



I. The Philosophical Framework of the Community Model

The Community Model developed by Lamp Community is based on a “harm reduction” service philosophy – treatment focused on reducing the negative consequences of addiction and mental illness. The effectiveness of this approach is reinforced with a second, agency-wide emphasis on “building community” – a continual, collective effort by both staff and members¹ to show how every individual is part of a larger whole. The approach seeks out opportunities to both draw from and contribute to strengthening an often underused resource – the individual members of the homeless and formerly homeless community.

It is this focus on both *harm reduction* and *community* that has made the Community Model particularly effective at serving chronically homeless people. Many members of this group have never had a say in directing the course of their recovery; few have had the opportunity to be members of an affirmative and supportive community. The Community Model makes it possible for them to realize both of these experiences. The following pages explore the general precepts of 1) harm reduction and 2) community building, as the two are understood within the context of the Community Model. This will be followed with more specific discussions of the Community Model’s *Characteristics and Components*.

“When we talk about what we do, just using the word ‘community’ is a huge statement,” says Paul Alderson, the director of Lamp Community’s newest program, funded by the federal Collaborative Grant to Help End Chronic Homelessness. “Very consciously, we’re saying we’re not an organization, we’re not an agency, we’re not a corporation – we’re a community. That’s a rare thing, and it’s emphasized right from the very first day of employee orientation.”

1. Fundamental Principles of Harm Reduction

What is Harm Reduction?

Harm reduction is a set of practical strategies that help people reduce the negative consequences of drug use, alcoholism and mental illness by addressing the *conditions* of use and treatment. Rather than focusing solely and immediately on cessation of drug use or acceptance of mental health treatment, harm reduction makes improving the quality of the individual’s life, health and wellbeing the primary criteria for success.

¹ This manual uses the terminology of Lamp Community, which refers to program participants as “members.” In addition, the term “drugs” can be understood to include not just illicit drugs, but also alcohol and legal drugs used without prescriptions.

Practitioners often say that harm reduction strategies “meet people where they’re at.” They mean that harm reduction does not impose one treatment goal (total abstinence or a psychotropic medication regimen) on every individual. Instead, the course and pace of treatment is determined by the individual; the practitioner’s role is to educate that person on available treatment options and the consequences of his or her choices.

In this way, the practitioner provides support and guidance to help individuals determine themselves how to improve their health and wellbeing, whether through medication, behavioral therapies, safer use of drugs, managed drug use or abstinence. Ambivalence and relapse are not unexpected, and are not reasons to cut off services or take away housing. Services are always voluntary, flexible and readily accessible.

Some mainstream substance abuse providers view harm reduction strategies as controversial or ineffective. Many subscribe to the more common “therapeutic community” model of drug treatment. The therapeutic community surrounds the individual with a highly-structured environment isolated from his or her normal surroundings. This environment reinforces abstinence with intensive counseling, peer pressure and medical treatment of the disease of addiction. This method has helped many motivated individuals achieve sobriety. However, therapeutic community providers have had considerably less success treating chronically homeless people, people with dual diagnoses and other persons facing extensive barriers to independence and self-sufficiency. The non-judgmental and graduated nature of harm reduction services offers a viable treatment alternative for these more vulnerable groups.

“A lot of shelter providers are intimidated by harm reduction,” says Shannon Murray, Lamp Community’s Deputy Director and chief clinician. “They think, ‘Oh, no, everybody in the shelter is going to start getting high!’ The fact is, there are probably people there who are already using drugs. Acknowledging this allows a more honest and open relationship with the member. This is what ‘starting where the person is at’ really means.”

Defining Principles of Harm Reduction

Harm reduction is practiced in a variety of ways by different providers. The Community Model follows an interpretation of harm reduction modified specifically to address treatment issues facing people with mental illness or dual diagnoses of mental illness and substance abuse. The Community Model’s harm reduction philosophy can be defined by the following principles:²

- **Mental illness and addiction are public health concerns, not criminal justice or moral issues.** Rather than respond with condemnation or enforcement, harm reduction focuses on minimizing the harmful effects of mental illness and addiction, both on the individual and on society.

² These principles are modified from harm reduction principles developed by the Harm Reduction Coalition. For more information and training resources on harm reduction strategies, go to www.harmreduction.org, the website of the Harm Reduction Coalition.

- **Improving quality of life – of the individual, the community *and* society at large – is the primary criteria for measuring the success of interventions and policies.** While abstinence is undoubtedly a positive outcome of treatment, for some addicted persons, managed and safer use of drugs may be a more realistic (and still beneficial) goal. Similarly, psychotropic medications can work wonders for many people, but can be ineffective for others. For some, the side effects of medication may outweigh the benefits. Rather than imposing a predetermined goal, all interventions are measured by the simple question, “Does it improve the health and wellbeing of the individual and those around him or her?”
- **Harm reduction also acknowledges the many severe and lasting harms and dangers associated with untreated mental illness and drug use.** Some ways of treating mental illness and using drugs are clearly safer than others. Harm reduction offers a range of treatment options and levels of sobriety to increase the chances of successful treatment, *not* to devalue abstinence. Says Mollie Lowery, Lamp Community’s founder, “To practice harm reduction without offering every avenue to recovery available just doesn’t make sense. Twelve-step groups are as much a part of harm reduction as needle exchanges.”
- **Choice is essential for recovery.** Individuals with mental illness or addiction are capable of making competent, informed decisions about the goals and consequences of their treatment and behavior. With education, guidance and support, they are the persons best situated to determine the course and pace of their treatment.
- **Socio-economic and biological factors influence people’s vulnerability to mental illness and addiction.** Poverty, class, racism, social isolation, past trauma, gender discrimination and other social inequalities all affect both people’s susceptibility to mental illness and drug-related harms, as well as their capacity for effectively dealing with these problems.

2. The Importance of Community

Community-Building Principles

Like most programs using harm reduction strategies to address homeless people’s mental illness and addiction problems, the Community Model harnesses the power of community to help homeless people improve the quality of their lives. As its name implies, the Community Model puts perhaps even more emphasis on building community than other harm reduction programs – so much so that it is perhaps the most important element in the success of its programs and services.

A few principles direct the Community Model’s focus on community:

- **Services are provided to the individual in the community in which he or she resides.** While some interventions may occasionally require leaving the

community for limited periods of time (hospitalization, medical detoxification or, if desired by the member, residential substance abuse treatment), the Community Model attempts to provide all necessary services and supports to the individual where they live. In this way, new, healthier behaviors are learned and adopted in the context of the community in which the individual will need to maintain them in order to continue a healthier way of life.

- **Services and housing are voluntary, non-coercive and loosely structured.** People choose to participate in the Community Model, and they retain control over the extent of their participation. They impose rules on themselves. While violence is not permitted and negative behaviors can have consequences (including brief suspensions of services), members themselves determine how they will use the Community Model's resources, without being penalized for non-participation.
- **The Community Model's members are the primary agents of change.** The Community Model seeks to empower members to share information and support each other in strategies which meet their actual conditions of use and health. Individuals are encouraged to explore their strengths and see how they can contribute to a larger community.
- **To the greatest extent possible, the Community Model is non-hierarchical and non-judgmental.** Members must be routinely consulted and have a real voice in the creation of programs and policies designed to serve them. Success is defined differently for each individual, according to their personal situation.
- **All programs and services within the Community Model are integrated with each other.** Staff at all levels regularly speak to and cooperate with each other in order to assist people achieve the most desirable outcomes in their treatment and care. Programs and policies are designed to encourage a high level of cooperation and continuity.
- **Mental illness and addiction are lifelong cyclical illnesses that often require lifelong recovery processes.** Mental illness and addiction are chronic health issues. Most individuals do not progress in a linear manner from psychosis and addiction to psychiatric stability and recovery. Repeated episodes of relapse and mental health decompensation are normal stages of this progress. For individuals with severe mental illness, addictions and challenging life circumstances, the recovery process often lasts a lifetime.
- **Housing is essential for good health, psychiatric stability and wellbeing.** It is almost impossible to achieve psychiatric stability without residential stability. The Community Model offers a wide range of housing options to accommodate people's diverse and cyclical needs for privacy, structure, socialization, services and support. Regardless of their health conditions, members always know they

have a home within the Community Model. Housing is never withheld as a punishment for members who relapse or decompensate.

Together, these harm reduction and community-building principles guided the development of the services and programs that now constitute the Community Model. These principles form the foundation of a comprehensive service philosophy that permeates all of the Community Model program components, from its drop-in center and respite shelter, to its independent housing units and member-operated businesses.

The Community Model's program components are discussed in Section II. But first, the next chapter will explore the characteristics that all of these programs share. While these characteristics are closely related to the principles listed above, they warrant more direct scrutiny within the context of the Community Model's day-to-day operations.

Adopting the Community Model: A Checklist

Use this checklist to identify the assumptions your organizational culture currently shares or does not share with the Community Model. This can help you assess the challenges you will face when integrating the Community Model into your organization's existing service philosophy.

Does your agency and staff:

- ...believe that mental illness and addiction are public health issues, not moral failings? Is this belief incorporated into all aspects of programs and services?
- ...accommodate both harm reduction and abstinence-oriented services, and offer multiple treatment choices to program participants?
- ...believe that services are more effective when voluntary?
- ...believe that housing is essential for recovery and stability?
- ...attempt to empower and involve consumers in both individual *and* organizational decision-making processes?
- ...have a long-term commitment to the community that it serves? Does it nurture an environment that provides life-long support to its program participants?

3. Characteristics of the Community Model

According to the Community Model’s practitioners, seven characteristics distinguish and unify service delivery in its program components. **The Community Model is:**

- 1. Supportive and Lifelong**
- 2. Tolerant**
- 3. Flexible and Non-Linear**
- 4. Voluntary**
- 5. Consistent**
- 6. Accessible and Integrated**
- 7. Diverse**

This chapter will review how these characteristics apply to the Community Model.

1. The Community Model is Supportive and Lifelong

Homeless single adults with mental illness tend to be isolated and afraid, with few resources or places where they can feel safe. Personal experience has taught them to distrust others and to avoid personal relationships and other entanglements. They are the most marginal members of a subculture already on society’s margins.

The Community Model attempts to recreate, or establish for the first time, a community in which the homeless individual with mental illness is welcomed as a valued member of a mutually supportive society. Members do not always form close friendships, but they are given the opportunity to interact with others in a safe space that encourages them to develop social bonds and trust others. They learn that other members respect their rights and will not injure them or steal from them.

And just as recovery from mental illness and addiction can be lifelong processes, the Community Model provides a supportive community that is available to members for as long as they need. Once an individual becomes a member of this community, she retains that membership for life, regardless of the strength or consistency of her participation. All of the program components are available to community members as they need them over time. This sense of community extends beyond program sites as well, as members tend to look out for each other when they meet in other housing and institutions.

2. The Community Model is Tolerant

Using harm reduction strategies to serve members “where they’re at,” the Community Model allows a

Like many homeless people with mental illness, Roger’s erratic behavior landed him in and out of jail for years. He credits the support network he developed at Lamp Community with helping him change. He now lives in a privately-owned residential hotel a few blocks away from Lamp Community’s facilities. While Roger rarely frequents the drop-in center anymore, he says that he and other Lamp Community members still look out for each other in his new residence. “That’s the way it should be. I first came to Lamp from jail, because I saw that the people there who had been at Lamp looked out for each other. And they didn’t end up back in jail. People in other programs always seemed to find their way back behind bars. I didn’t want that for myself.”

wide range of behavior often not accepted in other social contexts, even other shelters and service programs. Individuals' idiosyncrasies are not subject to the judgment, criticism or punishment they often encounter in other environments. This courtesy is modeled by staff and longtime members; as a result, new members quickly adopt the live-and-let-live attitude that surrounds them.

Lamp Community made a key decision in its effort to create an atmosphere of tolerance: none of the programs have uniformed security guards. The absence of what for many of the members is an oppressive symbol of capricious authority deescalates tensions. With no one to challenge, and no one to harass them, members rise to the occasion and take more responsibility for their behavior. Though the lack of uniformed security places additional burdens on staff from time to time, it has also made Lamp Community safer and less prone to incidents than most other programs serving homeless people.

The Community Model's high level of tolerance extends to service delivery as well. Housing and services are not withheld to punish members when they relapse, do not comply with treatment, or do not reach an expected level of success. Each member is expected to progress at his or her own pace. To be sure, staff challenges members to take responsibility for improving the quality of their lives, especially when members fail to meet the personal goals they set for themselves. But a mutual understanding that backward steps are a predictable part of the process helps make successful steps forward more frequent.

Members and staff regularly state that the Community Model works because it has no punishment, only rewards. There *are* consequences for some negative behaviors: a member may be asked to take a walk around the block, or leave for a few minutes, hours or days (and sometimes for as much as a couple of weeks), though no individual

"People leave other programs because they put too much pressure on you," one member observes. "They pressure you to do things only when they tell you to do them. It makes all the wrong things happen. Lamp doesn't do that. They don't have a bunch of rules that don't make any sense."

is ever completely cut off from the program. To remain a full participant, members are expected to continue working toward goals they have set for themselves. The difference is that staff serves mainly an advisory role; it is the member who is empowered to decide on the course of treatment and judge the pace of that treatment. Says Mollie Lowery, "I tell members what I think, but I also tell them that's just my opinion. I have my own biases." The final decision is left to the member.

3. The Community Model is Flexible and Non-Linear

Recovery from mental illness or addiction is a cyclical process. Individuals usually experience periods of full functioning and sobriety, alternating with decompensation and relapses. It is not a linear process where recovery moves forward in only one direction. The pace of recovery also varies among individuals. Many people struggle their entire lives with the wrenching back-and-forth of the recovery process.

The Community Model reflects the non-linear nature of recovery. Members are not expected to meet deadlines for moving from one stage of recovery to the next. There is no fixed path to achieving a healthier lifestyle. Instead, they are offered a diverse and comprehensive menu of services and housing options to help them improve their quality of life. Members tend to appreciate being given the opportunity to choose their course of treatment, and as a result, become more invested in successful outcomes.

The flexible nature of this non-linear method is most apparent in the Community Model's use of its housing resources. Members do not always follow the traditional "Continuum of Care" approach of moving through stays in drop-in centers, emergency shelters and transitional housing, on their way to an ultimate goal of permanent housing. Some are placed directly into settings that are appropriate without going through all these steps. Others choose to remain for unlimited amounts of time in a shelter bed, or in the Community Model's deceptively named transitional housing (which has some members who are actually permanent residents). In short, the Community Model will provide people what they need only if they decide they need it. Importantly, individuals are not seen as having failed when they decide to move from permanent or independent housing to transitional housing, though this would be viewed as a backward move in most other programs.

4. The Community Model is Voluntary

Most providers believe that treatment for mental illness and addictions is more effective when participation is voluntary. To maximize opportunities for success, Community Model services are delivered in a non-coercive manner. Members completely control the extent and nature of their participation in the Community Model program. It is up to each member to decide what types of services and housing that he or she is ready for and when.

*"I don't like to be ordered around. I want to have a choice. This place gives you a choice about how to get started again."
– Lamp Community shelter member*

The program's emphasis on choice doesn't mean that there are no rules. Violence, theft and drug use on program premises are all prohibited. Members who break these rules may be asked to leave on a temporary basis. In addition, members may choose to impose other rules upon themselves to further their recovery from mental illness or substance abuse. For example, a member may choose to move into a Community Model housing program that offers a lot of structure to members who are entirely trying to stop using drugs. The members in that housing have decided on imposing rules that include curfews and drug testing to help them reach their health management goals. Once a member volunteers to live in this housing, he must adhere to the rules. If the member repeatedly violates the rules, he will be counseled by staff and members to move to a less restrictive Community Model setting, while retaining the opportunity to return when appropriate.

Involuntary hospitalizations and incarcerations are avoided in the Community Model, and are used only when all other alternatives have been exhausted.

5. The Community Model is Consistent

Chronically homeless individuals experience substantial instability in their lives. To counter this volatility, the Community Model stresses consistent service delivery and a safe and stable environment. Programs maintain daily routines so that members can rely on predictable staff hours, meal times and activities. The flexible nature of the service delivery and the unpredictability of members' lives outside the program ensure that services are never too rigid. The Community Model attempts to balance order and consistency at a macro level, while remaining respectful of and adaptive to individual differences on the micro level.

Another important way to make services consistent is to ensure that the makeup of staff remains consistent. Holding on to qualified and passionate employees is a challenge for all organizations paying nonprofit salaries. Lamp Community is no different; its salaries average less than most area providers. Yet it has been able to retain many of its employees by providing multiple sources of supervisory support, access to extensive training, flexible schedules and a strong package of benefits. Most important, employees say they feel that their individual efforts are noticed and valued by Lamp Community management. While some may mention the obvious challenges associated with serving the Community Model population, they are able to take these in stride, in part because management constantly contextualizes their work within the larger mission of the organization.

6. The Community Model is Accessible and Integrated

The Community Model is open to all homeless individuals with mental illness. There are no additional eligibility criteria. Outreach teams search out homeless people living with mental illness, and anybody can wander into the drop-in center's courtyard, which opens onto the street. They will be welcomed by a staff member (or another member) and assisted with their immediate needs (food, showers, referrals, use of the phone, etc.); intake interviews come later. Members are allowed to just hang out in shared spaces. People who are not mentally ill are fed and referred to other programs and providers.

"I know who I can trust: my caseworker," one member relates. "Even when she knew I was up to no good, she was always around whenever I wanted to see her."

Staff members zealously maintain an open door policy: persons with mental illness become especially frustrated when they need to resolve an issue and are unable to talk to someone in a timely fashion. Staff tries not to miss any opportunities to be there when members decide to make significant changes in their lives. Physical accessibility is reinforced with

emotional accessibility. Staff are ready to return hugs and "shoot the breeze" with members because these interactions can often lead to positive changes.

Access to staff is also increased by *integrating* different Community Model programs as much as possible. Regular meetings, visits and cross-trainings, as well as the exchange of staff between different programs help ensure that all program components are working with the member toward the same goals. Members are encouraged to utilize services at different sites, which are located near to each other.

7. The Community Model is Diverse

Community Model staff reflect the racial, ethnic, socioeconomic, sexual orientation, gender and educational diversity of the members. This diversity facilitates staff's efforts to build trust with members. Equally important, staff's life experiences mirror those of members. Presently, more than half of Lamp Community's eighty staff members are former or current members who have personal experience with homelessness, mental illness and/or substance abuse. Staff also undergoes extensive training to ensure that members are treated in a culturally sensitive manner.