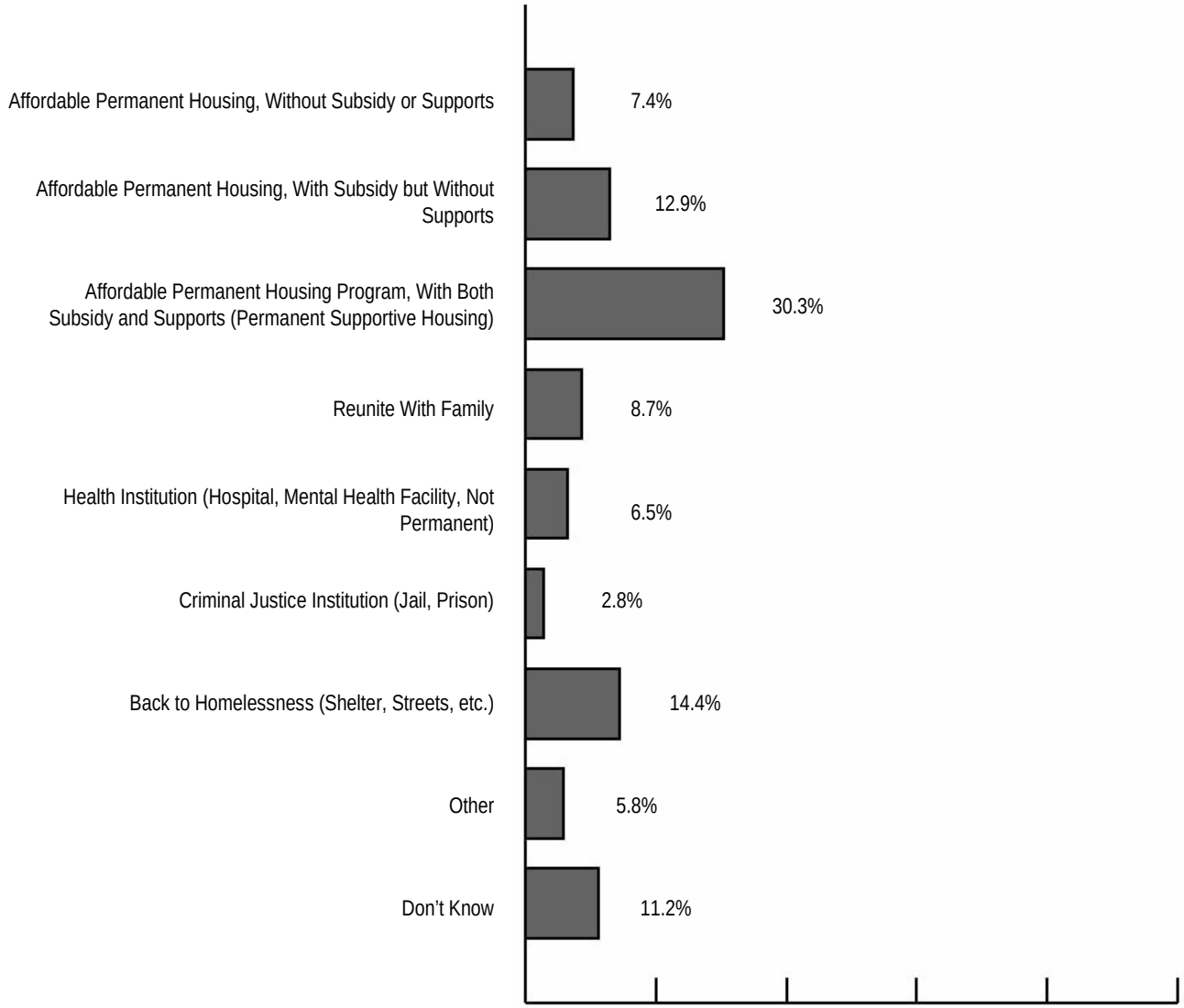
What Next After Safe Havens? (continued)

Proportion of Residents Exiting to These Locations



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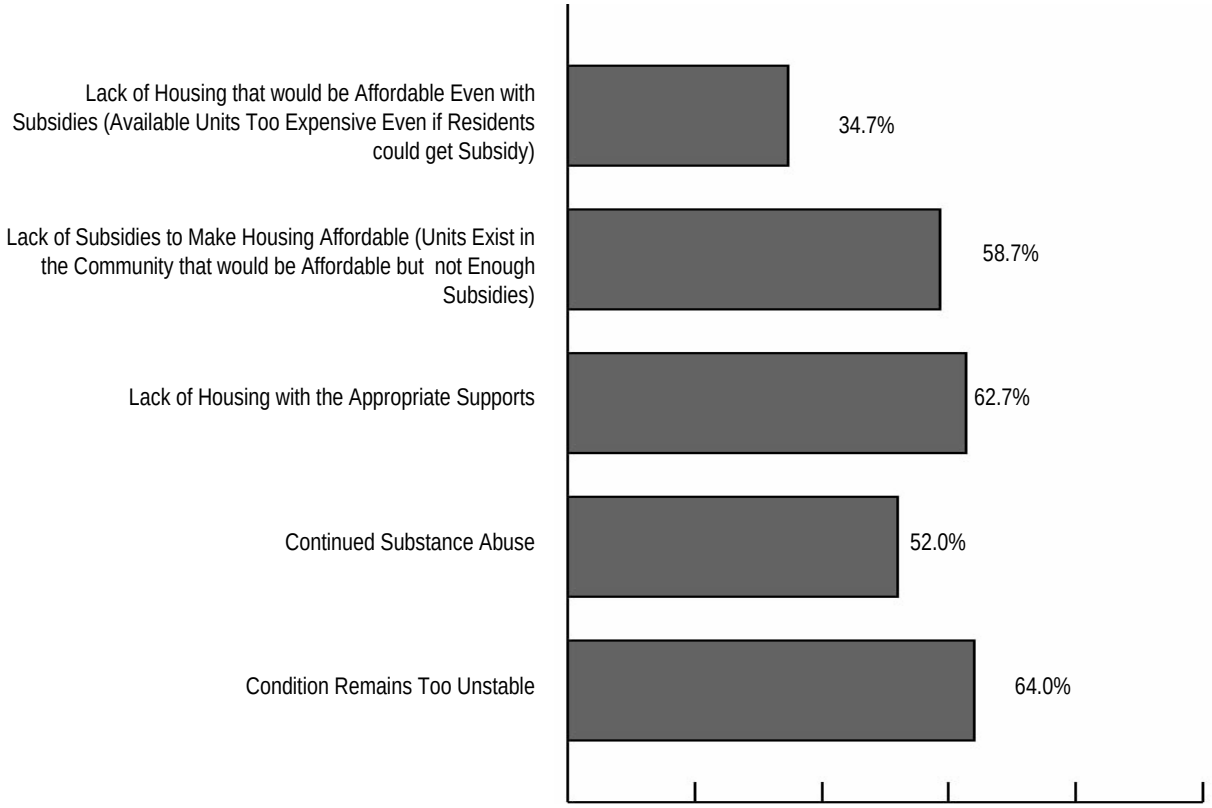
What Next After Safe Havens? (continued)

When asked for the most common reasons why residents are not able to move into permanent housing, respondents said that 64.0% of the residents' condition remained too unstable, 62.7% did not move into permanent housing because of lack of housing with the appropriate supports, and 58.7% did not move into permanent housing because of a lack of subsidies to make housing affordable (units exist in the community that would be affordable, but there are not enough subsidies).

Reasons Residents Don't Move into Permanent Housing



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What Next After Safe Havens? (continued)

The following are additional reasons listed by respondents for why residents of their Safe Haven programs do not move into permanent housing:

- Residents left to go back to family or other situation which won't likely work out due to poor judgment or impaired decision making or impulsivity.
- Lack of immigration status.
- Resident left program/got arrested.
- Residents are ineligible for subsidized housing.
- Residents leave program too soon, before housing barriers can be worked with adequately.
- Residents do not qualify for subsidy due to criminal record.
- Clients decide not to continue participation.
- Lack of entitlements for clients whose legal identity cannot be established.

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Approaches and Philosophies

The survey asked programs what services, or what aspects of their approach or philosophy, do they think are the most important things contributing to their success in helping residents leave homelessness for good. A number of programs cited the low demand nature of their programs as being instrumental to their success. All of the responses were unique in their description of their program's philosophy and approach to their residents and have been listed below as they were received:

- Engage in mental health and substance treatment; assistance in acquiring benefits; independent living skills/case management.
- Low demand approach to services that meets/accepts clients where they are; the availability of ongoing support and access to resources; access to Social Security advocate and job training program.
- The program has an array of housing options providing people access to the housing that most meets their needs at any given time. We are able to keep people housed. No one is barred from housing or loses their housing because of drug use or non-participation in mental health treatment.
- Low demand; harm reduction; no charge for rent or food.
- Integration of services and partnership service delivery: seamless continuum of care for all services, including vocational services; on site availability of many services: active outreach in natural places for services to occur and drop in center; coordination of care through an extra agency team approach.
- Obtaining rental subsidies; case management; mental health/substance abuse treatment.
- Low demand approach to engagement and trust building; continuum of care from outreach – shelter – housing – employment – healthcare within same agency; on-site medical and psychiatric care.
- Responsibility; respect; dignity.
- Rehabilitation model – all persons have ability to live in community.
- Developing and establishing rapport, trust and a relationship with the client allows overall treatment to be effective; working at the pace of the client. By not applying pressure and many restrictions on the client, we allow him/her to play a major role in the treatment process; helping the client develop necessary lifeskills to progress in independence.
- Follow up by case managers after person leaves Safe Haven; transitional housing; connecting person to services needed before discharge to ensure that they will continue follow up after discharge.
- Low demand, high expectation program; Harm Reduction Program; Respect Yourself, Respect Others and Respect Property.
- Harm reduction; Motivational Interviewing; symptom management.
- Trusting environment; benefit acquisition; follow up.
- Acceptance; respect; nurturing; safety.

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Approaches and Philosophies (continued)

- Person may live here as long as they like without demand so long as they abide by their lease and commit no violence toward themselves or others; tolerance regarding alcohol use; tolerance of background.
- Engagement process; encouragement to access services; assistance with navigating resources.
- Low-demand, client centered focus, harm reduction approach; Shelter Plus Care; Section 8.
- Flexible rules and case handling to specific needs; portal of entry to largest transitional housing provider in area; referral services.
- Harm reduction philosophy and minimal rejection/ejection; wrap-around holistic services/Assertive Community Treatment layered on top of housing; Housing First.
- Employment services; permanent housing service; mainstream resources.
- No time limit on length of stay; low demand setting; individual room/space; collaboration with YMCA and visiting case managers.
- Working with individuals who would be turned down for housing in most, or any, other housing programs; willingness to work with active substance abusers; providing housing to individuals regardless of ability to pay.
- Key to their own room – privacy; large community space for peer interaction; physically clean and spacious home – large yard – quiet neighborhood.
- Low demand; no cost for services; maximizing community resources and securing a safety network for the individual.
- We do not mandate a set of goals on clients, but work individually with each client on personal goals/self-determination; we work to increase skills and income starting at each clients' individual level of need to completely prepare them before a transition takes place; we treat each client/resident as the individual that they are, respecting their personal individual needs, fears and wishes.
- Stabilization on medication with appropriate psychiatric and medical care; opportunity for a safe, stable supported living environment.
- Providing safe and non-threatening housing; encouraging utilization of mental health services; assisting residents in the procurement of services necessary for reintegration into the community.
- Giving people time to stabilize and offering intensive case management services; helping people link with psychiatric and substance abuse treatment; helping people secure an income and explore housing options.
- Housing support; harm reduction and relationship building; financial entitlements.
- Low demand approach to services that meets accepted clients where they are; the availability of ongoing support and access to resources.

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Approaches and Philosophies (continued)

- Social rehabilitation model – home-like, normalizing environment and building relationships with staff as a support network; day treatment curriculum, i.e., parenting education, daily living skills, symptom management, job preparedness, anger management; medication education and support, and connection to Community Mental Health Services.
- Engagement; aftercare; recognizing worth and dignity.
- Eventual establishment of rapport that allows for connection to needed services; low demand.
- Treating all residents with dignity and respect; accepting residents where they are; allowing residents to progress at their own pace.
- Respect; empowerment; education.
- Safe and friendly environment; services are encouraged and promoted, not forced; all supportive services are available on site.
- Case management services.
- Mental health services; total abstinence of drugs/alcohol; ACT.
- Low-demand model; no time limit for length of stay; 24-hour on-site staff and case management stays with client after leaving safe haven for other housing.
- Low demand model; no length of stay; 24-hour on-site staffing.
- Engagement; representative payee services; advocacy.
- Access to mental health services and medication management; low demand program; individualized treatment.
- Faith based organization; we give a hand up not a hand out. We do this by helping our residents gain the skills necessary to move to a higher level of productive living; medication management instruction.
- Low demand; open to persons currently using who may not be ready for recovery but are able to live in stable housing; open to persons who struggle with a co-occurring disorder and how this affects the person.
- Appropriate/lasting life skills; empowerment; dignity and respect.
- Harm reduction model; case management – intensive; life skills and other educational components.
- Intensive case management on site; no limit on the length of stay; low client to staff ratio.
- Flexibility; comprehensiveness, continuum of services.
- Using Housing First model; applying harm reduction philosophy to drug and alcohol situations; low demand, high expectations model.
- Removing barriers to accessing housing; dual diagnosis accepted; continuity of care from staff.

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Approaches and Philosophies (continued)

- Hospitality; safe and nurturing community; treat with dignity.
- Intensive engagement by all staff; relationship-based case management services based in recovery model and harm reduction models; low demand approach.
- Recruitment of homeless clients who are most vulnerable and in greatest need – people seeking out the program are generally seen as higher functioning that the target population for the project; reduction of barriers to admission, flexibility in strategies to admit and retain residents with serious and persistent mental illness; close staff collaboration between housing and mental health outreach and case management on highly individualized, flexible responses to resident needs, behaviors and problems.
- Limited rules; safe haven guests involved in developing rules; guests able to access services when under the influence of drugs/alcohol.
- Respectful to self and others; belief in individual's ability to change; active case management.
- Low demand philosophy creates an environment of trust; foster an environment based on dignity and respect; encourage independence in daily activities.
- Start where client wants to start; no time limits on stay or engagement; minimal participation rules.
- Letting persons heal at their own pace; once they leave, they know we are always here to guide and support them toward their continued success; earning the residents' trust and respect and then teaching the tools to survive independently.
- Low demand low expectation model; Clubhouse Philosophy-Psychosocial rehabilitative model which we empower the residents to help themselves; residential support.
- Encouraging hope and a feeling of being a part of society; establishing stable income; ADL training, including medication and symptom management.
- Consistent, intensive daily support and training of daily coping skills and ADL issues; flexibility of program and training of staff in direct support of a client when she/he is struggling; client-driven goal planning, focusing on client accountability.
- Client-centered. Small size and high staffing ratio allow for very few elements of the program to be non-negotiable. Program can be made to fit client rather than trying to fit the client into the program. Intensive case management services that are focused on whatever issues need to be addressed to allow the client to stay housed rather than an exclusive focus on managing the disease. Recovery Model – General focus on helping the individual improve their life, rather than a focus on treating disease.
- Housing First Approach; no pre-determined timeline for clients to follow – they set the pace for accessing services; no quid pro quo or use of coercion attached to keeping their bed.
- Access to supportive housing; building relationship to engage resident in treatment; linking to mainstream resources for income, treatment.

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Approaches and Philosophies (continued)

- Low demand housing; "one stop shopping" for services.
- Housing support services – local Department of Mental Health has its own housing that is available to program residents on a priority basis; health services; mental health and primary care; low demand.
- Monthly or bi-monthly case conferences with consumer (resident), Intensive Case Manager, analyst from the Office of Mental Health, occupational therapists and other interested parties to discuss goals and target dates for achieving them.
- Medication compliance; money management; daily living skills.
- Harm reduction model; consumer focus treatment; multidisciplinary treatment approach; case management.
- Substance abuse treatment; links to social services; social services.
- Compassionate, understanding staff.
- Recovery philosophy in peer centered care; collaborative work between mental health professional, community and peer; peer support.

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Tracking Former Residents

In an effort to ascertain how clients do after leaving the Safe Haven, the survey asked respondents to report on the period of time they try to track residents after they leave their program. There was a lot of variation among responses received on this question. The responses indicated that a number of programs (26.7%) have no policy of attempting to track residents. In addition, a number of other respondents left the question about tracking residents blank. If one were to assume that programs that provided no response to this answer have no policy of trying to track former residents, the percentage of programs that do not track residents would be somewhat higher – 33.4%. Looking at other responses to this question, 18.7% of respondents said that they attempt to track residents for 1 to 2 years; 13.3% attempt to track them for 6 months; and 6.7% track them for 90 days or less. Approximately 13.3% said that they attempt to track residents indefinitely; 9.3% said that they attempt to track residents indefinitely but qualified that response by noting that they track only those residents who remain engaged in services or in housing operated by the Safe Haven's community. The other 5.3% of the respondents gave various responses to this question: one program said that it tries to track residents for 3 months to 1 year; one tracks them for 1 – 5 years. Residents of a third program are tracked by the Safe Haven's collaborative partner, which provides case management services; another program described a process in which its Safe Haven conducts a total of 5 interviews of each resident over a year's time in order to conduct an evaluation. If the resident leaves the Safe Haven before a year and has not completed all the interviews, the Safe Haven program will continue to track that individual until all 5 interviews have been completed, assuming that he or she consents to the evaluation.

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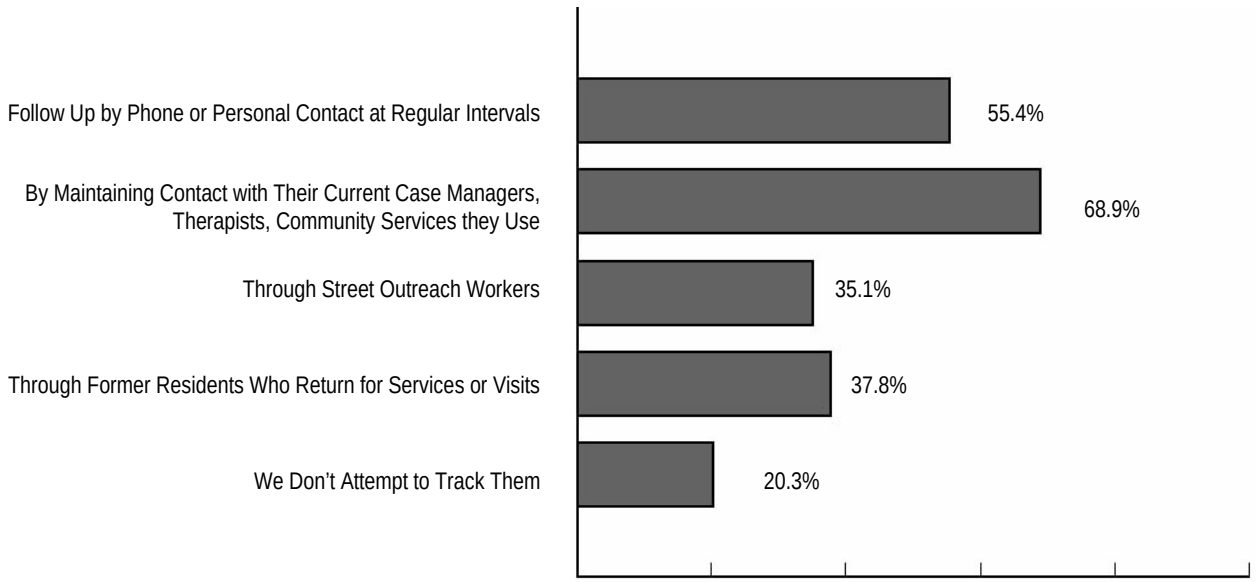
Tracking Former Residents (continued)

In a subsequent question, the survey asked how the Safe Haven respondents track residents after they leave the program. This question was intended to determine how programs that have a policy of formally tracking residents for a period of time after leaving the Safe Haven remain in contact with those residents. However, a number of programs that said they do not track residents provided answers to this question, making clear that programs that do not make a deliberate attempt to track residents often learn about them through a variety of informal ways. In response to this question, the majority of respondents (68.9%) indicated they maintain contact with former residents through their current case managers, therapists, their Permanent Supportive Housing program, or other community services they use, and a little over half (55.4%) said that they follow-up former residents by phone or personal contact at regular intervals. Two programs reported that they maintain contact with former residents through mailings and three programs said that they maintain contact with former residents who continue to use their services, such as Permanent Supportive Housing run by the same agency that operates the Safe Haven, or by continued use of a drop-in center.

Ways Programs Track Former Residents



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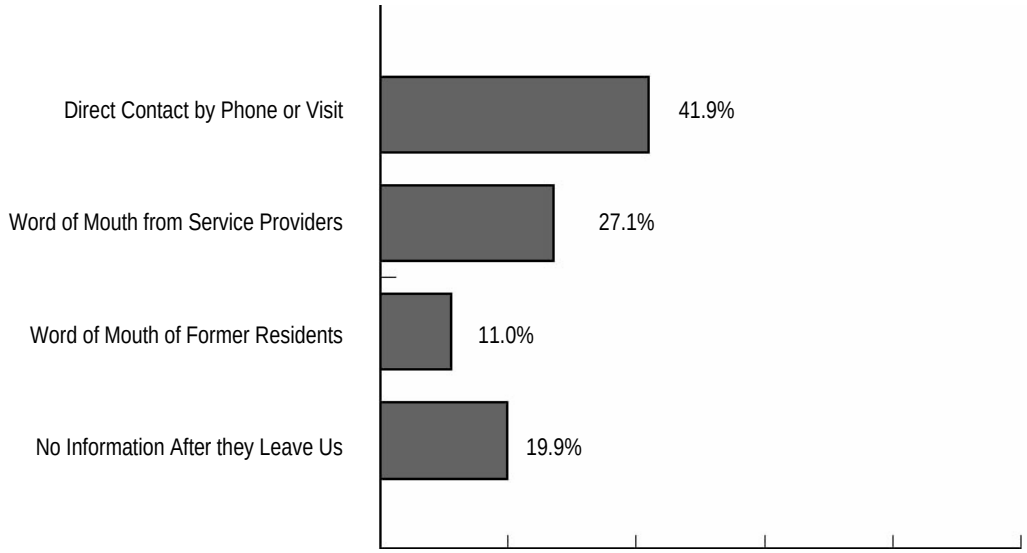
Tracking Former Residents (continued)

The final question of the survey asked respondents approximately what proportion of their residents do they remain in contact with and by what means does that contact occur. Respondents reported that they have contact with 41.9% of former residents through direct contact by phone or visit and 27.1% by word of mouth from service providers. The respondents indicated that they have no information on 19.9% of their former residents.

Ways Programs Track Former Residents



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Conclusions about Safe Haven Effectiveness

In conclusion, from the data collected by WFF, it would appear that Safe Haven programs are generally effective at retaining residents and keeping them engaged in the program, on average, approximately nine months. While the Safe Haven programs surveyed may have a number of variations in the structure of their programs and their expectations of residents while there, virtually all of these programs agree on one key indicator of effectiveness, which is where residents go when they leave the program. From there, assessing the true effectiveness of Safe Haven programs at transitioning residents into permanent housing becomes more difficult. While slightly over half of Safe Haven residents reportedly go on to some kind of permanent housing, 35.0% of residents return to homelessness, temporary health institutions, criminal justice institutions or to unknown destinations. Moreover, a number of Safe Haven programs do not pro-actively track residents for any long-term period, i.e., one year or more, once they leave their program, making it difficult to draw any long-term conclusions about the impact that many Safe Haven programs have on their residents.

In many cases, a lack of appropriate community resources appears to be to blame for the fact that more Safe Haven residents do not move into permanent housing. With nearly 63.0% of Safe Havens reporting that a lack of housing in the community with appropriate supports prevents more of their residents from moving into permanent housing, it is clear that Safe Haven programs alone cannot accomplish their principal goal. Without more housing that is appropriate for this clientele and meets their unique needs, a number of residents who leave Safe Haven programs will face an uncertain future.

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Appendix

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Appendix A – Safe Haven Programs Participating in WFF Study

Alabama
First Light, Inc., Birmingham; 205-323-4277

Arizona
NOVA Safe Haven, Phoenix; 602-528-0758
Sonora House Safe Haven, Tucson; 520-624-5518

California
Downtown Safe Haven, San Diego; 619-228-2800
Uptown Safe Haven, San Diego; 619-228-2800
Frank Rice Safe Haven, Los Angeles; 213-488-9559
OPCC Safe Haven, Santa Monica; 310-458-1292
Ashbury House, San Francisco; 415-775-6194
Naomi's House, Fresno; 559-498-6988
Our Place Safe Haven, Ventura; 805-652-2151
Opportunity House, Santa Rosa; 707-575-0979, ext. 12

Delaware
Delthine House Safe Haven, Wilmington; 302-984-3380, ext. 107

Florida
Henderson Village, Lauderhill; 954-735-4331
Safe Place, Tampa; 813-272-2168
Haven House, West Palm Beach; 561-650-1377

Hawaii
Safe Haven Honolulu, Honolulu; 808-524-7233

Illinois
Antonia Safe Haven, Chicago; 773-275-0269
Dolores' Safe Haven of Deborah's Place, Chicago; 312-944-8810
Pathways Home Safe Haven, Chicago; 773-334-7117
Thresholds MAU Austin Safe Haven, Chicago; 312-243-9295
Thresholds MAU Lawson Safe Haven, Chicago; 312-243-9295

Louisiana
New Orleans Womanspace, New Orleans; 504-895-6600
BRIDGES, Shreveport; 318-425-2912

Maryland
Ethel Elan Safe Haven, Baltimore; 410-732-1390
Safe Haven, Baltimore; 410-323-7123
Safe Havens, Montgomery County; 301-217-0314

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Massachusetts
Pathfinder Safe Haven, Lowell; 978-459-3387
BMC ACCESS Project, Roxbury; 617-427-7115
Safe Havens, Springfield; 413-734-5376, ext. 113
Leahy House, Westfield; 413-734-5376, ext. 113
Safe Haven, Worcester; 508-860-1199

Michigan
Safe Haven, River Rouge; 313-294-8821

Missouri
Access House Safe Haven Project, Kansas City; 816-756-2769

Nevada
The Salvation Army, Safe Haven, North Las Vegas; 702-657-0123

New Jersey
Aletha R. Wright Center (Safe Haven), Camden; 856-966-0909
Knickerbocker Residence, Dumont; 201-385-4400, ext. 3058
Urban Renewal Corporation, Irvington; 973-483-2882
Safe Haven Program, Morristown; 973-993-0833

New York
Goddard Riverside Community Center Safe Haven, New York; 212-724-6031
Project Renewal Safe Haven, New York; 212-246-8321
Bethesda House of Schenectady, Inc., Schenectady; 518-374-7873

Ohio
Waterloo Safe Haven, Akron; 330-571-0843
Safe Haven One, Cleveland; 216-441-5966
Safe Haven Two, Cleveland; 216-361-0365
Safe Haven Three, Cleveland; 216-635-1575
Building Towards a Better Tomorrows Continuity of Care, Cleveland; 216-430-0670
Weisman House, Springfield; 330-784-4281
Safe Haven for the Homeless Mentally Ill; Youngstown; 330-744-2991, ext. 106

Oklahoma
Safe Haven at the Y, Tulsa; 918-858-3337
12th Street Safe Haven, Tulsa; 918-584-2057

Oregon
Royal Avenue Program Safe Haven, Eugene; 541-461-2845
Safe Haven, Salem; 503-588-5857

Pennsylvania
My Brother's House, Philadelphia; 215-545-3011
Connections/Eliza Shirly House, Philadelphia; 215-940-1236
Connections/Ridge, Philadelphia; 215-236-2907
Connections/Our Brother's Place, Philadelphia; 215-685-3892
Kailo Haven, Philadelphia; 215-225-8645
One Day at a Time, Philadelphia; 215-765-5803

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One Day at a Time Safe Haven, Philadelphia; 215-227-0485
RHD Cedar Park, Philadelphia; 215-724-6380
Saint Columba, Philadelphia; 215-232-7236
Women of Change, Philadelphia; 215-564-0901
Safe Haven, Pittsburgh; 412-323-1516
Cascia House and Cortona House, West Chester; 610-692-3415
Poplar Street Apartments, York; 717-848-5767

South Carolina
Reedy Place, Greenville; 864-241-0462

Texas
Magoffin Safe Haven, El Paso; 915-838-1808
Safe Haven, Fort Worth; 817-336-1117
Safe Haven, San Antonio; 210-434-6384

Utah
Valley Storefront and Safe Haven, Salt Lake City; 801-531-1857

Vermont
Safe Haven, Rutland; 802-728-5233
Safe Haven, Burlington; 802-651-7036

Virginia
Max's Place, Falls Church; 703-933-2415
Safe Harbors – A Safe Haven, Hampton; 757-245-0217, ext. 1230

Washington
Harbor House Safe Haven, Seattle; 206-545-2377
Kerner-Scott House, Seattle; 206-621-7027

West Virginia
Safe Quarters, Huntington; 304-523-0293, ext. 335
Twin Cities Center, St. Albans; 304-727-6179

Wisconsin
Jeremy House Safe Haven, Waukesha; 262-549-8735
Safe Haven, Madison; 608-241-9447

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