

The Case for Low-Barrier, Wrap Around Drop-in Centers in New Haven, Connecticut

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DESK, a non-profit organization founded in 1987, is devoted to serving people experiencing homelessness or living in poverty by providing food assistance and services that promote health, community, and equity.¹

The GHJP is an interdisciplinary research, teaching, and advocacy program that aims to tackle contemporary problems at the interface of global health, human rights, and social justice.² The GHJP offers a practicum course each year that engages students in real-world projects with scholars, activists, lawyers, and other practitioners on issues of health justice.

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¹ DESK Mission Statement. <https://www.deskct.org/organization/>

² *The Global Health Justice Partnership*. (n.d.). <https://law.yale.edu/ghjp>

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Introduction: The Need, Principles, and Best Practices of Accessible and Effective Drop-In Centers

An estimated 12.1% of New Haven County residents report experiencing food-insecurity,³ and over 25% of New Haven residents live below the poverty level.⁴ In addition, the opioid crisis has hit hard in New Haven,⁵ with overdose deaths steadily increasing in recent years.⁶ In 2019, New Haven experienced a 41.5% increase in opioid overdose deaths compared to both 2017 and 2018 (58 deaths compared to 41).⁷ Large subsets of New Haven’s population rely on service providers to help meet their daily needs. As such, social service, public health, and medical agencies and programs serve critical roles in New Haven, Connecticut.

While New Haven is home to a number of vital health and social services, these services often lack coordination of care and fall short of the fundamental rights-based care standards of availability, accessibility, acceptability, and quality (AAAQ).⁸ The New Haven area would be well served by a more comprehensive, structured service provision and harm reduction program designed for its homeless, street-based, and/or poor and low-income populations. The aim of such a program is to consolidate services and increase access, while also increasing accountability within the currently disparate landscape of services. This paper serves as a foundation of information and advocacy efforts by Downtown Evening Soup Kitchen (DESK), its partners, and other stakeholders for the development of a comprehensive drop-in center in New Haven.

The COVID-19 crisis has revealed further shortcomings in service provision in New Haven: as service programs and businesses have closed or reduced hours, the majority of the homeless population has nowhere to seek respite or meet basic needs during the day, and few have means to self-quarantine. People are already experiencing what it feels like when they cannot access services and have nowhere to go. Drop-in centers are safe

³Feeding America Research (2017). *Map the Meal Gap: Overall and Child Food Insecurity by County in 2017*, https://public.tableau.com/profile/feeding.america.research#!/vizhome/2017StateWorkbook-Public_15568266651950/CountyDetailDataPublic

⁴ U.S. Census Bureau (2019). *Quick Facts: New Haven, Connecticut*. <https://www.census.gov/quickfacts/fact/table/newhavencityconnecticut/POP060210>

⁵ Faulkner, S. (2017), *An opioid crisis in the city and a bad night in the emergency room*, <https://medicine.yale.edu/news/yale-medicine-magazine/an-opioid-crisis-in-the-city-and-a/>

⁶ Connecticut Office of the Chief Medical Examiner, *Accidental Drug Related Deaths 2012-2018*, <https://data.ct.gov/Health-and-Human-Services/Accidental-Drug-Related-Deaths-2012-2018/ecj5-r2i9>

⁷ Backus, L. (2020, February 19). *Fatal drug overdoses rising in CT: Town-by-town view of 2019 deaths*. Connecticut Post. <https://www.ctpost.com/local/article/Fatal-drug-overdoses-rising-in-CT-Town-by-town-15066922.php>

⁸ World Health Organization. (2006). *Availability, accessibility, acceptability, quality infographic*. <https://www.who.int/gender-equity-rights/knowledge/aaaq-infographic/en/> Within the AAAQ framework, “availability” means that there is a sufficient quantity of functioning services; “accessibility” means that services are physically accessible and affordable, and information about them is easy to find; “acceptability” means that services are delivered in a respectful, confidential, and culturally appropriate manner that is responsive to the specific needs of different individuals; and “quality” means that services meet scientifically and medically approved standards of quality.

places for people to meet their needs related to social services, health care, rest, food, sanitation, and community. In response to the impact of COVID-19, a drop-in open air resource tent was opened on Blake Field to provide face masks, food, clothes, hand sanitizer, COVID-19 testing, and toiletries to New Haven's homeless population.⁹ While this response has been vital to service provision during COVID-19, a drop-in center, especially one grounded in the values of harm reduction and the globally accepted AAAQ standards, is now more vital than ever to meet the needs of New Haven's community members. Community members and advocates have already publicized their calls to city officials to open an urgently-needed, low-barrier drop-in center.¹⁰ Additionally, evidence from other cities shows that the inclusion of wrap around services is not linked to significant increases in violent crimes in the surrounding area; in some cases, such centers have been correlated with identical or increased property values.^{11 12 13}

The services provided by a drop-in center seeking to contribute to health and justice can be organized around two overarching goals:

- 1) **Responding to immediate, unmet basic needs**, which can include providing warm meals, showers and washing machines, clothing, health services (both physical and mental health), and a quiet space for people to rest;
- 2) **Facilitating long-term change through empowerment and health justice for the affected population.** The **guiding objective** of a drop-in center should be to provide a pathway towards empowerment and long-term change for clients.¹⁴ Ideally, this includes options for professional, educational, and employment-readiness training (either on site or through referrals), connections to job opportunities, housing services, referrals to drug treatment programs, support groups, and community empowerment initiatives that help strengthen interpersonal networks and social support.

Four principles can guide programming with these goals:

1. **Participatory planning and design**, which should guide the development of the program to ensure it meets needs and supports building community empowerment.
2. The design of the program should follow **harm reduction principles**, articulated here as a no- or low-barrier, non-judgemental program that meets clients "where they are" in their lives -- meaning that clients are supported in mitigating health risks with respect for their autonomy and with recognition of

⁹ McFadden, M. (2020, May 6). Dozen Homeless "Drop In" On Triage Tent | New Haven Independent. http://www.newhavenindependent.org/index.php/archives/entry/blake_field_drop-in/

¹⁰ Sex Workers and Allies Network & Yale Global Health Justice Partnership, *Letter to Mayor Justin Elicker: Considerations for Selection of Bathroom, Shelter & Temporary Housing Sites*, <https://yale.app.box.com/s/511chdzj9idaifxkwzysp3i75b8etlt9>

¹¹ Galster G, Pettit K, Tatian P, Santiago A, Newman S. (1999). *The Impacts of Supportive Housing on Neighborhoods and Neighbors*. 5.1-5.2. https://www.huduser.gov/Publications/pdf/support_1.pdf

¹² Boeckh, J., Dear, M., & Taylor, S. (2008). Property values and mental health facilities in metropolitan Toronto. *The Canadian Geographer / Le Géographe Canadien*, 24, 270–285. <https://doi.org/10.1111/j.1541-0064.1980.tb00342.x>

¹³ Atchison, N. (2018, April 20). *Community Organizations Have Important Role in Lowering Crime Rates*. Brennan Center for Justice. <https://www.brennancenter.org/our-work/analysis-opinion/community-organizations-have-important-role-lowering-crime-rates>

¹⁴ Blume, A. W., & Lovato, L. V. (2010). Empowering the disempowered: Harm reduction with racial/ethnic minority clients. *Journal of Clinical Psychology*, 66(2), 189–200. <https://doi.org/10.1002/jclp.20668>

the complex social conditions that shape individual circumstances. Decades of public health evidence demonstrates that such an approach not only best serves the immediate needs of clients, but also promotes sustained engagement and ultimately the effectiveness and sustainability of programs.

3. The provided services must **meet individual-level needs and connect to system-level efforts to change policies and conditions** needed for health. In other words, the decision of which wrap around services to provide should be made with the goal of changing practice and policies around key social and structural determinants of health at play in the lives of New Haven's most vulnerable: long term housing, opportunities for employment and job training, and treatment for their mental health.
4. The **programming must seek to ensure equitable access** through affirmative measures that effectively address the barriers faced by persons differently situated by race, gender, age, [dis]ability, and other identities.

Case management and linkage to additional services are fundamental components of a service provision strategy oriented towards long-term empowerment.¹⁵ For example, one barrier faced by street-based individuals is difficulty navigating the paperwork needed to obtain important documents or apply for benefits. This challenge is further exacerbated by lack of access to a phone, computer, or mailing address. Assistance with filing paperwork and securing consistent communication is vital to overcome these barriers.

The set of services offered by a drop-in center(s) in New Haven should be determined via community consultation, a process which DESK has already begun through a participatory workshop including community members, service providers, and DESK clients.¹⁶

Best Practices and Guiding Principles

What follows is a discussion of best practices and their guiding principles, derived from a review of public health and other social science literature, as well as a review and summary of services provided by comparable programs in several U.S. cities.

Participatory Planning toward Community Empowerment

All considerations for the services, design, and operation of a drop-in center must be made by actively engaging community stakeholders, including New Haven residents, business owners, city officials, and *most importantly* the anticipated clients of the drop-in center -- particularly those individuals directly impacted by homelessness, drug use, sex work, and poverty. From the outset of planning the drop-in center, DESK has taken active steps to engage these community stakeholders through a Co-Design Workshop, targeted focus groups, and informal, one-on-one conversations. These and other efforts must continue throughout the process of advocating for and opening a drop-in center that caters to the expressed needs and desires of affected community members.

¹⁵ Harkey, J., Sortedahl, C., Crook, M. M., & Sminkey, P. V. (2017). Meeting People "Where They Are": Case Managers Empower and Motivate Clients to Pursue Their Health Goals. *Professional Case Management*, 22(1), 3–9.

<https://doi.org/10.1097/NCM.0000000000000193>

¹⁶ See DESK, *Co-Designing a Downtown Drop-In Center* (2020).

<https://drive.google.com/file/d/17YCyGJ9v3lYmCvajlbgOTy8LH8yioCMq/view?usp=sharing>

Harm Reduction Approaches as a Core Part of Programming in a Comprehensive Drop-In Center

Harm reduction is an evidence-based public health framework focused on reducing the harm associated with high-risk behaviors and circumstances. Service providers and public health advocates have applied this framework to a number of contexts such as sexual health, substance use, sex work, and anti-poverty initiatives. A harm reduction approach recognizes the rights, agency, and dignity of individuals who engage in high-risk behavior, while aiming to alleviate stigma and enact effective policy and programming to keep people alive and enable them to take charge of their lives. In many cases, harm reduction approaches can be part of promoting social justice.¹⁷

The concept of harm reduction was developed by grassroots social movements in the late 1980s in response to the HIV epidemic among intravenous drug users.¹⁸ Recognizing that the “zero-tolerance” approaches driving many drug policies were impractical and ignored factors that stand in the way of stopping drug use, originators of the harm reduction framework sought to reduce the harms associated with drug use (such as preventing transmission of HIV through syringe exchanges) and provide treatment and addiction services. Harm reduction for substance use has historically included evidence-based interventions such as syringe exchanges¹⁹ and medication assisted treatment (MAT),²⁰ both shown to reduce negative individual and community effects associated with substance use. Many of these programs have expanded to include distribution of Naloxone (used to counteract opioid overdoses) and safer-use supplies, dissemination of materials and information through street outreach teams, and the establishment of medically- or peer-supervised Safe Injection Facilities (SIFs).²¹ Supported by extensive empirical evidence, harm reduction service provision has expanded beyond its initial context to refer to a broad array of issues and services with this guiding ethos of prevention.

The harm reduction framework has also been used to promote sexual health services, with targeted initiatives such as condom distribution programs, PrEP education and provision, and increased access to STI testing and emergency contraception among “key” or at-risk populations. Some organizations have applied harm reduction principles to the harms generated by the policing of street-involved persons: in these cases, evidence of health

¹⁷ See Harm Reduction International, “What is harm reduction?”, <https://www.hri.global/what-is-harm-reduction#>.

¹⁸ Des Jarlais DC, Friedman SR, Ward TP. Harm reduction: a public health response to the AIDS epidemic among injecting drug users. *Ann Rev Public Health* 1993;14: 413-450.

¹⁹ Stimson G. Syringe exchange programmes for injecting drug users. *AIDS* 1989;3:253-260.

²⁰ Newman R, Harm reduction -- a common cause, *Forensic Sci Intl* 62 (1993) 9-13. Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, alongside counseling and behavioral therapies, to treat substance use disorders. Opioid treatment programs provide MAT for individuals with opioid use disorder.

²¹ Safe Injection Facilities, sometimes referred to as Safe Injection Sites or Safe Consumption Sites, provide people who use drugs with designated, hygienic locations for drug consumption without the intervention of law enforcement and under the supervision of medical personnel. In addition to medical supervision, these facilities often provide sterile injection equipment and informational materials on safer drug use and substance use treatment options.

and rights violations is used in campaigns to repeal laws criminalizing drug use, sex work, poverty, and homelessness.^{22 23}

The expansion of harm reduction policies and programs reflects a growing body of evidence that supports their effectiveness. Among other positive findings, the evidence demonstrates that harm reduction initiatives have been effective in reducing long-term treatment costs for infectious disease²⁴ and substance use disorders,^{25 26} decreasing infectious disease transmission,²⁷ reducing drug-related mortality,²⁸ and improving overall health outcomes.²⁹ Recent research has also identified service centers, such as shelters, as key points of intervention for harm reduction programs.³⁰ A wrap around drop-in center could provide an ideal setting for this type of harm reduction intervention in New Haven.

What Are Wrap Around Services and How Do They Work Best to Address Needs and Support Long Term Change?

The term “wrap around services” describes programming that consolidates and makes available several types of needed services at one physical site. Harm reduction principles are realized through such programming that seeks to minimize the challenges that clients may face in accessing care. The approach recommended here, based on the literature on effective service delivery and sustained use, combines this model of “wrap around care” with an approach that also seeks to reduce the barriers to entry.³¹

This combination succeeds because it can address multiple and intersecting individual needs, such as those created by food insecurity, mental health issues, and drug use. The conditions which produce health or ill health can be referred to as the “social and structural determinants of health.” More specifically, structural determinants research looks at the systems, policies, and practices that create unequal exposures to

²² Harm Reduction International (2013) *When sex work and drug use overlap: Considerations for advocacy and practice*, https://www.hri.global/files/2014/08/06/Sex_work_report_%C6%924_WEB.pdf

²³ Drug Policy Alliance (2017), *A Public Health and Safety Approach to Opioid Addiction and Overdose*, <http://www.drugpolicy.org/resource/public-health-and-safety-approach-problematicopioid-use-and-overdose>.

²⁴ Aitken C, New Zealand Needle and Syringe Exchange Programme Review Final Report, Centre for Harm Reduction (2002)

²⁵ Goldschmidt PG (1976) A cost-effectiveness model for evaluating health care programs: Application to drug abuse treatment. *Inquiry*, 13, 29-47.

²⁶ Gossop M, Marsden J and Stewart D, NTORS After Five Years (The National Treatment Outcome Research Study), Changes in substance use, health and criminal behaviour during the five years after intake. London: National Addiction Centre (2001).

²⁷ Nadelmann E A, Coffin, P, Halingby L and Greenshields A (1999) *Safer Injection Rooms*, New York: Open Society Institute; Dolan K, Kimber J, Fry C, Fitzgerald JL, McDonald D and Trautmann F (2000) Drug Consumption Facilities in Europe and the Establishment of Supervised Injecting Centres in Australia. *Drug and Alcohol Review*, 19, 337-346

²⁸ Newman R, Whitehill W. Double-blind comparison of methadone and placebo maintenance treatments of narcotic addicts in Hong Kong. *Lancet* 1979;September 8:485-488.

²⁹ *See generally*, Hunt, N, Ashton, M, Lenton S, Mitcheson L, Nelles B, Stimson G (2003) *A review of the evidence-base for harm reduction approaches to drug use*. London: Forward Thinking on Drugs.

³⁰ Wallace B, Barber, K, & Pauly, B, Sheltering risks: Implementation of harm reduction in homeless shelters during an overdose emergency, *Intl. J. Drug Pol.* 53, 83-89 (2018).

³¹ Rose M Etheridge & Robert L Hubbard. Conceptualizing and Assessing Treatment Structure and Process in Community-Based Drug Dependency Treatment Programs, *Substance Use & Misuse*, 2000; 35:12-14, 1762.

health-damaging experiences and contribute to health inequities among and between populations.³² Examples of such determinants of health include access to healthy food, safe housing, and reliable transportation, as well as legal structures such as the criminal legal system.³³ ³⁴ Housing policy or bus systems, for example, must be studied to understand how they affect the health of different groups and individuals. The services which address these needs must be assessed in light of individual and systemic need.

Many individuals who are housing insecure or experiencing homelessness are at the intersection of different system failures, requiring multiple, simultaneous forms of support, and facing logistical barriers to connect with the various services they need. Think of a person reliant on buses or walking who seeks to move around New Haven to receive support with food, housing, mental health counseling, and to meet their basic hygiene needs. This individual's access to services (or lack thereof) can acutely impact not only their day-to-day survival, but their long-term health as well. A central site equipped to address the many different needs arising from social and structural determinants of health lowers the barriers to care: it creates the potential for more accessible, acceptable, and sustainable programming and healthier populations..³⁵

Providers in a variety of contexts, including substance use treatment programs, children's mental health care, and medical centers, have used wrap around services to connect and sustain clients with both medical and non-medical resources -- such as case management, employment assistance, childcare, and substance use-related treatment and other counseling.³⁶

Equitable Access

In the context of a comprehensive drop-in center, the principles of both harm reduction and equitable access mandate an approach that minimizes the barriers to access services. The elimination of eligibility criteria that exclude people from accessing the space is crucial from the outset; similarly critical is ensuring that no aspect of the space or service provision makes the program exclusionary through its design. For example, services should be free of charge and access should not be restricted by a need for identification.³⁷ In practice, low barrier means not only services that are physically accessible and financially affordable, but also culturally and socially responsive and competent. Examples include:

- Ensuring language accessibility;
- Ensuring protections against immigration enforcement for undocumented clients;
- Ensuring non-stigmatizing, respectful, and high quality care and services;

³² World Health Organization. (2008). *Closing the gap in a generation: Health equity through action on the social determinants of health*. https://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf

³³ See American Public Health Association (2018). *Addressing Law Enforcement Violence as a Public Health Issue*. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2019/01/29/law-enforcement-violence>

³⁴ *Mistreatment and Missed Opportunities (2020)*

³⁵ See Vest J, Menachemi N, Grannis S, Ferrell J, Kasthurinathne S, Zhang Y, Tong Y, Halverson P. Impact of Risk Stratification on Referrals and Uptake of wrap around Services That Address Social Determinants: A Stepped Wedged Trial. *J. Preventative Med.*, 2019; 56:4, e125-e133.

³⁶ Oser C, Knudsen H, Staton-Tindall M, Leukefeld C. The adoption of wrap around services among substance abuse treatment organizations serving criminal offenders: The role of a women-specific program. *Drug and Alcohol Dependence*, 2009; 103, S82-S90.

³⁷ HIPS <https://www.hips.org/our-services.html>

- Minimizing coercive or punitive interactions, such as minimizing or eliminating law enforcement presence.

Low barrier service provision requires ongoing effort to ensure that no individual is excluded on the basis of religion, gender, race, immigration status, drug use, housing status, ability to pay, or previous involvement with social services or the criminal legal system. **This requires deliberate and ongoing processes (during design and as part of ongoing accountability monitoring [see below]) to identify who currently cannot or will not access services are part of any commitment to low barrier service provision.** Concrete methods such as surveys, observation, cumulative tallies, etc. must be developed with regard to principles of equity and privacy and to variables such as age, sex, gender, and race.

Planning the Space/s and Designing Services

The principles articulated above help to shape the physical layout and plan of the space as well as services provided.

Considerations for Location

For many homeless, street-involved, and low-income individuals, access to services is hindered by limited means of transportation. A peer-led survey³⁸ conducted among street-based sex workers in New Haven, for instance, found that the majority of respondents were not able to afford the transportation they needed to access services: they relied on public transport, walking, or rides from others to reach their daily destinations. The lack of a robust and affordable intra-City public transit infrastructure, as indicated by this survey, creates barriers³⁹ to traveling even moderate distances between neighborhoods for services. As such, consolidating several needed services into accessible and strategically-located drop-in center/s offers the advantage of reducing the amount of commuting required to access different services.

Given the current service gaps and geographic dispersal of services in New Haven,⁴⁰ there is a good argument not just for wrap around service centers but for multiple drop-in center sites and/or sites with mobile outreach programs. The various neighborhoods in New Haven have different populations (along lines of race, ethnicity,

³⁸ See Sex Workers and Allies Network & GHJP, *Mistreatment and Missed Opportunities: How Street-Based Sex Workers are Overpoliced and Underserved in New Haven, Connecticut. A Primer for Policymakers, Service Providers, and Advocates*, (2020).

https://law.yale.edu/sites/default/files/area/center/ghjp/documents/mistreatment_and_missed_opportunities_ghjp_and_swan_report_july_2020.pdf

³⁹ *Mistreatment and Missed Opportunities* (2020)

⁴⁰ *Mistreatment and Missed Opportunities* (2020)

and socioeconomic status) with differing needs, and services have historically been inequitably distributed across the city, with isolated pockets of services in few neighborhoods.^{41 42 43}

Thus, the location(s) of a drop-in center should be carefully chosen to be in, close to, and/or accessible to neighborhoods where potential clients are based, and to be easily accessible by public transport for individuals from other parts of the city. In addition to drop-in centers, some harm reduction organizations⁴⁴ increase and maximize the accessibility of their services by operating a mobile van or street outreach teams. The decision of which model to use (a single, central drop-in center, multiple sites, and/or vans and other forms of outreach) depends on the size and geographic distribution of the populations to be served, as well as transportation/accessibility, zoning, and neighborhood concerns.

Engaging Affected Communities in Considerations for Physical Space

Wrap around service center location(s) should be selected in collaboration and consultation with local residents and potential clients in a transparent and public process. Considerations for how the physical space looks, feels, and operates should also be developed in collaboration with potential clients and employees. All resources provided by the drop-in center (physical, health care, case management, employment, empowerment, etc.) should be gender inclusive, gender responsive, and accessible to all body types and ability levels.

In a Co-Design workshop held by DESK in February of 2020, participants indicated that the physical space should include comfortable furniture, bright lighting where appropriate (not in the rest area), lockers, a quiet room or sensory room, a warm area (particularly during colder months), and a clean, gender neutral bathroom. Co-designers also commented on the importance of staff demeanor and presence in the physical space, emphasizing the importance of having staff with lived experience to ensure a welcoming and inclusive environment that is hospitable to those accessing the drop-in center.^{45 46}

Range of Services to Consider in New Haven

Table 1 below presents a range of services that could be offered by a drop-in center in New Haven. The proposed services are aligned with the previously discussed frameworks of harm reduction, meeting basic needs, and addressing social and structural determinants of health. They were identified through our review of services provided by other drop-in centers (see Table 2), the peer-led needs assessment survey conducted among street-based sex workers in New Haven (November 2018-July 2019), and the Co-Design workshop carried out by DESK in February 2020.

⁴¹ United Way 211 Services Map

https://www.211ct.org/search?terms=food%20pantries&page=1&location=06511&service_area=new%20haven

⁴² *Hill Health Plan Delayed; Alder Apologizes* | *New Haven Independent*. (2019, October 10).

http://www.newhavenindependent.org/index.php/archives/entry/hill_north/

⁴³ *Hill Leaders Slam Career Shelter Plan* | *New Haven Independent*. (2020, March 19).

http://www.newhavenindependent.org/index.php/archives/entry/hill_alders_career/

⁴⁴ Some Connecticut examples of harm reduction organizations operating mobile service vans: Greater Hartford Harm Reduction Coalition, AIDS CT, Alliance for Living New London, Yale Community Health Care Van, Perceptions Programs, MAT's Van, and soon SWAN (at time of publication).

⁴⁵ Massachusetts Transgender Political Coalition:

<https://www.masstpc.org/wp-content/uploads/2012/10/Shelter-for-all-Genders.pdf>

⁴⁶ See DESK, *Co-Designing a Downtown Drop-In Center* (2020).

Table 1: Potential Drop-In Center Services

<p>Physical Resources</p> <ul style="list-style-type: none"> • Bathrooms • Showers with toiletries • Secure lockers • Power outlets • Washing machines • A quiet room • Wifi • Computers with internet access and printers • Phones • Water, coffee and tea station • Hot as well as to-go meals • Food pantry • Mail receiving center using a P.O. box • Clothing • Kitchenette access for client use 	<p>Health Care Services</p> <ul style="list-style-type: none"> • Primary care services • Blood testing for STIs • Education on safer substance use • Provision of PrEP and assistance obtaining PrEP cost subsidies • Safer sex supplies • Menstrual supplies • Group therapy • Mental health professional drop-in hours • Syringe exchange • Medication assisted treatment • Referrals and linkages to higher levels of specialized care 	<p>Case Management</p> <ul style="list-style-type: none"> • Coordinated Access Network (CAN) assessments for housing and shelter services • Social workers drop-in hours • Assistance with government ID, Social Security Card paperwork • Assistance with Section 8 housing paperwork • Assistance with navigating government nutrition programs • Medicaid enrollment • Referrals to local nutrition resources
<p>Job Resources</p> <ul style="list-style-type: none"> • Skills training • Connections to job opportunities • Job fairs • Referrals to adult literacy programs, GED programs, affordable college courses 	<p>Community Empowerment</p> <ul style="list-style-type: none"> • Interactive asset map option to share experiences with services • Message board for individuals without a phone to exchange messages and share resources • Overdose prevention and Naloxone training • Recreational and community-building activities (puzzles, board games, etc.) 	

Table 1 shows a list of possible resources and services to be offered by a drop-in center, identified through a Needs Assessment conducted with people involved in sex work members organized by GHJP in November 2018, and a Drop-In Center Co-Design workshop with service providers and DESK clients organized by DESK in February 2020.

Table 2: Services Offered by Other Drop-In Centers

	Prevention Point Philadelphia, PA	Greater Hartford Harm Reduction Coalition Hartford, CT	HIPS Washington, DC	Preble Street Portland, ME
Free meals	●		●	●
Food pantry			●	●
Mail reception	●		●	●
Shower facilities			●	●
Laundry machines			●	●
Clothes distribution			●	●
Primary care	●		●	
Counseling/behavioral health			●	
Support groups			●	
Medication Assisted Treatment	●		●	
STI testing	●	●	●	
Safer sex supply		●	●	
Syringe exchange	●	●	●	
Legal services	●		●	●
Case management	●		●	●
Housing services	●		●	●
Linkage to health care		●	●	●
Referral to drug treatment	●	●	●	●
Employment services			●	●
Overdose prevention training	●	●	●	

Table 2 shows the range of services offered by four existing harm reduction-informed drop-in centers: Prevention Point in Philadelphia, PA (<https://ppponline.org/>); the Greater Hartford Harm Reduction Coalition center in Hartford, CT (<https://www.gbhrc.org/>); HIPS in Washington, DC (<https://www.hips.org/>); and the Preble Street resource center in Portland, ME (<https://www.preblestreet.org/>). These centers were selected for review based on their presence in mid-sized cities and how long they have been providing services, with the inclusion of at least one existing drop-in center in Connecticut. Information was gathered from these organizations' websites as well as knowledge from members of the GHJP with previous experience working with some of the organizations selected.

Additionally, in considering which services will be offered and how clients will interact with a drop-in center, DESK should consider developing a plan for sedation monitoring and activation of emergency medical services (EMS). Although DESK does not currently intend for the drop-in center to operate as a supervised injection facility (SIF), it is possible that clients will access the space while sedated or intoxicated. In creating the conditions for low barrier and inclusive service provision, plans must be in place for safe, non-stigmatizing, and medically appropriate responses to sedated individuals. Effective administration of such plans may also reduce the number of sedated individuals in public as well as rates of emergency room utilization.⁴⁷ Harm reduction principles should be followed in all plans for sedation monitoring, including:

- Training staff members on harm reduction, cultural safety, trauma informed care and practice, basic first aid, overdose response (e.g. naloxone administration, CPR), and infection prevention and control;⁴⁸
- Employing people with lived or living experience with substance use to aid in sedation monitoring;⁴⁹
- Providing snacks and beverages (e.g. coffee, water, granola bars) to those being monitored.⁵⁰

Metrics for Monitoring the Quality of a Drop-in Center

Metrics for monitoring the effectiveness of a drop-in center must be designed and chosen to provide accountability to clients and to assess the quality of services. Participatory monitoring and evaluation (PM&E) is a useful tool that allows program participants to act as both users of services and assessors of quality.⁵¹ PM&E is defined as a process through which stakeholders at various levels engage in the monitoring and/or evaluation of a particular project or program, share control over the content, process, and the results of the M&E activity, and engage in taking or identifying corrective actions.⁵² PM&E allows community members and drop-in center clients to: act as collaborators in the design of the monitoring and evaluation plan; facilitate a feedback loop between service providers and clients; and directly connect the performance of the drop-in center with the expectations and goals of the clients.⁵³

Quantitative indicators for common drop-in center services are listed in Table 3 (below).

⁴⁷ Pollack, H. A., Khoshnood, K., Blankenship, K. M., & Altice, F. L. (2002). The Impact of Needle Exchange-based Health Services on Emergency Department Use. *Journal of General Internal Medicine*, 17(5), 341–348. <https://doi.org/10.1046/j.1525-1497.2002.10663.x>

⁴⁸ Hyshka, K., Dong, K., Meador, K., Speed, K., Abele, B., LeBlanc, S., McFarlane, A., McNeil, R., Salokangas, E., Schoen, E., & Wild, T.C. *Supporting people who use substances in shelter settings during the COVID-19 pandemic*. Edmonton, Alberta: Canadian Research Initiative in Substance Misuse; May 17, 2020. 82 p. Version 1.

⁴⁹ *Supporting people who use substances in shelter settings during the COVID-19 pandemic*. (2020).

⁵⁰ *Supporting people who use substances in shelter settings during the COVID-19 pandemic*. (2020).

⁵¹ The Hunger Project, <https://www.thp.org/our-work/measuring-our-work/participatory-monitoring-evaluation/>

⁵² Sustainable Sanitation and Water Management Toolbox, [https://sswm.info/arctic-wash/module-3-health-risk-assessment/further-resources-participatory-approaches-and-health/participatory-monitoring-and-evaluation#:~:text=Participatory%20monitoring%20%26%20evaluation%20\(PM%26E\),and%20engage%20in%20taking%20or](https://sswm.info/arctic-wash/module-3-health-risk-assessment/further-resources-participatory-approaches-and-health/participatory-monitoring-and-evaluation#:~:text=Participatory%20monitoring%20%26%20evaluation%20(PM%26E),and%20engage%20in%20taking%20or)

⁵³ The Hunger Project, <https://www.thp.org/our-work/measuring-our-work/participatory-monitoring-evaluation/>

Table 3: Service Types and Metrics⁵⁴

Type of Service	Indicator/Metric
Medication-Assisted Treatment (MAT) ⁵⁵ (for Opioid Use Disorder)	Provision: # of clients on MAT
	Coverage (percentage): # of MAT clients divided by estimated number of people who use opioids
	Waiting time until first appointment (weeks)
	Dosage: grams of methadone/buprenorphine prescribed, # of clients in each dosage tier of distribution (daily, weekly, biweekly, etc).
Needle and Syringe Exchange Program (NSP)	Provision: # of syringes provided, clients, outreach sites (if any), # of used syringes collected
	Coverage (percentage): # of syringes provided divided by estimated number of people who inject drugs (PWIDs), # of syringe service program (SSP) members across the city (by ZIP code or neighborhood)
	Provision of other drugs use paraphernalia and equipment (other than syringes)
	# of members utilizing another SSP or Harm Reduction Service
General Harm Reduction/Cross Cutting Indicators	Counseling, testing, vaccination, and referrals for infectious diseases (e.g. HIV, Hepatitis B, Hepatitis C, TB)
	Provision of naloxone: # of doses, # of clients
	Provision of information regarding safer injection practices, safer drug use practices, safer sex
	Provision of condoms: # of condoms
	# of referrals to other service providers
	# of overdoses/reversals an individual has experienced or reversed

Table 3 lists metrics for the monitoring and evaluation of drop-in centers based on different services types: Medication-Assisted Treatment; Needle and Syringe Exchange Programs; and General Harm Reduction services.

⁵⁴ Wiessing, L., Ferri, M., Běláčková, V. *et al.* Monitoring quality and coverage of harm reduction services for people who use drugs: a consensus study. *Harm Reduct J* 14, 19 (2017). <https://doi.org/10.1186/s12954-017-0141-6>

⁵⁵ Medication-Assisted Treatment (MAT) is the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a “whole-patient” approach to the treatment of substance use disorders. Opioid treatment programs provide MAT for individuals with opioid use disorder. (Substance Abuse and Mental Health Services Administration <https://www.samhsa.gov/medication-assisted-treatment/treatment#medications-used-in-mat>)

Setting and (re)assessing services, priorities and impacts

In addition to the indicators listed in the tables above, there are other important considerations in assessing drop-in center(s), particularly with regard to cross-cutting harm reduction metrics. Regular consultation with clients (to encourage feedback and evaluation of services/programming) and other stakeholders is vital to the success of a drop-in center and crucial to upholding the principles of PM&E.⁵⁶

Services that are committed to reducing inequities, increasing inclusion, and building community accountability can make use of:

- The globally accepted AAAQ framework (Availability, Accessibility, Acceptability, and Quality)⁵⁷ for ongoing assessments to meet commitments to health justice;
- Regular participatory reviews (with staff, other providers, and clients of the drop-in center), in order to strengthen existing services and plan for the potential expansion and integration of new services, locations, and outreach methods (especially with regard to potential service provision in the greater New Haven area);

Different aspects of the program must be regularly reviewed. Measurement and feedback metrics should be relevant to the assessment of how services affect individual and community empowerment, dignity, and equity. Some key stakeholders and issues that should be included in the ongoing process of monitoring and evaluation include:

- Consultations with **clients** on a regular basis (e.g., every six months) with attention to barriers to use of drop-in center services, quality of services, quality of interactions with staff, acceptability and inclusivity of services, etc.⁵⁸ Feedback should be gathered regarding clients' perceptions of services being voluntary and non-coercive as well as their sense of autonomy and control over participation in services.⁵⁹
 - Particular effort and attention should be given to soliciting input from different sub-populations (by age, [dis]ability, gender, race, HIV status, drug use, citizenship status, among others) of the affected communities;
- Consultations with **service providers** to assess any ongoing structural barriers, including geographic accessibility; their perceptions of service gaps, other needed services, and rights-based impacts of services on clients;
- Regular and carefully facilitated consultations with **neighborhood residents, business owners, and first responders** (see note on law enforcement below).

⁵⁶ Onyango, Rohin. (2018). Participatory Monitoring and Evaluation: An Overview of Guiding Pedagogical Principles and Implications on Development.

⁵⁷ *Mistreatment and Missed Opportunities (2020)*

⁵⁸ Amara Legal Center. "Survey of United State Diversion Programs: Sex Work and Sex Trafficking." (2018)

⁵⁹ See Sex Workers Rproject of the Urban Justice Center and GHJP, *Diversion from Justice: A Rights-Based Analysis of Local "Prostitution Diversion Programs" and their Impact on People in the Sex Sector in the United States*, (2018).

https://law.yale.edu/sites/default/files/area/center/ghjp/documents/diversion_from_justice_pdp_report_ghjp_2018rev.pdf

A Note on Consultations with Law Enforcement

As part of the rapidly evolving discussion regarding law enforcement and policing in New Haven and across the country, consultations and a specific plan should be put in place regarding the role of police (NHDP, Yale PD, and other security forces) in order to outline what is expected of them, and what is acceptable/unacceptable in terms of their interactions with the drop-in center, its clients, and the surrounding neighborhoods. The goals of these consultations are to build regular monitoring and evaluation of law enforcement's relationship with the drop-in center, to build accountability toward the people served, and to support long-term structural changes that mitigate the harms of policing on people who are homeless, street-involved, and low-income or poor.

Evidence-based Responses to the Most Commonly Raised Concerns about Drop-In Centers

FAQ: We already have a shelter system and an array of services for people experiencing homelessness in New Haven. Why do we need a drop-in center?

While the existing services in Greater New Haven play a vital role in the lives of people experiencing homelessness, the limitations of service organizations leave these populations with significant gaps in care and services.⁶⁰ The shelter system does not provide clients with a dependable place to stay or access services during the day.⁶¹ New Haven's shelters have rather restrictive policies, among them rigid hours - often closed to occupants and clients by 8:00 a.m. and requiring their return as early as 4:00 p.m. in order to secure a bed for the night, effectively leaving them without a place to go in the interim/between those hours.⁶² Moreover, these shelter systems often fail to accommodate many of the symptoms associated with the chronic illness of substance use and addiction.^{63 64} The drop-in center is meant to complement the work of the shelter system by providing clients access to a safe and respectful daytime space that addresses needs not met through the shelter model. Just as critically, a centralized drop-in center addresses the current issue of access posed by services that are located in disperse or difficult-to-reach locations around New Haven.⁶⁵ Many people facing homelessness do not have access to transportation (neither buses, which are an erratic service in New Haven, nor cars or other transport), which makes strategically placed, wrap around service hubs a vital resource.⁶⁶

⁶⁰ *Mistreatment and Missed Opportunities (2020)*

⁶¹ Petrovich et al., *Creating safe spaces: Designing day shelters for people experiencing homelessness*, J. Social Distress and the Homeless, (2017) 26:1, 65–72, <http://dx.doi.org/10.1080/10530789.2016.1260879>

⁶² Sanders A (Jun. 9, 2012). *Many New Haven homeless feel shelters too restrictive*. New Haven Register, <https://www.nhregister.com/news/article/Many-New-Haven-homeless-feel-shelters-too-11535400.php>

⁶³ Saitz, R., Larson, M. J., LaBelle, C., Richardson, J., & Samet, J. H. (2008). The Case for Chronic Disease Management for Addiction. *Journal of Addiction Medicine*, 2(2), 55–65. <https://doi.org/10.1097/ADM.0b013e318166af74>

⁶⁴ Morse, E. D. (2018). Addiction is a Chronic Medical Illness. *North Carolina Medical Journal*, 79(3), 163–165. <https://doi.org/10.18043/ncm.79.3.163>

⁶⁵ *Mistreatment and Missed Opportunities (2020)*

⁶⁶ Evans et al., *On thin ice: Assembling a resilient service hub* (2018) doi: 10.1111/area.12448.

Drop-in centers are cost-saving and health-promoting. Other centers, including those that offer harm reduction services such as needle exchanges and safe consumption facilities (SIFs), have been shown to be effective in reducing the spread of communicable disease⁶⁷ and in connecting clients with consistent, ongoing preventative medical care.⁶⁸ The wrap around model of a drop-in center has also been shown to reduce costs by facilitating more efficient information-sharing and connections between services.⁶⁹

FAQ: Will a drop-in center hurt downtown businesses by attracting congestion, noise, drug-use, and crime?

Assumptions about clients as a source of crime and about drop-in centers as sites of disruptive activity often form the basis of opposition from community members and business owners. Data from other drop-in centers and service hubs present a powerful counter-narrative to such objections. **Not only do drop-in center services meaningfully improve the lives of clients and produce improved public health outcomes, but they have also been associated with positive neighborhood effects.** Research findings on drop-in centers have reported no strongly negative impact on business, less drug-related litter in surrounding neighborhoods, and no noted increase in loitering in these areas.^{70 71 72 73 74} Specifically, surrounding business owners noted a long-term decline in exposure to discarded syringes, fewer disturbances related to drug use, and no increase in loitering. The inclusion of wrap around services has been shown to have no significant increase in violent crimes in the surrounding area, and in some cases has been correlated with identical or increased property values.^{75 76 77}

⁶⁷ Ashford et al., *Peer-delivered harm reduction and recovery support services: initial evaluation from a hybrid recovery community drop-in center and syringe exchange program*, Harm Reduction Journal (2018) 15:52, <https://doi.org/10.1186/s12954-018-0258-2>.

⁶⁸ Kim et al., *Uptake of a women-only, sex-work-specific drop-in center and links with sexual and reproductive health care for sex workers*, International Journal of Gynecology and Obstetrics 128 (2015) 201–205.

⁶⁹ See Vest J, Harris L, Haut D, Halverson P, Menachemi N. *Indianapolis Provider's Use Of wrap around Services Associated With Reduced Hospitalizations And Emergency Department Visits*. Chevy Chase 37:10, 1555-1561 (2018).

⁷⁰ Bairstow, M. (n.d.). *Navigation Centers: What do Neighbors Have to Fear?* 20.

<http://hsh.sfgov.org/wp-content/uploads/Navigation-Center-Neighborhood-Impacts-Final-Report-1.pdf>

⁷¹ Beletsky et al., *The Law (and Politics) of Safe Injection Facilities in the United States*, Government, Politics, and Law; 2008 98:2, 232 <https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2006.103747>.

⁷² Wood E, Tyndall MW, Montaner JS, Kerr T. Summary of findings from the evaluation of a pilot medically supervised safer injecting facility. CMAJ. 2006;175:1399–1404.

⁷³ MSIC (Medically Supervised Injection Centre) Evaluation Committee. Final Report of the Evaluation of the Sydney Medically Supervised Injection Centre. Sydney, Australia: MSIC Evaluation Committee; 2003, https://www.drugsandalcohol.ie/5706/1/MSIC_final_evaluation_report.pdf

⁷⁴ Salmon AM, Thein H-H, Kimber J, Kaldor JM, Maher L. Five years on: what are the community perceptions of drug-related public amenity following the establishment of the Sydney Medically Supervised Injecting Centre? Int J Drug Policy. 2007;18:46–53.

⁷⁵ Galster G, Pettit K, Tatian P, Santiago A, Newman S. (1999). *The Impacts of Supportive Housing on Neighborhoods and Neighbors*. 5.1-5.2. https://www.huduser.gov/Publications/pdf/support_1.pdf

⁷⁶ BOECKH, J., DEAR, M., & TAYLOR, S. (2008). Property values and mental health facilities in metropolitan Toronto. *The Canadian Geographer / Le Géographe Canadien*, 24, 270–285. <https://doi.org/10.1111/j.1541-0064.1980.tb00342.x>

⁷⁷ Atchison, N. (2018, April 20). *Community Organizations Have Important Role in Lowering Crime Rates*. Brennan Center for Justice. <https://www.brennancenter.org/our-work/analysis-opinion/community-organizations-have-important-role-lowering-crime-rates>

FAQ: As a policymaker, I'm sympathetic to the cause, but won't my support for a drop-in center stir opposition from my constituents?

Despite the evidence of drop-in centers' positive effects on communities, policymakers and other elected officials might be hesitant to support what they perceive to be a politically unpopular move. Nevertheless, elected officials should not assume that community members would necessarily oppose a drop-in center: key community figures such as law enforcement officers and emergency service providers have proven to be important voices in support of similar efforts in other cities;⁷⁸ their voices should be included as part of a public education campaign around the realities faced by homeless and street-based communities. In fact, since early June 2020, there has been a surge in public sentiment regarding the need to redirect funds away from ineffective policing to much needed public and social services.⁷⁹ This discussion has made its way to the Connecticut State Legislature as part of its "Police Transparency and Accountability Task Force."^{80 81} Policymakers should be encouraged to see the opening of a downtown drop-in center as an important opportunity to bring attention to the unmet service needs of the target population.

The crises wrought by the COVID-19 pandemic have renewed and amplified calls for advocacy and policy change regarding the public safety of Black communities and people of color. Such local action could positively contribute to and increase public support for a drop-in center. Advocates have found that in the face of public health emergencies, the political barriers blocking otherwise major policy changes around similar harm reduction interventions have been lowered. For example, safe consumption sites have scaled up at a rapid pace in North American cities in response to the high overdose rates connected to the opioid crisis.⁸² Government actors have played important roles in this process by lowering administrative barriers to opening service centers and they can do the same now. The COVID-19 crisis has already incited calls for New Haven City officials to open an urgently-needed, low-barrier drop-in center, especially after the implementation of the open air drop-in center on Blake Field.⁸³ Effectively targeted communications made by and in cooperation with City officials can win public support by backing a drop-in center as a positive action in the name of public health and to the benefit of all residents.

⁷⁸ Beletsky et al. *The Law (and Politics) of Safe Injection Facilities in the United States*, Government, Politics, and Law; 2008 98:2, 232 <https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2006.103747>.

⁷⁹ Connecticut lawmakers prefer massive reform bill to "defunding" the police. (2020, June 9). *The CT Mirror*. <https://ctmirror.org/2020/06/09/connecticut-lawmakers-prefer-massive-reform-bill-to-defunding-the-police/>

⁸⁰ *Task Force Asked To Fast-Track Police Reform*. (n.d.). CT News Junkie. Retrieved June 17, 2020, from https://www.ctnewsjunkie.com/archives/entry/20200608_task_force_asked_to_fast-track_police_reform/

⁸¹ McGraw, D. (n.d.). *Police Transparency & Accountability Task Force*. 3.

⁸² See Bardwell et al., *Housing and overdose: an opportunity for the scale-up of overdose-prevention interventions?* ("In settings across North America, a lack of support by policymakers and governments to fund and implement evidence-based harm reduction interventions continue to pose major challenges to opening SCS. However, circumventing such political barriers has proven feasible within the context of a public health emergency. For example, in Canada, a shift in government policies has made it significantly less onerous to open SCS, given the severity of the overdose crisis [26].")

⁸³ Sex Workers and Allies Network & Yale Global Health Justice Partnership, *Letter to Mayor Justin Elicker: Considerations for Selection of Bathroom, Shelter & Temporary Housing Sites*, <https://yale.app.box.com/s/511chdzj9idaifxkwzyp3i75b8etlt9>

FAQ: Similar services have been tried and were consistently under-utilized: the women’s warming center that opened just last year in the Newhallville neighborhood of New Haven had to be shut down because people weren’t using it. How will this be different?

As with many services for unhoused people, the problem with the Newhallville all-women warming center was not a lack of need but rather a lack of effective implementation.⁸⁴ Though the City discontinued funding for the Newhallville warming center because it found the center to be under-utilized,⁸⁵ evidence from service providers working with street-engaged women suggests it is implausible that this service was not needed. Rather, conversations with service providers suggest that the warming center was inaccessible to many potential clients due to its location: an hour walk from neighborhoods such as Fair Haven and an almost forty-minute walk from downtown New Haven. Instead of serving as evidence against the need for a drop-in center, the warming center and other services are instructive in how to strategically and logistically meet clients’ needs.

DESK and its partners have engaged in an ongoing, participatory process to understand in detail and nuance the community’s various desires and needs. In strong contrast with the implementation of other service provision programs (such as the women’s warming center or New Haven’s Law Enforcement Assisted Diversion (LEAD) program),^{86 87} DESK’s process is dynamic and involves active, ongoing collaboration with all stakeholders, including potential clients, service providers, City officials, and non-client community members, to produce proposals closely informed by their guidance.

Conclusion

A wrap around drop-in center is both needed and well-suited to address the service gaps in New Haven. This kind of programming, accessibly situated in the city, would benefit the entire community. A comprehensive program offering service provision and harm reduction for homeless, street-based, and/or poor and low-income populations would increase access and build more community accountability within the disparate landscape of services in New Haven. Effective, community-oriented planning, implementation, and evaluation would ensure that these initiatives meet the benchmarks of wrap around service provision, harm reduction principles, equitable access, and community empowerment.

⁸⁴ See Sex Workers and Allies Network & GHJP, *Understanding the Experiences and Resource Needs of People Involved in Street-based Sex Work in New Haven, CT: A Primer for Constructive Response*, 2020 [link].

⁸⁵ Glesby, “Women’s Warming Center Set to Close,” *New Haven Independent*, Feb. 27, 2020, https://www.newhavenindependent.org/index.php/archives/entry/warming_center_to_close/

⁸⁶ See Breen T (Jan. 28, 2020). *Pilot Effort Fails. Who’s To Blame?*, *New Haven Independent*, https://www.newhavenindependent.org/index.php/archives/entry/lead_report

⁸⁷ See also Sex Workers and Allies Network & GHJP, *NHV LEAD Watchsite*, <https://leadwatchsite.wixsite.com/newhaven>