THE
UNIVERSITY-OAKLAND
METROPOLITAN FORUM
SERIES

Working Paper 96-11

COPC: Supportive Housing Models for Mentally Disabled People: Case Studies and Policy Issues

Tanya Temkin

October 1996

University of California at Berkeley

$12.50

Working Paper 96-11

(formerly COPC 7)

COPC: Supportive Housing Models for Mentally Disabled People: Case Studies and Policy Issues

Tanya Temkin

The University-Oakland Metropolitan Forum is a partnership of the University of California at Berkeley; California State University, Hayward; Mills College; Holy Names College; the Peralta Community College District; and the Oakland community.

University of California at Berkeley
Institute of Urban and Regional Development

BAY AREA COMMUNITY OUTREACH PARTNERSHIP CENTER

Stanford University *Haas Center for Public Service*

San Francisco State University
Public Research Institute / Urban Institute

University of California, Berkeley *Institute of Urban & Regional Development*
University-Oakland Metropolitan Forum

Supportive Housing Models for Mentally Disabled People in Berkeley: Policy Issues and Case Studies

Document # 7

Tanya Temkin

Fall 1996

Bay Area Community Outreach Partnership Center

316 Wurster Hall Berkeley, CA 94720 phone: (510) 643-9103

Acknowledgments

Development of this report was funded by a grant from the U.S. Department of Housing and Urban Development, Office of University Partnerships.

The author gratefully acknowledges the contributions and comments of BACOPC project management staff Victor Rubin, Richard LeGates, Genie Stowers, and Jay Tharp. This report would not have been possible without the generous assistance of all those who contributed information, documentation, and advice:

City of Berkeley staff:

Stephen Barton, Planning Department
Eric Landes-Brenman, Department of Health and Human Services
Dan Ezekiel, Department of Health and Human Services, Mental Health Division
Jim Hynes, Department of Health and Human Services, Mental Health Division
Tia Ingram, Berkeley Housing Authority
Teri Piccolo, Planning Department
Robert Shitamoto-Date, Department of Health and Human Services, Shelter Plus Care Program
Tim Stroshane, Planning Department
Harvey Tureck, Department of Health and Human Services, Mental Health Division
David Wee, Department of Health and Human Services, Mental Health Division

Supportive housing providers—Developers, property managers, owners, and service providers

Rick Crispino, Bonita House, Inc.
Teresa Drisker, Aztec Hotel Tenant Support Program
Kate Emmanuel, Resources for Community Development
Steve Fields, Progress Foundation
Linda Griffin, Berkeley-Oakland Support Services
Benita Harris, Rubicon Programs, Inc.
Sherry Hirsch, Rubicon Programs, Inc.
Seth Katzman, Conard House, Inc.
Eddie Littleton, Aztec Hotel Tenant Support Program
Anthony Maples, Berkeley-Oakland Support Services
Tyrone Moore, Housing for Independent People
Vickie di Sofi,.Ecumenical Association for Housing
Barbara Solomon, Episcopal Community Services of San Francisco
Nancy Thomas, Alameda County Network of Mental Health Clients
Jonathan Vernick, Baker Places
Kelly Wilkinson, Episcopal Community Services of San Francisco
Gitane Williams, Berkeley Drop-In Center
Rhonda Wright, John Stewart Co.

Others:

Michael Allen, The Bazelon Center, Washington, D.C.
Fred Collignon, University of California, Department of City and Regional Planning
Bill Hirsch, San Francisco Mental Health Association, Supportive Housing Advocacy Project
Madeline Johnson, Alameda County Behavioral Health Care Agency
Jeff Levin, City of Oakland, Department of Housing and Neighborhood Development
Yvonne Swift, U.S. Department of Housing and Urban Development
Phyllis Takehara, Alameda County Behavioral Health Care Agency, Continuing Care Housing
Hazel Weiss, Alameda County Shelter Plus Care
Carol Wilkins, Corporation for Supportive Housing

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The purpose of this report is to provide the City of Berkeley with background information on models of housing linked with support services for persons with mental disabilities. Such information can then be integrated into future revisions of the City's Consolidated Plan, Community Services Element of its General Plan, and Continuum of Care Plan. The report's discussion of general issues in the design and operation of supportive housing may be valuable to other communities as well.

Permanent supportive housing for people with mental disabilities is intended to provide residents with both stable housing and support services that help them live independently. It features:

- flexible services that can meet the changing needs and preferences of residents
- stable housing in which residents can stay even when they need intensive services
- respect for residents' wishes and preferences
- assurances that residents can stay in their homes as long as they meet their obligations as tenants
- affordability for very low-income tenants on fixed incomes.

Simultaneous provision of services and housing is necessary to help clients keep their homes. Support services are not effective when clients do not have stable housing, and housing alone is not sufficient when very disturbed people do not have readily accessible services.

Berkeley's need for housing and services for mentally disabled people. Berkeley is home to approximately 3,800 adults with severe and persistent mental disabilities, including about 500 people who are homeless or at risk of homelessness. The City's Mental Health Division, a component of the Health and Human Services Department, provides services to over 1,000 of these individuals, as well as to clients with less severe, less chronic problems. An array of non-profit human service agencies, including those who assist the homeless, complement the Division's efforts to help severely mentally disabled people.

However, the City lacks sufficient housing that people who rely on disability incomes can afford. In 1996, the median rent for a studio apartment is $440, over two-thirds the monthly SSI benefit for a disabled single person. Rooms in for-profit SRO's cost SSI recipients at least 43% of their monthly incomes. Board and care facilities provide supervised housing for at least 95 mentally disabled Berkeley residents, but they are semi-institutional settings that require residents to pay almost all of their SSI incomes for rent, meals, and medications monitoring.

Utilizing federal and local funds, the City provides rental subsidies to low-income households and supports non-profit organizations that operate transitional and permanent supportive housing programs for homeless persons with disabilities. At present, these can offer stable housing to only a fraction of the City's low-income, mentally disabled population.

The supportive housing model. Unlike board-and-care homes and transitional programs that have traditionally housed mentally disabled people in the community through the 60's and 70's, supportive housing offers permanence, independence, and greater adaptability of linked services. Permanent supportive housing is a model developed in response to

consumer empowerment, the need for housing with linked services for homeless people, and the limitations of transitional models. It has now become an essential component of the "continuum of care" for homeless people with a variety of disabilities, complementing the role of outreach programs, emergency shelters, and transitional housing. Its benefits, however, are not limited to the homeless.

Roles of supportive housing providers. Supportive housing provision involves collaboration between several parties: local public mental health agencies, planning departments, housing developers, property managers, and service providers. Residents of supportive housing and potential residents can and should be active collaborators as well. A single agency sometimes assumes the role of housing developer, property manager, and service provider. Frequently, separate agencies take responsibility for each role. Property managers and landlords in particular need to be familiar with provisions of the federal Fair Housing Act that require "reasonable accommodations" for disabled tenants who request them.

Services in supportive housing. The goal of services is to enable clients to be responsible tenants and to help them avoid returning to more restrictive and unstable living situations. Case managers provide a key service, conducting assessment, developing service plans with clients, and helping clients access other services. Other essential linked services include mental health treatment, substance abuse counseling, peer support, benefits counseling and money management, health care, independent living skills training, job-related services, and housing search assistance. These services are often provided at the supportive housing site and may be offered by a single agency. More frequently, case managers will help clients access specialized services at several agencies.

Variation in supportive housing programs. Supportive housing programs vary widely in the types of housing provided, property management practices, and range of services. Six dimensions of program characteristics can be used to describe a supportive housing program:

- dispersion/concentration: to what extent units are scattered throughout a community or concentrated at a single or a few sites.
- segregation/integration by disability status in both service participation and housing
- on-site/off-site location of services
- high or low demand settings, referring to both how extensively a program requires residents to take part in services, and how well residents are expected to function while in the program.
- organizational integration/diffusion, reflecting how many roles (housing developer, owner, property manager, service provider) are undertaken by a single agency.
- high or low degree of participation by clients in program planning, services delivery, management, and evaluation.

Movement from one "end point" in a dimension towards the other entails trade-offs between efficiency in developing housing and services and realizing community development goals. For example, although a community may wish to integrate mentally disabled people into its general population, financing requirements may lead developers to build housing

segregated by disability and income status. The presence of on-site staff may help residents more readily get access to services, but may lend an institutional quality to the project.

Issues in permanent supportive housing. In-depth interviews with representatives (including program coordinators, property managers, housing development staff, and others) at eight supportive housing programs in the Bay Area as well as a review of the literature revealed several challenges facing supportive housing providers. Many of the challenges confronting supportive housing programs center on aspects of service design, coordination of services with property management, and adapting programs to the constraints of funding requirements

.• tenancy issues: Some projects require residents to take part in services as a condition of tenancy, although this practice may conflict with landlord-tenant laws, fair housing laws. and service providers' principles of voluntariness.

- flexibility in property management practices: landlords and property managers have had to modify ordinary tenant selection practices in order to comply with non-discrimination provisions in fair housing laws. To provide disabled tenants with "reasonable accommodations," they have had to modify "house rules" in certain cases and take additional steps to help disabled tenants avoid eviction.
- maintaining boundaries between service providers and property managers: both parties strive to work together efficiently while respecting client confidentiality and understanding respective roles and responsibilities.
- providing appropriate crisis management.
- recruiting the most functional clients as tenants or seeking out those who are most disabled and "hard to serve."

Service costs: Several factors caused variation in program costs between the programs studied, precluding meaningful comparison of costs. A national survey of federally-funded programs had found that average daily costs for providing both housing and services to disabled homeless people was $45 per person and $51 per household.

Recommendations:

- ***The City should determine priority sub-populations among its mentally disabled residents.*** Most permanent supportive housing for mentally disabled persons in the City and elsewhere is for homeless persons, although others who are not technically homeless may lack access to affordable, stable housing with sufficient linked supports. These individuals may include "high utilizers" of mental health services who cycle between acute care, long-term inpatient facilities, and community-based residential care, or persons in board and care homes who may be ready to move to more independent living with support services.
- ***Site-based supportive housing projects should integrate mentally disabled residents with those who have other types of special needs and other low-income households.*** Mingling mentally disabled residents with those with other types of special needs, or who are simply low income, has several advantages. It promotes the goals of integrating disabled residents into their communities and avoiding concentrations of residents with a single type of special need. Integrated housing reflects the preferences of mentally disabled individuals, who

overwhelmingly express a desire to live in "normal" housing not segregated by disability status.

- ***The design of support services should reflect their purpose: to help residents fulfill their obligations as tenants and to prevent their return to a more restrictive or unstable setting.*** These are the essential purposes of services in the context of supportive housing. The type of service or mix of services that will fulfill these purposes will vary from one resident to the next, and may vary for a given resident over time.
- ***Housing and services should be provided by separate organizations.*** The roles of service provision may at times conflict with those of the property owner and manager. Whereas service providers focus on the needs of the individual client, property managers and owners are necessarily concerned with protecting the structure and operations of the housing site. Separating the roles of service provision and property ownership/management helps avert such programmatic conflicts within a single organization.
- ***Developers, landlords, property managers, and service providers should develop written memoranda of understanding that make explicit their respective roles, responsibilities, and processes of resolving disputes.*** This recommendation is a corollary of the previous one. Mutual understanding of each party's respective roles and responsibilities help all to work cooperatively and effectively, respect resident confidentiality, and minimize disputes. Each agency should make its respective responsibilities and roles clear to the project's residents.
- ***Service compliance should not be included as a requirement in lease agreements. If service compliance is to be required at all, the service agreement should be negotiated separately from the lease.*** This is a corollary of the recommendation that housing and services be provided by separate agencies. Making housing contingent on service compliance tends to blur the distinctions between the roles of service provision and property management. Landlords who threaten tenants with loss of housing for not accepting services may risk violating state and federal fair housing provisions and local landlord/tenant laws. If supportive housing providers insist on service compliance, they should negotiate service contracts separately from lease agreements.
- **Involve representatives of the resident base (mentally disabled individuals, including those with multiple disabilities and homeless people) in the planning process for housing development and service delivery.**

I. INTRODUCTION

The purpose of this report is to provide the City of Berkeley with background information on models of housing linked with support services for persons with mental disabilities. Such information can then be integrated into future revisions of the City's Consolidated Plan and the Community Services Element of its General Plan. Since a considerable amount of social service provision and housing development for mentally disabled persons are geared to meeting the needs of those who are homeless, this information may provide background for the City's Continuum of Care Plan as well.

According to its current five-year Consolidated Plan, the City intends to give high priority for housing to those at risk of homelessness and those with special needs, including disabled people. Another goal of the plan is to provide "housing with social services to help meet particular needs and better integrate residents into the community," This reflects the common knowledge among mental health providers that mental health services, treatment for concurrent alcohol and drug problems, and support services are not effective when clients lack stable housing. Current service delivery and public policy for homeless mentally disabled people has emphasized the simultaneous provision of services and affordable housing in integrated settings to ensure that clients remain in their homes.

This report, then, focuses on *permanent* housing--housing in which the resident can live as long as she or he chooses. The report does not dispute the need for temporary housing for persons making the transition from homelessness or more restrictive treatment settings.. Indeed, for homeless mentally disabled people in particular, a comprehensive "continuum of care" should offer outreach, intake, and assessment; emergency shelter; transitional housing; and permanent housing with support services. The sections of the City's Consolidated Plan that address resources for people who are homeless or at risk of homelessness have incorporated this continuum model. Permanent services-linked housing, as a part of this continuum, would provide mentally disabled residents the resources they need to avoid relapsing into homelessness or long-term, costly institutionalization.

Many persons with severe mental disabilities can live in their communities without ongoing supports. Some have disorders that are severe but episodic, and seek services only when their symptoms become acute enough to interfere with their day-to-day functioning. Others, including those well stabilized on medication, do not require or desire any further intervention. But even people who need only rare or occasional supports require housing where they can remain while they weather emotional crises, and to which they can return if they undergo brief hospitalization. Flexible mental health and other support services are essential to maintaining that stability.

This report will first review Berkeley's existing housing resources for persons with mental disabilities, looking at housing that is affordable to people on fixed incomes and housing that is linked to supportive services. Next, the development of the supportive housing model will be examined as an outgrowth of social pressures, including the movement for client empowerment and the growth of homelessness among the poor, that forced an expansion of older ways of providing services-linked housing.

After reviewing the respective roles of local public agencies, developers, property managers, service agencies, and potential residents in creating and sustaining supportive housing, the report then turns to the types of services that benefit residents in these programs. Case management, mental health services, substance abuse counseling, vocational counseling, mutual support groups, money management skills training, and other services are

offered to help residents stay in their homes and live as independently as they can. This section provides an overview of each of these service components and how they are coordinated on behalf of supportive housing residents.

Six dimensions that provide a useful framework for examining supportive housing programs are then identified. Each of these dimensions reflects a continuum of attributes reflecting a program's operations, program philosophy, and physical settings. Operations, for example, may be described as organizationally integrated or diffused; program philosophies may involve high demands or low demands on clients; and the location of residents' units may be concentrated or scattered.

The goals of making social services available to vulnerable people and providing them with housing are both necessary but involve different assumptions about provider responsibilities and client/resident rights. Sometimes the values that underlie the provision of housing and services conflict with each other, and may be manifest in disagreements about whether supportive housing is primarily a housing or service program, to what extent providers should intervene in the lives of residents, and issues of disclosure of information about residents. The last part of this report addresses some of these challenges confronting supportive housing providers.

The Appendix includes case studies of two supportive housing programs in Berkeley and four others throughout the Bay Area.

II. BERKELEY'S NEED FOR HOUSING AND SERVICES FOR MENTALLY DISABLED PEOPLE

A comprehensive assessment of the housing needs of mentally disabled Berkeley residents has not been conducted to date. However, a review of service and housing data available from the City suggests that existing resources do not meet the housing needs of severely mentally disabled people.

Demographics

Although no prevalence studies on mental disability in Berkeley have been conducted, statewide prevalence data are available. A 1994 study of California households found that an estimated 11.4 % of the non-homeless adult population have a mental disorder; and nearly 4% suffer from a mental illness that is severe and persistent (as evidenced by the functional impairments, symptoms, and psychiatric history).[1] About 1.1% are so severely disabled that they are unable to work and have been given major psychiatric diagnoses. Extrapolating these percentages to Berkeley's adult population, an estimated 3,300 non-homeless adult residents would have severe and persistent mental illness, with about 950 of these so disabled that they cannot work.

Among the homeless, mental disability is even more prevalent: according to the City's Homeless Services Office and estimates of local service providers, about 15% of the City's homeless population (which numbered 1,000 to 1,200 according to the 1990 Census, adjusted for acknowledged undercount) are severely mentally disabled, and an additional 30% suffer from both severe mental illness and concurrent substance abuse problems. We estimate that a total of at least 3,800 adult City residents have severe and persistent mental illnesses, with at

[1] Based on data from K. Meinhardt, A. Cablas, J. Jerrell, et. al. *The California Household Mental Health Survey* (Sacramento: California Department of Mental Health, 1994).

least 1,450 disabled from work by their conditions. These represent estimates of prevalence within any twelve-month period.

An assortment of public and non-profit agencies provide case management, therapy, and support services to mentally disabled people in Berkeley. As one of two city-run mental health departments in the state, Berkeley's Mental Health Division (a part of the Department of Health and Human Services) offers a range of services to mentally disabled children and adults, serving 1,596 unduplicated clients in FY 1995-96. (This does not include homeless clients that the Division's Homeless Outreach Program serves through brief contacts, persons served by the Division's Mobile Crisis Team, or clients referred by the courts for treatment for domestic violence problems.) About half of these 1,596 clients are served through the Division's Adult Services component, with another 20% served by its Family, Youth, and Children program and another 30% diverted into its Court Program through the criminal justice system. An additional 1,569 clients were served by the Division's mobile crisis team (MCT) in FY 1995-96. Ninety-four percent of the Divison's clients are over the age of 18, and 31% of adults served by BMH through its clinic-based programs and Mobile Crisis Team could be considered severely and persistently mentally ill.

The Division's clientele is very low income, with 55 % of Adult Services clients receiving SSI and a significant number of others subsisting on General Assistance, AFDC, and other public benefits. According to data provided by the Mental Health Division, an estimated 17% of its clients are homeless. The Division also estimates that about 35% of MCT clients are homeless or at substantial risk of homelessness, and that approximately 15-25% are severely and persistently mentally ill. However, only about 14% of MCT client contacts each month are with persons who are already engaged in other BMH service components.

The need for housing is not restricted to the Division's homeless clients: an estimated 50% of Adult Services clients identify housing as a need. These clients include not only the homeless, but those living with their families, in board and care facilities, or in transitional facilities, who want to find their own homes but are frustrated by the lack of affordable housing as well as the scarcity of housing that offers them sufficient supports.

The Division, then, directly assists an estimated 28% of the City's severely and persistently mentally disabled adult residents per year through its clinic-based services and Mobile Crisis Team, including at least 46% of those who are homeless or at immediate risk of homelessness. Its activities are supplemented by those of several agencies serving persons with mental disabilities and homeless and at-risk individuals and families. These include centers offering drop-in space and support services that are more readily approached by mentally disabled people who distrust professionally-run mental health services. Berkeley-based social service agencies whose clienteles include a significant number of mentally disabled people include the Berkeley Emergency Food and Housing Project, BOSS, Berkeley Drop-In Center, Berkeley Ecumenical Chaplaincy to the Homeless, Creative Living Center, Homeless Action Center, Women's Daytime Drop-In Center, Center for Independent Living, Mental Health Options, and others.

Thus, the City appears to have a well-developed services infrastructure for people who need assistance with ongoing serious emotional problems. However, agencies' efforts to help people find and keep stable homes may be compromised by the scarcity of affordable housing opportunities for those who depend on fixed incomes.

Permanent housing resources

The mentally disabled population of Berkeley lives in an assortment of settings, including inpatient units located elsewhere in Alameda County; halfway houses and other transitional programs; and board and care homes in both Berkeley and the surrounding area. Some individuals are able to live with family members who serve as primary caretakers. Some can live in their own quarters, alone or with roommates, and maintain their independence despite their disabilities. Of these, a relative few live in permanent services-linked housing programs such as the Bonita House Supported Independent Living Program, the UA Homes, and the Erna P. Harris Court.. Still others remain homeless for long periods of time, living in emergency shelters or "sleeping rough" in parks and on the streets.

The private market. Private-sector permanent housing that is affordable to persons receiving disability incomes has become more and more of a scarce commodity in Berkeley and the rest of the Bay Area. Even Berkeley's rent control program, which covers 77% the City's rental housing stock, does not ensure that such individuals will have access to housing they can afford. In 1996, the median rent for a rent-controlled studio apartment in Berkeley is $440, about 70% of the $626 per month paid by SSI at that time. For a one-bedroom unit, the median rent is $522. At present, there are less than 1,400 units of any size with rents under $400.

Single-room occupancy (SRO) hotel rooms represent the lowest rung on the private rental housing ladder. They have traditionally offered single mentally disabled people on SSI incomes, as well as other very low-income people, one type of housing option they can afford. In recent years, a significant portion of the City's SRO stock has been destroyed by fire; about 370 units remain on the market, of which 198 are owned privately and operated for profit; the remainder are owned and operated by non-profit organizations. As of February 1996, the rents of the least expensive for-profit SRO rooms, with neither kitchen facilities nor private bathrooms, ranged from $300 to $430 per month.[2] This represents from 43% to 62% of the $694-per-month income for a disabled SSI recipient with no cooking facilities. Considering that the City regards its 3,000 very low-income (earning less than $ 20,450 per year in 1996) non-student households that pay more than 50% of their income to be at risk for homelessness, it is clear that the unsubsidized private rental housing market cannot assure affordable housing for low-income mentally disabled people.

The City has utilized an array of subsidy and rental assistance programs to support mentally disabled and other low-income people in private-sector housing. Some programs link rental assistance with various types of support services.

Section 8. Berkeley's Section 8 program is funded through the Department of Housing and Urban Development and administered by the City's Housing Authority. It provides tenant-based rental assistance to households with an income of not more than 50% of the area median. (In 1996, this amount is $ 20,450 for a single-person household). Most Section 8 tenants live in private-sector rental housing and a small number reside in non-profit housing. Each Section 8 household pays 30% of its adjusted household income for rent; Section 8 pays the difference between the household's contribution and what HUD determines to be the "fair market rent" level for the area (Section 8 units are not subject to rent ceilings under Berkeley's rent stabilization law.) A single disabled SSI recipient with a monthly income of $626 may contribute about $188 per month towards the rent on a Section 8 unit.

[2] These figures do not include below-market rate rents charged on units at non-profit SRO developments.

Currently, about 1,500 households receive rental assistance through Section 8 certificates and vouchers; of these, 372 reside in studio apartments or one-bedroom apartments. Approximately 1,000 households, not all of which reside in Berkeley, are on the waiting list for Section 8 housing. The City does not have data on the number of mentally disabled people who receive Section 8 or are on the waiting list.

Until recently, the Housing Authority provided rental assistance to 14 units of "Section 8 Aftercare" housing which offered linkages with off-site support services for mentally disabled occupants. Since this program merged with the regular Section 8 program, tenants still receive rental assistance but the City has discontinued the linkage with services.

Berkeley's Shelter Plus Care. Through the Shelter Plus Care program of the federal McKinney Act, the City of Berkeley has received HUD funding to provide tenant-based rental assistance for homeless Berkeley residents with mental disabilities, substance abuse problems, or AIDS. The City was awarded Shelter Plus Care certificates for 129 households, include single persons and families with eligible members. The program is coordinated by the City's Department of Health and Human Services and the Berkeley Housing Authority. Shelter Plus Care participants must receive case management services through one of three designated community-based agencies that have substantial experience serving homeless people, including those with severe disabilities.

The rental assistance mechanism of Shelter Plus Care is similar to that of the Section 8 program. Participants must locate housing in the private rental market, and often do so through listings provided by the Berkeley Housing Authority. They pay 30% of their adjusted monthly incomes towards rental payments for units, and Shelter Plus Care funds provide the balance. (For units in Berkeley, rental assistance can be provided up to the level of the rental ceilings determined by the City's Rent Stabilization Board.) Because the rental assistance is tenant-based, participants can keep their subsidies if they move from one unit to another.

The program began placing tenants July 1, 1995. As of December, 68 Shelter Plus Care participants have found housing in Berkeley and Oakland; most of these individuals have mental disabilities and/or substance abuse problems. Shelter Plus Care will provide rental assistance for five years.

Alameda County's Shelter Plus Care. The County operates its own Shelter Plus Care program, utilizing rental housing units and social service agencies in Berkeley and elsewhere throughout the County. The program aims at housing homeless people who are the most difficult to serve: those who have mental disabilities, substance abuse problems, or AIDS, *and* who live on the streets or in cars, abandoned buildings, or other places unfit for human habitation.

Certificates are available for a total of 347 housing units (214 tenant-based, 74 project-based, and 59 SRO units) for single persons and families. Although participants may use their certificates to find housing in Berkeley, the program has not set aside a number of certificates for units in the City. As with Berkeley's Shelter Plus Care program, participants in the County program must receive case management services through designated social service agencies, including Berkeley agencies that serve homeless people.

Housing Stabilization Project. This collaborative effort between Berkeley-Oakland Support Services (BOSS) and the Berkeley Drop-In Center and Women's Drop-In Center assists

individuals and families in transition from homelessness to stable housing. The program serves clients in BOSS program components throughout Alameda County; per HUD guidelines, participation is open to those with mentally disabilities, histories of drug and alcohol abuse, or HIV+/AIDS, as well as to victims of domestic violence and families with children.

The project does not sponsor housing for clients, but provides them with rental subsidies administered by BOSS and support services provided by the Berkeley Drop-In Center and Women's Daytime Drop-In Center. These services are designed to help clients obtain stable incomes, manage their money, reunite with families, and address drug abuse problems. Participants have found housing in a variety of rental units on the private market throughout the County They may receive rental subsidies for 18 months (which can be extended to 24 months, if necessary), with support services provided throughout the 24-month period. As of May 1996, the project serves 28 clients. Fifteen households with a mentally disabled member receive support services from the Berkeley Drop-In Center, and a number of the households served by the Women's Daytime Drop-In Center include a mentally disabled member.

Board and care facilities. A dwindling number of mentally disabled Berkeley residents reside in board and care facilities. These state-licensed, for-profit residences provide 24-hour care and supervision of residents, and may store and dispense residents' medication. The proprietor may be the sole staff person. These facilities usually provide one or more cooked meals each day; residents frequently share bedrooms and have limited kitchen privileges. Although these homes may state a preference for either mentally disabled, developmentally disabled, or elderly residents; they may house a mix of residents. Although such housing is not time-limited and offers certain services, it is quasi-institutional in nature and is not regarded here as a form of services-linked housing that promotes independence or community integration.

Mentally disabled residents in licensed facilities pay $682 per month for rent, care, and supervision, and keep $90 from their SSI checks for day-to-day living expenses. Those who receive income from private sources may be charged a higher rate. In California, some board-and-care facilities receive a state supplemental rate of $285 per month to provide on-site services such as helping residents increase their skills in personal care, social skills, budgeting, use of public transportation, and taking more responsibility for their medication. The service obligations of each board and care home receiving supplemental payment are specified in agreements between the county mental health agency, the residents' case managers, and the board and care proprietors.

More often, however, board and care homes get no supplemental funding for services and provide little programming for clients. There is no formal linkage between board and care homes and outside support services, although residents may attend day treatment programs or get case management and medications monitoring through a local mental health clinic.

In Berkeley, six state-licensed board and care facilities prefer to offer shelter, care, and supervision to mentally disabled residents. Together, they have a capacity of 95 beds, some of which may be filled by elderly or developmentally disabled residents. Berkeley's 22 licensed board and care homes that indicate a preference for developmentally disabled or elderly residents may house a limited number of persons with mental disabilities as well.

Only two of the board and care homes that primarily house mentally disabled residents are certified by the County as eligible to receive state supplemental payments. Although state

law prohibits the operation of unlicensed facilities, a few such facilities continue to house mentally disabled people within the City.

The non-profit sector. Various non-profit organizations in Berkeley have developed a number of housing projects for mentally disabled individuals. These include housing developers who specialize in "special needs" housing as well as social service agencies who have undertaken housing development projects to expand their service programs. These permanent housing resources include:

* four units developed by Bonita House for persons with concurrent mental disabilities and substance abuse problems. Bonita House is the developer, owner, property manager, and service provider for this project. [3]

* thirty-five units developed and owned by Resources for Community Development (RCD) at the Erna P. Harris Court (the site of the former Bel-Air motel). This project is not solely for persons with mental disabilities, but for a mixed population of homeless people and other low-income households. Berkeley-Oakland Support Services (BOSS). provides on-site social services.

* seventy-four single-room occupancy units developed and owned by UA Housing at the corner of University and San Pablo Avenues. The housing is for persons who are low-income and formerly homeless, including those with mental disabilities. A seven-person team from BOSS provides on-site support services, with other regular site visits by Health Care for the Homeless and Berkeley Mental Health staff.

The preceding discussion and Table 1, below, reflect the range of housing options and residential programs for mentally disabled people in Berkeley. The totals in the bottom three rows represent only rough estimates of the numbers of households with mentally disabled members who may utilize such programs. A precise count is limited by several factors. First, many of these services-linked housing programs are open to persons with problems and needs other than mental disability, such as AIDS and substance abuse. Further, many transitional programs and emergency shelters for homeless people in Berkeley frequently serve residents with mental disabilities. Finally, housing for people with mental disabilities, like housing in general, is provided in a regional market; some Berkeley residents with special needs find housing in programs outside the City, while some households from other communities receive housing and services from programs operated within the City. Table 1 identifies only those services-linked housing programs that operate within Berkeley.

The permanent supportive housing resources represent the housing model that will be the focus of the remainder of this report.

---

[3] Extensive program descriptions of the permanent housing programs at Bonita House and Erna P. Harris Court are provided in the Appendix of this report. The UA homes is described in detail in L. Blash and M. Sampogna, *Profile of Berkeley-Oakland Support Services (BOSS): A Report for the Community Development Department of the City of Berkeley* (Berkeley: Bay Area Community Outreach Partnership Center, 1995).

TABLE !: Residential programs and housing linked with services for mentally disabled single adults and families

Facility	Type	Population served	Capacity
Bonita House	1-BR apartments in complex; permanent	Homeless; dual diagnosis	4 adults
Erna P. Harris Court	single-room occupancy and 1 BR apartments; permanent	Homeless / very low-income; Includes but is not limited to persons with mental disabilities.	25 single adults (SRO) and 10 families/single adults (1 BR)
UA Homes	single-room occupancy hotel; permanent	Homeless / at risk of homelessness. Includes but is not limited to persons with mental disabilities.	74 adults
Housing Stabilization	rental subsidies and support services for permanent housing	In transition from homelessness to stable housing; including but not limited to persons with mental disabilities	28 families
Bonita House	licensed residential treatment facility; transitional	Dual diagnosis (concurrent psychiatric disability/substance abuse)	15 adults
Berkeley Ecumenical Chaplaincy to the Homeless	transitional, up to 18 months	Homeless single adults with mental disabilities or other disabilities	7 adults
Berkeley Emergency Food & Housing Project - Transitional Program	transitional; up to 2 years	Homeless; mentally disabled women	12 women
BOSS 10th Street Houses	long-term transitional; 3-5 years	Homeless families with children; mentally disabled or substance abuse problems or HIV+/AIDS (2 of 3 diagnoses)	2 families
Berkeley Shelter Plus Care	scattered-site apartments, some SRO units; permanent	Homeless single persons and families; mentally disabled or substance abuse problems or HIV/AIDS	104 single people, 25 families (85% to be placed in Berkeley)
Alameda County Shelter Plus Care	apartments (scattered-site and complexes); SRO units; permanent	Homeless single persons and families; mentally disabled or substance abuse problems or HIV/AIDS	(unspecified number of Berkeley units) for 347 individuals and families countywide
Six board and care homes	board and care home	Mentally disabled adults	95 (total capacity)
TOTAL NUMBER OF BERKELEY HOUSEHOLDS SERVED BY: **TRANSITIONAL AND PERMANENT** SERVICES-LINKED HOUSING PROGRAMS			270-280
PERMANENT SERVICES-LINKED HOUSING (SUPPORTIVE HOUSING and BOARD & CARE)			210-220
PERMANENT SUPPORTIVE HOUSING			**140 - 150**

III. WHAT IS PERMANENT SUPPORTIVE HOUSING?

Permanent supportive housing is a relatively new way to ensure that people with mental disabilities (and others with "special needs") have access to both stable housing and support services that enable them to live as independently as they desire. Key features of permanent supportive housing include:

(1) Flexible services that can be tailored to meet the changing needs of residents, without requiring that residents move to another setting when their service needs change;

(2) Respect for consumers' preferences, with consideration of their perceptions and needs structured into planning of both housing and service components;

(3) Assurances that residents can stay in their homes as long as they like (and as long as they can comply with conditions of tenancy).

Supportive housing is a continually evolving model. Throughout the country, supportive housing projects continually refine the model's programmatic and residential features to meet the diverse needs and strengths of mentally disabled people, many of whom have concurrent problems such as long-term homelessness or drug and alcohol abuse. Examining prior housing models for this population will lend an illuminating perspective on what providers and policy-makers now as an integral part of the service continuum for homeless mentally disabled people.

Background: traditional housing for mentally disabled people

Options for housing for mentally disabled people have changed considerably since the 1950's, when deinstitutionalization efforts started. Some ex-patients returned to their families, while others were placed in private homes with families other than their own, who provided care under the supervision of a social worker. Halfway houses were developed to provide temporary residence, on-site services, and round-the-clock staffing for people not yet ready to live on their own. Residents typically had no income of their own or relied on family support or, more often, local welfare payments.

Board and care homes sprang up throughout the 1960's in response to the mass discharge of patients from state hospitals. These ex-patients had become eligible for federal disability payments, and boarding-house operators retooled their residences to serve this new tenant market. Typically, these facilities provided meals and medication supervision, and sometimes provided basic necessities such as clothing and incidentals to residents. Residents paid a large proportion of their monthly disability checks for their shelter and care. They received medication monitoring and other mental health services through community-based mental health clinics newly established with federal funds to meet the mental health needs of local residents.

Many residents were unable to make the transition out of these community-care facilities to more independent living for several reasons. First, with minimal incomes, ex-patients were at a disadvantage in the housing market, even for the low-cost housing for which they competed with other low-income groups. Second, after moving out of community care, people often lost all formal linkages with the services that had been provided for them through clinic-based social workers or staff of community-care residences For many, these providers had offered the only support system they knew, and they had no resources to help them deal with the stresses of independent living. Third, the housing environments of these community-care facilities, which provided 24-hour care to residents and sought to meet all their material needs on-site, had ill prepared residents for the rigors of living on their own. Finally, many communities lacked an adequate range of support services that could help mentally disabled people live independently.

In the 1970's and through the early 1980's, mental health providers developed the "continuum" model of community-based housing for mentally disabled people. According to this model, persons released from a inpatient psychiatric unit entered a residential facility such as a halfway house, then moved through a series of progressively less restrictive temporary residential settings as their functioning improved and they became capable of greater independence. Residents were expected to eventually "graduate" to their own apartments with minimal out-patient supports.

The mix of facilities in the continuum varied from one community to the next, but a well-developed continuum might have included:

* a crisis residential facility, offering a short-term alternative to involuntary hospitalization;

* a "three-quarter-way" house that offered less structure and supervision than a hospital, but were staffed round-the-clock ;
* halfway houses, providing 24-hour staffing but greater autonomy and less intense services;
* cooperative apartments where staff provide regular visits, but are not present throughout the day. Apartment residents cook their own meals individually or in groups and share housework tasks, but they must abide by rules established by the agency providing the services and may be required to take part in treatment programs as a condition of residency. Frequently, the providing agency leases the apartments from private landlords and subleases the unit to residents.
* satellite apartments, where residents live singly or with roommates, staff may come to visit for case management or other on-site services, and where requirements for program participation may still apply. Again, residents sublease the apartments from the provider agency.

Residential continuums varied substantially in terms of the types, numbers, and mix of their component facilities. In general, though, all continuum systems involved moving residents from one setting to another as staff deemed them ready for greater autonomy, less staff-imposed structure, and a lower level of service. Conversely, residents who relapsed could move back to a more structured facility with a higher level of staffing and services.

Sometimes, a single non-profit agency or public mental health department would develop and provide the entire range of residential settings; in other systems, programs would be provided by a network of agencies. Frequently, there was little coordination among the resources of these programs. Most communities offered very few such programs or none at all, and few provided a comprehensive continuum of residential programs

This model, although helpful to numbers of participants, was not without its limitations. Residents could not gain a sense of real stability as they were shunted from one setting to another, and often found their lives disrupted by such transfers and the loss of familiar supports. Also, programs tended to regard residents as "clients" in "service programs," rather than as tenants and community members with attendant rights and obligations. Further, consumer housing preferences were not a priority in the service philosophies of such programs, and residents were often "placed" in settings with little opportunity to choose their living space or their housemates.

Finally, this model could not accommodate people with chronic mental disabilities who would always need some kind of ongoing support. Some people would never be able to move on to completely unassisted living, but would require a level of service that could be increased or decreased commensurate with changes in their functioning. The continuum of time-limited residential settings, then, provided a partial but by no means complete response to the need for services-linked housing for mentally disabled people.

Those who were eventually able to function well enough to live with minimal supports faced the problem of how to find housing they could afford. Often, options were very limited. Disability payments at or below the poverty level restricted their choices to marginal apartments in undesirable parts of town or run-down single-room occupancy hotels. Those who were unable to cope in such settings had even fewer alternatives. Some returned to families who were willing to take them in, while others had no option other than entering board and care homes, which offered permanence but not autonomy or community integration.

The supportive housing model

Since the early 1980's, communities across the country developed and implemented a new approach to community-based housing for mentally disabled people. This new approach was variously known as "supported housing," "supportive housing," or "services-linked housing," each connoting slight variations in program philosophy and service delivery strategy. However, they all shared the underlying principles of greater respect for consumer preferences, flexibility of services, and permanence. Above all, they were committed to providing stable housing for clients and adapting services for each resident consistent with his/her needs, rather than changing residents' housing each time their service needs change.

Flexibility is the hallmark of supportive housing. It may operate in a range of settings, including scattered-site apartments, SROs, and single-family homes. Residents may live singly, with a roommate or two, or in larger communal households. The housing itself may be owned by private landlords (as in Berkeley's Shelter Plus Care program), non-profit social service organizations, or a local public housing authority. Affordability may be ensured by financing arrangements or by governmental subsidies for rental payment on behalf of tenants. When a non-profit service provider owns or leases the housing, it may also provide case management or support services to residents either at the housing site or at another location. Residents often get an array of services from other social service agencies as well. Thus, there is no single model that best exemplifies the practice of supportive housing.

A number of trends and social pressures have driven the development of supportive housing. Widespread homelessness, in particular, has impelled mental health service providers to find ways to offer low-cost housing for clients that, though separate from residential treatment systems, ensure support services to help clients stay housed. Research has shown that the conditions of poverty and disability interact in ways that dislodge vulnerable people from their homes and perpetuate their homelessness which, in turn, exacerbates their symptoms. [4]

Next to substance abuse, mental disability is the most common health problem among homeless people. Studies done in the 1980's found that mentally disabled homeless people frequently become unhoused as a result of their poverty and problems dealing with others. Those who could get a foot in housing of some type soon lost it as they were overtaken with the stresses of poverty, increased symptoms, and social isolation: although living outside of hospitals, they were not truly *in* their communities. Homeless and marginally housed people often ended up cycling back and forth between the streets, shelters, SRO rooms, and psychiatric emergency rooms and inpatient units.

`The federal government has responded to their plight by providing funding for communities to develop permanent services-linked housing for special populations as part of a continuum that includes emergency shelter and transitional housing. These federal initiatives include, among others, various components of the Stewart B. McKinney Homeless Assistance Act--the centerpiece of federal homeless legislation--and HUD's Section 811 Supportive Housing for Persons with Disabilities program. These federal programs and other governmental sources of support for services-linked housing are described further below.

Mental health consumers have exerted a strong demand for "normal" housing that allows them to live like other people in their communities. As several consumer housing preference studies have shown, mental health clients strongly desire stability in their living

---

[4] P. Koegel and A. Burnam, "Problems in the Assessment of Mental Illness," in *Homelessness: A National Perspective*, ed. M. Robertson and M. Greenblatt (New York: Plenum Publishing, 1992).

situations and want to live in places they can call "home." For the most part, they prefer to live in their own apartments, although a smaller but significant number of consumers have expressed a desire to live with others. Access to support services on a voluntary basis in accordance with self-defined needs is another important feature of desirable community-based housing, according to consumers. The supportive housing model unites the aspects of permanence, normality, and autonomy tied to flexible, voluntary services.

Mental health planners and providers, too, recognized the need for housing options beyond the limits of transitional housing programs and board-and-care homes. As housing subsidies and the supply of low-cost housing decreased through the 1980's, people preparing to leave these programs had trouble finding long-term housing they could afford on disability incomes. Movement into and through the residential-program pipeline was often stalled as the demand for placement exceeded capacity. Program expansion was difficult, as neighborhood opposition and lack of capital funding often slowed the development of new group residential facilities.

Supportive housing programs have tended to supplement, not replace, the system of time-limited, transitional programs. It is but one component of the "continuum of care" model that represents the current approach to housing homeless people. Many long-time providers of residential "continuum" programs for people with mental disabilities have adapted their programs to meet the special needs of homeless persons, including those with concurrent substance abuse problems. Frequently, providers have added a permanent housing program to these transitional components, taking advantage of the malleability of the supported housing model to shape their programs in accordance with their agency philosophies. The availability of federal funds for services-linked programs for people with mental disabilities, substance abuse, and AIDS has encouraged this type of program change and growth.

The role of supportive housing providers

Provision and operation of supportive housing is always a collaborative effort requiring cooperation between provider(s) of services, property management, property owners, and the housing developer. (In some cases, a single agency carries out two or more of these roles). Such programs must ensure opportunities for decision-making and feedback from their residents. All of these parties must to some extent work in collaboration with the public agencies responsible for planning health care, mental health care, and housing policy. Local public housing authorities are often partners in this effort.

Residents and potential residents. The users of supportive housing are far more than passive consumers of housing and services. Client choice and responsiveness to client preferences are essential in all phases of creating supportive housing, which should, after all, provide people with more than housing: it should provide them with homes. The federal McKinney Homeless Assistance Act mandates client participation in planning and operating supportive housing for homeless special populations.

Housing developers and service providers can consider users and potential users of supportive housing as a resource base to help their projects and programs succeed. In the planning phase, potential residents--people who constitute the client base from which residents may come--may participate in decisions about:

* program priorities in the development of community-wide housing plans;

* design of a community-wide needs assessment for housing for people with mental disabilities;
* building design and amenities for newly constructed supportive housing;
* decor and furnishings to be provided in furnished units
* neighborhoods in which they would like to live;
* design of the proposed on-site service program;
* "house rules" with which residents would be expected to comply.
* outreach efforts to neighbors and local merchants to address concerns about the development of special-needs housing in the area.

When the housing is ready for occupancy, residents may make their voices heard through:

* participation in hiring decisions for on-site service staff;
* employment policies by the service provider that try to recruit members of the client base as service staff;
* programming practices that ensure residents a voice in planning day-to-day program activities;
* participation in governance, by sitting on the board of directors of the service agency or housing provider;
* participation in a resident advisory council to the housing provider and property manager;
* involvement in a "community relations" team to maintain good relationships with local residents and merchants;
* taking part in mediation efforts to settle disputes between residents;
* ensuring clear grievance procedures to resolve resident complaints about services and property management practices;
* methods to ensure resident feedback and assessment of resident satisfaction.

Local public agencies: In some localities, such as those taking part in the joint Robert Wood Johnson Foundation/HUD National Demonstration Program on Chronic Mental Illness local mental health authorities have assumed a coordinating role with administrative, fiscal and clinical oversight of supportive housing development and operations.[5] In these localities as well as others, public mental health agencies have taken the lead role conducting needs assessments for service and developing multi-year plans for supportive housing in collaboration with other city agencies and community organizations. They have set up subsidiary organizations with staff experienced in housing development and in some cases have entered into partnerships with local housing authorities to oversee project development.

However, in other communities, local mental health agencies have played a less central role in planning the coordination of housing and services. Frequently, the housing and service needs of people with mental disabilities are folded into a more general strategy for ensuring housing for low-income and homeless individuals. This may be done on a city-wide or county basis: a city may include such a strategy in the Housing Element of its General Plan,

[5] M. Cohen and S. Somers, "Supported Housing: Insights from the Robert Wood Johnson Foundation Program on Chronic Mental Illness," *Psychosocial Rehabilitation Journal*, 13:4 (1990), pp. 43-50.

Consolidated Plan, or Continuum of Care Plan. In other places, the latter two plans are developed by the county. In either case, the local mental health agencies (which usually functions on a county rather than city level) assumes a consultative rather than a lead role.

Services-linked housing in many localities is developed on a project-by-project basis rather than as part of a dedicated development plan and implementation strategy. In these cases, no single local public agency is designated to take a coordinating role, and a number of agencies responsible for planning community development, housing, mental health, and/or homeless services share responsibility for overseeing project development.

The housing developer. Many communities that have drafted implementation plans specifically for services-linked housing for mentally disabled residents establish a non-profit housing development corporation to construct new housing or rehabilitate existing housing. Alternatively, a community may contract with a long-established nonprofit developer or community development corporation to carry out these responsibilities. More commonly, several developers in a locality, rather than by a single entity, develop housing on a project-by-project basis rather than as part of a comprehensive plan.

Many developers of services-linked housing have extensive experience creating other types of facilities for people with mental disabilities, and regard themselves primarily as providers of residential services rather than housing developers. Others see themselves as affordable housing developers who have responded to local needs by creating housing linked to services for special populations. Still others are social-service agencies who have ventured into housing development in an effort to meet the housing needs of their client base. Services-linked housing developers, then, represent a range of organizational missions, program philosophies, and skill and experience in attracting financing and managing project development.

Frequently, the developer of the property also functions as the property owner through direct ownership, "turnkey" arrangements, acquiring the property through long-term leasing or sale-leaseback strategies. Joint venture agreements between non-profit and private developers have been used at times to spread the risks of development; in other cases, housing development corporations have been set up to lease a building from a private owner and sublet units to tenants.

Property management. Property managers in services-linked housing have to be flexible in carrying out some of the traditional property management functions of lease preparation, tenant selection, rent collection, maintenance, and accounting. For example, tenants often have mental disabilities that have led to problems with landlords or creditors in the past and may still cause difficulties with money management in the present. Traditional tenant selection practices that bar prospective tenants because of bad credit or eviction histories may have to be modified to not exclude those who in other respects would be suitable tenants. Further, local, state, and federal provisions barring discrimination against persons with disabilities require that such accommodations be made. Examples of such accommodations are included in the descriptions of supportive housing programs in the Appendix.

To deal effectively with tenants with problems of mental disability and histories of long-term homelessness, property managers may assume responsibilities that go beyond ordinary management functions. When tenants experience emotional crises or act in ways that are disturbing to other tenants, property managers may intervene on an ad hoc basis. Even when third-party service providers are formally designated to handle crisis situations, on-site property managers may be the first to try to calm a tenant down, negotiate disputes between tenants,

urge a disturbed tenant to seek help from a case manager, or call in the mobile crisis team. The latter actions take on an aspect of service provision, but many property managers who practice such crisis intervention report that this is an expected responsibility in managing supportive housing.

When a single agency conducts both property management and service provision, managers may confer regularly with service staff to address problems that interfere with a tenant's ability to fulfill the terms the lease, such as paying rent on time or not getting into fights with other tenants. In some programs, lease preparation includes the requirement that tenants participate in a service plan as a condition of tenancy. However, this practice is fraught with ethical and possible legal complications, as will be discussed later.

SRO projects or apartment complexes occupied solely by persons with mental disabilities or other impairments, are especially likely to make such demands on on-site property managers. When mentally disabled tenants live in scattered-site housing, managers are less likely to have to take on such an augmented role on their behalf.

Property managers and landlords in projects that include disabled tenants must be familiar with the federal Fair Housing Act, which provides that disabled tenants are entitled to "reasonable accommodations" in their housing. Reasonable accommodations are changes in rules, policies, practices, or services, when such changes are necessary to allow a disabled person "equal opportunity" to enjoy the benefits of his or her dwelling unit[6] For mentally disabled tenants, reasonable accommodations may entail modifications in house rules, tenant selection procedures, enforcement of lease violations, and service compliance requirements. These will be discussed in more detail in Section VI, "Challenges in Permanent Supportive Housing Programs."

Tenants have the right to *request* reasonable accommodations; they cannot be imposed by property management as requirements for tenancy. When a disabled tenant makes such a request, the housing provider must consider making an accommodation, and must provide the accommodation tailored to the needs of the person as long as it does not impose an undue hardship on the provider or a "fundamental alteration" of the nature of a program.

Service providers. The goal of services is to enable the tenant to live stably in long-term housing. Services, then, should be tailored to the needs and strengths of the individual tenant. Such individualization means that some tenants will require services only intermittently, while others will need more or less continuous support. Some will need several types of support to live in the community, while others will manage well with a narrower range of services. Although many supportive housing programs do not insist that tenants receive case management or other services, other programs, as noted above, require participation in services as a condition of housing.

Service staff may be based at the site of the housing or at another place. Programs based in SRO's, in apartments inhabited only by program participants, and in congregate housing settings are most likely to involve on-site service delivery, whereas scattered-site housing programs rely primarily on services based off-site, Even if based off-site, providers may make visits to residents' homes to offer various types of assistance. Locating service staff on-site has the advantage of being more "efficient," of allowing economies of scale, since service providers are readily accessible to greater numbers of tenants at a single site and need not spend time traveling from one location to the next. However, physically separating services

[6] Fair Housng Amendments Act regulations, 24 CFR Sec. 100.204 (a)

from housing may encourage residents to feel that they are living in a "normal" environment rather than in a setting marked by the ongoing presence of staff and services.

Support services are not the same as reasonable accommodations. Reasonable accommodations, unlike services, include changes in rules and policies of the housing project. They are the responsibility of the landlord to provide as long as they do not cause an undue hardship or require the landlord to fundamentally alter the nature of the housing program. Reasonable accommodations may include *access* to support services, but the landlord is not legally required to provide the services.

Access to services may be ensured when, as in many supportive housing programs, a single agency provides both housing and services. In other programs, housing and services are provided by separate organizations. Agencies whose primary activity is the provision of "residential continuum" programs for people with mental disabilities frequently offer both housing and services, whereas housing developers tend to contract for service delivery with third-party providers. It is common for a single agency to have primary responsibility for delivering some services to residents "in-house" and coordinating linkages with other providers for a additional services. The next section discusses the gamut of services helpful to supportive housing residents.

IV. SERVICES IN SUPPORTIVE HOUSING

The purpose of services

The multiple agencies offering their resources to supportive housing residents may bring to bear a number of differing program philosophies about the role of services in the lives of their clients. It is worth emphasizing once more that support services in supportive housing are supposed to enable clients *to obtain and keep their homes*, so the goals of support services will be twofold. First, since the vast majority of supportive housing program involve residents as tenants rather than homeowners, services will be designed to help residents fulfill their obligations as tenants--that is, to comply with the terms of their leases. Second, services are meant to help residents maintain enough independence to avoid returning to a more restrictive and unstable living environment.

The Public and Assisted Housing Occupancy Task Force convened by HUD noted that there are five essential obligations of lease compliance:

* to pay rent and other charges under the lease in a timely manner;
* to care for the unit, avoid damaging the unit and common areas, not create health or safety hazards, and report maintenance needs;
* to avoid interfering with the rights and enjoyment of others, and avoid damaging the property of others;
* to not engage in criminal activity that threatens the health, safety, or right to peaceful enjoyment of other residents and staff, and not engage in drug-related criminal activity.[7]

Services to help residents avoid returning to more restrictive settings may offset problems that, while not posing immediate threats to tenancy, could undermine the level of independence they want to maintain. For example, some people with limited mobility due to

[7] Public & Assisted Housing Occupancy Task Force, *Report to Congress and to the Department of Housing and Urban Development* (Washington, D.C.: U.S. Department of HUD, 1994).

physical disability may require assistance from an attendant to bathe, prepare meals, and dress. A mentally disabled resident who has become withdrawn and afraid to leave his house may need assistance with shopping or traveling to and from appointments at the mental health center. On-site medical services by a visiting health team may be particularly important to people with AIDS and other chronic health problems. With these types of supports, residents with disabling conditions can stay in their homes and not forfeit their autonomy by entering nursing homes, board and care homes, or other long-term care facilities.

Service components

Case Management. The case manager is often the key person in helping residents find and keep their housing. Case managers are frequently the first persons to whom residents turn in times of stress, and they are usually the first to offer help when residents seem to have trouble with tenancy or independent living issues.

The duties of case managers vary from program to program, but in general they are responsible for assessment, developing service plans, and linking clients with services in the agency and in the wider community. In addition, they may advocate for clients, counsel them, offer emotional support, train them in independent living skills, and intervene in crisis situations. In many programs, they work as members of a team that includes social workers, substance abuse counselors, and other lay and professional staff.[8]

In supportive housing programs based at SROs or apartment complexes occupied solely by supportive housing residents, case managers are frequently based at the housing site. In scattered-site programs such as Shelter Plus Care or Housing Stabilization, and in some concentrated settings, they may be based off-site and visit residents at the housing site when necessary. They may be trained mental health professionals or lay persons with life experiences similar to those of the clients they serve. In agencies that offer transitional programs and services to non-residential clients in addition to permanent housing, case managers may serve clients across the continuum of programs.

Mental health services. The needs and preferences of mentally disabled individuals are varied, some will neither want nor require ongoing mental health services, while others will find them essential to staying housed. Most mentally disabled people in supportive housing who require such services will depend on the local public mental health system.

The Federal Task Force on Homelessness and Mental Illness recommends that a local mental health service offer needs assessment; diagnosis and treatment planning; medication management and monitoring; counseling and supportive therapy; hospitalization and inpatient care; 24-hour crisis response; habilitation and social skills training; and discharge planning.[9] Most of these services, except for inpatient treatment, are available through the City of Berkeley's Mental Health Division. (Alameda County Behavioral Health Services provides inpatient treatment for indigent mentally disabled people.)

Crisis intervention is one of the most critical and widely-offered mental health services in supportive housing. According to the evaluation of the federal Supportive Housing Demonstration Projects (which funded both permanent and transitional programs for homeless

---

[8] M. Ellison, E. Rogers, K. Sciarappa, et. al., "Characteristics of Mental Health Case Management: Results of a National Survey," *Journal of Mental Health Administration*, 22:2 (1995), pp. 101-112.

[9] Federal Task Force on Homelessness and Mental Illness, *Outcasts on Main Street* (Rockville, MD: National Institute of Mental Health, 1992), p. 43.

families and individuals with severe mental illness and other disabilities), it is the type of mental health service most frequently offered on-site.[10] Both the nature of a resident's disability (for example, onset of an acute psychotic episode) and the new demands of living independently in one's own apartment can precipitate sudden and very severe stress The purpose of crisis intervention services is to help the resident get through such a crisis without having to enter a hospital involuntarily. With sufficient assistance, the resident is able to stay out of the hospital with extra support from on-site supportive housing staff and off-site mental health and self-help services.

Providing appropriate and responsive crisis intervention services is one of the most challenging program planning elements of supportive housing. A later section of this report discusses some of the difficulties that programs have encountered in planning and implementing this service component.

Substance abuse counseling. Mentally disabled individuals who also have problems with alcohol and other drugs are at increased risk of homelessness. An estimated third to a half of mentally disabled homeless persons have concurrent substance abuse problems.[11] In many localities, mental health treatment and substance abuse treatment have been provided through separate service systems; this has resulted in uncoordinated service delivery to dually diagnosed persons. Within Berkeley, substance abuse services are offered through a network of city programs, including the Mental Health Division; city-funded multiservice agencies for the homeless; and City contracts with residential treatment programs. In addition, 17 agencies funded independently of the City provide methadone treatment, residential recovery programs, and counseling; these are supplemented by a number of "Twelve Step" self-help groups such as Narcotics Anonymous and Alcoholics Anonymous.

Many supportive housing providers require residents to be "clean and sober" at time of entry, which may mean that those with substance abuse problems must first go through detoxification and residential recovery programs before entering permanent housing. Therefore, case managers who work with clients prior to their entry into supportive housing have to help them access drug treatment programs that are geared to serve people with mental disabilities. Case managers must help their clients transition smoothly from one level of residential program to the next, and to link them with ongoing counseling or 12-step programs once they have become residents in permanent supportive housing.

Some housing programs require residents to refrain from alcohol and illicit drugs both on and off the premises; others allow alcohol consumption off-site; and some permit residents to drink alcohol on-site but enforce a policy of not permitting drinking or intoxication in common areas such as lobbies and meeting rooms. Some programs host on-site NA and AA groups.

Peer support and self-help. Over the last twenty years support groups and agencies run by and for people with mental disabilities have demonstrated their importance as a community resource. Self-help activities include mutual support groups, drop-in centers, and

---

[10] Westat, Inc., *National Evaluation of the Supportive Housing Demonstration Program: Final Report.* (Washington, D.C.: Department of Housing and Urban Development, 1995), p. B-8. The Permanent Housing for the Handicapped Homeless component of this program was renamed the Supportive Housing Program and became permanent as part of the 1992 Housing and Community Development Act

[11] R. Tessler, "What Have We Learned to Date? Assessing the First Generation of NIMH-supported Research Studies on the Homeless Mentally Ill." Keynoteaddress at an NIMH-sponsored conference, Bethesda, MD, February, 1989. In *Homelessness and Mental Illness: Toward the Next Generation of Research Studies*, ed. J. Morrissey & D. Dennis (Rockville, MD: National Institute of Mental Health, 1989).

multi-service agencies where clients provide services, carry out clerical and administrative responsibilities, and maintain the premises.

The benefits of self-help activities are numerous. People who are isolated and distrustful may develop a sense of connection and trust with others who understand first-hand the experiences of coping with disability, institutionalization, and poverty. Their sense of hope may increase as they see others with similar problems meeting life's challenges successfully. Further, by taking on responsibilities as volunteers and paid staff, they can gain new social skills, good work habits, and a sense of accomplishment.

Service providers in supportive housing programs can structure peer support components into their services by facilitating self-help support groups, creating volunteer roles for residents, and hiring people from the resident base as paid service staff. (Other means of ensuring client participation, which is an essential part of self-help, are outlined earlier in this document.) Case managers may encourage clients to attend self-help agencies and support groups elsewhere in the community. In Berkeley, the Berkeley Drop-In Center has operated a client-run multi-service center for several years, and has provided case management services for homeless mentally disabled participants in the City's Shelter Plus Care program. Berkeley-Oakland Support Services has integrated peer support aspects into many of its service programs and hiring practices.

Benefits counseling and money management. The steady income provided by a regular benefits check gives people the means to pay rent and stay housed. However, those who receive government assistance such as SSI, General Assistance, or Medi-Cal must deal with an often confusing array of regulations, rules, and paperwork. The process can be especially daunting to a person with a mental disability who may have difficulty keeping appointments, following instructions, or concentrating well enough to fill out the necessary forms. Benefits counselors can help clients negotiate complex applications processes, prepare for routine eligibility reviews, and appeal reduction or termination of their benefits.

People may be unable to manage their own money due to their mental disabilities, substance abuse problems, or the effects of long-term institutionalization, and may need the assistance of representative payees. A representative payee receives the disability check on behalf of the client and disburses funds for the client's rent, utilities, and other living expenses; the payee may entrust the client with small sums of money for incidentals. In some cases, the payee may help the client gradually learn to manage larger sums of money and, eventually, to handle a monthly budget. Even clients who do not require representative payees may need help with money management on an ongoing basis or from time to time. A benefits counselor or case manager can provide this assistance.

The City of Berkeley's Mental Health Division provides limited representative payee services to mentally disabled clients. In addition, a number of social service agencies serving the homeless offer money management training and representative payeeship services.

Health care. Mentally disabled people who are moving into housing from long-term life "on the streets" are--like other homeless people-- particularly likely to suffer from acute conditions such as respiratory infections and malnutrition, as well as ongoing problems such as high blood pressure, dental problems, peripheral vascular disease, and other chronic conditions. Chronic health problems are magnified among those with co-occurring problems of substance abuse and AIDS. Supportive housing program staff help residents access health services off-site; health care delivery on-site may also be structured into the service program. For example,

Health Care for the Homeless (HCH), a project of the Alameda County Public Health Department, operates a mobile van that makes regular site visits to the UA Homes, a services-linked SRO, and to places frequented by homeless people in Berkeley and the throughout Alameda County; the HCH van staff offer preventive care, health education, and urgent care at the sites they serve. A recently-started demonstration program in San Francisco and Oakland integrates visiting on-site primary medical services into a host of other support services for severely and multiply disabled people living at several supportive housing sites.

The City of Berkeley offers several clinic-based and outreach programs available to low-income persons, including those with mental disabilities, through its Department of Health and Human Services and subcontracting agencies.

Independent living skills training. Due to the effects of disability, long-term institutionalization, or "living rough" on the streets, some supportive housing residents may need to re-learn basic skills such as cooking, house-cleaning, shopping, and time management; others will have little need for assistance with these tasks. Community-based mental health service programs have long demonstrated that clients learn and apply these skills best when they are taught within clients' homes rather than at outpatient treatment centers or in institutional settings. Supportive housing provides the most "normal" kind of environment for developing such skills.

Some supportive housing programs require that entering residents have a minimum level of independent living skills; others allow case managers to invest more time on a case-by-case basis in helping residents "catch up" in their abilities to keep house, cook, shop, and otherwise keep homes for themselves.

Job-related services. Disabled people who have spent long periods of time away from the work force--or who have never entered the work force--may need more than job leads to help them find and keep gainful employment. Some may have to overcome barriers of illiteracy and lack of education; others may highly developed job skills that have become obsolete in the current labor market. The continuum of job-related services that may be offered to mentally disabled clients includes assessment; training in appropriate work habits; material support (appropriate clothes, grooming, transportation, etc.); training in interviewing skills, resume-writing, and other job search skills; job development; peer support and counseling in the job-search process; on-the-job training; and continued support once a job is secured.

Some agencies providing services at supportive housing projects offer a number of job-related services "in house"; others rely on strong linkages with third-party agencies for these types of services. Some supported housing programs, such as San Francisco's Canon Kip Community House and other SRO-based projects, have started to integrate residents into paid work in property maintenance, repair, and renovation through property management companies at participating SRO's. Others have pursued a more venturesome economic development strategy, launching small businesses that hire residents in subsidized or competitive positions.

Housing search assistance and moving. Prospective residents usually need assistance preparing for their move into permanent supportive housing. A well-coordinated continuum of services should be able to help clients find out about supportive housing options, get on waiting lists for these programs, articulate their housing preferences, help them apply for subsidies such as Section 8 or Shelter Plus Care, find movers and help with moving expenses, secure money for security deposits, arrange for utilities to be turned on, and find furnishings for their new homes. Supportive housing providers that offer an array of other support services to

mentally disabled and homeless clients can offer such assistance to prospective residents. On the other hand, providers who offer services only to their own supportive housing tenants must work in coordination with third-party agencies on whom they rely to do this work on behalf of prospective tenants.

Finding an apartment may pose special challenges for some mentally disabled housing-seekers. When the sites used for supportive housing are sponsored by an affordable housing agency or social service organization, sponsors can work with property managers to make the tenant selection process fair and responsive to the circumstances of mentally disabled, very low-income applicants. Owners of private rental housing, however, may be hesitant about renting their units to tenants with bad or nonexistent credit histories, histories of eviction or negative landlord references, or no recent rental history at all. Although landlords are barred by fair housing laws from discriminating against any applicant on the basis of his or her disability, they can be justifiably concerned about the ability of applicants with "black marks" on their rental histories to meet the requirements of tenancy

Agencies that provide support services for tenants in privately-owned housing have responded to these concerns by working directly with small property owners. With the client's permission, a provider can reassure a hesitant landlord that the applicant is receiving services to help him be a responsible tenant, and that the provider can be called on to assist in times of crisis. Service agencies report that, given such assurances, property owners have been willing to rent to their clients.

Housing counselors and case managers often help tenants negotiate reasonable accommodations with property managers and landlords. They can help a tenant identify the types of changes in house rules and policies that might enable her to use and enjoy her dwelling unit, communicate the tenant's request to the housing provider, and may be able to help the housing provider and tenant reach agreement on an accommodation that is useful to the tenant and not unreasonably burdensome to the provider..

Other services. Supportive housing programs provide a number of additional services that are instrumental to the goals of helping people be responsible as tenants and live with as much independence as they wish. These include educational activities, such as literacy classes, helping clients achieve General Equivalency Degrees, and ESL classes; family and child services, such as day care and parent skills training; and training in participatory skills and community organizing techniques. Some programs help residents plan social and recreational activities to help them overcome their social isolation, structure their time, and develop a sense of camaraderie with each other..

V. VARIATION AMONG SUPPORTIVE HOUSING PROGRAMS

As noted earlier, no single program which can be said to typify supportive housing; there is broad variation between programs in types of housing structures, range of services, property management practices, types of residents, and program philosophies. The Center for Community Change, a prominent policy research institute in the field of supportive housing, developed an operational definition of "supported housing." based on a survey of all identified programs in the U.S. The Center differentiates supported housing from the more general terms "supportive housing" or "services-linked housing." Supported housing for mentally disabled people, according to this definition, features:

* housing widely dispersed in the community, or multi-unit buildings not segregated by disability status;
* client choice among available housing options;
* client assistance in locating, choosing, and maintaining housing;
* no program restrictions on how long residents can stay in the housing;
* voluntariness of program participation; that is, provision of housing is not contingent upon receipt of services;
* flexible provision of services based on varying levels of need, both between clients and for an individual client over time, with services provided either at the housing site or elsewhere in the community;
* availability of services even if a resident's housing situation changes--for example, due to hospitalization.[12]

However, this definition does not reflect the true variation in programs that identify themselves as "supported housing," "supportive housing," or "services-linked" housing. The actual operations of any such program are influenced by local land and housing markets, land use regulations, the requirements of available funding, the missions and program philosophies of sponsoring agencies, the particular needs of residents, and other variables. Each of these may force a compromise with the principles embodied in the operational definition described above. For example, high land costs may make development of scattered-site units much more impractical than constructing a single multi-unit apartment building for mentally disabled residents. Regulatory restrictions on the use of certain federal rental subsidies for unoccupied units may force housing providers to end the tenancies of residents who are hospitalized for more than a month or two. Programs offering services to dually-diagnosed persons may require prospective residents to participate in substance abuse services to preserve a "clean and sober" environment for other tenants in recovery. Further, not all services-linked housing programs subscribe to the principles of the "supported housing" model.

Supportive housing programs can more accurately be described as occupying points along a set of continuums, with each continuum reflecting characteristics of housing, service program, and organizational structure. These continuums were identified through extensive interviews with supportive housing providers that form the basis for the case studies in the Appendix and a review of the published literature on program descriptions of supportive housing projects. These are not presented as a definitive typology of underlying dimensions. Rather, they constitute a way of looking at supportive housing programs that may prove more useful than assessing how closely a given program approximates an ideal operational definition. These continuums include:

Dispersal/concentration

This continuum reflects to what extent units within a program are scattered at different sites throughout a community, and to what extent they are physically concentrated in proximate locations or a single location. At one end of this continuum, program residents may live in single-family homes or single apartment units geographically well distributed throughout a community; at the other end, residents may be concentrated in a single SRO. "In-between"

---

[12] J. Yoe, P. Carling, & D. Smith, *A National Survey of Supported Housing Programs for Persons with Psychiatric Disabilities* (Burlington, VT: Center for Community Change, 1991)

points along the continuum may include units clustered in a single neighborhood but at separate sites, apartment complexes occupied only by program participants, and so forth.

As noted earlier, concentrated settings allow support services to be based on-site, which allows accessibility for residents and prompt service delivery. This advantage, however, is compromised by the limited housing choice offered by sole-site settings and its difference from ordinary housing.

Supportive housing residents want places to call home, with the privacy, safety, and freedom that implies.[13] According to a number of consumer preference surveys, mentally disabled people prefer living in their own apartments or with roommates, but not in segregated settings with other mentally disabled people or in SRO's.[14] In other words, they want "normal" housing like other people have. While consumer preference alone cannot determine housing development or program policy, research to date suggests that mentally disabled people who obtain housing of their choice stay housed longer and have less re-hospitalization than those who do not.[15] Scattered-site housing seems to offer the greatest degree of "normality" in supportive housing; a range of supportive housing programs that include scattered-site housing, dedicated apartment complexes, and SROs would offer the greatest diversity and choice.

Segregation/integration

Program participants may be relatively segregated or integrated by disability status, in terms of both service participation and housing,. Highly "segregated" settings provide housing only for mentally disabled participants; less segregated ones may provide housing and services to persons with mental disabilities as well as other types of disabilities, but still restrict their programs only to disabled people. The most integrated settings mix mentally disabled and non-disabled people.

A supportive housing program may be highly concentrated yet well integrated. For example, a program may operate in an SRO, which is a highly concentrated setting, but may serve people with mental disabilities, other types of disabilities, and non-disabled persons who may need some occasional supports or who may not participate at all in the program's support services.

Resident segregation may reflect organizational goals and missions of housing providers, such as social service organizations dedicated to serving people with mental disabilities. In other cases, segregation may reflect the constraints of available funding sources more than program philosophies. For example, Section 811 of the National Affordable Housing Act provides for development of housing projects only for persons who are disabled; the McKinney Act further restricts eligibility for participation in programs funded through its Supportive Housing Program to disabled persons who are also homeless; the Shelter Plus Care component of the McKinney Act targets homeless people disabled by mental illness, substance abuse, or AIDS. The constraints of financing through these categorical funds may lead programs to develop housing that is both highly concentrated and segregated, even though

---

[13] P. Ridgway & P. Carling, *A User's Guide to Needs Assessment in Community Residential Rehabilitation*. Boston: Center for Psychiatric Rehabilitation (1992).

[14] B. Tanzman, "An Overview of Surveys of Mental Health Consumers' Preferences for Housing and Support Services," *Hospital and Community Psychiatry, 44* (1993), pp.450-455.

[15] D. Srebnik et al., "Housing Choice and Community Success for Individuals with Serious and Persistent Mental Illness," *Community Mental Health Journal, 31* (1995), pp. 139-151; M. Brown et al., "Comparison of Outcomes for Clients Seeking and Assigned to Supportive Housing Services," *Hospital and Community Psychiatry, 42* (1991), pp. 1150-53.

such development runs counter to the principles of integrating disabled people into their communities and avoiding concentrations of "special needs" housing units.

The most well-integrated housing projects have managed to pull together diverse sources of capital financing and services funding that allow their programs to serve a broad base of low-income individuals and families.

On-site/off-site location of services

Some supportive housing programs consider on-site location of core services, especially case management, to be essential to their programs, especially when residents have severe and/or multiple disabilities and case managers must be readily available to respond to their needs. Other programs, attempting to provide a more "normal" environment that is not distinguished from neighboring homes by the continuous presence of service staff, locate all services off-site. Along other points in the continuum, programs may base core services off-site but provide some regularly scheduled services on-site, such as staff-led support groups and problem-solving groups. Programs sometimes provide no regular services on-site but offer on-site services as needed--for example, one-on-one independent living skills training or crisis intervention. One agency may provide the on-site case management services, linking clients with other community agencies that offer specialized services at other locations.

In relatively concentrated settings, on-site services can allow more efficient service delivery, since case managers don't need to travel from one site to another and can respond more readily to a greater number of people. The presence of on-site staff can help ease neighbors' concerns about whether the program provides adequate support for projects that house large numbers of severely disabled people. However, program capabilities and the needs of the resident base--not the concerns of third parties in the neighborhood--should determine the design of service staffing.

High-demand / low-demand settings

This continuum reflects the "demands" that the program places upon demands. It includes two dimensions: (1) requirements for program participation as a condition of housing; and (2) expectations of how well residents are to function.

Requirements for program participation. Programs that require residents to accept extensive program services subject them to "high" demands. Such high demands might include, for example, involvement in representative payeeship services, medications monitoring, regular substance abuse counseling, and frequent case management appointments. Conversely, required services may be quite minimal, such as brief monthly check-ins with a case manager..

Mandatory service participation was an unquestioned feature of residential programs in the traditional "continuum" model; providers of such programs often extend this program philosophy into their supportive housing projects. In other cases, providers structure mandatory service participation into their program design to compete successfully for federal funds targeted for "hard to serve" populations. (HUD's Shelter Plus Care, for example, requires grantees to match funds for rental assistance with support services for program participants) Finally, programs that try to maintain a "clean and sober" environment for people with concurrent drug/alcohol problems and mental disability may insist that residents get ongoing substance abuse services to help them stay in recovery.

Resident participation in services may help alleviate a number of problems with tenancy obligations. For example, residents who have trouble managing their budgets well enough to pay their rent on time may be helped by money management services, and a resident who becomes disoriented and fails to report serious maintenance problems might benefit from regular home visits by a case manager. Understandably, service providers may feel that requiring involvement in these types of services and others might help avert tenancy problems before they start.

Because of the potential benefits of support services and the considerable problems some tenants may encounter without them, many providers are induced to make service acceptance a condition of initial and continued tenancy. Frequently, they structure stipulations for service acceptance into the lease agreements that all tenants are required to sign. In some "high-demand" programs, tenants may be threatened with loss of their housing for not complying with the terms of their service agreements, even if their conduct does not otherwise jeopardize the obligations of their tenancy.

On the other hand, some programs simply let residents know that services are available whenever they want, but make "low" or no demands on them to participate. They may recognize that requiring residents to accept services in order to get housing is inimical to the principle of voluntariness that many supportive housing programs would like to promote. Even those with the least demands for resident engagement in services, however, may strongly encourage residents whose behaviors violate the obligations of tenancy to accept services to help them keep their housing. For example, staff may urge a resident who is consistently late with rental payment to accept help with money management, or a case manager may encourage a resident who shows up drunk in public areas to take part in substance abuse counseling and AA groups in order to avoid eviction.

By negotiating these service plans with residents, case managers or other service staff can mediate between residents and property managers. They may convince the latter to delay eviction proceedings and give the resident a chance to demonstrate that, with the assistance of services, he can act in accordance with his obligations as a tenant.

Still, residents have a right to refuse support services despite their potential benefits. A major programmatic difference between "high-demand" and "low-demand" settings is that the latter do not consider the exercise of that right, in and of itself, to be a cause for denial of housing. If a resident in a low-demand setting exercises her right to refuse services, she may nevertheless be able to comply with the terms of her lease requirements. If she can not, .eviction would result *only* from her failure to meet the obligations of tenancy, not her refusal to comply with offered services.

Requirements for resident functioning. The second aspect of this continuum has to do with the level of functional ability that entrants into the program must possess. Virtually all programs require that applicants have a basic level of self-care skills and enough self-control to not endanger their neighbors. Beyond this, though, programs have differing standards of what constitutes a sufficient level of demonstrated ability to fulfill the requirements of tenancy.

Some programs accept persons who, because of long-term institutionalization or "living rough" on the streets, have lost certain skills necessary for living inside and without constant staff supervision. Such programs may deliberately target the most recalcitrant homeless mentally disabled people, invest time in helping them learn to live in their own units with substantial supports, and expect that some residents will decompensate from time to time and

be re-hospitalized. Other programs, however, require that new residents in permanent supportive housing have substantial independent living skills and relative emotional stability, and refer more fragile applicants to transitional housing programs to become more stable and capable of caring for themselves.

Organizational integration/diffusion

A single agency may assume the role of housing developer, owner, property manager, and service provider; conversely, separate agencies may perform each of these functions. Frequently, agencies with long histories of providing residential continuum services have developed transitional housing, own and manage the properties, provide the bulk of support services in these facilities, and continue to do so in their permanent supportive housing programs. Organizations whose primary mission is to develop affordable housing are more likely to form working relationships with local service providers and property management companies to carry out their specialized functions in providing permanent supportive housing. When more than one agency participates in a supportive housing program, the cooperating organizations may draft written working agreements to clarify respective roles and responsibilities, set up formal processes for communication, and specify means of settling disputes. The use of such memoranda of understanding is highly recommended. The section below on "Local Program Models" discusses some of the issues that necessitate such agreements.

High participation / low participation of clients

Finally, this dimension indicates how well supportive housing programs ensure client direction in planning, providing, evaluating, and overseeing the housing development and service delivery processes. The regulations for certain McKinney Act programs contain some moderate provisions for client involvement. More importantly, however, public and non-profit mental health agencies recognize the value of client voice in shaping responsive and effective services, and have begun to include clients in planning, evaluation, hiring, and service provision. Consumers and providers can reasonably expect supportive housing programs to follow this trend of client empowerment.

Some professionally-run supportive housing programs accord clients a modest role in planning day-to-day social and recreational activities; other programs include client representatives on their boards of directors and actively recruit clients for staff positions. In a few supportive housing programs, individuals with histories of mental disability have designed service components and secured funding, and carry out service provision, staff supervision, program administration, internal evaluation, and governance.

VI. CHALLENGES IN PERMANENT SUPPORTIVE HOUSING PROGRAMS

The Bay Area is rich source of information on permanent supportive housing for mentally disabled people. It is home to a number of such programs with considerable variance in their missions, program philosophies, histories, size, staffing models, and capabilities. Program descriptions of six such programs are included in the Appendix.

Methodology

Extensive interviews were conducted with representatives (including program coordinators, executive directors, property managers, housing development staff, and others)

from eight permanent supportive housing programs in Richmond, Oakland, Berkeley, and San Francisco. The purpose of these interviews is twofold. First, the findings should reveal the how some local supportive housing programs operate in practice rather than plan or ideal. This can help reveal the workings inside the "black box" of service delivery and program design for planners and policy-makers who more are familiar with the capital finance and "bricks and mortar" aspects of housing for low-income people. Second, the interviews were meant to illuminate some recurring thorny issues that participants in supportive housing provision may encounter in planning and implementing their services. This report has already touched on some of these, such as reconciling the ideal of voluntariness with mandatory services and locating services on-site in a purportedly "normal" housing environment.

The programs were selected to represent some diversity of supported housing models: apartment-based housing and SRO projects; "self-help" programs as well as those directed by professionals; housing specifically for mentally disabled people in addition to projects that integrate the mentally disabled into a more general low-income tenant base; programs in which all functions are conducted by a single agency as well as collaborative projects; and so forth. Some service providers operate more than one supportive housing project, with differences in service program and housing characteristics between one project and the next.

The interviews covered at length issues of property management and service provision, and relations between each entity responsible for these functions. The interviewer attempted to identify service costs on a per-client basis, although variations in budgeting methods and record-keeping, as well as considerable differences in staffing patterns, client characteristics, and range of service components allow only a very rough basis for comparison. Capital financing issues were a lesser concern for purposes of this report and are dealt with only briefly here. Analysis of variations in development and operational costs is beyond the scope of this report.

The material yielded by these interviews, as well as a review of case descriptions in the supportive housing literature, form the basis for identifying the six continuums of supportive housing detailed above. The program descriptions in the Appendix discuss each of six local program in terms of its position along each continuum The interviews, as well as a review of the supportive housing literature, inform the findings below.

Findings: Some major issues in supportive housing

Certain issues have emerged as widespread concerns among a majority of programs. In some programs, staff and sponsors (including housing developers, property managers, and service providers) acknowledged these concerns as problem areas they have grappled with or are still trying to resolve. They regarded other issues not as problem areas but as inherent features of providing services-linked housing to people who may be difficult to serve and house. These issues will likely face parties involved in developing new supportive housing programs.

Tenancy issues. In general, the purpose of services in permanent supportive housing is to enable residents to stay in their homes. This implies that residents have a primary identity as tenants with attendant rights under state and local landlord/tenant laws, and that housing providers acts as landlords with concomitant legal obligations. Some supportive housing providers, however, see housing as just one component in the overall package of services they offer. They regard themselves primarily as service providers and see residents as clients benefiting from the housing "service." Social service agencies with lengthy experience providing

transitional living facilities for mentally disabled people are especially likely to extend this orientation to their more recently developed permanent supportive housing programs.

Agencies with a "services" orientation, unlike traditional landlords, often build provisions for service compliance into their lease agreements. They may treat a residents' noncompliance with services as substantial breach of the lease provisions and, therefore, as grounds for eviction. The enforceability of these provisions is questionable, since they impose performance requirements on disabled residents that would not be imposed on nondisabled tenants. Whether or not such provisions can be enforced, some programs use the threat of eviction to encourage recalcitrant tenants to take part in services.

The inclusion of service compliance provisions in lease agreements is one aspect of the larger issue of mandatory services in supportive housing. Despite the benefits that tenants may gain from such services, there are several reasons that argue against making these services compulsory. First, from a service delivery perspective, leaders in the fields of psychiatric rehabilitation and social work now recognize the value of client voluntariness. Client participation in developing service plans, not submission to the judgments of providers, is now a well-accepted principle in clinical work with severely mentally disabled people. And if voluntariness in housing correlates with residential stability, better psychological well-being, and less re-hospitalization, similar benefits may be gained by allowing supportive housing residents choice about the services they receive.

Further, compulsory services may have negative consequences for community development. Residence characteristics that are different from those of "normal" housing are likely to increase neighbors' perceptions of residents as stigmatized and deviant.[16] If supportive housing tenants are marked by the requirement, rather than the choice, to participate in services, neighbors may be less likely to regard them as responsible and contributing community members.

Finally, housing providers may run afoul of landlord-tenant law and fair housing laws if they try to force compliance by threatening or initiating eviction proceedings in response to refusal of services. Landlords and property managers must not try to circumvent legal requirements for due process in eviction proceedings; they cannot oust tenants for not complying with their service plans without going through the legal steps specified in state law. In Berkeley and other cities with eviction controls, landlords can evict only for "good cause" as defined by municipal law.

Fair Housing Act provisions may require that supportive housing providers consider providing a tenant with the reasonable accommodation of modifying their services requirements, Again, the purpose of such an accommodation is to allow the tenant an opportunity equal to that of others to use and enjoy his or her dwelling unit, as long as providing the accommodation does not place an undue burden on the provider or require a fundamental alteration in the nature of the program. A tenant's insistence on not going to a treatment group or seeing a case manager may be considered a request for accommodation, and that tenant's nonparticipation in services (or preference for alternative services) may not necessarily impose an undue hardship on the provider or interfere with the program goals of the supportive housing project. Such instances must receive case-by-case consideration by the housing provider.

---

[16] M. Hogan and P. Carling, "Normal Housing: A Key Element of a Supported Housing Approach for People with Psychiatric Disabilities," *Community Mental Health Journal, 28* (1992), pp. 215-226.

The practice that best promotes the interests of residents and their neighbors is to not require residents to accept services. However, if supportive housing programs are to insist on service compliance, they can more legitimately do so by negotiating a separate services contract with the resident rather than including compliance provisions in a lease. Even organizations that provide both housing and services can negotiate separate contracts for each. The requirements of service plans can then be adapted to meet the changing needs and expressed wishes of residents. This practice avoids complicating the landlord/tenant relationship with tenancy requirements that may be legally void and discriminatory against mentally disabled individuals..

Flexibility in property management practices. Providers of supportive housing projects have had to become flexible in conducting property management activities such as screening tenants, addressing violations of lease terms and house rules, and initiating evictions. Such modifications are matters of practicality in dealing with homeless and other very poor people as well as implicit requirements of Fair Housing Act provisions for reasonable accommodation for disabled tenants.

Tenant selection provisions. Like other landlords, supportive housing providers are interested in recruiting tenants who are responsible and do not disrupt the peace and safety of other tenants. Property managers who carry out the tenant selection process in ordinary rental housing usually screen out applicants with histories of bad credit, prior evictions, or criminal records. Such incidents, however, are common in the lives of people who are poor, mentally disabled, and homeless--the very people whom supportive housing programs are intended to serve.

. Consequently, property managers in many supportive housing programs have tried to modify their selection practices to give some leeway to applicants who report these "red flag" experiences. This means giving more consideration to an applicant's suitability based on present circumstances rather than past problems. For example, an applicant may be given the chance to explain why he had a bad landlord reference or a non-violent misdemeanor conviction in the past, and to suggest what kinds of supports (such as help with money management and participation in an AA group) he could rely on to avoid such problems in the future. Many supportive housing providers do not require standard credit checks on applicants, and allow alternate methods of verifying that the applicant is capable of making timely payments, such as a statement from a case manager, transitional housing provider, or counselor.

Persons with mental disabilities have often experienced problems with landlords and other creditors because of their disabilities. They may, for example, have become too disoriented to pay rent on time or have disturbed the peace of other tenants during a manic episode. Non-discrimination provisions of the Fair Housing Act imply that, in such cases, supportive housing providers should give mentally disabled applicants an opportunity to show that past problems resulted from their disabilities and that they can now meet their obligations as tenants, with or without assistance from support services.

Property managers report giving more weight to their sense of a person's present honesty and motivation to stay housed than to past experiences in determining suitability as a tenant, but tend to screen out applicants with histories of violence. When service providers and managers work collaboratively in tenant selection, each can provide a cross-check on the other's sense of whether an applicant would make a good tenant.

Addressing violations of house rules. Supportive housing programs often maintain house rules regulating a wide range of tenant behavior. These rules may go beyond assurances of conduct in conformity with the obligations of lease compliance, and impose curfews, as well as restrictions on pets, number of overnight visits, and length of visitors' stays. These rules are most extensive and commonly encountered in concentrated settings such as SRO's; other SRO's that do not operate as supportive housing programs often have similar house rules. Some of these rules may be adopted for the ostensible purpose of ensuring the safety of all tenants--a restriction on length of visitors' stays, for example, may be intended to keep active substance abusers from effectively moving in with consenting tenants.

However, housing providers may have to modify rules for individual tenants in the interests of reasonable accommodation. For example, a tenant undergoing a prolonged delusional episode may need constant on-site companionship and reassurance from visiting friends in order to enjoy the benefits of his dwelling unit--that is, to keep his home. The tenant could ask the property manager for a waiver of the usual rules barring extended visits during his crisis period. As long as the accommodation does not unduly burden the housing provider or fundamentally alter the nature of the housing program, the accommodation is reasonable.

Evictions and avoiding evictions. From time to time, supportive housing residents fail to meet the obligations of their tenancy and face the threat of eviction. What is at issue here is noncompliance with those lease provisions that bear on the central obligations of tenancy: such as paying for rent in a timely manner; not creating health or safety hazards, not interfering with others' enjoyment of the premises, and not using or selling illegal drugs on the premises.

As a rule, supportive housing tenants are expected to abide by the same standards of compliance as tenants in ordinary housing. However, as a matter of both practicality and making reasonable accommodations, supportive housing providers have adapted customary property management practices to give some latitude to offending residents who have otherwise been good tenants. For example, one property manager says she puts off issuing a 3-day notice to quit to a tenant who misses a rental payment because of nonreceipt of her disability check, as long as the tenant submits proof from Social Security that she has applied for a replacement check. In another supportive housing program, lease violators whose disabilities contribute to their noncompliance are often given extra time to find appropriate services to help them comply with their tenancy obligations.

Because services can help residents succeed as tenants, property managers are frequently tempted to require tenants to get services as a "reasonable accommodation." However, tenants rather than property managers must request reasonable accommodations, and continued tenancy cannot be predicated on acceptance of either services or accommodations, but on achievement of lease compliance. When tenants cannot achieve this through receiving services, reasonable accommodations involving a change in property management practices, or their own efforts, supportive housing providers are obligated to help tenants find alternative housing or shelter.

Maintaining boundaries between service providers and property managers. When separate organizations manage the supportive housing property and provide services, each must have a clear understanding of the limits of its respective roles and obligations. Each agency should make its responsibilities clear to the project's residents. Most supportive housing programs spell out the terms of such agreements through written memoranda of understanding.

These agreements also set up formal processes for communication and specify means for settling disputes.

These explicit understandings must address program activities in which property managers and service providers must collaborate. In ordinary housing, for example, tenant selection is the prerogative of the property manager. However, in supportive housing, service providers may claim special expertise in assessing applicants' abilities to live independently and get along with other tenants. The property manager may consider herself the best judge of an applicant's ability to fulfill the terms of tenancy and be willing to grant the service provider an advisory vote in tenant selection, but may want to retain ultimate decision-making power for herself. If one or the other is to have final authority in selecting tenants, this must be made explicit in the terms of the agreement.

Service providers who, in other settings, are highly conscious of confidentiality requirements may be tempted to divulge client information to property managers in supportive housing programs. Since services are intended to help residents stay in their homes, service providers may feel that they are helping their clients by telling property managers about the types of problems individual clients have and the services they get. Property managers may think they can do a better job if they have such information. However, service providers are ethically and legally bound to maintain confidentiality for their clients who reside in supportive housing. Client consent is required if the service provider is to release information to any third party. Property managers must understand and acknowledge this and not press service providers to divulge confidential client information.

A resident may have difficulties that pose issues for both services and property management --for example, repeatedly paying the rent late, banging on the walls during a psychotic episode, or attracting vermin by hoarding garbage. In such cases, the service provider could ask the resident to meet with both the property manager and service provider, who together can explain to the resident how his behavior does not comply with the terms of tenancy. make clear how his unacceptable behavior must change, and help the resident ascertain what support services can best assist him in doing so. Supportive housing providers report that this type of collaboration helps service providers and property managers work together on the resident's behalf while respecting the resident's right to give consent to any proposed sharing of information.

Providing appropriate crisis management. The level and type of crisis management provided is a function of both staffing capabilities and program philosophy. In some programs, property management staff can contact case managers or other service staff by beeper at any time to intervene when a resident undergoes crisis. Other agencies, however, lack the staffing capacity to have a back-up service provider on call at all times. Instead, the property manager relies on a mobile crisis team to intervene, if the local mental health department provides one, or may simply call the police. A program may forego providing 24-hour on-call staffing if it wishes to promote a "normal" housing environment that does not rely on constant availability of staff to intervene in crises. However, this goal must be balanced with that of meeting the needs of fragile residents who periodically become very agitated and rely on staff to be summoned on-site to help them stabilize and avoid hospitalization.

Both property managers and service providers report that it is helpful to assist residents in planning a back-up support system for crises, starting at the time of entry into the program. Either the property manager or service provider may ask the resident to designate someone to be called in case of an emergency, including an emotional crisis. The client may be

encouraged to identify what he or she finds helpful when in extreme distress and what tends to aggravate the situation. This approach is consistent with the principle of voluntariness and involves residents in planning their own service strategies. Although this approach is not always successful in averting hospitalization, it is certainly superior to dealing with crises in an unplanned manner with no explication of residents' preferences. It also provides both service staff and property management with advance consent to disclose client information to designated third parties when residents experience emergencies or profoundly disturbed states.

"Skimming" vs. recruiting the "hard to serve" As noted earlier, mentally disabled people, including those who are homeless, are a heterogeneous group. Some can live quite independently with minimal or episodic supports, whereas others need ongoing and intense assistance to stay in their homes. Providers consider some mentally disabled individuals to pose special challenges. These include those who have been homeless for a long time, have "lived rough" on streets and in city parks, have concurrent substance abuse problems, do not want to get involved in services, or have spent years in institutions. When people have lost or never gained basic independent living skills, and when this lack is complicated by drug and alcohol abuse, they may have a particularly hard time getting housing and staying in their homes.

Supportive housing programs, like all human service programs, want their efforts to yield good results for their clients. They want to show funders that their service plans are designed to have positive outcomes--above all, long-term tenancy for their residents. Some programs may practice a form of "skimming" those mentally disabled people (including those who are homeless) they deem most likely to succeed: people who are already "clean and sober," who know how to keep house, who are considered capable of independent living, or who have already become stabilized in transitional living programs. This practice derives in part from the desire to maintain a mix of tenants who respect each others' rights and who can be trusted to take adequate care of their rooms or apartments. Both legitimate property management considerations and service goals, then, can underlie the practice of recruiting the most functional people.

Other programs try to recruit "difficult to serve" people, and design their program requirements and staffing accordingly. Recruitment efforts may be conducted on the streets, not just through homeless service agencies or other social service programs. They may develop "low-demand" programs that do not require residents to be heavily engaged in services or to maintain a high level of independent living skills. (However, they still expect residents to follow behavioral standards of conduct, such as prohibitions against public drunkenness, violence, or illegal drug use on the premises.) Service providers may be posted on-site during evening hours and on weekends as well as regular weekday hours. While programs that are aimed at especially challenging people can require extra service staff effort and tolerance by property managers, they may be most consonant with local public policy goals of housing the most "hard core" homeless and severely disabled people.

A note about service costs

The case studies that follow in the Appendix include some information on service costs, either on a per-client or per-day basis, as reported by the service programs. However, these data do not permit comparison of costs between programs. Several factors cause considerable variation in reported costs, including:

* *variation in hours on-site availability of service staff.* Some programs provide on-site staffing during weekends and evening hours; other maintain staff on-site only during weekday daytime hours
* *volunteer labor used to provide some services.* Although some programs utilize volunteers extensively to supplement the work of paid service providers, valuation of volunteer labor is not included in program budgets, which thus do not reflect the full cost of serving residents.
* *economies of scale.* Some agencies support staff to serve clients in many program components, not only those in supportive housing; for example, case managers in a mental health agency might serve clients in transitional housing and cooperative apartments as well as supportive housing residents. These programs can achieve greater economies of scale in their staff resources than can programs that "dedicate" staff solely to a supportive housing project.
* *unionization.* The salaries of service staff represented by a labor union are considerably higher than those of their counterparts at non-unionized agencies.

Variation in service costs may also be contingent on whether the resident mix includes a high proportion of people who need ongoing support and whether the program requires residents to participate in services. Both of these variables are related to the intensity of services provided to clients. Finally, agencies that provide a broad range of services "in-house" may reflect higher annual service costs than those that rely primarily on linking clients with services provided by external agencies.

The evaluation of the National Supportive Housing Demonstration Program, which was conducted from 1987 through 1990, found that the average daily cost to provide both permanent housing *and* services to a disabled homeless person was $45 per person and $51 per household; on an annual basis, costs were $16,537 per person and $ 18,475 per household. The largest group of projects funded under this program, like the projects described in the Appendix, served persons with severe mental disabilities, and residents tended to have multiple disabilities such as alcohol and substance abuse or AIDS/HIV infection.[17]

VII. RECOMMENDATIONS

- ***The City should determine priority sub-populations among its mentally disabled residents***. Most permanent supportive housing for mentally disabled persons in the City and elsewhere is for homeless persons, although others who are not technically homeless may lack access to affordable, stable housing with sufficient linked supports. These individuals may include "high utilizers" of mental health services who cycle between acute care, long-term inpatient facilities, and community-based residential care, or persons in board and care homes who may be ready to move to more independent living with support services.
- ***Supportive housing projects based at a single site should integrate mentally disabled residents with those who have other types of special needs, and with low-income households in general.*** Mingling mentally disabled residents with those with other types of special needs, or who are simply low income, has several advantages. It promotes the goals of integrating disabled residents into their communities and avoiding concentrations of

[17] *National Evaluation of the Supportive Housing Demonstration Program: Final Report,* pp. 3-28.

residents with a single type of special need. Integrated housing reflects the preferences of mentally disabled individuals, who overwhelmingly indicate a desire to live in "normal" housing not segregated by disability status.

- ***The design of support services should reflect their purpose: to help residents fulfill their obligations as tenants and to prevent their return to a more restrictive or unstable setting.*** These are the essential purposes of services in the context of supportive housing. The type of service or mix of services that will fulfill these purposes will vary from one resident to the next, and may vary for a given resident over time.
- ***Housing and services should be provided by separate organizations.*** The roles of service provision may at times conflict with those of the property owner and manager. Whereas service providers focus on the needs of the individual client, property managers and owners are necessarily concerned with protecting the structure and operations of the housing site. Separating the roles of service provision and property ownership/management helps avert such programmatic conflicts within a single organization.
- ***Developers, landlords, property managers, and service providers should develop written memoranda of understanding that make explicit their respective roles, responsibilities, and processes of resolving disputes.*** This recommendation is a corollary of the previous one. Mutual understanding of each party's respective roles and responsibilities help all to work cooperatively and efficiently, respect resident confidentiality, and minimize disputes. Each agency should make its responsibilities and roles clear to the project's residents.
- ***Service compliance should not be included as a requirement in lease agreements. If service compliance is to be required at all, the service agreement should be negotiated separately from the lease.*** This is a corollary of the recommendation that housing and services be provided by separate agencies. Making housing contingent on service compliance tends to blur the distinctions between the roles of service provision and property management. Landlords who threaten tenants with loss of housing for not accepting services may risk violating state and federal fair housing provisions and local landlord/tenant laws. If supportive housing providers insist on service compliance, they should negotiate service contracts separately from lease agreements.
- ***Involve representatives of the resident base (mentally disabled individuals, including those with multiple disabilities and homeless people) in the planning process for housing development and service delivery***..

Selected Readings

Anthony, W., and Blanch, A. (1989) "Research on community support services: What have we learned," *Psychosocial Rehabilitation Journal*, 12:3, 55-81.

Bratt, R., et. al. (1994) *Confronting the Management Challenge: Affordable Housing in the Nonprofit Sector* (New York: New School for Social Research).

Brown, M., and Wheeler, T. (1990) "Supported housing for the most disabled: suggestions for providers," *Psychosocial Rehabilitation Journal*, 13:4, 59-68.

Carling, P (1993) "Housing and supports for persons with mental illness: Emerging approaches to research and practice," *Hospital and Community Psychiatry, 44*, 439-449.

Chipperfield, S., and Aubry, T. (1990) "The supportive housing program in Winnipeg," *Psychosocial Rehabilitation Journal*, 13:4, 91-94.

Cohen, C., and Thompson, K. (1992) "Homeless mentally ill or mentally ill homeless?" *American Journal of Psychiatry*, 149:6, 816-823.

Cohen, M., and Somers, S. (1990) "Supported housing: Insights from the Robert Wood Johnson Foundation Program on Chronic Mental Illness," *Psychosocial Rehabilitation Journal*, 13:4, 43-50.

Dear;, M. (1991) *Gaining Community Acceptance* (Princeton, NJ: Robert Wood Johnson Foundation).

Deegan, P. (1992) "The Independent Living Movement and people with psychiatric disabilities: Taking back control over our lives," *Psychosocial Rehabilitation Journal*, 15:3, 3-19.

Dennis, D., Buckner, J., Lipton, F., and Levine, I. (1991). "A decade of research and services for homeless mentally ill persons: where do we stand?" *American Psychologist*, 45:11, 1129-1138.

Drake, Dr., Osher, F., and Wallach, M. (1991) "Homelessness and dual diagnosis," *American Psychologist*, 46:11, 1149-1158.

Elliot, M., and Krivo, L. (1991) "Structural Determinants of Homelessness in the :United States," *Social Problems*, 38:1, 113-131.

Ellison, M., Rogers, E., Sciarappa, K., et. al (1995) "Characteristics of mental health case management: results of a national survey," *Journal of Mental Health Administration 22*: 101-112.

Fair Housing Amendments Act regulations, 24 CFR Sec. 100 et. seq.

Fairweather, G., Sanders, D., Cressler, D., and Maynard, H. (1969). *Community life for the mentally ill.* Chicago: Aldine Publishers.

Federal Task Force on Homelessness and Mental Illness (1992) *Outcasts on Main Street* (Rockville, MD: Interagency Council on the Homeless)

Hogan, M., and Carling, P. (1992) "Normal housing: A key element of a supported housing approach for people with psychiatric disabilities," *Community Mental Health Journal*, 28:3, 215-225.

Koegel, P., and Burnham, A. (1992) "Problems in the assessment of mental illness," in M. Robertson and M. Greenblatt (eds.), *Homelessness: A National Perspective* (New York: Plenum Publishing)

Lamb, R., ed. (1984) *The Homeless Mentally Ill* (Washington, D.C.: American Psychiatric Association, 1984).

Mandiberg, J., and Telles, L. (1990) "The Santa Clara County clustered apartment project," *Psychosocial Rehabiitation Journal*, 14:2, 22-28.

Meinhardt, K., Cablas, A., Jerrell, J. (1994) *The California Household Mental Health Survey of 1992* (Sacramento: California Department of Mental Health).

Molinaro, L.., ed. (1988) *Housing for People with Mental Illness: A Guide for Development* (Princeton, NJ: Robert Wood Johnson Foundation).

Newman, S., and Ridgely, S. (1994) "Independent housing for persons with chronic mental illness," *Administration and Policy in Mental Health*, 21:3, 199-215.

Pyke, J., and Lowe, J. (1996) "Supporting people, not structures: Changes in the provision of housing support," *Psychosocial Rehabilitation Journal*, 19:3, 5-12.

Public and Assisted Housing Occupancy Task Force (1994) *Report to Congress and to the Department of Housing and Urban Development* (Washington, D.C.: U.S. Department of Housing and Urban Development).

Ridgway, P., and Carling, P. (1992) *A User's Guide to Needs Assessment n Community Residential Rehabilitation* (Boston: Center for Psychiatric Rehabilitation).

Ridgway, P., Simpson, A., Wittman, F., and Wheeler, G. (1994) "Home making and community building: Notes on empowerment and place," *Journal of Mental Health Administration*, 21:4, 407-417.

Ridgway, P., and Zipple, A. (1990). "The paradigm shift in residential services from the linear continuum to supported housing approaches," *Psychosocial Rehabilitation Journal*, 13:4, 11-31.

Rosenfield, S. (1991) "Homelesssness and re-hospitalization: The importance of housing for the chronic mentally ill," *Journal of Community Psychology*, 19:1, 60-69.

Segal, S., and Aviram, U. (1978) *The Mentally Ill in Community-Based Sheltered Care: A Study of Community Integration* (New York: Wiley).

Srebnik, D., Livingston, J., Gordon, L. and King, D. (1995) "Housing choice and community success for individuals with serious and persistent mental illness," *Community Mental Health Journal, 31*, 139-151.

Tanzman, B. (1993) "An overview of surveys and mental health consumers' preferences for housing and support services," *Hospital and Community Psychiatry, 44*, 450-455.

Technical Assistance Collaborative (1994) *Creating Housing and Supports for People Who Have Serious Mental Illness* (Rockville, MD: Center for Mental Health Services, Us. Department of Health and Human Services)

Tessler, R. (1989) "What have we learned to date? Assessing the first generation of NIMH-supported research studies on the homeless mentally ill," in J. Morrissey and D. Dennis (eds.), *Homelessness and Mental Illness: Toward the Next Generation of Research Studies* (Rockville, MD: National Institute of Mental Health).

Wenocur, S., and Belcher, J. (1990 "Strategies for overcoming barriers to community-based housing for the chronically mentally ill," *Community Mental Health Journal*, 26:4, 319-333.

Westat, Inc. (1995). *National Evaluation of the Supportive Housing Demonstration Program: Final Report* (Washington, D.C.: Department of Housing and Urban Development).

Yoe, J., Carling, P., and Smith, D. (1991). *A National Survey of Supported Housing Programs for Persons with Psychiatric Disabilities* (Burlington, VT: Center for Community Change).

APPENDIX

Case Studies of Supportive Housing Programs in the San Francisco Bay Area

AZTEC HOTEL TENANT SUPPORT PROGRAM*
Oakland

The Aztec Tenant Support Program (ATSP), in operation since April 1992. provides support services on-site to residents of a single-room occupancy hotel near the downtown area of Oakland. Most of the hotel's residents have a mentally disability, not all the residents were literally homeless before living at the hotel. Unlike most other services-linked housing programs for homeless mentally disabled surveyed for this report, services are not supported by any HUD-administered McKinney funds.

One organization developed the property, owned it until recently, and continues to manage the property; a separate organization provides support services. The services component is distinctive in that its approach is based on a model of peer support and "self-help"; all services staff have received treatment for mental disabilities, and most have experienced homelessness and/or substance abuse problems. The county mental health services agency, which was interested in funding a self-help program to provide on-site services and build a sense of community among residents, awarded a services contract to a client-run organization which had developed a proposal for such a program. The program operates on the principle that persons who have undergone these experiences are uniquely equipped to assist others who are struggling with such problems.

Financing

The site was developed by Housing for Independent People (HIP), an experienced regional developer of special-needs housing. HIP obtained financing for acquisition and extensive rehabilitation of the earthquake-damaged site through FEMA, Oakland's Office of Community Development, and the State Department of Housing and Community Development. HIP until recently retained ownership of the building. Property management, which was also provided by HIP, has been financed primarily by the income stream from tenant rents. The support service component, operated as a project of the Alameda County Network of Mental Health Clients, is funded mostly by state mental health realignment funds provided through Alameda County Mental Health Services (ACMHS) supplemented by funds from the federal Center for Mental Health Services.

Site and neighborhood characteristics

The Aztec Hotel is a three-story structure with a capacity of 69 residents. The ground floor space includes a reception area, an office for the property manager, an office for the support service staff, a room for residents' mailboxes, and an adjacent common space with tables, chairs, and a TV. Tenant rooms are located on all three floors.

The rooms vary in size but are generally small, an average of 90 square feet. One large bathroom for men and another for women are located on each floor. A patio and a small kitchenette equipped with a microwave adjoin the first-floor common area.

Located in a mixed-use but predominantly commercial area on the southern edge of downtown Oakland, the Aztec is near a number of other SRO hotels and social services that serve homeless people. It is within walking distance of amenities such as fast-food restaurants--the main source of residents' meals-- a supermarket, banks, and both BART and buses.

* In late 1995, Operation Dignity assumed ownership and property management for the Aztec Hotel. The hotel now operates as a "clean and sober" transitional housing program for homeless veterans. The Tenant Support Program continues to provide on-site services for the residents.

Property management

The hotel was until very recently managed by its developers, Housing for Independent People (HIP), which has leased rooms on a month-to-month basis directly to residents. (Since December 1995, property management has been assumed by Operation Dignity.) Property management is provided on-site, but the central office for HIP is located in Santa Clara County. However, a property management staff person is on site at the Aztec 24 hours per day.

The hotel usually operates well under capacity, with only 29 rooms occupied steadily and very rapid turnover in the rest of the units. Tenure tends to divide into two tenant clusters: one group includes tenants who have resided at the hotel for an average of two to two-and-a-half years, whereas other hotel residents tend to stay only about three months. Vacancy problems have been variously attributed by program service and property management staff to the small size of the rooms, the strictness of hotel rules, and the lack of rental subsidies. The fixed $295 per month rent is within the range of market rates for the area, but is substantially more than the amount of rent that an SSI recipient would pay for a Section 8 SRO unit. As a result of the depressed rent revenue stream, HIP was unable to pay its debt service and the state initiated foreclosure proceedings.

As noted below, property management and service staff collaborate in the tenant screening and selection process. Property management considers not only whether the tenant has a sufficient income and seems to able to comply with the terms of the tenancy, but whether he or she is capable of living independently. (Tenants are required to have an SSI-level income--$620 per month in 1995--and most residents receive SSI.) For its assessment of a prospective tenant, HIP sought but did not require references from previous landlords.

The rental agreement stipulates a number of rules regarding, among other things, visits by overnight guests and consuming alcohol on public areas on the premises. The monthly rental payment covers the amenities of linen service. Incoming tenants are required to pay a security deposit..

Unlike most other services-linked housing projects with management and services provided by separate entities, HIP and the ATSP did not maintain a MOU or other written agreement delineating their respective roles and responsibilities. As a result, a mutual recognition of roles and boundaries was hard to maintain. Confidentiality emerged as a major issue on occasions when HIP property management staff asked ATSP caseworkers to provide service information on their clients.

Service Program

Target Population

The program is intended to serve Alameda County residents over the age of 18 who are identified as severely mentally disabled. Homelessness is not a condition of eligibility, but a significant number of residents have experienced homelessness. Many have undergone recent long-term stays in psychiatric facilities. The SRO building in which the program is based can accommodate only individuals living singly.

Recruitment, intake, and assessment

Unlike those services-linked housing programs that are geared towards homeless people, the ATSP receives few referrals from homeless multi-service agencies or outreach efforts. Most residents are referred from a range of acute, subacute, and long-term psychiatric inpatient settings through ACMHS's Continuing Care component. A lesser number come from transitional housing or board-and-care residences. The program accepts those who self-refer as well as those formally referred by a caseworker. The program, however, does not regard itself as a facility for "placements'; it is meant to serve those

who may need more flexibility than an inpatient or community care setting can provide, and residence at the hotel is voluntary.

Any prospective tenant whose referral does not originate with ACMHS is referred to that agency for an initial assessment to determine his or her capacity to live independently. The local mental health agency, then, is a participant in the selection process. A prospective tenant who is deemed appropriate by ACMHS undergoes a group interview with the ATSP program staff and a property management staff person. This serves as an additional screening tool to assess the person's ability to live outside a structured environment, and whether she or he can live peaceably (i.e., non-violently) in the Aztec setting. Note that both service staff and property management staff assert responsibility for determining whether an applicant is capable of independent living. Residents with substance abuse problems are not required to be "clean and sober" at the time of entry, but are encouraged to acknowledge these problems and make plans to work on them.

If accepted, the new tenant signs both a lease with the property manager and a separate "service contract" with ATSP, reflecting the bifurcated roles of property management and services. The service contract stipulates that the resident will work with ATSP staff to determine immediate needs and personal goals, and to develop a plan of action to meet those needs and goals. However, compliance with the service contract is not a requirement for continued tenancy.

Service capabilities

Staffing. Three core paid staff (3 FTEs) with overlapping but not identical job duties provide the support services, supplemented by 3 stipend positions filled 7-8 hours per week. The core staff provide services 8 hours per day, five days a week; stipend positions augment this to 12 hours per day. They are based in an office on the ground floor of the hotel. One stipend worker lives at the hotel and is "on call" after regular working hours. While the program lacks a formal case management component, each paid staff person serves as the "lead contact" for a caseload of residents.

In keeping with the program's self-help approach, staff qualifications include first-hand experience with mental disability or substance abuse, as well as experience working in human service settings. Experience in crisis settings is particularly valued. Academic training and professional credentials are not required. Staff do not receive formal on-the-job training, but attend off-site workshops for social service providers on various human service issues.

The program also makes use of resident volunteers who may work four hours per month assisting with clean-up, running errands, and helping out with on-site social activities, for which they are "paid" with bus passes. This too is consistent with the self-help philosophy of inclusiveness and client participation in service delivery.

Service content. Staff offer a range of services that includes peer counseling; counseling on issues of financial benefits, substance abuse, independent living skills, and employment; dispute resolution; outreach; advocacy; money management; leading group social and recreational activities; and information and referral. One staff member, in addition to these generalist duties, coordinates the program; another is considered to have expertise in substance abuse counseling and provides the bulk of that service. Thus, although the staff make ample use of referrals to community agencies, they provide a wide range of services "in-house." This differs from the brokerage model of case management used in many other services-linked housing programs, in which staff members' primary role is to help clients access and maintain contact with externally-provided services. (The ATSP staff see their roles as "services coordinators" rather than "case managers.")

The program has made a decision to not assume the responsibility of payeeships, believing that to do so would undermine their rapport with clients. Staff believe that not only would payeeship involve

a measure of coercion that is antithetical to the program's egalitarian philosophy, but, as one staff member put it, "money could become the total focus" of their relationships with residents. Instead, ATSP refers residents to ACMHS for sub-payeeship services, which are provided through the agency's Continuing Care program. The Aztec program also provides residents with some elementary survival resources such as clothes and bus passes as needed.

Crisis intervention capabilities. Service staff de-escalate a range of potentially disruptive situations, such as a resident showing up inebriated in the TV room or coming down off a drug-and-alcohol binge. There is no formal protocol for such intervention; instead staff address such situations on a case-by-case basis. Staff first intervene one-on-one to calm the person down. If necessary, the person's services coordinator is asked to assist. Staff may call on the property manager to help, or call an external case manager from ACMHS, and, in extreme cases, call the local Community Crisis Response Team (which has legal authority to place the person on a "72-hour hold" for psychiatric treatment). If a resident enters crisis when the service team is not on duty, the property management staff may call the police to intervene.

Program compliance requirements

On the continuum of "demand" for service compliance in services-linked housing programs, ATSP represents a very low-demand setting. As noted earlier, residents are encouraged but not required to be involved in recovery services if they have substance abuse problems. Although each staff member is assigned a casework load, residents are not required to meet with a caseworker.

Requirements for compliance with house rules, on the other hand, are quite specific. The "rules of the community" developed by ATSP prohibit drinking in public, smoking in the common areas, using violence, using abusive language, and possessing weapons. These are distinct from the lease stipulations that bar or limit more private conduct such as having overnight guests, baby-sitting, owning pets, or placing aluminum foil in windows.

Grievance

ATSP does not maintain an internal complaint resolution procedure for clients who have grievances about services. Because the program is funded by ACMHS, clients may call the county Patients' Rights Advocate if they believe that certain statutory rights of mental health clients have been infringed upon by the service staff.

Services financing and costs

Total annual service costs, exclusive of administrative overhead, are $134,757, of which $99,052 covers salaries and benefits for the three core staff members. The balance covers stipends for part-time client workers, trainings for staff, and a "community facilitation fund" (to cover costs of organized recreational and social activities: clothes, prizes, bus passes, etc.). The ACMHS contract that funds the ATSP is renewable on a year-to-year basis.

Client participation

The ATSP represents a high degree of client involvement in all current phases of program operations. As noted earlier, residents may work a limited number of hours assisting with program activities and may obtain paid stipend positions. Salaried staff are required to have life experiences similar to those of the residents. The ATSP's fiscal agent is governed by persons who have received mental health services and in some cases have experienced homelessness and substance abuse, and ATSP clients are eligible to become members of the governing body while still receiving program services. Hotel residents also participate in property management to a limited extent through part-time stipend jobs as desk clerks and clean-up workers.

BONITA HOUSE
Berkeley

Bonita House, Inc. provides permanent supportive housing in a four-unit apartment complex in Berkeley for single persons who have significant mental health and substance abuse problems, and who have been homeless. It represents a horizontally integrated model in which housing acquisition and ownership, property management, and services delivery have been conducted by a single agency. Along the spectrum of "demand" within supportive housing programs, it may be characterized as high-demand, requiring that clients be engaged in a flexible service plan; housing is contingent on compliance with such a plan.

Bonita House is a long-time provider of treatment programs in residential settings for mentally disabled people in Berkeley. . In addition to the permanent housing program, Bonita House operates three transitional housing sites.

Acquisition of the properties was financed through the McKinney Permanent Housing for the Handicapped Homeless component of the federal McKinney Act and the City of Berkeley's Housing Trust Fund. Program services, in operation since February 1993, are funded through the McKinney grant and county mental health funds.

Service Program

Target Population

The permanent housing program is targeted to homeless single adults who are mentally disabled and have concurrent problems with substance abuse, and who may have HIV+ /AIDS. Persons who are eligible for the program are those who fell within the McKinney Act's definition of homelessness at the time the program was funded. Thus, the program does not serve those mentally disabled persons who have been residing in a transitional living or drug rehabilitation facility for 30 days or longer--even though they may have been homeless before entering the facility-- nor does it serve those who are doubled-up in overcrowded housing situations with friends or family.

Recruitment, intake, and assessment

Recruitment efforts are directed at those homeless persons who have already become engaged in services for their mental health or substance abuse problems Residents come to the permanent housing program through Bonita House's outreach efforts, which are conducted through contacts with local social service providers, primarily substance abuse and mental health programs. Bonita House maintains contact with a liaison person at each agency site who serves as a link for initial contact between the permanent housing program and clients. When an existing or impending vacancy is available, Bonita House notifies the liaisons at the provider agencies; if a liaison knows of a client who may be interested and suitable as a program resident, Bonita House sends the liaison an application packet, which the client then completes with the liaison's help. The program places priority on recruiting Berkeley residents.

The next step in recruitment is a face-to-face meeting with Bonita House staff to ascertain what the prospective resident would like to achieve in the program, what his or her self-identified needs and goals are, and to explore further what the program has to offer and how it could meet those needs. Staff then may speak with service providers and others in an applicant's support system to confirm that the person meets program eligibility requirements. If s/he is found to be eligible, s/he/e is interviewed by other residents of the program.

If the applicant is accepted, the staff interview serves as the basis for formulation of a written "program agreement" that is incorporated into the lease, stipulating the individualized service plan the resident is expected to follow as well as landlord/tenant obligations. This dual nature of the "program agreement" reflects Bonita House's integrated role as property manager, landlord, and service provider.

Service capabilities

Staffing. The permanent housing project is one component of the Supported Independent Living Program (SIL). SIL is staffed by a program director, an assistant program director, and three case managers who provide services for clients in other Bonita House residential programs in addition to the permanent housing residents (residential caseload capacity among all SIL components is 38; total caseload, including agency clients living outside residential program settings, is about 50-55).. Case management assignments are made on the basis of caseload and the best "match" between the client's problems, personal history, and preferences, and the particular expertise and experience of the case manager. Case managers are required to have some type of formal training or substantial experience in substance abuse or mental health services, i.e. a master's degree in social work or psychology; a certificate in chemical dependency counseling; or three years' experience in mental health/substance abuse service delivery.

Case management staff are based off-site at the agency's administrative office, but provide some services on-site as needed. A staff member is available on-call via beeper 24 hours per day, 7 days a week. At present, the staff is not unionized and does not utilize volunteer support

Service content.. Consistent with the agency's integrated structure, case managers are expected to function as both service providers and property managers. As service providers, they participate in initial assessments, help clients plan goals; coordinate clients' participation in external mental health and substance abuse programs; provide referrals to vocational, educational, and other programs; link clients with financial and medical benefits; assist clients in improving independent living skills such as budgeting, housekeeping, self-advocacy; and counsel clients in substance abuse and mental health issues. They also help clients access primary health care and other health care services provided by the County of Alameda and the City of Berkeley.

Other case managers' functions are more closely related to traditional property management roles. These include recruitment of tenants; re-negotiation of the "program agreement" imbedded in the lease; noting tenants' requests for property repairs and maintenance; and helping arrange for repairs through outside services. The service and property management roles may be blended when the case manager mediates a dispute between tenants.

Crisis intervention capabilities. Because of round-the-clock staff availability, case managers are able to intervene as needed if a resident starts to decompensate or some other crisis develops. This may include visiting the resident's apartment. Intervention is directed at helping the resident stay in his or her home without going to the hospital.

The program tries to develop a plan with each resident about what steps to take if a crisis occurs. At present, written protocols for crisis intervention are not used. Agency staff do not have "5150" powers.

Service site. Although crisis intervention may be provided at residents' homes, group support sessions, AA/NA meetings, as well as meetings with case managers are held at the Bonita House, Inc. administration offices, several blocks from the residence site. In this way, services are for the most part physically separated from housing, in contrast to most SRO-based services-linked programs.

Program compliance requirements

Program residents are expected to adhere to their service plans. Modifications in the plan may be negotiated between a resident and case manager, but all residents are expected to be engaged in services, whether it is counseling, attendance at NA/AA meetings, or other services geared at promoting mental health and substance abuse recovery. In this sense, the program is not a "low-demand" environment. Substance abusers who do not become involved in pursuing recovery goals are encouraged to do so by staff and other residents; those who continue to avoid services are asked to move out. The incorporation of the "program agreement" into the lease is used to encourage program engagement.

Program benefits attach to the person, not the apartment unit. Persons who move out and want to continue to receive Bonita House's case management services can continue to do so.

Services financing and costs

Funding for services is covered by a McKinney Permanent Housing for the Homeless grant, which pays for one FTE. Costs for this FTE are increasingly assumed over a 5-year period with realignment funds provided through Alameda County Behavioral Services.

Program services are budgeted at $54,648 for FY 1995-96; this includes $41,750 for staff salaries and benefits. Daily service costs are estimated to be $39 per client, which includes program services, property expenses, and property management costs due to the dual role of the case managers.

Site and neighborhood characteristics

The four-unit complex in which program participants reside is located in a residential neighborhood of single-family homes and duplexes on the outskirts of the City's downtown area. The building is close to neighborhood amenities such as banks, laundromats, parks, and restaurants. It is a short bus ride away from health services, recovery support groups, outpatient mental health services, and other social service and support resources. Thus, although the building is inhabited exclusively by clients of the permanent housing program, it is integrated into a neighborhood that is not characterized by a concentration of "special needs" housing.

Each apartment in the complex has two rooms, not counting kitchen and bathroom. There is an outside patio but no common space inside. The building is not equipped with a washer or dryer.

Property management

As noted above, case management staff double as property managers for the apartment building. They are involved in tenant recruitment, drafting of the individualized "program agreement" incorporated into the lease, encouraging compliance with the terms of the lease and program agreement, registering tenant complaints and requests for maintenance, and communicating these requests so that the agency can contract for maintenance and repair services as needed.

The units are leased directly by Bonita House, Inc. to the residents. Units are subsidized through the McKinney grant: tenants pay 30% of their adjusted income in accordance with the standards that apply to Section 8 subsidized housing. Incoming residents are asked to pay a security deposit equal to the amount of one month's rental fees; this payment may be paid over several months if needed. Tenants are not required to pay the costs of background checks; these area absorbed by the program.

The units are furnished; the program can provide linens to new residents.

About ten clients have participated in the program since its inception, with an estimated average tenure of 10 to 12 months.

On occasion, a resident is hospitalized or enters another more restrictive living situation for medical or psychiatric reasons. If the person seems to be able to return to independent living, Bonita House will attempt to hold the apartment for him/her. However, HUD does not allow temporarily vacated units to be held for more than three months.

The program does not use a formal procedure for resolution of complaints related to property management. Informally, staff can discuss property management problems with a resident; if the matter is not resolved, the resident can then speak with the consumer representative on the Board of Directors.

Client participation

Client input into program issues has been ensured to a certain extent. At weekly group meetings with staff present, residents are encouraged to offer input into program practices. Clients participate in a number of committees to address program and agency needs.

Residents elect a client representative to the Bonita House's Board of Directors, although this representative does not have voting powers. This representative may assist tenants in resolving complaints about property management needs; otherwise, tenants have no formal mechanism for participation in property management. Former program clients, but not current clients, are eligible to become voting members of the Board.

Client feedback on satisfaction or dissatisfaction with services is formalized through (1) a written form for registering complaints, which is provided to the individual as part of the program agreement; and (2) a consumer satisfaction survey conducted the County funding source every three months. Finally, former direct users of mental health services--including those who belong to the population base from which Bonita House draws its clients--have served in the agency as front-line providers.

CANON KIP COMMUNITY HOUSE
San Francisco

In operation since October of 1994, this is a project of Episcopal Community Services, which planned and developed the project, and which provides most of the on-site case management services. Property management is provided by a separate company with extensive experience managing SROs. Canon Kip Community House is a newly constructed single-room occupancy building with a diverse tenant population that includes non-disabled low-income people as well as dually- or triply-diagnosed people, some of whom receive Shelter-Plus-Care rent subsidies. It has an extensive array of services provided on-site, and attempts to integrate neighborhood residents into the facilities and activities offered by CKCH. Although services, including case management, are readily accessible to House residents, they are not required to participate in these as a condition for getting or keeping their housing. CKCH may be characterized as a low-demand program in a very services-rich setting.

Episcopal Community Services (ECS) is a large provider of a range of social services to homeless San Franciscans, including two shelters, a multi-service center, a facility adjacent to CKCH that operates as a daytime senior center and an adult skills/education center. CKCH is ECS's first venture into development of services-linked housing.

Financing

Episcopal Community Services financed site acquisition and construction of the hotel through a package of low-income tax credits, federal HOME funds, and loans from the National Housing Equity Fund, the Mayor's Office of Housing, and now-discontinued Rental Housing Construction Program. Since the building's development was financed through long-term loans, there is no current debt service. The Corporation for Supported Housing provided technical assistance in obtaining financing. Rooms were furnished through in-kind donations.

Facility operations and on-site support services are financed by tenant rental payments, including subsidies paid by San Francisco's Shelter+Care program for up to 70 of the hotel's 104 units. Facilities at the "Skills Center" adjacent to the building were provided through a variety of sources, including foundation grants, McKinney funds, and donations of computer equipment.

Site and neighborhood characteristics

The program is housed in a newly-constructed, five-story, 104-unit building in the South of Market, an area where commercial and industrial enterprises are interspersed with apartment buildings. The neighborhood has amenities such as small grocery stores, restaurants, banks and check-cashing centers, and is close to major bus lines, BART, and the City's Downtown area. Another special-needs SRO is nearby.

Inside, the building features a number of amenities in its common spaces and private rooms. The building is secure, with a property management office located off a well-lit lobby. A wide-screen TV dominates the adjacent lounge, which is furnished with comfortable sofas and chairs. A large, fully-equipped kitchen is available for residents' use 24 hours a day. Other common areas include a laundry room and enclosed courtyard. Classrooms, including one equipped with several computers, are located on the first floor.

Most rooms have adjacent private bathrooms; about 30 rooms have shared bath facilities. Units are spacious, averaging 350-400 square feet (including foyer, closet, and bathroom) , and are each equipped with a microwave, small refrigerator, phone jacks, and cable access.

The building adjoins a senior center, with which it shares certain facilities. A commercial kitchen is adjacent to the senior center's dining room, and a billiards room is used by senior center clients as well as House residents.

Property management

Responsibility for all property management functions is contracted to John Stewart Co., a company with years of experience in managing several SROs in the San Francisco Bay region.. The company maintains a full-time administrator and assistant administrator on-site weekdays, as well as a maintenance person and desk clerks to monitor the front door 24 hours a day. Property management staff are responsible for conducting unit inspections, tenant selection, rent collection, maintenance, and repairs; instituting eviction proceedings; and management of paperwork for Shelter+Care subsidies. Tenant rental payments are made to John Stewart Co. as management agent for Episcopal Community Services, the owner. John Stewart and ECS maintain a written MOU to delineate their respective roles and responsibilities.

Turnover is 18% in the last year. The building is currently operating at close to 100% capacity, with waiting lists for both Shelter Plus Care participants and other applicants. CKCH houses the largest number of San Francisco's Shelter Plus Care participants residing at one site.

Rent determination and subsidies

Tenants enter a year-long lease, after which they rent units month by month. For those in Shelter Plus Care, rent payments are 30% of adjusted income, per federal standards; other tenants pay $306 per month. This is based on standards of the federal low-income tax credit program that financed the building--rent is pegged to 30% of 60% of the area median income for single-person households. Tenants must be low- and very-low income according to HUD standards for the area (specifically, those earning less than 60% of area median income).

About 30% of tenants receive GA, 50-55% receive SSI/SSDI, and about 15% have income from employment or VA benefits. Since Shelter+Care tenants without any source of income can receive completely subsidized rents, the hotel can temporarily accommodate no-income tenants while support service staff help them get regular SSI benefits.

Incoming tenants are required to pay first month's rent and a deposit equal to the amount of rent plus $50; the total amount may be paid in installments CKCH can provide incoming tenants with linens and pillows and, when necessary, give tenants vouchers to purchase household items at a local thrift store.

Tenant selection

Tenant selection is conducted by both property management and service staff. John Stewart Co. manages the waiting list for applicants who are not enrolled in the Shelter Plus Care program. Applicants are first interviewed by the administrator, and are required to provide ID and proof of income. However, the administrator does not conduct background checks to screen out those with histories of eviction or bad credit, since she regards that practice to be useless and possibly discriminatory for applicants who are poverty-stricken and whose homelessness may have resulted, at least in part, from their disability. Rather, the administrator is more concerned about applicants with histories of uncontrolled, violent behavior.

Acceptable applicants are referred to social services for assessment of their ability to live independently and service needs and goals. Applicants with histories of violence or who are fragile--those with apparent suicidal tendencies or psychosis--may be interviewed jointly by the administrator and a case manager. Applicants are assessed for their ability to live peaceably with their neighbors, to

provide for their own basic needs, to not get into fights, to not be drunk in the building's public places, and to otherwise comply with house rules, which are included as an addendum to the lease. The rules do not require that tenants abstain from alcohol.

Dealing with problems

The lease stipulates that eviction may ensue if a tenant "materially breaches" the lease by repeated late rental payments, which reflects some tolerance for lateness. Late payment is treated as both a property management and potential service issue. In practice, if the administrator does not receive payment by mid-month, she slips a notice under the tenant's door requesting payment and inquiring whether any problems are interfering with ability to pay. A copy of this is forwarded to social service staff, which lets them know that the tenant might need some help with money management. Despite this accommodation, repeated failures to make timely payments have resulted in eviction.

Tenants who disrupt the peace of other tenants (beyond simple one-on-one verbal arguments) are dealt with by the administrator and support service staff through a variety of means, depending on the nature of the disruption. There is not a formal property management protocol for dealing with such situations. Informal procedures depend to a great extent on the staff's ability to establish rapport and de-escalate conflict. The administrator is active in this process, although she is not considered to be a service provider. She may be able to persuade an obstreperous resident to simply go to his room, separate combative parties, and, in extreme cases, call in the police or the County's 24-hour mobile crisis team to intervene.

Grievances

John Stewart utilizes its own grievance procedure for matters related to property management issues, while ECS maintains a separate complaint procedure regarding service issues. With the assistance of the support services provided by ECS, a tenants' council was recently formed to represent tenants' interests in regard to both property management and service issues. So far, the council has not been active in resolving disputes between individual tenants or between tenants and management; it has mostly been involved in organizing social activities and registering tenants to vote.

Tenants are not formally involved in management of the CKCH property, but some participate in a multi-agency property management employment program described below.

Service Program

Target population

The program is intended to serve two sub-populations of San Francisco residents: those who are Shelter Plus Care eligible, and the broader base of those who are low and very-low income according to HUD standards. Unlike many services-linked housing programs that aim their recruitment efforts at people already engaged in services, CKCH also targets homeless persons who are labeled "service-resistant," who have avoided substance abuse or mental health treatment programs but who want stable and secure housing. The program integrates a diverse range of low-income people not limited to those with mental disabilities or histories of homelessness.

Recruitment, assessment, and intake

Shelter+Care participants reach CKCH through referral by the County's homeless service providers, including shelters, Health Care for the Homeless, and multi-service agencies. To help recruit these and other tenants, ECS conducted outreach to local shelters. other agencies serving homeless people, and "the streets." Some were referred from other local SROs and transitional housing programs. Applicant names were placed on two waiting lists (one for S+C participants, one for all others) and

screenings were conducted as described above until all rooms were filled. Vacancies created since then have been filled with waiting list applicants. The S+C wait list is maintained by the Department of Social Services, which refers potential tenants as needed.

Unlike many services-linked housing programs, CKCH does not require applicants to sign an agreement to participate in services on- or off-site. Housing is contingent on ability to abide by house rules and lease stipulations, not on service compliance.

Service capabilities

Staffing. The site is currently staffed by a service center director, three full-time case managers, and a vocational specialist. Four of these staff of are provided by ECS, the other--an HIV/AIDS and substance abuse specialist--provided through Baker Places, another San Francisco special-needs housing and services provider. This reflects some degree of specialization among case management staff. As each new tenant moves in, a case manager is assigned to offer help with moving belongings and any other immediate assistance the person may need. Case managers see their role as that of building community, linking residents with other external resources, and assistance with activities of daily living. They help clients access, but do not provide, ongoing counseling sessions or payeeship services. Currently, the case managers are on site 8-6 on weekdays (until 8 PM two days a week) and 8-4 on Sundays

Service staff are varied in their training and experience, ranging from college graduates with experience in homeless services to a MA in psychology with extensive background in mental health case management who serves as the service center director. Less experienced case managers get on-the-job training from more experienced staff and off-site trainings provided by other agencies. At present, the program does not utilize volunteers or interns on a formal basis.

Service content. A number of services based at other agencies are provided part-time at the CKCH site. A psychiatrist from the County mental health department and a mental health worker who serves all S+C program sites make regular outreach visits to CKCH and a substance abuse specialist visits twice a week to help residents access recovery services. Meetings of AA and NA are held weekly at CKCH. The site participates in the "integrated services" demonstration program developed by Corporation for Supported Housing, linking on-site health care services with special-needs housing programs to maximize independent living for persons with chronic illnesses while decreasing costly health care utilization such as hospital stays.

To this end, plans are underway to expand on-site social services by hiring a licensed clinical social worker with expertise in mental health and substance abuse issues, and starting regular site visits by a primary health care team through San Francisco's Health Care for the Homeless program. The recently hired in-house vocational specialist will help residents with a range of vocational services including individual support, organizing work crews for renovation of apartments, developing a project-based business, and job placement. These additional services, too, are part of the CSH integrated services demonstration project. Residents can already take advantage of computer training classes taught in the on-site computer labs.

Case managers link residents with a wide range of services delivered off-site as well, including representative payeeship services provided by Conard House nearby.

Crisis intervention capabilities. Case managers are not on site, and are reachable only by the administrator during night-time hours or on Saturdays. (The administrator is available by pager 24 hours a day, seven days a week). They try to help each resident develop a plan about how to handle crises that may occur when service staff are off duty, and may leave instructions with the 24-hour desk clerk on whether to intervene by calling the police.

Services compliance and termination. Service eligibility is linked to the project, not its tenants; services eligibility at CKCH ends when tenancy ends, although the person may still be served by programs external to CKCH, visiting professionals, and the integrated services team.

In cases of a clear breach of house rules--for example, a physical fight with a neighbor or public drunkenness--the problem may be treated as both a services as well as a property management issue. Tenants and/or service staff complete an "incident report" and may approach the resident(s) involved to discuss the problem and ways to avoid its repetition. Although case management staff do not provide service information on clients to John Stewart Co., the latter may provide copies of correspondence with the resident, such as "late rent" notices or problem behavior notices, to the case managers. If a resident faces possible eviction for disruptive behavior or nonpayment of rent), case managers and/or the administrator may negotiate an agreement with the person stipulating participation in some service program, such as money management, housekeeping services, or substance abuse counseling. However, continued residency is contingent on meeting obligations as a tenant (timely payment or rent, not becoming violent, etc.), not on compliance with a service plan.

Services financing and costs

The major portion of the services budget of $135,000 covers salaries and benefits; about $10,000 is allocated for non-personnel costs such as food, supplies, and equipment for meetings and organized social functions. (Social services staff at CKCH are unionized.) Eventually, as the integrated services demonstration project progresses, Medi-Cal reimbursement may cover certain on-site mental health and HIV/AIDS case management services.

Evaluation

The program, only a year old, has not yet been evaluated. An ongoing mechanism to provide feedback to program administration and staff has been attempted; this involved holding regular meetings of 30-40 tenants to discuss the benefits and drawbacks they have encountered while in the program. The program itself does not include a budget for an outcome evaluation, but outcome data is being collected for the County's Shelter+Care program on all S+C participants, and the CSH demonstration project includes an evaluation component for all project sites.

Client participation

In the planning phases of the project, homeless people participated in a series of focus groups and in general meetings to address plans for the services program and the physical design of the building.

Residents have become involved in limited aspects of property management: they have been hired in volunteer and paid positions as maintenance workers and desk clerks. ECS and John Stewart Co. have begun to formalize and expand this involvement through a vocational services component. They recognize the potential for conflict when employees are both residents and employees of the property management company which has powers to enforce sanctions for lease and house rule violations. They have developed an employment network with other special-needs housing providers and community-based agencies in which clients from one project can get paid work at another project site. Currently, some CKCH residents are learning maintenance skills under the supervision of an experienced maintenance worker by renovating rooms at other nearby services-linked SROs.

Residents are not presently employed as service staff, but 40% of staff at programs operated by ECS have been homeless. Currently, residents or others from the ECS client base are not represented on the agency's Board of Directors. The project does not maintain a project advisory board.

CONARD HOUSE HOTEL PROGRAM
San Francisco

The Conard House Hotel Program (CHHP) operates "supported independent living" programs for homeless mentally disabled persons at three SROs in San Francisco, with a fourth in the pipeline. The hotels were developed, and are owned and operated, under an assortment of collaborative arrangements between property owners and the service provider, the CHHP. A distinctive feature of CHHP's service program is its requirement for resident participation in its money management program, in which the program acts as representative payee for participants' benefits. Like other services-linked SRO projects, case management services are provided on-site, and housing is available only to adults living singly.

Conard House, CHHP's parent organization, is a long-time provider of housing services for mentally disabled people. In addition to its permanent housing programs, it operates two transitional hotels that offer more intense services.

Financing and services funding

The Riviera is leased by Conard House from an owner with several SRO holdings in the Tenderloin; rooms are subleased by Conard to their tenants. The Midori and El Dorado, on the other hand, were acquired and rehabilitated by two affiliate housing corporations that Conard House set up to develop each property; these were financed through the California Housing Rehabilitation Project, the Mayor's Office of Housing, and low-income tax credits; each affiliate acts as landlord for its respective site. The hotels have been in operation under Conard auspices for eight to ten years.. Their operating budgets are entirely supported by tenant rental payments (including the housing subsidies of the Shelter Plus Care tenants) to the landlord organizations, and cover property, utilities, security, and mortgage payments. Rental income does not cover the costs of providing services.

Since early 1995, San Francisco's Shelter Plus Care program can pay rental subsidies (based on 30 % of adjusted gross income) for a total of 25 tenants at the Midori and El Dorado Hotels. Program services for tenants at the three hotels are provided by general funds from San Francisco's Division of Mental Health and Substance Abuse.

Site and neighborhood characteristics

Two of the hotels--the Midori and the Riviera--are located in the Tenderloin, a densely populated, mixed-use neighborhood with a high concentration of SRO hotels, social services, and people living in poverty. Small diners, check-cashing services, and bars dot the area, and major bus lines run through its streets. The third hotel, the El Dorado is located on 9th Street in a predominantly industrial/commercial area; another SRO-based supportive housing project is nearby.

The Midori and El Dorado, which had both functioned as SROs at the time of their acquisition by Conard's affiliate housing development corporations, have 58 and 75 rooms, respectively. The capacity of the Riviera is 29. Rooms were not subdivided from their original size.. All the hotels feature kitchenettes for common use ; none provide kitchenette facilities in tenants' rooms. All have some type of common space for socializing and "hanging out" such as lobbies, TV rooms, and lounges. At the Midori, a private bathroom adjoins each tenant's room.

Property management

Many aspects of property management are assumed by CHHP, the service provider. They assume the entire responsibility for tenant screening and selection (described below), and do not delegate any part of this process to the landlord organizations. CHHP does not conduct credit checks on prospective tenants or require them to make security deposits. The program sees this as a reasonable

adaptation of tenant screening practices for impoverished people with severe mental disabilities. Service staff are also responsible for brokering repair services when needed; to date, maintenance has been provided by an external property management agency but this, too, will be brought "in-house."

Residents at the El Dorado and Midori sign lease agreements with the two housing corporations set up by Conard to act as landlords for the respective properties. Because tenants must participate in CHHP's money management program, they do not pay rents directly to the landlords; instead, rental payments are disbursed by case managers from tenants' accounts.

Tenant rental contributions vary depending on source of income and eligibility for the Shelter Plus Care program. Most tenants receive SSI; their unsubsidized rental contribution is a flat $300 per month. The hotels may provide a monthly subsidy of $102 for persons on General Assistance who are trying to get a more substantial income such as SSI. The duration of the subsidy is at the discretion of the landlord. These subsidies are a planned expense in the hotels' operating budgets. In accordance with federal requirements, tenants enrolled in the Shelter Plus Care program pay 30% of their adjusted income for rent. (In 1995, SSI recipients get $614 per month; those without access to kitchen facilities receive an extra $60). Linen service and utilities are covered by the rental payment.

Tenants enter into a lease agreement that usually runs on a month-to-month basis; at times, when CHHP staff are uncertain that a tenant will "work out," a room may be rented by the week on a trial basis. Although service compliance is not stipulated as a requirement in the body of the standard lease, tenants must sign a "program acceptance agreement" as an attachment to the lease. This document states that the tenant may occupy a room in the hotel only during the time that he or she is "a client in good standing" of the Conard House Hotel Program.

The hotels are operating at an aggregate 95% capacity. Length of residence is bi-modal, with one group of residents remaining for several years, while another group stays for only two or three months. For reasons that will be discussed later, Shelter Plus Care slots have been slow to fill.

The housing corporations have developed a tenant grievance procedure that provides for resolution of complaints related to property management practices. This is distinct from the grievance process developed by the County DMHSA for use by its subcontracting agencies. Aside from the formal grievance processes, CHHP staff encourage tenants to develop resident councils to represent their interests as tenants and program participants.

Conard House maintains written Memoranda of Understanding with its two affiliate housing corporations and with the Riviera's owner.

Service Program

Target population

In general, the CHHP serves clients with a primary diagnosis of psychiatric disability. The Shelter Plus Care program targets a sub-population that is homeless, has concurrent substance abuse problems, and may also have HIV+/AIDS. Residents who are not participating in Shelter Plus Care may have been homeless but are more likely to enter CHHP from transitional housing programs, including those operated by Conard House. The program has been having difficulty filling its Shelter Plus Care slots: it has imposed a program requirement that residents be capable of independent living and be clean and sober for 30 days at time of entry. This latter requirement may have made it difficult for dually-diagnosed Shelter Plus Care participants who are not yet in recovery to enter CHHP. At the same time, the program has been operating with the understanding that applicants who have been in recovery programs for more than 30 days are not considered "homeless" under the McKinney Act standard, and

are thus not eligible for Shelter Plus Care subsidies. (However, a recent HUD memorandum notes that under certain broad conditions such persons may meet the federal definition of homeless.)

Recruitment, intake, and assessment

Shelter Plus Care applicants for CHHP are referred by San Francisco's Shelter Plus Care Coordinator, who faxes a referral form from her office to Conard House's administration offices. Referrals for clients who are not enrolled in Shelter Plus Care may come from staff in Department of Mental Health contract agencies or private therapists. The applicant then calls an intake worker at CHHP to schedule an interview to determine basic eligibility, after which s/he is interviewed by service staff at one of the hotels, although not necessarily at the hotel at which s/he eventually resides. At that interview, staff) determine whether the applicant is "clean and sober" and capable of independent living, and explain house rules and the service program agreement. Applicants must agree to participate in the program's money management component, which involves designating CHHP as representative payee for their SSI benefits or having their GA checks sent to a CHHP-operated money management account.

Service capabilities

Staffing. Each site is staffed by four to six case managers (4-6 FTE's) and a program director. Case management staff are available weekdays from 8 AM to 11 PM. They are not required to have professional training; rather, experiential background with a similar client population is valued. Case managers are selected for their ability to feel comfortable with mentally disabled, impoverished clients and develop rapport with them. On-the-job training for new staff is provided in the form of direction from the professionally trained program directors, guidance from more experienced case managers, and monthly in-service workshops on de-escalation techniques, Social Security benefits, medication management, and other topics. Each case manager carries an average caseload of 10 clients.

The staff is not unionized and does not, at the present time, utilize volunteer support.

Service content. The backbone of the service program at CHHP is money management, in which case managers maintain accounts for residents' SSI or GA checks, make rental payments to the landlord corporation on behalf of residents, disburse small amounts of cash each day to clients, and help tenants work out payment schedules for their living expenses and debts. In addition, case managers help clients access advocacy and legal resources, and link them up with mental health and AIDS case management when needed. They conduct groups five times a week and arrange social and recreational activities for residents, with the goal of increasing clients' socialization.

The CHHP staff is supplemented by consultants and trainers who work with residents to build a sense of community and cohesiveness, to break down the barriers of social isolation, and to help residents communicate with each other.. This is attempted through planned social activities, outings, and weekly community meetings. These meetings may address problems such as a tenant's continuing disruptive behavior or disagreements about program rules, which must be negotiated with staff. Tenants are encouraged to learn how to resolve disputes between themselves without excessive intervention by staff.

Crisis intervention capabilities. CHHP expects residents to be able to function well enough in the community to get by without 24-hour services and to not have repeated crisis episodes. Consequently, the program does not provide back-up staff outside of regular (8 AM - 11 PM) hours when case managers are available on-site, and staff do not have "5150" powers. However, residents do undergo crises from time to time. When a resident has a crisis outside of regular on-site staff hours, staff may call the police to place the resident on a 72-hour hold; at other times, they may contact the person's therapist or county case manager to intervene. CHHP obtains blanket consent from each resident to provide information to these third parties at the time she or he enters the program.

Sometimes a crisis results in a resident's re-entry into a psychiatric facility or a residential alcohol or drug program. In these cases, CHHP can hold the vacated room until the end of the month, when the next month's rent is due.

Follow-up services. Clients who leave the hotel for are eligible for continued case management services for up to 90 days.

Program compliance requirements

Since CHHP controls receipt and disbursement of residents' SSI and GA benefits, they are effectively compelled to comply with the program's money management requirements during their tenancy. Although the "program acceptance agreement" incorporated into the lease stipulates that the program "promotes abstinence from alcohol and illegal substances for all residents," an alcohol abstinence policy (particularly regarding alcohol use by tenants in the privacy of their rooms) is difficult to enforce. Program staff believe that, despite this provision of the lease attachment, it may be legally unenforceable.

Grievance procedure

CHHP maintains a written grievance procedure to address issues related to services; this is separate from the procedure used by the landlord corporation to resolve complaints related to property management practices. Residents are to first notify their case manager about the problem; if the resident is not satisfied with the resolution, she or he may appeal to the program director and then to the program's Associate Director. As a contract agency of the county mental health system, residents are entitled to advocacy services through the county's designated patients' rights advocate at any time before or after they have exhausted the internal process.

Services financing and costs

The CHHP receives its funding through a renewable yearly contract with the San Francisco Division of Mental Health and Substance Abuse. The annual budget for the CHHP is $1,000,000; of which $615,000 goes to salary and benefits for the case management staff, program directors at the three sites, and the associate director. The balance is for service program operating costs, including insurance, administrative overhead, courier services for client check delivery, furniture and equipment, utilities, and maintenance for program offices.

Client participation

Limited client participation takes place in several ways. Although there is no client representation on the Board of Directors of the CHHP, residents take part in a clients' advisory group to the Board. Residents make decisions about day-to-day programming--for example, about what activities are to be planned--and can participate on hiring panels. CHHP does not conduct outreach efforts to hire staff who have experienced mental illness, substance abuse, or homelessness.

ERNA P. HARRIS COURT
Berkeley

This recently opened project at the site of the former Bel-Air Motel on University Avenue includes 35 units for formerly homeless people and others with low incomes, including those with mental disabilities. Apartments are available for single persons and families of up to three people. Housing ownership, property management, and support services are conducted by separate organizations, requiring a high degree of coordination and mutual recognition of role boundaries. The neighborhood is involved in oversight of program operations, with local residents and merchants participating on a Neighborhood Advisory Board. The project has of necessity been involved in establishing and maintaining "good neighbor" relations with local residents and merchants to mitigate the local antagonism that marked its early phases of development.

The service provider, Berkeley Oakland Support Services, is a major regional provider of homeless services, including a continuum of emergency shelter and transitional living facilities, a rich in-house array of case management and other support services, and experience in providing support services at the UA Homes, a nearby SRO that is home to a number of formerly homeless people with substance abuse problems and mental disabilities. Ecumenical Association for Housing, the property manager, is an experienced regional developer and property manager for an assortment of low-income housing projects, including those tailored to the needs of homeless, disabled, and elderly residents.

Financing

The project was developed by the non-profit Resources for Community Development (RCD), using the McKinney Act's Section 8 Moderate Rehabilitation SRO program to acquire and rehabilitate the run-down Bel-Air Motel that occupied the University Avenue site, and to ensure that units could be offered at well below market rate. The financing package also included loans from the City's Housing Trust Fund, the California Housing Rehabilitation Program, the non-profit Low Income Housing Fund, and a private loan through CCRC.

Property management is funded through the income stream from rental payments, and services are largely funded through the Supportive Housing Program of the McKinney Act. The latter is discussed in more detail below.

Site and neighborhood characteristics

The two-story project features twenty-five SRO-type units and ten one-bedroom apartments; one of the latter is occupied by the resident manager. The SRO units, all occupied by single adults, vary considerably in size; each is furnished with a kitchenette (microwave and refrigerator) and bathroom. Five of the units are adaptable to the needs of persons with physical disabilities. The one-bedroom apartments feature fully equipped kitchens. Although these units are available to families, at present all are occupied by single persons.

The units are arrayed around a central courtyard and parking lot, reflecting the building's previous use as a motel. There are a number of areas for common use, including a 640-square-foot "community space" with a TV room, reading room, a large kitchen equipped with food lockers, and a laundry facility.

Neighborhood amenities such as a supermarket, banks, and restaurants are within a few blocks of the project. The project is in a mixed residential/commercial neighborhood that does not feature a concentration of social services and special-needs housing, although mental health services and other social services can by reached by a short bus ride. The area is targeted for a substantial revitalization effort aimed at upgrading the housing stock and enhancing commercial activity, among other objectives.

Tenant financial eligibility and rental obligations

All tenants must have incomes at or below 50% of the area median, as determined by HUD. The SRO units are subsidized through project-based Section 8 certificates, with tenants contributing 30% of their adjusted gross income for rent. The one-bedroom units are offered below market rate ($468, including utilities), but the contract rent is not supplemented by a cash subsidy; residents have a minimum annual income (in 1995) of $12,480. This is the income level at which the monthly rental does not exceed 45% of monthly income. New tenants must pay a refundable security deposit equal to the portion of the rent for which the tenant is liable--that is, the total rent amount minus any subsidy the tenant might receive. Tenants are allowed to pay this amount in installments.

The Berkeley Housing Authority maintains a waiting list of applicants for the SRO units, certifies that applicants meet the very low income criteria, and ascertains that they are homeless. The next step of the tenant selection process is done jointly by the property manager and service coordinator.

Property management

Ecumenical Association for Housing (EAH.) provides management for the property; staff for the project include a resident manager, a part-time maintenance person, and two on-call relief staff. Property management is responsible for rent collection, maintenance and repairs, and unit inspections as needed. Until recently, the resident manager was available 40 hours a week, but these hours have been curtailed to 25 hours per week.

Occupancy in the project began in July 1995, and is currently at 95% capacity with very little turnover.

Tenant selection

. Although property management and service roles are organizationally and functionally distinct at Erna P. Harris, the property manager and on-site BOSS services supervisor collaborate in tenant selection, which involves several steps. The cooperative effort began when the waiting list of prospective tenants was first compiled; also, at this time, the project began to convene the Neighborhood Advisory Board made up of representatives from the local merchants' and neighborhood associations. Although the Board was informed of tenant selection procedures as well as other aspects of the project's management plan, it did not have a role in selecting tenants.

Initial tenant outreach and screening for tenants for the Section 8 SRO units was done by the Berkeley Housing Authority (BHA). Announcements were posted at local homeless agencies; interested people were directed to BHA, where they were screened for financial eligibility and homeless status and given the phone number for EAH, which would then direct them to a number of homeless agencies where they could pick up application forms. These forms, which applicants completed and returned to EAH, were checked for information about recent rental histories and criminal histories. EAH initially rejected applicants who reported histories of convictions for violent felonies or unlawful detainer judgments. Poor credit history was not a basis for exclusion since this may reflect an applicant's poverty, disability, or past substance abuse problems. As noted below, EAH was more concerned with applicants' honesty in admitting such experiences.

EAH notified those who were accepted of their eligible status. BHA maintained the waiting list of all Section 8 applicants, including those who passed the first round of EAH screening.

The next step in tenant selection was a joint interview of each eligible applicant at the project by the on-site property manager and service coordinator. At the on-site screening interview, each applicant was asked a series of open-ended questions about, among other things, how they would resolve conflicts with their neighbors, whether they have had trouble paying rent, and how they could make the project a

more comfortable and harmonious place to live. Their responses were rated by the interviewers, who also made an assessment of the applicant's readiness to live independently. (Applicants are now also given the chance to explain why they may have experienced felony convictions, evictions, or other "red flag" incidents.) The on-site property manager and service coordinator each would submit recommendations on acceptance or rejection to EAH administration, which conducted a check for criminal history and negative rental history information, and made the final decision about whether to accept an applicant. (Currently, when the background check reveals that applicants have lied about such experiences, they are rejected. Honesty is used a screen-in criterion)

This screen-in and application process continues at present, with the service coordinator and on-site property manager having an advisory rather than determinative role in tenant selection. Although the BHA is not involved in outreach and eligibility screening for applicants for the one-bedroom apartments, prospective tenants for these units also undergo a joint interview with the on-site property manager and service coordinator and are accepted or rejected according to the same criteria..

The high degree of coordination between provider agencies, the property manager, the service provider, and Housing Authority was developed in the context of an environment of neighborhood suspicion and hostility that marked the project's planning and development phases.

Lease stipulations and enforcement

Tenants must sign an agreement to abide by the rules and regulations of the Erna P. Harris Court; this is incorporated into the initial year-long lease agreement. (After a year, tenants pay rent month-to-month.) The rules and regulations cover standard lease provisions such as fees for late rental payment, responsibility for damage to the apartment, disposal of trash, permission required before alteration to a unit; and use of the laundry room and other common spaces. Service compliance is not a provision of this agreement.

Like other managers of rental properties for people who have been homeless, mentally disabled, or have had problems with substance abuse, EAH has had to be flexible in enforcing lease provisions. Although leases at Erna P. Harris stipulate that rent is due on the first of the month, some latitude is allowed for clients who inform property management that their rental payment will be late. Even tenants who are served with a three-day notice to vacate the premises for non-payment are allowed to negotiate with the property manager in certain cases, such as when an SSI check has been stolen or misdelivered. Late payment, however, has not been an ongoing problem for the majority of tenants.

If a resident becomes rowdy, abusive, or threatening to other residents, the on-site property manager may intervene. The property manager, who has received training in crisis management, may point out to the resident that this type of behavior is unacceptable and suggest that both of them meet with the service coordinator to deal with whatever problem is agitating the resident. Reportedly, in the vast majority of cases, this is effective in calming a resident down.

However, the property manager tries to avoid discussing these types of interactions with the service coordinator. Although arguably both property management and service coordination could be done most efficiently through sharing this kind of information, EAH is concerned that disclosure of such information by the property manager *without the permission of the resident involved* could be considered an invasion of privacy. Similarly, although the service coordinator is obligated to report evidence of illegal activity on the premises to the property manager, he does not divulge service information on any resident to the manager absent the resident's consent. It should be noted that this type of mutual recognition of role boundaries and resident confidentiality functions despite the fact that EAH and BOSS do not maintain a written memorandum of understanding delineating their respective responsibilities and confidentiality policies.

Service program

Target population

The project's target population includes, but is not restricted to, homeless persons with mental disabilities. The program emphasis on housing homeless people reflects the City's priorities as well as a requirement of the federal funding sources. All tenants must be "very low income" according to HUD criteria. The priority clientele for the on-site support services are residents of the project's SRO units.

At present, 40% of Erna P. Harris Court tenants receive SSI for mental disability; most of the rest get General Assistance, and a few receive Veteran's Assistance or employment income. A number of tenants, including those with mental disabilities, have concurrent problems with substance abuse.

Assessment and intake

Recruitment and tenant selection procedures have been described in detail above. The services supervisor provides each new tenant with a three-page handout that asks about personal information, self-identified support service needs, medical needs, and the resident's views on community living and contributing to the social environment at the project. This information is used to determine what support services may best meet the resident's needs; the information is confidential and is not divulged to property management or other non-service staff. However, *aggregate* information on referrals provided by the services coordinator are reported to the property owner, RCD.

Service capabilities

Staffing and service content. The program offers a mix of on-site and off-site services provided by BOSS. A services coordinator (1 FTE) is on-site 40 hours per week, including nights and on weekends. He provides a range of direct services as well as information and referrals to BOSS components at other sites and third-party agencies. As a specialist. in employment readiness counseling, he offers residents assistance both individually and through workshops in resume preparation, job search techniques, interview skills, and other preparation for work. His other responsibilities include crisis intervention, assistance with financial planning and money management, and helping residents organize social activities. Beyond these direct service and support responsibilities, he maintains "good neighbor" relations with local merchants and residents, and acts as a the liaison between the project and the Neighborhood Advisory Board. The services coordinator emphasizes that he does not provide case management services and that residents are not required to participate in a formal "service plan."

Other BOSS components that also serve clients who are not residents of Erna P. Harris bring their services on-site. The Community Organizing Team, conducts trainings in advocacy and teaches residents participatory skills and community organizing techniques. BOSS's Adult Education project has done on-site assessments of residents' literacy levels. Some on-site services are peer-run: residents with substance abuse problems participate in self-help support groups to achieve and maintain recovery.

Residents are referred to other BOSS components off-site and to third-party agencies for benefits advocacy, payeeships, adult education classes, mental health case management, and family and health counseling.

Qualifications for the service coordinator position include experience in case management and community-building. Professional license or educational experience is not a necessity. At present, the program does not utilize volunteer assistance on-site.

The on-site service coordinator is not available to residents who leave the project, although they can continue to be served by other BOSS components.

Crisis intervention capabilities. The service coordinator's approach to handling crisis is to attempt to "de-fuse" the critical situation. He relies on professional help, including Berkeley Mental Health's Mobile Crisis Team, for back-up. If a resident undergoes crisis while the service coordinator is off-duty, the resident manager calls the Mobile Crisis Team and is at times able to reach the service coordinator by beeper. In less severe crises, the property manager may be able to calm down an agitated resident without assistance from others.

Service financing and costs

The Supportive Housing Program of the McKinney Act supports the salary and benefits of the service coordinator (1 FTE). Start-up costs for the service coordinator's on-site office was provided by a $12,000 grant provided through RCD by the East Bay Housing Organization. No funds are allocated in the services budget to support recreational or social activities.

Grievance procedures

EAH maintains its own internal grievance procedure to address tenant complains. A resident with complaints about property management issues may first try to resolve them by speaking with the on-site property manager. If the matter is not solved to the resident's satisfaction, she/he may discuss the issue with the off-site property supervisor (who manages several properties in the region); the next step, if the resident is not satisfied, is the director of property management.

BOSS does not provide a formal grievance process, but residents with complaints about service issues can take recourse to the chain of command within BOSS, up to and including the Board of Directors if matters are not resolved by speaking to staff at lower levels or with the executive director. At the Erna P. Harris site, residents can submit anonymous suggestions or complaints through to the "suggestion box" located in the Community Room.

Client participation

Representatives of Berkeley's homeless and mentally disabled population did not participate in the design or development of the project, and residents do not take part in the management of the property. Although residents do not at present participate in any phase of on-site service delivery at Erna P. Harris, a significant number of BOSS staff employed at its other programs are former clients or have had experiences with homelessness, substance abuses, or mental disability, and former clients are represented on the BOSS Board of Directors. The organizational culture of BOSS appears to be receptive to having Erna P. Harris residents participate as volunteers and paid staff at its various service components, if they so desire.

RUBICON PROGRAMS, INC.
Richmond

Rubicon is a long-standing Richmond agency serving impoverished people, including those who are homeless or have chronic mental disabilities. It provides centralized case management and other social services to clients in a continuum of residential settings. Its permanent housing includes scattered apartment complexes, with some residents living singly, while others share units as roommates. At some projects, case management and counseling are provided on-site; at others, these services are available off-site. One project can accommodate permanent housing for families with mentally disabled members, which is unusual in services-linked housing programs. Some projects are dedicated to a mentally disabled, homeless clientele, while others serve a more varied low-income client base.

Like other established mental health service providers who operate a continuum of housing programs, Rubicon benefits from economies of scale; it is able to offer a wide variety of "in-house" social services, including a vocational component, to its permanent housing residents as well as its other program participants. Its projects are funded by a variety of HUD grants, from the old Section 202 grants to the more current McKinney programs. It represents a horizontally integrated model in which development, ownership, property management, and service delivery for all projects are provided within the same agency.

Projects differ in their development financing, eligibility criteria, residence models, availability of on-site case management services, recruitment and intake procedures, and services financing. They share the same rules established by property management, availability of off-site program services, and off-site agency staff.

Project Sites

Rubicon Homes, whose construction was funded by a HUD Section 202 grant, is a 10-unit building housing mentally disabled people, including seniors and persons with physical disabilities. Families as well as single people reside at this site. Except for some on-site independent living skills classes, support services are not provided on-site.

The **Virginia Street project** is also owned by Rubicon; it houses only persons with mental disabilities, with most of its eight units housing two unrelated individuals per apartment. Acquisition was financed by a state Special Housing Rehabilitation Project, with occupancy commencing in 1985. Cash subsidies for tenants are not provided, but affordability for SSI recipients is ensured by the low rents (currently $175-$178 per person). The double occupancy reflects the then-common practice of placing mentally disabled individuals in shared living situations. A counselor provides varied on-site services at this site and at a neighboring project also administered by Rubicon.

This neighboring building, the **West Richmond,** is the newest of the three. Acquisition, rehabilitation, and services for this project, which opened in 1994, have been funded by a McKinney Permanent Housing for the Handicapped (PHH) grant, supplemented by City of Richmond CDBG monies. The building provides four units for single mentally disabled homeless persons.

The project sites are in low-income, predominantly residential neighborhoods with a mix of multi-family and single-family housing. These areas do not host a concentration of special-needs housing and social services, but are close to neighborhood amenities such as recreation centers, banks, and stores. Rubicon considered closeness to these resources rather than to services to be a more important consideration in siting these projects.

One project in the pipeline will be funded by the Section 8 SRO Moderate Rehabilitation and Supportive Housing Programs, and will provide permanent supportive housing for 29 homeless people

who have mental disabilities or AIDS, or who are veterans. Housing costs for the residents will be subsidized for 10 years.

Service program

Target population

Although Rubicon originally aimed its services to persons with mental disabilities, the scope of agency operations has expanded to serve people who are very poor and, in many cases, chronically unemployed, physically disabled, or homeless. Mentally disabled people are one subset of the client base served by Rubicon. In the McKinney-funded projects, eligibility is restricted to those mentally disabled individuals who are homeless, per HUD guidelines.

Recruitment, intake, and assessment

Because the projects are intended to house different sub-populations of mentally disabled people, their referral sources and intake processes differ. Sec. 202 tenants are referred primarily through mental health service providers, including day treatment programs, transitional housing programs, the County case management system, and acute care facilities. Homelessness is not a criterion for entry into the Sec. 202 project, so applicants can transfer in from long-term residential settings.

Referrals for the Virginia Street projects are made by other social service agencies, the County case manager, and "walk-ins." Few referrals are made directly by shelters, although a number of residents in these projects were living in shelters just before entry into the program. A smaller number have lived outdoors or in cars before entering the program. Rubicon employs an outreach worker to engage homeless people in a variety of its support services as well as its supportive housing programs.

The agency tries to resolve the competing goals of serving people with severe mental disabilities and not concentrating people with very limited independent living skills in its housing programs. Some homeless applicants are not yet involved in either service programs or the relative stability of a shelter. They do not bring with them a documented "track record" of having the independent living skills necessary for staying in permanent supportive housing. Because of this, and because there are usually waiting lists for all projects, Rubicon tries to engage homeless clients interested in long-term housing in its other services while they wait for a vacancy to open up. These other service may include counseling, case management, money management, or substance abuse recovery groups. To address clients' immediate shelter needs, Rubicon tries to help clients find temporary lodgings in shelters or transitional programs. By getting homeless clients involved in services, Rubicon case managers have the opportunity to assess each client's ability to live independently and live peaceably with neighbors or roommates, and to determine what kinds of supports they would need to stay housed. Thus, staff may conduct for weeks or months the type of assessment that some other services-linked housing programs try to accomplish in a single screening interview.

When vacancies occur, applicants can go through an interview with the property manager within a week. By the time space in a permanent housing project becomes available, some clients have become settled in other housing accommodations, such as long-term transitional housing, with the help of Rubicon staff.

Service capabilities

Service content and staffing. The majority of Rubicon's services are provided off-site, at other non-residential program components. The one FTE on-site service provider is a counselor who serves the four residents of the West Richmond project in addition to the 20 residents of the neighboring Virginia Street projects during daytime hours on weekdays, and occasionally on weekends or evenings. The counselor but does not reside at the site. In addition, a MFCC serves as case manager for the residents,

working with them on developing services plans; connecting them with other service components within Rubicon and in external agencies; maintaining progress notes; and providing support.

Other services provided on-site include staff-led "recovery" groups for residents with substance abuse problems and additional support that residents may need from time to time. Services provided "in-house" but away from the supported housing sites include money management; independent living skills classes in topic such as nutrition, budgeting, shopping, cooking, and managing leisure time; job development and vocational assessment; psychotherapy; medication monitoring; and recovery support groups; and payeeship services. A staff of eight FTEs is available for the 100-200 clients Rubicon serves in addition to its supportive housing residents.

Residents whose mental disabilities meet County-defined standards of severity may be enrolled in the County's case management plan. Rubicon develops a "coordination plan" for each of these residents, specifying plans to achieve "milestones" which may involve service issues such as talking to one's counselor or medication compliance, or personal goals such as going back to school, getting a job, or mending broken family relationships. Counselors help clients identify barriers to achievement of these goals and determine what services and other resources might help in attaining them. These plans must be approved by the County, reviewed periodically, and revised as needed. In addition to the service goals designated in the County-approved plan, Rubicon staff and residents can negotiate additional goals and services.

Staff training and educational background ranges from a high school diploma to a Master's degree in a human service field. The agency has recruited case management staff from its client base. The staff is not unionized. At present, the agency has not developed a formal volunteer program.

Crisis intervention capabilities. When a resident starts to go into a state of crisis, the on-site counselor reports the situation to the service supervisor, and service staff then meet with the resident at his/her apartment to determine the cause and probable duration of the crisis, for example, whether drugs are involved and the crisis seems likely to pass soon. The staff makes efforts to maintain the resident in her/his home, providing additional on-site support as needed during working hours, encouraging the resident to visit the Rubicon offices for help with medication management and additional support services. The agency does not have 24-hour crisis intervention capabilities, but has not found it necessary to "5150" residents.

If a resident enters the hospital, the apartment can be held for a month or two. The resident is encouraged to pay rent if possible. The agency can absorb occasional non-payment of rent when, in some cases, a resident is unable to pay rent.

Program compliance requirements and follow-up services

The program does not attempt to oust people for noncompliance with their service plans. However, if a resident breaks house rules -- for example, uses drugs or continually disturbs other tenants--these incidents are dealt with as both services and property management issues. The problematic behavior may indicate that the resident could benefit from additional help from service staff in complying with the rules of tenancy.

Residents who leave their permanent housing situations can still get case management and other services through Rubicon. Eligibility for these services attaches to the client, not to the housing programs.

Services financing and costs

The agency provides a considerable range of services in-house, and most service support participants in a range of transitional and non-residential Rubicon programs in addition to its permanent

supportive housing components. The agency estimates that approximately $102,000 of personnel costs are used for providing services to the total of approximately 30 residents in the Rubicon Homes, Virginia Street, and West Richmond projects; this includes costs for a full-time on-site case manager for the latter two This amount does not include operational or indirect costs. Services are supported by federal McKinney funds, county mental health service funds, and the county housing authority.

Client participation

The avenues for integrating client concerns into Rubicon's governance include a consumer representative on the agency's Board of Directors and its Housing Committee. The direct service staff include some former Rubicon clients as well. The agency does not have a formal volunteer program that utilizes client effort and residents of the supportive housing programs do not participate in day-to-day or longer-term program planning.