Podcast Interview with District Alliance for Safe Housing, Washington, D.C. (12/1/2016)

FB: We are on the phone with folks from the District Alliance for Safe Housing. Suzanne Marcus is the Director of Training and Technical Assistance, and Michelle Linzy is a certified addictions counselor. Her old title was Chemical Addictions Program Director, and she is now the model practice's coordinator. Welcome to you both.

M. Linzy: Thank you so much.

S. Marcus: Thanks for having us.

FB: We're going to talk a little bit about the housing options that are available through DASH, and how services are provided. Feel free to tell us whatever you feel you need to tell us.

I'm going to start by just asking you to describe the cornerstone housing project and your empowerment model which are a site-based model, and a transition-in-place model. Just talk a little bit about how you decided to offer those two types of housing models, and in particular, I understand that the cornerstone project is sort of a hybrid between a shelter and a transitional housing program so that some people are there for a short time, and some people can be there for up to two years. I'd be interested to hear your thinking about why that was a good model to choose.

S. Marcus: Michelle, do you want me to go first? I can.

M. Linzy: Yes, go ahead.

S. Marcus: I'll talk about them and you can jump in if I miss something.

M. Linzy: Okay.

S. Marcus: We can start with the Cornerstone Program. We don't really use the term shelter, because it's a 42-unit apartment building. We take folks in regardless of whether or not they're in an immediate crisis, which would be typically what an emergency shelter would do. We also take folks in who might be transitioning out of an emergency program and looking for a longer stay. It really doesn't matter whether they're in crisis or whether they're cycling in and out of homelessness, which is often the case. The program is there for them if we have space, which is really often the only barrier, is that we have the capacity.

We started the idea of doing a program that is two years regardless of whether or not someone's in emergency or is cycling in and out of homelessness, not in immediate DV crisis, but just in search for safe housing. It's because when Michelle and I, we were first staff, in addition to Peg Hacskaylo, our founder, and when we started that along with Victoria Green, the four of us, we've all had extensive history in housing for survivors. We knew that there really is the distinction between somebody in transitional and someone in crisis is imaginary often, because people cycle in and out of crisis. We thought a two-year program just for anybody to have that space to find stability is important. We didn't want to have these imaginary guidelines or program parameters where we would have to uproot a family after 90 days and make them find another housing or housing program if it wasn't necessary, and that wouldn't change would be the family's location, but rather our support for them. Michelle, I don't know if I missed anything, but is that ...

M. Linzy: No, I think other than the fact that when we first started our housing program, we were actually in another location. Our idea immediately was, "Okay, well we'll do an emergency placement for people, and we'll keep them for 30-90 days."

What we realized was, first of all, there was nowhere to send the survivors for alternative housing, but also that most of the survivors were still in crisis. To say, "Okay, you have to go," and not provide a safe space for them to continue to heal in was just not what we wanted to do. Including that, we came up with, "Okay, we need to have a two-year program."

FB: Sometimes programs or agencies house a shelter program and a transitional program in the same building, and there is movement from the shelter part of the program to the transitional part of the program for people who want to make that transition. There's a sense of making some progress because I'm moving from one program to a more focused program on the future rather than maybe on resolving immediate crises. Is the loss of that sense of movement, of progress a problem, or is that just something that people experience internally and don't really need to be changing programs?

M. Linzy: One hundred percent, it's an internal, because everybody's progress is different. For us to judge when you are ready to move to the next level would do the survivors a disservice. Whether they move to another building or they stay where they are, they're still internally growing and progressing at their own pace.

S. Marcus: I agree with Michelle. It feels imposed. Moving is traumatizing. It can often be upsetting for the family who's already probably moved around a lot by the time they finally come to our program. And if you move someone into an emergency setting and say, "You're only going to be here for a short amount of time," it can prevent them from making connections with the staff, and resting and relaxing, connecting with their space, and really being able to take a deep breath and relax.

We feel like, as Michelle said, the benchmarks that they set for themselves and their growth doesn't have to do with, "I'm moving out of an emergency program. I'm moving onto transitional." It's really about what they themselves see as their own growth. That really differs from family to family. That connects back to our value that we put on the partnerships that our staff build with our survivors in developing that relationship and setting up personal service plans that are really different, that are very much case by case. There is still a sense of accomplishment, but it's based on their own goals that differ from survivor to survivor.

FB: When you have people in the building who are staying a short time, and people who are staying close to the full two year period, does that change the cohesion of the program and the residents, and participants, and staff sense of building a community, or are you able to have that mutual support and sense of community even though you have some people who are there for short times and others who are there a little longer?

M. Linzy: Yes to the latter. One of the things is that, each person has their own apartment, so there are people who are not able to build community. They're not interacting with and participating in programs, and you have others who team up, and they go to each other's apartments, they help each other cook and take care of the kids.

The community is there when a person wants it or needs it, but it doesn't make a difference whether a person stays for 3 months or for two years. It just depends on the individual and where they are. The community is self-sustaining.

S. Marcus: Most people, even though folks do stay for 3 months and then go, some people use the program as a place to take a deep breath and decide what they want to do.

Given the reality of the lack of housing in D. C., the fact of the matter is, if a survivor has reached out for housing support, 9 times out of 10, it's because they are struggling with housing instability, and that's not going to change after 3 months. I think for the most part, people are staying with us for up to the full 2 years.

M. Linzy: Yeah, I would say 95% of the people are staying for up to the full 2 years. Those that don't stay are people who came to us because they were in an emergency, they had to move right away, the batterer may not wanted to leave the apartment or the house, or they had to leave the house that they were living in with that person, and they have a really good job. They have connections, but they just, as Suzanne said, need to stabilize themselves, and kind of re-center, and figure out, "Okay, where do I go now," and "This is what I want to do." That doesn't happen that often.

FB: Okay. You also have a program that you call the Empowerment Project which is a transition-in-place program where people get a 2-year housing subsidy. They're on the lease. They're finding apartments that will work for them. How do you decide which housing model is best for a person, or how do they decide? How

does the decision get made where somebody's going to be, whether they're going to be in Cornerstone or Empowerment?

S. Marcus: That's a great question. The way that DASH works, is that about 95%, or maybe more than that even, survivors who come to us, come by way of our housing resource center. That's a non-residential program that we have in the community. We facilitate weekly community clinics, we have housing resource center staff in the homeless system, so when survivors are seeking housing and going through the various entry systems into DC's homeless system, we have advocates there who are able to assist survivors.

Through those points of entry, our advocates are meeting with survivors helping them to determine what it is that they are seeking. Through the clinics and the other opportunities for us to connect with survivors, our advocates are able to determine, "Is this somebody who is really in need of a housing placement in one of our programs for 2 years," because they might lack employment, and any kind of stability at all.

Is it often we meet survivors who think that moving into a homeless shelter is their option, but after they've talked with our advocates and learned that there are housing protections that exist either at the federal or local level, and that our advocates can help them get a safety transfer within their public housing, or help them maintain their lease, we're able to do that and actually prevent homelessness that way. That might be the route that we go with them if that's something that the survivor feels is a safe option.

We operate the Survivor Resilience Fund which is a flexible funding project. There might be a survivor who could actually maintain his or her housing where they are. They might be facing eviction and think that they have no options. We'll provide them with financial assistance.

Through our conversations, we feel confident, and the survivor feels confident that once we're able to help them with this immediate cash support, that they can support themselves moving forward. Then there are survivors where a referral to Cornerstone makes sense or a referral to our Empowerment project.

Those decisions our advocates make based on a combination of what the survivor wants ... Well, that's most important; what the survivor needs and wants, and his or her safety concerns is at the forefront. Then, of course, what our capacity is. Our programs fill up fast too, so that's another piece. That's how the decision and the match is made.

FB: Is it possible that somebody might want to try living in the community, so might want to go for your Empowerment Program and your staff at the Housing Resource Center might think that they would be better served in the Cornerstone Program? Does that happen, and if so, how does it work out?

M. Linzy: Yeah, it does happen, but one of the things that happens at the clinic is that they can't just have conversations with the individual that just comes in. They have, for the EP program, for the Empowerment Program, they have a separate, like an application or intake form that the individual will fill out.

If they are not ready to move into EP but we have Cornerstone space available, then they would work with the program director here to find out if there's space and decide if the person can come in. We don't make the decision whether a person move here or not, the clinic does, and then they send the form over to the program director.

It's a conversation and a decision made really by the survivor, but if the survivor doesn't have a job, there's no way they can sustain themselves, then they would not be able to move into EP anyway.

S. Marcus: I think the Empowerment Project option isn't an immediate one. If a survivor is seeking immediate housing placement or support, they'd likely go to Cornerstone like Michelle said.

FB: One thing I wanted to make sure we covered is ... you have on staff, Michelle, who is a chemical addictions specialist, and now what's called the model practices coordinator. This represents a little bit of a departure from where DASH was a year or two ago. Can you explain a little bit about how your thinking evolved, and what the role of folks with a clinical background would be either in terms of mental health, or trauma, or substance abuse, or also children's well-being?

S. Marcus: Yeah, sure. We started with the technical assistance team initially. We had a full-time chemical addictions counselor, that was Michelle, and a full-time clinical director. The idea initially was to provide that on-site expertise, and support for staff, and training.

The model was working well we thought, and it was to a certain degree, but a couple years ago, we had an intensive evaluation where we looked out our model. We have a model where we are trying to support staff.

Because we're low-barrier and we take folks regardless of addiction, mental health, as well as we utilize a voluntary service model, it's really hard work. What we're trying to do is just support our direct-service staff in particular to make decisions in the grey utilizing our organizational core values as opposed to an over reliance on rules and policies which don't fit folks.

Our thinking was initially that we would utilize at least on-site experts and supporting our staff. Through our evaluation we realized that our staff, our direct-service staff, our advocates is what we call them, still felt like they needed to rely on our experts when issues came up as opposed to feeling empowered or feeling like they had the tools they needed to make these decisions on their own.

There was still sort of a sense that the technical assistance team needed to be involved in all these cases. We have a really big organization and we really want our advocates to feel like they can make most of the decisions. That's when we moved towards a coaching model which ... Michelle, do you want to talk a little bit about what that shift looks like since you're the one doing the coaching now with all the advocates?

M. Linzy: Yeah. I think one of the things that I wanted to add onto what Suzanne was speaking about was that one of the things that we also realized was that our advocate staff was feeling a bit overwhelmed having 3 different supervisors. We were all coming from different places, but they were getting different answers from everybody. We had to take a step back along with the evaluation that was done, and try to figure out what would work so that they wouldn't feel overwhelmed so that they would also feel empowered as Suzanne said. It could free up the specialists' time to do things in the community as well as supporting staff.

M. Linzy: The part about coaching that really caught on was that we weren't directing them and telling them what to do. As a coach, I support them. I work with them on looking at their beliefs and how they affect their behavior and how their behavior affects the services that they provide to the survivors here.

S. Marcus: I'm sorry, go on. I was just going to say, I think that's really crux of our approach, is that the survivors really, 90% of their experience with our programs is their interaction with their advocates. We want the advocate to feel empowered and supported, and to feel like they have the tools that they need to make decisions on their own, but rooted in our core principles. When advocates are feeling that level of support and safety, that ideally the survivors are feeling that too.

FB: Can I ask ...

M. Linzy: Oh, go ahead. Go ahead.

FB: Well what I was going to ask was how you balance the emphasis on clinical versus non-clinical. On the one hand, there has been some concern among some providers about not pathologizing domestic violence and sexual assault. On the other hand, trauma has some real clinical implications as does substance abuse or mental health issues that somebody might have come in with.

Many people who are in domestic violence relationships have had some other traumas in their lives. There's a high correlation between childhood abuse and then being involved in an abusive relationship later on. How do you balance that? Is the coaching a good tool for doing that?

M. Linzy: Coaching is definitely a good tool for doing that, but let me first say that we follow the survivor's lead. If the survivor says, "Hey, I want to go into therapy. I need help." Then we make those connections for them, and then they receive those services outside of DASH. They are not required to be in counseling or in therapy.

Because we are a low-barrier program, we do have individuals who have substance abuse disorders. We have individuals who have mental health diagnosis. As long it's not interfering ... First of all, let me say about the addiction piece, they cannot use any illegal substance in here, but we don't tell them, "You can't move in because you have a disorder."

The same thing with mental health. They don't have to be on their meds, but with both of those groups of people, as long as their disorder is not causing conflict or harm in the community, then the choice is that person's choice.

As a coach, what I do is help facilitate conversations that the advocate wants to have with an individual that they know is, "Okay this is starting to become a problem. I need to know how to talk to her."

We talk about resources, him or her. We talk about resources in the community, how to direct and carry the conversation, and when necessary, I am called in to sit in on a Care Conference with a survivor who's struggling in with either mental health or with a substance use disorder.

S. Marcus: I do agree that, particularly in the domestic violence movement, there has been that tension about pathologizing domestic violence and I think following the survivor's lead and not requiring mental health counselling or anything like that is a huge part of staying away from that pathologizing. I also think that the movement in itself has come so far from that, particularly with the work of the Domestic Violence, Trauma, and Mental Health Institute and the support that they've offered the field of really understanding the way trauma impacts survivors. How to create trauma informed environments and care. I think that really is informed work too.

FB: Let me ask one more question, and then I'll let you go. I was wondering whether there's a clinical component to supervision, in particular somebody who is helping to make sure that if staff are showing signs of secondary trauma, vicarious trauma that somebody is able to catch that? Is that a role that you or somebody else with a clinical background plays in supervision?

M. Linzy: In coaching, yes. It's one of the reasons I really, really love coaching, because it's not therapy, but it can be therapeutic in a way.

When I'm meeting with an advocate, I'm not just talking about the work that they're doing, I'm also asking, "How are you? What's going on with you?"

A lot of times when there is a lot of stress, or I'm suffering with vicarious trauma, they begin to talk about how and why it's affecting them the way it's affecting them. Then we talk about some tools that they can use, even taking mental health days to take care of themselves.

S. Marcus: And I would just add, I think what makes the coaching model so important is that, at DASH, we do put a lot of expectations on our advocates to be able to be critical thinkers. They need a lot of support and training. Also the awareness of how they're feeling and their beliefs about the folks that they work with are impacting their decisions and their behavior. Michelle's really trying to help them identify the connection between those things. That's when it can get intense and deep, but it's really important work.

I just recently did a survey of our advocates to see how they feel about coaching and how it's going for them. I think because it's such an intense experience, and often a lot of advocates haven't ever had something like this in other social service jobs that they've had, it's been an adjustment, but they've all reported for the most part, feeling like it's been an extremely productive and important resource for them.

I think, especially in shelter and safe housing environments where we're working with folks with high needs, that sometimes just that opportunity to process and to get positive, supportive feedback is huge when even our supervisors, our managers are so stretched thin.

They've talked, in their feedback, just how much they appreciate the support, and the positive experience, and the general encouragement they get from their coach, and how important that is to them. We feel like when our advocate is experiencing such a positive experience with the coach, the hope is that that also then gets played out in their interaction with their survivors that they're working with.

FB: It also sounds like you've put together a variety of funding sources that allow you to do things that you might not be able to do just with a HUD grant, or adjust with an OVW grant. Certainly your flexible fund is helping people retain their housing, is something that's not typically something that folks that depend on HUD or OVW grants can do. It sounds like a really powerful resource. Clearly your clinical components; Michelle's position, are positions that require additional resources. Together, it sounds like you've really put together a wonderful program.

S. Marcus: Thank you so much.

FB: I wish you a lot of luck, and thank you for taking the time.