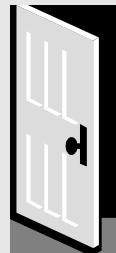


Conference Report

June, 2000

OPENING DOORS:



ADAPTING HOUSING & SUBSTANCE ABUSE
SERVICES TO MEET THE NEEDS OF
HIV/AIDS IMPACTED PERSONS

Conference Date & Location

March 21, 2000

University of Illinois at Chicago

Conference Convened by

Mid-America Institute on Poverty of

Heartland Alliance for Human Needs & Human Rights



Providing paths from harm to hope since 1888

Acknowledgements

Report edited by

Amy Rynell, Mid-America Institute on Poverty

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AIDS Foundation of Chicago

Bristol Myers Squibb

Substance Abuse and Mental Health Services Administration:
Center for Substance Abuse Treatment

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Forward

Amy Rynell
Policy & Advocacy Specialist
Mid-America Institute on Poverty

In 1998, the Mid-America Institute on Poverty (MAIP) convened a committee of substance abuse treatment, housing, and case management service providers in the Chicago metropolitan area to review research on program models designed to serve substance users who are also homeless or at risk of homelessness and impacted by HIV/AIDS. Review of empirical data and discussion of programmatic challenges led these providers to seek a vehicle for disseminating information about the challenges service providers face as more multi-barriered clients seek program services and to profile service models that have been successfully adapted to better serve the special needs of this population.

While the network of HIV/AIDS services has evolved tremendously since the epidemic began, recent changes in affected populations, specifically the increase in substance users, have presented challenges to providers of services in these networks. Innovations addressing these challenges have been difficult to develop because of funding limitations and because many service providers are not as well acquainted with the multiple issues faced by this segment of the HIV/AIDS impacted population and with service provision models designed to address these special needs. The committee decided to organize a conference to address these goals and concerns.

This conference is focused on identifying current and promising practices in serving special populations -- substance users who are also HIV/AIDS impacted and homeless or at risk of becoming homeless. It examines issues of a crosscutting nature and explores approaches and programs that enhance and expand treatment for this population with co-occurring issues. The dissemination of knowledge into practical applications at the local level is an emphasis of this effort. The conference will help providers, program managers, funders, and others to understand the components and operational challenges of adaptive models by identifying the areas where systemic change is needed to improve services, and by providing the information and resources needed to support that change.

While innovative models have been implemented in Chicago as part of the HIV/AIDS service continuum and have been successful with certain segments of the changing HIV/AIDS impacted population, others are not served well or at all by these models. Additional models exist in various specialty fields that could help serve those who fall through the gaps in the current continuum of HIV/AIDS housing in Chicago. A dialogue is needed between substance abuse treatment providers, housing providers, mental health service providers and the homeless service system in order to effectively address the needs of the changing HIV/AIDS population in Chicago. The knowledge developed by each specialty can assist in the development of truly innovative multi-disciplinary models of service. The *Opening Doors: Adapting Housing & Substance Abuse Services to Meet the Needs of HIV/AIDS Impacted Persons* conference is a forum through which that dialogue can be furthered as a diverse group of service providers and funders share their knowledge and experience.

Following is a report containing the transcribed conference proceedings. For more information on the conference please contact Amy Rynell at (312) 660-1349.

Conference Summary & Recommendations

May, 2000

Amy Rynell
Policy & Advocacy Specialist
Mid-America Institute on Poverty

The Mid-America Institute on Poverty recently hosted the conference: *Opening Doors: Adapting Housing and Substance Abuse Services to Meet the Needs of HIV/AIDS Impacted Persons*. More than 150 housing, substance abuse treatment, HIV/AIDS service and health care providers attended.

The presenters and attendees worked to develop a series of change priorities that can be used by people in their individual leadership roles and also as a platform that will be forwarded to a wide array of policy makers and policy entities to educate them about ways to better serve people who are impacted by HIV/AIDS, people who are homeless and substance users. This forum was used to identify service gaps and barriers as well as illuminate innovative models that are helping attain stability in housing and health. Areas addressed by the policy platform include:

1. Substance Use: *goals in this area include*

- Establish a continuum of substance abuse services that includes both harm reduction and abstinence-based models. A similar measure has been pursued in the city of San Francisco.
- Change stereotypes of people who use alcohol and/or drugs. Increase awareness that addiction is a disease.
- Improve treatment for heroin addiction.
- Create a seamless linkage between physical health and mental health care.

2. Housing: *goals in this area include*

- Increase long-term rental subsidies.
- Increase HUD funding so more affordable units can be built.
- Improve integration of housing and services including substance abuse treatment, health care and employment services, building on existing supportive housing models.

3. Income: *goals in this area include*

- Increase earned income through for example a living wage floor or an expanded earned income disregard in the SSI program.
- Restore the safety net.

4. Funding: *goals in this area include*

- Establish innovative and integrated funding pools that support non-compartmentalized services that, for example, support co-location of services or linkages between housing and treatment.

In the next few months the briefs will be released. Please join us in strategizing ways to use these to improve the current system. Thank you for your support.

OPENING DOORS:

ADAPTING HOUSING & SUBSTANCE ABUSE SERVICES
TO MEET THE NEEDS OF HIV/AIDS IMPACTED PERSONS

Transcribed Conference Proceedings

Welcome

Role of the Pharmaceutical Industry in Continuity of Care

Opening Briefings

National & Local HIV/AIDS Trends

National HIV/AIDS Housing Trends & Models

Local Affordable Housing Market

Current State of Substance Abuse Services

Model Panels

Blending Housing & Recovery Services

Housing Persons Using Alcohol or Drugs

Supportive Housing

Supportive Services in the Shelter Context

Housing Families

Funding Panel

Visionary Panel

Closing Address

Welcome

*Linda Traeger
Executive Officer
Chicago Connections*

Welcome to our *Opening Doors: Adapting Housing and Substance Abuse Services to Meet the Needs of HIV/AIDS Impacted Persons* conference. We are pleased that you are all here today and have this opportunity to share ideas and knowledge about the intersection between substance abuse services, housing and HIV/AIDS services. We have an excellent opening panel, a good series of workshops and we appreciate all of you who are assisting in bringing practitioners' knowledge to this conference so that we can share best practices and come out with new ideas about what can work better for the populations that we are all concerned about. Support for this conference has been generously provided and I would like to thank the people who have been involved with this: the AIDS Foundation of Chicago, Bristol-Myers Squibb Department of Immunology, and the Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment. I also want to thank all of the organizers who have contributed their time in helping plan this conference. Thank you to all of you who have helped put this together.

Just a few words about the conference. The opening briefings that are going to take place as soon as we finish this overview will address emerging trends, implications for existing models and systems, and the need for adaptations and changes within the existing system. The sessions that follow are practitioner-led and will provide information on exemplary and innovative models targeted toward the needs of substance users who are homeless or at risk of homelessness and may be HIV/AIDS impacted.

Later this afternoon there will be a funding panel comprised of people who will be able to brief all of us on current funding sources, emerging trends and potential changes in their areas of expertise. We hope that this panel will also be able to educate us about what funding is available to use in innovative and flexible ways and ways we can help encourage changes in funding strategies. There will be a panel discussion by established leaders in the field of social service development to discuss system changes necessary to better adapt and evolve existing programs and offer concrete recommendations. And, finally there will be a facilitated dialogue and summary session that will provide an opportunity for groups to discuss the assessments and recommendations that come out of their work and to talk about these in the context of the realities of service provision. This dialogue will end with an integration of these comments into a single list of prioritized recommendations for change.

Again, thank you for coming and please enjoy the day.

Role of the Pharmaceutical Industry in Continuity of Care

Eileen Mattimore
Community Liaison Specialist
Bristol-Myers Squibb Immunology

On behalf of Bristol-Myers Squibb I would like to thank Heartland Alliance for Human Needs & Human Rights and the other conference planners for the opportunity to support, participate and most importantly learn with all of you at this conference that focuses on two of the most critical needs facing HIV impacted individuals: housing and substance abuse. I want to take just a couple moments to talk to you about some of the initiatives and the leadership Bristol-Myers Squibb has taken within the pharmaceutical industry both globally and at the grass- roots level to partner with community based organizations and to truly live the mission that we have: to extend and enhance the lives of people living with HIV and AIDS.

The face of AIDS has changed. Obviously Bristol-Myers Squibb has changed too and I am really proud of the fact that we have taken such a leadership role in that change. Traditionally our approach had been to go out and educate physicians on the merits of the different drugs that are used to treat HIV and AIDS but as the impacted populations changed, there was recognition that this traditional approach really was not appropriate. When you think about the fact that there are so many people that are infected and impacted by this disease that may not know it or if they know it do not have the access to good HIV care. Though Bristol-Myers Squibb has been involved since 1992 in marketing Zerit and Videx, the most exciting thing I want to tell you about is my position as community liaison specialist. That is how you and I may work together if we are not already. I started in the position last year at the beginning of 1999. There are eight of us across the country in the major cities including New York, Los Angeles, Chicago, Miami, and Baltimore. Our mission is

to partner with the HIV/AIDS treatment providers and community based organizations in supporting prevention education, testing and medical treatment with the goal of extending and enhancing the lives of persons with or at risk of acquiring HIV.

I am very grateful to a number of you I see here today whom I have worked with before. Thank you for entrusting me with partnering with you on initiatives. I especially thank a number of you from the Chicago Department of Public Health (CDPH) who has been wonderful to work with. We have collaborated on a number of projects, continue to work together and are looking forward to a lot of things this year. Also, in terms of my education and orientation to this job, I want to thank Gwen Mastin, with New Phoenix, whom I met last year. She enlightened me as to the real critical need for housing in the HIV impacted population. She took me around to some of her housing sites and explained to me how important housing is if we are going to actually identify and help to medically treat people impacted by HIV disease. One of the most critical needs was to really stabilize people and get them good affordable housing. I have really come to have an understanding that housing is essential in bringing stability to a person's life.

There are a number of other things I have been involved with that I'll preview to give you a feel for the type of grassroots work I am talking about. I have done a number of things as I mentioned with the city. I have also been involved with some of the local planning groups. I have done a lot of work with the WHARP organization on the West Side and we continue to work very well together. Another initiative that I helped start up was a south

side physician providers group and it actually was the vision of the late Dr. Sherri Luck and now it is carried on by William Johnson. The group's main objective is to identify physicians who may not be the traditional HIV providers, but who are stepping up to the plate starting to do some HIV work but needed to be mentored, educated and supported. MATEC has helped quite a bit with that effort as well.

I have done work with the city on HIV Testing Day. I have worked with a number of the different community based organizations helping to stipend outreach workers or putting ORASURE tests in their hands if they need them. I also have done things like networking dinners in which treatment clinics are linked with the different community based organizations, methadone treatment sites, housing and all of the supportive services. They are all brought to the same table so they can meet one another face to face and enhance their working relationships. These dinners have been done on the West Side and on the Northwest Side with the Puerto Rican community and they have been very rewarding and beneficial for all of the participants. Finally, I have also done some work with Pam Muir at the state level around substance abuse and with many of you have who do HIV counseling with persons affected by substance abuse.

The other thing I wanted to mention to you today is that Bristol-Myers Squibb just recently announced a two million-dollar community leaders fund. This is an HIV and AIDS grant program basically designed to provide financial support for organizations and community groups that develop and implement innovative HIV and AIDS programs. The grants will be targeted to cities that have an extremely high incidence of HIV and AIDS: New York, Philadelphia, Baltimore, Washington D. C. Atlanta, Chicago, Miami, Los Angeles and Dallas. Grants will support prevention education, testing, treatment access and case management programs.

Bristol-Myers Squibb will also award grants to programs serving incarcerated and under-served populations. Over the next two years the fund will distribute more than two million dollars in grants.

Those are they types of things that I get closely involved with and it is a wonderful opportunity for you to have another resource to help support some of your efforts. Coming up this year I have a lot on my plate. I am proud to say I am doing interesting things with Roseland Hospital, HIV clinic in collaboration with CDPH. We are planning to bring additional resources to help them build their medical, case management and other services (case finding). I am also doing a lot of things with the WHARP organization—we just printed up some testing site cards for usage with consumers. I am sponsoring an edition of the Austin Voice newspaper which will be entirely devoted to HIV and AIDS with people telling their personal stories to help other people come forward to get tested and treated. Also along with CDPH, I am working with Cermak Jail on their CDC funded continuity of care grant to partner on various projects and facilitate their linkages with knowledgeable physicians who treat HIV in the community. I am also working with Dr. Eric Whitaker of the Mid-South HIV Prevention Coalition on a prevention and testing program. I am also trying to help a group that has come together that has been CDC funded—called the MOCHA 2000 group which is a number of different agencies that are building in capacity to serve gay men of color. I am also partnering with CDPH on a great conference that they are planning for June called AIDS in the Heartland. So, there are a lot of things happening.

There is a Bristol-Myers Squibb information table in the lobby with many types of information including educational videos, calendars, and brochures, all at no cost. Please come visit me out there and I will be happy to give you more information.

Opening Briefing: National & Local HIV/AIDS Trends

Cydne Perhats

Associate Administrator

Chicago Department of Public Health, Division of STD/HIV/AIDS

National HIV/AIDS Statistics

- Of the 400,000 to 600,000 individuals in the U.S. who are estimated to be living with AIDS, about one-third to one-half are either homeless or at risk of becoming homeless.
- CDC estimates that 40,000 new infections of HIV occur annually. That translates to about 100 people each day becoming infected with HIV: About half of them will be African Americans.
- From July 1998 to June 1999, CDC reports that
 - men accounted for 68% of adult AIDS cases, with 58% among Blacks and Hispanics;
 - among women, 77% of new infections were among Blacks and Hispanics,
 - 15% of new cases occurred among persons age 13-24 and women accounted for 49% (nearly half) of the cases in this age group.
 - 3.7 million adolescents in this country are uninsured and of those, over 2 million are eligible for, but not enrolled in Medicaid or the State Children's Health Insurance Program (CHIP) passed by Congress in 1997.
- Despite drops in the AIDS death rate due to new drug treatments, AIDS remains the leading cause of death for black men and women 25-44 years of age. The most recent figures from CDC indicate that from 1997 to 1998
 - the decrease in the number of AIDS Deaths slowed from 42% to 20%;
 - the decrease in new AIDS cases also slowed from 18% to 11% in the same time period.
 - the slowing rate of decline may indicate that much of the benefit of new therapies has been realized and that the duration of the effect of treatment may be limited for some. For example, people in treatment but at a more advanced disease stage, may experience improved health for a shorter period of time.

Chicago HIV/AIDS Statistics

- The picture is very similar in Chicago, with new HIV infections exceeding AIDS deaths by about 500 Cases each year in recent years.
- So the number of actual people living with an AIDS diagnosis continues to increase, making the complexity of care, and the costs of providing that care greater each year

Homelessness as a Risk Factor for HIV/AIDS & the Chicago Department of Public Health Response

African Americans comprise the majority of homeless populations with HIV/AIDS and African Americans with HIV have been shown to have less access to HIV care than white Americans, including testing services, prophylactic antibiotic therapy for opportunistic infections and other treatment regimens. Without knowledge of HIV status, an individual's chances for early diagnosis, prevention of transmission of the virus to others and access to potentially life-saving medications are all significantly reduced.

- Substance abuse and mental illness are highly prevalent among homeless populations and this further complicates early diagnosis and treatment for individuals who are facing multiple health issues. Often times, these services are unavailable even when a homeless individual does enter the health care system. Providers who are trying to establish linkages to support services report significant difficulties in making successful referrals in under-served communities where few or no services exist.
- Because homeless individuals spend the majority of their time and energy taking care of their basic survival needs for food, clothing, and shelter, we must find creative ways to reach them. Several new initiatives at the health department are underway to achieve that goal:
 - We are working with Night Ministry to provide STD/HIV/AIDS counseling and testing services to homeless youth through a new mobile van that travels to different sites throughout the City.
 - We are also conducting a pilot project to test the use of ORASURE in the field. ORASURE is a mucosal oral swab instead of a blood draw to test for HIV, and it can therefore be used on-site to reach people who are not likely to enter the clinic setting.
- Through over \$8 million in new funding that CDPH received this year, other new initiatives have begun that will address these health disparities. These initiatives include:
 - \$1.8 million in Community Coalition Development funds from CDC to develop integrated HIV and STD prevention services with linkages to substance abuse treatment, mental health, housing and violence prevention and other support services.
 - \$1 million for Correctional HIV/AIDS programs, with a focus on discharge planning and linkage to follow-up care upon release
 - \$1.2 million for MOCHA 2000, a coalition of 7 community-based organizations and CDPH to build a coordinated system of prevention services for gay men of color.
 - \$1 million to develop and implement the syphilis elimination campaign, as a response to the rising numbers of cases in Chicago, especially among young gay men.
 - In addition, over \$500,000 in Ryan White Title I Congressional Black Caucus dollars will be used to expand Substance Abuse, Mental Health, Food and Housing Services, Legal Assistance and Alternative Therapies to African Americans and Hispanics throughout Chicago.

Face of AIDS: Personal Stories from the Heartland

Finally, one of the ways in which we hope to advocate for people living with and impacted by HIV and AIDS is to create an opportunity for their voices to be heard. A project begun last year at CDPH and carried out through the support of numerous community partners represented here today is the Faces of AIDS: a book and photo essay exhibit that will be released in June at our conference entitled “AIDS in the Heartland”. The project is intended to focus attention on issues specific to Chicago, Illinois and the Midwest region and will bring together consumers, providers, legislators, advocates and community activists from eleven States. The purpose is to dispel the myth that the epidemic is over, to increase public awareness about the current state of HIV/AIDS and to advocate for reauthorization of the Ryan White CARE Act and increased appropriations.

Through the telling of these moving portrayals, we can begin to overcome the stigma associated with this disease and reduce some of the barriers to accessing prevention and care.

Summary Remarks

In closing, I want to share a story with you that I think represents both the strides we have made and the distance we have yet to go. This is a story from the “Face of AIDS” about Mary:

In 1989, I received the results of an HIV test from a CDPH clinic and as it so happened it was from an employee who was compassionate enough to insist I not leave until she contacted a professional for follow-up counseling at UIC. Fast forward to Seattle, Washington...In 1993, I experienced my first health-related crises and was hospitalized for severe diarrhea, high fever and extreme fatigue: I found out I had a parasitic infection called Giardia and that I had progressed to full-blown AIDS. I pointed out to the social worker, because of the source of infection, as soon as I left the hospital I would be homeless. The social worker told me that I was not eligible for emergency housing in Seattle because I had not lived there long enough, so I'd better return to my hometown Chicago. When I told her about the absence of family support, she suggested I renew contact with the Chicago counselor I had been seeing. She did not even offer bus tokens that could take me to wherever I went next. In spite of my educational background and potential to earn income, I found myself without support and being treated with a lack of respect. I returned to Chicago, roomed with a friend temporarily and in 1994 went back to the clinic at UIC. By this time, due in part to Ryan White CARE Act funding, the clinic offered comprehensive care. Later that year, I moved into an apartment building that offered subsidized housing for people with AIDS. Affordable decent housing continued to be a problem but after two years of rejections and appeals for Social Security Disability, I received a retroactive lump sum and was able to re-enter the rental market. As I pursued a search for affordable housing, something stunned me: the passivity with which people accepted the demands thrust on them to dig ever deeper into their pockets to satisfy a fundamental human need for shelter. I eventually found a somewhat affordable apartment. Seventy-five percent of my supplemented disability income now goes toward rent. I juggle my other need for food, clothing, the occasional haircut and cleaning supplies with a creativity I had not known I possessed. It is precisely this “great latent capacity” which we all must honor and embrace if a truly collaborative model is to be an effective tool for the future of AIDS care and support services.

As we go forward throughout this day and with the challenging task ahead, I know we will succeed if indeed we can look to all the “Mary’s” in our midst and the “great latent capacity” within ourselves and our communities to forge ahead with courage, intelligence, compassion and fortitude.

Opening Briefing: National HIV/AIDS Housing Trends & Models

Betsy Lieberman
Executive Director
AIDS Housing of Washington

Good Morning. My name is Betsy Lieberman and I am the Executive Director of AIDS Housing of Washington. I am honored and excited to be here today. First I'll begin with some additional epidemiology and then I'll move into some specifics on AIDS housing.

Emerging Trends in HIV/AIDS Epidemiology

In terms of national trends:

- As of June 30, 1999, it was estimated that more than 279,000 people were living with AIDS.
- AIDS deaths nation wide dropped 42% in 1997, but only 20% in 1998.
- In 1998, African Americans represented only 13% of the U.S. population, but accounted for 49% of AIDS deaths.
- Injection drug use (IDU) has accounted for over one-third (36%) of all AIDS cases and 59% of all AIDS cases among women since 1981.
- MSM continues to account for the largest number of people reported with AIDS each year.
- It is estimated that at least half of all new HIV infections in the U.S. are among people under 25.
- Prison inmates are 5 times more likely than non-inmates to have AIDS and 10 times more likely to have HIV.
- Incidence of new infections is extremely high among young, gay men and heterosexual women of color, particularly African Americans.

The following chart is specific to trends of HIV/AIDS in Chicago:

1994 Reported Cases	1999 Reported Cases
85% male 15% female	78% male 22% female
54% African American 31% Caucasian 14% Hispanic	65% African American 18% Caucasian 16% Hispanic
51% MSM 33% IDU 6% Heterosexual	40% MSM 35% IDU 11% Heterosexual

Context of AIDS Housing in FY 2000

I. Homelessness and HIV/AIDS

It was estimated that on any given night nationally, over 700,000 people are homeless, and up to 2 million people experience homelessness during one year. Estimates on the number of homeless people who are living with HIV/AIDS are difficult to make at this time. However:

- Studies indicate that the prevalence of HIV among homeless people may be as high as 20% in some cities.
- The three-year incidence of AIDS among public shelter users in Philadelphia was more than 10 times that of the general population (1992-1994).
- It is estimated that from 8% to 10% of the homeless population in Atlanta and San Francisco are HIV infected.

II. *Growing Need for HIV/AIDS Housing*

There is a growing need for assistance and housing across the spectrum of those affected by HIV/AIDS. The following chart separates out the needs and concerns of those who are affected but currently healthy or well from those who are currently sick. Many people in both categories are in current need of housing assistance. Those most in need are:

- People who are poor: many residents will have incomes of less than 20% of median income
- Those failing on the new medications
- Families with children
- People at risk of homelessness
- Increasing numbers of persons with multiple service needs due to homelessness, chemical dependency, and/or mental illness

Those who are well:	Those who are sick:
<i>Employment or re-training</i>	<i>Uncertainty of future need for end of life care</i>
<i>Moving people off of subsidies and addressing concerns about re-accessing services if needed</i>	<i>Expense of maintaining programs that are not fully utilized</i>
<i>Life skills management</i>	
<i>Criminal histories</i>	

III. *Landscape of AIDS Housing*

I am going to briefly present some initial AIDS Housing Cost Study data. Nationally, there are 27,993 HIV/AIDS housing units (17,190 rental assistance slots and 10,803 facility-based units) in 49 states. Sixty-six percent of AIDS housing providers receive some HOPWA (Housing for Person's with AIDS) funds. More than 40 percent of the HIV/AIDS units in the nation are in California and New York.

Current AIDS housing data for Chicago allows us to break down into specifics the type of housing assistance provided.

Chicago AIDS Housing (2000)

Inventory of AIDS housing:

- | | |
|--|---------------------------------|
| ● 355 clients receive emergency assistance | ● 56 assisted living beds |
| ● 570 clients receive rental assistance | ● 85 skilled nursing beds |
| ● 175 transitional housing units | ● 148 beds/units in development |
| ● 268 permanent housing units | |

The majority of these units are on the South and North sides.

Consumer Surveys

AIDS Housing of Washington has completed 27 AIDS housing plans across the country including three plans in the San Francisco EMA, and four plans in Seattle/King County where AIDS Housing of Washington is located. We are starting on our second plan in Chicago. In each community we do a consumer needs assessment and our database now includes interviews with 7000 consumers across the country. We hire consumers in each community where we do the AIDS housing plans. We hired consumers here. We try to interview people who are served by the current system as well as people who are not being served by the system: this often includes people in the shelter systems, people in the community health center systems, and people who are not necessarily engaged in community based or government based HIV/AIDS services.

From these surveys, we know that 41 percent of consumers self identify as having been homeless at some point. Seven percent were currently homeless. African Americans were disproportionately represented among the homeless compared to the sample as a whole (62 percent compared to 43%).

We also know where respondents stayed at night: 25 percent slept in their cars, 28 percent slept in a shelter and 16 percent self-identified as trading sex for a place to sleep.

Many individuals surveyed self-identified as having used alcohol and/or illegal substances. Their drug of choice break down is captured in the following chart. More than half (57 percent) self-identified that they did not use alcohol or other substances. Twenty-seven percent self identified as having received drug or alcohol treatment (that include AA/NA as well as residential beds).

Drug of Choice for Survey respondents:	
•	46% used alcohol (n=3,521)
•	35% used marijuana (n=3,309)
•	17% used crack (n=3,115)
•	16% used cocaine (n=3,082)
•	11% used heroin (n=3,063)

The survey respondents report having complex lives in which dealing with HIV or AIDS is just one of their concerns. More than one-third of consumers identified as having been in and out of the jail or the criminal justice systems: 50 percent of African Americans, 29 percent of Latinos and 21 percent of Caucasians indicated that they had been in jail. In addition, 68 percent of the homeless in the sample had been in jail. Thirty-eight percent self identified as being disabled by mental illness and 32 percent self identified as being chemically dependent.

In terms of housing preferences, the majority of people (71 percent) would rather have their own apartments than live in any shared housing or congregated housing. The majority of individuals (55 percent) would rather move to a cheaper apartment of their own rather than stay in their own neighborhood and share housing or an apartment with others. Finally, most (76 percent) would rather live in their own apartment with occasional in-home assistance than live in a group house with on-site services. And so just like for any group of people whether you have older adults or people with AIDS (PWA's), people really want their own roof over their heads.

The Critical Issues

1. Shrinking Resources

We see a growing number of homeless people in general in this country even as the economy has continued to do well for about 70 percent of Americans. For those people at very low incomes, they have a difficult time making ends meet right now as are programs that are competing for limited numbers of federal dollars. There are increasing numbers of people living with HIV/AIDS who are at risk of homelessness due to a loss of income and savings. They never thought they would be living ten to fifteen years into the epidemic. Many have spent all of their savings to meet their needs and are on the brink of homelessness. Again, while the economy has continued to do well, people are not able to find affordable units even if they are able to get some kind of subsidy. And Congress has forced significant decreases on the HUD budget primarily through federal spending caps, and we will see the increasing impacts of this over the next three years. There are also decreasing housing and income subsidies for very low-income individuals—the exact people we are trying to serve.

2. Changing Needs over Time

Most of the AIDS housing a decade ago was focused on end of life care—group housing and congregate models. There was a major focus on housing development, and we built our AIDS housing system anticipating turnover on average of every 12-24 months due to deaths. And now the good news for people who are in AIDS housing is that people are living

Changing Needs over Time	
Previously	Currently
Hospice and end of life care were the cornerstones of the system	High end care needed only intermittently
Shared housing models/congregate living	Priority for ongoing housing assistance
Focus on housing development – there was very little rental assistance	Permanent housing with on-site services
Units turned over within two years due to death	Focus on housing operations
	Widespread use of rental assistance

there three years, five years, ten years into the epidemic. For those folks who are housed, the system may work. For that increasing number of people who need housing assistance, we are at the end of the line for increasing production of very low-income housing units. We currently have some need for intermittent high end care so it's good not to close all of our long term care facilities, but the demand is really for ongoing housing assistance, rental assistance and permanent housing with on-site services.

3. Affordable Housing Crisis

In 315 of the nation's 399 metropolitan areas, which includes Chicago, 40 percent or more of renters cannot afford what HUD sets as the Fair Market Rent (FMR) for a 2-bed room apartment. That means that people cannot go out to the market and afford housing. The average household income for individuals living in public housing or Section 8 housing is \$10,000 or under. If you look at HUD's standard of paying 30 percent of our income for rent these individuals can only afford to pay \$250 per month for rent. Now tell me a neighborhood in this community or in my own community where you would find an apartment for \$250. They do not exist. Waiting lists for affordable housing and subsidies have become horrendous and long. Many housing authorities have closed their waiting lists, and more and more of the Section 8 units that existed even five years ago are being converted to market rate housing.

4. Affordability Gap

Many low-income people cannot afford to pay rent without incurring a cost burden (paying over 30 percent of income towards rent). Just to put all of this in perspective, if you lived in Seattle, you would have to work 106 hours per week at minimum wage of \$5.15 in order to afford the FMR for a 2-bed room apartment. In Charlotte, North Carolina, you would only have to pay up to \$278 per month without incurring a cost burden, yet the FMR that HUD sets for an efficiency apartment is \$434. In Chicago, given that HUD sets as the FMR for an efficiency \$516, you could only afford to pay up to \$335 per month without incurring a cost burden. People are often paying 75 to 80 percent of any income they have just to keep a roof over their head, even at the Fair Market Rent.

5. Barriers to Accessing Housing

In addition to the populations we are talking about today, substance users who are also HIV/AIDS impacted and homeless, we also need to talk about trying to house people who have no credit history, a criminal record, and/or immigrants who are undocumented. Most of the current HUD programs will not allow you to house undocumented people within federal programs.

Also, many people have burned bridges in the housing systems. They might lack the independent living skills. To transition someone with AIDS from the streets into an apartment is very challenging without providing them some assistance to increase their living skills.

Finally, there is still discrimination—there is racism and sexism. Women have a particularly difficult time finding housing. Large families have almost an impossible time finding affordable housing.

Vision for the Future of AIDS Housing

What is the vision? It is finding the right balance. This is part of why this conference is here today. We face a tension in our system of trying to house people who are on the streets living with AIDS as well as keeping people stably housed who may be paying 75-80-90 percent of their income for rent. We have a tension in trying to use our limited resources to provide rental assistance that meets immediate needs, but as units become more expensive, tenants cannot find affordable units and are in need of ongoing subsidies. There is a tension with investing in our limited HOPWA dollars and other federal funding in building buildings. We need to acknowledge that there are not enough resources to meet all the needs, which is a depressing issue given how much money and wealth there is in this country.

We need to involve consumers in all of our planning. We need to be realistic in our assessments and decision-making so as to not set ourselves and our clients up to feel like we or they have failed. We cannot just put people in housing without giving them the skills and the resources to be sustained, and we need to look at a range of partnerships, including those with low-income housing developers, housing authorities and service providers. In the housing world this is about dating, really matching up AIDS service organizations with existing low-income housing developers and looking at ways to house PWA's throughout all of the mainstream low-income housing systems. I will close by saying that we need a sincere movement towards better collaboration among systems at all levels. **Thank you.**

Opening Briefing: Local Affordable Housing Market

Janet Smith
Assistant Professor
University of Illinois at Chicago

Thank you everyone for being here and for the invitation to be able to speak about our findings from the Chicago Regional Rental Market Study that was recently completed by UIC. I have to confess to not knowing some things, which academics do not usually do. In this case I do not really know a lot about the specific housing issues affecting persons with HIV and AIDS. However, given what I have already learned this morning, what I am going to speak about cuts across all groups including persons with HIV and AIDS: the need for affordable housing. What I am going to present is information that unfortunately affirms what we heard earlier in Mary's story about the difficulty of finding affordable housing in Chicago.

My presentation is based on findings from our study of rental housing in the Chicago region. I will tell you briefly why this study was needed and provide a summary of some key findings that will be helpful as the day progresses and as you think about developing strategic plans for the region in the next five years.

Political Winds: Opening Doors?

I liked the door metaphor for this conference and this gathering. I will look at the concept of opening doors as a way to think about housing policy and what has been happening at the federal level. My own research looks extensively at national policy, which affects not just Chicago but everywhere in the US around the issue of affordable housing. Historically -- at least for the last 60 or so years -- we have had some form of national housing policy in the U.S. (I use that term very loosely because it is really not policy—it is usually a set of programs that are subject to funding discrimination and decisions). Depending on the whim of the political parties in power, we can think about policy making as being similar to a swinging door—its direction went back and forth, depending on who was in power (i.e., Democrats or Republicans). As we now look back at the '90s, I would say the metaphor that is more apt is an automatic door that is always closing behind you after you enter it, and frankly, it appears to be working towards closing permanently these days. I don't want to paint doom and gloom but it is hard to feel positive about what is happening given the clear

efforts by the federal government to get out of funding public housing.

Trends

When you are looking at a comparison of low cost units to low income renters for the US divided into four regions (data from 1995) the Midwest shows a shortage—for every 2.5 renters there are only 1.5 units and that is a growing gap we are seeing now in the year 2000. Throughout the country, this gap has been growing since 1970.

In terms of rental housing trends in this region, people who have lived in Chicago in the 1990's would know from observation that there is a great boom of housing production going on. Unfortunately it is mostly at the high end of the production scale, which is really outpacing production at the low end. We have a lot of great efforts by community development corporations and nonprofit organizations working to produce and preserve affordable housing. But these efforts are not keeping pace with what we see being produced at the high end by the for-profit sector.

Another thing you might know about is how affordable housing in Chicago is being affected by a confluence of several policy changes. While these policy changes are shaping what is going on around the United States, Chicago has a hypercritical concern because of the fact that so many of these changes have the potential to impact a large portion of our population. This includes welfare reform. When we talk about welfare reform I think everyone is familiar with what has been going on -- the ticking away of time towards when people are going to have to shift off of public assistance and find themselves jobs. We have heard today about what has been happening in terms of people's opportunities. We are not necessarily seeing the success stories even in this booming economy. A concern in the Chicago area is that four out of five persons who receive TANF do not live in any form of subsidized housing. What happens if you go to a low wage job or if you are going to get removed from the system -- how are you going to pay that rent? More importantly though, a real concern is with the large

number of people who get jobs that pay minimum wage. While in Seattle it takes 106 hours a month of minimum wage work to afford a rental unit at the Fair Market Rent (FMR) level, it takes 121 hours to afford a two-bed room unit working at the minimum wage in Chicago right now.

In terms of employment housing needs, we see clearly the spatial mismatch problem in the region when we look at where affordable housing is located compared to where jobs are being created. We know that most of the job creation and growth is not occurring in the city of Chicago, especially in entry level but even in higher paying jobs. Most of the affordable housing and rental housing specifically is in the city of Chicago, making the issue of getting to jobs if you want to stay living in your community a real concern. For example, it can take several hours using public transportation to get from the South side of Chicago to Schaumburg where there is a high concentration of jobs.

2 Key Things That Affect Housing Specifically

1. **Public Housing Transformation:** if you haven't been hearing the news, Chicago is the biggest experiment in the country based on the numbers of units that are going to be taken down. Most are the gallery style high rises, like the ones you see driving down the Dan Ryan expressway when going south from the Loop. Those are all pretty much slated to come down with the exception of some of the senior housing. Some of these units will be replaced. How they are to be redeveloped is yet to be determined. We are currently in the phase of trying to understand that process. There are guidelines in place, and the federal government has put some rules that restrict what can be done; however, there is no requirement that those units be replaced.

Tenants in these units can be given Section 8 vouchers. Section 8 is a subsidy that allows a person to pay 30 percent of their income for rent and the government pays the remainder up to the FMR. In Chicago, use of these vouchers is challenging since it is a really tight housing market. A concern for a lot of housing advocates right now is where people are going to go, especially people who need extensive assistance and counseling about how to live in the private market, let alone deal with some of the barriers that are faced in general by persons who are stigmatized due to their income or source of income, race and/or family size, let alone finding housing that will be accessible if they are disabled.

2. **The Section 8 Conversion:** The Section 8 program was developed to provide vouchers, but also to develop housing. It was a way to subsidize producers of housing

to keep those units affordable for at least a 20-year increment. Section 8 contracts for those developments are now coming due. In the next five years we anticipate losing up to two-thirds of our units in the Chicago region. What I mean by "losing" is that while technically those households won't be affected since they will be given a voucher to help them afford their housing, those units will no longer be considered part of the affordable housing stock since they will revert to FMR units or possibly higher. If converted to a voucher, those units are no longer part of a permanent stock of affordable housing such as public housing. This loss of permanent units is a concern for many advocates and groups.

Regional Rental Market Analysis

I want to now present some findings from the UIC study. The Regional Rental Market Analysis (RRMA) was needed given the lack of current and complete data on rental housing conditions. There was a lot of anecdotal knowledge of consumers and producers experiences but we did not have much hard or grounded evidence. The data on development trends was also limited.

The goal of the RMMA was a daunting one considering that we only had about eight months to fulfill it and had to cover six counties. The timeline was so quick because there was a pressing mandate to get information out, so that the community could make decisions about the CHA transformation plan signed into law February 5, 2000. The data was needed to help the CHA and HUD make decisions about what could be done. Besides these specific goals, the overarching goal of the project was to produce a comprehensive up-to-date analysis of the region's rental housing market. We really didn't know much about the current market status since the last census was ten years ago and is dated especially given the boom in the Chicago area. More importantly though, the goal was to produce baseline data needed to craft innovative policies, programs and investment strategies. And while we didn't deal specifically with identifying the housing needs of persons with HIV and AIDS, the affordable housing gap is clearly the thread that connects the people in this room with a lot of other people in the area. It also underscores the importance of coalition building around housing issues these days.

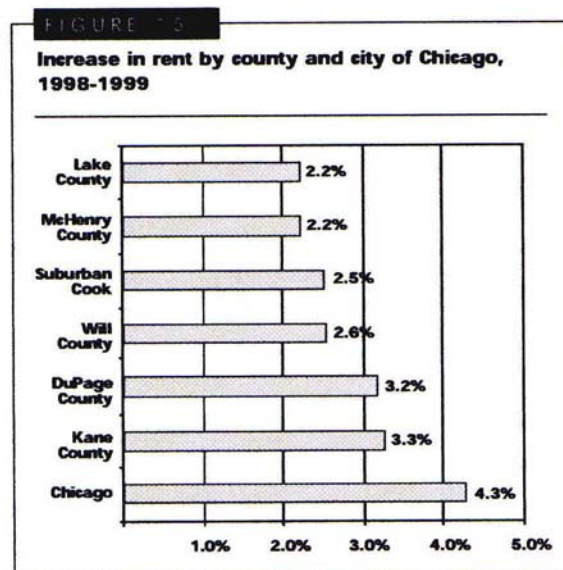
Supply Side Conditions

In general, the whole region is under producing units in terms of any type of housing. I think about the situation in terms of economics, and specifically supply and demand. We are not meeting demand for any type of housing overall, but especially at the low-income level.

Right now we are down to a little over a million rental units in the 6 county area. This is the net situation, taking into consideration both new production and what has been lost. Since 1990, we estimate that at least 52,000 rental units were lost. That 52,000 is on top of roughly the same amount that was lost between 1980 and 1990. Some of that loss is attributed to condominium conversions and some of that is loss of housing that was probably bad quality. Regardless of why the units are gone, the key problem is we are not replacing units lost.

It is a tight market for renters. Based on the definition from the federal government, a tight market means a six-percent vacancy rate or less. That is, no more than 6 out of 100 units are available at any given time. In Chicago we have a tight market. In a tight market, if you do not have enough units to choose from when you are out looking for housing, then that means you have a harder time finding one that meets your needs. In turn, it may take you longer to look for housing. Complicating it further is the likelihood that only half of the available units are affordable to low-income households. We assume that in this tight market, then, it is very difficult to find housing for everyone.

The market varies depending on location. When we look at rental housing conditions, we know they vary across the region. The average rent for housing in the region - across bedroom size and location - is \$723. The vacancy rate is 4.2 percent. In different submarkets, we find that as vacancy rates go down we usually see rents going up, and that because of the unmet demand, the market can command those higher prices. The Chicago north side is a key area to pay attention to because we have a very tight market there and the highest rents in the city of Chicago. Similarly, Northern Cook, where most of the jobs are located, is a very tight market with high rents as well. McHenry has a tight market although the rents are relatively low. As a smaller community, they have very little rental housing to begin with. DuPage, which has a lot of jobs as well as a lot of housing, also has a tight rental market and very high rents. In comparison, the south side of Chicago has the highest vacancy rates, although still not that high. Rents are running around \$619, well below the region's average.



Source: UIC Rental Market Survey

When we look at rents versus inflation, the inflation from 1998 to 1999 was roughly two percent. In comparison, rents increased in Chicago almost 4.3 percent on average, and across the region, the increase was always higher than the inflation rate in that time period. If you are paying rent and your rents keep increasing at a faster rate than your income, then it is likely that you will be paying more and more of your income for rent, and will have less money for other things. This disparity between rent increases and inflation affirms what has been happening across the nation for the past ten or so years.

Demand: Who Can Afford What?

In general, renters in the Chicago region are lower income when compared to homeowners. The following chart, which compares renters and homeowners, assumes that affordable means paying no more than 30 percent of your income towards rent. Of course, this 30 percent is a relative measure. There is a difference between how much 30 percent is in actual dollars paid for rent when you make \$100,000 vs. when you make only \$10,000. This gets back to the issue of people with limited income having to pay 70 to 80 percent of their income for rent.

This chart divides renters and owners into different assistance categories, which are relative to the Area Median Income (0 to 30%, 30 to 50%, 50 to 80%, 80 to 100%, 120% of the AMI). Just to put these in perspective, the AMI for the Chicago region is about \$63,000 for a family of four. If you want to think about what is affordable in terms of rents when compared to income, you can only afford to pay \$500 a month if you are earning up to \$20,000. Approximately 30 percent of

all renters in the area can afford paying no more than \$500 for rent. Furthermore, any renters -- about 75 percent -- are in income brackets that can be considered eligible for assistance (earning up to 80 % of AMI) under federal programs right now.

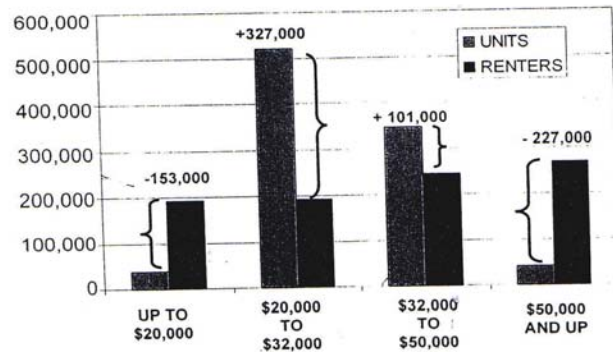
Renter and Owner Household Income, 1999							
Income Level:	Total Households #	Total Households %	Owner Households #	Owner Households %	Renter Households #	Renter Households %	Acceptable Rent (1)
0 to 30% of AMI (up to \$20,000)	489,600	17.5%	181,400	10.2%	308,200	30.1%	Up to \$500
30 to 50% of AMI (\$20,000 to 30,000)	254,700	9.1%	55,000	3.1%	199,700	19.5%	\$500 to 795
50 to 80% of AMI (\$30,000 to 45,000)	534,400	19.1%	285,600	16.1%	248,800	24.3%	\$795 to 1,200
80 to 120% of AMI (\$45,000 to 75,000)	589,900	21.5%	447,300	25.2%	152,600	14.9%	\$1,200 to 1,900
120% or more of AMI (\$75,000 and above)	918,000	32.8%	803,300	45.3%	114,700	11.2%	More than \$1,900
Total	2,796,600	100.0%	1,772,600	100.0%	1,024,000	100.0%	

Source: Claritas and UIC Demand Report
 (1) Assumes household pays approximately 30 percent of income toward rent.
 The ranges are calculated based on what a family of four could afford.

Comparing Supply and Demand

The region clearly has a mismatch between supply and demand. This is important since we need to understand where we have gaps in our housing production and in our housing market -- inefficiencies in the market that we need to pay attention to so that we can better meet the housing needs of all. When we compared the number of unsubsidized renters (no one is receiving assistance) to the number of unsubsidized units out in the market, we found that a shortage of housing exists for those who are at the lowest income level. We currently are over 153,000 units short for the 6 county region. We also find a gap at the other end of the income spectrum where a lot of the demand is being met in new housing production. We also have what we call a surplus of units affordable to renters in the middle-income stage. When you look at this chart, the key thing to pay attention to is the group at the lower end. Where do they go to live if there is no housing affordable for you and you earn less than \$20,000? Usually these households move over to the other rental unit category-- that is they are in the higher rent range, and are clearly paying more than 30 percent of their income for rent.

Supply – Demand Mismatch



There are several things to keep in mind then when looking at this chart. First, surplus does not equal available. At the current vacancy rate we only have at one time about 45,000 units available. Second, the gap of 153,000 units indicates there clearly is a shortage of unsubsidized affordable rental units for very low-income households. Third, given the vacancy rate it is safe to assume many people below the poverty level are paying too much rent.

Finally, there are other things affecting choice in the market, including the location, quality and physical accessibility of the units available as well as barriers to access. Our research points to all of these things as factors that definitely limit a renters ability to find housing that meets their needs when looking in today's rental market. You can get more detail from our summary report. In general, we find most of the housing that is available is located in areas where the quality and accessibility is not that great.

Furthermore, where there is good quality housing available, it is often not accessible because of other barriers attributable to the long standing history of segregation and discrimination in the United States and in the city of Chicago specifically, as well as the current attitude toward affordable housing for low-income people. Assisted housing has become a very negative term even though this can include housing for people who are earning up to nearly \$50,000 a year. A major challenge in our region, then, is changing that perception and working to preserve and expand the amount of affordable housing for people everywhere. Thank you.

For Rent: Housing Options in the Chicago Region

For Rent: Housing Options in the Chicago Region was produced by a team of researchers at the University of Illinois at Chicago in November of 1999. It summarizes the findings of seven technical reports, providing an overall picture of current rental housing conditions in the region. You can access these reports from the Metropolitan Planning Council by either calling 312-922-5616 or from their website www.metroplanning.org.

SUMMARY OF CURRENT RENTAL HOUSING MARKET CONDITIONS

Several key findings help to capture the current rental housing market in the Chicago region and the conditions that have shaped it throughout the 1990s.

Regional Population Growth

- Overall, the region's population has grown by close to eight percent since 1990 to an estimated 7,829,870 people living in six counties in 1999, an increase of 568,694 people. Most of the growth has occurred in the collar counties, ranging from 12.6 percent (DuPage) to 31.5 percent (McHenry).¹ Still, Cook remains the largest county with 67% of the region's population.
- While there is growing diversity in all counties based on the number and proportion of people from different racial and ethnic groups, whites continue to comprise about 75 percent of the region's population, with the highest numbers of non-whites living in Chicago.²
- Half the population regionwide is over the age of 25 and one-third is over 45. Baby boomers are aging and new families are forming, both of which will increase housing demand for people at various life cycle stages in the next ten years.³

Demand-Side Shifts

- There has been an increase in home ownership rates since 1990 nationwide and in the Midwest. The Midwest home ownership rate grew from 67.1 percent in 1990 to 72.1 percent in 1999.⁴
- An estimated 1,024,000 households in the region rent in 1999. Eighty-seven percent of all renter households do not receive any housing subsidy. Approximately 13 percent (129,000 households) are living in some form of subsidized rental housing, including public housing, Section 8 (tenant-based and project-based), Low Income Housing Tax Credit sites, and other housing funded through federal, state or local sources.⁵
- Approximately 30 percent of all renters in the region (308,000) have income levels that are at or below \$20,000, which is approximately 30 percent of the 1999 Area Median Income (AMI) of \$63,800.
- Approximately 26 percent of all renters in the region (267,000) have household incomes at or above \$50,000, which is approximately 80% of Area Median Income.
- Based on 1999 estimates, about 38 percent of all renters paid more than 30 percent of their income for rent.⁶ Of these renters, about one-third paid more than 50 percent of their income for rent.

1 Figures for DuPage and McHenry Counties are through 1998. See Smith, Janet and Barbara Sherry. *Estimating Demand for Affordable Rental Housing in the Chicago Region*, 1999.

2 See Smith and Sherry, 1999.

3 See Smith and Sherry, 1999.

4 HUD "Daily Focus" 10-99. Data is not available for the Chicago area only.

5 Based on number of occupied units in *1998 Picture of Subsidized Households*. As of 1998, the vacancy rate in non-public housing, subsidized units in the region was less than 3 percent. Public housing, excluding the Chicago Housing Authority (CHA), had a slightly higher vacancy rate on average (around 5 percent), with CHA units having a 36 percent vacancy rate.

6 This includes both subsidized and non-subsidized renters. In 1995, the American Housing Survey (AHS) indicated that approximately 14 percent of residents living in housing units with government subsidies paid more than 30 percent of their income for rent.

Supply-Side Responses

- In 1999, there are 1,066,800 rental units in the region, with most located in Chicago (602,200) and suburban Cook County (238,600), which together represent approximately 79 percent of the entire rental stock.⁷ This is a net region-wide decrease of approximately 52,000 rental units since 1990, a 4.6 percent loss.⁸
- The estimated overall vacancy rate for rental units in the region's private rental market is 4.2 percent. While there is some variation in this rate across the region, most vacancy rates are below 6 percent, which the U. S. Department of Housing and Urban Development (HUD) considers the threshold for a "tight" housing market.⁹
- Average rent for the region is \$723. Rent levels vary within the region by building type and location. For example, average monthly rent for a two-bedroom unit ranges from \$859 in DuPage County to \$640 in Will County. In Chicago, the average rent for a two-bedroom unit is \$736.¹⁰
- Rents in the 1990s have continued to outpace the overall rate of inflation. Between 1991-95, rents increased 15.4 percent compared to an 11.4 increase in the Consumer Price Index (CPI). Since 1995, we estimate rents have increased at a faster rate (about 19 percent compared to an 11 percent increase in the CPI).¹¹ Between 1998 and 1999, rents increased by an average of 3.6 percent regionwide, compared with a 2.0 percent increase in the CPI.
- In general, Fair Market Rent (FMR) exception rents have been granted in many community areas where rents are estimated to be higher than FMR, particularly parts of the north side of Chicago, northern Cook County, DuPage County, Lake County (minus 6 towns), and four communities in McHenry County.¹²
- Overall, the data suggests a serious mismatch between the rents tenants can pay and the actual rents being charged by property owners.
- Currently, there is little incentive for developers to build rental housing given zoning policies, the cost of land, high property tax rates, and a general preference among local jurisdictions for owner- over renter-occupied properties. Furthermore, some property owners and managers are more selective in choosing tenants given the tight rental housing market. Under these circumstances, however, apartment building owners have indicated greater willingness to upgrade their properties.¹³

ESTIMATES OF AVERAGE RENT, TOTAL AND VACANT RENTAL UNITS BY LOCATION, 1999

LOCATION	AVERAGE RENT	CHANGE IN RENT 1998-99	OVERALL VACANCY RATE	TOTAL VACANT UNITS	TOTAL OCCUPIED UNITS	TOTAL UNITS
CHICAGO - NORTH	\$826	6.1%	2.7%	5,791	211,109	216,900
CHICAGO - WEST	\$618	3.4%	5.0%	6,033	114,867	120,900
CHICAGO - SOUTH	\$619	2.6%	6.3%	15,065	224,435	239,500
COOK COUNTY - NORTH	\$863	2.7%	3.2%	3,168	95,832	99,000
COOK COUNTY - WEST	\$628	2.8%	4.4%	3,388	73,612	77,000
COOK COUNTY - SOUTH	\$639	2.1%	4.5%	2,700	57,300	60,000
DUPAGE COUNTY	\$842	3.2%	3.3%	2,697	77,803	80,500
KANE COUNTY	\$634	3.3%	5.2%	1,902	35,098	37,000
LAKE COUNTY	\$774	2.2%	4.3%	2,183	48,817	51,000
MCHENRY COUNTY	\$669	2.2%	2.4%	557	22,543	23,100
WILL COUNTY	\$660	2.6%	5.0%	1,546	29,554	31,100
TOTAL	\$723	3.6%	4.2%	45,030	990,970	1,036,000

Source: UIC Rental Market Survey. NOTE: These estimates do not include the approximately 30,000 public housing units in the region.

7 Johnson, Timothy, Martine Sagun, Jonathan Dombrow, Jin Man Lee, Young Ik Cho, *Metropolitan Chicago Regional Rental Market Analysis: Rental Housing Supply Survey Report*, 1999.

8 Some of this loss of rental units can be attributed to condominium conversions, which are estimated in Figure 6 in the Appendix.

9 *M2M Program Operating Procedures Guide*, April 1999, p 3-9.

10 Johnson, Sagun, Dombrow, Lee and Cho, 1999.

11 Johnson, Sagun, Dombrow, Lee and Cho, 1999.

12 The Fair Market Rent (FMR) reflects rents in the 40th percentile for the region, and represents the amount up to which HUD will subsidize a unit. For example, HUD set the FMR for a two-bedroom unit at \$737 in FY1999. Exception rents up to 110 percent of FMR are granted in areas where rents appear to be higher than average.

13 See Lenz, Thomas J. and James Coles, *Providing Rental Housing in the Chicago Region: Challenges and Issues*, 1999 (a).

Opening Briefing: Current State of Substance Abuse Treatment Services

Tom D'Aunno, Ph.D.
University of Chicago
School of Social Service Administration
Pritzker School of Medicine

Good morning. I would like to make a few points about the intersection of substance abuse and HIV. Over the last 17 years I have been working with colleagues on national studies of drug abuse treatment services and I have been fortunate to have my work funded by the National Institute on Drug Abuse (NIDA). One of the other nice things about the study is it is drawn from a national sample so when I say bad things about treatment providers, it is not specifically anybody in this room. It is people in other parts of the country that I've been studying. The other thing that I think is important about our work is that we are able to keep it going over time and in fact the most recent data are hot off the press. This is very much a good news/bad news story. I will tell you a little bit of good news and I will tell you a little bad news and where I think we need to work on the bad news side of it.

Treatment for Heroin Addiction

One of the most important things that we can do to prevent HIV infection is to improve heroin treatment services across the country and certainly in the city of Chicago. One of the key routes of HIV infection is injection drug use, especially heroin use. Heroin has become so cheap and so pure that you do not have to inject it and you can snort it to get high. But, in the city of Chicago, there is still a lot of injecting going on and heroin deaths, overdoses and use are on the rise. So, one of the most important things I want to say this morning is that if we want to prevent HIV we have to do a good job of getting people in methadone maintenance treatment for heroin addiction and heroin use. There has been study after study that methadone treatment, when it is used properly, is very effective in preventing the spread of HIV.

The good news is that methadone treatment works. The bad news part of my story is that access to treatment remains a problem. In an analysis that we have just recently completed, it turns out that most drug abuse treatment providers do not have waiting lists. Where the waiting lists really are coming up is in the area of

methadone. There aren't enough treatment slots. And, the other bad news story that I want to emphasize very quickly is that methadone doses provided across the nation, and I happen to know from at least anecdotal evidence here in the city of Chicago, are too low to be effective. If you can go home and do a quick check on this for providers that are in the room and those of you who are working with methadone providers if the dose level that your average client is getting is less than 60 milligrams per day it is not effective. And, we then will be feeding into a very self-fulfilling prophecy, which is that methadone treatment does not work. Well of course it doesn't work. It doesn't work if you don't give high enough doses. I am referring to the most recent studies including one published in JAMA last week that said that 80 milligrams and above is what is needed to be effective.

HIV Prevention

The second part of the good news is that HIV prevention with drug users is on the rise. These activities are on the rise across the country by drug abuse treatment providers. In other words, providers have gotten on the bandwagon and realized that they need to do prevention work, including outreach work, and they need to do HIV testing and counseling. So across the country we've seen an increase here and that's the good news. But the bad news is that the increase is probably not as steep as we would like it to be and there is not enough HIV prevention work and outreach being done by substance abuse treatment providers. Resources and social support are key. What we have found in our analyses in a paper that was just published recently (in June) is that treatment providers are like everybody else—they have tight budgets. They need to allocate their resources carefully and when they do not have enough resources it is the HIV prevention work that does not get done. They stick to the knitting—they stick to treatment, which is fine - that is their job. But, when resources are tight they are not doing enough HIV prevention. What we need to do is make sure that providers have enough resources to do this work and that there is social support among the leadership of these treatment units to do HIV prevention.

Access to Medical Care

Thirdly, for substance abuse clients who already have the infection or have some symptoms of AIDS there needs to be adequate access to medical care. Here I have part of a bad news story, which is that overall, substance abuse treatment providers across the country are reporting to us that their client's use of particular medical services for HIV/AIDS infection and related diseases is actually decreasing. There is a concern about access to medical care and one of things that I think is needed to help overcome this problem is to actually provide more one stop shopping for substance abuse clients. That is to say, to provide more on-site medical care services so that clients can come to one place to get what they need. A great example of this is right here in the city of Chicago where Haymarket House is collaborating with Sinai Family Health Systems. They established a wonderful primary health care clinic specializing in obstetric care for pregnant women who are getting treatment at Haymarket. The health care clinic is right there on-site and I have to tell you that the results from the evaluation work that we are doing there are really stunning. There have been over a hundred women who have delivered babies free from substance abuse and any substance infection with very good birth weights. A lot of credit goes to those two organizations for doing the kinds of collaborative work that needs to get done. We need a lot more of that kind of collaboration if we are going to improve access to health care for these clients.

Effective linkages

Case management is an important linkage but what we have found in our research is that transportation is actually the single most important thing that you can do if you are a substance abuse treatment provider or service provider out there to make sure that people link up with the appropriate medical care they need. If they are a substance abuse client and they have got other kinds of problems, it turns out that in our studies transportation is the number one effective linkage mechanism.

Quality of Care

Substance abuse treatment providers need to improve the quality of care overall in services that they provide. There continues to be a gap between what research shows as effective and what most substance abuse treatment providers

are doing (what their actual practice is). This gap is glaring in the area of methadone treatment, but it shows up in a couple of other areas as well. Part of this is a resource problem. I do not want to seem like I am blaming substance abuse treatment providers. Part of the issue here is clearly resource shortages. We need to do lobbying at the state, federal, local levels to make sure that there is adequate investment in substance abuse treatment services. Studies now show, including a very large-scale study done in California, that for every dollar of public money invested in substance abuse treatment services, seven dollars are returned back. That is a very high level of cost effectiveness and it comes from keeping people out of prison, out of emergency health care, preventing HIV infection, keeping people from committing crimes – all of which comes from effective substance abuse treatment. There is also a threat from managed care. I am currently working on a national study of how managed care is affecting the quality of substance abuse treatment across the country. The results are kind of mixed. Not all managed care is bad but there is some managed care that is certainly bad, which is hurting the quality of substance abuse treatment across the country. So again, policy advocates, managers, activists in this room, we need to keep an eye on managed care and make sure that it is practiced the right way: that care is being managed, not just money.

The Need for Education

Finally, the need for education. I think that substance abuse treatment providers need to be educated more about what works and what does not. There is certainly a role of ideology. There are people who are holding fast to their traditional ways of doing things and not keeping up with the literature that they need to keep up with. And, finally I think that researchers like myself and others, need to do a better job of building partnerships with substance abuse treatment providers and other service providers to make sure that what we know is best practice gets used as best practice.

We have sort of a good news/bad news story out there about the intersection of substance abuse treatment services and HIV/AIDS. I think we've made some progress but there are other areas I have pointed to where we need to make more progress and I hope we get a chance to discuss these issues as the day goes on. Thank you.

Model Panel I: Integrating Housing and Recovery Services

Presenters: John Ames & Steve Clarke

John Ames*
Director of Programs and Services
Bonaventure House

** Presentation not available due to recording malfunction*

Steve Clarke
Housing Coordinator
First Step Program of Rafael Center

First Step is a residential program devoted to effecting change in the individual, enabling him or her to return to a productive, alcohol and drug-free life. The program offers a chance for a renewal of life and a commitment to the future.

First Step recognizes that recovery from addiction is an ongoing process. For many individuals, this process requires a supportive environment and adequate time to develop a lifestyle of continuous sobriety. To this end, residents are asked to voluntarily commit to the program for a minimum of six months, but they may remain for up to one year.

Based on the 12-step model of recovery of AA & NA, three essential elements of recovery are emphasized by the program: individual responsibility; a strong support system; and personal faith and belief in a Higher Power.

Admission to First Step is open to male, female and transgendered HIV-positive adult's 18 years of age and older. All admissions are made without respect to race, religion, nationality or sexual orientation. It is expected that all residents have completed primary treatment for alcohol/drug addiction and it is preferred that they enter the program directly from a substance abuse treatment center. The facility can house 15 residents.

First Step's activities fall into five categories: social/case development, therapeutic services, community formation, social/recreational activities and proactive HIV/AIDS services.

Social/Case Development:

Residents are required to attend a minimum of five 12-step meetings outside the House each week and to have and utilize a 12-step program "sponsor." On-site caseworkers also refer residents to HIV/AIDS agencies for case management services (when not already in place) in order to facilitate such ancillary services as medical/dental/optical care and for assistance in obtaining financial benefits. Residents may not seek outside employment, job training or remedial education for the

first 4 to 6 months of residency: primary emphasis during early residency is on strengthening recovery and relapse prevention skills.

Therapeutic Services:

Rafael Center clinical staff conducts small process groups for residents, usually dividing the residents into two separate groups. On-site house workers who are CADCs provide some group and individual work around ongoing recovery and relapse prevention. Referrals to outside therapists to address special concerns, such as transgender issues, may be made.

Community Formation:

The mutuality of shared experience, both of addiction and recovery, is the primary vehicle of 12-step recovery. First Step administrative, supervisory and casework staff utilize a weekly “community meeting” at which residents are encouraged to discuss issues and problems affecting the common welfare of the house and to seek consensus and resolution. A house committee composed of four senior residents, is utilized as a means of fostering a sense of individual and group responsibility by means of a system of peer review and accountability. The house’s daily schedule includes a morning “Spiritual Group” led by, and for, residents as the first community activity of the day. By this means, the broadly spiritual nature of 12-step recovery is reinforced in the residents’ daily experience. A monthly “sponsor night” is held in which residents’ 12-step sponsors are invited to attend one of the weekly in-house A.A./N.A. meetings, followed by fellowship. Lastly, residents participate in some form of service/volunteer work with outside agencies or programs which reinforces the emphasis of the 12th step: being of service to others as a means of helping self.

Social/Recreational Activities:

Sober socializing is an integral part of the recovery process. Staff and residents participate in Chicago-area-wide activities and conventions of Alcoholics Anonymous and Narcotics Anonymous. Residents also attend theatrical and musical events, often put on by HIV/AIDS groups, as well as picnics along the Lake and excursions to museums, Great America, sporting events, and social events and dances conducted by AA and NA groups around the city.

Proactive Involvement in HIV/AIDS Issues:

Staff encourage and assist residents to incorporate a healthy and positive approach to their HIV disease as an integral part of their recovery process. Residents are assisted in maintaining regular contact with a primary health care provider and encourage them to keep informed of current developments in HIV prophylaxis and treatment, as well as alternative therapies available locally. Residents have participated in making panels for the Names Project AIDS Quilt. Additionally, clients volunteer at Open Hands pantries by unloading, stocking and distributing foodstuffs to persons with AIDS in the community. By becoming proactive in HIV/AIDS issues, residents lose a sense of stigmatization associated for some with the disease, as well as what is, for some, a perceived need to “secretize” their HIV-positive status, often a contributing factor in relapse to substance use. Thank you.

Model Panel II: Housing Persons Using Alcohol or Drugs

Presenters: Betsy Lieberman & Scott Peterson

Moderator: Matthew Silver

Matthew Silver ***Better Existence with HIV***

As you may have heard this morning and may already know, the greatest reported increase in HIV seroprevalence is related to intravenous drug users and their sexual contact. Although this is often referred to as the changing demographic of HIV, you are probably all aware that this has been the hidden and historically silent demographic of person's impacted by HIV. This session is designed to address adapting housing services to a substance using population. As you will hear, our presenters have been successful in providing housing and other supportive services to persons historically excluded by other providers who require total abstinence from drugs and alcohol. The format of the breakout session is as follows: each presenter will speak for approximately 15 minutes providing a brief overview of their specific program and model. Some of what you will hear will be about the development of those programs, and their successes and failures and ideas about adapting existing services to a substance using population. After these overviews the speakers would like to field questions from you, the participants. The presenters want me to state up front that they want this to be an intimate, didactic experience. They are here for you—they want to meet your needs, your questions, and your concerns.

Betsy Lieberman **Executive Director** ***AIDS Housing of Washington***

I am Betsy Lieberman, Executive Director of AIDS housing of Washington. My presentation today will be on the Lyon Building which is a project for multiply diagnosed clients which has been open now for two and half years.

Project Overview

AIDS Housing of Washington wears multiple hats. One of those hats is as a developer of housing locally for people with AIDS. The Lyon Building project is definitely the project I feel most proud of in my career. What inspired me to want to do this project is that I volunteer on Christmas morning at Bailey Boushay House in the day health program transporting people to day health. My job is to pick people up who live under the viaduct in Seattle who go to day health. There were ten clients who lived under the viaduct who came to the day health program an average of five to six times per week (it was open seven days per week). I realized that I really needed to figure out how to do a housing project for people who are living with AIDS, who are homeless, who have histories of substance use, mental illness and who are not necessarily clean and sober. So, thus, the Lyon building.

It is a historic office building, built in 1910, which we purchased from the county. They were surplus the building. The City of Seattle did an underground bus tunnel, and they had acquired this building to have some bus tunnel entrances. It sat empty for about ten years. We converted this existing downtown office building into housing. It is literally right across the street from our Seattle police department. The windows of all the units look out on the windows of the police department.

Project Financing

The Lyon Building is a big project. It is a nine million-dollar development project. The primary funding source was low income tax credits and historic tax credits. We also have rental subsidies, project based Section 8 as well as a supportive housing grant through the McKinney program.

The operating budget is about \$250,000 per year. Operations include maintenance, taxes, insurance, utilities – everything that is connected with maintaining the structure of the project. The support services are \$451,000 per year. Project income includes rental income, Section 8, the three commercial tenants rent payments (the income from the commercial tenants contributes to the bottom line of this project), and a little Ryan White funding.

Program Details

Our work begins with collaboration prior to doing any project. We brought the mental health system, the substance abuse system, the homeless system, and the AIDS system together to ask how could we do this together. This was the first collaboration of its kind in the country, and was one of the key pieces in the development of this project – bringing the players together prior to doing anything to really develop some investment in the project and think through how to best serve this population.

As I mentioned, the building was the conversion of a six-story office building. The building was too big. Our original intent was to do a 40-unit construction on a site in another part of the city near a lot of hospitals but the neighborhood was not very supportive. We saw a need for this project and the ability to acquire this building at the appraised value so we had to figure out how to use it. The financially feasible way was to develop 64 studio and one-bedroom units, space for offices, group rooms, a dining area, kitchen and living room. Each unit is totally contained. It is permanent supportive housing, governed under landlord-tenant rules.

We used a number of strategies to really engage tenants. In addition to having their own apartments and paying 30 percent of their income for rent, we have a nightly dinner that is provided by our AIDS food organization, Chicken Soup Brigade, and we have an average attendance of 45 tenants for this free dinner. We also have a range of groups and access to needle exchange.

Staffing

The building is staffed 24 hours a day with a minimum of two staff on every shift. There are 16 full time staff.

Opening Doors Conference

Sources of Funding:	\$9,441,054
HOPWA – City of Seattle	957,389
HUD Supportive Housing program	400,000
City of Seattle	
1,680,341	
WA State Housing Trust Fund	1,000,000
Low Income Housing Tax Credits	3,165,000
Historic Tax Credits	1,200,000
Private Contributions	1,038,324
Uses of Funding:	\$9,441,054
Land and Building Acquisition	1,448,593
Construction Costs	6,832,363
Furniture, Fixtures and Equipment	247,349
Fundraising and Organizational Fees	313,097
Operating and Service Reserves	599,652

There has almost been complete turnover in the staffing since it originally opened thirty months ago. Hiring staff was very challenging for the first year.

Admission

In order for someone to move into the Lyon Building, there are three key criteria:

1. They have to be engaged in case management,
2. Because this project has a range of homeless funding, they have to either be homeless or at risk of homelessness (meaning paying more than 50 percent of their income for rent) or they are doubled up or in transitional or emergency housing, and
3. They have to have a very low income (below 30 percent of median income).

The first priority for tenancy is being disabled with AIDS and mentally ill (may also be chemically affected). The second priority is being AIDS disabled and chemically affected or HIV positive, mentally ill and chemically affected. But our priority population for all of our housing services is to serve people who are disabled with AIDS. However, the definition of disability has changed over these last few years.

Demographics & Outcomes of Residents

We conducted a two-year evaluation with the University of Washington. The findings from operations during September 1997 through August 1999 are as follows:

- 88 people were housed (82 men, 6 women)
- 77 percent were homeless at the time they moved in and 23 percent were either at risk of homelessness or in some type of transitional setting
- 68 percent are HIV disabled and have a mental illness and a chemical dependency.
- 27 percent are HIV-positive and mentally ill
- 5 percent are HIV-positive & chemically dependent.

The people in this building are all multiply diagnosed. We have 54 percent that are still housed there since the project opened, and I consider this a success. Forty-eight of the 64 residents have been there over a year. So I feel positively that this project is working to stably house people. Eight percent of the residents have died, and in the last month there have been three deaths. For those who move on to other housing, they are very fortunate to be in Seattle. Seattle has a very organized continuum of housing, so people can move from the Lyon building into a long-term care facility if they need 24 hour nursing care. Eleven percent needed to leave because they needed a higher level of housing or care.

Lesson's Learned

The lessons and the issues that have been the most challenging are related to security, especially the visitor policy. The building has had to move toward somewhat restricting visitors. If someone comes to visit a tenant, the tenant has to come down to the front entrance of the building and escort the visitor up, and the visitor needs to leave some kind of picture ID at the front desk. If someone wants to have overnight guests, they have to get that approved at least 24 hours before, to primarily prevent tenants from picking up people in the bars and bringing them home. We made one serious design mistake. The building has a security system and each tenant has a voice call box that goes down to the front desk in case they have an emergency request. In our first six months, a few tenants strung out on drugs would be calling around to every other tenant at three and four a.m. in the morning, looking to score. So that was a lesson we learned.

I would say one of the lessons that really caused some staff turnover was really not being clear about what was acceptable behavior in the project and what was grounds for eviction or lack of tenancy. Particularly in the first six months, there was some confusion about what the real goals were. Our goal was housing stability and whatever that took. For some case managers, their goal was that people would become clean and sober in this project. This is not a treatment facility.

Critical Issues

We conduct consumer evaluations every six months. Our findings include:

- Eighty-five percent of residents report being satisfied with the services and staff.
- The kinds of concerns that were raised by residents include continued drug use and prostitution.

- For those tenants trying to be totally clean and sober, they find this to be a challenging environment.
- We also had a disproportionate number of people of color who were underrepresented among the evaluation. So this needs to be kept in mind.

The success of the outcomes is linked to two key aspects. One is constant engagement with a case manager. This doesn't mean via telephone. This means the case manager going to the program to engage with the tenant. Two is continuity with a primary care physician. Finally, we find higher success with tenants who have a higher disability with AIDS. This may have something to do with more of a motivation to stay on their medication, and to try to stay successfully housed.

We also looked at what happens to tenants when they move into supportive housing to determine what are the key factors to keep people engaged in housing. What leads to eviction is really the crime, the violence and the non-adherence. The staff does a lot of work with tenants around adherence with combination therapies. In our first six months, we had a very aggressive tuberculosis outbreak in this facility and had four tenants end up with active TB. So there have been some big challenges. In terms of providing stable housing for multiply diagnosed people with AIDS, I would say it is working. Our bigger success has been with heroin addicts. We have had a very hard time housing people using crystal methamphetamine because of the sexual activity and some of the criminal behaviors associated with that drug. Heroin has been more of our drug of choice in terms of co-morbidity factors.

The key measure of success is housing stability but we also want to support people 'where they are at' to decrease use or to use more safely. If people want treatment we have to make sure they have access to it, but it is really about the housing stability and supporting people around compliance with AIDS medications.

I am delighted to talk to people more about this. This project is very amazing. Our partner in this is an organization called the Downtown Emergency Service Center, the largest homeless service provider in Washington State, Community Mental Health Center, and a certified substance abuse treatment program. In working with them, our partnership has been wonderful. Thank you.

Scott Peterson
Director of Case Management Services
Better Existence with HIV

One of the things I would like to do in starting is to offer some perspective. This morning we heard a lot about how tight the affordable housing market is, lots of statistics, lots of ideas about policy. The program I am going to be talking about, Safe Start, emerged out of exactly this kind of experience. As you heard earlier, Betsy's organization was involved in doing a very comprehensive needs assessment of AIDS Housing in Chicago as part of evolving the housing plan for the Chicago EMA for people with AIDS. As a result of that assessment we actually held a conference about this time in 1995. Out of that conference the idea for Safe Start emerged. It was also at that conference that I met Keith Cylar who runs a fairly extensive housing program for people with AIDS (Housing Works, Inc.), most of who are multiply diagnosed and active substance users, and he has been doing that for quite a long time. At that conference I sat down here and listened to Keith talk and proceeded to raise my hand and say 'you have got to be kidding. There is absolutely no way that you can successfully house active substance users'. Keith and I proceeded to go at it for the entire day.

A year later I was a case manager for the Safe Start program which provides housing to active substance users and have been doing it ever since. This project has not been without its challenges. I agree with a lot of what Betsy said – there are challenges. This is not easy work. I am going to talk a little bit about the weaknesses of the program and some of the challenges we face. But it also has been successful.

We are starting our fifth year of operations. We are funded through HUD and are a partnership between Better Existence with HIV (BEHIV) and Community Supportive Living Systems (CSLS), coordinated by AIDS Foundation of Chicago. BEHIV and CSLS each operate 12 scattered site units and provide intensive case management (1.5 case managers to 12 residents). Psychiatric services are also offered. Services offered are done so using a harm reduction approach.

The basic services offered include:

- Help with entitlement programs
- Linkages with mental health, & day health
- Linkages with drug & alcohol treatment
- Home services
- Transportation subsidies
- Food services
- Medical services
- Home health
- Hospice
- Long-term care

Admission Criteria

- **Homeless**
 - persons coming from the street
 - persons coming from an emergency shelter or other homeless service agency
 - persons coming from transitional housing for homeless persons
 - persons at risk of becoming homeless
- **AIDS**
 - persons must be diagnosed with AIDS and exhibit some evidence of HIV/AIDS- related disability
- **Substance Use**
 - persons must have a history of alcohol or other drug use, misuse, abuse or dependence.
 - abstinence from alcohol or other drug use is not a requirement for program admission or ongoing participation in the program
- **Mental Illness**
 - persons considered eligible for program admission may also be affected by mental illness

Harm Reduction

As I mentioned earlier we use a harm reduction approach. We define harm reduction as a philosophy as well as a set of strategies with the goal of meeting drug users 'where they are at' to help them reduce any harms associated with their drug use, which prioritizes the aim of decreasing the negative affects of drug use. There are different areas of harm that we address including health, economic, psychological and social, as well as harm on many levels including individual, others, community and society. I have passed around to you a harm reduction specific service plan.

HARM REDUCTION SERVICE PLAN

Name: _____ Date: _____
 Case Manager: _____ Drug History Completed: Y N
 TX Provider (if applicable): _____

Types of Substances Used:

Alcohol Crack
 Benzodiazepines Heroin
 Cannabis Methamphetamine
 Cocaine Other: _____

Concerns:

Financial: _____
 Housing: _____
 Interpersonal: _____
 Legal Challenges: _____
 Mental Health: _____
 Physical Health: _____
 Personal Safety: _____
 Other: _____

Attempts at Abstinence Based Model:

	DATES	OUTCOME
12-Step	_____	_____
Inpatient Tx	_____	_____
Outpatient Tx	_____	_____
Detox	_____	_____
Other:	_____	_____

Non-Abstinence Acknowledgement
After repeated attempts to achieve abstinence, as documented above, this client recognizes that abstinence is not a realistic goal at this time and is therefore requesting assistance with substance use management and harm reduction activities. Abstinence is not excluded as an eventual goal.

Client Signature _____ Case Manager Signature _____

HARM REDUCTION SERVICE PLAN

Name: _____

1	Harm Reduction Behavior Change Goal	Harm Reduction Strategies and Plan	Progress
Anticipated Outcome		<input type="checkbox"/>	<input type="checkbox"/> fully met <input type="checkbox"/> nearly met <input type="checkbox"/> some progress
Notes (progress, revisions)		<input type="checkbox"/>	<input type="checkbox"/> no progress to date <input type="checkbox"/> goal eliminated
Anticipated Outcome		<input type="checkbox"/>	<input type="checkbox"/> fully met <input type="checkbox"/> nearly met <input type="checkbox"/> some progress
Notes (progress, revisions)		<input type="checkbox"/>	<input type="checkbox"/> no progress to date <input type="checkbox"/> goal eliminated
Anticipated Outcome		<input type="checkbox"/>	<input type="checkbox"/> fully met <input type="checkbox"/> nearly met <input type="checkbox"/> some progress
Notes (progress, revisions)		<input type="checkbox"/>	<input type="checkbox"/> no progress to date <input type="checkbox"/> goal eliminated
Anticipated Outcome		<input type="checkbox"/>	<input type="checkbox"/> fully met <input type="checkbox"/> nearly met <input type="checkbox"/> some progress
Notes (progress, revisions)		<input type="checkbox"/>	<input type="checkbox"/> no progress to date <input type="checkbox"/> goal eliminated

REVIEW OF STRATEGIES: yes no Date: _____
 Date: _____ yes no Date: _____
 Date: _____ yes no Date: _____
 Date: _____ yes no Date: _____

ABSTINENCE REINFORCEMENT: yes no Date: _____
 Date: _____ yes no Date: _____
 Date: _____ yes no Date: _____
 Date: _____ yes no Date: _____

The harm reduction model in housing provision promotes low-threshold access to services as an alternative to traditional high-threshold approaches where there are many conditions placed upon potential applicants prior to program entry. For example, most housing programs require abstinence from use of all drugs and alcohol and often do criminal background checks. This raises the threshold in terms of who can enter the program. In a harm reduction program, housing might be provided as the first and foremost service regardless of whether a person is actively using. Many harm reduction programs' philosophy is that abstinence can be included as an ideal end-point along a continuum ranging from excessively harmful to less harmful behavior but it is not a requirement of the program. This model shifts the focus of the intervention away from drug use itself to the consequences or effects of addictive behavior. Harm reduction as a model has been presented by Edith Springer (1996) as a spectrum spanning all aspects of life which includes HIV-related interventions, ancillary interventions, and drug use management interventions and can be implemented in different ways depending on the focus of the intervention.

HARM REDUCTION HOUSING: RECOMMENDED SERVICES

- ❖ "Non-drug" alternative activities
- ❖ 12-step groups
- ❖ Access to drug treatment
- ❖ ADL training
- ❖ Advocacy (landlords/property managers; criminal justice system)
- ❖ Apartment "starter kits"
- ❖ Cellular phones and pagers for staff
- ❖ Cleaning and routine maintenance service
- ❖ Client/staff participation in appropriate community meetings/organizations
- ❖ Clinical supervision for program staff
- ❖ Crisis intervention (for participants and landlords/property managers)
- ❖ Day program for participants
- ❖ Furnished units
- ❖ Harm reduction drug education
- ❖ Harm reduction service planning
- ❖ In-home/outreach services
- ❖ Intensive mobile (home-based) case management
- ❖ Knowledge of landlord/tenant laws
- ❖ Knowledge of petition/certificate process
- ❖ Medication monitoring/adherence counseling
- ❖ Money management
- ❖ Overdose prevention workshops

HARM REDUCTION HOUSING: RECOMMENDED SERVICES

- ❖ Participant "Program Information" Guidebook
- ❖ Participant driven policies and procedures
- ❖ Participant mentors
- ❖ Primary care
- ❖ Professional development opportunities for program staff
- ❖ Psychiatric services
- ❖ Regular team meetings for staff
- ❖ Routine property/unit maintenance
- ❖ Safer sex materials
- ❖ Safer drug use kits (pipers, injectors)
- ❖ Staff with competencies in drug use and harm reduction
- ❖ Substance use management (1:1, group)
- ❖ Support groups (with a meal)
- ❖ Syringe exchange
- ❖ Tenant councils
- ❖ Transitional unit (s)
- ❖ Transportation assistance
- ❖ Utility assistance
- ❖ Vocational training

Reducing Harm Drug Use and Housing

- Develop and enact a safer use plan
- Work on safer coping practices.
- Consider the legalities of use. Know the law.
- Work with finances to manage your expenses and afford drugs consumed.
- Create a safer drug use environment:
 - Choose your time of use wisely
 - Reduce outside responsibilities
 - Prepare for adverse reactions
 - Consider advantages and disadvantages of using alone/with others
 - Consider physical surroundings
- Consider effects of use. Are you ready for the effects?
- Consider effects of drug use on neighbors, if any.
- Consider other ways to achieve the goals of drug use.
- Consider switching to less harmful drug(s).
- Reduce frequency of use (increase frequency of not using).
- Take care of your business prior to use (pay bills, house cleaning, eating, etc.).
"Buy the pampers first."
- Understand and consider interactions between drug use and any medications you are taking.
- Consider impact of drug use on health, relationships, job performance, legal standing, community involvement, quality of life, and stable housing.
- Discuss and consider utility of reducing harm related to your particular drug (s) of choice.
- Discuss and consider advantages/disadvantages of using in your place or somewhere else.
- Share and discuss all forms and types of abstinence (which drugs, time-limited, situation limited).
- Know where you can get help.

There are many examples of HIV-related interventions. We could address injection drug use risks through syringe exchange or bleaching injection equipment. We can promote safer sex. We can make referrals to HIV antibody testing and HIV related medical care. Again, there are many examples of ancillary interventions. We can address economic issues, perhaps through assistance with benefit and entitlement programs. We could link someone with psychotherapy or alternative therapies or support groups. All of these actions attempt to lessen harm and to strengthen different areas of a person's life. Please refer to the *Drug Use and Housing* handouts.

The Harm Reduction Coalition has published a list of principles of harm reduction:

- Accepts, for better or for worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them, and both affirms and seeks to strengthen the capacity of people who use drugs to reduce the various harms associated with use.
- Understands drug use as a complex, multi-faceted phenomenon that surpasses a continuum of behaviors from dependence to abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being - not necessarily cessation of all drug use – as the criteria for successful interventions and policies
- Calls for non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harms.
- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harms.
- Does not attempt to minimize or ignore the many real and tragic harms and dangers associated with licit and illicit drug use.

Outcomes

The Safe Start Program has many program goals and measurable objectives:

1. Permanent Housing: 75% of program participants will remain in permanent housing for at least one year or until the time of death. The average length of stay for participants is now slightly greater than 15 months.
2. Income and Quality of Life: within 30 days of program entry, 95% of eligible participants will apply for Social Security and IDPA benefits and entitlements. This objective has been fully met.

3. Greater self-determination: during the project year 75% of program participants will initiate and sustain their receipt of appropriate medical care services. We have exceeded this goal.
4. Greater self-determination: After 180 days of program participation, 50 percent of participants who are sexually active will practice safer sex behaviors. Nearly all report use of safer sex techniques.
5. Greater self-determination: After 180 days of program participation, 50 percent of participants will report decreased substance use compared to their own practices at program entry and 40 percent who continue to use injection drugs will practice safer syringe use behaviors. We have exceeded these goals. In fact, four of six injecting drug users report decreased substance use, five of six report adopting safer injection practices and one reported abstinence.

Discharge Criteria

This is determined on a case-by-case basis. We do expect participants to follow the rules and expectations outlined in agency/participant agreement that they sign when they move in. We base discharge decisions on behavior(s), not drug use. We rate discharges three ways: successful discharge, unsuccessful discharge and therapeutic discharge. In terms of attrition, 22 participants left during the first 24 months: 7 left voluntarily, 8 were asked to leave (1 for non-payment of rent and 7 for non-compliance with supportive service requirements), 2 left for unknown reasons, 1 left for criminal activity, 1 left due to loss of program eligibility, and 3 died.

Lesson's Learned

- Harm reduction is a very fluid concept that is in the process of being defined in a variety of settings.
- Harm reduction philosophies and strategies are essential to success with program participants.
- Participants bring with them what they need to succeed.
- Change is participant driven.
- Relationships with the landlords are key.
- There are many demands on staff and they need many supports.
- There needs to be a transitional housing option for people to move on to from here.
- The scattered site apartments provide participants with a sense of ownership.
- The first 60 to 90 days in the program are key for both program and participant.
- HIV/AIDS is often not the primary issue people are facing.
- Participant's capacity for independent living is essential.
- Not all problem behaviors are related to drug use.
- This program is not for everyone.
- It works!

What's Next?

The program has been renewed for three more years. In our next evaluation, we plan on comparing it more with other models. We are also considering sites for future programs. And lastly, we are working towards the expansion of harm reduction as a strategy. Thank you.

Question & Answer Session

Q: *Betsy, can you discuss more explicitly the reason for staff turnover – why there were only 2 left from the original project.*

Betsy: The high turnover is a combination of two factors. The first factor was staff not knowing what they were getting into. We were not as clear with the rules and limits and I think people really need to confront their own issues about drug use. Secondly, these jobs do not pay particularly well and Seattle is a hot employment market right now. Also, we were not clear on the best kind of people to hire when the project first opened. We know better now and we have had a very stable staff there for the last 18 months. You need to know where you are going but also be open to the fact that things may change and what you think you need is not what you may end up needing.

Scott: I think it is especially true that what is needed, because of all the stuff that goes on with harm reduction, is really good support for the staff – things like good clinical supervision, regular team meetings, lots of communication, professional development opportunities and time off. It is hard work. We need to support staff as much as we can and hopefully they will hang around.

Q: *Do you have many zoning issues, issues with local politicians from the community where your housing is located? If the individuals were still using zoning would be an issue here in Chicago.*

Betsy: This was not our first project. We provide a huge amount of housing to this very challenging population and we wanted to do new construction in a different neighborhood and the neighbors really went ballistic. So we moved the project and purchased this building. Seattle is very clear about the fact that people may be using in this building. We were very explicit about what we were doing. Some were nervous about telling people that we were housing people with AIDS and that maybe people were using drugs, so they would mumble it. This is a neighborhood that has a big street population. It is right in the heart of downtown, across the street from the police department. It is a neighborhood that is in the process of pretty substantial gentrification.

Seattle is very clear that if a project is allowed by zoning and you are providing the right amount of services, the location of a project in a neighborhood cannot be denied because someone might not like what is going on in the project. We made a commitment to the neighborhood that there would not be any additional street activity. This was a building that had sat empty for 10 years, so we were bringing a strong local presence. We restored the whole street front retail so that was another anchor to the neighborhood. We had a wonderful neighborhood advisory committee of merchants, police and other residents to help us think through how to do this, how to pay attention to the security issues. People were much more concerned about what was going to go on the street versus what going to happen up in people's apartments. We work very hard to be good neighbors. We have a big community-policing project going on. So, I do not want to say there have not been issues but we work hard to be good neighbors.

Q: *Do you work with people who use specific drugs or do you accept all types of users?*

Betsy: We accept any kind of drug users as long as people comply with the policies. We know that we are more successful with heroin users. Despite this knowledge we still take people using crack or crystal methamphetamines and try our best. In terms of rules, we do not allow people to traffic or sell out of their units and they have to pay their rent and they need to not disturb their neighbors.

Scott: BEHIV is also more successful with people whose primary drug of choice is heroin or alcohol. When we do get a referral in which someone says crack and cocaine are their drugs of choice we know it will be

tough and it often is because there is a whole different set of behaviors. But again it is about opening up the conversation and saying what is it about this person's crack cocaine use that is impacting their ability to maintain stable housing and some people are more successful at addressing that than others. I am not saying that you just have to open up the conversation and everything turns around overnight - it takes time. There are things that go along with crack cocaine use that make it difficult for people to maintain independent stable housing. We cannot deal with that unless we are talking with people about it and that is what we try to do as much as possible.

Betsy: There are people in the harm reduction movement who do a lot of work with people around switching their drugs, trying to get people to shift to other drugs or fewer fixes. It is really about trying to figure out how to meet people where they are at and support them in their housing stability.

Matthew: Crack cocaine use calls for case managers and program directors to be very creative in the things that they set the table with. There are many advantages to payee-ship for people who have difficulty managing their money. There are a myriad of things that we did not do when the program started that we now do specifically to address issues with clients who do use cocaine.

Q: *Are the staff trained to address recovery issues/employment issues or are they just doing case management geared toward harm reduction?*

Scott: Most of the people we work with are AIDS-disabled, so we do not focus specifically on return to work. For people who decide they want to go that route we support them and try to link them with services. We take them to job fairs and collaborate with other providers to offer a range of services. We have a designated staff person for return to work issues. If people want to go back to work, we encourage it absolutely. We have a couple of tenants working part time right now. In terms of staff training around recovery, we have one person with a harm reduction background, and one person who is a specialist in culturally competent abstinence-based care. The staff now feels that they are able to address the continuum of substance use services ranging from harm reduction to abstinence based care. This works well.

Q: *Is needle exchange legal?*

Matthew: It is legal in Illinois if you are part of a research exemption. People need an exemption card.

Betsy: The situation is similar in Seattle.

Q: *How do you handle people's criminal records. Do you follow the standard background check?*

Betsy: We have project-based Section 8 units in this project funded through the SRO mod rehab project which is managed by our housing authority and so we had to do some negotiation with our housing authority. We have had to work that whole piece about criminal checks. We do take people who have criminal histories. I think it is something like 70 percent of the tenants in the Lyon building have some kind of criminal history. There are a few kinds of convictions that we cannot handle. For example, we cannot take arsonists; we need to protect the building. And, there are some kinds of felonies that we feel people should do some kind of treatment program before they come to the Lyon building. But most of our tenants have had some kind of criminal history.

Scott: Same with Safe Start. We do not discriminate with regards to criminal history regardless of what that criminal history might be. We get referrals directly from the jail from time to time. We have had people in the program who became incarcerated during their tenancy for a variety of reasons and if we are able to, depending on the disposition of the charge, we try to have the unit open until they get out if it is not a period of more than 30 to 60 days. They are welcome to come back in. We had a gentleman who did become incarcerated for six months. While he was incarcerated we had to fill his

unit but we put him at the top of the waiting list when he was released. He has been back in the program going on his third year. So we really to work with it. There are programs in Chicago that cannot accept people with that background and it is tough. I have referred people to other housing programs who meet every criterion until a criminal background check is done.

Q: *Do you see these types of units as a trend that will continue? Is it too controversial?*

Scott: We can talk all day about programmatic solutions but if the changes aren't happening at the policy level then we will have 30 units in the city of Chicago for people that are living with AIDS and that have problems related to current drug use.

Betsy: Chicago and Seattle are communities that are willing to put public dollars into housing people who are still using and this is not true in most cities in this country. It is really important and you can see both our organizations feel a responsibility to talk about how this works what has not worked - to be candid about where the mistakes have happened. This has not been an easy road for any of our organizations. Each one of us has to confront our own feelings about people using. It pushes each one of us working in this field to deal with our issues around this and know our own limits.

Q: *What are the real goals of your programs? Are you really helping people get clean or make a better life for themselves or are you enabling?*

Betsy: Our goal is to have our tenants be successful in housing and in the best world we would support all our tenants to be clean and sober. What we are doing is teaching tenants how to reduce their risk but the issue is not setting them up so that they only have sobriety and using as the ends of the spectrum of goals and services. We are trying to get people to move from some of the higher risk behaviors into living more successfully. For instance if someone is using three bags of heroin a day you want to support them to start using two bags and then one bag. Or if they are tricking to support their crack cocaine habit, you want to support them to figure out how not to trick. You want to support them to be complaint with their AIDS medications. It is really finding that middle ground to support your tenants to move to in order for them to remain stable in housing.

Scott: It is about health. It is about making any positive change. I have seen for too long - I have seen friends die on the street because there were not services available to them. It was not until someone met me where I was, Edith Springer from New York City, that I started to make some changes. The two options that were being presented to me back and forth for the previous five to ten years - neither fit. Finally, someone met me and said "Look here is what we can do when you are ready. Let me know." I cannot accept all or nothing as a health care provider. What I can accept is giving people everything I can possibly give them where they are at to help them make some positive changes. I agree for many people the best positive change and the best quality of life for them is going be if they are abstinent. You will notice on that service plan that we use with our participants there is a whole box on there about abstinence and abstinence reinforcement. That is a huge issue. For most people, especially people who have been out there awhile and have been doing a lot of using, that is the best way. But the question that I continue to struggle with is how to get them there. Whatever we have been doing in the past has not always worked and a lot of people have fallen through the cracks. So, let's try to look at different ways.

Matthew: We need to wrap this up but I want to announce that there will be a National Harm Reduction Conference this October in Miami. This November in Chicago there will be a conference called Bridging the Gap which is aimed at bringing together people from all different components of the substance use services continuum and trying to hash out differences in order to provide services that people need in the best possible way we can.

Model Panel III: Supportive Housing

Presenters: Jackie Bowens, Audrey Thomas & Pat Tucker Moderator: Adrienne Krasowitz

Jackie Bowens *
Community Supportive Living Systems, Inc.

Pat Tucker*
Lakefront SRO
Senior Vice President

Presentations unavailable due to a recording malfunction.

Audrey Thomas
Associate Executive Director
Deborah's Place

Overview of Deborah's Place Supportive Housing:

Deborah's Place began in 1985 as an emergency overnight shelter for women who are homeless. The goal was to provide safe shelter, food and support. The philosophy of service is to treat each woman as an individual, respect her right to make her own choices, build relationships and celebrate small victories.

Deborah's Place continues to serve single women who are homeless and formerly homeless. Some of the women may have children, but their children are not in their care. Women range in age from 18 to 80, though most are between the ages of 35 and 50. Seventy percent of the women are women of color and 30 percent are Caucasian. Common characteristics of women are that they are strong, independent, stubborn, resourceful, humorous, proud women who are engaged in struggles everyday. Struggles with poverty, physical and mental illness, addiction, alienation from family. Struggles to learn skills, get a GED, find or maintain employment, find or maintain housing. Struggles with self-esteem and loneliness.

Since 1985, Deborah's Place has grown to include a daytime support center, transitional shelter, second-stage housing program, for-profit jewelry and handmade paper making business, and 39 units of supportive housing. Program participants have access to comprehensive case management, health and therapeutic services, education and employment services. In April, Deborah's Place will open another 90 units of supportive housing for women in the East Garfield neighborhood of Chicago.

Through all of this growth, the core identity of Deborah's Place continues to be that of a shelter organization that is doing supportive housing. The decision to develop housing came out of the organization's 1992 strategic plan. Two needs were identified: safe, affordable housing and support for women once they had moved into housing. This planning also coincided with our need to relocate our overnight shelter to a permanent site. A group of staff visited models for housing in New York, Connecticut, Massachusetts and Rhode Island. Washington Square in Newport, Rhode Island presented a model for co-location of shelter and housing in the same facility. They provide people in their shelter an opportunity to make the move to permanent housing with little risk because they are still in the same facility and are able to retain the relationships with staff and participants that they had formed in the shelter. And if the housing does not work, they can return to the shelter and re-enter the housing later.

Supportive Housing Model

This was the model we used in the development of our supportive housing. We co-located the 30 bed emergency shelter, ten bed transitional shelter, 39 units of supportive housing and a learning center at the same site. The 39 units have a separate entrance from the program and have a separate social service staff from the other programs in the building. The management of the 39 units, which we call Deborah's Place II (DPII), is a model that was taught to us by Lakefront SRO who did our technical training before the building opened in 1995. The model is one of blended or integrated management in which the property management and on-site supportive service staff work together to identify problems, address tenant issues, helping tenants maintain housing, and meet their common goals of running a safe and well kept building.

The DPII apartments are project-based Section 8 subsidies. That means that the tenants go through interviews with Deborah's Place and then both they and the unit they are moving into must be approved by Chicago Housing Authority. There is a year-to-year lease and the tenants pay 30 percent of their income for rent. Some of the units have galley kitchens, private bathrooms, a microwave and a refrigerator. The support service staff check in with everyone regularly.

We also believed that the co-location of the shelters and supportive housing would provide the program participants and tenants an opportunity to interact socially with one another, creating an atmosphere of community. To that end, tenants are welcome to eat the evening meal with the overnight shelter participants four nights a week and have access to any of the education and employment programming, recreational and cultural opportunities that are available through the residential programs.

Some of the tenants see the apartments as permanent housing where they will stay for a long time. They are the tenants whose primary relationships are with other tenants and staff. They are active participants in all of the program activities available to them. There are also tenants who see the apartments as housing, but housing that is a stepping stone on their way to regaining custody of their children, building a work history, etc. These tenants participate in in-house activities periodically, but they generally have relationships and activities outside of Deborah's Place.

Lesson's Learned

So, how has this all worked out? There have been mistakes and struggles, success and victories.

- *Mistake #1:* Made a lot of rules before the building opened about where program participants and tenants could and could not go, how the building would be used, etc. We spent a lot of time predicting problems.
Struggle: Most of the problems we predicted did not happen. But it was very hard to change the rules, policies and procedures once staff had formed patterns and attitudes.
- *Mistake #2:* We allowed people other than the women who would be living in the apartments to define what dependent and independent meant for the women we were serving.
Struggle: Program participants were reluctant to look at the apartments because they saw that once they were in housing and "independent," resources they had as program participants would be terminated (food, personal grooming items, fare cards, etc.).
- *Mistake #3:* We underestimated the impact of a program organization doing housing and we did not prepare adequately for that impact.
Struggle: Staff perceptions that housing was "taking over" the organization and the development of an "us and them" dynamic.
- *Mistake #4:* We had a human service program attitude and approach to property management.
Struggle: Five property managers and an array of failed strategies for keeping the building clean and maintained.

- *Mistake #5:* We did not understand how the requirements of funding would impact our ability to make adaptations and accommodations for the women we serve.
Struggle: To find ways to make the DPII apartments and the new apartments accessible to the women we serve and at the same time meet the funding requirements.

(Example: The apartments are project-based Section 8, which is great because many women have no income at all. However, it also means that there are certain non-negotiables: identification papers, landlord references, and the homeless definition that does not apply to people staying with friends or family members.)

For a time, there were few women from our overnight shelter who were able to access the apartments. This was very frustrating to them and to program staff. After all, they were the reason we developed the housing.

What adaptations and changes have we made to deal with the mistakes and manage the struggles?

1. Staff changes in key positions meant that we were able to hire people who have the skills set to work in a co-located building. There are fewer turf wars and the building has a community feel to it. There is a community center that for the first three years of the building was only used in the evening by the overnight shelter. Now it is used everyday by tenants, program participants, and staff.
2. We have become invested in property management and have a property manager who works well with the program staff and has an understanding of what the issues are for the women who stay at the overnight and transitional shelters. The program staff and participants now feel that the apartments are more welcoming to the overnight and transitional shelter residents.
3. We recommitted to the organizational value and goal of participant-centered planning and services. The reality was that the women may have moved into housing but they were still in need of resources and we decided that we needed to provide those.

The biggest adaptations that were made were the attitudes of staff, which in turn impacted our ability to be flexible and to make accommodations. The biggest attitude shift was that we stopped trying to make the tenants fit into a definition of independence that was not their definition or experience.

What are the successes and victories?

1. Through hard work, training and communication, the organization has been able to reach a balance of being a service and housing provider. There has also been an integration of the fact that as long as we do both program and housing, there will be competing priorities and intrinsic tensions. We have learned and continue to learn ways to embrace those rather than resist them.
2. More women from the overnight shelter have moved to the DPII apartments in the past two years. And, about 30 women from the residential programs went on a recent tour of our new supportive housing development. I think that this reflects the integration of housing into the organization.
3. The lesson of our co-located supportive housing taught us that we must be better prepared for the development of any new housing. For the 90 units that are opening in April we brought the property management and supportive service staff for the new site on months in advance in order to integrate them to the organization, programs, as well as into their new jobs. They have spent that time forming relationships not only with each other, but also with program staff and program participants. We feel that this is crucial to the success of integrating the new housing and we believe that it is working.
4. I think that the biggest success is that five years after the first 39 units of housing opened the goal of the co-location of housing and programs fostering community has happened.

Supportive housing is done in a variety of ways and our model is really a reflection of the needs of the women we serve and the mission, values and culture of Deborah's Place.

Model Panel IV: Supportive Services in the Shelter Context

Presenters: Tim Jones & Arturo Bendixon

Moderator: Maryann Mason

Tim Jones
President/CEO
Connexions Enterprises

Good Morning. My name is Tim Jones and I am the President of Connexions, an agency that services people who are homeless with a mental illness, who may also have a history of substance abuse and/or be impacted by HIV/AIDS.

Overview

Connexion is a Safe Haven program. As this, it is designed to serve the hard to reach homeless with severe mental illness that are on the streets and have been unwilling or unable to participate in supportive services. Our main funder is HUD, the Department of Housing and Urban Development.

Our Safe Haven model was specifically designed to meet clients' particular issues within certain guidelines according to our funders. Our goal is to make our programs effective and make a difference in the lives of the homeless mentally ill. In our planning process, we met with our psychiatrist and clinical team, as well as our case manager to develop a program that was culturally sensitive to the needs of our clients and was within the guidelines of our funders.

Our Concept of Safe Haven

As mentioned above, a Safe Haven is a low-threshold residential program targeting homeless persons with severe mental illness. Safe Haven clients are persons who have been very difficult to reach and have often lived on the streets for years. They do not tolerate the shelter system and have often been rejected from many shelter programs because they exhibit delusional behavior and often have co-occurring substance use problems. Safe Havens are "low demand, high structure" programs, meaning that persons are not required to participate in treatment to live there, and the rules are simple but firm.

Safe Haven clients can stay as long as they need to. The goal is to engage the client in on-site activities that lead them to enter into mental health and substance abuse treatment, and eventually move the clients on to transitional or permanent housing. Therefore, a Safe Haven is used to bring people into services at their own pace and on their own terms. Most of our referrals come from a mental health program that conducts street outreach. Participants receive day programming, benefits and entitlements and psychiatric services.

Mental Health and Substance Abuse:

The Safe Haven model uses a strategy of treating mental health and substance use issues in an integrated fashion. Traditional service providers believe that you cannot deal with a mental health issue if someone is using, and you cannot deal with the substance abuse issue if someone is not taking their psychotropic medication. Harm reduction techniques are used in Safe Havens, meaning that clients are taught how to reduce the damage they cause to themselves by using, if they are not able to stop using all together.

Program Strengths

- Our program accommodates clients in semi-private and private rooms with less stimuli and structure than most housing programs and shelters.
- We highly encourage clients to comply with medication but do not require it. Medication is stressed because of importance of stabilizing our clients' mental status.
- Once clients are stabilized they are encouraged to become active in some form of daytime program such as those run by mental health clinics. Seventy percent of our clients are involved in some form of day programming.
- Case management is essential in most cases.
- Most clients return from day programs to prepared meals and community meetings.

Program Weaknesses

- Often the clients' mental status is so deteriorated when they get to us that they have to be hospitalized. Since most do not have any medical cards, we have a hard time getting them some form of treatment as well as their medication.
- Clients with a mental illness take a while to reintegrate/regroup back into the community. This program is long term due to the nature of the illnesses.
- It also takes a long time to begin to set some structure for people and to help them focus on real issues, again due to the nature of the illnesses. We have to spend a great deal time on reality orientation.
- We have to be very careful of staff burn out. We continuously meet with staff weekly to motivate and encourage them to stay focused. We also stress how important it is to work as a team to make the job easier and to accomplish our goals.

Program Design

Central to our Safe Haven design are supportive services. Included in these services are:

1. Entitlement assistance.
2. Medication management
3. Payee referral through other avenues, if needed
4. Activities of daily living
5. Interpersonal skills, conduct issues resolved
6. Substance abuse
7. HIV/AIDS education
8. Psychiatric Services through a psychiatrist
9. Recreation activities
10. Medical issues through linkages of health providers

Clients

Because we serve people with a psychiatric history and diagnosis, we are often faced with explosive behavior. Staff members are trained to redirect such behavior or if all else fails, petition them to psychiatric hospitals. Despite our weaknesses, we have helped turn some of our clients' lives around. For example client behaviors such as talking to themselves, eating out of garbage cans, and hostile behavior have changed for the better. We also deal with other issues our clients face including substance abuse and HIV/AIDS status.

All Safe Haven participants are encouraged to undergo screening for TB and HIV. Safe Haven residents are not usually functioning at a level that would allow them to be employed, although Connexions is developing employment programs specifically for formerly homeless people with serious mental illness. Connexions Safe Haven facilities are accessible to persons with disabilities. Connexions Safe Haven programming includes prepared meals with an emphasis made on eating healthy.

Now I am going to turn this over to Art, but there will be time for questions and answers at the end. Thanks

Arturo Bendixon
Executive Director
Interfaith House

I would like to start with two quick stories about two of our former residents who were at Interfaith House about 18 months ago. Even though their names are not their real names, they certainly are very real people.

Carlos' Story

Carlos, a Latino man, a few months ago during winter after having too much to drink, fell asleep in the street and woke up the next morning with frostbite. He was taken to Cook County Hospital and while they were taking care of his feet, they diagnosed him as having HIV. After a couple of days in the hospital, he was sent to Interfaith House, which I will tell you about in just a few moments. He arrived at our place scared and terrified having just been told that he was infected with HIV. He was very much disabled because of the frostbite. He had no insurance and was homeless. He was very much what you would call traumatized. He came to Interfaith House, which is a clean, safe, dignified emergency facility—stage I facility according to HUD standards. During the next few days Carlos was able to receive personalized attention. He saw a physician, did a psychosocial assessment, was assigned a case manager and a volunteer minister who spoke Spanish and who is trained in working with people living with HIV/AIDS. They all began working with him to help him deal with his fears and his anxiety as a newly diagnosed person with HIV. We have doctors on site from the PCC community clinic, which is a clinic on west side, and some nurse practitioners from Rush. The nurse practitioners were able to support Carlos in his medical recovery and medical stabilization. We also had our substance abuse counselor refer him to outpatient treatment at Association House. Ten weeks later Carlos completed our program, his foot had healed so he could walk again and he was placed in a supported housing facility here in Chicago and he was staying steady in his recovery. Basically we were able to support him and house him for about two and a half months.

Martha's Story

The second story is the story of Martha. Martha is an African American woman who came to us about two years ago. Martha had a broken arm. She was a survivor of street violence and had been treated at Cook County Hospital for her broken arm and had also received treatment there for the past two years for HIV infection. After she arrived at Interfaith House, she went through the usual supportive interviews and sessions with our clinician, case managers, doctors and substance abuse counselor. The psycho-social assessment showed very clearly that she was dually-diagnosed with substance abuse (addiction to cocaine) and bipolar disorder and of course on top of that HIV-positive - essentially triply diagnosed. It was determined that she needed to have intensive case management services because there were a lot of issues in her life that needed attention.

We put her on the waiting list for Haymarket dual diagnosis program, but five days after she arrived at Interfaith House she used cocaine. She had gone out on a walk around our neighborhood, which has a lot of cocaine dealing, and she came back and tested positive for cocaine. Then she had to sign an agreement with us, which we do for people the first time they use while at Interfaith House. The agreement restricted her to Interfaith House for the remaining of her medical recovery. She signed the agreement but ten days after her arrival, she went out for a medical appointment and never came back. We called her discharge a self-discharge, destination unknown.

Program Overview

Interfaith House is a unique respite center. It is unique to the Midwest and was unique to the country five years ago. We use a social service model to provide shelter for people who are homeless and ill or injured. We support these individuals with a complete medical recovery plan and then they move on to a stage II or stage III facility in the continuum of care. Twenty percent of our residents right now (we serve about 500 residents per year) are living with HIV/AIDS as identified. There are probably more that are unidentified. Our job is to help them get out of the trauma of homelessness, the streets, wherever they may have been living, and to help them to stabilize medically, psycho-socially and spiritually and then connect them to the next stage in the continuum of care.

Best Practices

I want to talk about four best practices that we believe are needed for stage I facilities—emergency shelters—to help in the transition of someone living with HIV/AIDS into housing opportunities.

1. First, you need a shelter that is safe, clean and dignified. As many of you know, not all shelters for people who are homeless are safe, clean or dignified. When someone is traumatized, someone is in pain, someone is very afraid or terrified of what is going on in his or her life, if they don't find this place a healthy and secure place to be, they are not going to really deal with what is going on in their lives. It is such a need, especially here in Chicago.
2. The second best practice needed is a non-judgmental, caring and healing community. As many of you know, we do not call people who do not have a roof over their head or a table to eat their meal, we do not call them houseless. We call them homeless. They need more than just a building to live in. They need support systems. Again, as many of you know, many people who are homeless have lost their support systems or maybe never had them or if they do have support systems, they are very limited. We have found out that, for everyone but especially for people living with HIV/AIDS and homeless, you really need staff and a community that does not judge them, that is compassionate, that makes them feel like anyone else in the house. We are able to do that at Interfaith House. Since only 20 percent of our population is living with HIV/AIDS, they are able to blend very nicely with the rest of the population. Nobody, except for the staff that needs to know, knows their status unless they reveal themselves.
3. The third best practice needed is what we would consider support services to complete medical recovery plans or stabilize medically. Again, as many of know, medications and the homeless sometimes can be quite a challenge. Medications are lost, traded, sold; whatever happens to medications quite often people do not complete medical recovery plans. We need shelters where individuals who are homeless and ill or injured or living with HIV/AIDS have support to take their medications, to safe keep their medications, to complete medication plans.

Secondly, transportation is a big issue. Getting to the doctor, getting to the appointments. Keeping those appointments is very key. That is a major issue for many people who are homeless and are ill and injured.

The third area that is so important in helping people complete their medical recovery plan is rest. In most of our shelters people cannot rest. During the day they either have to leave the facility or there is too much commotion going on. One of the doctors who advises us says it is as simple as taking your medications, going to the doctor and getting rest. For most of us who have a home that is not a major challenge. For people who do not have a home, it becomes a major challenge.

4. Lastly, some of the best practices needed include (there are probably a lot more but because of limited time I selected four) integrated case management and at times intensive case management services. With the substance use issues, the mental health issues, the housing issues, the medical issues, the dealing with family members or significant others in their lives, unless a program has one or two case managers working together with the individual to help integrate all of this, he or she feels torn in different directions. We have assigned to all of our residents a case manager who is trained in social services and a health services provider. The two of them work very closely with the individual to make sure that all of the services are integrated. One of the weakness that we have in dealing with 500 individuals per year, 60 at any one time, is that some individuals like Martha do not get the intensive case management services that they need. I think if we would have been able to pay more attention to Martha on a daily basis she might not have self-discharged with destination unknown. Unfortunately about half of our residents living with HIV/AIDS self discharge. We are fortunate that two-thirds of our residents do continue in the continuum of care towards some kind of housing opportunities.

Question & Answer Session

Q: I like both programs—my experience in working with people who are homeless is that there are a lot of misdiagnoses. A lot of people have been in facilities and received care that wasn't long enough, especially with women who have smoked crack, cocaine. Often they present symptoms of schizophrenia early in treatment.

We know it takes about 2 to 3 months to make a good diagnosis. It seems that the way your facilities are set up with psychiatrists and other professionals, could you tell me a little bit about how often they reevaluate people and give them a different diagnosis and tell me how prevalent it is?

Tim: We get some clients who we do question whether they are mentally ill or if their symptoms are due to drug use. The doctors will take a couple months to assess their symptoms and behavior before they diagnose them.

Art: Our experience is that an assessment takes time. It is not something you do on someone, it is something you do with someone. And if they do not let you in, if they do not trust you, you are not really going to get a good assessment. We find that it takes at least two to three weeks to do an initial psychosocial assessment and get some kind of clinical diagnoses. Sometimes three or four months later if we revisit the assessment with the person feeling much more secure, much more comfortable they may let us in and we can really get a more accurate picture. But it takes time. We are a short-term facility. Our residents stay anywhere from two to eight weeks. So, sometimes we do not get to that second or third level.

I will tell you a quick funny story. When we first opened five years ago, the Department of Human Services gave us money. They were going to funnel single men and women through our place and in five days we were supposed to do a thorough psychosocial assessment and a thorough medical assessment and then send them somewhere else in the system. It became a big joke because in five days no one lets you in very much and even if we had done the most perfect job in five days where do you send him or her for services in Chicago? We still are an assessment center but we have integrated it into our respite program so that hopefully what we were supposed to have done in five days we can do in five to six weeks.

There are enough misdiagnoses occurring to worry about it. Trained people for serving dually diagnosed individuals are few and between so, if you are a substance abuse program, you tend to diagnose that way, if you are a mental health counselor, you tend to diagnose that way, but sometimes it is a mixture of both and you need specially trained counselors.

Q: Does the rush to assess and diagnoses come out of a lack of funding?

Art: From a lack of funding and inadequate past assessments.

Q: As an agency serves families and single head of households, we may begin to mainstream people with HIV/AIDS into our regular client criteria, simply because we think this is something we can do that will not require a lot of additional funding.

I just want to get feedback on bringing in this population, specifically families affected by HIV. What preparation would we need to do?

Art: I do think continuity of care as individuals go through the continuum from stage I to stage II is very important and information is important, as is always respecting the rights of individuals. You need releases of information and you need well-trained staff. Let me tell you one quick story about what happened at Interfaith House about four years ago when we officially began a program for people living with HIV/AIDS.

Our support staff, which does not need to know resident's HIV status, suddenly wanted to know who is HIV infected so they can protect themselves. We had to do a special training and now we have universal prevention procedures. You are more likely to get infected from somebody with tuberculosis than someone with HIV/AIDS so our procedure is we practice universal prevention here. Staff do not need to know who has HIV/AIDS; as long as they practice universal prevention they will be OK. Also, do a lot of training with staff members to deal with the ignorance that is quite often associated with this disease. So, I would say before you start getting HIV/AIDS information about people, make sure your staff members are trained.

Q: How many other agencies exist that offer the same type of support that Interfaith House offers?

Art: As far as a respite center for the homeless, we are the only one in Chicago and the Midwest. There are other shelters that are starting to provide health services in the shelters but they do not have the structure that we have. Our board is talking about opening up a second Interfaith House in the next two to three years. We just need to raise some money first.

Q: Tim, what is the length of stay of your programs?

Tim: We have no particular length of stay limit. We encourage residents to move on when they are stable.

Q: How do you deal with someone who refuses to take medications?

Tim: We ask some people to try medication for a 30-day trial period. We have others work with different staff, as they may trust others better. For some people, we encourage them to take a shot since it is only needed once a month. We do not discharge people because they won't take medication. People usually come around and are willing to try some.

Art: People have to be able to self-care at Interfaith House. They have to be able to take their medications. If somebody constantly refuses to take their medications, they are not appropriate for our facility.

Q: How do you plan on dealing with the affordable housing shortage?

Tim: Our next project is to develop affordable housing for people with disabilities with supportive services.

Model Panel V: Housing Families

Presenters: Vickie Edwards, Gwen Mastin, Kathy Doherty Moderator: Shelly Ebbert

Shelly Ebbert

Director of Service Coordination & Planning, AIDS Foundation of Chicago

The goal of this session is to discuss three different models of providing family housing for people who are infected or affected by HIV. We have three distinguished guests here today. This session will include program overviews, the elements that make programs successful, the definition of families, what they feel has worked well and lessons they have learned from their projects.

Vickie Edwards

Director of Volunteer Services, Vision House

I am Director of Volunteer Services at Vision House, a 25-unit project consisting of studios, one-bedroom, two-bedroom and three-bedroom furnished units. We opened in 1997. We have single male head of households, single female head of households and husband and wife head of households. The children's ages range right now from 18 months to 17 years old. We have a floor accessible to persons with disabilities.

The main criteria for residence in Vision House is someone in the family must be HIV positive. People are referred to us by their case manager. We run a criminal background check and a credit check. If a person has no income at all and they meet our other criteria, if an apartment is available they can move in and we work with them to get an income either from TANF, SSI or Social Security, or employment. People pay 30 percent of their total income for rent. The only bills the tenant pays are rent and central air.

Services Offered

We have a linkage agreement with Cook County Hospital/CORE Center, Provident Hospital, Mercy Hospital, and Michael Reese Hospital. We have a food pantry that people can access six times per year. We have vouchers, bus passes, full-time case managers on-site, a child development specialist, a director of volunteer services, an executive director, an engineer, and a janitor.

Innovative Practices

The tenant council is one of the unique things that we have. The tenants select their own chairman, co-chair, and secretary. They use this as an avenue to have input on anything the staff are proposing or changing. We are working now at adding a library on site. The tenants are selecting books they see as necessary for their children. They are incorporating a tutoring program for the adults on how to do storytelling to the children in which they will receive a training stipend. The teenagers will be trained to read to the younger children. We are in the process of opening a day care center to house 60 children affected by the virus and in the summer we will increase capacity to 90 children. We have come a long way in these last two years.

In terms of building community we celebrate many things, have bi-monthly fish fries, holiday celebrations, trips to the beach and sporting events, and many other activities. There is never any pressure to attend or to participate. We want people to relax and have fun. We worked together on the landscaping and yardwork.

Structure

In terms of rules we have a few. The rules are not that bad.

- To have a weekend guest they must go through their case manager to get the okay. Guests can only stay three days unless it is a family member, in which case we are more flexible. During the week, guests must leave by 10:00 p.m. and weekends by 11:00 p.m.
- No alcohol or drugs in the building. We check sometimes if a bag looks heavy or a bottle is showing.

Gwen Mastin
President/CEO
New Phoenix

Overview

I founded New Phoenix Assistance Center for HIV women in the early 1990's. Over time it has turned into an HIV women and children's program. We do family reunification, family support and advocacy, case management for the whole family, scattered housing units in South Shore (six buildings and three offices). We furnish the units and provide all of the support services for the families. We are a child welfare agency for the state so we have pregnant and parenting teens who are HIV or non-HIV positive. This is a pilot project and is considered innovative housing by HUD so we have homeless housing that is also for HIV-positive or non-HIV-positive. We have permanent housing. We are opening a new pilot project for the city that will be for HIV-positive teen non-ward girls. All in all the families we serve are comprised of male heads of households, grandparent head of households, intact families, women and children and a few single adults.

New Phoenix began by looking at other social service agencies across the country. We decided on scattered site housing because people wanted to live by themselves. Getting involved with building owners across the community was unique because selling the program and getting into the housing stock in each community was extremely hard in the early nineties. Now we have developers and owners and rehabbers who call us as they rehab buildings and ask us if we are looking for additional units.

Program Operations

We focus on providing micro-management. Once we approve the building we furnish the apartments ranging from the toothbrush, to the bed, to the food in the pantry. We select the clients and put the support services in place. The building owners basically get a check from us each month, unless there is something wrong with the physical site, which is the owner's primary responsibility. The clients' sign leases with the program, not the owner, so we literally are the landlord and have to take on any evictions. This makes it easier for developers to buy into the project. The uniqueness of the scattered-site set-up is that the children go to the regular schools and the clients use the community. If any of the buildings we work with are emptied out you would not know whom any of my clients are.

We put support services and a lot of activities in place. We have garden programs in every building. We do a lot of entertainment and educational sessions. We have two mandatory meetings a month. We also have a nutritionist. We cook for any gathering, house meeting, anything, so it resembles Thanksgiving on a continual basis - often two or three times per month. This keeps people from being isolated and gives staff a time to get an overview of the mental health of client and the situation of the family and the disciplining of the children, etc. This is a good time for observation.

In regards to community building, we have two mandatory house meetings. One is a nutritional meeting which has turned into an all day event. We have a nutritionist presentation, a meal, and then the women do a lot of sharing. The second meeting brings in people who can inform them. The residents look forward to these get-togethers both for the information but also for the networking opportunity and support. We do many family-focused activities, and have the families interact and support one another so in times of illness they become one another's caretakers. We provide transportation and food coupons as the basics but the get-togethers bring a cohesion that allows them to live independently as individuals in scattered site housing with support but no stigma. In terms of rules, I run the program like I run my house so the rules I had at home are the program rules.

Kathy Doherty
President & CEO
Chicago House & Social Service Agency

Overview

Chicago House started scattered site housing back in 1994. In 1997 we brought that all down to permanent housing in two different places. We have a nine-unit HUD 811 apartment building for families and then we have a three flat for families funded through Shelter Plus Care. We provide furnishings, require 30 percent of monthly income for rent, and we have leases for our families. If families are unable to pay for housing they are not required to pay rent until their situation becomes such that they can pay.

The demographics of our families are 70 percent African American, 20 percent Latina/Latino and 10 percent Caucasian. Our families are anything from gay couples to intact families and we have a lot of single moms with children. Approximately 90 percent of our adults are women, 10 percent men and about 33 percent of our total population are children under the age of 10. Besides the HIV, which is a requirement for the head of household to belong to this particular family support program, approximately 50 percent or more of our families have been homeless, at risk of homelessness, or the hidden homeless. 70 percent have substance abuse issues and over 50 percent have mental health issues. The composition of the families that we work with are pretty needy.

In terms of staffing, we have a Family Services Coordinator and Case Manager that work on site with the families. We contract with a Family Psychologist. We also have a Substance Abuse Counselor, a Property Manager, a Program Volunteer Manager, Volunteers and Maintenance.

Strengths & Weaknesses

We were asked to address some of the successes and non-successes of our programming. It is permanent housing so we attempt to make a community within the community so to speak, as well as the community at large. Our programs are located in the Uptown neighborhood. A lot of traditional programming did not work with our particular families. What that means is that as we think about psychiatric counseling of some kind, we think of an appointment we go to in order to get those services. That did not work with our families and since many of them needed psychiatric or psychological on-site services we changed it around to provide drop in hours for the families, which worked much better than setting up an appointment. We also have something called Legacy Arts N' Crafts Group which instead of a traditional support group we provide services through that group. The concept is to provide psychosocial support and provide an opportunity for people to talk about particular issues that come up in their day-to-day living as they do an arts and crafts activity, with the result of that activity being something that they can take back to their families. One project we have done is a recipe book. People took recipes passed down from grandparents and aunts and uncles culminating in a recipe book that they will then leave with the children in their families.

The drop-in hours are successful as the families set their time for the kids as well as the adults to drop-in and talk with the family psychologist. We have kids groups that we do that are different than sitting down talking face to face with the psychologist. They are designed to promote the development of age appropriate skills both in group and outside of group. We have a supervised playground activity in the summer time and throughout the year we have two groups a month called Kids Club. They learn how to share and how to play nice and how to do a variety of things.

Traditional education did not work in terms of us deciding what the residents wanted to know and how they wanted to learn it. Instead, the clients decide what they want to know, whom they want to know it from and how it is presented. We have a monthly luncheon educational series where they pick the speaker and the topic and the lunch menu.

We found that the more activities are brought on-site the more successful they are unless we provide transportation. Case management is provided on-site. The goal is that we offer activities so that we create community on-site as well as creating relationships with the community in which they live.

In planning for this program, because of the population we serve, we talked about psychosocial needs of the clients being met in order to successfully stabilize themselves in housing. The traditional way of providing psychosocial support was not successful so we went to non-traditional ideas such as the arts and crafts group. Substance abuse is a big reason why families do not stay in our housing so we had to come up with some different ways of providing recovery support for our clients. We work with Chicago Connections Next Step Program. They have an on-site

recovery support social group where the clients get together, both those with and those without addictions. They gather around a meal and an inspirational speaker comes and talks to the groups about their own story of addiction.

Traditional	Non-traditional (on-site)
*Psychological support group	Legacy Arts N' Crafts Group (lunch)
*Psychological individual & group counseling	Drop-In Hours, Kid's Club (dinner) Summer Playground Group (snack)
Substance Abuse: group & individual meetings & assessments	Recovery Support Social Group (dinner)
Psychological assessments	
Education	Luncheon Speakers' Series
Case management (on-site 3 days/week)	
Mandatory monthly meetings	
*Client Advisory Board	Use of client committees, lunch meetings, client volunteers, and client incident reports
*Newsletter	
Community building: quarterly outings	Holidays, special events (potlucks), mural, memorial garden
	Collaboration with The Children's Place Assoc.

*Indicate unsuccessful projects with the families

Structure

We have mandatory monthly meetings where we get feedback from clients. They make the agenda and discuss issues in the community. A client advisory board was not successful for us. The families did not want to be involved in any particular board that they felt might set some direction over the other families. Instead we involve clients in short-term groups and committees that make decisions about programming. This has been fairly successful.

As part of our community building we do quarterly outings with the whole family, different types of potlucks and special events. We also celebrate many holidays and use client committees and client volunteering to plan the events and outings. Food really is a great way to bring kids and families together. Often we incorporate snacks or meals.

One of the lessons we learned was in terms of rules. We have program guidelines. Know the demographics of the population you are serving and be clear about the goals of the program and then create policies and procedures around that. We have policies for visitors, for pets, other general programmatic policies in terms of property management, rent payment, grievance procedures, etc. We present all of this up front so families know exactly what the program is about and what they are agreeing to do.

Lessons Learned:

1. Know the demographics of the population you plan to serve and the goals/purpose of your program—then create policies/procedures accordingly.
2. Be clear from rent-up on all lease expectations and include all Program Guidelines and policies (visitors, drug & alcohol, pet, grievance, etc).
3. Work to meet the needs of the entire family.
4. Substance abuse is the number one reason clients are not successful in our program, so developing a strong recovery support program is essential.
5. Develop programming with input from the clients, getting buy-in and empowering clients.
6. Find ways of obtaining client feedback on programming.
7. Incorporate clients in actually planning and implementing programming.
8. Provide transportation when possible.
9. Teaching skills and impacting the lives of clients does not always have to be serious work for the clients.
10. Develop collaboration with other agencies that offer what the families need that you cannot provide.

Future Plans:

- | | |
|--|---|
| 1. Occupational therapy - basic living skills, vocational, educational | 3. Increased collaborations with other agencies |
| 2. Innovative ways to create a recovery supported life style | 4. Increasing the measurement of outcomes to better gauge success |

Question & Answer Session: Housing Families Breakout

Q: *How did you finance acquiring these individual properties and renovate them for families? And how do you deal with funding when it comes to linking with other social supports?*

Gwen: I do not actually own the buildings. My support services are funded through different city, state and federal dollars.

Vickie: Vision House gets Shelter Plus Care, HOPWA, funding through the AIDS Foundation of Chicago, City of Chicago, the state, and the federal government. We bought our building and rehabbed it with multiple sources of funding and borrowed some money. Our furniture was donated.

Kathy: We own the three flat, have Shelter Plus Care funding and receive HUD 811 as well. The rest of our funding comes from Ryan White Title I and II and we furnished the facilities through CDPH funding.

Q: *How do you deal with NIMBY – Not in My Back Yard Syndrome?*

Gwen: I deal directly with the owners and so no one knows my client base. By being scattered no one knows I am there and it gives autonomy to my clients. Our main office is in an apartment so it looks like my clients are visiting neighbors. There is no identifiable New Phoenix site per se.

Vickie: We had that problem with just a few neighbors. After we went to community meetings we basically cleared it up though there are still some people who don't want us there.

Kathy: The nine flat was built as a new construction so it was hard to hide. Chicago House has traditionally provided confidentiality for all of its clients in addition to not talking to neighbors in the neighborhood about the fact that we have a building that works with people with HIV/AIDS. But in this particular case of the new construction we met with the neighborhood association and answered questions they had, although we refused to talk about the exact population. We talked about that it was low-income housing and that the building in the neighborhood would match the architecture of other buildings in the neighborhood. We addressed this to the best of our ability. The most negative response we have had is from the block club. They want things always pretty and in-sync and they want us to tell the parents how to raise the kids. We have a lot of support from the alderman, which has been helpful.

Q: *What is turnover like in the apartments and why do people leave? What do the waiting lists look like?*

Vickie: Turnover is slow. Three-fourths of the tenants have been there since 1997. We've had four deaths, and a couple people moved out due to non-payment of rent or moved closer to work. Our waiting list is about 50 or 60 people. The list was at 200 before the doors even opened. I wish we had more money to do a larger building because the demand is so great for people with families.

Kathy: Since 1997 we have had three or four people die. Most turnover occurred due to substance abuse. Most have left because of that. We can not have adults using drugs around kids. We have had to evict about one family per year due to substance abuse. Sixty five to seventy five percent of our families have remained stable since 1997.

Gwen: We do not keep a waiting list. We are trying to create a continuum of care by going into the HUD housing and permanent housing. We have only lost three clients to death since the early nineties. A few clients are homeowners now. Only a few have stayed with for a longer time. We encourage everyone to move on. The maximum stay in New Phoenix is two years in any of the programs. None of it is totally permanent because the funding could go away tomorrow.

Q: *What happens to families when the qualifying HIV/AIDS person dies? What happens to the children if a single adult dies?*

Vickie: The family can stay but we do work with them to find housing to match their income. We don't break the lease. We had one stay almost a year until we could find other housing. In terms of the single parent we ask them to do a living will when they move in.

Gwen: We deal with guardianship if someone is ill by bringing in the legal authorities. If the client refuses guardianship previous to their death the children go into DCFS system.

Kathy: We do a lot of permanency planning. When the family comes into the program there needs to be a plan for where the children are going to go if mom dies. We've had a couple kids go to another family in the program under guardianship.

FUNDING PANEL

Panelists: *Perry Vietti, Tracy Fischman, Shelly Ebbert, Brenda Hanbury, Kelvy Brown*

Moderator: *Ellen Sahli, Senior Program Director, SRO/Supportive Housing, Chicago Dept. of Housing*

Perry Vietti

In ten minutes I will try to cover eleven slides and nine HUD programs so if after this you are totally confused I will not be surprised. I am happy to stay afterwards to answer questions. I want to give you a flavor of the different HUD programs that exist out there and some of the restrictions. I will go through the two different kinds of funding that HUD has in general and then talk about the specific funding in each area.

You probably have heard of formula allocations of funding and you have heard of competitive money. What that means is that some of the money that we give out from the Department of Housing and Urban Development is by formula. It is based upon population demographics, all those kinds of things that say there is a high incidence of poverty or there is a high incidence of homelessness in an area or HIV/AIDS or whatever the measure is. That is a formula allocation. The other way we give out money is through competitive processes. Under the formula area there are four programs I want to briefly touch on: the Community Development Block Grant (CDBG), the HOME program, the Emergency Shelter Grant (ESG) Program, and Housing for Persons with AIDS (HOPWA). In the Competitive area I am going to talk about the three homeless programs that we have at HUD: HOPWA competitive, SHPD (Supportive Housing for Persons with Disabilities also known as the Section 8-11 program), and the SRO program.

In terms of CDBG, it is one of the largest federal block grants. Last year it was almost five million dollars. It goes to large cities, to urban counties and to the states. In the state of Illinois, we fund directly 43 communities and it tends to be the larger communities, counties and of course the state. The funding is very flexible. We can do

anything from housing to services and so on. In a lot of communities that we give the money to, for example Chicago, Cook County and Peoria, those communities decide what to do with it. You have to talk to those folks locally to access those dollars. You cannot come to HUD for CDBG. We give it to the governments and then they decide through their own processes, usually a competition or some other mechanism, how to award those funds. It is very flexible funding but the problem with CDBG is that it has been around a long time and in some communities it is hard to get your foot in the door so you might have to work extra hard to get that money.

Now I want to talk about the HOME Investments Partnership Program also known as HOME. In some ways it is a very complicated program and in some ways very simple. It is a very targeted program to very low-income people. When the act was passed in 1990 that authorized the HOME program, Congress was trying to, at some level, replace all the programs that they eliminated in the 1980's. HUD, for a while there, was doing very little housing except supporting existing projects. HOME to some degree is adding to the stock of housing. You can do a variety of activities under the HOME program such as new construction and rehabilitation. Again the city or state receives the money from HUD and they in turn have their own procedures for awarding it. In some jurisdictions they decide only to do rehab programs. They can do that if they want. In some communities they are big on homebuyer programs. So again you have to talk to your local officials and I can help plug you in hopefully with the right folks in your community if that is of interest to you. Seventeen communities in Illinois receive HOME based on populations, demographics, etc.

Very quickly I am just going to touch on the ESG program – the Emergency Shelter Grants Program. It is one of the four McKinney Act homeless grant programs that HUD administers but it is the only one that is formula driven. We give ESG to eleven communities in the state. If you know the continuum of care, it is essentially the notion of permanent housing, transitional housing and emergency shelter.

Others today will talk about HOPWA much more than myself. Just briefly, it is important to understand that HOPWA has two sides to it. Ninety percent of the HOPWA money is distributed by formula and 10 percent by competition. The formula allocation only goes to two jurisdictions in Illinois, the Illinois Department of Public Health and the city of Chicago/surrounding collar counties. HOPWA is based upon the number of AIDS cases in a jurisdiction.

Now onto competitive funding. The Supportive Housing Program (SHP) is the largest homeless program that HUD oversees. You can do all kinds of things with this funding from transitional housing to permanent housing. The permanent housing, please note, is only for persons with disabilities. Under the SUPER NOFA (notice of funding availability for HUD's 40 competitive programs) there are three McKinney Act homeless programs: Supportive Housing, Shelter Plus Care, and the SRO Program.

The thing you need to remember about Shelter Plus Care is that it is permanent housing, it is rental assistance that can be scattered-site or project-based. It is very flexible in that regard. The notion is that HUD provides the housing through rental assistance sort of like Section 8 although it is not Section 8, but similar to it, and then you as the provider provide the care. We don't provide the social services, you do and you match dollar for dollar what we give you in rental assistance.

The next program is the SRO program, the Section 8 SRO Mod Rehab Program. We have funded several of these that you are probably familiar with in Chicago. Basically this is a project-based deal. It is for single adults only, not for families. Pretty much all of the other programs I talked about can serve families and/or single adults. But with an SRO, single room occupancy means by law one person so that is all you can put in these units. HUD pays for rents but we give you higher rents to help retire any debt service you incur because of the rehab we require you to do.

HOPWA competitive money funds two sorts of categories of projects. One is special projects of national significance. These are like models that might be worthy of replication in other communities. The other part is allocations to entities that are not eligible. For example Peoria, Springfield, etc do not get HOPWA directly under formula so they are eligible to apply for HOPWA competitive.

One last program: Supportive Housing for Persons with Disabilities, also known as the Section 8-11 program. Again, this is an excellent, very generous program but it is highly, highly competitive. It is probably the only program that HUD has in its arsenal that pays really for everything. It pays for the construction and it pays for the operating costs by giving you Section 8 certificates. HUD is not generous like that in most of its programs any more.

Now the summary. The three homeless programs: SHP, Shelter Plus Care and SRO, which are all bundled together, have \$850 million altogether and the demand determines who gets funded. You cannot apply for those grants directly. You have to go through a local continuum of care. The HOPWA competitive program is funded at \$23 million this year. These funding levels are for the entire country, not just Illinois.

TRACY FISCHMAN
DIRECTOR OF POLICY & LEGISLATIVE AFFAIRS
CHICAGO DEPT. OF PUBLIC HEALTH

I will focus national macro level of housing providers and funding for AIDS housing and opportunities. Specifically I am going to highlight the two main sources of funding for AIDS housing providers which are Housing for Persons with AIDS (HOPWA) and the Ryan White Care Act and discuss the political and policy challenges and opportunities we face in Washington. In particular, I will focus on our endeavors to ensure that the Ryan White Care Act is reauthorized before it expires in September of this year.

HOPWA and Ryan White are the two most common sources of funds for AIDS Housing. Sixty-six percent of all AIDS housing organizations receive HOPWA funding, 55 percent of all AIDS housing organizations receive Ryan White funding and about 44 percent of all AIDS housing organizations receive both sources. Many organizations receive various other types of HUD funding such as Shelter Plus Care, Supportive Housing, etc.

HOPWA is funded through HUD. It provides housing assistance and related supportive services for low-income persons with HIV/AIDS and their families. I think that when we talk about housing there are some specific things that cross boundaries when it comes to the housing needs of low-income people. But there are very specific needs that people living with HIV face. The thing that is so important is that with AIDS housing we have to make sure that we have integration with a whole range of primary medical care and support services. It is absolutely crucial and in fact the Health Resources and Services Administration (HRSA) is mandating that people that receive funding to provide housing services actually demonstrate that there are linkages into the primary medical care system. So it is absolutely crucial for anyone who is considering getting into housing provision, if you do not already do so, to make sure that you are going to have some sort of integrated system in place. There are a total of about 97 HOPWA grantees around the country and there are 67 eligible metropolitan areas (EMA's). Chicago is an EMA that also includes eight collar counties and Cook County as well.

Chicago, through the Chicago Department of Public Health, receives about \$3.9 million in HOPWA funds and we fund about 20 agencies. We do a continuation three-year cycle. At the national level in fiscal year 2000 HOPWA was appropriated \$232 million nationally. Every year during the appropriations process when we lobby on the Hill for increased funding the national community gets together and puts a need number together. We estimate that we need a minimum of \$292 million in fiscal year 2001 and when we are on the Hill talking to members of Congress that is the number that we push.

The Ryan White Care Act also funds housing providers. Specifically in Chicago, through Title I, about 6.5 percent (\$1.1 million) of our total funding that is allocated by the Planning Council, which I will talk about in a second, goes to pay for housing services. The process of applying for Title I funding which includes housing funding will be open for FY 2001 funding. It is also important to know that the process of determining how much of the Title I dollars will go

towards housing services is based on a community planning process. Our Planning Council is composed of people living with HIV and providers around the EMA. The Planning Council is legislatively mandated to assess needs for local HIV services and set priorities around the allocation of those funds. It is important to get involved in this community process and that housing providers are around that table and part of the needs assessment and priority setting process. You don't have to be a Planning Council member to participate in those committees.

The Ryan White Care Act is nationally appropriated in fiscal year 2000 at just over \$1.5 billion. It is the largest and most important source of funds for people living with HIV in terms of health care and social support services. The Chicago EMA in fiscal year 2000 received just over \$19 million including the Minority AIDS Initiative of the Congressional Black Caucus, which was just under a million dollars. And as I said, right now a little over a million dollars pays for AIDS housing services.

A quarter of the AIDS Housing Providers are located in New York and California alone. I think that that is a little bit disproportionate in terms of the epidemic overall. Its close but Chicago probably doesn't receive quite proportionately the amount of funding in terms of the epidemic even though it is based on AIDS cases.

Most AIDS housing providers target at risk and more severe need populations with HIV/AIDS. Nearly 70 percent of those served are homeless and nearly 60 percent have one or more additional health conditions such as substance abuse or mental illness, which again speaks to the real importance of having that integrated continuum of care in place for the people that we serve.

We are about to embark again on a housing planning process and as we do that, as providers and planners and consumers and advocates we must ask ourselves the very, very tough questions about how to most efficiently and effectively utilize very scarce resources. Since the epidemic has shifted so dramatically in the last few years in that we have people living longer, we still have no fewer infections. We have more people infected, we have more people living with HIV so we have a larger pool of people in the system that need housing services and all of the other services that we provide through our continuum of care and our infrastructure that we put into place.

Finally, I just want to talk a little bit about the reauthorization of the Ryan White Care Act because it is such a crucial program for all of us in this room. I think many of us are probably funded at our agencies or receive care through agencies that are funded through the Ryan White Care Act. As I said earlier, the current legislation for this program it expires on September 30, 2000. It is truly the most important program. It serves as a safety net, predominantly for uninsured and underinsured individuals who are living with HIV/AIDS. We get about \$30 million throughout the entire Care Act, Titles I through V, in the state of Illinois and we serve almost 15,000 individuals, 3,000 of them being children. The Care Act has really helped to develop a fragile but very vital public health infrastructure. We know that AIDS is still an emergency, is still with us and is not going anywhere so it is really critical that the Ryan White Care is reauthorized this year. Thank you.

Shelly Ebbert
Director of Service Coordination & Planning
AIDS Foundation of Chicago

There is a shortage of funds, there is a shortage of housing and there is a big shortage of affordable housing. In order to advocate for our clients everyone here has to become involved in some planning process, be it the Continuum of Care process which governs the McKinney Act funds or the HIV Planning process which governs the Ryan White Care Act funds.

The Ryan White Care Act, as you have heard, is one of the sources of funding for many AIDS housing providers in the city. But it is a drop in the bucket because the cost of providing housing is really exorbitant. Programs not only have to provide services for the people living in housing but they also have to pay for the place. Most housing providers have done some kind of combination of Ryan White Care Act, funds through HRSA as well as utilizing some of the different kinds of HUD funding streams.

The changes that HRSA has implemented with regard to housing services funded under the Ryan White Care Act are something to really pay attention to. It did not happen in a vacuum and I think there is a lot of scrutiny in Congress over what the Ryan White Care Act paying for. Congress has a lot of resistance to paying for housing services in the Ryan White Care Act when there is HUD. I think that is something that we really need to be conscious of and act against.

All Ryan White Care Act funds right now that are related to housing services must be used for housing referral and placement, short term or emergency housing that is transitional in nature and it must include either medical or supportive service or be essential for an individual or family to gain or maintain access and compliance with HIV related medical care and treatment. That is actually what the

HRSA guidance says. The bottom line is that under the Ryan White Care Act housing services have to be short term and they have to be linked to other services. The interesting thing is that the services it can be linked to can be medical services, substance abuse treatment services, and can also be mental health services. When we talk about linkages to treatment for housing services that is where there is real possibility for some dynamic linkages and I think that we as a community can be talking about that.

Also the Care Act must be the payer of last resort. How many times have we all heard that, the payer of last resort. But where is the payer of first resort? Who is it when there are no waiting lists or waiting lists are completely full or there is not access to some of the housing resources? We need to figure out how to document both the payer of last resort and what is the next step for our clients. The other key change that HRSA has talked about is that programs have to have a long-term plan for your clients. If programs offer a housing service right now that is funded in part through the Ryan Care Act they need to have a plan for what happens next - the next step - for their clients. We have been struggling with this. The need for supportive services to help clients realize what it takes to be a successful tenant, to maintain housing and to abide by rules. In terms of emerging trends, I think that the Care Act is going to be the last place that we look for to support our housing services. We have got to look in other places and that is why I brought up the homelessness continuum of care, the housing consolidated plan, and many other planning processes including the SUPER NOFA process.

AIDS Foundation of Chicago (AFC) wrote a grant to HUD four years ago for the Safe Start program. We wrote a proposal, submitted it

and were awarded the funds. One of my first jobs at AFC was to get that program refunded. We couldn't just write the grant anymore to be considered for funding. The grant actually had to be considered through the Continuum of Care process, which is another step in the approval process. The good thing about that is ideally the Continuum of Care is a planning process that results in a continuum of care with no duplication. But for people who haven't been fluent in that planning process it seems like another step, it seems very confusing, and programs have to be on the ball to know when all the deadlines are. It was a real challenge. Knowing that more and more of federal dollars are being planned for at the local level, and then having your agency be positioned to be involved in that planning process is crucial.

So, what can you do to be innovative? You have clients, you have great services, and you want to continue your services. If you are a current provider, one of the things that makes sense, if you receive Care Act funding, is to begin to look at the housing funds that you get as being short term in nature and think about the services that you provide as being where the Ryan White Care Act can support you. Much more in the service area, much less in the housing area. It just makes sense. The Care Act is for services. So that is one way that you can take a look at it.

Another thing to do is to get involved with planning processes, both to advocate for the programs you know work but also to make linkages with other agencies that are providing services. There are a lot of creative partnerships going on. Through these partnerships programs can carry on pieces of the program that they think are particularly important or get the expertise that they need for their clients. So I think that partnership

is real important also. What we really need to do as providers is to make new relationships and get to know each other better and to take that to the next step, which is making partnerships.

Before I close, I want to say that the AIDS Foundation of Chicago has agreed to steward a new five-year AIDS housing plan. The first-five year AIDS housing plan was a collaboration between the City of Chicago Department of Public Health, all of the providers, and consumers. We all came together to look at what some of our goals are. Immediately following the completion of that plan, came protease inhibitors so then we were in a situation where the first plan looked at sort of an automatic aging out or dropping out of the program by people who were participating in housing programs because their life expectancy was shorter. Now the life expectancies are longer and we obviously need the new plan. So the goals of the new plan are to support HIV and other housing providers with information that can be used in budgeting and planning. Everybody needs the best information that they can get and we hope the planning process can identify that and share it with providers.

We want to serve as a resource for funders and government officials to help allocate resources where they are most needed. Hopefully this plan will be able to be carried forth through the Continuum of Care process, through the HIV Planning Council and other places to advise them on what kinds of models we know work for our clients. Also, the purpose is to educate and inform a wider audience about the importance of housing to HIV health care as well as some of the critical issues that are facing providers. I encourage you to contact us and to become involved in one of the committees. Thank You

Brenda A. Hanbury
Chief of the Bureau of Homeless Services and Supportive Housing
Illinois Department of Human Services

It is a pleasure being here today in a couple regards. I started working in homeless services about 15 years ago. When we first did homeless services we talked about emergency services, providing beds and meals to people and we did not really go beyond that. I have been very pleased to see the evolution of homeless services in the state of Illinois. Over time we recognized that emergency services were not a real response; they were just band-aid solutions to a problem. I think that goes for AIDS programs as well. We started with just providing services with the knowledge that life expectancy was short. I am very pleased to be involved with the evolution of that to the point that we have gone from emergency services to now providing permanent supportive housing.

Permanent supportive housing is where we as providers need to look. We have learned over this period of time that our participants will not succeed unless they have supportive services in place with permanent affordable housing. About five or six years ago we at the Department of Public Aid allocated about \$200,000 for what we called an innovative new idea called 'Supportive Housing'. That \$200,000 was thrown out there to see what would happen to people if you provided permanent housing with supportive services. Well guess what, it happened and it happened in a big way. We found that people who are in supportive housing who had previously been homeless now maintained their stability in the housing; they have fewer incidences of readmission to hospitals; they have less recidivism for drugs and alcohol; and by and large it costs less to provide services to people in a supportive housing environment than it would if they became homeless. So began the revolution of supportive housing in Illinois. Just about the time we started thinking along the terms of supportive housing, the Continuum of Care SUPER NOFA process came to be. I am a huge proponent of Continuum of Care because I see the value in all of us being involved in the planning process for the people we serve.

At the state level in the past we would throw some money out there and see what happened in terms of homeless services. The people who wrote the best grants were the recipients of those funds. But now Continuum of Care allows people at the provider level and consumers to have a voice in how we are going to direct homeless services and how we are going to serve the targeted needs populations that we have in our communities. Supportive housing is such an integral part of the Continuum of Care. I encourage anyone who is thinking of doing a housing project to become involved in the Continuum of Care, not just for the fact that we are all out there chasing dollars but I think that it is important that we network with each other, and that we involve each other in the planning of these supportive housing projects.

Supportive housing projects are very difficult to do because there are two components. First there is the housing piece, which can be very difficult to put together. Typically for a housing project that serves special needs or a targeted needs population there may be five or six different funding sources just for the housing piece. Secondly is the supportive services piece which often has a couple different sources as well. To get all that to come together is very difficult and takes a long time. Typically it takes two to three years to really do a housing project for our populations from conceptual stage through implementation stage.

I am very pleased that Governor Ryan who, for the first time, allocated \$3.6 million for supportive services associated with supportive housing. In the past we were able to use some of our TANF

money in this regard but now there is a line dedicated in the Illinois budget to supportive housing and to those services. You can look at that in relationship to the HUD funding so when you meet with the funders prior to developing a project, talk about not only the permanent housing piece but also about the necessary supportive services. It is real important to talk to HUD, to CDOH, to IDHS if you have a project in mind because you are going to need to put together all of that funding and it is very difficult to do. Each source has its own little requirements and nuances that make it seem nearly impossible to do but it can be done.

We served as the applicant agency for a group called Community Response in Oak Park about five years ago. That was our first introduction into AIDS services. We have talked today a lot about what services people need that are HIV/AIDS impacted. We used the Shelter Plus Care Program with Community Response. HUD provided the sheltering part of the funding and the Department of Human Services then provided the care part, the services part. This has been a very successful venture for both of us. It allows us to take our populations, look at them and ask how can we put all these pieces together.

Supportive housing is so useful in serving our population because they do not have to repeatedly go out and look for housing and spend one day at a shelter and the next day living with this friend and the next day, and on and on. It is very difficult for you as providers to provide service to people who are constantly moving. We know that eventually they will fall through the cracks and we will have a much more difficult time serving them. So I want to encourage you to contact the potential funders right up front and tell them what you have in mind. We can then help you put your program plan together. Not only just your services plan but to also give you some suggestions and input to your housing plan.

I also want to tell you about a new thing that we are beginning to work on that you may hear about in the near future, a Family Supportive Housing Program. Most of the funding that HUD has is for single individuals. We have also recognized that it is very important for us to talk about families who may need supportive housing. IDHS with the Corporation for Supportive Housing, the Illinois Development Authority, and with a lot of different players have started to ask how can we craft a supportive housing program for families. We know we have to put together a services plan that will respond to all members of the family including the children as well as a housing plan that will be able to provide permanent housing with support services. So that is where we are headed in the near future. Thank you.

Kelvy Brown
Legislative Coordinator
Mayor's Office of Substance Abuse Policy

I will focus today on a form of housing called recovery homes. This is a type of housing that has only recently become licensed. It is licensed by the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse. Becoming licensed as a recovery home opens the door to general revenue funds for paying for stays for your clients, including individuals with HIV/AIDS. Of the fourteen homes licensed in the city of Chicago, Bonaventure House is the only recovery home that targets individuals with HIV/AIDS. There are other homes that are out there that target other populations including women, women with children (not including teenagers), and single adults.

Section 2060 is the rule at the state level that licensed recovery homes. Although the recovery home model is ideal for many people, the state is not heavily investing general revenue dollars or federal block grant dollars into them at the moment. Recovery homes have only become licensed within the last two and a half years so it is a relatively new form of care. It is an excellent set-up for collaboration with treatment providers.

Also, the Illinois Facilities Fund (IFF) offers low cost loans to not-for-profit groups who wish to expand their facilities, property acquisition, renovation of rented or owned property, critical or deferred maintenance needs or refinancing of existing debts. They also offer real estate development consulting and technical assistance and research on not-for-profit facility and finance issues. They are an excellent avenue for finding additional resources to expand your facility or build a new one. The IFF target market is not-for-profits who are not able to obtain financing from traditional lending institutions.

Regarding the Continuum of Care planning process, there are not many treatment providers and recovery homes participating in the process. We believe that although housing and other components are important, that when you sit around the table and put together the plan for this city that more treatment providers and recovery home need to be involved. My office is working on this and many providers are interested in lending their expertise to the planning process.

Ellen Sahli
Senior Program Director
SRO/Supportive Housing
Chicago Department of Housing

Summary

I want to make a few summarizing points. I took a number of similar points from each of the panelists:

1. Housing and services need to be integrated. While it is mandated in some situations, research also indicates that it is good practice and will yield the most results.
2. Local planning efforts lead funding decisions.
3. People with HIV/AIDS pass through many services and might access subsidized or affordable housing through different funding streams.
4. Call to action on the reauthorization of the Ryan White Care Act.

Section 2060.509 Recovery Homes

Recovery homes are alcohol and drug free housing components whose rules, peer-led groups, staff activities and/or other structures operations are directed toward maintenance of sobriety for persons in early recovery from substance abuse or who recently have completed substance abuse treatment services or who may be receiving such treatment services at another licensed facility. In order to be called a "recovery home," the home shall:

- a) provide a structured alcohol and drug free environment for congregate living that shall offer regularly scheduled peer-led or community gatherings (self-help groups, etc.) that are held a minimum of five days per week;
- b) have written linkage agreements with substance abuse providers in accordance with the provisions specified in Section 2060.329 of this Part;
- c) establish a referral network to be utilized by residents for any necessary medical, mental health, vocational or employment resources;
- d) establish a budget which specifies monthly operating expenses and demonstrates sufficient income to meet these expenses plus emergency reserve by providing documentation of access to a minimum sum equivalent to be total of two months of operating expenses;
- e) comply with all applicable zoning and local building ordinances and provisions specified in Chapter 20 (Lodging or Rooming Houses) of the National Fire Protection Association's (NFPA) Life Safety Code of 1994 for any building housing 16 or fewer residents and with the provisions specified in Chapter 17 (Existing Hotels and Dormitories) of the NFPA Life Safety Code of 1994 for any building housing 17 or more residents;
- f) maintain fire, hazard, liability and other insurance coverage appropriate to the administration of a recovery home (i.e., fiscal, personnel, rule compliance, etc) who shall:
- g) employ at least one full-time Recovery Home Operator who is responsible for the daily operations at the recovery home (i.e., fiscal, personnel, rule compliance, etc) who shall:
 - 1) either:
 - A) hold clinical certification from IAODAPCA or receive such certification within two years after the date of employment; or
 - B) have a minimum of 300 hours of education in the field of substance abuse, 50% of which shall have been under clinical supervision of a professional staff as defined in Section 2060.309 of this part; and
 - 2) have a minimum of 2000 hours of work experience or 4000 hours of volunteer experience in the field of substance abuse of which 1500 hours shall have been in direct clinical services; and
 - 3) have two years of continuous sobriety; and
 - 4) provide three letters of recommendation from substance abuse professional staff as defined in Section 2060.309 of this Part; and
 - 5) provide a signed and dated acceptance of the Code of Ethics and established by the Illinois Association of Residential Extended Care Programs (IARECP), 891 South Route 53, Addison, Illinois 60101; and
- h) have on-site at least one Recovery Home Manager who oversees all recovery home activities under the direction of the Recovery Home Operator. Recovery Home Managers shall:
 - 1) hold certification as a National Certified Recovery Specialist (NCRS) as specified by the Assoc of Halfway House Alcoholism Programs of North America, Inc., 680 Steward Ave, St. Paul, MN, 66106, or receive such certification with two years after the date of employment; or
 - 2) hold certification from IAODAPCA or receive such certification within two years after the date of employment; or
 - 3) have one year of continuous sobriety and 60 hours of substance abuse education and training verified by transcripts, certificates of attendance and/or third party signed statements.

Panelists: Betsy Lieberman, Nathan Linsk, Jean Butzen, Dr. Jewell Oates & Dr. Seth Eisenberg
Moderator: Mark Ishaug

Mark Ishaug
Executive Director
AIDS Foundation of Chicago

There are four big questions that we have been asked to think about today on this panel:

- How are agencies adjusting their missions and services to meet the changing needs of individuals living with HIV/AIDS
- What is their vision for an ideal continuum of housing and substance abuse treatment for people living with HIV/AIDS
- What are the institutional, policy and funding barriers to integrated housing services for individuals who are impacted by HIV, mental illness or substance use?
- What policies should be in place to provide better services to these populations.

Betsy Lieberman
Executive Director
AIDS Housing of Washington

This is a very compelling and distinguished topic. Regarding the shift of mission issue, we are an agency that is about to celebrate its twelfth birthday. We were founded with one sole mission: to build the first long-term care facility and day health program new construction for people with AIDS in this country. We thought there would be a cure by the year 2000. Also, when we did the first AIDS housing conference in 1992 in Lisle, Illinois we wanted to call the conference “Planning for the 21st Century” but the whole advisory committee said AIDS will be gone by the 21st century as we will have a cure by then. It is both humbling to me to have to stand before you almost ten years later and be thinking about how to do we meet a larger, more complicated growing need. The shift in our need has changed dramatically from a focus on end of life care to really looking at housing and to house permanently for a long time a range of people with a range of very complicated issues.

In terms of the policy side, housing is a right and every person in this country should be guaranteed a safe, affordable unit. From a pure policy standpoint it pains me that we have to spend every session having to lobby Congress to even retain the amount of funding we have as well as to get slight incremental change. We are at the level of flat funding for existing homeless programs. Unless we figure out how to shake Congress loose to put more money into operating and support service funding what we see is what we get. Our ability to do more than one or two new supportive housing programs for multiply diagnosed in every community is almost next to impossible because the money is just not there to sustain operations. I do want this done responsibly. We cannot build buildings and not be able to operate them.

The second policy piece has to do with housing people who have substance abuse issues. We need to house people wherever they are at on the continuum of using alcohol and drugs. From a policy standpoint, we need to make sure people receive housing and services that can support their well-being and that we end the discrimination that exists in this country.

Nathan Linsk
University of Illinois at Chicago

In terms of policy solutions, first we need a floor of services available to everyone (poor, HIV positive, homeless, users, etc.) based on a level of need that is not as categorical and compartmentalized as services are now. One of the things that has been disturbing in the HIV field is that very often we have been viewed as competitors coming in and competing for the same funds that others have been trying to utilize rather than as collaborators. From the perspective of a client obviously there is really no difference. Where does HIV fall on the list of people's personal needs? A case manager today said that in most cases in minority communities it is fifth or less unless you happen to be acutely ill at a certain point in time or have a child who is ill. That is something for us in the HIV field to think about. We are all trying to serve a common population and trying to do it equitably. We need a basis infrastructure in policy and have been disappointed on the federal level in that there hasn't even been a unified health policy so the states have come up with various ways of achieving that on their own.

Most of the work I have done on HIV and housing was some years ago when the AIDS Foundation of Chicago asked me to look at issues about long-term care here in Illinois. We developed a project called the AIDS Long-Term Care Access Project. We did work with various communities that were affected by the fact that people who needed long-term care were not wanted by any of the current providers. We tried to look at things in a slightly different way. From the perspective of nursing home providers, they did not see a demand for service that would be profitable for them. We adapted our language and our thinking to put it into a context that was reasonable for them. The lessons that we learned there are applicable for all the problems that we are dealing with here. Basically, because people didn't trust each other in the community, no one wanted to refer to each other for services and everyone liked to complain more than they liked to act. One of the ways that we dealt with that was we had a conference called "Opening Doors and Minds" right here in this room about seven years ago and we had your counterparts: people in the substance abuse community, the HIV community and the housing community, come together and try to figure out how to address the problem. Some solutions occurred at that point through legislative changes, through a lot of education and support, and through some real old-fashioned advocacy and brokering of how to solve problems that really opened some of those doors for awhile.

But these doors are revolving, they open and they shut and they open and they shut. So in terms of policy we need to be vigilant. If we have a strong set of expectations that housing is a right, health care is a right, basic human services are a right, we would be on a better course. Instead we tend to have a more patched together approach. It is not so much that way in HIV care any longer given that we have the Ryan White Care Act so we have a structure of an approach in place. Whether it really achieves those targets, the news is still coming in on. We have to have a real policy commitment to having the services there. And an understanding that just because you put money somewhere does not mean the services will get to people in the way they were designed to do so.

Technology transfer is something I have learned a lot about since joining the ATTTC's, the Addiction Technology Transfer Centers. One of the things it means is that you transfer knowledge from one venue to another, from one level to another. In the ATTTC's we try not just to provide training but to also insure that people get the basic information about how substance abuse is in fact brain disease. We make sure that the research that is coming out gets in the hands of practitioners and we try to resolve the barriers so they change their behaviors and provide good care. Now that is a complicated set of ideas. What I would challenge us as a group is to think about ways that we can take knowledge from the different fields who have come together today and really develop transfers between them in such a way that we see some results where it really counts, and that is on the clients behalf.

**President
Lakefront SRO**

I work for Lakefront SRO, and we provide supportive housing for people who are homeless and very low income, right now exclusively for adults but soon also for families. Regarding the first question, the shift in mission, Lakefront, as a supportive housing provider, started out looking only at people who are homeless and over time, used its supportive housing model to adapt to the changing needs of people who are homeless in Chicago.

To give you an idea of how that change has been, the predominant health issue that people had when we started fourteen years ago was alcohol addiction. Of course today we are looking at other severe health needs, not only HIV/AIDS, but also people with substance abuse problems. We estimate anywhere between forty and fifty percent of all the people we serve have a history of substance abuse.

A couple of weeks from now we will be opening a new building in the South Loop. It represents how we have evolved because in that building, besides providing housing for people who are homeless, we have ten units that are set-aside for people who are HIV positive or who have AIDS through the Chicago Department of Public Health. Every one of those units is taken. All of our

SHP units for people who are disabled are gone and taken by people who are HIV positive and have substance abuse and other disabilities.

What we have begun to do is move from the McKinney programs into the other health related kinds of funding to figure out how to meet the changing needs of people with severe disabilities. I think that is a really interesting story because it represents the model for where we need to go as a community of people who care about people whose needs are not being served in the Chicago area.

I will share two public policy ideas as well as concur with what has already been said: I agree that housing, more housing absolutely is needed. We have to fight for more money for affordable housing. We also need to fight for non-compartmentalized services. This is a huge issue. We have systems that just don't work together. We need universal approaches from HUD and HHS and everyone else that weighs in on this.

Also, on a daily basis there is a severe need for health services for our people who do not have health insurance and do not always know that they are HIV positive. For example, we worked with an elderly gentleman, who I'll call Mr. Johnson, who in his late sixties started to lose weight and become very ill. A short time later he ended up in the hospital and discovered he had AIDS and died soon thereafter. That is not an unusual story. People have no idea they have the illness and some are so afraid to know that they don't seek treatment. Without preventative care people are dying much younger than they would otherwise. The other thing I want to mention is that there is a huge need to work with people in all levels of government,

particularly in the federal government, in terms of changing how we view the disease of substance abuse. Also we need to support the tremendous work that has been done by people in the AIDS community to fight against the negative images of people who have that disease. We need to do that for people who have substance abuse issues. It is a health disease.

There is a group called Physicians Leadership on National Drug Policy, which is currently recruiting physicians to lobby Congress on the need to consider substance abuse a health issue. They have compiled statistics that compare the cost of incarcerating someone for a substance abuse problem versus treatment and treatment is something like five times cheaper than what it costs to put someone in jail. They have also cited studies that show the risk of inheriting a vulnerability to an addiction. They compare it to the same kind of risk of inheriting asthma or diabetes. And in that sense we really

should be treating drug addiction as a chronic illness.

For those of you who have a family member with a chronic disease, like I do with a son with asthma, you can look at this differently. I can't imagine going to him and saying, 'now if you have one more asthma attack, that is it, you are out!' You realize the ridiculousness when you think of that of how we look at substance abuse treatment.

Again, my policy priorities are:

1. a need to get health services into housing programs, and
2. to deal with image of substance users, i.e. looking at substance abuse as a chronic disease.

These are critical and come together when looking at people who are HIV-positive and substance users.

Dr. Seth Eisenberg
Medical Director
Caritas/Central Intake

My comments reflect what we are doing at Central Intake and also my involvement on the state MISA task force, which is addressing co-occurring disorders with substance abuse and psychiatric illness. At Central Intake, we do not provide treatment services: it is an assessment, referral, and linkage facility.

When talking about populations impacted by HIV, substance abuse and homelessness, we need to include mental illness. It needs to be more than just an add-on. So many of the individuals we serve have all of these co-occurring disorders and in addition are homeless. Also, the co-occurrence of substance abuse and mental illness is a cumulative risk factor for HIV infection. We have to include co-morbid services when we are talking about these populations.

In terms of policy issues that need to be addressed, first the need for integrated services. This is much harder to do than say. The city has been involved in numerous attempts to integrate services and form consortiums, notably Target Chicago and the Mental Illness/Substance Abuse (MISA) consortiums. Bringing people together does not mean that you will provide integrated services. It really requires incredible planning and people finding where their place is. That is a big part of what goes wrong with the processes. People come together but everyone is still looking out for himself or herself. We need a consortium plan where people are both giving and taking.

In terms of the treatment for the integrated services, I would start with comprehensive and longitudinal assessment and diagnostics. That is especially important in terms of MISA issues. You do not know what you have got just by looking at it. Common symptoms can be caused by any one of the co-occurring disorders that we are talking about. Extensive, comprehensive, thorough and ongoing evaluation services are at the basis for providing integrated treatment services.

In general I feel that the more on-site the integrated services are the better. What we have experienced in the MISA consortium are the difficulties in funding barriers and being able to bring different services together under one roof with different funders. Intensive case management appears to be a critical part because that is where the intense relationships are formed.

Another area that should be addressed by policymakers and that is as equally important as integrated services is human resource development. That is, taking care of our service providers on several different levels. They need on-going training because we are asking frontline providers to provide more and more complex types of services to varied populations and they did not come into the field knowing how to do that. We absolutely must support them in terms of their individual training. Sessions like this are also critically important for networking and allowing our service providers to see who they can link with and where else they can supplement services that are needed. In addition, they need support in terms of wages and benefits. We want to keep the people that we have in the field that are doing good work and we do not right now due to low salaries. We also want to avoid burnout so we should build in supports around this.

Finally, consumer involvement needs to be well thought out, articulated and effective instead of just an add on. In general now it is not as effective as it could be. In some situations people drag consumers along to meetings and they sit there and do not do anything. It might be more effective to have consumer's function in an autonomous fashion, determining their own agenda and then bringing that agenda to meetings of the consortiums.

Dr. Jewell Oates
Executive Director
The Women's Treatment Center

I work at the continuum of actually implementing services for this population. The Women's Treatment Center's mission is to provide substance abuse treatment services for women and their children. What we have done over the past ten years is integrated all the various different populations and the different problems that the women come with into our services. We do not just have women who are substance abusers. We also have women who are mentally ill, women who are impacted by HIV, women who have not finished school, and women with developmental delays: we have all types of women. We have tried to develop a continuum of care, or continuum of services so we can work with these women for a period of about two years. We provide detox services, residential treatment services, a recovery home, a transitional living program and outpatient services. We also found in working with these women and children that there are a lot of services that are necessary for the children. We only have children aged zero through five years of age, but there are childcare issues and medical issues. We added a crisis nursery.

Crisis nursery or respite care is an interesting concept to integrate into permanent housing for this population. Programs often figure that children attach to the mother somewhere and just come with her. Programs do not really plan for the types of services and the kinds of space children need. Children's needs must be considered when designing housing and developing policy for families with children. In addition to childcare and adequate apartment space, outdoor space, play space and community space should be considered. There are so many issues that go into housing other than putting a roof over someone's head.

Mark Ishaug

I just want to summarize some of the great things that people on this panel said:

1. *Housing is a human right, health care is a human right, and human services are a human right.*
2. *The importance of educating our partners about needs of substance users, people with HIV/AIDS and people who are homeless. AIDS service providers have a lot to offer to housing providers, addiction providers have a lot to offer to the AIDS service providers, etc.*
3. *The importance of meeting people where they are at – concept of harm reduction as an important starting point on the continuum of substance use services.*
4. *Treat addiction like the disease that it is. Take the AIDS lobby with the advocacy success that it has had to other arenas including the substance abuse treatment arena.*
5. *Importance of considering the type of space that is integral for children and their development.*
6. *Importance of integrated services – it is difficult yet integral and critical.*
7. *Importance of remembering that many of the people we are talking about are also mentally ill. Mental illness cannot be an add-on to these discussions but an important part of a comprehensive service package.*
8. *Intensive case management across all these types of programs is necessary to provide the high quality of care that people with multiple issues need.*
9. *Need for solid human resources, ongoing training/development for staff working in these challenging programs.*
10. *Finally, consumer involvement needs to be well thought out, articulated and effective instead of just an add on.*

Question & Answer Session

Q: How can we encourage people to stop having unprotected sex. Often people are using drugs and making money through sex or just having sex and it has been such a challenge to encourage people to be safe and to have them follow through.

Seth: One avenue to take is the harm reduction model. People who are having unprotected sex may ask “who am I protecting in my harm, I am already HIV positive so what is the difference?” Harm reduction techniques in part begin with values clarification. If you engage someone in those kinds of conversations you come to a common sense of humanity that everyone has and they will identify at bottom root that they don’t want to hurt other people. Then take it from there.

Nathan: Our whole prevention strategy around HIV has been directed towards those who are HIV negative. Counseling and testing and even the recent case management prevention programs have really been designed to reach those people who are negative and to help them stay that way. Early on in the epidemic we thought about it slightly differently. We talked more about the person who was positive and what kind of supports we offered them to avoid transmitting the virus to someone else. This is not so easy to do. In the beginning of the epidemic there were efforts to market condoms different ways by adding scents, different colors and sizes, and things of that nature. What we need to do is develop a prevention technology that would be helpful to people. I don’t know what the answers are. We have gotten trapped into thinking that all we can do is give people advice. We know that when you give people advice and that when we receive advice ourselves very often there are many reasons why we don’t take that advice. We have to think through the steps of how to help people deal with this. Also, we have to put out there that one of the attractions of sex is the mystery and very often it is accompanied by alcohol. When people have had alcohol or other drugs to some extent they may not remember to do the things that we have tried to teach them to do or might not even remember what they did.

We need to figure out ways of speaking more directly about how to achieve prevention both for those who are infected and for those who are not infected. We have done very little except give advice to the person who is infected in terms of not transmitting the disease to others. We assume that if a person is living with HIV that they are not going to infect other people. This might have been useful early on in the epidemic when people had severe symptoms but now we have a lot of people living with HIV who either never have been symptomatic or who have achieved some level of restoration to health post therapy. From a policy perspective we could direct our resources more to thinking about new models in terms of peer support, technologies and in terms of changing the norms so using protection is seen as a positive in our society.

Q: We have found that clients who receive intensive case management early on do better. The problem is to access those funding streams that support these types of services.

Jean: It will take advocacy at the state and federal levels to change how we fund these kinds of services and to move away from compartmentalization of funding. The other problem is how do you get enough funding to train people well to do that case management and to retain experienced people.

Q: As far as resources and availability of services I think that managed care is taking over a big part of determining these things. Services are not as accessible as they were a couple of years ago, especially detox

and things like that. It is frustrating to work with people day in and day out and not being able to help them access the services they need.

Jewell: In thinking about funding, in terms of cost of living for next year for programs funded by IDHS, the legislature is looking at only giving a two percent increase for these community-based services when we really should be getting a 4.5 or 4.8 percent increase. There is nothing to make them do that. But the legislature is the only place where cost of living and de-compartmentalizing funding is going to change. We need to write our elected officials or go down to Springfield and insist that they start funding these kinds of community-based services or housing services, or that they stop putting out funds categorically and that they start combining funding.

Seth: We have to take these ideas and needs back to the agencies we work with and funders and let them know what is required to access the money for the services in the way that we want to provide them. There are a lot of rule barriers that can be looked at and changed with a certain amount of impetus and pressure.

Q: I work as a substance abuse counselor with people who are HIV positive using a harm reduction philosophy and have a substance use management program. What I have found is that traditional treatment and harm reduction philosophies tend to be in conflict with one another, when they can be used in conjunct with each other. I worked in traditional treatment for ten years prior to this setting and when I first heard about harm reduction I said no, its total abstinence. But many in my class were not ready to get clean, so what do I do? Just drop them?

What ended up happening is that I found that I had to adapt my attitude and my approach to working with them to the point that I counseled them toward getting into treatment. For people who decide that they don't want to get clean I have to work with them where they are. I have to teach them how to use crack safely. How not pass their pipe if their lips are bleeding to another person whose lips are bleeding. Some clients aren't even ready to deal with the substance abuse piece. They have so many other anxieties going on and substance abuse is their only coping mechanism. I work with them on developing some trust with going in and letting go of the drugs and taking care of themselves. What I've found is that when people come to groups where someone is talking about learning how to stop or trusting that they can stop what ends up happening is that they exchange information and they begin to take a look at taking that risk to go into treatment.

I would like to say that in working with this group for about a year and a half, when I started 100 percent of the people were using and about 95 percent of the group now are clean. One of the problems has been when they get clean they can't go back to their community and then there is a new conflict, including agency conflict because our agencies are often located in the areas they are now avoiding in order to stay clean. There are a whole lot of issues going on that we really haven't touched on in terms of personal relationships with agencies and the policies within agencies and the different ideologies we have about treatment. We need to come together and meet on one accord with the resources that we have.

Seth: I would expand that notion of integrating models of care into the housing issue in terms of a continuum of housing that can address the various stages of illness or recovery that people are in for their various disorders. That is what the challenge is here, to bring the different models of care together.

Closing Address

Sid L. Mohn

President

Heartland Alliance for Human Need & Human Rights

We have spent much of today listening, learning, presenting, discussing, agreeing and disagreeing. Now is the time for us to begin to weave a consensus, a common base on which we can stand so as to advance an agenda of compassion and an agenda of justice for the individuals that we serve. My role in the next 30 to 35 minutes is that of a facilitator – to facilitate the development of a series of recommendations which can be used by each of us in our individual leadership roles and also recommendations that can be forwarded to a wide array of policy makers and policy entities. In particular, we need to present a consensus change plan from this body to the HIV/AIDS strategic housing planning committee, the Homeless Continuum of Care Planning Council, the city and state’s Consolidated Plan and Department of Public Health planning councils – a wide array of organizations and entities.

Our recommendations will focus on four principle areas: one is population priorities, second is preferred housing and service models, third is policy and funding needs and finally what we would identify as our top three change priorities for the coming year and years. So, given what you have heard today, in particular some of the discussion in the panel and audience participation from our last workshop, let us begin to see if we can come together and craft that common agenda that will serve as a basis for a collective change agenda in the future. I will play facilitator and scribe and rely on you to put ultimate meaning to this conference so that our day-long efforts do not result in just communication and good words but result in good action that serves and changes the future for the people that we are charged to serve.

Population

In looking at population priorities as you have listened and thought throughout today’s sessions, what are the populations that you would urge a light of new compassion to be shown on. Who are the people who are most forgotten amidst our current policy?

- Complexly very ill (who find themselves homeless suddenly due to substance use or mental health)
- People needing nursing care
- People with a mental illness
- People who are homeless
- People leaving the correctional system
- People terminated from TANF
- People who are using alcohol or drugs
- Healthy(HIV positive) but unserved
- Homeless with HIV and other infectious diseases
- Transgendered
- Documented and undocumented refugees
- Non-English speaking
- People with HIV/AIDS who are re-disabled

Housing

What are these housing models and services that you through the discussion of this day have to be most effective and therefore should be replicated through policy and a funding commitment?

- Single Room Occupancy Buildings
- Non-traditional supportive services coupled with housing
- Organic model of housing support
- Flexible funding
- Large family housing
- Scattered-site family housing for HIV-affected
- More affordable housing
- 2 year scattered site transitional housing
- Safe emergency shelters (HIV, Gay/Lesbian, Domestic Violence)
- TB Housing

Non-Housing

- Treatment on demand along a continuum
- Vocational Training
- Flexible funding for counseling, testing, prevention
- Flexible access to services across agencies
- Linkage with spiritual resources
- Medical coverage

Policy Priorities

Lets move onto our next question. What policy commitments do you believe are essential in order to reach these populations with these necessary services. How would you articulate the above in terms of a policy recommendation that we take to the Mayor's office or Springfield or DC?

	votes
• <i>Mandate a continuum of substance abuse services including harm reduction</i>	33
• Shelter plus care flexibility that allows gradual consumer control of lease	5
• <i>Living wage commitment</i>	24
• <i>Affordable rent commitment</i>	40
• Health insurance funded housing subsidy models	4
• Maintenance of neighborhood diversity and countering NIMBY	3
• Integrated /Innovative funding pools	20
• Community based education and planning	1

Summary

We will take responsibility for developing this entire roster of policy priorities and disseminating it to all the various planning bodies, governmental as well as private/public planning bodies that I mentioned earlier as well as distributing it to each individual and organization who is present here so that each of us individually as well as collectively can include these policy commitments in our work in the year and years ahead.

I want to take this opportunity to thank each one of you for spending a day and evolving such a change agenda and to remind each of us that we will still need a pioneering spirit in order to advance such an agenda. Many of you in this room have been long time pioneers working in the field of HIV/AIDS care and advocacy since the early eighties. The battles were fierce in that first decade fighting a relatively unknown physical disease and combating a societal disease of homophobia and moral judgment. Now old pioneers and new pioneers together must be working in this new millennium. I regret to declare that the battles will likely be as fierce if not fiercer than ever before.

As we have heard throughout today, our environmental landscape has changed. Rental housing costs are higher than ever in recent history. Fewer rental units are available. HUD has declared the Chicago market a tight market. Fewer dollars are available now than in the past two decades for new affordable housing development. The disease of HIV is coupled increasingly with other diseases and most particularly with the dis-ease of poverty. And while strides have been made relative to societal acceptance of persons with HIV, social stigmas, bias and ostracizing evil are still virulent on the basis of race and class. Moral judgments against persons with substance abuse diseases and a pariah mentality towards persons with mental health disabilities are still very prevalent public mindsets.

The irony of our age is that even in this economic boom time the largess of our resources has not resulted in a spirit of sharing or in an increased investment in the common good, resulting in growing gaps between the haves and the have-nots and to use a New York Times coined phrase, the have-some-mores. I regret that I can count fewer accepting neighborhoods today than I counted twenty years ago. The times ahead will be tough to achieve this agenda. But as is said in such times, the tough get going. And so all of us need to get tough and all of us need to get going. There are optimistic signs relative to doing that. There are scenes of a new activism in this new millennium. Seattle has been the center of powerful signs of new activism.

So I propose that we not conclude this conference. Rather that we see this conference as a preamble, a preamble to being tough, a preamble to being new activists in a new millennium, to shining a light of justice on persons with HIV, mental illness and substance abuse. A preamble to battling exclusionary treatment and discrimination. A preamble to winning. To winning housing as a right, health care as a right, and human services as a right. We have articulated a platform at the end of this day. And so on that platform, policies and programs have yet to be built. So my colleagues, this conference is not concluding. Rather our conference is just beginning. We thank you for being a part of that beginning.

Conference Agenda

- 8:30-8:50am Welcome: Linda Traeger, Heartland Alliance for Human Needs & Human Rights
Eileen Mattimore, Department of Immunology, Bristol-Myers Squibb
- 8:50-10:00 Opening Briefings
- **National and local HIV/AIDS trends**
Cydne Perhats, Chicago Dept. of Public Health
 - **National HIV/AIDS Housing Trends & Models**
Betsy Lieberman, AIDS Housing Washington
 - **Local Affordable Housing Market**
Janet Smith, University of Illinois at Chicago
 - **Current State of Substance Abuse Services**
Tom D'Aunno, University of Chicago
- 10:00-10:15 Break
- 10:15-11:15 & Concurrent Breakout Sessions I & Concurrent Breakout Sessions II: Choose from 5 topics
- 11:20-12:20pm Innovative housing-based models: Basic overview, lessons learned
- I. Blending Housing & Recovery Services**
Moderator: Steve Clarke, Rafael Center
John Ames, Bonaventure House
Sid Groseclose, First Step Program, Rafael Ctr.

II. Housing Persons Using Alcohol or Drugs
Moderator: Matthew Silver, BE-HIV
Congregate
Betsy Lieberman, AIDS Housing of Washington
Scattered site
Scot Peterson, Safe Start Program, BE-HIV

III. Supportive Housing:
Moderator:
Adrienne Krasowitz, Corp. for Supportive Hsng
Pat Tucker, Lakefront SRO
Jackie Bowens, Community Supportive Living Sys.
Audrey Thomas, Deborah's Place

IV. Supportive Services in the Shelter Context
Moderator:
Maryann Mason, Mid-America Institute on Poverty
Art Bendixon, Interfaith house
Tim Jones, Connexions (Safe Haven model)

V. Housing Families
Moderator:
Shelly Ebbert, AIDS Foundation of Chicago
Congregate
Kathy Doherty, Chicago House
Vicki Edwards, Vision House
Scattered Site
Gwen Mastin, New Phoenix
- 12:20- 2:00 Lunch & Lunch Presentation: Service funding sources panel presentation: current sources, constraints, emerging trends, potential changes
Moderator: Ellen Sahli, Chicago Department of Housing
- Perry Vietti, Department of Housing and Urban Development
 - Shelly Ebbert, AIDS Foundation of Chicago
 - Tracy Fischman, Chicago Department of Public Health
 - Brenda Hanbury, Illinois Department of Human Services
 - Kelvy Brown, Mayor's Office of Substance Abuse Policy
- 2:00 – 2:10 Break
- 2:10– 3:15 Panel discussion: What policies do we need in place to provide better services to very low-income persons with substance use issues and who are impacted by HIV/AIDS?
Facilitator: Mark Ishaug AIDS Foundation of Chicago
- Betsy Lieberman, AIDS Housing of Washington
 - Nathan Linsk, Midwest AIDS Technology & Education Ctr
 - Dr. Jewell Oates, Women's Treatment Center
 - Jean Butzen, Lakefront SRO
 - Dr. Seth Eisenberg, Interventions
- 3:15 - 4:30 Facilitated discussion & Invitation to action:
Topic: Based on your experience and given the issues identified in the previous panel discussion, what are the change priorities for the next 5 years?
Facilitator: Sid L. Mohn, Heartland Alliance for Human Needs & Human Rights

Speakers and Panelists

John Ames: *Director of Programs and Services, Bonaventure House*

John Ames is the Director of Programs and Services at Bonaventure House where he has been employed for four years. Prior to working at Bonaventure House he was the Director of Lake County PADS (Public Action to Deliver Shelter). He is a recovering addict. Issues of housing and health care are among his primary concerns for Chicagoans, especially those impacted with HIV/AIDS. He holds a Masters of Divinity from the Lutheran School of Theology.

Arturo Valdivia Bendixon: *Executive Director, Interfaith House*

Arturo Bendixon is the Executive Director of Interfaith House, a respite, assessment and supportive living center for homeless, where he has worked since 1994. He is also an adjunct faculty member at DePaul University. Arturo is the Co-Chair of the Grantmakers Concerned with Homelessness Task Force and was the Vice Chair of the Partnership to End Homelessness. He holds a Master of Arts in Theology and a Licentiate (Master) in Church Law and Administration (J.C.L.) from Catholic University of America, and a Master of Social Work from University of Illinois at Chicago.

Kelvy Brown: *Legislative Coordinator, Mayor's Office of Substance Abuse Policy*

Kelvy Brown is the Legislative Coordinator for the City of Chicago Mayor's Office of Substance Abuse Policy. He monitors and comments on state, federal and local legislation and regulations regarding all aspects of substance abuse. Prior to this position, Kelvy worked as Public Policy Director for the Public Welfare Coalition and for over two years as a Budget/Program Analyst for the Executive Office of the Governor, Illinois Bureau of the Budget. He received a Bachelor of Arts in Public Service/Political Science from Northern Illinois University and a Master of Arts in Public Administration from University of Illinois at Springfield.

Jean Butzen: *President, Lakefront SRO*

Jean Butzen has served as President of Lakefront SRO since its incorporation in 1986. She has supervised the development of almost 700 units of supportive housing for homeless adults, an investment of over \$24 million. Ms. Butzen led the creation of Lakefront's model solution to homelessness including a 'blended management' approach to housing development. She has won many awards including an Honorary Diploma from Archeworks in 1998, the W. Clement Stone Award from the Uptown Chamber of Commerce in 1998, and the Outstanding Achievement Award for Community Leadership from the YWCA of Metro Chicago in 1994. She is on the Corporation for Supportive Housing National Board of Directors.

Thomas D'Aunno, Ph.D.: *Associate Professor, University of Chicago*

Thomas D'Aunno (Ph.D., 1984, Organizational Psychology, University of Michigan) is Associate Professor in the University of Chicago's School of Social Service Administration and Department of Health Studies, Pritzker School of Medicine. He joined University of Chicago in 1994 after ten years on faculty at the University of Michigan and the Institute for Social Research. Dr. D'Aunno has conducted national studies funded by the National Institute on Drug Abuse (NIDA), the Agency for Health Care Policy and Research, and the Pew Memorial Trust. With grant support from NIDA, he is studying relationships between managed care firms and outpatient drug abuse treatment providers across the US. He is a past chairman of the Academy of Management Division of Health Care Management and past Acting Director of the Graduate Program in Health Administration and Policy.

Kathleen A. Doherty: *President & CEO, Chicago House and Social Service Agency*

Kathleen Doherty, LCSW, CSADC, is the President and CEO of Chicago House and Social Service Agency, a leader in the development of innovative solutions responsive to the changing needs of individuals and families living with HIV/AIDS. Since 1996, she has directed the planning, operation and evaluation of all programs: case management, volunteer management, supportive living, family living and 24-hour care for persons living with HIV/AIDS. Prior to 1996, Kathy worked for fourteen years at Hope Center Youth and Family Services in Houston, Texas, where she directed the operation of a boy's treatment center that serves youth who are physically abused, sexually abused, neglected and/or chemically dependent. Kathy has a Master of Social Work from the University of Houston and is continuing her studies for a Master of Business Administration at North Park University.

Vicki Edwards: *Director of Volunteer Services, Vision House*

Vicki Edwards is the Director of Volunteer Services at Vision House where she has worked for four years. Vision House is one of the nation's first independent living facilities for low-income persons living with HIV/AIDS and their families. Ms. Edwards' duties include outreach with community organizations, HIV/AIDS trainings, service coordination and volunteer recruitment. She is a member of the 4th Ward Organization, a trustee at the Liberty Baptist Church, and a member of the Association of Volunteer Administration and the Chicago Northern District Women's Association.

Seth Eisenberg, M.D.: *Medical Director, Caritas*

Dr. Eisenberg is the Medical Director of Caritas, The Women's Treatment Center in Chicago and Advanced Behavioral Care (ABC), a managed care behavioral health care network. Caritas operates Central Intake and has been in operation for over 25 years, providing medical and clinical assessments for individuals entering Illinois publicly funded substance abuse treatment programs. Previously, as Medical Director of Interventions, he developed, implemented and maintained medical programming and procedures for all Interventions programs. Prior to this, Dr. Eisenberg was the Medical Director of the Charter Hospital of Northwest Indiana,

spent two years at Kahi Mohala Hospital in Hawaii where he managed an adolescent chemical dependency program and in California, he worked for the Marin County Criminal Justice Mental Health System. In July of 1999, he was elected President of the Illinois Council on Problem & Compulsive Gambling and is on the Illinois Task Force on Mental Illness, Substance Abuse & Dual Disorders. Dr. Eisenberg has a M.D. from Chicago Medical School and is on faculty at Northwestern University Medical School.

TRACY FISCHMAN: *DIRECTOR OF POLICY & LEGISLATIVE AFFAIRS, CHICAGO DEPT. OF PUBLIC HEALTH*

Tracy Fischman, the Director of Policy and Legislative Affairs for the Chicago Department of Public Health Division of STD/HIV/AIDS Public Policy and Programs, analyzes state and federal policies that effect people with HIV/AIDS. She sits on the Executive Committee of the CAEAR Coalition (Cities Advocating Emergency AIDS relief), a national organization that advocates for increased funding for Title I and Title III of the Ryan White CARE Act. Tracy also sits on the National Public Policy Committee of the AIDS Action Council in Washington, D.C. and on the Governing Boards of the Illinois Caucus for Adolescent Health, the American Jewish Congress of the Midwest, and is on an Honorary Board for the AIDS Legal Council.

Brenda A. Hanbury *Chief of the Bureau of Homeless Services and Supportive Housing, Illinois Dept of Human Services*

Brenda A. Hanbury is the Chief of the Bureau of Homeless Services and Supportive Housing for the Illinois Department of Human Services (IDHS). Ms. Hanbury is responsible for the administration of Illinois' Emergency Food and Shelter program, Assistance to the Homeless program, and the Supportive Housing Program. These three programs represent \$14.5 million in state funds to provide food, shelter and supportive services to more than 48,000 homeless and formerly homeless persons. She also administers the USDA Emergency Food program, providing oversight of the distribution of food to more than 640 shelters, soup kitchens and food pantries. Prior to her position with IDHS, Ms. Hanbury has held numerous administrative positions within State government including overseeing Illinois' Emergency Shelter program.

Tim Jones: *Executive Director, Connexions Enterprises*

In March 1993, Tim Jones founded and became Executive Director of Connexions Enterprises, an agency that provides shelter, supportive housing and services to adults who are homeless and mentally ill in the Chicago area. Tim is a founding board member of the new Partnership to End Homelessness. He is also a member of Mid-South Hunger Walk Committee, member of Phi Sigma Fraternity, and serves on the Board of Trustees for Apostolic House of Prayer Church. In 1999, he received an Outstanding Service Award and continues to attend workshops and conferences as a member of the National Alliance to End Homelessness. In 1984, Tim attended Wilberforce University in Ohio, majoring on Health Care Administration. He also studied substance abuse at National Louis University, and recently attended Harvard University for Strategic Perspective in Non-Profit Management.

Betsy Lieberman: *Executive Director, AIDS Housing of Washington*

Betsy Lieberman, founder and executive director AIDS Housing of Washington (AHW), is one of the nation's most respected housing developers and technical assistance consultants. She created the nation's first newly constructed skilled nursing facility and day health program for persons living with AIDS. Ms. Lieberman also launched AHW's National Technical Assistance Program that offers a range of planning, consulting and technical resources to AIDS service and housing agencies throughout the country. In 1993, she co-authored *Breaking New Ground: Developing Innovative AIDS Care Residences*, the first book published on AIDS housing development and still the standard text. Ms. Lieberman has presented at numerous national AIDS and housing conferences, has taught at Harvard University's school of design and is a frequent guest lecturer at the University of Washington graduate schools of social work, public administration and community medicine. She served for two years on the Ryan White Title I Planning Council and on the EMSA HOPWA Advisory Committee since its inception in 1994 and has been on the Advisory Committee for the Washington State Housing Trust Fund and joint HHS/HUD planning group for joint initiatives addressing issues for multiply diagnosed individuals. She received her Masters Degree in Health Services Administration from the University of Michigan.

Nathan L. Linsk, Ph.D.: *Professor, University of Illinois at Chicago*

Nathan L. Linsk, Ph.D., is Professor at the Jane Addams College of Social Work at UIC. Dr. Linsk established and serves as Principal investigator for the 6 state federally funded Midwest AIDS Training and Education Center since 1988; he is also Principal Investigator on the Great Lakes Addictions Technology Transfer Center, which provides training and technical support to addictions, health and criminal justice professionals in Illinois, Wisconsin and Ohio. Dr. Linsk has been a leader of the MATEP Adherence Initiative, which has developed clinical tools, system recommendations and programs of personal support to maintain treatment adherence for HIV-affected people. He is co-Director of the evaluation team for Ryan White CARE Title I services with the Chicago Department of Public Health. Dr. Linsk is a Fellow in the Gerontological Society of America and was an Associate of the National Research and Training Center on Social Work and HIV/AIDS, and is a founder and co-chair for the National Association of HIV Over Fifty.

Gwen Mastin: *President/CEO, New Phoenix Assistance Center*

Mrs. Mastin is the founder and has served as the President/CEO of New Phoenix Assistance Center, a non-profit organization, since 1992. New Phoenix was the first scattered site, independent transitional housing and support services program for women and children in the greater metropolitan Chicago area. Mrs. Mastin's background prior to establishing New Phoenix was an educator, engineer, Title I Director, governmental administrator and administrator of a domestic violence center, a substance abuse program and a homeless housing site. She has over twenty years of proven success in social services, and expertise in areas of staff organization, management and strategic planning.

Rev. Dr. Sid L. Mohn: *President, Heartland Alliance for Human Needs & Human Rights*

Sid Mohn is the President of Heartland Alliance for Human Needs & Human Rights, a comprehensive anti-poverty and human rights organization engaged in service and policy solutions to issues of poverty, disadvantage and displacement. He joined the organization in 1980 and serves as the President of its three partner agencies: Chicago Connections, a legal and social service provider; Century Place Development Corporation, an affordable housing organization; and Chicago Health Outreach, Inc., a primary health care organization. Dr. Mohn is a graduate of Temple University, received his Master of Divinity from the School of Theology at Claremont, California and his Doctorate from McCormick Theological Seminary in Chicago. Dr. Mohn currently serves as the Chair of the Board of Directors of the National Immigration Forum, and is member of the Board of Directors of the following organizations: International Social Services and the Ethiopian Community Association Advisory Council. He is active with the AIDS National Housing Steering Committee, Chicago Commission on Human Relations, Co-Chair of the Continuum of Care Coordinating Council and Co-Chair of the AIDS Foundation of Chicago HIV Strategic Housing Plan Committee.

Jewell Oates, Ph.D.: *Executive Director, The Women's Treatment Center*

Jewell Oates has been the Executive Director since 1991 of The Women's Treatment Center, a facility that provides a continuum of services to women eliminating common barriers to treatment. Programs include three residential programs for women and their children, a 16-bed medical detox unit, a recovery home, a transitional living program, a developmental daycare program, a 24-hour crisis nursery, outpatient programs, and a special pre-kindergarten program. Dr. Oates earned her Doctorate of Philosophy degree from Northwestern University, Evanston, Illinois. The degree is in Administration and Policy Studies from the School of Education. She is an appointed member of the Women's Committee for the Illinois Department of Alcoholism and Substance Abuse Advisory Board, and chaired the Governor's Committee on Special Populations for Illinois Plan on Substance Abuse, 1992.

Cydne Perhats: *Associate Administrator, Chicago Department of Public Health*

Cydne Perhats is the Associate Administrator for the Chicago Department of Public Health, Division of STD/HIV/AIDS Public Policy and Programs. She manages a one million dollar budget and vendor contracts as well as develops and implements media, marketing and public relations strategies and initiatives. She has extensive previous work experience as a project manager and program evaluator for projects ranging from *Youth AIDS Prevention* to a study on *Diffusion of Substance Abuse Programs* and has published numerous journal articles. Ms. Perhats has a Bachelors of Science from Oregon State University and a Master of Public Health from University of Illinois.

Scott Petersen: *Director of Case Management Services, Better Existence with HIV*

Scott Petersen has a Bachelor's Degree in Psychology from Loyola University Chicago and in 1993 completed CADC certification with studies at Grant Hospital's *Clinical Training Program for Addictions Counseling*. He has been working with persons living with problems related to alcohol and other drug use since 1991 as an outreach worker, substance abuse counselor, case manager, and coordinator of a housing program for active substance users. Currently, Scott is the Director of Case Management Services at Better Existence with HIV where program services are based on harm reduction philosophies and strategies. He has presented locally and nationally on issues related to homelessness, dual-diagnosis, HIV/AIDS and harm reduction.

Janet L. Smith, Ph.D.: *Associate Professor, University of Illinois at Chicago*

Dr. Janet L. Smith holds a Master of Urban Planning degree from the University of Illinois at Urbana-Champaign and a Ph.D. of Urban Studies from Cleveland State University. This is her third year on the faculty in the Master of Urban Planning and Policy Program at UIC. Currently Janet is a Great Cities Scholar at UIC where she is studying the redevelopment of public housing in Chicago. She is looking at how changes in federal policy intended to transform public housing, particularly the HOPE VI program, are being interpreted and implemented at the local level. Working this past year with a team from UIC and the Urban Institute in Washington, DC, she served as a principle investigator for the recently completed Chicago Region Rental Market Study. As co-team leader, she helped direct the collection and analysis of data in order to assess current status of affordable rental housing in six county area and factors affecting supply and demand.

Audrey Thomas: *Associate Executive Director, Deborah's Place*

Audrey Thomas has worked with people who are homeless for eighteen years, the past thirteen at Deborah's Place providing direct service, advocacy and administration. Deborah's Place is a fifteen-year-old human service organization that serves women who are homeless or formerly homeless by offering a range of residential programs, support services and 129 units of supportive housing. As Associate Executive Director, she oversees program planning, operations and evaluation that is participant-centered.

Pat Tucker: *Senior Vice President, Lakefront SRO*

Patricia Tucker has a Masters Degree in Industrial Psychology. Since 1991, Ms. Tucker has worked with Lakefront SRO, an organization that provides permanent housing for men and women who are homeless or in danger of being homeless. Lakefront SRO also provides in-house social services and substance abuse treatment for its tenants. She has helped establish the supportive housing principle of Blended Management, which balances the goals of social services and property management to ensure that residents' needs are met while the building remains safe and secure. Recently, Ms. Tucker has worked to redefine supportive housing to include employment and recovery. And finally, she is leading the organization in its groundbreaking effort to partner with the Chicago Housing Authority and the Mayor's Office of Workforce Development. Ms. Tucker is a member of the NAACP, the American Psychological Association and the Greater Chicago Association of Industrial and Organizational Psychologists.

Conference Attendees

Bruce Aaron
Chicago Connections
Rafael South Consultant

David Allen
Canticle Place

John Ames
Bonaventure House
Director of Program Services

Charles Anderson
Chicago Connections
Rafael Center Case Manager

Clifford Armstead
South Side Health Center
Supervisor Outreach Team

Derrick Arna
Cathedral Shelter of Chicago
Community Outreach

Roosevelt Banks
BRASS Foundation
Counselor

Art Bendixon
Interfaith House
Executive Director

Chris Bohlander
Chicago Connections
Rafael Center: Next Step

Jerry D. Bolden
Lawndale Christian Health Center
Case Manager

Jackie Bowens
Community Supportive Living Sys.

Pat Boyle
AIDS Ministry of Illinois
Housing Specialist

Kelvy Brown
Mayor's Office of Subs Abuse Policy
Legislative Coordinator

Veronica Brown
South Side Help Center
Case Manager

DeShanna Brydlong
TASC, Inc.
Health Educator

Paul Buchholz
El Rincon Community Clinic
Deputy Director

Valerie Burgest
Sinai Family Health

Earl Burl
Jackson Park Hospital/Medical Center
Counselor

Marylalice Burse
Sinai Family Health Center
HIV Case Manager

Allen Burson
Haymarket House
Coordinator

Robert Butler
Chicago Connections
Rafael Center

Jean Butzen
Lakefront SRO
Executive Director

Troy Cargo
Chicago Connections
Supportive Housing

John Carter
BEHIV
Case Manager

Dorothy Chvatal
Chicago Connections
Rafael Center R.N.

Anthony Clark
The Greater Chicago Committee
Director of Programs & Admin

Steve Clarke
Chicago Connections/Rafael Center
Housing Coordinator

Michelle Coffin
Chicago Connections/Rafael Center
Administrator

Jen Cox
Midwest AIDS Technology & Education Center

Candi Crause
Champaign-Urbana Public Health
Case Manager

Evelyn Creed
HOPE Village
Director

Jeanne Crenshaw
Community Response
Housing Advocate

Crystal Culler
Cermak Health Services
Public Health Edc.

Sharon Curry
Roseland Hospital

Tom D'Aunno
University of Chicago
Associate Professor

Derrick Davis
Lakefront SRO
Employment Manager

Ms. Murrie Davis
Prevention Thru Education

Paula Davis
Concerned Citizens, Inc.
Case Manager

Stephanie E. Davis
CDPH
Public Policy & Programs

Andrea Densham
CDPH
HIV Program Coordinator

Amy Derringer
Chicago Connections
Rafael Center

John Dinauer
Chicago Connections
Rafael Center

Jodi Doane
Ulich

Kathy Doherty
Chicago House & Social Svc Agency
President & CEO

Diane Drzymkowski
TASC, Inc.
Team Leader

Shelly Ebbert
AIDS Foundation of Chicago
Director of Service Coordination & Planning

Vicki Edwards
Vision House
Director of Volunteer Services

Dr. Seth Eisenberg
Caritas Central Intake
Medical Doctor

Mary-Lynn Everson
Chicago Health Outreach
Mental Health Services Director

Tracey Fischman
Chicago Dept. of Public Health
Dir. of Policy & Legislative Affairs

Cassie Fleig
Chicago House & Social Svc Agency
Resident Manager

Ewing A. Foulks
Safer Foundation
Dir. of Intake/Prevention Svcs

Ericka Fox
Ascension Respite Care Center

Andrea Fuller
Haymarket House

Kenya Garrett
Chicago Women's AIDS Project

Tonya Gilbert Haymarket House	Cynthia Jones Deborah's Place Health Services Coordinator	Ebed Ma'leeh Community Supportive Living Sys.
Sterling Gildersleeve A Safe Haven Executive Director	Jeffrey D. Jones Community Supportive Living Sys. Case Manager	Lawrie Marshman Community Response S+C Advocate
Vince Gillon BEHIV	Tim Jones Connexions Executive Director	Maryann Mason Mid-America Institute on Poverty Director
Ralph Gougis BRASS Foundation HIV Counselor	Christine Kahl TASC, Inc. Administrator	Gwen Mastin New Phoenix Assistance Center Executive Director
Larry Green Champaign-Urbana Public Health Case Manager	Floria Kappa Unity Parenting Counseling Center	Eileen Mattimore Bristol-Myers Squibb Dept. of Immunology Community Liason Specialist
Sid Groseclose Chicago Connections Rafael Center Program Director	Adrienne Krasowitz Corporation for Supportive Housing	Paul McCabe PRIDE Institute Chicago Lakeshore Hospital
Brenda Hanbury Illinois Department of Human Services Bureau of Homeless Services & Supp. Hsng	Allen Skip Land Eric Family Services Program Director	Maria McDonald Chicago Connections Rafael Center Housing Advocate
Jacqueline Hawkins South Shore Hospital Infection Control Manager	Helen Land Haymarket House Health Educator	Rosalind McGee Sinai Family Health Center
Carol J.Hedin Project Vida Inc. Prevention Case Manager	Shannon Lane Chicago Connections Rafael Center Case Coordinator	Ms. AlixL. McMurray BEHIV Clinical Supervisor
Tearella C.Herbert Chicago Connections Rafael Center Program Administrator	Rosemary Lebron Chicago Dept. of Public Health	Sheila McNary Advanced Care, Inc.
Allen Hines Lake County Health Department	Robert Lee Haymarket House	Luciano Medellin BEHIV Case Manager
Michael Holmes Westside Holistic Director of Program Operations	Eula C.Lewis LePenseur Youth & Family Services Dir. of HIV/AIDS Prev.	Wilda Michel South Shore Hospital Infection Control Coordinator
Mark Ishaug AIDS Foundation of Chicago Executive Director	Betsy Lieberman AIDS Housing of Washington Executive Director	Jacqueline Miles Cathedral Shelter of Chicago Director of Social Services
Alice Jackson Concerned Citizens, Inc. Program Coordinator	Nathan Linsk Midwest AIDS Technology & Education Center	Katie Milton Unity Parenting Counseling Center
Michael Jacobs National Equity Fund Senior Portfolio Manager	Mary Loucks U.S. Pretrial Services	Sid L. Mohn Heartland Alliance for Human Needs & Human Rights President
Angelique Johnson Sinai Family Health Centers Program Manager	Elaine R.Love Westside Holistic Director of Health	Esther Moreno Chicago Dept. of Public Health Staff Assistant
Dan Johnson Chicago Connections	Monica Mably Central Illinois Care Consortium	Edith Morton Interfaith House HIV/AIDS Instructor
Erik Johnson Community Response Executive Director	Fred Maclin Community Supportive Living Sys. Case Manager	Michael Mosley Women's Outreach & Support Svcs. Director
Kevin Johnson Legal Assistance Foundation	John Major Indiana Ave. DUI Service	Aesha Muhammad Haymarket House Coordinator

Maurice Murray BEHIV	Brian Rowland A Safe Haven CEO	Audrey Thomas Deborah's Place Associate Executive Director
Sara Musa-Rosario Cermak Health Services Medical Social Worker	Steven Rudolph Lakefront SRO Case Manager	Clarence Thomas Unity Parenting Counseling Ctr.
Angela Natal Central Illinois Care Consortium HIV/AIDS Coordinator	Doug Ryan CCH Div. of Adolescent Medicine Case Management. Supervisor	Charlie Tobin AIDS Care Director of Residence
Robert Norman Community Mental Health Clinical Therapist	Amy Rynell Mid-America Institute on Poverty Policy & Advocacy Specialist	Linda Traeger Heartland Alliance for Human Need & Human Rights/ Chicago Connections Executive Officer
Dr. Jewell Oates The Women's Treatment Center Executive Director	Ellen Sahli Chicago Department of Housing Senior Program Director	Pat Tucker Lakefront SRO Senior Vice President
Pam Outlar Chicago Connections Rafael Center Case Manager	Carmen Sandoval Youth Service Project Counselor	Pyrai Vaughn Miles Square Health Center Case Manager
Ernest Patterson The Greater Chicago Committee Dir. of Client Services	Anne Schaeffer Chicago Connections Rafael Center	Evelyn Vazquez Chicago Dept. of Public Health
Cydne Perhats Chicago Dept. of Public Health Associate Administrator	Sara Schmidt BEHIV Case Manager	Perry Vietti Dept. of Housing and Urban Dev. Community Planning & Dev.
Scott Peterson BEHIV Director of Case Management Svcs..	Edward F.Schurz Magnolia House	Lacey Weil Community Supportive Living Sys. Case Manager
Sharon Pierce Illinois Department of Public Health	Pat Shaw The Women's Treatment Center Nurse	Takala Welch AIDS Care Case Manager
Inita Powell New Phoenix Case Manager	Mathew Silver BEHIV	Joe Whitlock Heartland Alliance
Stephanie Powell The Night Ministry Public Policy Advocate	Rochelle Sims Sisterhouse Co-Director	Clara L. Williams Chicago Health Outreach Housing Resource Specialist
Patricia Pulliam Provident Hospital of Cook County	Jill A. Skole AIDS Ministry of Illinois Executive Director	Craig Williams Sinai Family Health
Mark Putnam AIDS Housing of Washington	Janet Smith University of Illinois at Chicago Assistant Professor	Ronald Williams Chicago Connections Supportive Housing
Patrick Reed Community Supportive Living Sys. Case Manager	Patrice Smith Uhlich	George M. Wilson Chicago Connections Supportive Housing
Jodie Reeser Howard Brown Health Center Case Management. Coordinator	Robert Stewart Chicago Connections Rafael Center	Barbara G. Winston Chicago Department of Public Health
Kristi Riegelman Chicago Connections Rafael Center Social Worker Intern	James Stolz PRIDE Institute LCSW	Chonda Woods Sinai Family Health Centers
Debbie Rijos Haymarket House Supervisor	Bill Streepy Chicago Connections Rafael Center Case Manager	Buford Wright Lakefront SRO Senior Case Manager
Sabrina Robinson Mid-America Institute on Poverty Program Assistant	Paula Taper Mission Metamorphous CEO	Beth Wyatt-Draper Bethel New Life Supp. Housing Program Assistant Director
		Timothy Zenner Chicago Connections Rafael Center Housing Advocate

THE MID-AMERICA INSTITUTE ON POVERTY

208 S. LaSalle, Suite 1818, Chicago, Illinois 60604

WHO WE ARE

The Mid-America Institute on Poverty (MAIP) is the research, policy development, and advocacy department of *Heartland Alliance for Human Needs & Human Rights*. Established in 1989, MAIP's objectives include increased access to health care, employment and housing for low-income persons.

Our Mission

To meet human needs and protect human rights of hard to serve populations, MAIP secures integrated system changes by creating informed dialogue around emerging issues of multi-barriered poverty populations and by advancing findings-based recommendations to policy makers.

Our Partners

MAIP works with service providers, policymakers, community-based organizations, advocates and others in identifying, researching, and developing solutions to poverty and isolation for low-income individuals and families. MAIP seeks to form new partnerships with organizations and programs to work on emerging policy issues. For more information contact Maryann Mason at 312-660-1345 or Amy Rynell at 312-660-1349.

Our Work

Over the past ten years MAIP has emerged as an innovative leader by surfacing issues through research, policy analysis, and policy development, providing resources for policy change, as a campaign leader, and in building programs/meeting needs. In recent years our work has included:

- We are helping to shape new public policies regarding relocation of public housing residents through our current evaluation of the New Start/New Home pilot project, a partnership of the Illinois Department of Human Services, Chicago Housing Authority and the Chicago Low Income Housing Trust Fund.
- Early in 1999, MAIP published an evaluation of program models designed to serve people impacted by HIV/AIDS and homelessness: *Finding the Fit: A Review of Three Intervention Models for working with HIV/AIDS Impacted Substance Users who are Homeless*.
- In 1998, MAIP released the first data in the nation on the impact of federal SSI benefit elimination in *Without a Net: A Study of Early Impacts of Supplemental Security Income Benefits Elimination for Persons with Disabilities due to Drug and Alcohol Abuse in Cook County, Illinois –Impacts, Policy Alternatives and Action Steps*. The study has been distributed nation-wide and is being used by numerous groups in advocating for changes in local and federal policies to ameliorate the negative impact of benefits elimination.
- MAIP's 1998 release of *Building Linguistic and Cultural Competency: A Tool Kit for Managed Care Organizations and Provider Networks that Serve the Foreign-Born*, is a groundbreaking collection of materials to help managed care organizations make strategic changes in their approach to serving cultural and linguistic minorities. This publication presents state of the art thinking and key information on legal issues, staff training, organizational development, and management.

For a full publications list please contact Sabrina Robinson at 312-660-1342.



