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Creating Community

Integrating Elderly and Severely Mentally Ill Persons in Public Housing

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Creating Community

Integrating Elderly and Severely Mentally Ill Persons in Public Housing

Prepared for:

U.S. Department of Housing and Urban Development
Office of Policy Development and Research

and

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services

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Finally, we dedicate this report to the residents of public housing for elderly families who are working to create a true sense of community that allows all residents to feel at home.

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Introduction

When I first moved in here, I felt uncomfortable; there were a lot of older people who were friendly with each other but not with me. One day, my caseworker introduced me to some of my neighbors, and one started talking to me about baseball, which I love. Last summer, we even went to a ball game together. It took time, but I think my neighbors have come to accept me.

— Younger public housing resident with severe mental illness

Public housing for elderly families in the United States has changed substantially in recent years. Residents who have lived in these developments since they opened 20 or more years ago have aged and grown frail. Many have died or moved to nursing homes. Over the past few years, new residents have been more likely to include younger persons with disabilities, including severe mental illnesses. This situation has created numerous challenges for both public housing agencies (PHAs) and community mental health providers as they work together to support residents living in public housing and to create a new sense of community in public housing developments.

Background and purpose

This report is jointly sponsored by the U.S. Department of Housing and Urban Development (HUD) and the Center for Mental Health Services of the U.S. Department of Health and Human Services (HHS) as part of their ongoing effort to encourage coordination of housing and services for low-income and homeless families and individuals, including those with severe mental illnesses. The information is designed to help management and staff of PHAs and community mental health agencies seeking ways to effectively integrate younger individuals with mental illnesses into public housing for elderly families.

Together HHS and HUD are developing a model for establishing collaborative agreements between public housing agencies and mental health authorities. The "Blueprint for Cooperative Agreements Between Public Housing Agencies and Local Mental Health Authorities" is intended to outline the respective roles and responsibilities of each agency in the process of coordinating housing and support services for persons with severe mental illnesses.

Although the Blueprint is applicable to all PHAs that house people with severe mental illnesses, cooperative efforts are particularly relevant to PHAs that make use of the provisions of the Housing and

Community Development Act of 1992, signed into law October 29, 1992. This Federal law permits public housing agencies to designate developments, buildings, floors of buildings, or specific numbers of units for elderly persons, persons with disabilities, or elderly and disabled persons. PHAs that want to make such a designation must submit an allocation plan that describes the developments to be designated, including the pool of applicants, the reasons for the designation, and a plan for securing additional resources for those whose housing needs are restricted by this designation.

For designation of a public housing development for occupancy by disabled families, a PHA must submit, in addition to the allocation plan, an application to HUD which describes the developments to be designated, outlines a supportive service plan describing the service needs of those who are expected to occupy the housing, and makes provision for delivery of appropriate supportive services. HUD will issue regulations to implement this provision in the near future.

The information in this report was gathered in early 1992 from PHAs and mental health agencies that have established formal programs to address the challenges inherent in providing services to younger persons with mental illnesses living in public housing for elderly families. Although elderly public housing residents may also have health, mental health, and social service needs that can be addressed by the approaches discussed, the information in this report focuses specifically on the service needs of younger persons with severe mental illnesses. The eight PHAs that form the basis for this report are located in Boston, Massachusetts; La Salle County, Illinois; St. Paul, Minnesota; Danbury, Connecticut; Providence, Rhode Island; Seattle, Washington; Rockford, Illinois; and Toledo, Ohio.

Collaborative efforts

The collaborative efforts between the PHAs and local mental health agencies developed in different ways. In some cases, housing officials approached mental health providers about offering needed services to their residents. Just as often, community mental health providers contacted public housing agencies seeking suitable housing for their clients. Though they start at different ends of the spectrum, they share a common goal—to support individuals by assuring access to housing linked to supportive services that will facilitate their success in living independently. Many of these collaborations led to the development of service-enriched housing not only for younger, disabled residents, but also for frail, elderly residents with health, mental health, and social service needs.

In addition to collaborating with local mental health providers, many of the featured PHAs have also developed working relationships with social service, health, and other agencies, to make a range of services and opportunities available to residents, young and old alike. The PHAs have also been resourceful in using limited staff and budgets to better serve the new mix of residents.

As illustrated by the PHA profiles, meeting the service and support needs of residents in public housing for elderly families requires commitment, planning, cooperation, and innovation. This type of collaboration is particularly important in an era of limited resources, when both housing and service providers must determine what residents need, how existing programs and resources can be adapted to meet their needs, and how to provide the continued support that will make the efforts successful. The result can be a well-functioning, supportive community that meets the needs of both elderly persons and younger, disabled persons.

Public housing agency initiatives. Without exception, each PHA and local mental health agency featured in this report share a commitment to working together. In particular, these PHAs found it helpful to:

- Conduct a comprehensive needs assessment and develop a plan to meet the health, mental health, and social service needs of elderly persons and persons with disabilities.
- Develop funding strategies by exploring available Federal, State, local, and private funding sources and by making innovative use of their own resources in order to serve public housing residents.

- Expand and intensify efforts to reach out to community-based service providers.
- Increase the presence of public housing agency staff in all areas: building management, resident services, security, and maintenance.
- Conduct thorough screening for all applicants based on clear, objective criteria.
- Educate residents to understand and tolerate differences among people, and train staff to work with all residents who have service needs.
- Work to strengthen resident councils to make them active partners in developing a sense of community in public housing.
- Use lease enforcement to help prevent costly and disruptive evictions.
- Make the buildings and grounds attractive and accessible.
- Develop adequate security to promote a sense of personal safety.
- Make a commitment at all levels within the agency to collaborate with local mental health providers.
- Work with local mental health providers to expand the range of housing alternatives and service options for persons with severe mental illnesses.

Mental health agency initiatives. By establishing a close working relationship with their local public housing agency, many mental health providers have been able to redirect limited resources to what they do best—provide mental health treatment and rehabilitation. By responding comprehensively to the needs of persons with severe mental illnesses, the broader mental health community has been more responsive to the mental health needs of all public housing residents. Specifically, mental health providers have acted to:

- Create centralized mental health systems with direct responsibility for all individuals with severe mental illnesses.
- Establish and maintain regular contact with PHA management and line staff.
- Provide services to persons with severe mental illnesses in public housing, including assessment and treatment planning, case management,

Residents of the Providence Housing Authority's Dextor Manor pose for a picture in the community room.

supportive counseling, daily living skills training, service coordination, and crisis intervention.

- Identify and reach out to residents with severe mental illnesses who may be in need of services, but who are not currently engaged in treatment.
- Train public housing agency staff to recognize and respond to mental health problems, and help staff and residents break down stereotypes about mental illness.
- Work with PHAs to expand the range of housing alternatives and service options for persons with severe mental illnesses.

Putting these pieces together is hard work. None of the PHAs and mental health agencies featured in this report has established all of the elements listed above, and each of them struggles on a daily basis to maintain and improve services to residents. In an era of limited resources, it takes the concerted efforts of housing and mental health service providers at all levels to make it work.

Using the report

This report is divided into four sections. The first describes emerging trends, including changes in the makeup of public housing and the delivery of mental health services, that have led to the recent increase in the number of younger, disabled persons living in public housing for elderly families.

The second section discusses the challenges that mixing these populations create, including the need to understand and deal with lifestyle differences, the stigma of mental illness, and the expanded responsibilities of housing agency staff and mental health providers.

The third section describes innovative approaches to meeting these challenges. It presents an overview of the key components of PHA and local mental health agency initiatives designed to help integrate younger persons with mental illnesses into public housing for elderly families. Examples are provided for each component, and more detailed information is contained in the case studies.

The last section features eight case studies of PHAs around the country that have begun to work with community mental health providers to help younger, disabled persons live successfully in public housing for elderly families. The case studies highlight the particular demographic and social factors that presaged the change in public housing populations, the needs created by the new population mix, and some innovative ways the PHAs and local service providers have worked together to meet these needs. A contact person is listed for each case study, so that organizations and individuals can benefit from direct interaction with experienced persons and program sponsors.

A set of materials provided by the case study PHAs that can be used to facilitate some of the approaches is included in the Appendices. While each locality will develop programs based on its particular needs and resources, these materials can be used as a starting point for planning efforts. References for further reading and a list of organizations that can provide additional information are also included at the end of this report.

Emerging Social and Demographic Trends

Emerging Social and Demographic Trends

The Nation's public housing program was established in 1937 to provide affordable housing for low-income families. Public housing is owned, developed, maintained, and operated by approximately 3,100 PHAs nationwide. HUD funds development and modernization costs and provides operating subsidies to the PHAs. Rents, which include utilities, are set by Congress at 30 percent of a family's adjusted annual income.

As of December 1990, elderly families occupied 537,000 public housing units around the country.[1] Many of these units are in developments built in the last 20 to 30 years and designed specifically for elderly families. PHAs also administer the Section 8 Rental Certificate and Rental Voucher programs, which provide rental subsidies to private landlords on behalf of eligible low-income households.[2]

The Federal Government's definition of "elderly" for the purposes of eligibility for public housing has evolved and expanded since 1937. First defined to mean a family, including a single person, age 65 or older (later changed to include persons 62 years and older), the definition was amended in 1959 to include disabled persons over the age of 50. The age requirement for disabled persons was eliminated in 1961. The current regulatory definition of "elderly" is a family whose head, spouse, or sole member is at least 62 years old, or is disabled or handicapped.[3]

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[1] U.S. Department of Housing and Urban Development. *Report to Congress: Housing Mentally Ill Disabled Persons in Public Housing Projects for the Elderly.* Washington, DC: HUD, 1990, p. 4.

[2] While there are a number of other HUD programs for which low-income elderly persons and persons with disabilities may qualify, this document focuses specifically on programs administered by PHAs in public housing for elderly families.

[3] In the public housing field and in this report, the term "elderly" has two sets of meanings. When used in the context of eligibility requirements for public housing, it has the technical meaning described above. When "elderly" is used elsewhere, it refers to persons age 62 or older. In this report, "younger" refers to persons under age 62.

The Housing and Community Development Act of 1992 (Title VI, Section 621) establishes separate definitions for elderly families and disabled families. Some components of those definitions are the same as those currently in use. An elderly family is one whose head, spouse, or sole member is at least 62 years old.

The new definition of a disabled family includes elements of the current definitions of disability and handicap. The separate category of handicapped person has been eliminated. Thus a disabled family is one whose head, spouse, or sole member: (1) has a disability as defined in section 223 of the Social Security Act; (2) is determined, pursuant to regulations issued by the Secretary, to have a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration, substantially impedes his or her ability to live independently, and is of such a nature that the ability could be improved by more suitable housing conditions; or (3) has a developmental disability as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act.

Section 223 of the Social Security Act defines disability as the inability to engage in any substantial, gainful activity by reason of a medically determinable physical or mental impairment that can be expected to last for a continuous period of not less than 12 months or that can be expected to result in death.

A developmental disability is a severe, chronic disability of a person that: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifested before the person attains age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and (5) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

The definition of a person with disabilities does not exclude persons who have the disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for AIDS, as amended in section 504 and section 512 of the Americans with Disabilities Act.

The term "mental impairment" covers several conditions associated with mental disability, including mental illnesses and some classes of head injuries and strokes. Mental illness specifically means a severe and persistent emotional disorder, such as schizophrenia or manic depressive disorder, that interferes with one or more major life activities. These illnesses are distinct from developmental disabilities and disabilities associated with head injury and stroke in terms of their origins, associated disabilities, and treatments.

The signs and symptoms of severe mental illnesses can vary widely, but their disabling effects commonly include long-lasting or recurring difficulty in coping with the tasks of daily living, finding and retaining work and housing, forming and maintaining relationships, and sustaining physical and mental health. Although severe mental disorders tend to be enduring, sometimes for life, they frequently follow a cyclical course.

Persons who have experienced alcoholism or drug addiction qualify for admission to public housing as disabled persons if their experience has created a handicap or disability as defined above. Individuals currently using illegal drugs do not meet the basic screening requirements.

For purposes of this report, the term "public housing developments for elderly families" refers to public housing (defined above) which is occupied predominantly by the elderly (as the result of preferences) or which was developed as non-family units and used primarily by elderly persons (e.g., high-rise developments).

The changing population in public housing

Those who first moved into public housing developments for elderly families were often relatively healthy, active persons in their sixties and seventies, of modest means but able to maintain a comfortable lifestyle. Many developments boasted an active, self-governing resident council that sponsored social and recreational activities.

Until the mid-1980s, public housing for elderly families was filled almost exclusively with elderly residents, and waiting lists were long. In recent years, several factors have reversed this trend, contributing to vacancies in these developments and to a shift in the composition of the current population:

- Many residents who moved into the buildings when they were new are now older and more frail and have moved to settings providing a higher level of on-site care. Those who remain are significantly more disabled and less mobile and often require intensive support services.
- The range of affordable housing options for elderly persons has expanded. These options may offer more amenities or may be located in more desirable neighborhoods.
- Some elderly residents have chosen to move rather than to live in a mixed-age community with younger, disabled persons. Others may decide not to apply. Elderly persons who do enter public housing tend to have lower incomes and to be in greater need of support services than earlier residents.
- More elderly persons are choosing to remain in their own homes as more in-home services become available.
- Increasing numbers of young, disabled persons are applying for and becoming residents of public housing. Many of these individuals have severe mental illnesses. As young people, their lifestyles are often significantly different from those of older residents.

In 1992, a U.S. General Accounting Office (GAO) report estimated that 8 to 10 percent of current residents of public housing developments for elderly families and 51 percent of all new admissions in the past year were disabled persons under age 62.[4] Thus, both elderly and younger persons living in public housing today require a level and range of services not anticipated when the developments were originally built. Neither group is immune to severe mental illnesses and substance abuse problems. In addition, some elderly persons need support to deal with conditions often associated with aging, such as Alzheimer's disease.

Federal legislation and HUD preference rules

Since young persons with mental illnesses became eligible for public housing in 1961, two Federal laws have been enacted that reinforce the right of such individuals to assisted housing. Section 504 of the Rehabilitation Act of 1973 explicitly prohibits discrimination on the basis of handicap in programs receiving Federal support. Section 504 requires that reasonable accommodations be made to enable otherwise qualified disabled persons to reside in assisted housing. This legislation also expanded the definition of handicapped to include persons with a disability resulting from alcoholism or other drug abuse who are not currently using illegal drugs.

The Fair Housing Amendments Act of 1988 expanded Title VIII of the Civil Rights Act of 1968 (known as the Fair Housing Act) to include persons with disabilities and families with children. The Act extends many of the antidiscrimination protections of Section 504 to nearly all private and public housing. It further expands the requirement for reasonable accommodation for persons with disabilities, strengthens HUD's enforcement role, gives individuals greater recourse through the courts, and allows civil penalties in cases of alleged discrimination.

[4] United States General Accounting Office. *Public Housing: Housing Persons with Mental Disabilities with the Elderly*. Gaithersburg, MD: U.S. GAO, 1992, pp. 17, 25.

In 1987, Congress enacted preference rules for assisted housing. Persons who are eligible for assisted housing receive priority if they are: (1) being involuntarily displaced from their current housing, (2) living in substandard housing or are homeless,[5] or (3) paying more than 50 percent of their family income for rent and utilities.

Since the cyclical nature of mental illnesses can make it difficult to retain jobs and housing, many persons with mental illnesses have very low incomes and depend on Supplemental Security Income (SSI) and housing assistance.

Organization and delivery of mental health services

While the population in public housing was aging and vacancies were rising, several factors led to an increase in the number of individuals with severe mental illnesses who required affordable, community-based housing. Services for persons with severe mental illnesses are funded, organized, and delivered through an often complex mix of public and private providers that varies by State. A list of State mental health authorities is included in Appendix A. Readers are encouraged to contact their State mental health authority to learn about the organization and financing of services.

Beginning in the mid-1950s, the locus of care for severely mentally ill persons shifted from State hospitals to the community. Prompted by the development of new medications, changing treatment philosophies, the civil rights movement, and significant new Federal funding for a nationwide network of community mental health centers, the number of patients in State hospitals declined from 560,000 in 1955 to 216,000 in 1974, and to 100,000 in 1989. A related policy of diversion was also begun, whereby the admission or readmission of patients to State hospitals for long-term care was strongly discouraged.

[5] According to HUD preference rules for assisted housing, a homeless family includes any individual or family who is without a fixed, regular, and adequate nighttime residence; or whose primary nighttime residence is a shelter or other temporary living accommodation, an institution (excluding jails or prisons), or a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

In the years following the first major waves of deinstitutionalization, scattered efforts were made to address the housing and support needs of persons with severe mental illnesses living in the community. Most mental health centers tended to focus on clinical treatment, leaving housing and social services to others, often the families of the individuals. No single organization or agency took overall responsibility for the multiple needs of this group.

Persons with severe mental illnesses have difficulty locating and maintaining safe, affordable housing for a number of reasons. In addition to the sometimes debilitating symptoms of the illness itself, they often have an inadequate income, lack social supports, and have alcohol and/or other drug problems. They also face the stigma associated with their illnesses and the fears of potential landlords or neighbors. When housing for low-income persons is scarce, individuals with mental illnesses who lose the housing they have may find it difficult to secure another home.

By the late 1970s, the lack of housing for persons with severe mental illnesses had become a national crisis. Many thousands were living in substandard, inappropriate housing, often with little or no access to mental health care, social supports, or other services. Still others became homeless. In 1992, about 5 percent of the nearly 4 million persons with severe mental illnesses in the United States were estimated to be homeless at any given time.[6] This figure represents approximately one-third of the single, adult homeless population in the country.

In 1978, the National Institute of Mental Health launched the Community Support Program (CSP), which supported the development of comprehensive, community-based systems of care for persons with severe mental illnesses and established a focal point of responsibility for these programs within each State mental health authority. Although this effort was modest in scope and funding, these and

[6] Federal Task Force on Homelessness and Severe Mental Illness. *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness.* Washington, DC: Interagency Council on the Homeless, 1992, p. 18.

other community-based programs have demonstrated that most people with severe mental illnesses can live and work in communities if: (1) they receive ongoing treatment and other support services; (2) their needs for housing, income, and other basic necessities are met; and (3) neighborhood residents are educated to understand the nature of mental illnesses and the legal rights of persons with psychiatric disabilities to live in the community.

In 1986, as part of an omnibus health bill (P.L. 99–660), Congress included a provision requiring States to establish and implement an organized, community-based system of care for persons with severe mental illnesses. The law authorized grants to develop State Mental Health Plans, including case management services to persons with severe mental illnesses who receive substantial amounts of State funds, outreach to homeless persons with severe mental illnesses, and plans to reduce inpatient hospitalization. The law became effective in Fiscal Year 1988 and was amended in 1992 (P.L. 102–321).

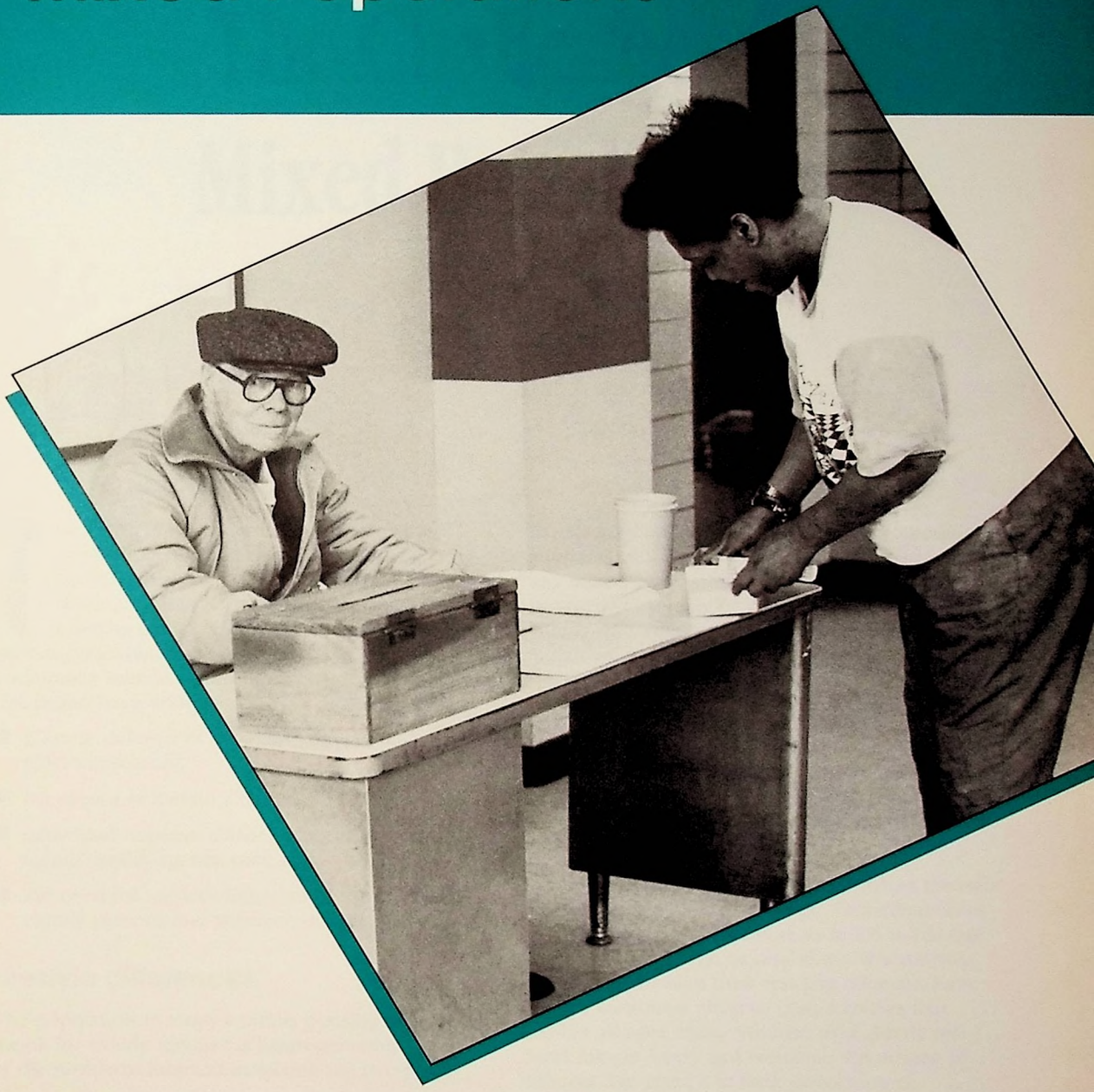
For most communities in the United States, however, service coordination is more an ideal than a reality, and limited resources preclude the provision of mental health services to all who need them. Given the difficulties of trying to secure housing for people with severe mental illnesses, especially in a tight housing market, mental health agencies are beginning to work with local housing developers, nonprofit organizations, and PHAs to create a broader range of housing options. The importance of consumer involvement and the need for individualized and flexible supports, including case management, crisis intervention, and rehabilitation services, have been identified as key principles.

Challenges and opportunities

Together, these social and demographic factors—the aging of residents in public housing and their health and social service needs; an increased number of vacancies, many filled by individuals who require intensive services; the need for safe, affordable housing for persons with severe mental illnesses; and recent Federal legislation and regulatory changes—have combined to create a number of challenges and opportunities for both PHAs and community mental health providers.

To be certain, the challenges are great, particularly in an era of diminished resources. They include the difficulties inherent in housing two age groups with disparate lifestyles; the stigma of mental illness; the need for PHAs and community mental health providers to assume a new set of responsibilities and collaborative efforts; and the necessity of linking services to housing for both elderly persons and younger, disabled persons. These challenges are discussed in more detail in the next section.

The Challenges of Mixed Populations



The Challenges of Mixed Populations

The PHAs profiled here report that as the population mix in public housing for elderly families changes, so too do the character of the developments, the requirements for building management, and the need for service coordination. Together, the PHAs and community mental health providers described in this report have addressed:

- lifestyle differences between younger and elderly residents;
- the stigma of mental illness;
- expanded responsibilities for both PHA and mental health agency staff; and
- the need for services linked to housing for both elderly persons and younger, disabled persons.

Lifestyle differences

The population in today's public housing developments for elderly families is heterogeneous. Some of the problems inherent in mixing the two populations may be little more than normal intergenerational conflicts that would be likely to arise in any mixed-age community. The simple fact of a person's youth may be more disturbing to some elderly residents of public housing than the individual's specific disability.

Different tastes in music, dress, and social and recreational activities may be perceived as roadblocks to successful interaction. Elderly residents may think they have little in common with the younger persons, and some of the younger people may show little interest in becoming involved with their elderly neighbors.

But many of these perceptions fade when the two groups interact on a daily basis. Individual tastes and interests often contribute as much to lifestyle differences as do age or disability. Where PHAs, particularly through their resident councils, have made a conscious effort to plan activities that involve all ages, many younger and elderly residents mingle freely and welcome the mixing of different age groups in their development.

The stigma of mental illness[7]

Many individuals with severe mental illnesses living in public housing for elderly families would not be suspected of having a disability if not for their youth. With appropriate treatment and support services, many people with severe mental illnesses are good tenants. However because symptoms vary, individuals may function better at some times than at others. When severe mental illness is untreated or when symptoms recur, some people may have difficulty coping with everyday life.

For example, severe depression can be so exhausting or overwhelming that some people are unable to cook or otherwise care for themselves or their apartment. Others who suffer from delusions, suspicion, or fear may shun contact with their neighbors; while still other persons with mental illness may be exceptionally friendly but unable to organize their thoughts and plans. Some people may have involuntary repetitive movements or tremors, pace the building at night, mumble to themselves, or exhibit any number of other behaviors that while not dangerous, illegal, or a breach of the lease, may be misunderstood or frightening to other residents.

Rarely, and only when acutely ill, do some people with severe mental illnesses become incoherent and possibly dangerous to themselves and/or others. At such times, inpatient treatment or alternative crisis stabilization services are usually required.

To complicate matters, it is often difficult for other residents and PHA staff to distinguish between behaviors caused by mental illnesses, substance abuse, or such organic problems as head injuries. In addition, some of what appear to be symptoms of severe mental illnesses may in fact be side effects of prescribed medications.

Although stereotypes that label people with mental disabilities as helpless, unable to care for themselves, or dangerous are generally unfounded, they create very real fears for uninformed residents and significant barriers for disabled persons who would like to be accepted in their new homes. These fears and misperceptions are difficult to overcome, and can negatively affect the quality of life in public housing developments. Some elderly residents who previously socialized in the common areas of their buildings may be afraid to leave their apartments, and younger, disabled residents may feel unwelcome.

Despite perceptions, acts of violence are rare. But the potential for unsafe situations increases when large numbers of persons, many of whom have some type of disability, live together with few or no support services. Whether this involves a resident forgetting to turn off a stove or not taking prescribed medications, such problems on the part of any resident must be addressed quickly and equitably to ensure the safety and comfort of all.

When in treatment, and during periods of remission, people with severe mental disorders often achieve or return to high levels of functioning. With stable housing, medication when required, and other support on a regular basis, most persons with severe mental illnesses function well in the community.

Expanded responsibilities

PHA building managers in developments for elderly families have always served as more than landlords. In addition to collecting rents and supervising building maintenance, they organize social events and arrange for support services for residents. While the official job description has changed little over the years, the actual activities have expanded significantly as the population in public housing for elderly families has changed.

Today's managers are likely to spend more time offering support and informal counseling, arranging on-site and off-site services, responding to health and related crises, coordinating building security, working intensively with individual residents to prevent unnecessary eviction, and mediating conflicts between residents.

[7] This section is adapted from portions of *Outcasts on Main Street: Report of the Federal Task Force on Homelessness and Severe Mental Illness* (Ibid).

Many of the PHAs profiled in this report believe that it is no longer sufficient to place one manager in charge of several high-rise developments. They would like to be able to provide a manager for each development, with additional on-site staff, at least part-time and especially in the evenings. At the same time, PHA management is still concerned with the important tasks of meeting HUD regulations and standards, maintaining and upgrading developments, and keeping occupancy rates at levels established by HUD.

To serve persons with severe mental illnesses and other residents of public housing, some local mental health agencies have begun to educate PHAs about the services they can offer. In addition to the services they provide to their clients who live in public housing—including treatment planning, case management, and crisis intervention—mental health agencies have made themselves available to provide assessment and referral for other residents of public housing, particularly those with severe mental illnesses who may not be receiving treatment.

Mental health providers have also taken an active role in training PHA staff and in helping staff and public housing residents break down stereotypes about mental illnesses. Together with PHA management and staff, mental health providers are working to find creative ways to expand the range of housing and service options for persons with severe mental illnesses in their communities.

Mental health service linkages

PHAs recognize that their developments for elderly families have an increasing number of residents, both young and old, with long-term health, mental health, substance abuse, and other problems. Most are eager to assist their residents in gaining access to appropriate services, recognizing that such support can help people live successfully in public housing.

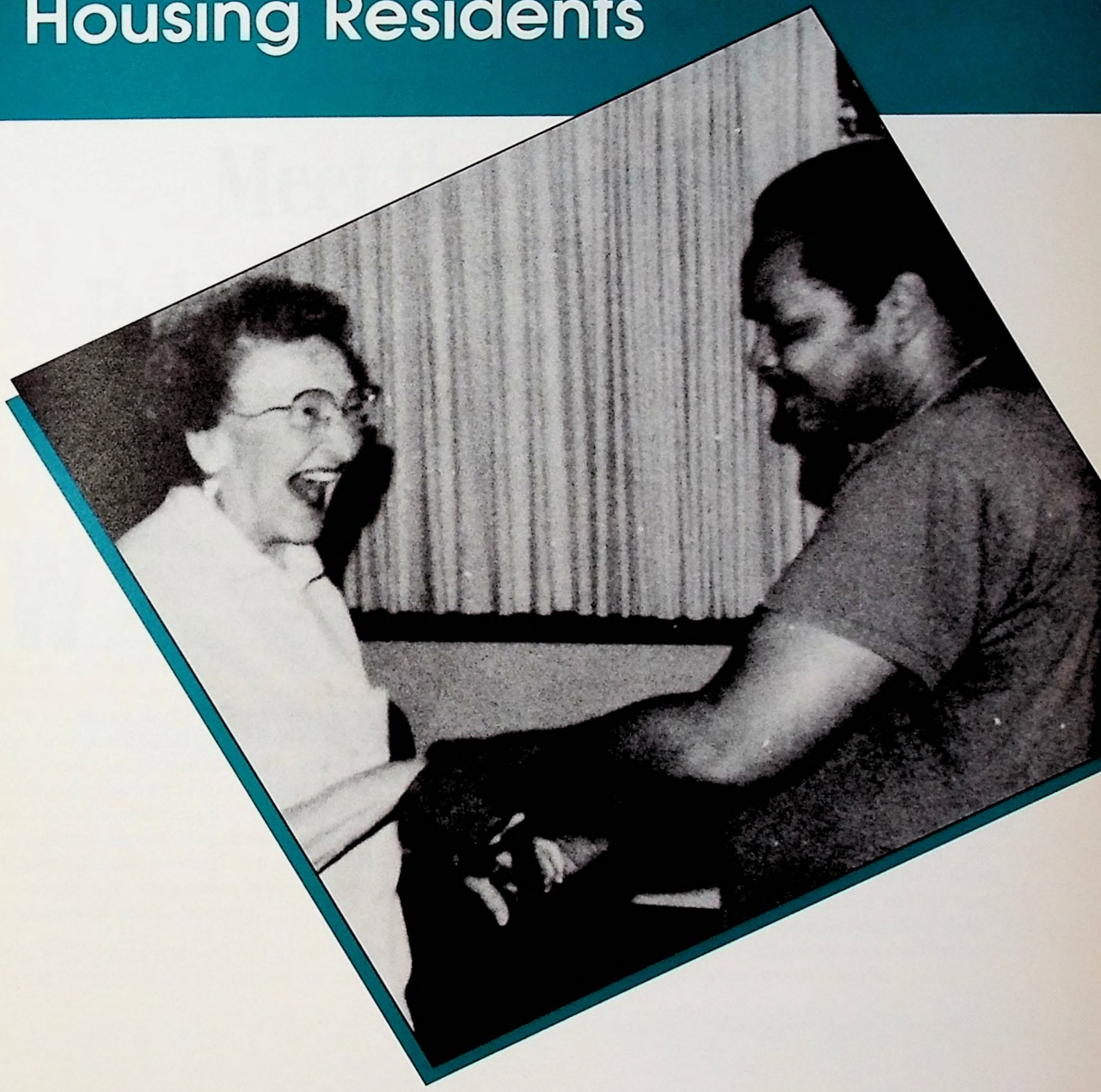
While HUD funding for social service programs is limited, HUD strongly encourages coordination with mental health, social, health, and other services that may be available in the community. PHA administrators who seek to plan comprehensive services for their residents should negotiate with community-based organizations, approach local and State governments with a variety of proposals, and develop cooperative agreements. The ability to engage in planning and a knowledge of local service systems are vitally important.

New opportunities

These challenges, and others that may arise, are difficult but not insurmountable. To meet them, it is necessary to identify the problems, understand the root causes, be willing to introduce changes, and have access to appropriate and sufficient resources. Solutions can be as simple as a resident education program that stresses the importance of accepting differences and respecting one's neighbors. Or they may involve complex agreements among diverse service agencies, each with its own funding sources, management procedures, and treatment philosophies.

While PHAs will develop individual programs based on the particular needs of the residents and the availability of local resources, some of the innovative efforts undertaken by the PHAs profiled in this report may guide others along the way. Key components of their efforts are highlighted in the next section.

Working Together to Meet the Needs of Public Housing Residents



Working Together to Meet the Needs of Public Housing Residents

Working together, PHAs and local mental health agencies across the United States have developed innovative, cooperative efforts to facilitate the integration of persons who have severe mental illnesses into public housing for elderly families. To do this, PHAs use their own staff and resources and also reach out to the larger community to provide the best possible mix of housing and services to residents. Local mental health agencies provide the necessary support to their clients in public housing and make assessment and referral services available to other residents. Together, the PHAs and mental health agencies profiled in this report have worked to create safe, supportive living environments for residents of public housing.

The eight PHAs featured in Figure 1 (page 22) have made special efforts to address the new challenges of mixed populations in public housing for elderly families. Clearly, many of the approaches highlighted in this section cannot be undertaken without the resourceful use of limited funds and/or successful competition for additional resources. This report shows how it can be done.

None of these PHAs claims to have found the ideal approach for housing elderly individuals and younger persons with severe mental illnesses together. Most were quite willing to admit shortcomings and areas for improvement. Moreover, each has had to contend with a range and intensity of needs that far surpass available resources. All the PHAs profiled share a commitment to collaborate with community-based agencies, to negotiate solutions, and to try new approaches. And they have all experienced a degree of success that makes their approaches worth sharing.

Making Support Services Available

To address the increasing health, mental health, and social service needs of both elderly persons and younger, disabled persons in public housing, the PHAs profiled emphasize the importance of arranging for or offering basic support services to all residents. These services usually include:

- assessment of service needs,
- crisis intervention,
- information and referral to community-based agencies that provide specific services, and
- followup to be sure that services were received and residents' needs met.

Any service agency that works with special needs populations, including health, mental health, aging, or other social service organizations, can provide such basic assistance to residents of public housing. PHAs have made arrangements with a wide variety

Figure 1. Overview of Case Study Public Housing Agencies[1]

Location of PHAs Visited	City/County Population (1990)	Federally Subsidized Public Housing Developments for Elderly Families				
		Number of Units	Number of Developments	Size of Developments (# of units)	% Current Residents Under Age 62	% Applicants on Waiting List Under Age 62
Boston, MA	574,283	3,697	35	40–299	20%	40%
La Salle County, IL	106,913	605	9	14–170	33%	55%
St. Paul, MN	272,235	2,620	16	72–231	30%	46%
Danbury, CT	65,585	400	5	50–100	5%	10%
Providence, RI	160,728	1,141	7	24–291	42%	62%
Seattle, WA	516,259	3,000	30	59–300	51%	79%
Rockford, IL	139,426	1,000	5	151–418	30%	80%
Toledo, OH	332,943	1,100	12	14–164	30%	50%

[1] Information provided by individual PHAs in January 1992.

of such agencies or hired staff directly to provide basic support services.

The housing agency in Seattle contracts with Community Home Health Care to offer basic support services. Although the nonprofit agency usually serves only elderly persons, the agency agreed to make its services available to all residents of Seattle's public housing for elderly families. Services include outreach and assessment, information and referral, crisis intervention, education, and recreational activities.

In Providence, the housing agency was awarded a grant from the State Department of Elderly Affairs to hire three social workers. A social worker visits each new resident, regardless of age, to conduct an initial screening and needs assessment and to develop short- and long-term goals. Social workers link residents with community-based services, are available for crisis intervention, and help arrange social and recreational activities.

In addition to offering basic support services, each PHA featured has taken steps to make additional supports and linkage to mental health treatment services available to persons with severe mental illnesses. Mental health treatment and the coordination of additional support services are usually provided or arranged by a case manager from a local mental health service agency. Appendix B contains sample agreements between three of the PHAs featured in this report and their local mental health agencies. Ideally, the full range of community-based mental health treatment and rehabilitative services for persons with severe mental illnesses includes:

- assertive outreach,
- medication management,
- counseling and supportive therapy,
- hospitalization and inpatient care,
- 24-hour crisis-response services, and
- habilitation and social skills training.[8]

Case managers also are responsible for coordinating other essential elements of an integrated system of care for persons with severe mental illnesses, such as housing; alcohol and/or other drug abuse treatment; health care; income support and benefits; rehabilitation, vocational training, and employment assistance; consumer and family involvement; and legal protections. The intensity and duration of services is usually agreed upon by the mental health consumer and provider and lasts as long as an individual needs or requests the service.

In Danbury, residential counselors hired by the Mental Health Association provide intensive case management to MHA clients living in public housing for elderly families. Each counselor has a caseload of about seven clients. Intensive support services include making daily visits when necessary, teaching basic living skills, helping clients obtain entitlements, linking them with other health and social services, and providing followup. The MHA staff are also available for 24-hour crisis intervention.

The housing agency in Rockford developed an agreement with a local nonprofit mental health provider to offer 24-hour supervision, case management, and crisis intervention to residents of public housing with severe mental illnesses who have left nursing homes and psychiatric hospitals. Under the Illinois Community Integrated Living Arrangements (CILA) program, the mental health agency provides comprehensive support services including skills training, medication monitoring, and referrals to such community-based services as vocational training and substance abuse treatment. Case managers provide information and referral to other residents on a limited basis.

The specific arrangements for the delivery of support services will vary by site, depending on the housing and support service network in each locality. Often a service agency is willing to provide support services to some or all residents of a development at no cost to the PHA when a significant number of residents are already receiving or are in need of (and eligible for) their services.

[8] Ibid., p. 43.

In some cases PHAs, often with the active support and participation of a service agency, seek out new resources via public or private grants to pay for increased services.

In Toledo, the Lucas Metropolitan Housing Authority works closely with the Lucas County Mental Health Board and two of its local mental health centers to offer basic support services to all public housing residents and more intensive services to persons with severe mental illnesses. Case managers are on-site 18 hours each day to provide intensive case management, treatment planning, skill building, and crisis intervention to mental health center clients. Because a number of mental health center clients reside in public housing, on-site services to these and other residents can be made available at no direct cost to the housing agency. The housing agency provides in-kind office space for the case management staff.

Sometimes a single community agency takes responsibility for coordinating care for all residents in a specific development or geographic area corresponding with the agency's service area. In other PHAs, two or more service providers may share this responsibility.

The local mental health center in La Salle County provides both intensive case management to participants of the housing agency's Residential Rehabilitation Program and basic information and referral services to public housing residents, young and old alike. Case managers monitor clients' progress and facilitate group and individual therapy. Other residents who request services are linked to appropriate community agencies, including the mental health center.

In St. Paul, the Safe Alternatives program provides intensive case management for its clients with severe mental illnesses living in public housing for elderly families. To meet the needs of residents not served by this program, the housing agency and a local nonprofit service agency created the Services to Assist Residents (STAR) program. STAR provides all residents with information and referral, health education, and linkage to other community services.

Services can be delivered to residents by arranging for home visits by social service staff, transporting residents to local service providers, or offering services on-site. When service providers are located on-site, the housing agency may provide office space, furniture, and other in-kind services for the use of the service agency staff. When space is not available or when the service agency does not have staff available to remain on-site, the service agency may arrange regularly scheduled visits, and the PHA may provide community space or a vacant office for occasional use by providers and residents.

Some PHAs have agreements with mental health service agencies to set aside a specific number of units for residents who need mental health treatment and coordination of additional support services in order to benefit from the housing. By prior arrangement with a local mental health agency, these residents receive treatment and services tailored to their individual needs and preferences.

As part of an agreement with the Stepping Stones mental health program, the Rockford Public Housing Agency has set aside three units in one of its high-rise developments for office space and apartments for live-in staff and 17 units for the clients of the Stepping Stones program. The mental health agency provides intensive on-site case management, skills training, recreational activities, and crisis intervention to all Stepping Stones clients, as well as information and referral to other residents.

The Housing Agency of the City of St. Paul has had an agreement since 1987 with Safe Alternatives, a long-term housing support program for adults with severe mental illnesses. The housing agency designated 10 units in 1 building for program clients. Safe Alternatives furnishes the units and provides client advocacy, case management, financial assistance, and 24-hour crisis intervention.

In 1991, the Boston Housing Authority entered into an agreement with the Massachusetts Department of Mental Health to set aside 25 studio or 1-bedroom units—5 in each of 5 public housing high-rises for elderly families—to house formerly homeless men and women with severe mental illnesses. A local

mental health center provides intensive case management; individual and group therapy; and skills training, including housekeeping and money management. Both agencies have been so satisfied with the collaboration that the housing agency is planning to make 32 additional units available.

The remainder of this section examines the specific steps that the PHAs and local mental health service agencies featured in this report have taken to address the challenge of effectively serving younger, disabled persons in public housing for elderly families.

Residents of the Housing Authority of La Salle County's public housing for elderly families meet to discuss events and issues in their building.

Public Housing Agency Initiatives

Making support services available to public housing residents takes the concerted efforts of PHA staff at all levels. There are a variety of activities that PHAs can undertake to help elderly persons and younger, disabled persons live together in public housing. As can be seen in Figure 2 (page 39), each PHA focused its efforts on different combinations of activities. While it is not necessary to have all the elements in place to have a successful program, these components were common across many of the PHAs visited.

Conducting a needs assessment

Creating a supportive mixed-population community within public housing developments requires strong planning skills to address a series of important considerations:

- What services do residents need?
- How can the PHA assure that the needs of all residents are met?
- What community-based services are available to public housing residents?
- How can the PHA and community-based service providers work together to meet residents' needs?
- How will such programs be financed and administered?
- How will service programs be monitored to determine whether needs are being met and adjustments made?

Answering these questions can be difficult when a local service system is fragmented, with limited funds and insufficient capacity to meet the totality of the community's needs. Still, this work is critical. Identifying residents' service needs and setting priorities helps PHAs target their limited resources and access the resources of existing community-based service providers. Seeking advice from residents and community groups in the planning phase can help determine the range of needs to be addressed and ways to meet those needs.

In 1991, the Seattle Housing Authority gathered 60 housing agency staff, residents, and service providers to address service needs and problems in high-rise developments for elderly families. Participants divided into teams and were asked to create new strategies for addressing residents' needs given current resources. The resulting report, "Helping Seattle's Low-Income High-Rises Succeed: Solutions Within Reach," was later presented to a group of government officials and community leaders as the basis for discussions concerning greater access to funding and community-based services.

PHAs that understand the needs of their changing populations and pursue approaches to meet these needs can make significant improvements in the quality of life for residents of developments for elderly families. Appendix C contains two sample PHA needs assessment summaries.

In Providence, Rhode Island, housing agency staff surveyed residents' needs and found that transportation was a problem for both elderly residents and those with disabilities living in high-rise developments. The housing agency could afford a van, but not a driver. The planning director approached several agencies and eventually hired two residents as drivers through a locally administered, federally funded senior employment program. All residents of the housing agency's high-rises, regardless of age, may reserve a ride for appointments, grocery shopping, and other activities.

Developing funding strategies

The service needs of public housing residents continue to grow, while the financial resources to meet those needs fail to keep pace. Many PHAs have explored multiple funding sources and made innovative use of their own resources to serve all residents effectively. They use Federal, State, and local government programs in conjunction with private funding and their housing agency resources.

Federal funding. The PHAs in this report have used various Federal programs, particularly those

administered by HUD, to develop programs and services in public housing for elderly families.

The La Salle County and St. Paul housing agencies were awarded funding through the HUD Congregate Housing Services Program (CHSP) to provide housekeeping, meals, and counseling services to elderly residents and younger, disabled residents. This assistance helps prevent early nursing home placements and hospitalizations through personal intervention and support.

The Seattle Housing Authority contracts with the Central Seattle Recovery Center for five certified substance abuse counselors funded through HUD's Public Housing Drug Elimination Program.

Both the Danbury and Seattle housing agencies use HUD's Community Development Block Grant (CDBG) funds, provided by their respective cities, to meet the housing and service needs of their communities. In Seattle, CDBG funds help support crisis intervention and information and referral services for residents in public housing. Danbury is using CDBG funds to expand the local range of housing alternatives by rehabilitating 20 units of single-room-occupancy housing for homeless and homeless mentally ill persons.

State and local funding. PHAs have received State monies to fund on-site programs and services, but funding opportunities vary according to available resources and local needs. Many private nonprofit groups compete with one another and with PHAs for funding. In some cases, nonprofit agencies and PHAs have applied jointly for State funding.

In St. Paul, the housing agency and the nonprofit Westminster Resident Services Corporation received funding from the city's Neighborhood Revitalization program to provide case management and limited nursing services for residents in public housing.

The Providence Housing Authority received funding from the State Department of Elderly Affairs to provide social services to public housing residents. When this funding was no longer available, the housing agency applied for and received a grant from the State Department of Mental Health, Retardation, and Hospitals' Division of Substance Abuse to hire social workers to continue case management and to offer substance abuse education and counseling.

In La Salle County and Rockford, the State Department of Mental Health's Community Integration Living Arrangement (CILA) program provides resources for case management and other services to help persons with severe mental illnesses leave nursing homes and psychiatric hospitals and move into community-based housing.

The Danbury Housing Authority received a grant from the city to purchase a van and hire a driver to take residents shopping and to community activities.

Internal and private resources. All of the PHAs in this report use their own resources, such as in-kind contributions of office space and staff, to support social service programs.

When a services program in Seattle was going to be discontinued for lack of funding, the housing agency requested and received special congressional authorization to use surplus revenues from a successful Section 8 New Construction housing development owned by the housing agency to maintain social service programs within public housing.

In addition, some philanthropic groups and other private organizations have assisted PHAs with funding or services.

In Providence, the local nonprofit group Project Hope serves a daily hot lunch to housing agency residents, and the American Association for Retired Persons' (AARP) Senior Employment Program funds two van drivers to take residents to various community services and outings.

The housing agency in St. Paul has developed an "Adopt a High-Rise" program. Local corporations and civic groups sponsor an assortment of activities for residents of one or more developments that they have "adopted."

As the needs of public housing residents continue to increase, PHAs and community mental health

agencies must become even more resourceful in seeking the funds to provide necessary services.

Reaching out to community-based service providers

As existing residents grow older and increasing numbers of persons with various disabilities become new residents of public housing, PHAs are expanding and intensifying efforts to reach out to local community-based service providers. With such varying needs, services of all kinds—including health, mental health, and substance abuse services; homemaker and home health aide services; transportation; and nutrition programs—must be provided to, or arranged for, public housing residents.

While services exist in nearly every community to address many of these needs, they are often limited to specific subpopulations, such as persons with AIDS, persons over age 62, or persons with severe mental illnesses. Even if services are available, many residents do not receive the type or degree of services they need to live safely in public housing. Coordinating with numerous service agencies to benefit public housing residents has become a necessity for PHAs.

Such coordination takes place on several levels. Many PHAs emphasize the importance of establishing linkages with upper and midlevel service agency program administrators as well as with line staff who are often in the buildings daily or weekly.

The Seattle Housing Authority includes representatives of key service agencies on its board of commissioners. In addition, the housing agency hosts quarterly meetings of service agency and local government representatives to address common issues. Building managers and service agency staff who work with residents of Seattle's high-rises also meet periodically to conduct cross-training and to discuss available services and ways to improve communication. These meetings serve as both formal and informal opportunities to coordinate services for residents.

Many PHAs have designated one or more staff persons to assess the needs of residents, coordinate the services of local providers, and seek new sources of funding for additional support services. The services coordinator usually has a social service background with strong interpersonal skills and knowledge of the community-based organizations needed to help maintain stability and build community within high-rise developments. Sometimes this individual may be a volunteer with a group such as Volunteers in Service to America (VISTA) or the Retired Senior Volunteer Program (RSVP).

In Providence, the director of the housing agency's Department of Special Services aggressively seeks funding to fill service gaps identified during the agency's needs assessment process. Covering six high-rise developments, three housing agency social workers are responsible for identifying and reaching out to residents in need, making referrals, and following up to see that services have been received. Actively linking residents to community-based services has helped avoid potential problems.

The services coordinator can also act as a community organizer, bringing people of diverse backgrounds together to reinvigorate a resident council that has ceased to function or to re-engage a service provider that is not living up to its responsibilities within public housing. The PHA services coordinator is pivotal in the successful integration of residents with multiple service needs and in the development of community within individual buildings.

A formal agreement is necessary when PHAs arrange service provision with community-based agencies. The agreement should spell out PHA and service provider responsibilities, the services or resources each will provide, and as much detail as possible regarding staffing, hours of services, and numbers to be served. Agreements should allow for flexibility, and both parties must monitor the agreement and renegotiate as needs or circumstances change. Examples of public housing and mental health agency agreements from the case studies featured in this report can be found in Appendix B.

The Family Service Association of Greater Boston created a consortium of nine health and social service providers to coordinate services for elderly

persons in public housing. Services included assessing needs, providing short-term counseling, making referrals to other agencies, and strengthening and/or developing resident councils. The Boston Housing Authority helped to extend these services to all residents, regardless of age, by providing $20,000 from operating funds to Family Service to cover part of the cost of hiring social workers who provide 5 hours of services a week to residents of the housing developments for elderly families.

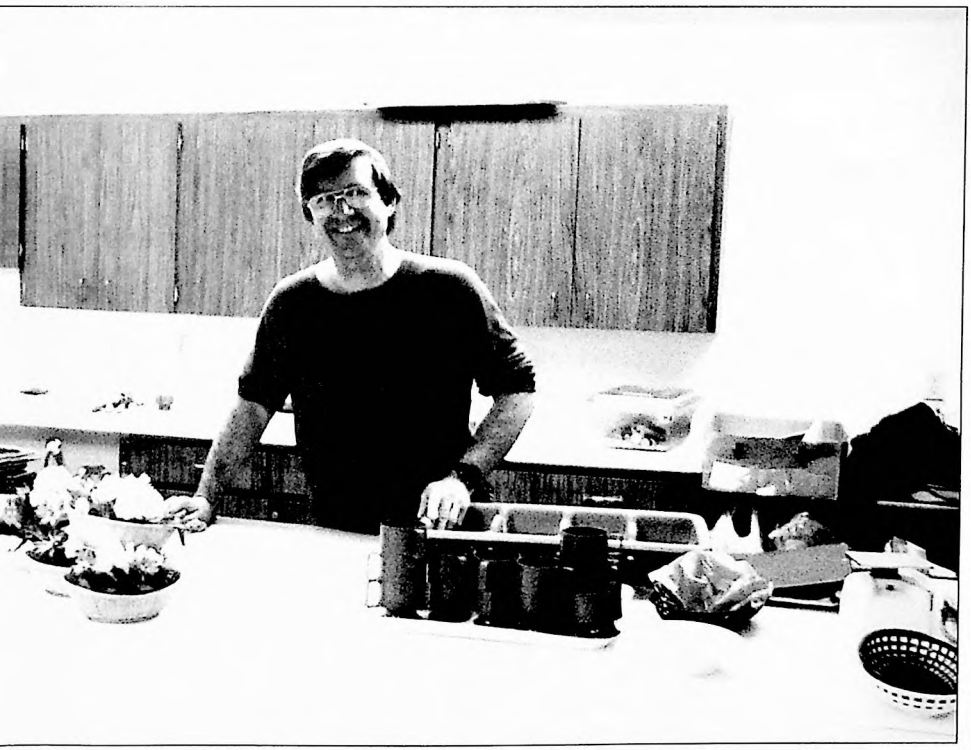
Increasing the presence of public housing agency staff

The changing population of many PHA developments for elderly families may require an increased presence of PHA staff in all areas: building management, resident services, security, and maintenance. All of the PHAs profiled in this report have staff on site, ranging from live-in management aides to a manager on site 2 days a week.

PHAs usually have limited resources for staff coverage. In many cases, the multiple needs of residents call for the skills of a social service staff person whose primary responsibility is linking residents with community-based services and providing followup. In some cities, such as Providence, PHAs have received State or local grants to hire such individuals. Other PHAs have hired building managers with the skills needed to coordinate services. These managers then supervise staff who handle the more routine building management tasks.

In St. Paul, the housing agency director found that one high-rise needed more on-site management due to an increase in the number of reported problems. The housing agency converted vacant apartments on the second floor to offices for managers and aides. Having management staff on site during the day and social service staff available during the afternoon and evening decreased reports of problems and increased residents' feelings of security.

Building security is a major concern of all residents. Scheduling security staff in the evenings and/or overnight can help residents feel safe, as well as reassure them that their



A resident of public housing for elderly families in St. Paul volunteers to help with the afternoon congregate meal.

safety and well-being are important to the PHA. Good security staff can serve as the nighttime "eyes and ears" for building managers, informing them of potential problem situations which may not be apparent during the day.

In Toledo, both the housing agency and local mental health provider were concerned about criminal activities just outside one elderly high-rise development. The mental health agency provided the housing agency with a grant to hire a security guard for the evening hours and trained this individual to recognize and intervene in mental health crisis situations.

Making permanent assignments of maintenance personnel rather than having them rotate among buildings can be useful. Maintenance workers attached to one building are generally more invested in that building and its residents; some become well-known and trusted by residents, thereby providing an extra measure of support and security. This is especially the case when arrangements can be made for maintenance workers to live on site.

Establishing thorough screening and application procedures

Establishing and maintaining a careful screening process for new applicants helps ensure that only those applicants who can meet the terms of their lease are accepted. While each applicant is screened using a set of objective criteria, it is possible within this framework to consider mitigating circumstances and to make reasonable accommodations for individuals with mental and other disabilities. Recommendations from mental health agencies and residents can help PHAs learn what accommodations may be necessary and most useful.

The Council of Large Public Housing Authorities (CLPHA) manual *Applicant Screening and Nondiscrimination: Complying with HUD's Tenant Selection, 504 and Fair Housing Rules*, and HUD's handbook *The Public Housing Occupancy Handbook: Admission* both contain specific information on the screening and admissions process. Appendix D of this report contains a change to the HUD handbook clarifying the policy on applicants with handicaps, and Appendix E includes a model of the application process for people with disabilities. The CLPHA guidelines center on three key questions:

- Will this applicant pay the rent?
- Will this applicant care for the unit?
- Will this applicant be a good neighbor?

Gathering as much information as possible makes the screening process thorough and accurate. Police records, reports from previous and current landlords, and credit checks all provide important information. While potential residents are not automatically excluded from public housing by a police record or a poor rent payment history, such information helps PHA staff make an informed judgment about an individual's ability to live by the terms of a lease. Home visits can be particularly useful, and orientation sessions can help prospective residents understand and be better prepared to meet the requirements for residency.

The Providence Housing Authority follows the CLPHA screening guidelines, makes home visits, and checks police records. In addition, all prospective residents are required to attend two 3-hour orientation sessions prior to signing the lease. These information sessions inform applicants of their rights and responsibilities, orient them to available services, and offer basic training in apartment upkeep. The sessions also provide an opportunity to introduce new residents to the positive aspects of living together with persons of different ages and special needs.

If applicants fail the screening criteria, they may request consideration of mitigating circumstances. Applicants should provide the PHA with an explanation and indicate whether and how the situation had been or would be corrected. For example, where the situation was the result of the applicant's mental illness and might reoccur, the explanation could be accompanied by a statement from a mental health service agency detailing the assistance to be provided to the applicant. The statement should contain a commitment to continue the

aid as long as the individual needs and wants it. The PHA can consider this information in determining whether, given such help, the applicant is likely to be able to meet his or her responsibilities as a resident. The statement from the mental health provider may not be used as an addendum to a lease, nor may the individual be evicted simply on the grounds that he or she has ceased to use the services of the agency.

In St. Paul, applicants without landlord references, such as individuals who have a history of homelessness and mental illness, may provide references from a social worker at a shelter or transitional residence. In addition, case managers may provide assurances that they will support their clients in housing and help them comply with their lease.

Public housing need not be viewed as "the housing of last resort." PHA managers agree that it is a great disservice to all residents if individuals who cannot meet the screening criteria are allowed to live in public housing. Without appropriate screening, management problems and evictions increase, and morale among residents declines. It is possible to comply with all Federal legislation regulating housing for persons with disabilities, including the Fair Housing Amendments Act and Section 504 of the Rehabilitation Act, while still holding all applicants to rigorous standards.

Training staff and educating residents and community providers

Professionals from mental health and other service agencies can be enlisted to train PHA staff to better understand the needs of persons with severe mental illnesses and related problems.

In La Salle County, all housing agency staff attend training seminars on stress management, effective organizing, and dealing with substance abuse. The local mental health center provides training on severe mental illnesses. Staff indicate that training has enabled them to be more effective with people who have severe mental illnesses or substance abuse problems.

All new residents should be given an orientation before moving in with information on the different types of persons represented in public housing, the realities and benefits of living in a diverse community, positive approaches to potential conflicts, and ways to develop sensitivity to the special needs of others. For current residents, presentations can be arranged through resident councils.

To help residents understand and be more tolerant of the diversity of individuals living in the high-rise communities, the Seattle Housing Authority created an orientation program titled, "We All Live Together." In a brochure and presentation (see Appendix F) made at all high-rises periodically, housing agency staff educate residents about who is eligible to live in public housing for elderly families, how their needs and lifestyles may vary, and how to address issues concerning building safety. They explain in detail the housing agency's screening criteria and mechanisms for resolving problems.

For PHAs to house elderly persons and younger, disabled persons together in their public housing developments, they must recognize the need to educate the broader community, including potential residents and local service providers, about what they have to offer. Some housing agencies—including those in Rockford, La Salle, Toledo, and Seattle—have developed brochures, videotapes, and outreach programs for social service and aging agencies.

The housing agency in Rockford has developed a brochure marketing a high-rise development that had a poor reputation and many vacancies. The brochure lists services available at the high-rise, highlights recent renovations, and provides a floor plan of a typical unit. Recently there has been an increase in the number of applications for public housing in Rockford, attributed largely to the housing agency's marketing efforts.

Strengthening resident councils

Resident councils can be a valuable resource in smoothing the way for younger residents who have severe mental illnesses, or a powerful force of resistance. PHA staff can help strengthen resident councils and increase their capacity to be active partners in integrating new residents into developments for elderly families. They can inform resi-

dent councils of anticipated changes in their buildings and seek their advice about effective responses to these changes. Resident councils are an excellent forum for workshops on understanding mental illnesses and building a supportive community with a diverse mix of residents.

With minimal, but essential, support from PHA staff, resident councils can be the "glue" that holds building communities together. Active councils sponsor activities as diverse as Alcoholics Anonymous (AA) groups, anti-drug campaigns, coffee shops, flea markets, field trips, hall monitors, and holiday celebrations. They send flowers to hospitalized residents, raise funds to help beautify their surroundings, and arrange for such on-site community services as health clinics. It is hard to imagine a more productive way to develop a positive sense of community than for PHA management to empower residents by giving them encouragement and the tools to create healthy, strong resident councils.

In a high-rise building in Rockford, the resident council has an office that serves as a resource center where residents can learn about activities sponsored by the housing agency, the resident council, or others in the community. The housing agency consulted the council during a recent renovation for suggestions on common area furnishings. Council officers report that younger residents with severe mental illnesses generally have few problems fitting in with their elderly neighbors and are welcome participants in council activities.

Using lease enforcement to prevent eviction

Lease enforcement can be a valuable management tool, allowing PHAs to prevent costly and disruptive evictions. When a potential lease violation becomes apparent, building managers inform the resident and either the on-site social service or mental health staff or the community providers who serve building residents. PHAs must document both the problem and the attempted resolution, in the event that eviction becomes necessary. They must be certain that the lease violation does not result from a failure to provide reasonable accommodations to residents with disabilities who request them.

Each PHA is required to have a grievance procedure and to inform all residents how to use it. The grievance procedure provides residents with an opportunity for a hearing before an impartial third party, and it gives the PHA and residents a chance to resolve disputes before the PHA feels it necessary to initiate eviction proceedings.

A resident may use the grievance procedure to resolve disputes he or she has with the PHA. Such a dispute may involve a PHA action pertaining to the resident's lease, or it may relate to a PHA regulation that the resident believes has adversely affected his or her rights, duties, welfare, or status. Mental health agency staff may serve as a representative of the resident during the grievance process.

Separating building management and social service functions allows PHA staff to concentrate on enforcing the rules, while social service staff can help clients learn how to live by the rules. This requires adequate staff support for residents and cooperation between PHA managers and mental health or social service providers. Residents and social service providers must have clear, objective guidelines regarding behavior that violates the lease.

If problems persist despite attempts to resolve the situation, eviction proceedings may begin, even as the mental health or social service staff continue to work with residents. In general, eviction proceedings are the last resort, since preventing eviction is usually more cost-effective for PHAs, and retaining residents helps to build a more stable community.

In Toledo, an elderly resident who lived between two younger residents with mental disabilities complained about loud music late at night. When the situation did not improve after the manager spoke to the young residents, they were given a warning about possible eviction, and staff from the mental health center intervened to help them understand what they needed to do to avoid losing their apartments. In this case, lease enforcement helped correct a difficult situation and prevent eviction.

Maintaining and developing the buildings and grounds

As the population in public housing for elderly families has changed and aged, so have many of the buildings and the neighborhoods in which they are located. In some developments, common areas have fallen into disrepair or disuse, or have been converted into much-needed office or service program space. Attention to details such as attractive furnishings or a fresh coat of paint can give residents a renewed sense of pride in the building and encourage them to socialize.

The housing agency in La Salle County created three smaller community rooms—a kitchen/ dining room, a small, cozily furnished television room, and a more formal sitting room for quiet conversation—out of what had formerly been a large, unused community room.

In some PHAs, residents have developed vegetable or flower gardens on the building grounds. Such activities not only contribute to the overall appearance of the building and the neighborhood but also provide much-needed daily activity for persons who may be socially isolated.

The PHAs profiled in this report have carefully considered the need to develop on-site programs. The need for office or program space to serve a specific subgroup of residents must be balanced with the need to make some common space accessible to all residents. A program that is used by only a small number of residents and occupies valuable common space for long periods of the day may not be worth having, even if it provides high-quality services.

Promoting security

The potential for unsafe situations increases when large numbers of persons, many of whom have some type of disability, live together with few or no support services. Disruptive or dangerous behaviors on the part of any resident—young or old, with or without a mental illness—should be addressed by the PHA through careful, consistent management and support services to promote greater personal safety.

Often, highly visible and sometimes inexpensive changes can reduce both real and perceived threats to security. For example, having a working intercom system for residents and encouraging them to use it at all times often may avoid dangerous situations.

In Boston, Providence, and Toledo, the housing agency created a staff office with a window overlooking the lobby and entrance to monitor traffic in and out of the building. Allowing staff (including security guards if they are used) to "see and be seen" can create a more secure building.

In buildings where adding staff or an office with a window is not possible, there may be other options:

In Rockford, the local cable television company installed a television monitoring system in the lobby of the housing agency. Both residents and housing agency staff can turn to a designated channel on their television set and observe the lobby area. Thus residents can see who is ringing their bell, and staff can monitor the lobby.

In Seattle, the housing agency is testing an electronic key system at the entrance to a building that posed persistent security problems. The system uses a plastic "key" that cannot be duplicated and that is encoded with individual entrance codes that can be deactivated when someone moves out or loses a key.

The housing agency in St. Paul found that having management and social service staff on site more frequently increased residents' feelings of security. In Toledo, an additional security guard helps the housing agency respond to crisis situations.

Committing to interagency collaboration

The success of any of these efforts depends in large part on the degree to which PHA and local mental health agency management and line staff are committed, in theory and in practice, to making these programs work.

In La Salle County, the directors of the housing agency and the mental health center meet on a

regular basis to monitor the progress of their initiatives. At the staff level, the building managers and the mental health case managers also meet to discuss day-to-day operations.

Flexibility in the relationship between PHAs and mental health agencies can be useful in expediting programs and solving problems. The PHAs featured in this report have led the way by converting vacant units to office space for mental health agencies that provide and coordinate services on site. This action provides immediate access for residents in need of services and results in better interagency communication.

When the Rockford Housing Authority allocated newly renovated units for service providers, it designated one as office space for the resident council, resulting in an increased presence and renewed level of activities sponsored by the group.

Some PHAs and mental health agencies have hired additional personnel to meet the needs of both agencies. Appendix G contains a sample description of how one mental health provider has agreed to share its services with the local PHA.

In Toledo, the Lucas Metropolitan Housing Authority approached the County Mental Health Board for assistance in hiring additional security personnel. Since the mental health board had many of its clients in public housing and had developed a strong working relationship with the housing agency, the board provided a grant to fund an evening security guard. The guard is trained by mental health staff to assist with crisis intervention for program clients and other residents, should the need arise.

Many PHAs will accept agreements from mental health agencies to provide needed services as a reasonable accommodation to individuals who might not otherwise meet the criteria for public housing.

The St. Paul and La Salle County public housing agencies have developed agreements with mental health service providers to aid individuals who require assistance in order to meet the agencies' screening criteria. The mental health agencies agree to provide assistance in order for the resident to be lease compliant as long as he or she needs or requests such help.

A resident of TenEyck Towers in Toledo praises the free blood pressure checks provided by the Ruth Ide Mental Health Center.

Mental Health Agency Initiatives

Services for persons with severe mental illnesses are predominantly funded and organized by States and are delivered through an often complex mix of public and private community-based providers. Thus the type and availability of mental health services in any locality will vary depending on the State and the local service context of each community.

For some of the PHAs featured in this report, such as the St. Paul and Seattle PHAs, it was necessary to establish relationships with several mental health providers. In other cases, such as Providence, funding for mental health services in the local area was so limited that new resources had to be created to meet the PHA's needs.

Regardless of the difficulties, a number of initiatives undertaken by local mental health agencies made true collaborations possible for each of the eight PHAs in this report. These initiatives are highlighted below.

Creating a centralized mental health system

A strong, centralized mental health system—one with responsibility for all persons who have severe mental illnesses and adequate funding and flexibility to provide necessary support services—can be a key ingredient in the close collaboration between housing and mental health officials. A comprehensive system of care for persons with severe mental illnesses, including a full range of treatment, housing, and supports, can be facilitated when the administrative, clinical, and fiscal responsibility for the population rests with a single authority, such as a county mental health board.

In Toledo, one of nine demonstration sites for the Robert Wood Johnson Foundation/HUD Program on Chronic Mental Illness, the Lucas County Mental Health Board serves as the central mental health authority. The director of the public housing agency, who had been a member of the County Mental Health Board of Directors, was named board chairperson for a year. By making a commitment to understanding both the housing and mental health systems in Toledo, the directors of the two agencies established a basis for future collaboration.

Establishing and maintaining contact with public housing agencies

A regular channel of communication must be established and maintained between PHAs and local mental health service providers. Agreements to provide or exchange services work best if they are spelled out in writing. Administrators of both agencies should also meet periodically to ensure that the collaboration is meeting the needs and expectations of both agencies and to make the inevitable adjustments necessary in any effort of this sort.

The Boston Housing Authority (BHA) and the State Department of Mental Health have designated key staff from both organizations to meet on a regular basis. Both agencies find these meetings useful for planning additional services for residents. As a result of their ongoing, mutually beneficial relationship, the BHA and the Department of Mental Health are expanding opportunities for collaboration.

The La Salle County and St. Paul housing agencies find that working agreements are essential to providing high-quality services. The housing agency in St. Paul has a formal agreement with a social service agency called Safe Alternatives. Individuals with mental illnesses who have participated in a Safe Alternatives transitional housing program occupy 10 units in one of the PHA's buildings and receive intensive on-site services from Safe Alternatives. In La Salle County, the housing agency and the County Department of Mental Health work together to aid persons with disabilities living in housing for elderly families. Sample copies of these agreements can be found in Appendix B.

Line staff (e.g., building managers and mental health case managers) need to communicate on a regular basis. In addition, regularly scheduled meetings to share information, develop ways to support one another's work, and resolve any conflicts are essential. When appropriate, other PHA staff should also attend these meetings.

In Providence, communication between the housing agency's social service staff and the staff of the local community mental health center had broken down. Housing agency staff did not know which case worker was responsible for individual mental health clients, and both agencies blamed the other for problems that arose. Eventually, the mental health center agreed to provide one clinician to rotate among six high-rise developments and hold weekly meetings with each building manager and social worker. Within several months, relationships had improved, and housing agency and mental health center staff once again look to each other for support and advice.

The issue of client confidentiality is one that PHAs and mental health providers must address as they attempt to balance the privacy of persons with severe mental illnesses against the need to make informed decisions about a resident's ability to live by the terms of his or her lease. Several of the PHAs featured in this report emphasized that they neither needed nor wanted detailed history or current treatment information for residents as long as the mental health providers could assure the PHA that they would be responsive to residents' needs. Together, PHAs and mental health agencies need to develop procedures that will allow them to communicate in ways that do not violate client confidentiality. For example, clients might be asked to sign a release form allowing selected information to be provided to PHA staff.

Providing services to persons with severe mental illnesses

To work effectively with clients in public housing, mental health staff must be available for in-home visits. Typically, visiting case managers (see Appendix H for a sample job description for a case manager):

- arrange for mental health treatment and other support services, including assistance with entitlements, health education, and money management, for existing clients;
- reach out to persons with severe mental illnesses who may not be receiving services; and
- provide quick-response crisis intervention.

To be effective in outreach, mental health staff need to be accessible. Some providers help serve meals, attend social functions, and circulate informally among building residents.

In a large high-rise for elderly families in Providence, a hot lunch is served in the building's community room by a local senior nutrition program. It is open to residents of all ages, and many gather nearly an hour before lunch to socialize and stay afterwards to visit or play cards. Mealtime provides an opportunity for mental health staff to assess service needs and build rapport with residents who may initially be reluctant to accept services. Staff presence at social functions also helps break down the stigma associated with receiving mental health services.

To ensure adequate followup, mental health staff should have sufficient time to provide assessment and treatment planning, offer supportive counseling, teach daily living skills, and plan service coordination. Though this does not necessarily mean a full-time commitment to PHA residents, such an arrangement can work to everyone's advantage. A sample job description for a supported housing manager can also be found in Appendix H.

In a development for elderly families in Toledo, a mental health worker lives in the building to provide services to program clients. A nurse by training, she works evening hours and is on call overnight. Her unit is provided by the housing agency for the operation of this on-site mental health program.

Because mental health crises can, and do, occur at any time, a mental health provider should be on call to provide 24-hour crisis intervention. Preferably, on-call staff will be known both to residents and to building managers.

The housing agency director in Danbury was unsure how a mental health program would respond until the night that he and the mental health worker on call were both telephoned about a crisis involving a resident with mental disabilities. By the time the director reached the building, two mental health staff had arrived and the situation was under control.

Reaching out to residents not currently in treatment

Mental health staff must be accessible to residents other than their designated clients. Their efforts to become known throughout the housing development and to be responsive to complaints about their clients, as well as to provide informal counseling, assessment, referrals, and crisis intervention for other residents, can be beneficial for all concerned. Mental health staff can also make themselves available to address the fears and concerns of elderly residents. This availability can have a significant positive impact on the way PHA staff and elderly residents view the "mental health program" and its clients.

In high-rise developments in St. Paul and Toledo, the on-site mental health staff take this concept a step further. In addition to providing such services as case management and crisis intervention for program clients, staff make a point of inviting all residents to mental health program-sponsored social activities, and they involve clients, other residents, and the building manager in planning large, buildingwide holiday parties. This approach proved to be key in breaking down barriers between mental health program clients and other residents.

Mental health center staff make themselves available to assess, or arrange for the assessment of, mental health problems in residents who are not their clients. By providing professional assessment and referral services, mental health program staff can help residents receive the services they need to remain in the public housing community.

Providing specialized training for public housing agency staff

Training on how to recognize and respond to mental health problems and how best to encourage integration of younger and elderly residents can help PHA managers become more confident in working with residents who have mental illnesses. Local mental health service providers can have a significant impact on the success of their clients in public housing by educating PHA staff about mental illnesses and substance use disorders.

In particular, mental health providers can help staff and residents differentiate between behavior that is dangerous and that which is just different and possibly unsettling. They may suggest ways in which PHA staff and residents can allow persons with mental illnesses to make their own choices as long as their behavior is not dangerous to themselves and does not infringe on the rights of others.

In Toledo, 17 individuals with severe mental illnesses were preparing to move into a public housing development for elderly families. Before the new residents moved in, mental health center staff met with public housing building managers several times to discuss the needs of the new residents and to develop a cooperative management approach. They then spoke at a meeting of residents to provide general information on the signs and symptoms of mental illness, the benefits and potential side effects of medication, and ways to help the new residents adjust. Residents and staff feel this approach was effective in preventing problems and helping the mental health clients gain acceptance.

Making It Work Better–Expanding Housing Options

Many communities do not have adequate housing options for persons with severe mental illnesses. There is often a problem when housing agencies are faced with an applicant who does not want to live in a development with primarily elderly residents but has no alternative. It becomes stressful for the applicant, other residents of the building, the PHA, and the mental health service provider.

The more housing options people have, the easier it is to find the most appropriate setting for each individual and to build a sense of community within specific developments. Some PHAs are responding to the great need for expanded housing options for both elderly persons and persons with disabilities by offering them Section 8 rental certificates or rental vouchers and by exploring other housing opportunities, such as Federal McKinney Act grant programs for homeless persons.

In Toledo, the housing agency offers younger applicants with severe mental illnesses choices of public housing developments and Section 8 rental certificates or rental vouchers to use in the private housing market. Younger individuals often prefer to use a rental certificate or voucher to find housing of their choice in the community.

The housing agency in La Salle County created a separate nonprofit development corporation to work with mental health and other agencies to develop new housing models. These include scattered-site apartments in the private housing market using government and private funding sources.

In Danbury, the directors of the housing agency and the local mental health program agreed that public housing for elderly families was not the optimal choice for many younger persons with severe mental illnesses, and that there was a great need for other options. In consultation with the mental health program, homeless shelters, and other agencies, the housing agency applied for and received Community Development Block Grant (CDBG) funds to develop a 20-unit, single-room-occupancy (SRO) residence with support services for homeless adults. It is now in operation, and half the rooms are occupied by individuals with mental illnesses.

A resident of Dougherty Manor in La Salle County, Illinois, stops to check the social calendar.

Putting the Pieces Together

Each community confronting the challenge of finding adequate housing and support services for persons with disabilities develops its own unique response based on the specific needs of the individuals involved; the availability of resources; and the organization of the local housing, mental health, and social service systems. Not all of the PHAs and local mental health agencies profiled have instituted all of the initiatives described in this chapter, but each has recognized a need and responded to that need in a number of creative ways. Figure 2 summarizes the initiatives taken by the PHAs in this report. A more detailed look at each PHA/mental health agency collaboration is offered in the case studies that follow.

Figure 2. Key Components of Public Housing Agency Approaches

Public Housing Agency Initiatives	Location of PHAs Visited							
	Boston	La Salle Co.	St. Paul	Danbury	Providence	Seattle	Rockford	Toledo
Conducting a needs assessment			✓		✓	✓		✓
Developing funding strategies	✓	✓	✓	✓	✓	✓	✓	✓
Reaching out to community-based service providers	✓	✓	✓	✓	✓	✓	✓	✓
Increasing the presence of public housing agency staff	✓	✓	✓	✓	✓	✓		✓
Establishing thorough screening and application procedures		✓	✓	✓		✓		✓
Training staff and educating residents and community providers		✓	✓		✓	✓		
Strengthening resident councils	✓	✓				✓	✓	
Using lease enforcement to prevent eviction	✓		✓	✓	✓			
Maintaining and developing the buildings and grounds		✓	✓	✓			✓	✓
Promoting security	✓				✓	✓	✓	✓
Committing to interagency collaboration	✓	✓	✓	✓	✓	✓	✓	✓
Mental Health Agency Initiatives								
Creating a centralized mental health system		✓	✓					✓
Establishing and maintaining contact with public housing agencies	✓	✓	✓	✓	✓	✓	✓	✓
Providing services to persons with severe mental illnesses	✓	✓	✓	✓	✓	✓	✓	✓
Reaching out to other residents			✓	✓	✓	✓	✓	✓
Providing specialized training for public housing agency staff		✓						✓
Expanding Housing Options	✓	✓		✓			✓	

Case Studies

Boston, Massachusetts
Creating a Supported Housing Program

La Salle County, Illinois
Meeting Its Mission

St. Paul, Minnesota
Building Partnerships

Danbury, Connecticut
Offering Options

Providence, Rhode Island
Providing a Range of Services

Seattle, Washington
Developing a Comprehensive Approach

Rockford, Illinois
Establishing a Sense of Community

Toledo, Ohio
Reaching Out

Boston, Massachusetts

Summary

The Boston Housing Authority was faced with chronic vacancy rates and increasing numbers of persons with severe mental illnesses seeking housing. To address these concerns, the agency has worked with local nonprofit social service agencies and with the State Department of Mental Health to provide services to residents in public housing for elderly families.

Under a Federal grant, funded by the Stewart B. McKinney Homeless Assistance Act and administered by the Center for Mental Health Services, the housing agency and the Massachusetts Department of Mental Health created a Supported Housing Program, designed to provide comprehensive services to formerly homeless men and women with severe mental illnesses living in public housing. Several features are key to its success:

- Screening applicants thoroughly allows the agency to select only those individuals who can successfully meet the terms of their lease, leading to greater residential stability for all residents and fewer crisis situations.
- Arranging for intensive services to be provided by mental health case managers helps residents live more independently and allows housing managers to devote more time to administrative work.
- Coordinating services at the client level permits the housing agency and the Department of Mental Health to extend services to additional clients as assistance for those who are functioning well is gradually decreased. It can also prevent eviction by addressing the needs of residents who warrant extra help.
- Coordinating services at the administrative level keeps the program functioning to the benefit of both agency personnel and public housing residents.

BOSTON, MASSACHUSETTS

Creating a Supported Housing Program

Diagnosed with schizophrenia in his early 20s, Tom graduated from college and traveled around the country pursuing a career in acting. After a period of hospitalization in Boston, Tom was homeless and came to live at Boston's Parker Street West shelter for homeless persons who have severe mental illnesses. At the shelter, he became eligible for the Supported Housing Program sponsored by the State Department of Mental Health and the Boston Housing Authority (BHA).

Tom has lived in a BHA high-rise for 5 months. Overcoming the difficulties associated with his youth and his illness, he has become fairly independent and active and is friendly with neighbors of all ages. For Tom, the Supported Housing Program has been his passage back to community living.

Boston is a large city with a population of 574,283. Like other metropolitan areas, Boston is challenged with meeting the housing needs of people with limited resources. In 1990, a one-bedroom apartment averaged $606, while the maximum Supplemental Security Income benefit available to elderly persons and persons with disabilities was $515.

The Boston Housing Authority manages 35 high-rise developments with a total of 3,697 units occupied by elderly families. Buildings range in size from 40 to 299 units and include efficiency, 1-bedroom, and some 2-bedroom apartments. Building managers supervise 400 to 500 units each, and every building has a live-in custodian to clean and make minor repairs.

Most BHA high-rise developments have on-site laundry facilities, meal programs, common areas on each floor, and a large community room on the first floor. Residents play an active role through the resident councils, organizing social and recreational activities, and providing suggestions to BHA on building conditions and areas for capital improvement.

Responding to community change

Throughout the 1980s, BHA had chronic vacancy rates in its high-rise developments. This fact can be attributed in part to movement from inner-city neighborhoods by elderly individuals eligible for newer federally subsidized housing, as well as to a lack of demand for BHA efficiency units. Eventually, BHA was faced with the possible loss of HUD subsidies due to persistent vacancies.

At the same time, mental health advocates in Boston were seeking safe, affordable housing for their clients. On behalf of persons with severe mental illnesses, Greater Boston Legal Services was prepared to bring legal action against BHA in an

attempt to gain greater access to its public housing developments.

In 1991, 40 percent of the BHA waiting list was composed of individuals under the age of 62, while these individuals constituted 20 percent of the population in the developments. This increase in the number of younger, disabled residents prompted BHA to seek services for this population, much as it had developed services for elderly residents a number of years earlier.

Expanding service linkages

The Family Service Association of Greater Boston, a nonprofit social service agency, created a consortium of nine health and social service providers in 1984 to organize services to elderly residents of public housing. BHA provided $20,000 from operating funds to Family Service to cover part of the cost of hiring social workers to provide 5 hours of services per week to residents of public housing for elderly families, regardless of age. Services include needs assessment, short-term counseling, referrals, and coordination between BHA staff and visiting social workers.

This program proved to be a successful agent for change within the buildings, leading to the development of a Peer Advocate Alcoholism Program, health screenings and monitoring, and active resident councils—all open to residents of any age. The program also prompted the development of similar service agreements between other community-based agencies and BHA. Still, resident needs outstripped the consortium's resources.

Developing a supported housing program

In 1991, the Massachusetts Mental Health Center and Harvard University received a grant to study alternative housing models for homeless adults with severe mental illnesses. The grant was funded by the Stewart B. McKinney Homeless Assistance Act Demonstration Program for Homeless Mentally Ill Adults and administered by the National Center for Mental Health Services.

As part of the grant, the Massachusetts Department of Mental Health (DMH) and BHA collaborated to create the Supported Housing Program, designed to provide intensive services for formerly homeless men and women with severe mental illnesses living in public housing. BHA welcomed the opportunity to receive services for residents with severe mental illnesses who were not being served under its current programs and to use vacant efficiency units for program clients to help increase occupancy levels in its high-rise developments.

BHA agreed to set aside 25 units, 5 in each of 5 high-rise developments for elderly families. The initial success of the program has led to an agreement to set aside 32 additional units available to program clients.

The Supported Housing Program has several important features, including:

- a comprehensive screening process for applicants;
- intensive support services; and
- service coordination at the client and administrative levels.

Screening applicants for success. Referrals to the Supported Housing Program come from each of three DMH-run shelters for homeless persons with severe mental illnesses. Participants are prescreened by DMH to ensure their suitability for the program. They must be judged to not be a threat to themselves or others, to have addressed substance abuse problems, and to be able to maintain themselves in public housing with the aid of services offered through the program.

Once accepted into the program, participants apply for housing with BHA and go through the regular screening process. Because these applicants are homeless and living in a shelter, BHA accepts references from Supported Housing Program staff in place of its usual requirements for landlord references, credit checks, and a home visit. As with all applicants, a police record check is routinely conducted.

Providing intensive services. All individuals accepted into the Supported Housing Program receive intensive support services from DMH. Apartments are completely furnished by DMH, and program participants meet with their case managers to discuss goals and develop an individual treatment plan before moving in.

Once these individuals have moved in, case managers make weekly or more frequent home visits to discuss clients' progress, arrange for additional services, accompany clients to appointments, and work with them on such skills as money management, housekeeping, and cooking. With an average caseload of 12 clients, case managers have the flexibility to provide intensive services, including individual and group therapy, and help with money and household management on an as-needed basis.

Case managers also provide 24-hour crisis intervention, which gives BHA housing managers and live-in custodians access at a moment's notice to professionals who can deal effectively with mental health crises.

Coordinating service delivery. BHA and DMH coordinate services on both client and administrative levels. Where clients have agreed that the two agencies may exchange pertinent information, staff from both agencies meet monthly to determine whether these residents are demonstrating sufficient ability to comply with the terms of their lease. The long-term goal is to decrease the level of support as an individual's ability to live more independently increases.

On an administrative level, the DMH director of housing meets regularly with the BHA director of resident services to review the Supported Housing Program and to ensure that agency and resident needs are being addressed. Both agencies find these meetings useful for planning additional services for residents and expanding opportunities for collaboration.

Looking ahead

Building on their success, the Department of Mental Health and the Boston Housing Authority are in the process of designating 32 additional units for DMH clients. DMH will also extend mental health services, such as assessment, referral, and crisis intervention, to other BHA residents who are not part of the Supported Housing Program. BHA will continue working with the Family Service Association of Greater Boston to increase service provision from consortium members and to develop new programs.

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La Salle County, Illinois

Summary

The Housing Authority of La Salle County wanted to provide services to some of its younger, disabled residents who were in danger of eviction, and the local mental health center needed housing for clients being discharged from hospitals and group homes. Together, the two agencies established a Residential Rehabilitation Program to provide housing and support services for persons with severe mental illnesses in one of the housing agency's high-rise developments for elderly families.

A strong commitment to this program on the part of both the housing and mental health agencies helps promote residential stability for younger, disabled residents and creates a sense of community within public housing developments. In addition:

- Staff training helps housing agency employees learn problem solving and stress management techniques and ways to work with aging and disabled populations.
- Resident education helps prepare elderly residents for living with younger, disabled persons and assures them that mental health providers will be responsive to their concerns.
- On-site services help persons with mental illnesses learn to live independently, and 24-hour crisis intervention provides a measure of security for program clients, housing agency management, and other residents.
- Monthly meetings between housing managers and mental health center staff ensure the smooth operation of the program and provide an opportunity to resolve problems in a timely and efficient manner.

LA SALLE COUNTY, ILLINOIS

Meeting Its Mission

Mission Statement of the Housing Authority of La Salle County

To pursue new and creative ways to continue to meet the changing housing needs of the diverse populations of La Salle County.

To promote affordable, decent, safe and sanitary housing for all residents of La Salle County.

To expand housing opportunities and alternative lifestyles for the residents of La Salle County.

To enhance existing housing programs through the provision of support services.

To improve the overall quality of life in Authority developments.

To encourage and develop the empowerment of Housing Authority residents.

To provide Authority residents with dignity, comfort and a place to call "home."

La Salle County, Illinois, is a rural area 100 miles southwest of Chicago with a total population of 106,913. About half of the county's residents live in one of four small cities: Ottawa is the largest with a population of 18,000; Streator has a population of 15,000; and La Salle and Peru have a combined population of 20,000. Most housing in La Salle County consists of private one- and two-family homes and farms, with a few high-rise apartment buildings in downtown Ottawa.

The Housing Authority of La Salle County (HALC) began construction of public housing for elderly families in the 1960s. In 1991, HALC had 605 apartments in 9 developments, ranging in size from 14 to 170 units. Most are large efficiencies, with a few one-bedroom units.

On-site staff and special amenities

Each high-rise development for elderly families has an on-site management aide who coordinates social activities, links residents to services, and assists housing managers. Housing managers are responsible for up to three developments, where they screen applicants, enforce leases, supervise management aides, and oversee general operation of the developments. HALC trains all employees in building management as well as human relations issues, including stress management, communications skills, and issues of aging. The local mental health center provides training on severe mental illnesses. Staff indicate that training has enabled them to more effectively house people who have severe mental illnesses or substance abuse problems.

For the convenience of residents, buildings have laundry facilities, a kitchen/dining area, and one or more smaller community rooms. In addition, each building has one or more special amenities, such as a country store operated by the resident council that stocks small quantities of essential food and supplies, a hair salon, and an exercise room. Some developments also offer blood pressure screenings and medication monitoring coordinated through area hospitals.

In addition, HALC was awarded funding through the HUD Congregate Housing Services Program (CHSP) to provide housekeeping, meals, and counseling services to eligible elderly and disabled public housing residents. This assistance helps prevent early nursing home placements and hospitalizations through personal intervention and support.

A shift in the need for public housing

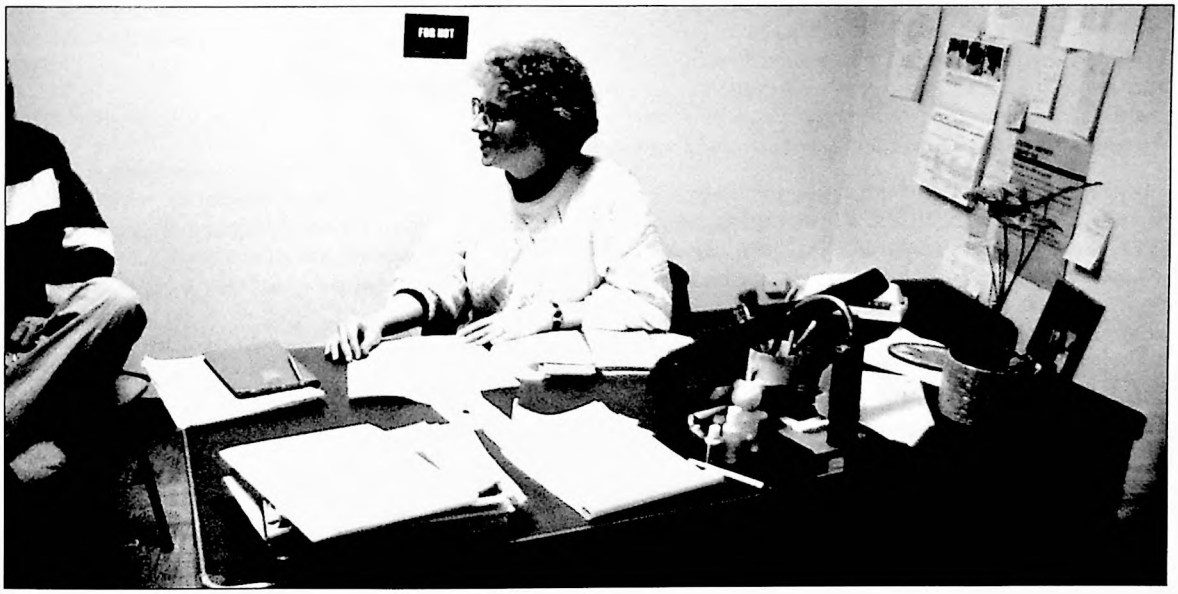
In the early 1980s, the Farmers Home Administration (FmHA) supported the construction of several low-rise developments that soon attracted many elderly persons who were living in the public housing high-rises. By 1985, with increasing vacancy rates, HALC received approval from HUD to admit nondisabled individuals under age 62 who would not otherwise be eligible to live in these developments.

Although most developments have low vacancy rates, the waiting list for the high-rise developments is relatively short. In most cases, a unit becomes available within 30 days. In 1991, 55 percent of individuals on the waiting list were officially designated as individuals under the age of 62.

Responding to a younger population

The majority of HALC's vacancies were occurring in its older high-rise developments, especially Dougherty Manor, a 67-unit high-rise with high turnover and a large number of vacant units. As a result, many of the residents who came to live at Dougherty Manor were under age 62 and had no known disability.

A case manager from the Mental Health Center for La Salle County works with residents in her Dougherty Manor office.



However, soon after the younger persons moved in, HALC began hearing from elderly residents about the new residents' loud music and odd behavior. Concerned, the housing agency director arranged a meeting with the director of the local mental health center to find out whether services were available to public housing residents.

At this initial meeting in 1986, the directors found that they each had something to offer the other. The mental health center needed housing resources for its clients who were being discharged from hospitals and group homes. The housing agency needed access to mental health services for residents who appeared to be disabled and who were in danger of eviction. Together, they agreed informally to designate key contacts at both agencies and to exchange information about service needs, screening procedures, and housing opportunities.

Establishing a residential rehabilitation program

In 1988, their informal relationship resulted in a formal agreement to establish the Residential Rehabilitation Program (see Appendix B). The mental health center gained greater access to housing for its younger clients and provided the housing agency with several important services. These included pre-screening of younger applicants and on-site case management for clients, as well as education, crisis intervention, and information and referral for all residents, regardless of age.

This program was funded in part by the State Department of Mental Health's Community Integration Living Arrangement (CILA) program, which provides resources for case management and other services for persons with severe mental illnesses leaving nursing homes and psychiatric hospitals to move into public housing.

Resident education and involvement. Before HALC implemented the program, mental health center staff and the HALC executive director met with residents of Dougherty Manor to answer questions about mental illnesses and to explain the benefits of on-site services. Residents who were initially fearful of living with younger, disabled persons have generally been satisfied with the results of the program. The Dougherty Manor "senior" council has been renamed the "resident" council, and residents of all ages are welcomed. As a result, participation in resident council meetings has increased.

The council's opinions are important to HALC management and have helped shape housing agency policies. During the year, HALC's executive director visits each building to listen and respond directly to residents' concerns. HALC also sponsors an annual picnic for all residents in its developments.

Prescreening services. The mental health center prescreens individuals before referring them to HALC to be certain they are not a threat to themselves or others and to determine whether they can adhere to the terms of a lease. Mental health center staff assess an applicant's level of functioning to determine the range and extent of support services he or she may need.

Applicants who successfully complete the prescreening process are referred to HALC, where they go through the agency's regular screening process. For those individuals who have been homeless, referrals from shelter staff may be substituted for landlord references and credit checks. A police record check is routinely conducted for all applicants.

On-site case management. The mental health center provides on-site case managers, each with a caseload of 25 clients. They monitor clients' progress, accompany them to appointments, facilitate group and individual therapy sessions, and help the housing manager conduct inspections and rent reviews for program clients. They also refer clients and other residents to community programs, as needed.

In addition, the mental health center offers an off-site day treatment program for individuals with severe mental illnesses. This is a rehabilitative and extended treatment program designed to restore or maintain individual functioning and to provide opportunities for clients to acquire and enhance interpersonal and daily living skills. Case managers

make weekly contact with participants to monitor their progress.

Case managers also meet with housing managers and management aides to discuss program activities and share information. The directors of the housing agency and the mental health agency meet on a regular basis to monitor the progress of their initiatives.

Crisis intervention. The mental health center is committed to providing 24-hour crisis intervention. Case managers rotate coverage and can be paged by housing managers and management aides.

Looking ahead

HALC is working with the mental health center to create more housing options for individuals with mental illnesses, as well as to increase the range of housing opportunities for all populations. The housing agency has established a separate non-profit development corporation to develop innovative housing using government and private funding sources.

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St. Paul, Minnesota

Summary

With an increasing number of younger, disabled persons on its waiting list for public housing and a limited set of available mental health services, the Public Housing Agency of the City of St. Paul took a number of concrete steps to provide services to residents. These included planning, committing its own resources to arrange for services, developing public-private partnerships, and empowering residents. Specifically:

- The agency conducted a formal needs assessment to guide its internal planning efforts and to help it justify the need for cooperation from community providers, support from elected officials, and monies from funding agencies.
- As a result of its planning efforts, the housing agency committed its own resources to applicant screening, arranging for the provision of services, and education and lease enforcement to facilitate the integration of elderly and younger persons and to maintain a safe and secure environment for all residents.
- The agency also established public-private partnerships with local service agencies to create two separate initiatives: one to provide support services to adults with severe mental illnesses, and the other to coordinate services for, and promote a sense of community among, all residents of a mixed-population high-rise building. Such efforts require close coordination at the client and agency level and a sense of commitment to meeting the needs of elderly persons and persons with disabilities.
- Empowering residents to become involved in planning for and meeting their needs has given them a stake in the success of service programs and created a sense of community within public housing developments.

ST. PAUL, MINNESOTA

Building Partnerships

St. Paul is a moderate-sized city with a population of 272,235. During the 1980s, the city lost most of its single-room-occupancy (SRO) housing through gentrification, creating a shortage of affordable housing for persons with disabilities. In 1990, a one-bedroom apartment in St. Paul averaged $455, while the maximum Supplemental Security Income benefit available to elderly persons and persons with disabilities was $461. At the same time, housing opportunities for elderly persons were increasing.

The Public Housing Agency (PHA) of the City of St. Paul constructed housing for elderly families between 1959 and 1976. It operates 2,620 efficiency and 1-bedroom units in 16 high-rise developments, ranging in size from 72 to 231 apartments. In 1991, 46 percent of the waiting list was composed of individuals under the age of 62, 28 percent of whom had a severe mental illness.

A reputation for excellence

In 1991, PHA received an award from the Department of Housing and Urban Development for its sustained performance. PHA was recognized for sound fiscal management, administrative excellence, resident involvement, and participation in public-private initiatives.

Planning has been key to the agency's success in meeting the needs of its residents. In 1988, PHA issued a comprehensive planning document titled "Social Service Needs in Public Housing High-Rises" that reviews needs, identifies community providers, recognizes service gaps, and makes recommendations for change.

As a result of this effort, PHA hired a full-time program services manager to coordinate services. The services manager plans programs, writes grant proposals to obtain funds, and coordinates the work of community providers. She supervises three human services coordinators, also PHA employees, who provide needs assessment, crisis intervention, and followup with outside agencies.

A manager, associate manager, and four assistant managers oversee operation of 14 high-rises. The remaining two high-rises in family developments have on-site management staff, and each high-rise development also has a resident caretaker. Any of the management staff may refer residents to the human services coordinators for assistance.

Each of the 16 high-rise developments offers a variety of services to residents, some of which are provided by outside vendors. These include congregate dining, health clinics, beautician/barber services, a shopping bus, food stamp certification, and substance abuse support groups.

Serving a younger population

In the 1980s, the housing agency in St. Paul began to see a shift in applicants for public housing—the number of elderly persons on the waiting list was decreasing, while the number of younger persons with severe mental illnesses and other disabled persons was on the rise. But services for persons with severe mental illnesses were more limited and difficult to access than those for elderly, non-disabled persons.

The local mental health authority, Ramsey County Mental Health System, was undergoing major changes as a result of new State legislation reconfiguring public mental health services. Under the new system, the county contracts with 35 nonprofit agencies to provide mental health services to persons with severe mental illnesses. Case managers' caseloads in these agencies typically run as high as 50 clients per case manager, which means that home visits are rarely possible.

As a result, PHA decided to commit its own resources to facilitate integration of the two populations through a comprehensive approach consisting of careful applicant screening, arranging for the provision of support services, and education and lease enforcement.

Applicant screening. All applicants are screened for their ability to pay rent, maintain their apartments, and comply with all other relevant provisions of a PHA lease. The housing agency obtains information through credit checks; interviews with landlords, board-and-care professionals, and social workers; and a police record check. Applicants without landlord references, such as individuals who have a history of homelessness and mental illness, may provide references from a social worker at a shelter or transitional residence. In addition, case managers may provide assurances that they will support their clients in housing and help them comply with their lease.

Arranging for support services. PHA is committed to arranging or providing support services for the residents of public housing through the development of a comprehensive network of local providers. Representatives of community agencies serve on the PHA Board of Commissioners; the agency's program services manager solicits services from community providers on behalf of public housing residents and coordinates these activities; and the human services coordinators develop relationships with direct service staff at community agencies that serve residents.

In addition, PHA was awarded funding through the HUD Congregate Housing Services Program (CHSP) to provide housekeeping, meals, and counseling services to eligible elderly and disabled PHA residents. This assistance helps prevent early nursing home placements and hospitalizations through personal intervention and support.

Education and lease enforcement. PHA staff plan and organize educational sessions for all residents. These sessions address the special characteristics of each population and provide information on living successfully with diverse groups of people. Management staff are available to investigate complaints about lease violations and to enforce provisions of the lease in a timely and objective manner. Having management staff on site during the day and social service staff available during the afternoon and evening has decreased reports of problems and increased residents' feelings of security.

Accessing services for residents with mental illnesses

Despite the limited mental health resources available to it, PHA was able to work with several local mental health service agencies to create specialized services to meet the needs of persons with severe mental illnesses in its developments. Two of these efforts are highlighted below.

The Safe Alternatives program. In 1987, PHA entered into an agreement with Safe Alternatives, a long-term housing support program for adults with severe mental illnesses (see Appendix B). Individuals with mental illnesses who have participated in a Safe Alternatives transitional housing program occupy 10 units that were set aside in one of PHA's buildings. Case managers from Safe Alternatives meet with PHA caretakers, managers, and service coordinators to discuss service plans for program participants and offer the following direct services to residents:

- assistance with the PHA application process;
- furnishings for individual units;
- client advocacy;
- case management;
- an off-site, drop-in center for clients and other PHA residents in need of mental health services;

- 24-hour crisis intervention; and
- financial assistance for clients.

While Safe Alternatives offered intensive services to its participants, PHA staff lacked resources for persons with severe mental illnesses who were not part of the program. To address this need, PHA's program services manager developed a joint initiative with another local mental health service provider to provide support services in eight of the high-rise developments.

The STAR program. Together, the St. Paul PHA and the nonprofit Westminster Resident Services Corporation applied for and received a $67,200 Neighborhood Revitalization Grant from the city to create the Services to Assist Residents (STAR) program. PHA provides such in-kind donations as office space, equipment, and some clerical support. The program's goals are to:

- initiate and encourage participation of residents in the development of programs to meet their common needs;
- develop a more comprehensive residential community and positive interaction between diverse groups;
- maintain residents' ability to remain in affordable housing by addressing economic, health, and other needs; and
- increase the participation of residents in neighborhood activities and in addressing community needs.

Three long-time residents of public housing for elderly families in St. Paul relax after a potluck dinner sponsored by the STAR program.

The grant provides for the STAR program to be staffed by two resident services advocates, a psychiatric nurse, and a community services coordinator. Staff are on site from noon to 8 p.m. weekdays, providing needed coverage in the early evening hours when most residents are home.

The resident services advocates are responsible for assessment, case management, referrals, and service coordination. The psychiatric nurse provides weekly consultation to the STAR program. She gives information on psychiatric and medical concerns and interviews residents referred by PHA or STAR staff.

A social worker by training, the STAR program's community services coordinator uses her community organization skills to encourage residents' participation in program development and involvement in community activities. She holds regular meetings for residents to exchange information and socialize.

Residents publish a monthly newsletter, and younger persons have become active members of the resident council. At the suggestion of several of the younger residents, the "Life and Times Exchange" was created to bring younger and elderly persons together. Activities have included potluck dinners, a dance, and seasonal parties. The STAR program has been credited by PHA management with greatly improving relationships among diverse groups of residents in the building.

Looking ahead

In its efforts to provide and coordinate services for public housing residents, PHA has faced problems of insufficient funding and a fragmented service system. The STAR program was funded under a one-time grant that will soon be completed; PHA and STAR program staff agree that if alternative funding cannot be found to continue services, the end of this program will be a great loss to residents. Inadequate funding for county case management services leaves many residents with mental illnesses without needed care.

Also, some agencies that can provide services to elderly persons cannot serve disabled persons, and vice versa, and many agencies have restrictive eligibility requirements and/or long waiting lists. Some of these concerns are addressed through PHA's concerted efforts to work with community providers to serve all public housing residents.

St. Paul is working with the business community to continue and expand a successful "Adopt a High-Rise" program. Corporate volunteers make a commitment to sponsor an activity in a high-rise building either monthly or annually. PHA also plans to apply for funds from the HUD Community Development Block Grant (CDBG) program to provide continued funding for some of its program services.

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Danbury, Connecticut

Summary

The Danbury Housing Authority and the local Mental Health Association are working together to expand housing options for persons with severe mental illnesses and to provide services to clients living in the housing of their choice. Their collaboration is based on the following principles:

- With sufficient support services, most persons with severe mental illnesses can live independently.
- Living with elderly people in public housing should be offered as one of several options available in a community.
- Persons with severe mental illnesses must choose their housing; success is more likely if individuals are living where they want to live.
- Both public housing and mental health agencies have valuable resources to offer one another, and each gains important benefits through collaboration.

The Mental Health Association provides individualized long-term services and 24-hour crisis intervention to all its clients, regardless of where they live. The housing agency has placed a renewed emphasis on such activities as screening, security, and an active management presence. Staff are reaching out to community-based service agencies to gain access to the services needed by public housing residents and seeking new funding sources to create additional housing options and support services for persons with severe mental illnesses in Danbury.

DANBURY, CONNECTICUT

Offering Options

With a population of 65,585 and a location only 60 miles from New York City, Danbury, Connecticut, and the sur rounding county are home to many residents who work in New York. The competition for affordable housing is intense, especially for people with low incomes. Rent for a one-bedroom apartment averages nearly $700 per month. When less expensive housing can be found, it is often in poor condition and in areas considered unsafe.

The Danbury Housing Authority (DHA) has 5 developments for elderly families, including 3 high-rises and 2 garden-style apartment complexes, for a total of 400 units. The high-rise developments include a renovated 98-unit turn-of-the-century hotel in downtown Danbury, a 98-unit high-rise built in the late 1970s, and a 54-unit high-rise.

In 1991, the vacancy rate for DHA's housing for elderly families was less than 2 percent, with more than 500 people on the waiting list. Five percent of Danbury's public housing developments for elderly families and 10 percent of the waiting list were composed of persons under age 62, many of whom have a severe mental illness.

Two agencies, a common goal

The Danbury Housing Authority did not always have a low vacancy rate in its housing for elderly families. In the mid-1980s, vacancies climbed as two privately operated Section 8 New Construction high-rises opened. At about the same time, a local mental health advocacy group inquired about the availability of Federal housing subsidies for persons with severe mental illnesses.

The DHA director approached the director of the Mental Health Association (MHA), one of several local, nonprofit agencies that provide mental health services under contract to the Connecticut Department of Mental Health. MHA was finding it harder to locate affordable housing in Danbury for its clients and had not been using public housing as a resource. The agency was also looking for housing that offered more privacy and opportunity for independence than that afforded by the group living arrangements it operated.

Together, the two agencies designed an approach that met the needs of both organizations. MHA applicants were placed on the combined waiting list for Section 8 rental vouchers and rental certificates and public housing and were given priority in accordance with the HUD preference rules. MHA agreed to provide support services for clients living in publicly subsidized housing and made assurances to the housing agency, as well as to landlords who accepted Section 8 rental vouchers or rental certificates, that clients' rent would be paid and the rental unit would be maintained.

These agreements greatly expanded housing alternatives for MHA clients. Clients choose from among private housing subsidized with a rental voucher or rental certificate, public housing high-rises and garden apartments, and the several group living options offered by MHA.

By January 1992, 11 MHA clients lived in DHA's public housing for elderly families, and 10 others lived in apartments subsidized by rental vouchers or rental certificates. Most younger persons with severe mental illnesses choose a rental voucher or

rental certificate, while most clients over age 45 decide on the convenience of a high-rise or garden apartment owned by the housing agency.

Providing intensive support services

Support services are provided to MHA clients by residential counselors who typically have master's degrees in a human services field. With caseloads of about seven clients each, residential counselors visit clients daily, if necessary, and assist them in all aspects of their lives, including teaching basic living skills, sponsoring group social activities, helping them obtain entitlements, and linking them with other health and social services.

Individualized, long-term commitment to clients. MHA staff begin by engaging clients in services they are willing to accept and setting goals for involvement in other services. Individual treatment plans are regularly revised to reflect changing goals and skills development. While some clients work with their counselors on finding competitive employment, others are learning basic hygiene, self-care, and socialization skills.

The MHA accepts responsibility for clients as long as they need and want services. While the level and intensity of services to MHA clients may vary depending on individual needs, few cases are ever closed. Reluctance to accept mental health services at any point is met with continued outreach, not rejection.

A resident of Danbury Housing Authority's public housing for elderly families describes the success of the visiting case management program.

Twenty-four hour crisis intervention. MHA staff are available for 24-hour crisis intervention, including weekends. If a crisis arises, DHA management staff or the private landlord knows who to call and can be confident that a rapid and appropriate response will be made. In one incident in which both the housing agency director and the mental health worker on call were both telephoned about a crisis involving a resident with mental disabilities, two mental health staff had already arrived and had the situation under control when the director reached the building.

An emphasis on what housing agencies do best

In addition to its collaboration with the Mental Health Association, the Danbury Housing Authority has placed a renewed and expanded emphasis on the activities that housing agencies have traditionally provided.

Screening. DHA has developed a careful screening process that includes a rental history and police record check. Reasonable accommodations are made for persons with severe mental illnesses who have little or no rental history if an agency such as MHA provides some assurances that rent will be paid and support provided. Thus, applicants who might otherwise not be accepted are often approved.

Management accessibility. DHA staff at all levels are encouraged to interact with residents on a daily basis. The director spends time at each development and is known by residents.

Depending on its size, each development has either a full-time or half-time building manager on site. Building managers are encouraged to get to know the residents and trained to make referrals to community service agencies.

In addition, each development has a part-time senior aide, provided by the local Community Action Program with funding from the Older Americans Act. The aides, some of whom are residents, work with the building managers to reach out to isolated residents, respond to complaints, and identify potential problems or resident needs.

Relationship with legal services. The housing agency has developed a relationship of mutual respect and trust with the local legal services agency. Because it is assumed that both agencies are working for the best interests of people with low incomes, complaints brought to legal services are usually resolved informally. DHA trusts that legal services will not pursue frivolous cases, and legal services staff know that when they feel they must pursue a case, their complaint is taken seriously.

Security. To help alleviate resident concerns about safety, DHA provides a security guard posted at each development throughout the evening hours.

Visiting case management. Recognizing that it is not enough to train building managers to be more "people-oriented," DHA recently collaborated with Connecticut Community Care (CCC) and the Danbury Department of Elderly Services to develop case management services for elderly persons and persons with disabilities in each development. A $10,000 grant to CCC from Union Carbide provided start-up funds, with the remaining support for a full-time case manager at each development provided by the Department of Elderly Services. The case managers will be a focal point for assessing and identifying resident needs, linking residents to services, and building a sense of community in each development.

Transportation. The Danbury Housing Authority received a $12,000 grant from the city to hire a driver and purchase a van that makes regularly scheduled stops at each development and takes residents shopping, to medical appointments, and to community activities.

Lease enforcement. DHA has clear, objective standards regarding grounds for eviction, as well as a formal grievance procedure. While lease violations are not tolerated, staff focus on resolving problems long before eviction becomes necessary.

Looking ahead

Danbury Housing Authority staff are aware of the need for both increased services and housing opportunities for persons with severe mental illnesses. Some public housing residents who need mental health services cannot be served because local mental health providers do not have sufficient resources. Also, a finite supply of Section 8 rental vouchers and rental certificates and the long waiting period for public housing restrict the availability of housing for persons living on limited incomes.

To expand housing options in Danbury, particularly for persons with severe mental illnesses, DHA is involved in the following efforts:

- Using $300,000 in Community Development Block Grant (CDBG) funds to rehabilitate a 20-unit SRO residence with support services for homeless persons, at least half of whom have severe mental illnesses (a private grant to enhance the service component is pending).
- Collaborating with a nonprofit service provider and the Danbury Department of Elderly Services to build a 100-bed congregate care facility for elderly persons and persons with disabilities using Congregate Housing Services Program (CHSP) funding from HUD.
- Using Section 8 rental vouchers and rental certificates as well as State Rental Assistance Program vouchers.

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Providence, Rhode Island

Summary

Nearly half of the residents in the Providence Housing Authority's public housing developments for elderly families are under the age of 62. To address this dramatic shift in population, the agency administered a needs assessment and developed a long-range plan to address residents' health, mental health, and social service needs. The agency director has been aggressive in seeking out creative financing for support service programs.

With successive State grants—first from the Department of Elderly Affairs and, subsequently, from the Department of Mental Health, Retardation, and Hospitals' Division of Substance Abuse—the housing agency hired social workers to provide services that include outreach and assessment, crisis intervention, education, advocacy, and referrals to community agencies.

The fact that social workers are employed by the housing agency and are available on a daily basis has advantages for both staff and residents:

- Elderly and younger residents have access to services provided by the social workers and can be linked to resources in the local community.
- Building managers have knowledgeable individuals to whom they can refer residents with health, mental health, and substance abuse problems, or who need help with daily living skills or socialization.
- Early intervention helps prevent evictions and creates a more positive relationship between residents and building management.

PROVIDENCE, RHODE ISLAND

Providing a Range of Services

Jim believes that the staff and residents at his Providence high-rise saved his life in more ways than one. He suffers from epileptic seizures as a result of a head injury sustained during adolescence, complicated by alcoholism and severe mental illness. Jim was able to pull an emergency cord in his apartment during a crisis, and housing agency staff and residents responded. When he was stabilized, he was referred to a visiting social worker. Today, he is working with her to help maintain his physical and mental health, and he attends Alcoholics Anonymous support groups on a regular basis. Formerly a "loner," he now spends his days helping others in the building.

Providence is the capital of Rhode Island and its largest city, with a population of 160,728. Like many cities of similar size and composition, Providence lost much of its low-income housing through gentrification in the mid-1980s, and rents soared. There remains a shortage of affordable housing for persons on limited incomes.

The Providence Housing Authority (PHA) has 7 developments for elderly families, with a total of 1,141 units, constructed between 1962 and 1984. Six of these developments are high-rises ranging in size from 106 to 291 units; the seventh is a garden apartment development with 24 units. As of December 1991, occupancy was at 93 percent, with fewer than 5 percent vacancies in all but one building.

A dramatic shift in populations

By January 1992, 42 percent of the population in the high-rises for elderly families was under age 62, and many of the younger residents had disabilities. This situation represents a dramatic population shift from 5 years earlier, when fewer than 5 percent of residents were under age 62. It is anticipated that these developments will soon be occupied primarily by younger, disabled residents, who comprised 62 percent of those on the waiting list in 1992. Approximately two-thirds of these individuals claim a Federal preference.

In 1988, the executive director of PHA created a Department of Special Services to begin to address the needs of the increasingly heterogeneous population in the agency's public housing developments. This population included frail elderly persons, physically disabled persons, individuals

with substance abuse problems, and the growing number of residents with severe mental illnesses.

A plan to address service needs

The Department of Special Services administered a needs assessment and developed a long-range plan to address residents' health, mental health, and social service needs (see Appendix C). PHA then approached community agencies to obtain resources for services. In 1988, the Rhode Island Department of Elderly Affairs awarded PHA a grant to pay for three social workers for the high-rise developments for elderly families. When this funding ended in 1990, PHA applied for and was awarded a $58,000 grant from the State Department of Mental Health, Retardation, and Hospitals' Division of Substance Abuse to fund substance abuse counselors. Three counselors, employed by PHA and based at three of the high-rises, provide coverage at all six high-rise developments for elderly families.

A range of services

The substance abuse counselors form the backbone of what Providence calls the Social Services Program. In addition to providing substance abuse counseling and referrals, PHA social workers perform a number of vital services for elderly residents and younger, disabled residents throughout the six high-rise developments for elderly families. These services include:

- **Outreach and assessment**. The social workers visit each new resident to conduct an initial screening and needs assessment and to develop short- and long-term goals. Residents are informed of available services provided by the social work staff and in the local community.
- **Information and referral**. Social workers link residents with social services, health and mental health care, and benefit programs. They provide information, make telephone referrals, accompany individuals to appointments if necessary, and conduct followup. The social workers have made it a priority to become known by local service providers, which has significantly improved PHA relations with outside agencies and has enhanced service provision to residents.
- **Crisis intervention**. Social workers are available to respond to problems with residents or visitors. They provide on-site support and will contact an outside agency if needed (e.g., mental health crisis unit, police, or ambulance).
- **Resident support and advocacy**. Social workers act as liaisons between building managers and residents, working with residents who may be in danger of violating their lease and bringing resident complaints to the attention of building managers.
- **Education and training**. The social workers conduct occasional workshops for interested residents on topics ranging from AIDS education to death and dying. They have also arranged for outside groups to provide training sessions and health care screenings.
- **Recreation and socialization**. The social workers arrange trips to outside attractions and events, often coordinating with the Department of Recreation, and work with resident councils to provide holiday celebrations and parties.

Many residents feel that the Social Services Program counselors are accessible, responsive, and of great help to a number of the residents. Housing agency staff report that the presence of on-site social service staff has increased tenfold their ability to respond to problems before they become crises. At one building, the resident council president gave the program high praise when he said, "The Social Services Program counselors have been the saving grace for this building."

Community connections and in-house initiatives

In addition to providing support services, the Providence Housing Authority has reached out to the local community and begun a number of in-house initiatives to increase the variety and accessibility of services to elderly residents and younger, disabled residents. These efforts include:

- **Interagency coordination**. The Providence Center, the local community mental health center, is the primary mental health provider for public housing residents with severe mental illnesses. Approximately 15 percent of residents of PHA high-rises are Providence Center clients. Services include outpatient treatment, case management, crisis intervention, an adult day care program, and vocational services. Providence Center has designated a single staff person as the liaison between the mental health center and PHA. This housing coordinator is available on a half-time basis to the six PHA high-rises for elderly families to provide follow-up and crisis intervention to Providence Center clients and consultation to PHA social workers.

- **Weekly service coordination meetings**. PHA social workers, building managers, and the mental health center's housing coordinator meet

A disabled resident of public housing for elderly families in Providence is a former chairperson of his development's resident council.

weekly to solve problems, coordinate services, and ensure smooth communications between housing and mental health center staff.

- **Hot lunch program**. Project Hope, a local nonprofit agency serving elderly persons, provides hot lunches at four of the six high-rise developments for elderly families. All residents are eligible, and the lunches have helped ease isolation, encourage socialization between younger and elderly residents, and create a stronger sense of community within developments. Mealtimes provide an opportunity for mental health staff to assess service needs and build rapport with residents who may be initially reluctant to accept services.
- **Visiting nurse services**. The Visiting Nurses Association provides a variety of services, including home care, physical therapy, visiting homemakers, and geriatric health maintenance.
- **Medication management program**. Two pharmacists from the University of Rhode Island visit each of the high-rises for elderly families weekly to educate residents about medication management, answer their questions, and inform them about available health care services.
- **Transportation services**. The American Association of Retired Persons' (AARP) Senior Employment Program supports two drivers for a PHA-owned van serving residents of the housing agency's developments for elderly families. It has increased the mobility of both elderly and younger residents, who may ride the van to outside medical and other appointments.
- **Increased security**. Security, a major concern of elderly residents, has been increased and improved. With $140,000 in State funding and other resources, PHA has hired security guards for the evening hours and uses volunteers for daytime monitoring.
- **Resident orientation and education**. The Department of Special Services has developed a "Preparation for Community Living" course, with two mandatory 3-hour sessions for all prospective residents and a 3-hour session for current residents. Among topics covered are money management, health care, substance abuse prevention, housekeeping, and available community services. These sessions also provide an opportunity to introduce new residents to the positive aspects of living with persons of different ages and special needs.

Looking ahead

PHA and the local mental health center have worked to strengthen their relationship, which has resulted in better and more reliable mental health services to public housing residents. PHA staff report that confidentiality for mental health clients has created problems in screening potential residents and in treating residents who have an apparent mental health problem. The two agencies will continue their ongoing dialog on this and other issues.

The most critical gap in the Providence approach is one faced by many housing agencies: lack of sufficient resources to meet the wide range of needs among residents of public housing. Ideally, PHA would like to provide one social worker per building and add a supervisor for the program. But these ideas may have to wait. The Social Services Program has operated under grants from two successive State agencies, and future funding is not guaranteed. Mental health staffing has been reduced—the local mental health center's housing coordinator is available only half-time to serve six high-rise developments.

Despite the difficulties inherent in coordinating multiple services and ensuring continued funding, the Providence Housing Authority is working closely with providers in the local community to meet its goal of offering "a decent home in a suitable living environment" to all residents in Providence public housing developments.

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Seattle, Washington

Summary

The Seattle Housing Authority responded to the changing population in its high-rise developments for elderly families by identifying problems and developing comprehensive plans to address them. A group of 60 staff, residents, community leaders, and local service providers developed a strategy for addressing residents' needs in high-rise developments. A number of their proposals are addressed by ongoing or new programs:

- The housing agency arranged for the provision of on-site services to elderly persons at risk for severe mental illnesses. When the initial source of funding for this program ended, the housing agency used its own resources to expand the program to include younger individuals with disabilities.
- To help residents with differing needs and lifestyles learn to live together, the housing agency developed a resident orientation and education program. This includes a detailed discussion of the screening process and the procedures for handling problems and grievances.
- To empower residents to build a sense of community, the housing agency organized a Resident Action Council to oversee the social, educational, and recreational activities sponsored by individual building resident councils and to be an advocate for residents within the community.
- The housing agency coordinates its services with those in the community by sponsoring quarterly meetings among service providers to increase awareness of residents' needs.

SEATTLE, WASHINGTON

Developing a Comprehensive Approach

When Mr. C. first moved into a Seattle high-rise development as a recent widower, there were few younger residents. As time went on, he and his neighbors became concerned about increasing numbers of young people who were acting in ways the elderly residents did not understand. But after attending the housing agency's "We All Live Together" program one evening in his building, Mr. C. felt more comfortable. "I hate using the terms 'young' and 'old.' We have a lot to offer one another, and this program helps us come together as a community."

Seattle, with 516,259 people, is one of many West Coast cities that have enjoyed a recent surge in popularity, with an attendant rise in housing costs. In 1990, a one-bedroom apartment in Seattle averaged $427, while the maximum Supplemental Security Income benefit available to elderly persons and persons with disabilities was $414.

The Seattle Housing Authority (SHA) has been actively involved in meeting the city's need for low-income housing since 1939. SHA has 3,000 units for elderly families in 30 high-rise developments built between 1960 and 1970. The high-rise developments vary in size from 59 to 300 units, and most are 1-bedroom apartments.

While many single-room-occupancy (SRO) units and efficiency apartments that might have been home to persons with mental disabilities were lost through gentrification efforts in the 1980s, Seattle has a number of attractive housing options for elderly persons. In 1984, the city issued bonds to create 1,000 units of housing for elderly persons. Applicants for this new housing were allowed to choose the neighborhood in which they wanted to live, making it particularly attractive to elderly persons and decreasing the demand for SHA high-rise developments.

In 1982, 83 percent of those living in public housing developments for elderly families were over the age of 62. By January 1992, that figure had dropped to 49 percent and 79 percent of the SHA waiting list was composed of individuals under age 62.

Responding to change

In 1982, as increasing numbers of patients from the area's State psychiatric hospital were being transferred to community living, the Seattle Housing Authority began to house increasing numbers of younger persons with severe mental illnesses in

public housing for elderly families. Because it maintains an active management presence in each building, SHA was able to monitor residents' reactions, which included an increased level of fear and concern on the part of elderly residents, many of whom found it difficult to accept their younger neighbors.

In 1989, SHA issued a "High-Rise Mixed Population Report" identifying factors and problems that negatively affected the quality of life within the buildings. These included misconceptions about mental illness, substance abuse problems, and fear of reporting incidents. The report was developed by an ad-hoc committee of elderly and younger residents, social service staff, and SHA building managers, and it became the basis for later planning efforts.

Maintaining an active management presence

Building management is key at SHA. The agency has, typically, one building manager and a management aide for every three buildings. In addition, each building has a live-in management assistant. Managers are responsible for administrative functions, including collecting rents, handling complaints, and supervising aides and assistants. Management aides and live-in assistants act as liaisons between management and the residents, referring at-risk residents to community resources, helping to prevent possible evictions, and dealing with health and related crises. Live-in assistants are responsible for building maintenance and are on call for emergencies during the evening.

SHA also has a resident services coordinator and resident services assistant who obtain and organize services on behalf of residents and the developments' resident councils. Each SHA high-rise offers one or more amenities that may include on-site adult day care, large community rooms on the main floor and small common areas on each floor, laundry facilities, and offices for such on-site services as podiatry and health screenings.

Developing comprehensive plans

In 1991, the Seattle Housing Authority gathered 60 staff members, residents, and service providers to address service needs and problems in high-rise developments. Participants divided into teams and were asked to create new strategies for addressing needs in the high-rise developments, given current resources. Five of the teams focused on specific clusters of high-rise apartment developments located in Seattle. Two teams concentrated on systemwide strategies. The design teams had a single all-day session to create strategies around the following goals: improving residents' personal safety, strengthening the sense of community among residents, improving the independence and successful tenancy of individual residents, and strengthening relationships between residents and the neighborhood.

Consistent themes that were expressed by all groups included:

- Resident involvement in all aspects of subsidized housing, from screening and orientation to governance, is basic to the development of a shared sense of responsibility and community.
- The changing mix of residents should be viewed as an opportunity to develop new strategies that overcome fear and misconceptions between populations.
- Housing management is a difficult job, requiring the development of increased professional approaches to building management, with adequate compensation and administrative support.
- The level of support services needs to be increased in all high-rise developments for elderly families to ensure access to social services and early intervention in resident problems.
- The physical layout of facilities needs to be designed or rehabilitated to accommodate needs of residents with physical limitations, to promote a sense of security and personal safety, and to create a stronger sense of community.

The resulting report, "Helping Seattle's Low-Income High-Rises Succeed: Solutions Within Reach," was later presented to a group of government officials and community leaders as the basis for discussions concerning greater access to funding and community-based services (see Appendix C). A number of these themes are being addressed by ongoing or new programs sponsored by the Seattle Housing Authority, several of which are highlighted here.

Supporting residents through on-site services

In 1986, the State of Washington Department of Social and Health Services in conjunction with Community Home Health Care, a local nonprofit services provider, received a 3-year demonstration grant from the National Institute of Mental Health to address the needs of elderly persons at risk for severe mental illnesses. The objectives of the Community Connections program were to provide services to elderly persons, to remove barriers to their use of mental health services, and to train public housing managers and residents to make referrals and respond effectively to situations involving elderly residents with mental illnesses. Because of the program's success, the housing agency has used its own resources to expand the program to include younger individuals with mental disabilities.

The program has 9.5 professional social service staff who provide 10 hours of on-site services per week to each of the 30 high-rise developments. Each staff member carries a caseload of approximately 25 residents, and the goal is to link residents with community services and to provide support. Building managers can refer at-risk residents of any age to Community Connections staff, who maintain an on-site office and a small food pantry that helps them engage residents.

In addition, using funds awarded through HUD's Public Housing Drug Elimination Program, SHA contracts with the Central Seattle Recovery Center to address substance abuse within the high-rise developments. Five certified substance abuse counselors run alcohol and drug recovery support groups, develop educational sessions, and refer residents to detoxification or rehabilitation programs, as needed.

Once a week, SHA building managers and assistants meet with Community Connections staff and the substance abuse counselors to conduct cross-training and to discuss available services and ways to improve coordination of services within the developments. The SHA hosts quarterly meetings with local governmental and community agencies to address issues of concern to public housing residents.

Helping residents live together

To help potential and current residents understand the diversity of individuals who live in the high-rise communities, SHA has created a program called "We All Live Together." In a brochure for new applicants (see Appendix F) and in a seminar offered periodically to current residents, SHA helps residents understand and be tolerant of different needs and effectively address problems that may arise. Topics include:

- **Different populations**. The material includes an explanation of who is eligible to live in public housing for elderly families, how their needs and lifestyles may vary, and how to understand the difference between real and perceived danger.
- **Screening**. SHA explains its screening criteria in detail. These include past rental or homeownership history; references from agencies, professionals, and creditors; a home visit by SHA staff; and a criminal record check.
- **Problem resolution**. Each current and prospective resident receives information on how to report complaints or problems to SHA, complete with a blank complaint form. Details are provided on the SHA grievance procedures for denied applications and contested evictions.

Believing that residents need to get involved in their buildings to maintain safety and cleanliness and to create a sense of community, SHA strengthened or reestablished a resident council in eight of the high-rise developments where such groups had

become inactive and were perceived as a potential agent for change. The agency also works with a central steering committee called the Resident Action Council, which includes a representative from each building and advises SHA on security and residents' needs. The Council meets quarterly and acts as a liaison between individual resident councils. SHA provides clerical support.

In addition to facilitating social, educational, and recreational activities within the buildings, the Council has become active politically, convincing the city to have a new traffic light installed outside one of the buildings and testifying at local budget hearings when Community Development Block Grant (CDBG) funding for the Community Connections program was in jeopardy.

Financing services

The Seattle Housing Authority makes maximum use of available funding opportunities to create

A resident of the Seattle Housing Authority's Ballard House says the "We All Live Together" Program has helped her get to know and accept her new neighbors.

and sustain services for residents in public housing for elderly families. In 1992, SHA received $258,000 in CDBG funds to continue the Community Connections program. The CDBG grant provides partial funding for social workers to provide crisis intervention and information and referral to all residents of SHA's high-rise developments for elderly families. In addition, the housing agency requested and received special congressional authorization to transfer $450,000 in surplus revenues from a successful Section 8 New Construction housing development owned by the housing agency to help maintain its social service programs within public housing.

In 1990, SHA's CDBG funds were in jeopardy. SHA residents and staff testified before local legislators on the importance of the CDBG grant. They specifically spoke about the improved conditions in high-rises and the importance of the services to residents. As a result of this concerted effort, SHA was awarded another round of CDBG funds from the city.

SHA is continually looking for new funding opportunities to meet the needs agreed upon in its report, "Helping Seattle's Low-Income High-Rises Succeed: Solutions Within Reach." For example, the substance abuse services provided in 1991 by the Central Seattle Recovery Center were funded through a HUD Public Housing Drug Elimination Program grant.

Looking ahead

Insufficient funding to develop its programs fully is the most difficult problem encountered by SHA. Each program operates at minimum levels, and future funding is in doubt. Each year it becomes more difficult to provide existing services, and the needs far outweigh available resources.

SHA would like to see community providers take responsibility for maintaining services to individuals who need assistance on an ongoing basis. They have found that some service providers have little contact with clients once they become housed.

The housing agency has also identified the need for congregate meals, on-site employment and vocational services, support groups for persons with mental illnesses, services for persons with dual diagnoses, and increased affordable housing options of all types.

Working within administrative and fiscal constraints, the Seattle Housing Authority has made great strides in addressing the needs of elderly persons and younger, disabled persons in its public housing developments in an effort to provide safe, affordable housing and a sense of community for low-income individuals in Seattle.

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Rockford, Illinois

Summary

When the Rockford Housing Authority filled openings in one of its developments with young persons, both with and without disabilities, further vacancies were created as elderly persons decided to leave. To stabilize the building, the housing agency:

- Made extensive interior and exterior renovations to the building.
- Conducted a needs assessment to determine where to spend scarce resources (both dollars and staff time) in order to have the greatest impact on the housing agency's and residents' concerns.
- Strengthened the resident council to provide leadership, support, and a sense of "ownership" among residents.
- Established on-site support services, with the collaboration of a local mental health service provider, to offer individualized programs of services and support to persons with mental illnesses, and to be responsive to the concerns of all building residents.
- Actively marketed the newly renovated building and its services to potential residents.

The housing agency administration and staff demonstrate a high degree of commitment to developing a public housing program that contributes to the well-being and successful residency of all residents. Providing comprehensive, flexible support services and creating a sense of community within this one development has given the housing agency a model it would like to replicate in its other developments.

ROCKFORD, ILLINOIS

Establishing a Sense of Community

The Brewington Oaks Resident Council officers were discussing the pros and cons of mixing younger and elderly residents in high-rise public housing developments. Some members expressed concern that the two groups couldn't live together, especially if some of the younger residents had mental illnesses. At that point, Mr. R. spoke up.

"We need to welcome these younger people, show some compassion for them, and realize that they'll fit in just fine as long they receive the support they need," he said. After some discussion, the other council members nodded in agreement and moved on to another topic.

Rockford is the second-largest city in Illinois, with a population of 139,426. Once a busy manufacturing center, Rockford experienced a significant loss of industry in recent years and was hit hard by the recession in the early 1990s. Inexpensive housing is plentiful, though it is often in disrepair and is located in run-down neighborhoods.

The Rockford Housing Authority (RHA) manages 1,000 units of housing for elderly families in five 14-story high-rises. Until the early 1980s, RHA maintained full occupancy, with long waiting lists. In the mid-1980s, two high-rise developments assisted through HUD's Section 8 New Construction program opened, and many elderly persons moved from RHA housing to these buildings.

In 1991, 30 percent of residents in Rockford's public housing developments for elderly families were young, disabled individuals. They comprised 80 percent of the waiting list, although the demand by elderly persons for affordable housing has been increasing recently, in part as a result of RHA's marketing initiatives.

Responding to a changing population

By 1984, RHA had a vacancy rate of more than 10 percent in high-rise developments for elderly families. As increasing numbers of younger, disabled persons applied for public housing and became residents, RHA received approval from HUD to house younger persons who would not otherwise be eligible.

Most new residents moved into Campus Towers, which had the highest vacancy rate. But the decision by younger persons to live at Campus Towers led to more vacancies as a number of elderly residents chose to leave. By 1989, the vacancy rate in this development was 32 percent.

RHA staff identified five activities that they believed would be necessary in order to turn this situation around. These activities included:

- renovating the building;
- conducting a needs assessment;
- strengthening the resident council;
- establishing on-site support services; and
- marketing the newly renovated building and its services.

Getting started

Built in 1969, Campus Towers was the largest and oldest RHA high-rise development. It had a total of 418 apartments in two towers connected by a common lounge area and was in need of rehabilitation. Using $3.2 million in HUD Comprehensive Improvement Assistance Program (CIAP) funds, RHA undertook extensive renovations over a 2-year period, beginning in 1989. A name change, honoring a long-time RHA employee and highly respected member of the community, was made to complete the transformation. RHA believed the new name, Brewington Oaks, conveyed an image of strength and ability to overcome adversity.

As renovations began, RHA staff conducted a needs assessment to determine the priority services. RHA staff and members of the resident council met with local and State service providers to develop ways to meet the needs of elderly residents and younger residents with severe mental illnesses.

One of the agencies involved in these discussions was Stepping Stones, a private, nonprofit mental health agency that provides case management services for persons with severe mental illnesses under the terms of the State Department of Mental Health's Community Integrated Living Arrangements (CILA) program. The CILA program funds a set of comprehensive services for persons with mental illnesses released from nursing homes and psychiatric hospitals.

Together, the two agencies developed an agreement whereby RHA would provide three units in Brewington Oaks for Stepping Stones to use as office space and apartments for live-in staff. Stepping Stones agreed to help clients complete the requirements of the RHA application process, assist them in moving in, and provide 24-hour supervision, case management, and crisis intervention (see Appendix B).

Providing intensive support

The Stepping Stones program at Brewington Oaks began in 1990. There are currently 17 clients served by the CILA program who are residents of Brewington Oaks. Stepping Stones staff prescreen clients, then refer them to RHA. Once their lease is signed, staff assist residents with selecting and purchasing furnishings and housewares for their new apartments with funds provided by the CILA program.

The fact that Stepping Stones clients have lived in institutions for many years means they have few of the lifestyle conflicts with their neighbors that some younger persons with mental illnesses may experience. They may, however, require extensive training in daily living skills, such as housekeeping, shopping, cooking, and use of public transportation.

The State's CILA funding allows Stepping Stones staff to offer substantial assistance to clients, with the level of supervision and intensity of support based on individual need. Program staff and services include:

- a case manager who provides supervision and skills training, linkage with other health and social services, liaison with the building manager and resident council, and crisis intervention;
- two resident assistants who live on-site, providing evening and weekend supervision, socialization, recreation, transportation, and some skills training; and
- a social service coordinator, who serves as a liaison with the RHA administration, coordinates services with other providers, and conducts educational workshops on mental health issues for all Brewington Oaks residents.

Stepping Stones staff maintain close contact with other community providers, referring clients to such services as vocational rehabilitation, substance abuse treatment, and day programs. The Stepping Stones staff have no direct responsibility for residents other than their clients, but they meet regularly with the building manager, intervene in crisis situations, and provide mental health assessments and referrals for other elderly and younger, disabled residents.

Building a model community

With renovations nearing completion, Brewington Oaks has become a model development for RHA. The director obtained additional on-site services, including a meal program, a health care clinic, and a day treatment program for elderly and young, disabled residents. The Visiting Nurses Association provides a case manager 5 days a week, funded by the Illinois Department on Aging, to help link

A renovated Brewington Oaks is now the Rockford Housing Authority's model for managing public housing for elderly families.

residents with supportive services and to hold monthly health screenings.

The renovation project has resulted in an attractive, modern building with comfortable common areas and new recreation space, including an exercise room and a billiards room. Security has been tightened, with a card system for residents, security guards at night, and a television monitoring system. Maintenance personnel live on site. They are well known by the residents, who can report problems to them, and they provide an extra measure of security and backup to the building manager.

RHA actively involves residents in planning and encourages them to take leadership roles in their developments. The resident council at Brewington Oaks has its own office equipped with a telephone and photocopy machine where residents produce a newsletter and arrange shopping trips, potluck dinners, bingo, parties, and barbecues. The office serves as a resource center where residents can learn about activities sponsored by RHA, the resident council, or others in the community.

RHA consulted the council during a recent renovation for suggestions on common area furnishings (including the development of a physical activities room with stationary bicycles and aerobic machines) and outdoor plantings. Council officers report that younger residents with severe mental illnesses generally have few problems fitting in with their elderly neighbors and are welcome participants in council activities.

To help maintain a diverse population mix, RHA has begun an extensive marketing program. The agency developed a brochure that lists services available at the high-rise, highlights recent renovations, and provides a floor plan of a typical unit. A videotape narrated by building residents is shown to agencies working with elderly persons. Recently, there has been an increase in the number of applications for public housing in Rockford, attributed largely to RHA's marketing efforts.

Looking ahead

RHA is aware of the need to maintain and strengthen communications with service providers at a time when scarce resources create service gaps for public housing residents. In particular, there are a number of younger residents with mental illnesses living in RHA public housing who are not clients of the Stepping Stones program. Some are served by the local community mental health center, which does not have the resources to provide the intensive services offered by Stepping Stones.

Efforts are underway to strengthen ties between RHA and the mental health center to better serve persons with severe mental illnesses in public housing. Rockford has applied for funds from the HUD Public Housing Drug Elimination Program to hire social workers as prevention specialists to assist residents with substance abuse problems in all public housing developments.

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Toledo, Ohio

Summary

Once beset with vacancies and significant numbers of residents who needed services to help them remain housed, the Lucas Metropolitan Housing Authority has dramatically increased its occupancy rates and reduced turnover. Proud of its accomplishments, the agency is committed to addressing problems in public housing by:

- Working with the local mental health system and other providers to offer housing for persons with severe mental illnesses and support services to all public housing residents.
- Upgrading its physical facilities.
- Conducting an active marketing campaign.
- Working to expand housing options for persons with severe mental illnesses in Toledo.

The housing agency, the Lucas County Mental Health Board, and the local mental health centers have a shared commitment to making their programs work. They plan for services together, and they work closely both at the administrative and staff levels.

They work within the framework of a strong centralized mental health system with responsibility for all persons who have severe mental illnesses and adequate funding to provide extensive, flexible support services to younger persons with severe mental illnesses living in public housing for elderly families.

The housing agency has had considerable success recruiting new residents, both elderly persons and younger, disabled persons, to public housing. This allows the agency to maintain a diverse mix of residents in its developments.

TOLEDO, OHIO

Reaching Out

The building manager at the Flory Gardens apartments in Toledo was wary when she learned that young persons with mental disabilities would be moving into her building. But with the help of on-site mental health staff, she finds that the new residents are thriving. She especially likes the fact that all residents are invited to participate in cooking classes, ceramics classes, and holiday parties sponsored by the mental health program. The program has been successful, she believes, because of advance planning and ongoing communication.

Toledo is a moderate-size city with a population of 332,943. A former manufacturing center, Toledo has lost much of its industry in recent years. Downtown retail establishments have closed, and more affluent residents have moved to the suburbs.

Toledo and its suburbs received funding from HUD-administered programs, such as Section 202 Direct Loans for Housing for the Elderly and Section 8 New Construction, to build privately developed housing for elderly persons. As these buildings became available, many elderly persons living in public housing chose to move. Others have received Section 8 rental certificates and rental vouchers that have enabled them to rent housing on the private market.

Addressing declining occupancy rates and increased resident needs

In 1992, the Lucas Metropolitan Housing Authority (LMHA) managed 1,100 housing units for elderly families in 12 complexes, ranging in size from 14 to 164 apartments. One of the first public housing agencies in the Nation to construct housing for elderly persons and to house elderly persons and younger, disabled persons together, LMHA was beset in the 1970s and early 1980s with declining occupancy rates and an increase in the number of young, disabled residents. Apartments in its downtown high-rises sat vacant, and newer residents needed services to help them remain housed.

In January of 1992, occupancy was at 94 percent (excluding units under renovation), and it continues to climb. The percentage of residents under age 62 in each development ranged from 14 to 64 percent, with an overall average of 30 percent. Despite the high proportion of younger, disabled residents, apartment turnover is low, and evictions are minimal.

These statistics are a testament to LMHA's collaboration with local service agencies and its commit-

ment to actively address public housing vacancies by:

- Working with the Lucas County Mental Health Board (LCMHB) and two of its local community mental health centers to develop a model for providing housing for persons with severe mental illnesses and support services for all public housing residents.
- Upgrading its physical facilities with more than $25 million in HUD Comprehensive Improvement Assistance Program (CIAP) funds.
- Conducting an active marketing campaign that resulted in a net gain of 100 households in December 1991 alone.

Creating a range of housing for persons with mental illnesses

LMHA and LCMHB have been developing housing alternatives for persons with severe mental illnesses in Toledo since the mid-1980s. At that time, the Ohio Department of Mental Health and the Ohio State Legislature created a community-based system

Residents of Flory Gardens in Toledo come together in the community room to socialize.

of care for persons with severe mental illnesses by distributing State funds, saved by moving people from inpatient care, to county mental health boards to expand community-based mental health services.

In 1987, Toledo became one of nine demonstration sites for the Robert Wood Johnson Foundation/ HUD Program on Chronic Mental Illness. HUD provided 125 Section 8 rental certificates to expand housing options for persons with severe mental illnesses. The foundation provided a grant to the Lucas County Mental Health Board for services and administrative costs. Close collaboration between the board and the public housing agency was required. As a result, the director of the public housing agency, who had been a member of the County Mental Health Board, became board chairperson for a year. By making a commitment to understand both the housing and mental health systems in Toledo, the directors of the two agencies established a basis for future collaboration.

Although LMHA had been housing younger persons with severe mental illnesses in public housing for many years, the changes in the mental health system created new challenges for the housing agency and the local mental health community. LMHA needed to fill public housing vacancies, and LCMHB was looking for safe, affordable housing for clients leaving institutions.

In November 1990, the Lucas County Mental Health Board arranged a meeting between LMHA and two local mental health centers, the Ruth Ide and the Zepf community mental health centers. Together, they began planning for the development of a "shared services" model that would combine the resources of both the housing agency and the county mental health system (see Appendix G), with an emphasis on serving all residents of public housing for elderly families, young and old alike.

Developing a program that serves all residents

The program has been in place since 1991, and in early 1992 there were 15 clients of the Ruth Ide program at TenEyck Towers, a downtown high-rise with 153 units, and 26 Zepf Center clients at Flory Gardens, a 161-unit garden apartment complex. Individuals in both programs range in age from the mid-20s to over 60 years. Mental health center clients receive intensive on-site services, while other residents benefit from cooperation in processing housing applications, nighttime security staff, and access to on-site mental health staff for information and referral, assertive outreach, and recreation and socialization activities. Program features are described in detail below.

Intensive on-site services. State funds provide all program clients with the necessities required to help them maintain their own apartments, including furniture, housewares, linens, and homemaker services, if necessary. Case managers are on-site at both locations 16 hours a day to provide daily face-to-face contact, intensive case management, treatment planning, medication monitoring, and skills building, and to plan social and recreational activities for program clients. They are also available for 24-hour crisis intervention.

During the night, two residents trained as client advocates are available on a rotating basis to help program clients. Program clients and other residents with mental illnesses also have access to a host of nearby services. These include a psychosocial day program, a clubhouse program, and an acute crisis facility.

Education of residents and staff. Before the program began, mental health center staff met with public housing building managers several times to discuss the needs of the new residents and to develop a cooperative management approach. They then held meetings for all residents to introduce staff, answer questions about mental illnesses and about the program, and seek their cooperation. Residents and LMHA staff feel this approach was effective in preventing problems and tempering bias against mental health clients.

Outreach to other residents. In addition to serving program clients, on-site staff conduct active outreach to other residents, providing support, counseling, and referrals as needed. Social and recreational activities sponsored by the program are open to all residents, some of whom are mental health center clients but not part of the

on-site program. All residents at TenEyck Towers are eligible for regular blood pressure screenings conducted by a Ruth Ide nurse who works evenings and resides in the building. The case managers maintain ongoing coordination with building managers.

Security as mental health support. The County Mental Health Board funds a security guard at TenEyck Towers for the evening hours, which has provided a welcome measure of protection for all residents and increased LMHA resident and staff support for the mental health center program. The guard is trained by the mental health staff to assist with crisis intervention for program clients and other residents should the need arise.

Creating demand through modernization

Interior and exterior modernization efforts have given LMHA residents a renewed sense of pride in their surroundings and have made the developments attractive to potential residents as well. The work involves both structural changes, including exterior reconditioning and the installation of a new heating system, and such amenities in lobby areas and community rooms as new carpeting, hand rails, and storage cabinets for arts and crafts supplies. Also, kitchens and bathrooms in vacant units are being refurbished, and changes are being made in some buildings to make them more accessible to persons who have hearing or visual impairments.

Reducing vacancy rates with effective marketing

LMHA has actively marketed its developments for elderly families, resulting in increased applications from both elderly persons and younger, disabled persons. The agency director informs senior citizens' groups, housing advocates, and community leaders, providing them with information and asking them to tell their members about the special benefits of living in LMHA housing for elderly families.

Also, a brochure is distributed to community groups and municipal agencies that serve eligible individuals, and the housing agency markets the elderly developments at senior fairs conducted in the city. These efforts are designed to further increase occupancy rates and to create well-functioning, diverse communities within LMHA public housing developments.

Looking ahead

LMHA is actively seeking additional on-site services for both elderly residents and younger, disabled residents. In addition, the agency is working to expand existing housing options for persons with mental illnesses in Toledo, including the use of Section 8 rental vouchers and rental certificates and other Federal programs that may assist this population.

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For More Information

Selected Readings
Contacts
Appendix A: State Mental Health Authorities
Appendix B: Sample Public Housing Agency/Mental Health Agency Agreements
Appendix C: Sample Needs Assessment Summaries
Appendix D: The Public Housing Occupancy Handbook: Admission Handbook Change July 12, 1991
Appendix E: A Public Housing Application Process Model
Appendix F: Seattle Housing Authority Resident Orientation Program
Appendix G: Toledo Shared Services Model
Appendix H: Sample Job Descriptions

Selected Readings

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U.S. Department of Housing and Urban Development. *Report to Congress: Housing Mentally Ill Disabled Persons in Public Housing Projects for the Elderly.* Washington, DC: U.S. Department of Housing and Urban Development, 1990.

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U.S. Department of Housing and Urban Development. *The Public Housing Occupancy Handbook: Admission.* Handbook 7465.1 REV–2 – CHG–2. Washington, DC: U.S. Department of Housing and Urban Development, July 12, 1991.

U.S. General Accounting Office. *Public Housing: Housing Persons with Mental Disabilities with the Elderly.* Gaithersburg, MD: U.S. General Accounting Office, 1992.

Vischi, T.R. *Financing Community Services for Persons with Severe and Disabling Mental Illness: A Technical Assistance Manual.* Rockville, MD: National Institute of Mental Health, 1988.

Contacts

U.S. Department of Housing and Urban Development
Office of Public and Indian Housing
451 7th Street, SW
Washington, DC 20410
Contact: Nancy Chisholm, Senior Program Analyst
Policy and Evaluation Division,
Room 4236
Phone: (202) 708–0713
Fax: (202) 708–0799

Contact: Edward C. Whipple, Director
Occupancy Division, Room 4206
Phone: (202) 708–0744
Fax: (202) 401–6867
TDD for both HUD contacts:
(202) 708–9300 or 1–800–877–8339

Center for Mental Health Services
Homeless Programs Section
Adult Serious Mental Illness Branch
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane, Room 7C–08
Rockville, MD 20857
Contact: Walter Leginski, Ph.D., Acting Director
Phone: (301) 443–3706
Fax: (301) 443–6349

National Resource Center on Homelessness and Mental Illness
Policy Research Associates, Inc.
262 Delaware Avenue
Delmar, NY 12054
Contact: Deborah L. Dennis, Project Director
Phone: (800) 444–7415
Fax: (518) 439–7612

Council of Large Public Housing Authorities
122 C Street, NW, Suite 865
Washington, DC 20001
Contact: MaryAnn Russ, Executive Director
Phone: (202) 638–1300
Fax: (202) 638–2364

National Association of Housing and Redevelopment Officials
1320 18th Street, NW, Suite 500
Washington, DC 20036
Contact: Marcia Sigal, Housing Programs Officer
Phone: (202) 429–2960
Fax: (202) 429–9684

National Association of State Mental Health Program Directors
Hall of the States, Room 401
444 North Capitol Street, NW
Washington, DC 20001
Contact: E. Clarke Ross, Assistant Executive
Director for Federal Relations
Phone: (202) 624–5837
Fax: (202) 624–7892

National Council of Community Mental Health Centers
12300 Twinbrook Parkway, Suite 320
Rockville, MD 20852
Contact: Charles G. Ray, Chief Executive Officer
Phone: (301) 984–6200

National Association of Protection and Advocacy Systems
900 Second Street, NE, Suite 211
Washington, DC 20002
Contact: Vicki Smith, Deputy Director
Phone: (202) 408-9514
Fax: (202) 408–9520

Appendix A

State Mental Health Authorities

State Mental Health Authorities[1]

ALABAMA

Commissioner
Department of Mental Health &
Mental Retardation
200 Interstate Park Drive
P.O. Box 3710
Montgomery, AL 36109–0701

PH: (205) 271–9208
FAX: (205) 240–3195

ALASKA

Director
Division of Mental Health and
Developmental Disabilities
Department of Health & Social Services
Pouch H–04
Juneau, AK 99811

PH: (907) 465–3370
FAX: (907) 465–3068/3190/1061
(nearby offices)

AMERICAN SAMOA

Chief, Social Services Division
Department of Human Resources
American Samoa Government
Pago Pago
American Samoa 96799
PH: (684) 633–4485 (Ext. 49) -or-
663–1130

ARIZONA

Director
Department of Health Services
Division of Behavioral Health Services
411 North 24th Street
Phoenix, AZ 85008

PH: (602) 220–6506
FAX: (602) 220–6502

ARKANSAS

Director
Division of Mental Health Services
Department of Human Services
4313 West Markham Street
Little Rock, AR 72205

PH: (501) 686–9164
FAX: (501) 686–9182

CALIFORNIA

Director
Department of Mental Health
Health & Welfare Agency
1600 9th Street, Room 151
Sacramento, CA 95814

PH: (916) 654–2309
FAX: (916) 654–3198

COLORADO

Director
Division of Mental Health
Department of Institutions
3520 West Oxford Avenue
Denver, CO 80236

PH: (303) 762–4073
FAX: (303) 762–4373

CONNECTICUT

Commissioner
Department of Mental Health
90 Washington Street
Hartford, CT 06106

PH: (203) 566–3869
FAX: (203) 566–6195

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[1] For more information or an updated list, contact:
National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
PH (703) 739–9333 FAX (703) 548–9517

DELAWARE

Director
Division of Alcoholism, Drug Abuse
and Mental Health
Department of Health & Social Service
1901 North DuPont Highway
New Castle, DE 19720

PH: (302) 577–4460
FAX: (302) 421–6086

DISTRICT OF COLUMBIA

Commissioner
Commission on Mental Health Services
Department of Human Services
Building A, Room 105
2700 Martin Luther King Jr. Ave., SE
Washington, DC 20032

PH: (202) 373–7166
FAX: (202) 373–6484

FLORIDA

Assistant Secretary
Department of Health & Rehabilitative Services
Alcohol, Drug Abuse & Mental Health
Program Office
1323 Winewood Blvd.
Tallahassee, FL 32301

PH: (904) 488–8304
FAX: (904) 487–2239

GEORGIA

Director
Division of Mental Health, Mental Retardation &
Substance Abuse
Department of Human Resources
878 Peachtree Street, NE, Room 304
Atlanta, GA 30309

PH: (404) 894–6300
FAX: (404) 853–9058

GUAM

Director
Department of Mental Health and
Substance Abuse
P.O. Box 9400
Tamuning, Guam 96931

PH: (671) 646–9261
FAX: (671) 649–6948

HAWAII

**Deputy Director for Behavioral
Health Services**
Department of Health
Division of Mental Health
1250 Punchbowl Street, 2nd Floor
P.O. Box 3378
Honolulu, HI 96801

PH: (808) 586–4434
FAX: (808) 586–4444

IDAHO

Administrator
Division of Community Rehabilitation
Department of Health & Welfare
450 West State Street
Statehouse Mail
Boise, ID 83720

PH: (208) 334–5531
FAX: (208) 334–5694

ILLINOIS

Director
Department of Mental Health and
Mental Retardation
401 South Spring Street
Springfield, IL 62765

PH: (217) 785–7226
FAX: (217) 782–9535

INDIANA

Director
Division of Mental Health
Department of Family & Social Services
402 West Washington Street, Room W–353
Indianapolis, IN 46204–2739

PH: (317) 232–7844
FAX: (317) 233–3472

IOWA

Administrator
Division of Mental Health, Mental Retardation and Developmental Disabilities
Department of Human Services
Hoover State Office Building
East 12th & Walnut Streets
Des Moines, IA 50319-0114

PH: (515) 281–5126
FAX: (515) 281–4597

KANSAS

Commissioner
Mental Health & Retardation Services
Department of Social & Rehabilitation Services
State Office Building
10th and Topeka Streets
Topeka, KS 66612

PH: (913) 296–3774
FAX: (913) 296–6142

KENTUCKY

Commissioner
Department for Mental Health & Mental Retardation Services
Cabinet for Human Resources
275 East Main Street
Frankfort, KY 40601

PH: (502) 564-4527
FAX: (502) 564-3844

LOUISIANA

Assistant Secretary
Department of Health & Hospitals
Office of Mental Health
P.O. Box 2790, Bin #18
Baton Rouge, LA 70821-2790

PH: (504) 342–6717
FAX: (504) 342–1384

** 1201 Capitol Access Road, 4th Floor
Baton Rouge, LA 70802

MAINE

Commissioner
Department of Mental Health and Mental Retardation
411 State Office Building
Station 40
Augusta, ME 04333

PH: (207) 289–4223
FAX: (207) 289–4268

MARYLAND

Director
Mental Hygiene Administration
Department of Health & Mental Hygiene
201 West Preston Street, Room 416A
Baltimore, MD 21201

PH: (301) 225–6611
FAX: (301) 333–5402

MASSACHUSETTS

Commissioner
Department of Mental Health
25 Staniford Street
Boston, MA 02114

PH: (617) 727–5600 & 5500
FAX: (617) 727–5600 (Ext. 426)

MICHIGAN

Director
Department of Mental Health
Lewis-Cass Building
320 Walnut Boulevard
Lansing, MI 48913

PH: (517) 373–3500
FAX: (517) 373–8074

MINNESOTA

Commissioner
Department of Human Services
Mental Health Program Division
Human Services Building
444 Lafayette Road
St. Paul, MN 55155–3828

PH: (612) 296–2710
FAX: (612) 296–6244

MISSISSIPPI

Director
Department of Mental Health
1101 Robert E. Lee Building
239 North Lamar Street
Jackson, MS 39201

PH: (601) 359–1288

MISSOURI

Director
Department of Mental Health
P.O. Box 687
Jefferson City, MO 65102

** 1706 East Elm Street
Jefferson City, MO 65102

PH: (314) 751–4122
FAX: (314) 751–8224

MONTANA

Administrator
Mental Health Division
Department of Institutions
1539 Eleventh Avenue
Helena, MT 59620

PH: (406) 444–3969
FAX: (406) 444–4920

NEBRASKA

Director
Department of Public Institutions
P.O. Box 94728, State Capitol
Folsom & Van Dorn Streets
Lincoln, NE 68509

PH: (402) 471–2851 (Ext. 459)
FAX: (402) 479–5145

NEVADA

Administrator
Division of Mental Health & Mental Retardation
Department of Human Resources
Kinkead Building, Room 403
505 East King Street
Carson City, NV 89710

PH: (702) 687–5943
FAX: (702) 687–4773

NEW HAMPSHIRE

Director
Division of Mental Health &
Developmental Services
Department of Health & Human Services
State Office Park South
105 Pleasant Street
Concord, NH 03301

PH: (603) 271–5007
FAX: (603) 271–5051

NEW JERSEY

Director
Division of Mental Health and Hospitals
Department of Human Services
50 East State Street
Capitol Center, CN 727
Trenton, NJ 08625

PH: (609) 777–0702
FAX: (609) 777–0835

NEW MEXICO

Director
Division of Mental Health
Health and Environment Department
1190 St. Francis Drive, Room 3150N
Santa Fe, NM 87503

PH: (505) 827–2651
FAX: (505) 827–2695

NEW YORK

Commissioner
Office of Mental Health
44 Holland Avenue
Albany, NY 12229

PH: (518) 474–4403
FAX: (518) 474–2149

NORTH CAROLINA

Director
Division of Mental Health, Mental Retardation and Substance Abuse Services
Department of Human Resources
325 North Salisbury Street
Raleigh, NC 27611

PH: (919) 733–7011
FAX: (919) 733–9455

NORTH DAKOTA

Director
Division of Mental Health
Office of Human Services
Department of Human Services
State Capitol Building
Bismarck, ND 58505

PH: (701) 224–2767
FAX: (701) 224–2359

OHIO

Director
Department of Mental Health
30 East Broad Street, Room 1180
Columbus, OH 43215

PH: (614) 466–2337/4217
FAX: (614) 752–9453

OKLAHOMA

Commissioner
Department of Mental Health and Substance Abuse Services
P.O. Box 53277, Capitol Station
Oklahoma City, OK 73152

PH: (405) 271–7474
FAX: (405) 271–7413

** 1200 North East 13th Street
Oklahoma City, OK 73117

OREGON

Administrator
Mental Health and Developmental Disability Services Division
Department of Human Resources
2575 Bittern Street, NE
Salem, OR 97310–0520

PH: (503) 378–2671
FAX: (503) 378–3796

PENNSYLVANIA

Deputy Secretary for Mental Health
Department of Public Welfare
Office of Mental Health
P.O. Box 2675
Harrisburg, PA 17105–2675

PH: (717) 787–6443
FAX: (717) 787–5394

** Room 502, Health & Welfare Building
Commonwealth & Forster Streets
Harrisburg, PA 17120

PUERTO RICO

Secretary of Health
Department of Health
G.P.O. Box 61
San Juan, PR 00936

PH: (809) 781–5660
FAX: (809) 781–6102

RHODE ISLAND

Director
Department of Mental Health, Retardation and Hospitals
600 New London Avenue
Cranston, RI 02920

PH: (401) 464–3201
FAX: (401) 464–3204

SOUTH CAROLINA

Commissioner
Department of Mental Health
P.O. Box 485
Columbia, SC 29202

PH: (803) 734–7780
FAX: (803) 734–7879

** 2414 Bull Street
Columbia, SC 29202

SOUTH DAKOTA

Division Director
Division of Mental Health
Department of Human Services
700 Governors Drive
Pierre, SD 57501

PH: (605) 773–5991
FAX: (605) 773–4855

TENNESSEE

Commissioner
Department of Mental Health and Mental Retardation
Suite 600 Doctors Building
706 Church Street
Nashville, TN 37243–0675

PH: (615) 741–3107
FAX: (615) 741–0770

TEXAS

Commissioner
Department of Mental Health and Mental Retardation
P.O. Box 12668, Capitol Station
Austin, TX 78711–2668

PH: (512) 465–4588
FAX: (512) 465–4560

** 909 West 45th Street
Austin, TX 78756

UTAH

Director
Division of Mental Health
Department of Human Services
120 North 200 West, 4th Floor
Salt Lake City, UT 84103

PH: (801) 538–4270
FAX: (801) 538–4016

VERMONT

Commissioner
Department of Mental Health
Agency of Human Services
103 South Main Street
Waterbury, VT 05676

PH: (802) 241–2610
FAX: (802) 244–8103

VIRGIN ISLANDS

Director
Division of Mental Health, Alcoholism
and Drug Dependency Services
Department of Health
Charles Howard Memorial Hospital Complex
Christiansted, St. Croix
U.S. Virgin Islands 00820

PH: (809) 773–1311 (Ext. 3013)
FAX: (809) 774–4701

VIRGINIA

Commissioner
Department of Mental Health and
Mental Retardation
Office of the Secretary of Human Resources
P.O. Box 1797
Richmond, VA 23214

PH: (804) 786–3921
FAX: (804) 371–6638

** 109 Governor Street
Richmond, VA 23219

WASHINGTON

Director
Mental Health Division
Department of Social & Health Services
Mail Stop OB–42F
Olympia, WA 98504

PH: (206) 753–5414
FAX: (206) 753–2746

WEST VIRGINIA

Director
Office of Behavioral Health Services
Department of Health & Human Resources
State Capitol Complex, Bldg. 6, Room 717
1900 Kanawha Blvd., East
Charleston, WV 25305

PH: (304) 558–0627
FAX: (304) 558–1008

WISCONSIN

Director
Office of Mental Health
Department of Health & Social Services
P.O. Box 7851
Madison, WI 53707

PH: (608) 266–3249
FAX: (608) 266–0036

** 1 West Wilson Street
Madison, WI 53702

WYOMING

Administrator
Division of Behavioral Health
Department of Health
447 Hathaway Building
2300 Capitol Avenue
Cheyenne, WY 82002

PH: (307) 777–6495
FAX: (307) 777–5402

** Street address for Federal Express and UPS delivery

Appendix B

Sample Public Housing Agency/ Mental Health Agency Agreements

1. St. Paul, MN
2. Rockford, IL
3. La Salle County, IL

LETTER OF UNDERSTANDING BETWEEN
PUBLIC HOUSING AGENCY OF THE CITY OF SAINT PAUL
AND
SAFE ALTERNATIVES
RAMSEY CLINIC ASSOCIATES

The Safe Alternatives (SA) program and the Public Housing Agency of the City of Saint Paul (PHA) intend, as a pilot project, to provide in the Hi-rises of the PHA, a high quality housing support services program for up to 10 residents with persistent and chronic mental illness in order to facilitate their success in living independently in their own apartments. Both agencies wish to serve the residents and have developed this letter as one means of maintaining effective interagency communications and service coordination.

BASIC DESCRIPTION OF SAFE ALTERNATIVES PILOT PROJECT:

Safe Alternatives is a long-term housing support service program for adults with chronic mental illness who want to live independently in their own apartments. This program was developed by the Safe House Program of the Department of Psychiatry, Ramsey Clinic Associates. Organizational and management responsibility for the program lies with the Director of Safe House/Safe Alternatives and with the Program Manager of Safe Alternatives. Twenty-four hour staff contact numbers are attached.

KEY SUPPORT SERVICES INCLUDE:

- Assistance with securing and furnishing an apartment.
- Personal resource development and maintenance.
- Professional advocacy at a level acceptable to the client.
- 24-hour crisis intervention services (drop-in and phone).
- Financial resources for social/vocational/rehabilitation directions.

Strong emphasis will be placed on personal autonomy and development of community and support networks among participants.

ADMISSION CRITERIA:

Prospective clients must be:

- Adults who have a diagnosis of chronic mental illness.
- Under the care of a psychiatrist and able to self-administer their medication.
- Willing to apply for and cooperate with Case Management Services through the County.
- Willing to cooperate with SA staff in their role as sponsor on the PHA Sponsor Statement.

APPLICANTS WILL BE CONSIDERED INELIGIBLE UNDER THE FOLLOWING CIRCUMSTANCES:

- Acute alcohol or drug use/abuse.
- Indication of persistent anti-social and sociopathic behaviors.
- Significantly impairing condition of organic brain syndrome.

REFERRAL PROCESS TO SA PROGRAM:

Requests for referral forms to SA will be taken from any source. Upon receipt of the completed form and initial screening by SA staff, intake interview will be arranged for applicants meeting program criteria. To request referral forms, please call 221-0305. Other specific contact numbers are listed at the end of this Agreement.

SPECIFIC AREAS OF AGREEMENT - SA SPONSOR RESPONSIBILITIES

1. PHA Intake: SA will accompany clients to the Rental Office and will assist with the rental office screening process including providing full and accurate histories, landlord information and other verifications.

2. Case management coordination: SA will ensure that clients are set up with a county case manager and inform the PHA as to who it is.

3. Move-in transition: SA will take measures to ensure that clients understand the lease and are successfully moved into the hi-rise, including getting unpacked, settled and set up with a phone.

4. Response to *CRISES situations: Twenty-four hour on-site response to crisis is available by SA and will occur within three (3) hours of a call to SA staff.

5. Response to *NEAR CRISES: SA will respond to near crises situations within two calendar days when called by the PHA.

6. Response to *GENERAL REFERRALS: SA will respond to general referrals within one week upon notification of a problem.

7. Out-placement of Clients: SA will meet with PHA staff to discuss any serious problems with SA clients as they arise. SA staff will make permanent out-placement of a client where there is concrete evidence that the client has threatened the life or safety of one or more residents, PHA staff, or any other person, or where there is evidence of a pattern of disturbances detrimental to the peaceful enjoyment of the premises by other residents. If it becomes necessary for the PHA to terminate a lease, a resident has the right to due process, as required by the United States Housing Act and regulations adopted under it.

* See Addendum for Definitions

8. Duration of SA's responsibility: SA remains responsible for clients referred through SA throughout each client's tenancy unless SA and PHA mutually agree that a client no longer requires the key supportive services on page 1 of this Letter of Understanding and can graduate from the program and continue to live in the hi-rise. However, SA maintains an open door policy for all their former clients, and will continue to act as a sponsor for any graduate of the program.

9. Move-out process: When SA clients intend to move out of a PHA hi-rise, SA staff person will see that proper notice is given and that units are returned to the PHA in the condition in which they were received.

10. On-going administration of the program: In the absence of the designated or primary coordinator of the SA program, it is agreed that an alternate SA staff person will be designated and identified to the PHA to fully carry out this Agreement. SA will notify PHA of changes in names of phone numbers of SA staff as they occur.

11. Regularity of communication with the PHA: An updated list of SA's clients in hi-rises will be submitted to the PHA managers and caretakers each time SA clients are added or terminated from the SA program.

    SA staff will attend Coordination meetings if SA has four or more clients in a building or if problems exist for SA clients. However, whenever SA staff can't attend meetings, they will call the coordinator in advance to give a report to the coordinating team.

12. If SA or the PHA determines that a revision in terms or conditions of this Letter of Understanding is necessary, the request for revision shall be negotiated between the agencies. Any necessary changes will be incorporated into the current Letter of Understanding by written amendment as mutually agreed to by the PHA and the SA.

PUBLIC HOUSING AGENCY OF THE
CITY OF SAINT PAUL

In the Presence of:

By:_____
Its Director of Resident Services

_____

SAFE ALTERNATIVES PROGRAM

In the Presence of:

By:_____

_____

SERVICE AGREEMENT

Rockford Housing Authority

and

Stepping Stones of Rockford, Inc.

The Rockford Housing Authority (RHA) and Stepping Stones of Rockford, Inc. have agreed to a cooperative working relationship in order to better serve current and future RHA tenants who have mental illness.

It is understood that some RHA tenants may voluntarily seek supportive services from Stepping Stones of Rockford, Inc. to assist them in their adjustment to living in public housing. It is for these particular tenants that this agreement is made.

The prospective tenants with mental illness may come to RHA from many diverse sources. Most tenants within this agreement will be referred to RHA from the Department of Mental Health (DMH) prescreening (PASARR) agent, United Cerebral Palsy. This prescreening process is the requirement and responsibility of DMH and is designed to allow clients to choose their living arrangement. These clients are called CILA (Community Integrated Living Arrangements) clients and have chosen to live in RHA subsidized units prior to the RHA formal application process. The application process is the same for all RHA applicants and these CILA applicants must meet all regular RHA admission criteria.

It is the intention of the Rockford Housing Authority and Stepping Stones of Rockford, Inc. to meet all the requirements of the Fair Housing Act and CILA standards respectively in housing and supporting tenants with mental illness. All referred clients must be in compliance with the approved Rockford Housing Authority "Admissions Policy." This agreement also does not limit in any fashion a client of Stepping Stones of Rockford, Inc. from otherwise qualifying for housing at any other Rockford Housing Authority housing development.

The following shall be the responsibility of the Rockford Housing Authority.

1. The Rockford Housing Authority shall deprogram three units in the building known as Campus Towers "B" for use by Stepping Stones of Rockford, Inc. in operating their program.

   Two apartments will be provided for Stepping Stones of Rockford, Inc. staff personnel. The terms and conditions of their use of these apartments are defined on the "Dwelling Lease" attached as Addendums 1 and 2.

2. The Rockford Housing Authority shall be liable for claims arising out of the condition of the deprogrammed units and shall maintain fire extended coverage and public liability insurance for those units exclusive of the contents therein.

3. The Rockford Housing Authority will provide Stepping Stones of Rockford, Inc. personnel access to building facilities as possible to facilitate the operation of their program.

The following shall be the responsibility of Stepping Stones of Rockford, Inc.

1. Placement

   a. Present the possible living situations to prospective tenants for their review.

   b. Complete the application process with clients who wish to live in RHA.

   c. Help accepted tenants set up housekeeping and move them into RHA.

2. Case Management

   a. Complete residential assessment and individual rehabilitation plan with 30 days.

   b. Provide basic skills training in areas of housekeeping, personal hygiene, money management, socialization, recreation, and mental health.

   c. Refer tenant for additional array of MH services to the Janet Wattle Mental Health Center to include psychiatric, day treatment, emergency services and other CILA services (Addendum #4).

   d. Refer and follow up on all other needed health and vocational services.

   e. Refer and support the integration of the CILA tenant into all RHA activities in which they show interest and are assessed appropriate for.

   f. Provide transportation when necessary.

   g. Maintain regular contact with the tenant council and RHA site manager.

3. Supervision

   a. Provide basic 24-hour supervision on site.

   b. Provide on call services for crisis intervention through on site personnel and RHA answering service.

4. Administration

   a. Process referrals from Janet Wattles.

   b. Meet on regular basis with appropriate RHA staff.

   c. Provide education on mental health issues to RHA tenants.

5. Staffing

a. Two Resident Assistants will live on site in units provided by RHA to work evenings and weekends. They will provide supervision, some skills training, socialization, recreation and transportation.

b. One Case Manager will provide on site coverage during regular working hours. Responsibilities will include case management functions including the completion of all required paperwork, on call responsibility, the first line of contact with the tenant council and RHA manager and complement the responsibilities of the Resident Assistants.

c. The Rehab Supervisor will be responsible for the initial referral process, act as liaison with RHA administration, the Qualified Mental Health Professional from Janet Wattles, and DMH. Responsibilities will also include education in mental health classes for all RHA tenants at site, supervise and assist the Case Manager and Resident Assistants in their functions and be on call.

6. Liability

Stepping Stones of Rockford, Inc. shall be liable for claims arising out of the operation of their program and shall maintain liability insurance against such claims and shall agree to hold Rockford Housing Authority harmless from any and all claims including attorney's fees and costs.

This working agreement describes a new cooperative relationship and should be reviewed for change whenever necessary but not less than three months from initiation and not less than annually thereafter. This Agreement may be terminated by either party with 60 days written notice.

President, Board of Directors Stepping Stones of Rockford, Inc.	Board of Commissioners Rockford Housing Authority
Date	Date
Executive Director	Executive Director
Date	Date

SERVICE AGREEMENT

Mental Health Center of La Salle County

and

Housing Authority for La Salle County

This Agreement entered into this _____ day of _____, 1988, between the Mental Health Center of La Salle County (hereinafter referred to as Mental Health) and the Housing Authority for LaSalle County (hereinafter referred to as the Housing Authority), WITNESSETH:

WHEREAS, Mental Health serves many clients who, although are not in need of residential mental health care, are in need of adequate low-cost housing, a resource Mental Health clients are often denied or have difficulty finding; and

WHEREAS, the Housing Authority operates a housing complex commonly known as Dougherty Manor at 900 Paul Street, Ottawa, Illinois, which is proximately close in distance to the Ottawa office of Mental Health facilitating travel to and from Dougherty Manor and said Ottawa office; and

WHEREAS, Mental Health and the Housing Authority each desire to maintain complete independent status from each other, but do wish to facilitate the receipt of their respective services for potential mutual clients.

WHEREFORE, Mental Health and the Housing Authority agree as follows:

1. Mental Health will refer clients to the Housing Authority who are not in need of residential mental health care, but who are in need of housing as is available at Dougherty Manor.

2. The Housing Authority will make vacant units available at Dougherty Manor to said referrals to the extent possible within compliance of the Housing Authority's admission and occupancy criteria. This agreement does not limit in any fashion a client of Mental Health from otherwise qualifying for housing at any other Housing Authority residence, but merely intends to create a preference to housing at Dougherty Manor to the extent of the Housing Authority's guidelines.

3. Mental Health and the Housing Authority will each designate liaisons to facilitate this agreement.

4. Upon notification from the Housing Authority liaison that said liaison believes any residence of Dougherty Manor is in need of emergency mental health treatment, Mental Health will promptly respond with an emergency assessment. The Community Hospital of Ottawa provides emergency backup for Mental Health if an emergency assessment occurs after 5:00 p.m. or weekends or holidays.

5. The Housing Authority will provide outreach workers from Mental Health access to building facilities as possible to facilitate mental health outreach workers to make visits with their clients.

6. As both agencies are remaining completely independent of each other, neither agency shall in any fashion create a false impression that the agencies jointly assume obligations or liabilities. Should a mutual client attempt to raise a matter relevant to the other agency, such matter should be referred to the other's liaison. Both agencies shall maintain adequate liability insurance and, on request, provide copies of said insurance policies for review.

7. The Housing Authority shall not disclose beyond their agency and limit disclosure within their agency the identity of individual residents or potential residents whose referral originated from Mental Health.

8. This agreement may be terminated by either agency with thirty days written notice. This agreement may be modified only upon mutual written agreement.

MENTAL HEALTH CENTER OF LA SALLE COUNTY

BY_____

TITLE_____

HOUSING AUTHORITY FOR LA SALLE COUNTY

BY_____

TITLE_____

Appendix C

Sample Needs Assessment Summaries

1. Seattle, WA
2. Providence, RI

HELPING SEATTLE'S LOW-INCOME HIGH RISES SUCCEED:
Solutions Within Reach

Executive Summary

In 1990, Seattle Housing Support Committee decided to conduct a series of three intensive design and planning workshops to develop solutions to pressing issues in Seattle subsidized housing programs. This report has been developed to report the findings of the first planning workshop, co-sponsored by Seattle Housing Authority and the City of Seattle, focusing on critical issues facing Seattle's low-income high rise buildings.

Seattle Housing Authority and local non-profits manage over 3,300 units of high rise housing in 35 buildings. Low-income high rises provide a critical resource for housing elderly and low-income disabled populations. The availability of these affordable units is the first line defense against homelessness. When the high rises are unable to provide safe, secure, affordable housing, the residents may be faced with limited options such as nursing homes, boarding homes or even emergency shelters. Currently these buildings face many significant issues.

- The characteristics of the tenants of many of Seattle's high rise housing programs are changing from primarily elderly, to increasing mixed populations of very frail elderly and younger disabled people.

- The tension between mixed populations has created increased levels of fear among the elderly residents and a declining sense of community within the buildings.

- Many of the high rise buildings are located in neighborhoods with high crime rates. There are increased reports of public safety incidents against high rise residents, including robbery and victimization by neighborhood street persons.

- Housing management staff are experiencing a high level of burn-out. Housing support services, which would help them deal with tenant issues, are fragmented at best.

- There are significant concerns over public safety/buildings security issues such as: assaultive tenants; unauthorized friends and disruptive visitors; exploitation of tenants by drug dealers; robbery of tenants.

On January 14, 1991, a group of sixty (60) housing service providers, housing advocates, government staff and consumers gathered to apply their individual talents and strengths cooperatively to a common task — identifying strategies and solutions for these critical problems being experienced in Seattle's low-income high rise buildings.

The planning process was based upon an architectural design competition format known as a "Charrette." The process involved the formation of seven design teams who were challenged to create new models and strategies for responding to critical issues. Five of the teams focused on

specific clusters of high rise apartment buildings located in Seattle. Two teams focused on system-wide strategies. The design teams had a single, all day session to create strategies, around the following goals:

- Improve the level of personal and public safety of residents.
- Strengthen the sense of community among the residents.
- Improve the successful residency and independence of individual tenants.
- Strengthen the building and resident relationships with the neighborhood.

On January 31, 1991, the teams presented their models to a jury that included representatives from the Mayor's office, City Council, City departments and a private architect. The design teams organized their models under four headings: new screening, referral and orientation strategies; new support service strategies; and physical rehabilitation or new construction strategies.

CONSISTENT THEMES FROM ALL DESIGN TEAMS

The wide variety of participants and different nature of the building clusters encouraged many differing strategies to meet the goals of the process. However, certain consistent themes were expressed by all groups.

- Tenant involvement in all aspects of subsidized housing, from screening and orientation to governance, is basic to the development of a shared sense of responsibility and community.

- The changing mix of tenants should be viewed as an opportunity to develop new strategies which overcome fear and misconceptions between tenant populations.

- Housing management is a difficult job, requiring the development of increased professional approaches to building management, with adequate compensation and administrative support.

- The level of housing support services needs to be increased in all high rise buildings to ensure access to social services, resources and early intervention in tenant problems.

- The physical layout of facilities needs to be designed or rehabilitated to: accommodate needs of tenants with physical limitations, to promote a sense of security and personal safety, and create a stronger sense of community.

DISTINCTIVE ELEMENTS FROM THE DIFFERENT TEAM MODELS

Each team was assigned different buildings to focus on, and included a different array of perspectives. Through the creative process a number of distinct elements emerged, all of which merit consideration in developing new management strategies.

Intake Process

- Prospective tenants could choose to live from a set of cluster buildings, based upon changing needs.

- Building managers would have increased involvement in the placements of prospective tenants.

- New residents would be provided individual orientations with materials developed in partnership with existing residents.

- A "good neighbor" system would be set up in which an established tenant would be paired with a new resident to help the newcomer "learn the ropes" of living in the high rise building.

Staffing/Program Services

Existing services need to be re-configured to better meet the needs of high rise building residents as well as expanded to eliminate gaps in service.

- The most frequent suggestion was to establish a new staffing model to include a resource coordinator and program manager for each building.

- Most teams believed that facilities need 24-hour staff, to assist with crisis situations, other emergencies, and provide residents with an increased sense of personal safety.

- One recommendation was to assign staff, such as chore workers, to buildings rather than to individuals, enabling aides to render care in brief increments.

- Some teams insisted on the need for a policy requiring referring agencies to maintain regular contact with a client upon establishment of residence in subsidized housing.

Developing Community

- Create improved resident management councils empowered to address such issues as public safety, new tenant orientation, incentives for resident council participation and establishment of housing rules and regulations not governed by law.

- Help residents create their own support networks through self governance, job skills development and employment search, volunteer activities, education and establishing a resident skills resource bank.

- Create education opportunities on the needs and issues related to aging and handicapped toovercome misconceptions and increase opportunities for positive interactions between mixed populations.

Specialized Buildings

About half of the groups suggested that the development of specific services within a given facility are a magnet for attracting prospective tenants with special needs.

- A specific model was the configuration of a series of buildings with different services to provide a range of opportunities for formerly homeless persons, depending upon their level of support needs.

- Another suggestion was to establish a facility for persons wishing to live in a board and room type program and paying additional fees for maid service and hot meals.

Facilities Development

There were numerous suggestions about what could be done to change the physical space of the buildings. Most were unique to the cluster being reviewed. A universal proposal was to conduct an assessment of each building. The assessment would be used to create a long-term strategic plan for building renovations promoting new communities and safe environments.

Conclusions

Having completed this design work, the models are now available for a variety of uses, offered as ideas for consideration in developing high rise housing opportunities. The models were reviewed by a jury of professionals representing funding sources, policy makers and professionals. This report also includes responses to design models by the jurors and residents themselves.

The results of this collaborative effort, and the design models described in this report represent innovative ways of solving complex problems. They also offer clear and compelling evidence that real accomplishments are possible, and solutions are within reach.

It is intended that this report be widely available to a broad audience, including elected officials, public policy planners, human service providers, consumers and public and private sector founders.

PROVIDENCE HOUSING AUTHORITY

PLANNING / SPECIAL SERVICES DEPARTMENT
SENIOR / HANDICAPPED SERVICES PROGRAM

PLANNING FOR SOCIAL SERVICE NEEDS
IN HIGH-RISE DEVELOPMENTS

OCTOBER 1991

PROVIDENCE HOUSING AUTHORITY DEPARTMENT OF PLANNING AND SPECIAL SERVICES SENIOR/HANDICAPPED SERVICES PROGRAM

INTRODUCTION

Planning for Social Service Needs in the Elderly Highrise Buildings

When a local authority, such as the Providence Housing Authority, initiates a public housing development, there should be a concern about two kinds of planning, physical and social planning. Since both are fundamental to the housing authority's function, emphasis on one (to the detriment of the other) may result in a development that is satisfactory neither to the residents, the authority, nor the community. The concept of integrated planning for physical and social need is applicable to all public housing developments but is especially important when housing for the elderly is concerned.

Planning for social needs of elderly residents in public housing throughout the country has received much less attention than physical planning. Not only is there little accord on whether a community program can be justified philosophically or legally under federal housing legislation, but in addition, some authorities have failed to examine the new management problems that come with housing the elderly/handicapped populations.

Since 1962, the Providence Housing Authority has obtained funds from the Department of Housing and Urban Development (HUD) for the development of seven elderly highrises. These buildings were built for the purpose of providing decent, safe, and sanitary dwelling units for many of the low-income elderly families and individuals living in Providence. Today, twenty-nine years later, only forty percent of the residents living in PHA highrises are over sixty-five years old, the remainder of individuals residing in these buildings are either physically or mentally handicapped. This factor has helped housing authority administrators to recognize the developing need for on-site social services to aid the elderly/handicapped populations as they "age in place," as well as to assist the handicapped/disabled with their special needs.

STATEMENT OF THE PROBLEM

The goal of the Providence Housing Authority is to respond to conditions existing at the Authority which will prevent it from performing its primary goal of providing a "decent home in a suitable living environment." The PHA is currently responding to conditions which have developed at the Authority which are the result of:

A. the increased number of substance abuse related problems in the elderly/handicapped developments;

B. the social isolation among the elderly and handicapped population;

C. the lack of adequate health care for handicapped individuals and seniors living in the developments as they "age in place";

D. the deinstitutionalization of the mentally ill into the community with limited supportive services; and

E. the growing number of AIDS related cases due to substance abuse and/or by acquiring the disease through "at risk" sexual behavior.

Today, housing authorities throughout the country are finding it increasingly more difficult to address the needs of elderly and handicapped individuals due to the fact that housing authorities often do not have on-site social service providers who are trained to interact with residents in need. The result of this lack of integrated and coordinated social service programs on-site is the eviction of residents who do not properly maintain their units (or do not pay their rent) and disrupt the PHA's goal of providing suitable living conditions for all. Ultimately, the end result for these individuals is homelessness, a result which affects all social service providers and the community at large.

In order to address management needs in the elderly highrises, the PHA has applied for and received money to ameliorate the in-house problems of elderly/handicapped social isolation, drug and alcohol abuse and mental illness. Never before has the housing authority witnessed the fear and isolation of its residents as it has in the past few years. Many of the elderly residents are afraid not only to leave their own buildings, but to leave their own apartments due to the distrust of their neighbors (substance abuse in the developments and the deinstitutionalization of the mentally ill into public highrise buildings have contributed to this fear). However, the PHA's success in receiving grants from the state has been unprecedented. Since September 1988 this housing authority has received over $270,000 for the development and implementation of a Senior/Handicapped program. This figure does not include the over $200,000 applied for by the PHA for the improvement of the elderly security system.

It has been through the support of the state that the Providence Housing Authority has been able to integrate programs that were previously lacking in public housing.

STRUCTURE OF PROGRAMS/ACTIVITIES UNDERTAKEN/FUNDING SOURCES

In the past three years the PHA has provided the following on-site social services to the elderly/handicapped populations through funds provided by the Department of Elderly Affairs (1988-1990) and the Department of Mental Health and Retardation Division of Substance Abuse (1991). There exists other agencies who have independently helped this housing authority to obtain on-site programming through their own operating budgets (Project Hope, American Association of Retired Persons (AARP), U.R.I. Pharmacy Program "Brown Bag Program" and the Providence Intown Churches Association (PICA)).

The following programs have been implemented on site:

1. **Two Substance Abuse Counselors:** primarily responsible to identify residents' needs through initial intake assessments and group therapy.

2. **Social Worker:** is primarily responsible to provide social activities and identify residents' needs through intake assessments and outreach.

3. To address the social, recreational, and spiritual needs of the residents, the **Providence Intown Churches Association** provides activity programming based on resident needs assessment.

4. The **Visiting Nurses Association** (limited on-site programming) provides a variety of services including home care, nursing, physical therapy, visiting homemakers, and geriatric health maintenance programs.

5. **Meal Sites:** in order to meet the nutritional needs of the residents and to make an attempt to provide socialization, the Providence Housing Authority (through Project Hope) is providing meal sites directly on-site at three of its elderly highrise buildings. In addition, this meal site will address several psychosocial and mechanical risk factors that are prevalent among this resident population. These risk factors include: limited income, abuse of alcohol and other central nervous system depressants, bereavement, loneliness, living alone, and confusion. The meal site will enable those individuals who may have one of these risk factors to maintain a proper diet.

6. **Senior Services Van:** an emergency van for the senior/handicapped residents of Dexter Manor, Dominica Manor, Kilmartin Plaza and Parenti Villa has been provided to assist elderly residents in acquiring transportation for emergency medical appointments.

7. **Three Resident Assistants:** have been hired through the AARP program to assist in the implementation of the on-site Senior Services Program. Two of these three resident assistants drive the PHA Emergency Medical Van.

8. **U.R.I. Pharmacy Program:** currently, there are two pharmacists from the University of Rhode Island who visit weekly at each of the highrises. The main goal of the pharmacists is to educate the residents as to how to properly use their medication and to answer any questions relevant to the medication. The pharmacists also inform residents about the various health care services which are available to them.

The PHA's Senior/Handicapped Services Program has established a supportive environment for those residents living in public highrise buildings. This program has provided a "senior service network" that has: identified those individuals living at risk (substance abuse/AIDS prevention); established linkages between residents and community services; provided educational and social programming based on resident needs; facilitated on-going training for those involved with project based needs; and fostered independence of residents through supportive workshops.

CASE STUDIES

Case Study 1

Miss S is a 40-year-old woman living at Parenti Villa. She has a dual diagnosis of mental illness and alcohol abuse. In the past she has been inconsistent in following a treatment plan set up by a local mental health agency and in attending her Alcoholics Anonymous group.

Recently, the Social Worker noticed that Miss S had lost a substantial amount of weight. She was no longer socializing with other tenants and appeared despondent and disconcerted.

The Social Worker approached the client offering assistance with issues that may be of concern to her. She related that she could not help but notice that Miss S had lost a lot of weight and inquired as to the reason. After several hours of discussion, Miss S admitted to actively drugging and stated her entire check was spent on drugs.

To better determine what agency and mode of intervention would best meet the needs of this client, the Social Worker asked what type of drugs were used. The client related that she was "free basing and shooting up." At that point the Social Worker discussed the client's behavior and determined that she was at high risk for being exposed to the AIDS virus. Miss S admitted that she was aware of the risk factors involved by sharing needles, however, she felt powerless to stop.

Miss S agreed to have the Social Worker contact a drug treatment program and set up an intervention plan. At present Miss S has been drug free for the past 5 weeks. Progress reports are sent to the Social Worker by Miss S's drug counselor. She also attends support groups with Narcotics Anonymous and Alcoholics Anonymous daily. Each morning she sees the Social Worker to discuss problems that encompass obstacles connected with recovery. Miss S is also seeing a worker at the local mental health center for medication maintenance and money management.

In just a short period of time she has managed to gain weight, have a positive outlook on recovery and consider what future goals she has. The Social Worker will continue to render supportive services and monitor clients for as long as needed to fully recover.

Case Study 2

Mr. R has resided at Dexter Manor for seven years. He has been blind since birth. Until recently he has been cared for by his aging father. Recently Mr. R has decided that he required more independence and wants to learn to be self-sufficient. He is 39 years old and able to care for his personal needs. He is unable to cook, clean or go outside without the assistance of another person.

Mr. R plans to return to an independent lifestyle by attending a workshop called "Insight." Insight has an intensive day program to help blind people become physically independent, feel good about themselves and establish a network of agencies to maintain this goal.

The young man works daily at small concession stand in a local city building and manages the job well, but was hindered in the past by his father's well meant assistance. Although he gave the appearance of self-sufficiency, he was taken care of and never learned to do tasks alone. He is learning to sign his name, which to the average sighted person seems trivial, but to a blind person it is a wonderful accomplishment. To do this he uses a slotted cardboard guide which he feels and signs his name inside the guide.

Mr. R is happy he is able to sign his name. It gives him a sense of accomplishment and control over his identity. He will be exploring other areas of daily living, such as preparing meals, cooking and making his own bed, going to the bank, shopping and using limited transportation.

Every task is a new experience and he learns it with enthusiasm. The program will help him maintain his apartment and encourage Mr. R to live alone without having to enter a shelter care environment.

SHORTCOMINGS OF THE PROGRAM

The shortcoming of the Senior/Handicapped Services program is the constant struggle to leverage funds to continue the implementation (and possible expansion) of the program.

It is also true that a shortcoming of the program is the influx of mentally and physically handicapped individuals that have daily needs that cannot be met by one social worker on-site. Hence, for every one problem solved, five more individuals with similar problems are walking through the door. It can be stated, however, that with on-site social workers as members of the Providence Housing Authority's staff, the response time to address social service problems before they become crises has increased ten-fold. In addition, such on-site social workers have the experience and expertise in their field to steer individuals with such needs back to the appropriate agencies that referred such individuals to the housing authority in the first place. Hence, the agencies who refer such individuals to public housing will also be held accountable to provide the follow-up social service needs to the particular client they represent.

PROSPECTS FOR THE FUTURE

Future prospects for the Providence Housing Authority's Senior/Handicapped Services program are bright. There are several HUD representatives from Washington, DC who have inquired about how this authority is implementing the program and have requested further information. Future funding from the federal government (unless it is through the Department of Health and Human Services) is not predicted to help supplement the costs of this program in the immediate future. However, if this housing authority can maintain the Senior/Handicapped Services program through state funds for the next two years (as is anticipated) then new federal programs that are currently being explored by Washington may, in fact, be developed and funds may very well be set aside for supportive services for elderly/handicapped residents in public housing authorities.

Appendix D

The Public Housing Occupancy Handbook: Admission

Handbook Change
July 12, 1991

Special Attention of:
Regional Administrators; Directors, Regional Fair Housing and Equal Opportunity Divisions, Directors, Offices of Regional Public Housing; Field Office Managers; Housing Management Directors; Chiefs, Assisted Housing Management Branchs; Public Housing Agencies; Resident Management Corporations.

Transmittal Handbook No.: 7465.1 REV-2 - CHG-2

Issued: July 12, 1991

1. This Transmits a change to Handbook 7465.1 REV-2, Public Housing Occupancy: Admission, dated 7/91.

2. Explanation of Materials Transmitted

Rescinds paragraph 4-2, ABILITY TO UPHOLD THE LEASE, because of the Department's concern that some of the advice provided to PHAs in that paragraph may have been interpreted and applied in a way which could discriminate against handicapped applicants. The new paragraph 4-2, APPLICANTS WITH HANDICAPS, asserts HUD's policy and provides technical assistance to PHAs in the area of the rights of handicapped applicants under current civil rights laws. As revised, paragraph 4-2 reflects the following advice of the Department:

a. DO NOT judge whether handicapped applicants are capable of living independently.

b. DO NOT require a physical examination as a condition of admission.

c. DO NOT impose conditional leases requiring handicapped persons to participate in support activities.

The Department recommends that PHAs review their policies and procedures to assure that they are consistent with the new handbook provisions. In developing policies under these guidelines, PHAs should take into consideration all of the advice provided in Chapter 4 of this handbook. Nothing in this transmittal diminishes the PHA's responsibility under the law and the regulations to adopt and enforce policies directed toward limiting admission to applicants who are willing and able to uphold the obligations of the lease. Subject to the provisions of this transmittal which address the reasonable accommodation of applicants with disabilities, and the consideration of mitigating circumstances, paragraph 4-1 reflects the following advice of the Department:

a. DO evaluate each applicant to determine whether the applicant meets the PHA's criteria for admission.

b. DO examine the applicant's history of meeting financial obligations and check for a history of disturbing neighbors, destroying property and living habits which could adversely affect the health, safety or welfare of other tenants.

PMO: Distribution: W-3-1, W-2(H), W-3(H), R-1, R-2, R-3, R-3-1(PIH), R-3-2, R-3-3, R-6, R-6-1, R-6-2, R-7, R-7-1, R-7-2, 138-2, RMCs.

HUD-23 (9-81)

c. DO deny admission to applicants whose habits and practices may be reasonably expected to have a detrimental effect on other tenants or the project environment, but such denial must not discriminate on the basis of handicap as described in this handbook.

3. Filing Instructions:

Handbook 7465.1 Rev-2	Handbook 7465.1 Rev-2, CHG-2
Remove:	Insert:
TABLE OF CONTENTS Pages i-ii	TABLE OF CONTENTS Pages i-ii
Pages 4-5, 4-6 dated 8/87	Pages 4-5, 4-6, 4-6B, 4-6C dated 7/91

Assistant Secretary for Public and Indian Housing

7/91

PUBLIC HOUSING OCCUPANCY HANDBOOK

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4. 24 CFR 912 - Definition of Family
5. 24 CFR 913 - Income Limits
6. 24 CFR 960 - Admission

*4-2. APPLICANTS WITH HANDICAPS

a. POLICY

(1) Generally, the PHA may not inquire if an applicant, a person residing or intending to reside with an applicant or any person associated with an applicant has a handicap or inquire as to the nature or severity of a handicap. The PHA is permitted to make inquiries to the extent necessary to:

(a) Determine an applicant's eligibility or level of benefits under the program. When the sole basis for determining an individual's eligibility is based on the person's handicap or disability, the PHA must verify the handicap or disability.

(b) Determine if an applicant is qualified for a unit available only to persons with handicaps such as an independent group residence or a project serving frail elderly.

(c) Determine if an applicant is entitled to a priority for a specially designed unit such as a barrier-free unit if the applicant desires such a unit or priority or determine if a handicapped applicant may qualify as an "elderly family" and be entitled to a priority for admission to an elderly project.

(d) Verify an individual's handicap to determine whether a "reasonable accommodation" in rules, practices or services requested by a handicapped applicant may be necessary.

(2) A PHA may not require applicants to provide access to confidential medical records in order to verify handicap or disability.

(3) When a PHA makes inquiries as to the nature and severity of handicaps, it must do so for all applicants to whom such inquiries might pertain whether or not they have handicaps. For example, if the PHA has specially designed units for persons with disabilities, it should ask all applicants if they or a member of their family

wish to be considered for such a unit and, if so, if they would benefit from such a unit.

(4) Subject to the limitations in subparagraphs (1) and (2) above, the PHA may make inquiries necessary to determine the applicant's eligibility, level of benefits and suitability for tenancy provided such inquiries are made of all applicants whether or not they have handicaps. This includes:

(a) Inquiring whether an applicant for a dwelling is a current illegal abuser or addict of a controlled substance or is currently engaging in the illegal use of drugs. (See Section 512 of the Americans with Disabilities Act of 1990, 104 Stat. 327.)

(b) Inquiring whether an applicant has been convicted of the illegal manufacture or distribution of a controlled substance.

(5) A handicapped applicant who does not meet the PHA's criteria for suitability for tenancy must be admitted if the applicant can meet the PHA's criteria for suitability through "reasonable accommodation."

(6) Objectionable behavior impacting on the applicant's ability to fulfill essential lease obligations may form the basis for rejection of a handicapped applicant, where such behavior cannot be corrected by reasonable accommodation, <u>even if</u> the behavior is related to the disability. Examples of these types of objectionable behavior include failure to pay rent, disturbing neighbors, destroying property or living or housekeeping habits adversely affecting the health, safety or welfare of other persons.

(7) The PHA must not assume that the presence of a particular handicap or disabling condition automatically disqualifies an applicant for participation in the program or for a particular dwelling or type of dwelling. For example, the PHA may not deny a mobility impaired applicant an opportunity to move into a unit with its only bathroom on the second floor. The PHA may not request a special showing by a handicapped

applicant that he or she can comply with the terms of the lease based on speculation that the applicant's disability may make compliance more difficult.

b. DISCUSSION

(1) An elderly family (which includes a family where the head or spouse of any age is handicapped or disabled as defined in the United States Housing Act of 1937 as amended) receives a $400 deduction from income and a deduction of un-reimbursed medical expenses in excess of three percent of Annual Income for determining rent. If an applicant's sole qualification as an elderly family depends on a disability or handicap, the PHA must verify the existence of the disability or handicap or the applicant must forgo the deduction.

(2) PHAs must make inquiries about the nature and severity of handicaps to the extent necessary to determine whether the family's adjusted income should reflect a deduction based on handicapped assistance expenses. (See 24 CFR 913.102.)

(3) PHAs must make inquiries about the nature and severity of handicaps to the extent necessary to determine whether a live-in aide is essential to the care and well being of a handicapped or disabled person. (See 24 CFR 913.102 and 24 CFR 913.106(c)(5).)

(4) Verification of disability includes receipt of Social Security or Supplemental Security Income disability benefits. If such benefits are not being received, proof of residence in an institution, documents showing hospitalization for a disability or verification by a health or service professional such as a social worker may provide a basis for verification. As in verification generally, direct contact with a third party is preferable to accepting documents provided by the applicant.

(5) The PHA may not require a statement or verification from a physician when adequate verification is available from other sources.

(6) In evaluating an applicant with a handicap, the PHA must consider "mitigating circumstances" just as it does for any applicant. In the case of a person with handicaps, mitigating circumstances may include participation in treatment programs and the availability of services and assistance from the community, friends and family.

(7) When an applicant (including applicants who are not handicapped) cannot provide the customary information required to verify suitability for tenancy such as references from former landlords and credit reports, the PHA should consider other sources of information such as personal references, institutions where the applicant has lived, doctors, therapists and service agency personnel. Home visits and interviews also provide valuable information for making a determination of suitability for tenancy.

c. REFERENCES

(1) Section 504 of the Rehabilitation Act of 1973, as amended.

(2) The Fair Housing Act.

(3) Section 512 of the Americans with Disabilities Act of 1990.

(3) 24 CFR Part 8 - Nondiscrimination Based on Handicap in Federally Assisted Programs and Activities of the Department of Housing and Urban Development.

(4) 24 CFR Part 14 - Implementation of the Fair Housing Amendments Act of 1988.

(5) 24 CFR Part 912 - Definition of Family and other related terms.

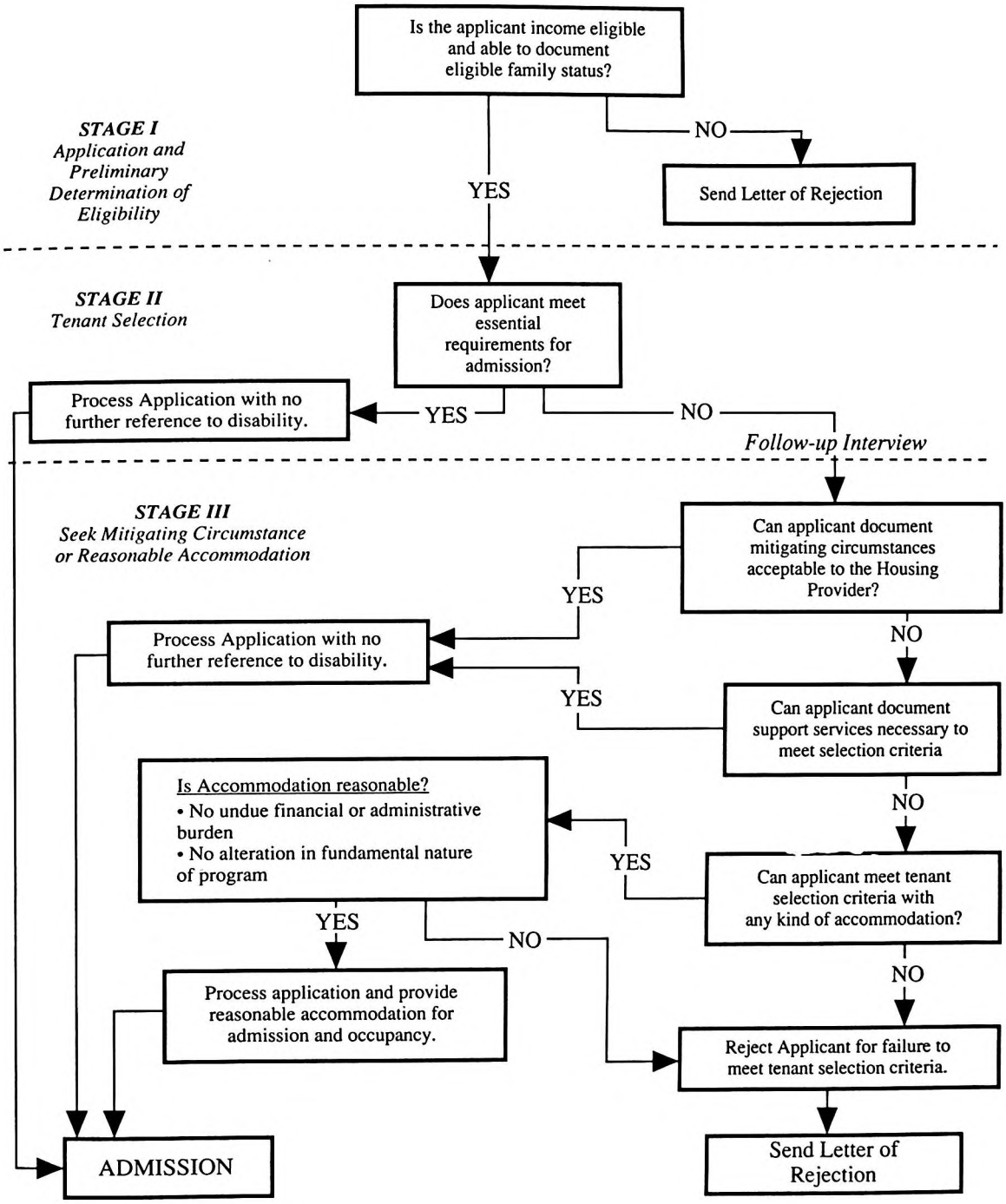
(6) 24 CFR Part 913 - Definition of income limits, income, rent, etc.

(7) 24 CFR Part 960 - Admission To, and Occupancy of, Public Housing.*

Appendix E

A Public Housing Application Process Model

Application Process Model:
Applicants with Disabilities



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Appendix F

Seattle Housing Authority Resident Orientation Program

WE ALL LIVE TOGETHER IN SHA'S HIGH-RISE APARTMENT BUILDINGS

WE ALL LIVE TOGETHER IN SHA'S HIGH-RISE APARTMENT BUILDINGS

The Seattle Housing Authority is committed to providing affordable, modern low-income public housing for all eligible persons. SHA owns and manages 30 high-rise buildings scattered throughout the city. These buildings vary in size from 59 to 300 units, contain mostly one-bedroom apartments, and were constructed in the late 1960s and early 1970s. Under the Department of Housing and Urban Development (HUD) federal regulations, the buildings are designed for occupancy by persons age 62 or older, as well as disabled or handicapped (mentally or physically impaired) adults aged 18 or older.

THE DEFINITION OF DISABILITY AND HANDICAP

DISABILITY: Inability to engage in any *substantial gainful activity* by reason of medically determinable physical or mental impairment which can be expected to *result in death* or which has lasted or can be expected to last for a continuous period of not less than *12 months.*

HANDICAP: A *physical or mental* impairment which is expected to be of *long-continued* and *indefinite duration;* substantially *impedes the ability to live independently* in present housing; and is of such a nature that ability to live independently could be improved by more suitable housing conditions.

Examples:
- Physical Paralysis
- Mental Retardation
- Epilepsy
- Cerebral Palsy
- Mental Illness (Manic Depressive, Schizophrenia, etc.)
- Heart Condition
- Emphysema
- Alcoholism
- Drug Addiction
- AIDS
- Terminal Illness

CURRENT SITUATION

When the high-rises were first opened, the original occupants were primarily people who were 62 years of age and older. But times have changed. SHA currently has a mixed population of residents living in the high-rise buildings. The elderly are becoming older and more frail, and in the past several years a growing number of younger disabled and/or handicapped persons have begun applying for low-income housing.

WHY IS THIS HAPPENING?

There are reasons for the increase in applications by disabled and/or handicapped persons. Agencies and applicants assertively promote integration into the community. Location of services and community-based treatment facilities, combined with the lack of affordable housing in the city, make living in SHA's high-rises very attractive. The disabled and handicapped are willing to move and may be more mobile than some elderly applicants. Since 1981, apartments built under the Seattle Senior Housing Program (SSHP) have filled a great need by creating more housing for elderly, handicapped and disabled people.

WHAT DOES THIS MEAN TO ME?
Perceived or Real Danger?

We all have to live together. We sometimes need to remember that people are people. We all have our differences, be it personality traits, life styles, values or physical attributes, but we are all individuals and would like to be treated as such.

Not all disabled or handicapped people show their symptoms outwardly. And, we must be tolerant of those who look or talk differently. We cannot make assumptions about, or stereotype, those we live near.

If the actions or behaviors of some people cause discomfort to others - no matter what age - we need to address this first by becoming more aware of other people's differences, and being more considerate of them. Gossip, nasty looks, and comments tend to exclude others - and they definitely hurt one's feelings. We may not like the way others dress, or talk, or walk, but these things are not illegal.

However, if behaviors are not acceptable or become dangerous or threatening, SHA will take corrective action as provided by our rules which may result in the offending tenant having to leave the building.

WHAT IS SHA DOING?

SCREENING CRITERIA

SHA looks at the following items in order to predict as accurately as possible the likelihood of applicants being satisfactory tenants:

Past Rental or Home Ownership History. Landlord references are probably one of the best indicators of what sort of tenant someone will be.

Other References. Agencies, professional persons, creditors, and others who have personal knowledge of the applicant can provide references to supplement or replace landlord references.

Home Visits by SHA Staff. SHA staff may visit the applicant's residence to determine if housekeeping is adequate or if damage has been caused to the premises, and to evaluate the living situation, particularly if unsatisfactory landlord references have been received.

Criminal History. If the applicant indicates a past criminal conviction(s) or if SHA learns of a criminal record by other means, further inquiries will be made of the public conviction record to determine if the applicant would be a suitable risk.

Aberrant or Disruptive Behavior Observed by Staff. SHA staff will not process the application of any individual whose behavior indicates that they are operating with diminished capacity or whose behavior is violent or threatening.

SHA staff will carefully review all information received relevant to the applicant's suitability as a tenant, in addition to eligibility criteria. Those determined to be unsuitable will be so advised and given an opportunity to explain or correct problems. Those unable to do so will be denied access to SHA housing.

Denied applicants may appeal such a decision by requesting a *grievance hearing.*

No matter how strict the criteria, it is impossible to catch all potential problem tenants. Also, once a prospective tenant has passed the criteria, his or her behavior may change for the worse.

THREE THINGS SHA EXPECTS OF ALL TENANTS

1. Payment of rent in full and on time.

2. Satisfactory housekeeping and maintenance of premises.

3. Behavior that does not adversely affect other residents' quiet and peaceful enjoyment of their premises, including not creating or allowing to exist nuisances or other situations which endanger the health and safety of other residents or staff.

SHA'S DUE PROCESS FOR ADDRESSING PROBLEMS

IF A TENANT FAILS TO ABIDE BY THESE THREE GENERAL RULES

If you cannot solve the problem or are unable to talk to your fellow tenant for whatever reason, bring the problem to the attention of management and they will talk to the tenant about it. If the complaint has substance, it is followed up with a letter to the tenant confirming what happened and what SHA is asking them to do about it.

After repeated problems (or in the case of one serious problem), SHA staff will have a formal conference with the tenant. This conference will be followed by the service on the offending tenant of a "Ten-Day Comply or Vacate" notice. If the tenant complies and the problem is resolved within ten days, no further action is taken.

If the tenant fails to comply, either a 3-day or a 30-day "Notice of Lease Termination" is served on the tenant. Under the 30-day notice, the tenant has a right to a grievance hearing under HUD rules.*

If SHA wins in the grievance hearing (or in the case of the 3-day notice where no hearing is required), and the tenant then does not vacate voluntarily, SHA's attorneys prepare and send the tenant a "Summons and Complaint," the first step in court proceedings. If the tenant does not respond to the "Summons and Complaint," a Default Judgment can be taken against them and the Sheriff will evict them.*

* Editor's note: After this brochure was written, HUD regulations on public housing lease and grievance procedure requirements were revised. As a result, some of the information is out of date. For current information, see 24 CFR Part 966 Subparts A and B.

If the tenant contests the action by responding to the "Summons and Complaint," SHA must take the tenant to court and prove to a judge or jury that the action to remove them is warranted.

But please remember, if all the steps described above are used, and assuming SHA proves its case, it can take from 75-90 days to evict a troublesome resident. SHA is required, as all landlords are required, to follow this "due process" when terminating the lease of a tenant. This due process protects the rights of tenants and guards against unlawful, unreasonable eviction.

WHAT DO I DO IF I HAVE A PROBLEM?

Report *LEGITIMATE* complaints promptly. You will *NOT* be evicted for airing legitimate complaints.

SHA cannot act against a tenant without actual complaints and these complaints must be supported by witnesses. Unless SHA personnel actually witness the offending behavior, we must rely on residents to prove and justify our actions. This means you must be prepared to stand behind your complaint. It if difficult to maintain the anonymity of complaints in such cases unless it is certain that retaliatory acts or harassment will result.

Examples of Legitimate Complaints:

NOISE	PETS
GUESTS	VEHICLES
HARASSMENT	SANITATION
VANDALISM	CRIMINAL ACTIVITY

Use SHA complaint forms (located at the Manager's office).

HOW CAN RESIDENTS HELP?

Be tolerant of those who are different from you and your standards unless they truly infringe on your rights.

Understand and *be patient* while SHA pursues remedies of problems brought to staff.

If SHA fails to act on legitimate complaints, take the matter to the next level supervisor, BUT FIRST give the Manager the opportunity to address the problem. If the problem continues, please let the Manager know so that he or she can follow up on it. You can reasonably request that your Manager let you know what is happening in regard to your complaint.

Living together isn't always easy. Tolerance and understanding are essential, whether we live in a neighborhood or a high-rise building. By remembering that people are people, we can all make living together just a little bit easier.

We want your years in Seattle Housing Authority's high-rises to be long and happy ones. We sincerely hope that you will like the experiences and associations you have at SHA.

Seattle Housing Authority Complaint Form

Date: _____

Name of Person Making Complaint: _____

Address: _____

Telephone: _____

Check Appropriate Category:

___ Children	___ Guest	___ Harassment	___ Noise
___ Pets	___ Vehicles	___ Sanitation	
___ Vandalism	___ Criminal (describe)	___ Other (describe)	

Complaint (be brief and to the point. Your name will be kept confidential, but in the case of an eviction, you may be required to testify. List other witnesses).

_____

_____

_____

_____

Received by: _____

Date: _____

Action Taken: _____

_____

_____

_____

_____

Referral: _____

_____

_____

_____

_____

SHA-883 (3/88)

Appendix G

Toledo Shared Services Model

Ruth S. Ide CMHC & LMHA Supported Housing Program

A New Shared Services Model

This proposal reflects the joint efforts of the Ruth S. Ide Community Mental Health Center, Inc. and Lucas County Metropolitan Housing Authority. The proposal will outline current needs of each organization and how combining of resources can produce a successful shared services venture.

Problem

LMHA
* Declining occupancy level
* Changing tenant demographics—young disabled & elderly
* Client behavior management
* Afterhour service support and security

Ide Center
* Increased need for conventional housing
* Opportunity for normal community integration
* Available & accessible support services
* 24-hour staff support & intervention

Solution

Individuals experiencing mental illness often face discrimination in their pursuit of meaningful and full community lives. Access to housing, and many community resources are unattainable because of the stigma associated with mental illness. These needs and issues are not unlike what the elderly and handicapped must face in their struggle for basic rights and dignity in their life. Recognition of attitude and environmental barriers to quality of life for the elderly and handicapped, is as essential for individuals experiencing mental illness. Disabled individuals face a great number of demanding circumstances, with very little or no support from traditional service systems. Few people who rely on disability income and who lack other necessary resources and skills can make it in the community without services and support. Independent living places many explicit and implicit demands on people and intensive support may be needed to enable them to cope effectively. Supported housing is a critical need for individuals with mental disabilities and homelessness, and is the foundation of this shared services model.

In this shared services model the emphasis is on quality of life for all tenants. Special efforts and support will be focused on those tenants who are most at risk of experiencing difficulties with independent living. Services and support may be provided on-site through the core support unit or by outside community organizations by way of advocacy, referral, and service acquisition. Planning will address arrangements to identify and coordinate access to a wide range of community resources and services. Apartment placements shall be dispersed throughout the complex, rather than house all persons with disabilities on a single floor. This will not preclude the occupancy of five to eight residents on a single floor if peer, staff and tenant support will be enhanced. Yet, scattered units allow for maximum integration and interaction with non-psychiatrically disabled tenants. This

arrangement enhances the opportunity for non-psychiatrically disabled tenants to serve as role models for normal community functioning. Normal environments set the stage for normal behavior and activity, as the psychiatrically disabled tenants are constantly exposed to the rhythm of daily life around them (Ridgeway & Zipple, 1990).

Program Design

Program design is based on the provision of 24-hour case management support services. Two (2) apartments shall be utilized for housing of a core support team, external case management and other Ide Center services. Housing support services shall be offered at two levels based on tenants' support needs.

Level 1
Eight (8) apartment units shall be identified on a single floor for tenants requiring intensive case management support. This design shall utilize a team approach in the provision of supportive services to tenants. Internal and external case managers shall plan individual goals and strategies with tenants, focusing on skill development, crisis intervention, medication compliance, community integration and establishing peer and family support. Existing system services shall be utilized whenever appropriate. The program will be flexible, and tenants may receive this level of support as long as they need it.

Level 2
Seven (7) apartment units shall be identified throughout the building for tenants requiring moderate to minimal case management support. This design will rely on external case management with flexible support by internal staff where appropriate. Support is focused primarily on community integration, vocational, social, recreational, and peer and family support.

Flexible Service and Support

Flexible and Individual Services and Support (FISS) is the goal of the model. This will be done through adequate, qualified 24-hour, on-site case management support and linkage with Ide Center services and other community resources. As the residents' needs change, the services and support can be increased or decreased within the environment. Support may include but is not limited to the following:

* Daily face-to-face contact
* Case management services
* On-site nursing & health education
* Off-site day programming
* Skill development
* Entitlements application assistance
* Medication monitoring
* Homemaker services
* Social and recreational activities

All efforts will be made to identify and draw resources from the general community and local, community support system where appropriate.

Other Ide Center Services

Individual case managers will provide additional and coordinated support services.
* Functional assessments of specific skills and/or resource strengths and deficits
* Referral and linkage to existing system services (i.e., Gateways, Aim High, SERV, Merit, Social Security) and to other community resources
* Resource acquisition
* Representative payee and/or money management

Nursing education services shall be available to tenants as determined by the core support team and tenants' council. Educational services shall include the following:
* Medical education
* Pharmacological education
* Prevention program

Counseling and personal enrichment education shall be available to tenants as determined by the core support team and tenants' council. Educational services shall include the following:
* Eight (8) hours per week
* Personal enrichment classes

Tenant & LMHA Support Services

The Ide Center and LMHA recognize that the success of this model is linked to efforts to address the needs of the tenants and landlord in this enclosed community. Therefore, we are proposing to staff the unit with adequate personnel to identify and enhance the quality of life for all tenants. Many services created will be extended to all the tenants. The following support services may be provided to tenants and LMHA management.

Tenants
* Nutritional planning and preparation
* Social and recreational opportunities
* Health education
* Entitlements application assistance
* In-home referral assistance
* 24-hour, in-house staff monitoring assistance
* Staff support for tenant council meeting
* Recruitment of community services and resources
* Tenant advocacy

LMHA Management
* Rent collection & payment assistance
* Eviction assistance when appropriate
* Appropriate screening and selection of tenants

Management

Responsibility for the physical site and support services should be separated. LMHA shall retain landlord duties for property management. The separation of functions allows each organization's expertise to be targeted and simplifies implementation of the support model (Trainor, Lurie, Ballantyne, & Long, 1987).

The management structure shall be set up to promote partnership between the tenants, the core support unit, and the LMHA management. Central to the structure is a decision-making body which includes the tenants' council, the core support staff, and the LMHA manager. The tenants' council and core support staff shall assume responsibility for developing a routine means of surveying tenants about their perceptions and needs. Regular meetings with minutes to record identified problems and actions, brief questionnaires, and a structured format for conducting exit interviews with tenants who leave the unit shall be developed. A complaint or grievance process with a procedure for providing feedback and solving problems will also be developed.

Program Staff

The on-site support staff and the LMHA manager are the key to whether the project is meeting its objectives. Because of their considerable influence on the physical and social environment, the work of these staff shall be routinely evaluated.

Program Evaluation

Given the importance of this project, ongoing evaluation is essential. The following questions shall be addressed by an evaluation:

* Does the model serve to improve quality of life for all tenants?
* Does it provide permanent homes that are alternatives to the shelters or the streets?
* Are the resources and supports available to help tenants stabilize their lives?
* Are safety and control measures adequate and least restrictive?
* Is the physical environment satisfactory?
* Are tenants involved in the management of the building?

Criteria for Admission

The screening process for selection of tenants shall include LMHA, and the Ide Center. Criteria for occupancy shall consist of but are not limited to the following:

* Adult
* Psychiatric disability
* Homeless
* Drug and alcohol free for at least 3 months
* Statement of willingness to cooperate with LMHA and support services
* Accept terms of lease

Program Commitment

* The careful selection of tenants who are at risk for hospitalization
* A willingness to assume ultimate professional responsibility for tenants well-being
* Assertive advocacy on the residents' behalf to achieve program goals
* A heavy reliance on staff teamwork, with absence of individual caseloads
* A staff to client ratio of 1 to 8
* Immediate linkage to crisis services when needed
* A commitment to working with the tenants as long as they need or request services
* Formal and informal education of other apartment tenants
* Assisting, linking, and identifying other apartment tenants in need of community services and outreach

Program Goals

* Explicit mission to achieve residential stability
* On-site intervention
* A focus on the resolution of everyday life problems
* A focus on housing normalization
* A focus on individualized growth and development
* A focus on community integration and increasing support systems
* A focus on anticipation and prevention of personal crisis
* A focus on participation in a government council and planning of program services

Shared Services Staffing Pattern

FTE (Monday thru Friday)

1 Live in Case Manager (works primarily days and evening hours)

1 Case Manager (12 noon to 8 p.m.)

1 Guard (11 p.m. to 7 a.m.)

FTE (Saturday and Sunday)

2.5 Two per diem staff scheduled Friday thru Monday a.m.
Will be paid for actual hours worked

Appendix H

Sample Job Descriptions

1. Case Manager
2. Supported Housing Manager

Zepf Center, Inc.
Job Description

Job Title:	Case Manager
Job Classification:	Pay Range 5
Department:	Residential Services
Program:	Supported Housing
Supervisor:	Program Manager

Position Purpose: To provide case management services to severely mentally disabled agency clients.

Nature of Work: The person in this position provides a wide range of case management services to an assigned caseload. Services include assessment, treatment planning, advocacy, linking, assistance in daily living, crisis intervention.

Functions:

1. Assesses client needs and strengths.

2. Develops comprehensive treatment plan.

3. Makes linkages and referrals.

4. Tracks appointments and assists clients to keep appointments (e.g., psychiatric, day treatment, medical, dental, etc.).

5. Monitors progress.

6. Advocates for individual clients.

7. Helps residents with their monies, budgeting, etc.

8. Assists clients in learning how to maintain their apartment.

9. Provides assistance for in-house group activities.

10. Intervenes and manages client crises.

11. Participates in problem solving efforts with clients and other residents of the facility.

12. Maintains required documentation.

13. Maintains sufficient contact with client to ensure satisfactory stability.

14. Provides supportive communication with client around daily living stress and/or individual goals.

15. Provides beeper/emergency support to other program staff.

16. Provides face-to-face contact with clients residing in TMHC to facilitate discharge into the community. This will include but not be limited to working with all hospital disciplines.

17. Participate in staff development.

18. Attends all agency and department meetings.

19. May serve on agency committees.

20. Carries out agency policies and procedures.

21. May participate in agency-wide projects as directed.

22. Other related duties.

Essential Behaviors: Abides by professional and agency code of ethics and rules of confidentiality in relationships with clients, community resource and other agency staff.

Education and Experience: BA, or AA plus 2 years related experience. Must be well organized, have excellent oral and written communication skills and have demonstrated competency in major functions of this position.

Subordinates:
none

1/91

Zepf Center, Inc.
Job Description

Job Title:	Supported Housing Manager
Job Classification:	Admin. Support Pay Range 10
Department:	Residential Services
Program:	Supported Housing
Supervisor:	Clinical Director

Position Purpose: To administer and manage a supported housing program for severely mentally disabled adults.

Nature of Work: The person in this position manages, controls, plans, and evaluates a supported housing service, including coordinating residential and case management services, supervision of all staffing to ensure continuity of care within the program and interdepartmentally.

Functions:

1. Administers daily activities necessary for ongoing operation of the program.

2. Acts as liaison with the Lucas County Metropolitan Housing Authority Management staff.

3. Coordinates payment of rents, deposits, etc. by clients to LMHA.

4. Coordinates problem solving, activities between Zepf Center staff and LMHA staff and residents.

5. Develops, implements and monitors instructional and recreational activities for residents.

6. Coordinates services with other program components of Zepf Center.

7. Supervises the development, implementation and monitoring of individual treatment plans for clients assigned to the case management staff.

8. Assists clients to comply with the rules and regulations of residency within the facility that they reside.

9. Conducts residents meetings routinely.

10. Screens prospective clients.

11. Insures orientation of all residents to policies and procedures of the facilities as well as lease requirements.

12. Insures orientation of all pool staff to house and safety procedures.

13. Coordinates and provides beeper/emergency to program staff.

14. Establishes and maintains a liaison relationship with relevant groups and program external to the agency. These shall include treatment programs, neighborhood groups, and other community organizations which may impact on the integration of residents into the community.

15. Supervisors all staffing including recruiting, orienting, evaluating, disciplining, scheduling and approving payroll.

16. Assists in developing housing opportunities and community resources for residents.

17. Attends all relevant meetings as directed.

18. Keeps all records as required; performs related work as assigned; participates in staff development; carries out policies and procedures of the agency; participates in agency- wide projects as required by supervisor; may participate in community work.

19. Coordinates the planning implementation of training activities for residents.

Essential Behaviors: Must be able to communicate well both orally and in writing. Must be able to work independently.

Minimum requirements for the position: Masters degree plus two years full time employment experience working primarily with people who have a severe mental illness or two year degree in a mental health discipline plus four years human service work experience, two of which should include supervisory experience in community residential settings, and at least one year in residential support services; comprehension of the Developmental Acquisition model of case management; knowledge of the range of symptoms associated with severe mental illness; efficient written and verbal communication skills; ability to work effectively with a wide range of constituencies; demonstrated leadership skills and goal orientation; strong resource acquisition, supervisory and managerial abilities.

Subordinates: Case Managers
Residential Monitors
Residential Pool Staff

January, 1991

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