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Special Housing Needs Location Study: A Special Housing Needs Task Force

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SPECIAL HOUSING NEEDS LOCATION STUDY

A Report Presented to the

SPECIAL HOUSING NEEDS TASK FORCE

by the

CENTER FOR URBAN STUDIES

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For a number of years the City of Portland and Multnomah County have experienced a heightened awareness of the increasing demand for safe, sanitary, and affordable housing for people with specialized needs. The City Council, in February 1982, and the Multnomah County Commissioners, in April 1982, approved resolutions which established a Special Housing Needs Task Force. The Resolution requested the Task Force to provide the following:

A description of the various types of special needs populations and associated problems of those with "special" housing needs.

A description of the resources presently available to meet these needs, and additional housing resources required.

Recommendations for changes in City, County, or State codes, licenses, and other regulatory tools which affect the provision of adequate housing to meet the specialized needs of this population.

It was determined that the following populations should be represented on the Special Needs Task Force: Mentally Retarded, Emotionally Disturbed, Physically Handicapped, Alcoholics, Battered Women, Ex-Offenders, and Homeless Youth.

Several Types of housing are used by special needs people. According to the Report and Recommendations of the Special Housing Needs Task force, "for consistency and clarity, the definitions used are those accepted by the state funding agencies." Those categories are: Single Room Occupancy, Rooming House/Boarding House, Satellite Apartment/Semi-Independent Living Program, Emergency Shelters/Respite Housing, Foster Care (Adult and Children's), Residential Care Home, Residential Treatment/-

Training Facilities, Halfway House, Detoxification Centers, Nursing Homes, Community Intermediate Care Facilities for the Mentally Retarded, State Institutions, and Welfare Institutions. Unfortunately, for the purposes of this study, the categorization of Types of Housing is neither consistent nor clear. The categories include a mixture of types of housing and programs that in some cases overlap making it difficult to separate them into clearly distinct entities. The following categories are used in this study (followed by the sources for each category):

Children's Service Division Foster Homes (Children's Service Division currently certified foster homes list)

Detoxification Centers (selected from various lists by program or population designation)

Emergency Shelters (Northwest Pilot Project listing, battered women's shelter list, selections from various lists by program or population designation)

Nursing/Convalescent Homes (Senior Services Division list of Nursing Homes; Multnomah County Adult Care Home Registry; and Portland Yellow Pages)

Residential Care, Treatment, and Training Facilities (Portland Residential Care Facility [RCF] list, Multnomah County Adult Care Home Registry, Multnomah County Alcohol and Drug Subcontract Agencies list, Oregon Mentally and Emotionally Disturbed RCF list, Multnomah County Mentally Retarded/Developmentally Disabled Subcontract Programs list)

Rooming/Boarding House (Multnomah County Adult Care Home Registry, Northwest Pilot Project list)

Single Room Occupancy (Northwest Pilot Project list)

The following are not separately included in the listing:

Community Intermediate Care Facilities (none have been identified in the city or county)

Halfway Houses (they are registered in the city as Residential Care Facilities and are included in that list above)

Satellite Apartment/Semi-Independent Living Program (the ones identified are included on the Multnomah County MR/DD

Subcontract Programs list above)

Retirement Homes and Public Housing (although these categories of housing may equally impact a neighborhood, they were not defined as special needs housing by the Task Force and are not included in this report)

Even with this listing which attempts to define categories by housing type rather than program or population, there was some difficulty in drawing clear lines of distinction. For example, the listing of Adult Care Homes was actually divided into several housing categories.

In this report we are using the term Community Based Residential Facility (CBRF) to refer to the complete listing of categories above.

The trend over the past 20-25 years has been to house special populations in the community rather than in large institutions, however the number of community based residential facilities have not kept up with this increased need. There has also been resistance in communities to some or all of these special populations. This resistance has led in some cases to enactment of legal measures to prohibit exclusion of residential facilities for certain populations. Nevertheless, in Multnomah County and Portland there has not been equal distribution of CBRF's for these special populations in all neighborhoods. There is noticeable evidence of clustering of CBRF's in certain neighborhoods. This clustering is often perceived by some residents to have negative impacts. One goal of the Special Housing Needs Task Force is the integration of special needs populations throughout the entire community.

The purpose of this study, therefore, is to more accurately docu-

ment the actual location of all types of special needs housing, to identify motivating factors for siting of that housing by providers, to identify patterns of resistance to and support for these facilities by neighborhoods, and to document through census data, any correlations between neighborhoods and the presence or absence of facilities for housing special needs populations.

The Center for Urban Studies at Portland State University was contracted to conduct this study. A team composed of Professor of Urban Studies Sumner Sharpe and graduate research assistants James Reitz and Kay Pollack was supervised by a subcommittee from the Special Housing Needs Task Force.

Data for this report was gathered from several sources. First, a comprehensive list of providers from various city and county bureaus was compiled. Lists were obtained from various members of the Special Housing Needs Task Force and other key actors associated with providers of special needs housing. A color-coded dot map has been produced from this information which indicates locational patterns of all categories of special needs housing. Secondly, a sample of providers of special needs housing and representatives of neighborhood organizations were mailed surveys (see appendix for sample surveys and summary results). The provider survey was aimed at discovering motivating forces in the siting process of the provider as well as perceptions concerning difficulties in regulatory procedures, and neighborhood relations. The survey to neighborhood association contacts was aimed at discovering their awareness of special needs housing facilities in the neighborhood, their attitudes toward various catego-

ries of special needs housing, involvement by neighborhood residents in the siting and regulatory process of the facility--either supporting or opposing, and any particular problems or issues which had arisen concerning housing facilities.

The report therefore, clearly shows where CBRF's are located in Portland and Multnomah County and attempts to identify the reasons why a provider chooses a particular location. The forces which a neighborhood may exert on this process are also examined.

This information may lead to development of policy which will provide incentives for more even distribution of special needs housing facilities.

REVIEW OF LITERATURE

SITING ISSUES: Siting issues are common throughout the nation: concerns over property values, crime and safety, traffic and parking and the apparent overconcentration of facilities in certain neighborhoods are raised whenever a new facility attempts to locate. These are the primary barriers to the siting of any facility, regardless of the population it may serve.

PROPERTY VALUES: Many neighborhoods oppose CBRFs on the grounds that they will depress the value of nearby property. Most studies performed over the last twenty years have demonstrated that this fear is unfounded: CBRFs usually have no impact on surrounding property values. However, some exceptions to this rule exist. One study--in Ottawa, Ontario, Canada--showed that CBRFs can have a positive effect on property values. In that study, 62% of property near a CBRF had higher selling prices than property

further away. Another study, performed in Oakland, indicated that CBRFs can indeed adversely effect property values. (Planning Advisory Service Memo, November 1983) (Table of property value studies performed in other cities to be included here)

A second, related issue deals with the type of population served. Property values are no more impacted by a CBRF for ex-offenders than they are by one for the mentally retarded; however, property values do seem to be affected by the age of the population served. Property located near a CBRF for juveniles will typically sell sooner once placed on the market than property near a CBRF for adults. Furthermore, the Oakland study indicates that CBRFs for adults have a greater adverse impact on property values than do facilities for children. (FAS Memo) However, this issue has not been studied well, and to form any conclusions at this time would be premature.

Despite studies throughout the nation on this issue--most demonstrating no adverse effect on property values--this fear remains common.

CRIME & SAFETY: Another misconception is that the residents of a CBRF are more prone to crime and violence than the surrounding neighborhood. This too has been proven false. For the mentally retarded, studies have shown that "they are less likely to become involved in the criminal justice system than nonhandicapped people." (Popular Government Spring 1980) (Emphasis mine). Even neighborhoods containing facilities for ex-offenders and substance abusers fail to show an increase in the crime rate.

CLUSTERING: CBRFs tend to cluster in certain areas; this is the one concern that neighborhoods have that is, in fact, taking place.

VARIABLES THAT AFFECT SITING: CBRFs tend to cluster, often in areas of lower property values and rent, and where residents do not present an organized opposition. Other factors that are important are: the age, race, sex, behavior and physical appearances of the clients; and the socio-economic, ethnic and racial composition, and land use of the neighborhood. All these factors affect community attitudes toward a CBRF. (Journal of Offender Counseling, Services and Rehabilitation, Summer 1982)

These factors become especially important when a new facility is attempting to find a suitable location. Neighborhoods whose residents have higher incomes and better educations will usually accept CBRFs only for the physically handicapped, children, and the mentally retarded. CBRFs for substance abusers, juvenile offenders, and the mentally ill are relegated to neighborhoods of low social status, with a higher percentage of renters, and often a high minority population. In other words, CBRFs for "low stigma" clients can successfully locate in the suburbs, while CBRFs for "high stigma" clients usually locate only in the central city. (Social Service Review, June 1981)

Nationally, residents fear that allowing any CBRF to locate in their neighborhood will encourage still others to locate nearby. Meanwhile, those neighborhoods with facilities are beginning to demand a more equitable distribution. One approach now being tried--and one that should benefit both sides of this issue--is

the enactment of dispersion laws and ordinances. These usually take the form of minimum distance criteria to separate facilities, thereby controlling clustering. Many CBRFs now in existence were "grandfathered" in; even those that have been sited since these laws were enacted could circumvent the ordinances through special permit procedures. Portland, for example, may allow a CBRF to locate within 400 feet of another if it obtains the approval of at least 55% of the occupants and property owners within 200 feet of the boundaries of the proposed site. Due to "grandfathering" and such special permit procedures for new CBRFs, it may be years before the effectiveness of dispersion ordinances can be measured. [City of Portland Density Guidelines for the Siting of Residential Care Facilities, (VI) (B) (2)]

METHODS TO REDUCE OPPOSITION: Opposition to CBRFs is based largely on fear: fear of the clients, of crime, and of a decrease in property values. For any CBRF to locate successfully, it must address and alleviate these fears.

A number of strategies have been used to overcome neighborhood opposition. Approaches most often used are educating the public, lobbying neighbors and appropriate officials, using the media, and inviting neighborhood residents to visit similar CBRFs in other neighborhoods have all proven successful in reducing opposition. (Planning, May 1981)

Another approach that has been used is for the facility to remain low key and to lobby quietly, if at all. In () for example, a halfway house for mentally ill offenders successfully

used this approach:

"Guided by the experience of others, hospital staff concentrated the search in mixed commercial-residential neighborhoods where organized opposition was thought to be unlikely. The next step was the use of a poorly explicated but probably commonly used strategy for moving in. Dubbed by the staff as the 'selective sneak-in,' the strategy called first for soliciting support from a few selected community leaders who could act as advocates for the house should this prove necessary. They were also to become the nucleus for an advisory board. Following this, a quick and unobtrusive entry into the neighborhood was made. The strategy proved successful, in part because the neighbors questions and concerns could be answered more realistically after the fact." (American Journal of Psychiatry, January 1977)

This method is probably quite common; however, its very nature is secretive, and as such has not been studied very well. It is therefore difficult to determine whether this method is more, less, or as successful as establishing open communication.

A third approach involves taking advantage of present ordinances: an organization in California began a residential program for ex-offenders, but limited the size of the program to six persons, thereby avoiding the RCF licensing procedure. Only after this facility had established a positive community presence did it apply for a permit to expand its program. (Correspondence with Joseph D. Ossman, Executive Director, Friends Outside)

Once established, conscientious CBRFs have taken their communication process a step further by establishing a grievance procedure and by inviting local residents to participate on the CBRF board. This allows for steady, two-way communication between the CBRF and the neighborhood, which, when combined with the periodic reviews often required for licensing, permits problems

to be dealt with before they become insurmountable.

STATUTES: To counter the resistance that is common at the local level, many states have enacted legislation that allows CBRFs to locate in residential and commercial zones. These statutes identify and define each type of CBRF allowed; the maximum number and type of residents permitted in each CBRF the zones where CBRFs are permitted; and the requirements--if any-- for their dispersal.

These criteria can take many forms, and include: (1) Allowing small CBRFs outright in any residential zone; (2) Limiting larger CBRFs to multi-family and/or commercial zones; and (3) Limiting the proximity of CBRFs to one another.

Appendix ___ shows that in most states, these laws are applicable only to facilities serving the mentally retarded/developmentally disabled and the physically handicapped, groups that are not thought of as threatening to the surrounding community. Other types of residents--including substance abusers and ex-offenders--are not specifically mentioned in any of these statutes. However, Michigan allows residential facilities for persons in need of supervision or care, and Wisconsin allows facilities for all children or adults, apparently without further restrictions on the type of residents allowed.

DISPERSION ORDINANCES

Distances required between facilities varies considerably, ranging from a low of 300 feet to as much as 3000 feet. Some states permit local ordinances to reduce the distance required,

while other states have no dispersion requirements at all. Distances, rather than being established arbitrarily, can be set according to the density of the neighborhood. For example:

Person/Square mile	Minimum Distance (in feet)
Under 1000	1700-1300
1000-4999	1400-1000
5000-9999	1100-700
10,000+	800-400

("A Place They Call Home" Westchester Department of Planning 1983)

Other possible density standards include (1) Limiting CBRF population to a percentage of of the neighborhoods population; (2) Limiting the size--population or square footage--of the CBRF; (3) Basing limits on the number and size of existing CBRFs (although this has been suggested, we haven't discovered any city or county where this has been tried). (4) Limiting the number of CBRFs per block. However, limiting the number of facilities per block or per neighborhood is not necessarily the most equitable solution, since more densely populated neighborhoods should be able to absorb the impact of without adversely affecting the nature of the neighborhood.

County and municipal ordinances demonstrate similar diversity, and some ordinances exhibit added dimensions. Minneapolis, for example, also specifies minimum lot areas and minimum lot widths, which vary according to the residential zone a CBRF attempts to locate in. (See Appendix ___ Minneapolis ordinance)

Neighborhoods also differ in the types of services and housing stock available, factors that must be taken into account when developing any type of dispersion formula.

LOCATION OF COMMUNITY BASED RESIDENTIAL FACILITIES IN PORTLAND
AND MULTNOMAH COUNTY

Most neighborhoods in the metropolitan area have at least one type of CBRF--usually a CSD foster home--but some do not have any at all. The end result is that some neighborhoods are becoming "institutionally impacted," while others remain free from accepting their social responsibility.

CSD Foster Homes: Childrens Services Division foster homes are the most widespread and the most concentrated, as well as being the most numerous of any CBRF. They are present in almost every city and county neighborhood, and are especially evident in the city's North and Northeast areas. Six neighborhoods--King (30), Irvington (24), Woodlawn (20), Concordia (19), Humboldt (19), and Piedmont (18)--contain about one-quarter of all the CSD foster homes in the metropolitan area. Other neighborhoods that contain a significant number of CSD foster homes are Richmond (16), Montavilla (19), Hazelwood (19) and Centennial (19), although it should be noted that county neighborhoods cover a considerably larger area than their city counterparts, and their foster homes are much more dispersed.

ROOMING AND BOARDING HOUSES: Rooming and boarding houses are also well dispersed throughout the city and county, although they too are somewhat concentrated in the city's Northeast neighborhoods. King, with 25 of these facilities, is especially impacted; this neighborhood contains more than twice as many RH/BHs as any other neighborhood.

A considerably smaller cluster of these facilities is located in Richmond(?) and Buckman(?) neighborhoods; remaining facilities are well dispersed throughout the area.

RESIDENTIAL CARE, TREATMENT AND TRAINING FACILITIES: Residential care treatment and training facilities have clustered primarily in one neighborhood: Buckman. These 13 facilities, combined with those present in Sunnyside (4), Hosford-Abernethy (3), and Richmond (3) make the inner Southeast more heavily populated with residential care, treatment and training facilities than any other section of the city or county. Northwest, with 6 of these facilities is a distant second, while other neighborhoods contain no more than four. It is plainly evident that these facilities tend to locate in the same area.

SRDs: Single room occupancy hotels are located in the Burnside-Downtown area. For many, many years the older, relatively inexpensive hotels and apartments near downtown have served as housing for homeless poor and transients. Therefore, the very populations which they serve have been drawn to the area.

All other housing types--detoxification centers, emergency shelters, and nursing/convalescent homes--display no apparent patterns of location.

Many neighborhoods, however, contain no facilities, or only a very few. Most of the neighborhoods with no facilities are on the west side, and include: Arlington Heights, Westwood Hills, Healy Heights, Corbett-Terwilliger, Crestwood, Marshall Park,

Arnold Creek, Far Southwest, Lair Hill Park, Riverdale, Hillside, West Portland Park, Linnton, and Northwest Industrial. On the east side, only Lower Albina, Columbia, and East Columbia have no facilities of any kind.

Those neighborhoods with only one facility are Sylvan, Maplewood, Jackson, and Collins View, all in the Southwest section of the city.

Neighborhoods with more than one, but no more than five CBRFs include: Ash Creek, South Burlingame, Wilson Park, Multnomah, Robert Gray, Bridlemile, Goose Hollow, Homestead, and Southwest Hills, all in the Southwest; Brooklyn, Reed, Eastmoreland, and Pleasant Valley, all in the Southeast; and Laurelhurst and Hollywood in the Northeast.

METHODOLOGY FOR SAMPLES:

In addition to examining similar research across the United States and detailing actual location of CBRFs in Portland and Multnomah County, contact with neighborhood associations and community planning organizations in the area was made through the use of mail surveys. The list of neighborhood association contacts and city area coordinators was obtained from the Portland Office of Neighborhood Associations. The Community Planning Organizations contact list was obtained from Multnomah County's Office of Citizen Involvement. The total number of surveys mailed to these contacts was 106, and at the date of this writing, ___ completed surveys had been received. (See appendix for sample copy of the surveys including summary response)

The providers of CBRFs number over one thousand, with CSD foster

homes accounting for more than 600 of that number. Since neighborhoods rarely perceive a foster home serving one or few children as a CBRF, we decided to exclude this group from the survey. SRO's were also excluded from the sample because of the history of their locational patterns and population served.

The sample was selected from our comprehensive listing of the remaining CBRFs: Detoxification Centers, Emergency Shelters, Nursing/Convalescent Homes, Residential Care, Treatment and Training Facilities, and Rooming/Boarding Houses. Within each neighborhood we selected at least one case of each type of housing which we found to exist in that neighborhood. If more than five of a particular type of CBRF existed in a neighborhood, 20% of that number was used.

____ surveys were mailed to providers of special needs housing, and at the date of this writing, ___ completed surveys had been received. This is a relatively small number of responses upon which to base any statistical conclusions. Also, proportion of the responses was not the same as the proportion mailed out; some CBRF types responded at a higher rate than others.

NEIGHBORHOOD SURVEY RESULTS:

(Here will be inserted a comparison of perceived number of facilities with numbers actually existing in various neighborhoods)

Well over half of the neighborhood representatives (12 of 21) responded that, in their opinion, some special needs populations are less acceptable in their neighborhoods than others. Of those

twelve, seven indicated that ex-offenders would be less acceptable than others; both drug/alcohol abusers and adolescents were each named twice; Chronically Mentally Ill and Mentally Retarded/Developmentally Disabled were each named once as being less acceptable. One neighborhood representative said that "all" special needs populations would not be acceptable. Perhaps the notable bit of information here is that the Chronically Mentally Ill population received fewer "negative" responses than might have been given the emphasis placed on this population in the literature.

Nineteen neighborhood representatives responded to the question about facilities in their neighborhood generating comments or issues: (see question #4 in neighborhood survey) eight said "yes," seven said "no," and four didn't know whether any of the issues listed had caused comments. This breakdown in itself is interesting in that the responses were split somewhat evenly rather than being mostly positive as one might have expected.

Property upkeep and behavior of facility residents had a slightly greater number of responses, and two comments were listed slightly less frequently than the others: danger to facility residents and quality of program/ staff. Overall, no issue stands out noticeably among the others. Responses remained fairly consistent before and after opening, except that those comments concerning property upkeep were slightly more frequent after opening than before. There was no noticeable difference in frequency among the various forums for airing grievances--public meeting,

local government, founders, residents, or staff.

NEIGHBORHOOD RELATIONS:

In response to the question about how much support or opposition had been expressed by the neighborhood over establishment of special needs housing, generally, more support than opposition was indicated (36 indicated weak or strong support while only 20 indicated weak or strong opposition). The "neutral" category received more responses than any other (47). If this is interpreted to mean not in opposition, then the degree of support becomes even stronger.

Nine neighborhoods associations/community planning organizations had supported siting of special needs housing facilities in their neighborhood, while four had remained neutral and only three had opposed them. Here, again, if one can infer lack of opposition from a neutral response, even more support may be indicated.

Seventeen responses were received from the question: have there been any attitudinal changes toward a specific special needs housing facility in your neighborhood? Positive and negative responses were split fairly evenly: five responded "yes," and six responded "no." The attitude change for better or worse was split evenly--three to three (one neighborhood respondent listed one of each). Reasons given for an improvement in attitude were: more information and the demonstration of need. Reasons cited for worsening in attitude were density (too many already in the neighborhood) and equity (more than their share in that neighborhood)

Nineteen responses were received to the question "have any facilities contacted individuals or groups in the neighborhood before or after the facility opened?" Seven replied "yes," five replied "no," and six didn't know.

The respondents reported the NA or CPD as having been contacted more frequently than other groups or individuals: nine responses in the before opening category, and five in the after opening category. The immediate neighbors were the second most frequently contacted group--six responses in the before opening category, and only one in the after opening category. The reported frequency of contact with the neighborhood group is possibly due to the fact that a neighborhood association representative is completing the survey.

In the follow-up question concerning the degree of support or opposition expressed about each CBRF by groups which had been contacted, a generally high degree of support was noted. The exception was that in one case, immediate neighbors expressed strong opposition while the other groups contacted expressed support. This question had so few responses that it would be difficult to draw any general conclusion from the responses.

PROVIDER SURVEY RESULTS

NOTE: Due to the limited number of completed surveys, the data obtained should be used for informational purposes only.

Providers of special housing consider a variety of characteristics when locating their facilities. Those characteristics that received the greatest number of responses

were, in descending order:

- * Walking distance to public transportation (17)
- * Walking distance to neighborhood shopping/services (14)
- * Close to services provider needs (11)
- * Low purchase or rental price (11)
- * Close to outreach/support services (10)
- * Walking distance to treatment or training services (9)

While neighborhood characteristics are considered, what a provider is more interested in is locating the CBRF where accessibility to public transportation and other services can be maximized. Virtually all respondents are near public transportation; most are near recreational opportunities--such as parks, community centers and theaters--and neighborhood shopping services, while approximately one-third to one-half of the respondents located near treatment/training or other social/support services.

This may explain why so few CBRFs are located in the Southwest: supporting services are few and far between, and public transportation is confined to a few narrow corridors. On the other hand, CBRFs wanting to locate on the east side can almost always find a site within walking distance of services and public transportation. When a potential site is rejected by a provider, it may be due to the lack of services available, as well as the cost and/or inadequacy of the structure.

PARKING--Providers believe that the parking available near their facilities is adequate for staff, residents, and visitors. This belief contrasts with neighborhood perceptions, however (continue with NH comments here)

PUBLIC HEARINGS--Providers indicate some difficulty in obtaining support for their CBRF before opening, but gaining support here is evidently not as difficult as it is elsewhere around the country. In general, providers had little trouble obtaining support at public hearings; after opening, support of the CBRFs increased. This was true even for the CBRF responding that serves ex-offenders. Great opposition was expressed at the neighborhood meeting before opening. After opening, not only did opposition decrease, but support increased.

NH RELATIONS--CBRF staff and founders indicate that they initiate contact with the neighborhood and other interested people or organizations. Contact is primarily focused on the immediate and other neighbors, followed by the neighborhood association or community planning organization, influential individuals, and lastly, other groups or organizations.

This contact increases once the CBRF is open and operating. Respondents indicate that the facility's contact with immediate and other neighbors increases significantly, and with NA/CPD to a lesser extent. Contact with influential individuals and other groups or organizations also increases after opening, but it is unknown just who these people/groups may be.

On-going contact with the residents and staff of CBRFs seems to go a long way toward allaying the fears of the surrounding community. The immediate neighbors of a CBRFs show the most dramatic shift, from reserved support or ambivalence, to strong support. All other groups show a similar pattern, even for the CBRF for ex-offenders. In that instance, immediate and other neighbors

demonstrated strong opposition to the facility, while other groups remained neutral. After opening, all neighbors and groups supported the facility, even to the point of submitting letters of support at the annual RCF re-licensing meeting.

Concerns about traffic, property upkeep, real estate values, and danger to the neighborhood were not in evidence. According to the providers, these anticipated problems were either resolved or failed to appear, and all respondents report good, on-going relationships with their particular neighborhoods.

(Here will follow a bit more on the survey analysis and particularly a comparison on the differences which show up between the perceptions of neighborhood respondents and providers.)