HOUSING AND SUPPORT SERVICES PLAN FOR LUCAS COUNTY CITIZENS RECOVERING FROM CHEMICAL DEPENDENCY

December, 1991

Project Funding

This project was supported by the Alcohol Drug Addiction Services Board for Lucas County, Comprehensive Addition Services Systems (COMPASS) and by Grant #90-DG-F02-7586 awarded by the Bureau of Justice Assistance, Office of Justice Programs, U.S. Department of Justice Programs, and U.S. Department of Justice. The Assistant Attorney General, Office of Justice Programs, coordinate the activities of the following program offices and bureaus: Bureau of Justice Assistance, Bureau of Justice Statistics, National Institute of Justice, Office of Juvenile Justice & Delinquency Prevention, and the Office for Victims of Crimes. Points of view or opinions contained within this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

Document Preparation

Planning Concepts
33 N. Erie St.
Toledo, Ohio 43624

Table of Contents

Introduction

Scope of the Plan

The purpose of this document is to develop a housing and support services plan. This plan will serve as an instrument in the design and implementation of long-term, supportive housing for people recovering from chemical dependency. The plan will provide options in which to establish and operate safe, drug-free, supportive living environments according to the philosophy of total abstinence, participation in 12 step recovery programs and participation in community resource programs. The plan will consider individuals' needs and desires as to the type of housing and services necessary to help maintain drug-free lifestyles. The entire plan will reflect the continuum of supportive housing required for the recovery of chemically dependent people.

Purpose of Plan

The results of this plan will recommend the investment and allocation of resources (fiscal and program) to encourage the development of additional supportive housing programs. Implementation of new projects, in conjunction with existing programs, is expected to complete a continuum of housing and support service opportunities within Lucas County.

It is essential to expand the continuum of care in the Lucas County substance abuse and criminal justice systems due to the deficiency of services presently available and the need for such services.

In order to develop programs which meet the needs of area residents who are recovering from substance abuse, the planning philosophy and process was driven by responses from people in the system. Through this analysis, the plan will illustrate improvements that can be made, foundations that should be built upon, and opportunities to develop and implement affordable, independent and transitional housing with supportive services.

Overall, the plan will assist Lucas County agencies in improving the quality of life for an individual through quality recovery of substance abuse, providing a transitional setting that is safe and drug-free in order to minimize the opportunities for relapse.

Process

In order to complete the plan as defined in the scope, the document included the collection of primary and secondary data. Primary data collection included:

- researching the resources in Lucas County for individuals who are recovering from substance addiction and preparing an inventory of those resources;
- conducting a needs assessment survey of people in Lucas County substance abuse programs;
- investigating local, state and federal regulations which impact the creation of housing and supportive services.

The secondary data collection included conducting a literature review of prior research in substance abuse and supportive housing.

The results of this research have been organized into the current planning document. A typical planning format has been used to report the findings of this research. The following sections are included in the plan:

- Introduction
- Background
- Methodology
- Data Collection
- Data Analysis
- Recommendations
- Conclusions
- Appendix
- Bibliography

The data collection section constitutes the largest share of this document. The issues of substance abuse services are massive in itself, and when combined with the issue of housing, reporting all information becomes very lengthy. It was thus difficult to reduce the amount of data without eliminating essential documentation.

Background

The substance abuse system has undergone a transformation over the past 20 years. In order to plan for the future, it is necessary to understand the past. This section reviews the evolution of the population impacted by substance abuse, changes in the continuum of care model and the increased demand for supportive housing options in the community.

Population

Homeless people have been in existence through a number of centuries; in every society; in good economic times and in poor economic times. Homelessness has been studied and researched over a number of years. The same findings, until the 1980s consistently appeared--that the population of homeless persons consisted "mainly of white, single or unattached middle aged and elderly men. These men were relatively uneducated, lacked occupational skills, had irregular job histories and subsisted on chronically low income or benefit levels. There was also a high prevalence of disabilities among these people stemming from physical or mental illness and especially from alcoholism" (Garret, 1989).

Urban renewal and dispersion of inner-city homeless populations is thought to have disbanded the "skid-row" population. Though, "paradoxically, as skid row areas were eroded, evidence suggested that the number of homeless persons increased" (Fischer, U.S., DHHS, 1991). Homeless people have not vanished. Research in the role of alcoholism among homeless persons was pursued and supported efficiently until the late 1970s when mental illness became the focus and was considered the more prominent problem. The focus of substance abuse was promoted in the 1980s and results indicated a change in population characteristics.

"The increasing size and heterogeneity of the homeless population over the last decade represents a shift from the past when homeless individuals were primarily older male public inebriates" (R.O.W Sciences, 1991). The focus of investigative research has shifted to the recent findings of substantial rates of substance abuse among the homeless population. The role of alcohol/drugs in the lives of homeless people has again become an issue. Recent findings portray the "homeless as younger and more heterogeneous than the old skid row populations and is composed of greater proportions of women and minorities, particularly blacks and Hispanics, an alarming number of families with young children and increased numbers of persons with mental illness and histories of drug abuse. Typical characteristics include poor social relations, poor health and high levels of contact within the criminal justice system relative to the general population" (Fischer, 1991).

Continuum of Care

Programs for the chemically dependent population, homeless or not, have evolved from within state institutional settings for chronic alcoholics to mainly outpatient and short-term inpatient rehabilitative services. Institutional settings for detoxification and mental health purposes provided long-term care for chronic alcoholics decades ago. Services have evolved to meet the needs of the total population who wish to recover from chemical dependency. Programs have been developed to meet the needs of males, females, minorities, incarcerated individuals, adolescents and children to more effectively integrate them into society as functional and capable of living independent lifestyles, free from alcohol and drugs. This remains a challenging task. Services now range from inpatient and partial hospitalization to outpatient/aftercare programs. The individualized approach

to treating the chemically dependent person has emerged from what was previously considered mainly treatment for homeless, skid-row alcoholics in institutional settings.

Residential care settings have also evolved through the system of drug/alcohol treatment. Therapeutic Communities were initiated in the 1960s and provided a community free from drugs/alcohol, supported by fellow recovering addicts. Recovering people were free to reside within the community as long as they remained drug/alcohol free. Therapeutic Communities like "Synanon" were typically started by recovering people who realized a gap in the system of treatment. The lack of supportive atmospheres conducive to clean and drug-free lifestyles was recognized as a basic life need.

At approximately the same time, halfway houses and three-quarterway houses had also been initiated to provide a supportive, transitional atmosphere of recovery. These types of residential settings are monitored by chemical dependency staff and governed by state licensing requirements. Most recently, self-run homes, managed purely on a democratic basis by residents, established with the main premise to reside there, one must maintain clean and drug-free living. The most common and well known model is The Oxford House, established in the mid-1970s.

Self-help groups emphasize reliance on the philosophy of a 12 step method to achieve and maintain clean and drug-free lives. Support groups consist of recovering peers who meet regularly to rely on each other for support and encouragement, with people who share common feelings, situations and the goal of abstinence. Alcoholics Anonymous (AA) was the first self-help group to be established. Other groups such as Narcotics Anonymous and Cocaine Anonymous share the same philosophy of the 12 step method and have evolved based on AA's concept.

A Continuum of Care for recovering people provides an overview of the treatment components available for those who wish to recover. The total continuum of care rests upon one's involvement with inpatient and outpatient treatment, residential care and self-help groups. The interrelationships among each treatment component represents avenues of linkage toward the next step in the recovery process.

Housing

The concept that a safe, drug-free, and supportive residential environment is required for continued sobriety is gaining substantial support within treatment programs. In a recent nationwide study of exemplary treatment programs, Friedner Wittman reported a shifting of emphasis from detoxification services and staff-intensive residential recovery program activities to housing and ancillary support services directed at reducing the problems of substance abuse and homelessness (1989). Programs have begun to initiate long-term services to help maintain abstinence in a self-supervised or minimally supervised residential setting (Wittman, 1989). The key to the success of these programs depends upon promoting and facilitating recovery and maintaining sobriety, rather than intense resource allocation to a time limited detoxification program (Wittman, 1989).

This research is contrary to the present resource allocation process in Lucas County and Ohio. At this time, no funding is allocated through the Alcohol Drug Addiction Services Board for residential programs other than certified treatment facilities (i.e. halfway house with extensive staffing). Within Lucas County, there have been attempts at operating independent supportive housing for recovering substance abusers. By establishing cooperative agreements among

community agencies to provide supportive services, individual housing providers are assuming all financial liability in order to provide a drug-free living environment to people in recovery.

The need for comprehensive supportive housing options have been witnessed on two fronts. First, agencies providing comprehensive alcohol and drug treatment services observe the problems recovering people encounter due to the lack of long-term, safe, drug-free living environments. Too often after detoxification, people have few supportive housing options available to them and thus return to the same environment which promoted their chemical dependency. Such agencies have attempted to meet this demand for supportive housing by operating their own facilities. The operation of this housing has not been consistently available due to operational difficulties. Success has occurred where the treatment providers have worked in association with other community agencies (ADAPT Program, see page 9). But even successful programs face limited funding which jeopardize the availability of safe, stable, supportive housing to members of the at-risk community.

Secondly, recovering substance abusers have indicated that they realize they need a long-term, supportive housing environment. The inpatient, 30-day detoxification and recovery process is not an adequate amount of time for people to learn to live independently of drugs.

Aside from the need to increase the number of housing options, additional consideration must be given to the operation, management, ownership, regulation, and coordination of services and the monitoring of this type of housing. If a residential provider is not receiving federal, state or local funding through the ADAS Board, no programmatic or operational standards are required. The need to secure housing for people who are recovering results in referring people to residential programs which have minimal standards. Without such standards, the potential exists to create housing which does not meet the needs of the recovering population. This plan will recommend a number of such standards in order to guarantee safe, decent, affordable, drug-free, supportive housing. It will remain the responsibility of funding bodies to adopt and enforce such standards.

Summary

As the research has indicated, vast changes have occurred in the delivery of substance abuse services, the availability of supportive housing and demography of people who are attempting to gain access to these services. It has been determined through research that there has been a rapid onset of drugs over the past ten years, especially with crack. As a result, the current plan will focus upon increasing or altering the present service delivery system and developing additional housing resources.

These recommendations are based upon research conducted by Planning Concepts including: personal interviews with people in recovery; treatment staff and administration; review of the current literature and research; housing and support service data collection; and the assessment of housing and land use regulations. The sole purpose of the recommendations is to increase the availability of supportive housing options to Lucas County citizens in recovery from substance abuse.

Methodology

The methodology used to prepare this plan included the collection of both primary and secondary data.

Secondary Research

Secondary research is defined as a comprehensive review of substance abuse through the analysis of material already researched by "field experts". This provides the primary researcher with a detailed evaluation of the issues facing the subject.

The following subjects were researched through journals, articles and other documents regarding:

- Relapse
- Recovery and Environmental Factors
- Motivation and Personality Factors
- Recidivism
- Change and Utilization of Community Resources
- Supportive Housing
- Costs of Homelessness Versus Benefits of Housing

Primary Research

The purpose of conducting primary research is to evaluate housing and support services as they relate to the substance abuse and criminal justice systems in Lucas County.

Primary research for this project was conducted to determine the needs and status of recovering Lucas County citizens in terms of present housing and support services.

Three primary research tools included:

1. Conducting an **inventory of community resources and continuum of supportive housing** to identify and review programs presently available for using and recovering substance abusers;

2. Conducting a **needs assessment** to determine housing and supportive service demands necessary for people recovering from chemical dependency;

3. Reviewing and assessing **local, state and federal regulations** to identify mandatory requirements surrounding housing and support services.

All primary research was completed by the staff of Planning Concepts.

Inventory of Community Resources/Agencies

In order to determine the housing and support service programs available for recovering substance abusers, an inventory of community resources in Lucas County was conducted. This inventory includes several non-profit agencies that provide housing and supportive services for people who are recovering from their addiction.

Through meetings and telephone interviews, descriptions of 19 agencies were collected and compiled in annotated form (see pages 21 through 38). Included in the summaries are the programs' overviews, target groups, fees, and administration. The inventory is also intended to be used as a resource guide for potential coordination among existing programs, as well as an educational guide for those wishing to establish new housing and support programs.

Needs Assessment Survey

The most direct method to determine the needs and perceptions of recovering individuals is to survey the individuals. Upon completion of the community inventory, eight agencies permitted their clients to be interviewed. People from the following programs were surveyed:

- Aurora Project
- COMPASS
- FORWARD
- Idle Time
- Jerusalem Outreach Center
- Lucas County Jail
- Salvation Army
- SASI

A non-random sample survey was conducted using 100 Lucas County recovering substance abusers. Respondents were staying in various outpatient, transitional, long term residential, and criminal justice programs. Because the respondents were not a random group, the certainty of the results can not be calculated to a specified margin of error. However, the results accurately indicate trends in housing and supportive services requested by recovering substance abusers.

Responses from the surveys were cross-tabulated and evaluated to determine specific needs regarding housing issues, support service issues, and environmental factors concerning drug using and relapse. Basic demographics were also calculated to determine the majorities of substance abusers in terms of sex, age, race and marital status.

Local, State and Federal Housing Regulations

Based upon the present regulations, the development of a supportive residential environment will necessitate the involvement of a number of regulatory agencies. Depending upon the location of a planned home, the type of supportive services provided on site, number of people occupying the dwelling, and the age of the occupants, a number of regulations will impact the development of a safe, drug-free living environment. These regulations include local zoning and building codes, fire safety codes, and licensing requirements by the Ohio Department of Alcohol and Drug Addiction Services and the Ohio Department of Health.

The Fair Housing Amendment Act of 1988, effective March 12, 1989, serves as the first legislation to bring people with disabilities under the protection of the federal fair housing law. This law will have a sweeping impact on land-use regulations affecting housing for people with disabilities. Many government imposed restrictions on the ability to open group homes or other housing for people with disabilities will be a violation of federal law (Mental Health Law Project, 1988). According to the Act, individuals in drug and alcohol recovery programs are a protected class.

Depriving such individuals of housing, or evicting them would constitute irrational discrimination that may seriously jeopardize their continued recovery (H.R. Rep No. 711, 1988).

Data Collection

Secondary Research - Literature Review

Researchers agree that there is a lack of housing for low-income people. The end of the 1980s produced research indicating that efforts were necessary to increase the availability of housing within our nation. Shortfalls of up to 5 million units in comparison to just a sufficiency of units in the 1970s was apparent (Curtiss, 1991). People with chemical dependency problems have become overrepresented among the displaced, homeless population. They will continually recycle through the public systems if additional housing is not provided. "Losses of low-income housing especially suited to homeless people with alcohol and drug problems have been particularly severe," (Curtiss, 1991).

Another source of concern for the chemically dependent population is the loss experienced in the closing of units for chronic substance abusers within state mental institutions as well as private hospital programs. Funding has been decreased in a movement to promote community integration instead of institutionalization. Throughout the past decade it has become apparent that some form of managed housing on an affordable basis is necessary for recovering people, in order to obtain and maintain long-term clean and drug-free lifestyles without prominent chance of relapse.

In order to evaluate the present philosophy of supportive housing systems and provide additional options, an extensive literature review was conducted. The following topics were examined:

- Relapse
- Recovery and Environmental Factors
- Motivation and Personality Factors
- Recidivism
- Change and Utilization of Community Resources
- Supportive Housing
- Costs of Homelessness and Benefits of Housing

These topics will provide a foundation for the recommendations which result from this planning effort.

Relapse

Research indicates a connection between environmental factors and relapse. A number of situational and environmental stressors appear to be associated with relapse in all types of addiction including smoking, drinking, gambling, overeating and narcotics. Helen Annis et al., 1990, reports a study of drinking behavior performed by Annid, 1982. An inventory of drinking situations reported eight common categories of relapse:

> experiencing unpleasant emotions
> physical discomfort
> pleasant emotions
> testing personal control
> urges and temptation
> conflict with others
> social pressure to drink
> pleasant times with others.

"Relapse is the process of becoming dysfunctional in drug-free, clean lifestyle, due to symptoms that lead to either renewed alcohol or other drug use, physical or emotional collapse or suicide. It is a process marked by predictable and identifiable warning signs, that begin long before alcohol, other drug use or collapse occurs" (Gorski, 1990). Relapse is the interaction of "biological, psychosocial, social and spiritual factors that impel the recovering person to engage in the behavior that he/she knows to be dangerous and self destructive. It is a continuous impulse and a characteristic of chemical dependence" (Weiner, 1990). The process of relapse typically begins when an addict begins to embrace mistaken beliefs that enforce irrational thinking, thus identified as the "addiction centered belief structure" (Gorski, 1990). The process continues when the addict then begins to relapse into addictive thinking, experiencing painful, unmanageable feelings and emotions. Finally, the addict initiates reactivation of self-defeating, uncontrollable behaviors as a way to cope with the pain. Contact with the subculture of addiction through drug-centered people, places and things gradually leads the addict back to chemical use (Gorski, 1990).

Treatment that is not relapse-prone has not been effectively developed to date, though essential elements for recovery have been indicated in a wealth of research. The element which is most relative to this plan of housing and supportive services for the recovering population is environmental factors affecting relapse.

Recovery and Environmental Factors

Common objectives of individuals in the recovery process are:

- recognition of chemical dependency as a disease;
- recognition of the need for lifetime abstinence from all alcohol/drugs;
- development and use of an individualized program of recovery which would serve as an ongoing aid in maintaining abstinence and the identification of other problems and/or circumstances which may disrupt the recovery process.

Stressful life events and one's personal view of the impact of such situations influences the process of recovery and relapse. Ex-drug users report that relapse follows stressful events or periods of depression. In retrospective view, ex-drug users reported that high stress levels were associated with greater risk of relapse.

Giving up a drug-centered lifestyle is a difficult task which requires behavioral change and much support through structure, stability and predictability. Achieving this task is a challenge and often impossible for people who return to their original drug-infested environments after completing a drug treatment program, or upon release from correctional institutions. Wittman, 1989, reports a study in which findings indicated that "most homeless graduates of programs have no alcohol-free, physically secure place to live after establishing sobriety in primary recovery. They are often referred to self-care, general welfare and are advised to seek an AA meeting." This is also applicable to incarcerated individuals who return to drug-infested areas upon release. Maintaining drug-free, clean living may be more difficult to resist if one is "forced to reside in a blighted inner-city community, surrounded by poverty, illiteracy, dilapidated housing, unemployment, broken families, high crime rates, random violence, rampant drug dealing and use, inadequate schools, high infant mortality rates, filth, poor health care and inadequate public services" (Weiner et. al., 1990). All the preceding situations represent high stress factors which influence relapse.

The ability to survive these conditions as well as maintain clean and drug-free living is difficult. The recovery process requires that one be acquainted with the signs and symptoms of relapse in order to prevent its occurrence. Further, everyday environmental experiences stimulate a drug-seeking and -taking behavior. Prior personal relationships, locations, or passing the corner where one bought drugs appears to trigger a revival of drug craving, even in situations where abstinence has been prevailing for a period of time. Day-by-day experiences include encounters with situations and conditions which stimulate the recall of events associated with drug seeking and taking behavior. Arnold Schecter et al., 1975, suggest that primary reinforcement of drug taking is associated more with familiarity with surroundings and other social reinforcers than with drug effects. Schecter et al. further suggested that "the approach of the rehabilitation of the addict in the community where his addiction thrived, is beset with difficulty. The reinforcers to addiction more than likely outnumber (or are stronger than) the alternatives to treatment".

Numerous negative reinforcements from the treatment standpoint exist in the sub-culture of addiction and are noted as so strong that they are sometimes more powerful and appealing than treatment alternatives and processes. This may indeed be relative to the high rates of recidivism in the correctional system as well as within the substance abuse treatment system. Recovering addicts within treatment programs have minimal or no opportunities to gain prestige, status, recognition or achievement. Drug hierarchies exist within subcultures of addiction and represent the opportunity to gain prestige and status within that community. Participants within the drug/alcohol subculture consider this desirable. Community substance abuse programs may not have the impact to alter this social system for ex-offenders.

A number of reinforcements exist which serve to "keep the addict an addict." Peer group practices and social drug use within familiar environments reinforce the addict's need to gain acceptance through using and abusing alcohol or drugs. Strong influence is directly linked to peer groups and social groups. Experimenting, getting high, and hanging out are required for one to believe he is a member of the group. Community practices and neighborhood value systems which offer prestige and status in drug-seeking and -taking actions are positive reinforcements in maintaining links with addictive subcultures.

Stanton Peele states that researchers Falk and Falk "argue primarily on the basis of animal experimentation, that an organism's environment influences drug-taking behavior more than do the supposedly inherently reinforcing properties of the drug itself." Research further suggests that eliminating the rituals which accompany drug use can cause an addiction to lose its appeal.

Motivation And Personality Factors

It is also agreed that personality may predispose people toward the use of drugs as well as affect how deeply they become involved with drugs at all. Cognitive expectations and beliefs (what one believes to be true) strongly determine and influence reactions to drugs. One's personal thoughts about the need for a drug may also be influenced by the behavior of those around them.

Personality change and total abstinence, in addition to environmental change and support are essential elements for effective recovery. An individual must be motivated and be an active participant in their own recovery. For a person to remain "dry" requires personality change and the drive to do so. Nearly two-thirds of relapses occur within the first six months of recovery (Washton, 1990). Research shows that the longer one is able to maintain clean and drug-free living, the less likely it is that relapse will occur.

The ability to stay clean and drug-free comes from associations with others who are indeed

recovering and who desire to remain that way. The opposite is also clear then, that those who lead addictive lifestyles are supported by associations with others who lead addictive lifestyles. Environment appears to be a leading element in maintaining addictive practices and behaviors as well as in attaining and maintaining clean and drug-free lifestyles. One main principle seems clear for this population, the longer one is able to remain clean and drug-free in a residential, supportive atmosphere, the fewer their relapses. Also the longer they remain an active participant within the residential setting, personality change becomes more likely and the more apt they are to be successful upon gaining permanent, independent housing. Active involvement in 12 step, self-help groups, development of effective coping skills and involvement in community programs to assist the individual in developing necessary skills for independent survival throughout the stages of recovery is required for success.

Recidivism within the Treatment and Criminal Justice Systems

Research indicates that recidivism rates are high within treatment programs as well as among chronic criminal offenders. "Homeless participants who successfully complete residential treatment but who do not find safe, drug-free housing tend to recycle through detoxification services, medical services and jail facilities to reenter treatment programs" (Curtiss et al., 1991). Earl Rubington, 1960, describes a "revolving door game" in which addicted offenders typically commit crimes which lead to police contact, court hearings, sentencing, jail and release, with the cycle beginning over again upon release if interventions are not pursued or are unsuccessful. Rubington points out there is a dilemma, not a choice, for offenders released. The only open, supportive alternative upon release is one in which the offender is familiar with and is most likely to be drinking or drug-taking groups. Recidivism is likely after release as the ex-offender experiences a crisis with the lack of resources available or made known upon release. Rubington claims social and economic support systems have not been made available to chemically dependent people exiting the criminal justice system to address their needs in maintaining drug-free, clean lifestyles. He further indicates that the effects of incarceration and punishment vanish rapidly upon release. The ex-offender lacks social and economic supports and the alternative remains chemical dependency.

Rubington's "revolving door syndrome" was most specifically applied to people during the 50s and 60s who were continually arrested for drunkenness, though also appears applicable today. Views on public drunkenness gradually changed and the Uniform Alcoholism and Intoxication Treatment Act, passed in 1971, "provided legislative groundwork for decriminalizing public intoxication" (Garret, 1989). The result was the development and implementation of medical treatment as the elective, instead of criminal justice system intervention. The continuum of care for substance abusers was thus initiated. "Although networks of detoxification centers, sobering stations and medical units are now relatively common, some point out that these new facilities also promote a revolving door recidivism that parallels the jail cycle of earlier decades" (Garret, 1989). The "revolving door syndrome" appears to remain applicable in present times, within the criminal justice system and within the substance abuse treatment system. Links with supportive community resources upon release remain weak. Recovering people have minimal choices, or no alternatives than to return to original environments where substance abuse activities prevail. Garret remarks, "past literature too, offers numerous examples of cities that sought to help skid row winos and others through special projects at a state or city hospital, at rehabilitation camps far removed from skid row and the permissive drinking culture, or through police- and court-sponsored diversion programs. None of these projects appears to have been successful, but not because they were under funded or lacked honorable objectives. Instead, these men were almost always discharged back to their skid row habitats and back to the homelessness/substance abuse cycle. The treatment of homeless alcohol or drug abusers has little or no possibility of success without the promise of

housing to foster and support alcohol/drug free living. Policies and programs to merge housing with therapeutic and social services during the recovery process must be a major priority in the 1990s" (Garret, 1989).

Changing one's environment to delay relapse and/or control and maintain clean and drug-free living offers turning points in ex-offenders careers and to the recovering population in general.

Economical savings in dollars and cents would be enormous considering the high utilization of treatment within clinics, hospitals and the lengthy time spent in correctional institutions if interventions were designed to meet the needs of recovering people within the correctional system and within the treatment system.

Change and Utilization of Community Resources

Change is dependent on a number of interrelated factors such as environment, personality, structure, opportunities for productivity and participation in community resource programs.

To incorporate change in people who desire recovery from chemical dependency, it is necessary to break their old ties to subcultures of addiction; their groups and their norms and bind them to socially and economically supported alternatives like supportive housing establishments. This will provide the opportunity for transferring dependence on the addiction to the supportive housing establishment instead, to instill its values and norms, reverse the process of relapse and interrupt the cycle of the revolving door game for ex-offenders as well as chronic users of the substance abuse treatment system.

An environment consisting of more than just housing--free from alcohol/ drugs--is necessary to promote abstinence and recovery for individuals who are motivated to accept the challenge. Self-responsibility, supportive relationships with peers and links to community resource agencies will serve to interrupt the cycle of abuse and dependency, and facilitate change for those who so desire. The design should reinforce the need of participants to initiate and maintain independent living skills and lean away from fostering a dependent relationship with the residence itself. Attention must also be paid to the individual, who must be motivated and comfortable with the goals of obtaining and maintaining a clean and drug-free lifestyle. "The goal of each resident should be to promote self-sufficiency and personal growth while maintaining sobriety; the operation of the residence should be designed with this goal in mind" (Fischer, DHHS, 1991).

Providing opportunities for rewarding, productive activities is necessary to be successful in changing lifestyles. Opportunities to establish productivity are provided through a number of alternatives. Community resources may have programs oriented toward vocational training, educational training and job assistance skill building, among others. Links between residents of housing establishments with area programs will serve to promote meaningful, ongoing activities which support change and build a more meaningful existence.

Opportunities provided in conjunction with supportive housing and community programs which address maintaining clean and drug-free lives, will serve to establish the following outcomes:

> "recognize problems clearly;
> improvement in intimate relationships;
> changes in social networks;
> increased work opportunities;

> health concerns
> maturation and a sense of who the addict is or wishes to be" (Peele, 1985).

Recovering individuals will then have an opportunity to promote change and achieve personal goals. Values and goals will be in tune with expectations of self and society. "Changing the addictive lifestyle becomes a permanent investment and commitment and requires involvement that provides rewards that are stronger and more valued than those from the addiction" (Peele, 1985).

The residence itself requires policies and procedures to be designed and implemented, largely by the residents and guided by residential professionals. This incorporates a community system, created by residents, that governs their lives according to values and expectations they have defined. Working together in the management of the household distinguishes the residence from what would otherwise be considered a residential treatment program or an institutional facility. This also supports the premise that the residence is considered a regular home. Remaining free from "residential treatment and institutional governance" does not prohibit the intervention of treatment case managers who visit the home on a case-by-case basis or AA volunteers who hold meetings. This in fact would be comparable to visiting a family household.

Supportive Housing

"Treatment programs accomplish detoxification and clean, drug-free living for brief periods of time and what cannot be provided by them is the necessary, arduous, social-emotional individual and group processes required for addicts to really change their personality and behavior" (Yablonsky and Lewis, 1989). Long periods of time are necessary for stable, drug-free personality development. Housing availability alone will not serve the purpose of stabilization and helping one remain clean and drug-free. Alternative, diverse housing models are needed at various points in the process of recovery, ranging from short-term transitional housing to permanent, independent living arrangements. "Supportive services in the way of recovery interventions must be combined with housing availability to provide an opportunity of safe, drug-free living environments for recovering people in which they will be able to refer to as "home" (Curtiss et al., DHHS, 1991). Curtiss et al. continues to state that "recovering people need more than just housing that is free of alcohol and drugs. The assumption made is that recovering people need an environment specifically designed to promote abstinence, continued acceptance of self responsibility, supportive peer relationships and linkage to other social, health or vocational services when needed." The design of supportive housing establishments should be conducive to building independent living skills. Residents must be motivated and comfortable with the goals of obtaining and maintaining drug-free, clean lives. One main principle appears clear for recovering people: the longer the a period of clean and drug-free lives in a residential, supportive atmosphere, the less likely and the fewer occurrences of relapse. Also, the longer they reside in a supportive environment after detox, the more likely it is they will be successful in preparing for permanent, independent living.

Costs of Homelessness Versus Benefits of Housing

The National Institute of Alcoholism and Alcohol Abuse (Curtiss et al., 1991), reports that "housing can provide gains in three areas for people with alcohol and other drug problems:

- increasing health, well-being and quality of life for otherwise homeless individuals who are in recovery or who are seeking recovery;

- satisfying basic beliefs held by many that even the community's most problematic homeless people should have opportunities for access to decent housing and related services;

- saving on expenses for health, social and protective services that would otherwise be required for homeless people who are drinking and using."

The NIAAA also suggests that maintaining homelessness is likely to cost more than maintaining individual residences for this population. Costs for communities to maintain homelessness is relative to costs of shelters for the homeless, $20 per night multiplied by a number of monthly visits; general assistance is $100 to $200 per month; food stamps are $50 to $90 per month; costs of city police utilization and emergency room episodes will typically amount to hundreds or thousands of dollars, per episode, per person. These costs as compared to the savings generated from the development of residential suppportive settings are higher than if a person is rehabilitated to the level of functioning where he or she could eventually maintain employment and pay for independent housing.

Summary - Secondary Research

While not inclusive, this secondary research indicated that the successful recovery of substance abuse requires:

- a safe, structured, substance-free residential environment;

- an extended period of time (greater than six months) to live in this environment in order to gain the total package of skills to live independently;

- an extensive program designed to meet the needs of ex-offenders who are entering the community; and,

- programs designed to reinforce individual growth, control and self responsibility.

A person's environment plays a critical role in becoming substance free. But this is only one element in a multi-factored addiction. Other elements must be addressed through existing community support services.

Primary Research - Inventory of Community Resources in Lucas County

A guide to community resources serving people who are recovering substance abusers in Lucas County (found on pages 21 through 38) has been developed as a result of conducting an inventory of area resources. The purpose of this inventory was to determine the availability of present services within the area. This guide is intended to provide a comprehensive listing of services for people with a chemical dependency within a single source.

Information for this guide has been compiled through on-site interviews with agencies, telephone contacts, and United Way's First Call for Help Guide to Human Resources. Every effort has been made to make this guide as comprehensive as possible.

Data has been gathered from 19 different resources for this guide. Each of the entries includes the following categories: Target Group/Capacity; Source of Referral; Funding; Overview/Program Components; Administration; and Contact Name(s). Each resource is a part of the continuum of care as defined below.

The Salvation Army Adult Rehabilitation Center

Target Group/ Capacity

The Salvation Army has a capacity for up to 50 people--40 men and ten women.

Source of Referral

Area detoxification programs such as COMPASS and hospitals. They also accept self-referrals.

Funding/Fees

The Salvation Army Rehabilitation program is funded primarily through a work program and the Thrift Store profits. The Center is a non-profit agency.

Fees are based on a sliding scale. If the client has no source of income, the fees are waived.

Overview/Program Components

The Rehabilitation Center provides temporary housing for homeless people who are recovering from chemical dependency.

The Center also offers a "work therapy program" in which residents of the facility are expected to work 40 hours per week for the Salvation Army outlets.

Admission criteria is based on the client's willingness to participate in the program. A 90-day minimum commitment to the program is required. However, residents are allowed to remain as long as they desire, provided that they adhere to the guidelines of the program.

Consumers of the program must attend self-help groups such as AA, CA, and/or NA, as well as attend church weekly.

Upon discharge, many clients return to their original environment or housing arrangements can be made through local housing resources.

Administration

The program is administered by the Major of the Salvation Army. The General Supervisor is in charge of the warehouse and is second in command.

There are one part-time and two full-time counselors at the Rehabilitation Center and other supporting staff to run the office operations.

Contact

Kathy McElroy
Counselor
27 Moorish Avenue
Toledo, OH 43602-0355
419-241-8231

The Aurora House/Project for Women

Target Group/ Capacity

Women recovering from chemical dependency. The housing program serves a total of nine women and their children--seven at one site and two at the other.

Source of Referral

Referrals primarily come from COMPASS and Lucas County Children's Services (LCCS). Other community resource agencies may also refer.

Funding

Funding comes from various entities including the following: The Ohio Department of Development, the United Way, the Community Development Block Grant Fund, Junior League, and LCCS.

Overview/Program Components

The Aurora Project has been in operation since July, 1985. Aurora works in close conjunction with COMPASS and LCCS for referrals, particularly regarding the "Parent/Child Reunification and Recovery Program."

The St. Clair home is a 24-hour staffed facility offering a supportive, structured environment. Average length of stay at this site is nine months, though it varies, depending upon needs.

The Stickney residence is a more independent environment with part-time supervision. Residents stay an average of six months, depending upon available housing within the community.

The project provides programs such as GED training, daily living and parenting skills, and money management.

12-step programs are mandatory for the women, and links with other support programs are also available.

In addition, a day-care program for children residing at Aurora called the "Mustard Seed" is also available.

Administration

The Aurora Project has the following staff: one executive director, two case managers, one full-time house manager, one night supervisor, one life skills director and two part time supervisors.

The child development center has one part time director and four aides.

Contact

Sr. Dorothy Nussbaum
Director
738 S. St. Clair
Toledo, OH 43609
419-241-7975

Lucas County Corrections Center

Target Group/ Capacity

Recovering male substance abusers who are awaiting sentencing and/or serving a sentence at the jail. The program has a 30-bed capacity.

Source of Referral

All participants of the Sober Living Program are self referred during incarceration.

Funding

Funding for the Sober Living Program is awarded by the Criminal Justice Coordinating Council on an annual renewal basis.

Overview/Program Components

The Corrections Center offers the "Sober Living Program" to any male who expresses an interest in obtaining/maintaining sober living.

This treatment program promotes participation in 12-step self-help programs and aids the participants in learning clean and sober lifestyles in preparation for release into the community.

Jerusalem Outreach Center is funded to by the Program to develop links between community programs and incarcerated individuals. This provides alternatives to alcohol and drug abuse for ex-offenders upon release from jail.

Programs such as "Read for Literacy" are available to incarcerated individuals.

The Facility is hoping to expand to provide the same services to women.

Administration

The Sober Living Program includes one program supervisor and one full-time counselor. There will be two other counselors hired upon expansion of the program.

The Program is part of Inmate Services, headed by a director and several floor counselors who aid in court and jail adjustment issues.

Contact

Lois Ventura, Director,
Inmate Services
Enid Black, Supervisor,
Sober Living Program
1622 Speilbusch
Toledo, OH 43624
419-245-4972

Substance Abuse Services,Inc. (S.A.S.I)

Target Group/ Capacity

SASI primarily offers outpatient substance abuse services for recovering men and women. They also provide transitional housing for five men and five women at separate sites. This fiscal year to date (July, 1990 to April, 1991), SASI has served 2,350 people.

Source of Referral

Individuals are referred by community resources such as the criminal justice system, probation and parole offices; Children's Services Board and many others.

Funding

SASI is funded by the Lucas County Mental Health Board. Fees are based on a sliding scale.

Overview/Program Components

Men and women who are motivated to recover from substance abuse are treated at SASI.

Several counseling and treatment programs including 12-step programs, group therapy and support, and intensive day treatment for drug prevention and education are offered. Methadone treatments are also given for IV drug users to abate withdrawal.

The residential program for men and women is staffed 24 hours. Residents must commit to at least 30 days and are required to participate in SASI's programs. Transportation is provided for all SASI programs.

The residential program provides case management to insure planning and follow-up prior to and upon release into the community.

Administration

SASI is administered by an executive director and several support staff.

The outpatient center consists of a clinical director, two case managers and six counselors--all who are full time. A part time psychologist and a part time psychiatrist also administer services.

The residential facility employs a residential manager and a total of eight residential housing specialists (four per site).

Contact

Jennie McCartney,
Residential Manager
Marquita Algee,
Case Manager
SASI
2012 Madison Avenue
Toledo, Ohio 43624
419-243-2168

Open Door Ministries

Target Group/ Capacity

Open Door Ministries is targeted for males seeking support and guidance while recovering from chemical dependency. This residence houses eight men.

Source of Referral

Referrals are received from any organization, agency or individual. Most referrals come from hospitals, missions, churches and self.

Funding

This non-profit facility is funded through private donations. Presently, the organization is seeking private and foundation grants.

Residents are required to contribute a fee if an income has been established.

Overview/Program Components

Any homeless male seeking sobriety and willing to maintain recovery is welcome to Open Door Ministries.

Open Door offers a personalized 90-day program in which the individuals meet once daily for group support. Household chores, cooking, participation in house meetings and small financial contributions are required.

The goal of Open Door Ministries is to get the recovering individuals to return to society in a sober, functional manner.

Typical length of stay at this residence is one year to 18 months. Upon discharge, individuals most likely return to independent housing.

Administration

The executive director of Open Door Ministries and his Associate Director operate all functions of the organization. All other responsibilities are filled by volunteers or consumers.

Contact

Jim Stover, Director
2825 Cherry Street
Toledo, OH 43608
419-242-7281

Formerly Oppressed Recovering Women Reaching for Deliverance (F.O.R.W.A.R.D.)

Target Group/ Capacity

This program is targeted for women who are recovering from chemical dependency. The residence houses six women and their children.

Source of Referral

Individuals are referred by COMPASS, Children's Services Board (CSB), SASI, and other resource agencies.

Funding

FORWARD is funded by the Alcohol and Drug Addiction Services Board of Lucas County.

Women receive financial federal assistance from AFDC and receive food stamps.

Overview/Program Components

Initiated in October, 1990, FORWARD has served a total of 11 women. Its focus is to serve the community as a drug treatment facility and a halfway house for recovering women and their children.

Women who are admitted into the program must have 30 days of documented sobriety before entering and must be motivated to maintain sobriety. The program consists of day treatment, educational and vocational training, independent living skills, and parenting courses.

FORWARD also gives opportunities for women to establish a savings with money placed in escrow during their stay. This provides money for their use upon discharge.

The typical length of stay for these women is four months. CSB provides day care for pre-school children.

A follow-up program is provided with contacts every three months, one year following discharge.

Administration

FORWARD is administered by an executive director, who is also a certified chemical dependency counselor (CCDC). There is one other CCDC and a full-time residential manager. A full-time bookkeeper and a part-time relief residential manager are also employed.

Contact

Elizabeth Watson,
Director
B. T. Washington School
514 Palmwood
Toledo, OH 43602
419-255-4437

Idle Time Club

Target Group/ Capacity

The Idle Time Club serves homeless men recovering from chemical dependency. The housing facility serves 20 men and services are also open to non-residents.

Source of Referral

Community resource agencies such as COMPASS, hospitals and missions refer clients to Idle Time. Self-referrals are also accepted.

Funding

All funding is provided through private donations. Clients pay a $100 fee per month for rent, although no one is turned away if they have no income.

Overview/Program Components

Idle Time Club was initiated to provide support and shelter for men who are recovering from substance abuse/dependency--primarily alcohol.

For admission, the individuals must admit a problem with alcohol/ drugs and have a sincere determination to address and conquer the problem. All residents of the program must remain sober during their stay.

Services offered to the clients are AA and group support. Outside treatment and employment are encouraged. The Club has strict house rules and guidelines all residents must follow to continue their stay.

The Idle Time Club purchased another site for housing and will be placing men into the unit upon receipt of more funds.

Administration

The executive director of the Idle Time Club administers complete facility operations. Volunteers are also available for such duties as cooking and cleaning.

Contact

Donald Allen, Director
2044 Genessee
Toledo, OH 43605
419-691-8882

Comprehensive Addiction Service Systems (COMPASS)

Target Group/ Capacity

COMPASS serves both men and women in their drug treatment center. The detoxification area has 18 beds and the inpatient primary care area has 22 beds.

Source of Referral

Participants in COMPASS' program are referred by local hospitals, other community resources and self.

Funding

Primary funding comes from the Alcohol and Drug Addiction Services Board for Lucas County. The Lucas County Board of Mental Health and other donations are contributed to COMPASS.

Overview/Program Components

COMPASS, initiated in 1967 as a halfway house, serves any chemically dependent individual who desires to recover from his/her addiction.

Treatment programs include detoxification, primary inpatient and outpatient care and support programs (12-step programs).

The detoxification center is monitored 24 hours. The primary inpatient care is an intense rehabilitation program providing a 28-day supported environment.

Outpatient primary care and extended care includes specific programs dependent upon the person's needs. Such specific programs include a homeless shelter project, women's and men's day treatment services and evening outpatient programs.

Other programs serve those within the criminal justice system.

Administration

COMPASS employs 49 employees--several who are recovering. There is one executive director and 16 certified alcohol and chemical dependency counselors.

COMPASS is certified by the Ohio Department of Alcohol and Drug Addiction Services and the Ohio Department of Mental Health.

Contact

Gary Feree
Clinical Director
3350 Collingwood
Toledo, OH 43602
419-241-8827

Volunteers of America

Target Group/ Capacity

VOA is designed specifically for men and women who have been convicted of a felony, many of whom are substance abusers. These people are either ex-offenders, parolees, furloghees or probationers.

The agency has 68 beds and serves approximately 300 people per year.

Source of Referral

Most referrals come from federal and state criminal justice institutions. Others come from parole and probation officers.

Funding

VOA receives funding through the State and Federal Prison Bureau; fees paid by the clients, and through donations.

Overview/Program Components

VOA has been in operation in Toledo since 1906 and has worked with the federal prison system for 20 years and the state prison system for nine years.

The men and women who reside at VOA stay an average of 89 days. Programs that VOA offer the individuals include job skill training, drug and alcohol referrals to community resources, in-house AA, and NA meetings, aid in obtaining their GED and money management.

VOA works in conjunction with the Private Industry Council and the Ohio Bureau of Employment Services for employment and job training assistance for clients.

A daily record of each man is kept to monitor job search activities and recovery programs.

Administration

The agency is staffed 24 hours a day with trained case managers and support staff. VOA employs one executive director, one assistant director, three case managers and several support members.

VOA is certified through the Federal Bureau of Prisons and the Ohio Department of Rehabilitation and Correction.

Contact

David Shade
Program Director
1201 Champlain Street
Toledo, OH 43604
419-241-7191

St. Paul's Community Center

Target Group/ Capacity

The primary target group is people who are homeless. About 80% of the clients served are chemically dependent. The shelter has 30 beds and the transitional home has 14 beds.

Source of Referral

St. Paul's accepts walk-ins and referrals from other agencies. Referrals by case managers are needed for the transitional home.

Funding

St. Paul's is funded by Housing grants, Lucas County Board of Mental Health, City of Toledo, United Way, and the United Methodist Church.

Fees for the shelter are based on a sliding scale.

Overview/Program Components

At the present time, St. Paul's is a shelter for homeless adults with an average length of stay of 32 days. After 30 days, a review process takes place to determine the reason for the client remaining at the Shelter.

The transitional home is expected to open in August, 1991. This will provide transitional living for men, women, and families. One housing unit is handicapped accessible.

St. Paul's provides referral and assessment services to community resources for their clients. This includes referrals to outpatient care, detoxification and 12-step self-help groups.

Residents of St. Paul's Shelter must attend their Day Program daily. The program consists of case management services, educational and job skill training, medical care, psychiatric care, and a payee program. Social Security staff provides screening for individuals for general assistance and SSI. About four people are accepted into SSI monthly.

Administration

St. Paul's has one executive director, a clinical director, a residential services director and a support services director. Services are provided by five case managers and over 500 volunteers.

Contact

Barry Eitel
Clinical Director
Dan Stevens
Residential Services Director
Susan Keller
Services Director
230 13th Street
Toledo, Ohio 43620
419-255-5520

Court Diagnostic and Treatment Center

Target Group/ Capacity

People referred to the Court Diagnostic and Treatment Center are presently within the criminal justice system. Many of these individuals are substance abusers.

Source of Referral

Clients are referred by the court system, probation officers, and the adult parole authority.

Funding

One half of the funding is from The State Bureau of Forensic Services. Other funding is received by the County Commissioners and the Mental Health Board.

Fees for services are charged on a sliding scale basis.

Overview/Program Components

The Court Diagnostic and Treatment Center provides mental health and drug evaluations for the court system to determine competency to stand trial.

This presents conclusions for an individual's criminal responsibility and his/her drug dependency in connection to the offense in pre-trial.

The Center also provides evaluations after conviction to determine treatment potential for each individual.

Treatment programs are available on an individual therapy basis for those people on probation.

Administration

Court Diagnostic and Treatment Center has an executive director, three social workers with Master's degrees, two full-time psychologists, four other psychologists on a contract basis, and two psychiatrists.

Contact

Barbara McIntyre, PhD.
Clinical Director
One Stranahan Square
Suite 353
Toledo, Ohio 43604
419-244-8624

Toledo Rescue Mission

Target Group/ Capacity

Toledo Rescue Mission serves homeless men, women and their children. Lodging is provided for men only. 16 beds are available for transients and long-term units are available for retirees and the indigent population.

Source of Referral

Self referrals and referrals from friends and other resource agencies are the primary sources for receiving participants.

Funding

All funding is provided through contributions.

Overview/Program Components

The Mission provides meals and clothing for homeless individuals, and shelter for transient men. Three meals each day are available for residents and evening meals are served to those who do not live at the Mission.

The average length of stay for residents is about two to three weeks, but many stay longer, depending upon additional housing available.

Staff from the Mission refer those individuals who are chemically dependent to such community resources as COMPASS and SASI for detoxification and rehabilitation.

Spiritual counseling is also available at the shelter.

Administration

The administration of the Toledo Rescue Mission consists of one executive director and two full-time supervisors. The rest of the staff of the Mission are volunteers.

Contact

Receptionist on duty
1917 Jefferson Avenue
Toledo, OH 43624
419-241-6579

Cherry Street Mission

Target Group/ Capacity

The Cherry Street Mission accepts men only. The Mission can hold a total of 64 men in their bunk room, each allotted a stay of 15 days per month. Their are 21 men in their residential program.

Source of Referral

The majority of the clients are walk-ins, however, referrals from area resource agencies such as Rescue Crisis and COMPASS are taken.

Funding

Cherry Street Mission is funded by area churches and private contributions.

Overview/Program Components

Along with the two residential components, the Mission also offers clothing and two daily meals for men, women and children.

Men wishing to enter the residential program must go through a screening process and desire to change through finding a job, recovering from a chemical dependency, etc.

The individuals in the walk-in program can stay 15 days each month and in the residential program, individuals stay an average of 8 months.

There are three parts of the residential program: spiritual, educational, vocational.

All men staying at the Mission must attend chapel every evening at 7:30. There is also a teacher from the Toledo Public Schools who comes twice each week to aid residents in gaining their GED or to further their education.

The Mission also works with Ohio Bureau of Employment Services, Private Industry Council and Goodwill.

Finally, medical care through MCO is also available three days per week during MCO's school year.

Administration

Employed at the Mission are the executive director, the men's division supervisor, evening supervisors, office and clerical staff.

Other duties such as cleaning and security, are completed by the residents.

Contact

James Ritterbach
Men's Dvsn. Supervisor
1015 17th Street
Toledo, OH 43624
419-242-5141

Toledo Hospital Alcohol and Drug Treatment Center

Target Group/ Capacity

The treatment center's target group is privately insured men and women suffering from chemical dependency. The adult inpatient facility holds 34 beds. Aside from the adult facility, the Hospital also has a 24-bed inpatient unit.

Source of Referral

Most referrals are walk-ins or referred through friends, family and/or employers. Recommendations for admission are also made by physicians and the court system.

Funding

Funding for treatment is covered through private medical insurance, Medicaid and Medicare and self payment.

Overview/Program Components

The Center offers a comprehensive program including detoxification, inpatient, partial hospitalization, out-patient, and continuing care treatment.

An initial assessment is completed to determine the intensity of drug addiction to plan individualized treatment.

The detoxification, which is staffed 24-hours, lasts 3-5 days and the 34-bed inpatient facility has an average 21 day stay. A 12-week aftercare program is advised upon completion of inpatient stays. Treatment consists of therapeutic support groups, films and lectures, 12-step group therapy and individual and family therapy.

Day-intensive and night-intensive outpatient treatment is also available. Participants of this program attend therapy four times each week for six weeks, or as long as needed.

The continuing care and aftercare include weekly sessions lasting six to nine months.

Administration

The Center is headed by a full-time executive director. A manager of operations takes care of all facility operations including clerical and scheduling. The Center also staffs an assistant clinical director, a medical director, an activities therapist, six counselors and an outreach coordinator.

Contact

Karen Morse, CEAP
Outreach Coordinator
2142 North Cove Blvd.
Toledo, OH 43606
419-471-2300

Talbot Outpatient Center of St. Charles Hospital

Target Group/ Capacity

Both men and women recovering from chemical dependency are served at this outpatient treatment center.

Source of Referral

All clients of the Talbot Center are referred by the court system, physicians, friend and family and self.

Funding

Primary funding is received through private insurance, Medicaid, and Medicare. People receiving general assistance can be served through the detox program for three days. Detox is available at St. Charles Hospital.

Other funding is obtained through private grants.

Overview/Program Components

Talbot is an outpatient center offering primary outpatient treatment and continuing care for privately insured men and women.

Primary treatment is a three month program consisting of two components. The first portion of the program is a six-week educational group program in which participants meet two times per week. During these sessions, films and discussions are held. Family members of the participants are encouraged to also attend. Individual therapy is also required during these six weeks where participants attend sessions once per week.

The second portion of outpatient treatment consists of group and individual therapy. Meetings are twice per week.

Continued care is conducted for a minimum of three months, once per week following primary treatment.

12-step self-help groups are encouraged three times per week.

The Talbot Center also offers co-dependency treatment for an eight week period.

Administration

The administration of Talbot consists of a program director, a clinical director, two full-time and one part-time therapists, all of whom are certified.

Contact

Rita McDougle
2600 Navarre Avenue
Oregon, OH 43616
419-698-7578

Tennyson Center of St. Vincent Medical Center

Target Group/ Capacity

Tennyson Center has 14 beds for adult men and women who desire recovery from alcoholism and/or chemical dependency.

Source of Referral

All referrals are welcome at Tennyson Center. Primary referrals, however, come from self, family and employers.

Funding

All funding is provided through private insurance.

Overview/Program Components

The treatment programs available through Tennyson Center include a detoxification program, inpatient/adult residential, partial hospitalization, outpatient, aftercare, and family education and support groups.

Provided in the inpatient program are medical support and treatment, and group, individual and recreational therapy.

The outpatient program lasts an average four weeks but can vary depending on clients' needs. The program allows participants to attend sessions in the evenings (four days per week) so that he/she can work during the day or in the mornings for those who work later.

Aftercare/continuing care is 12 weeks or longer, depending upon an individual's needs. Participants in this program attend group sessions for one hour, one day per week.

Administration

This non-profit organization is administered by a medical director, a head nurse, a program manager and a program coordinator who operates both the inpatient and outpatient programs. Others include eight counselors and a nursing staff.

Contact

Lorraine Mason
Program Coordinator
2213 Cherry Street
Toledo, OH 43608
419-321-4886 or
Fred Jordan
Admissions Counselor
321-3170 or
255-5665

Jerusalem Outreach Center

Target Group/ Capacity

All recovering men and women are welcome, however, the Center primarily targets ex-offenders who are chemically dependent.

Source of Referral

Primary referrals come from the court system and the jail. Other referrals from resource agencies and walk-ins are also accepted.

Funding

Funding is received through the Criminal Justice Coordinating Council and the Jerusalem Baptist Church.

Overview/Program Components

A multiple number of services are available for participants of the Jerusalem Outreach Center. Because the Center serves individuals within the criminal justice system, many services are based upon staying clean and sober as well as meeting probation/parole requirements.

The program offered to ex-offenders is titled "Second Chance." This 12-week program provides such services as group/ individual/family counseling and support, GED training, and employment skill training.

Second Chance offers an opportunity for individuals to remain sober and drug-free.

Administration

The Jerusalem Outreach Center employs one executive director and one outreach coordinator who operate the Second Chance program and other activities. Other services are provided through volunteer support.

Contact

Rev. H.M. Crenshaw
Director
445 Dorr Street
Toledo, OH 43602
419-248-2139

Family Service of Northwest Ohio

Target Group/ Capacity

Adult men and women who have emotional problems within family, marriage, employment. Initial screening also determines substance abuse.

Source of Referral

Referrals come from within the community, including mental health centers, United Way agencies, and the courts. Although people may be referred to the Center, all participants refer themselves to therapy.

Funding

Funding for Family Services is obtained from the United Way, sliding scale fees and health insurance (including Medicaid and Medicare).

Overview/Program Components

Family Services offers a wide range of services on an individual, family, and husband/wife basis.

Initial assessment is taken over the phone to determine type of treatment/therapy necessary and if such issues as substance abuse and mental health problems are an apparent problem.

If substance abuse is present, Family Services either allows the person to attend their outpatient therapy groups, or refers them to other community resources, including AA and CA.

Administration

The administration and support service staff of Family Services includes a president/CEO, a director of professional services, a supervisor of clinical services, and both full- and part-time coordinators, counselors, and therapists (12 total). Members of the staff are state certified.

Contact

Donna Koehn
Intake Coordinator
One Stranahan Square
Suite 414
Toledo, OH 43604
419-244-5511

Primary Research - Continuum of Supportive Housing

Individuals who desire recovery from chemical addiction have a number of opportunities for treatment and rehabilitation. Most people who have newly established drug-free, clean lifestyles live within a "Continuum of Supportive Housing." Specifically, the continuum provides opportunities within certain components and generally provides a step-by-step basis to continue rehabilitation. The following is a description of each component of the Continuum of Supportive Housing.

Referral and Information Service

Treatment and rehabilitation for individuals who seek recovery from addiction usually begin with the referral and information process. This results from inquiries about services provided in the community by health care organizations. The service also coordinates contact with other health care providers in order to obtain services for a client. Referral and Information services compile information about alcohol and drug addiction and identifies services available within the community. The service helps to insure accessibility to available community resources for those in need. Services may take place on a face-to-face basis or through telephone contact with the client in need or another individual.

Detoxification

This process results in addicts experiencing withdrawal symptoms usually within the first 24 hours or up to five days after initial contact with the detoxification center. Criteria for admission is generally that the addict has been using chemical substances within the past 24 hours. The detoxification process is required in order to monitor and facilitate the process of safe withdrawal of an individual from alcohol and/or drugs and transition to ongoing treatment. Detoxification means "the systematic reduction of the amount of alcohol and or other drug in a person or the elimination of alcohol and/or other drug from a person's body" (ODADAS).

Detoxification Services may be provided through the following categories:

Hospital Detoxification Services provides face-to-face interactions with an individual for the purpose of alcohol and/or drug addiction detox in a hospital registered with the Ohio Department of Health and certified as an alcohol and drug addiction program. Services are provided on a 24-hour basis and are staffed with a registered nurse and an on-call physician.

Ambulatory/Social Detoxification Services provides face-to-face interactions with an individual suffering mild to moderate symptoms of withdrawal, for the purpose of alcohol and/or drug detoxification. This is provided on an outpatient basis, in a nonresidential setting.

Freestanding Residential Detoxification Services provides face-to-face interactions with an

individual for the purpose of alcohol and/or drug detox in an alcohol and drug addiction certified, non-medical residential program. Services are staffed with a registered nurse and/or licensed practical nurse on a 24-hour basis and supervised by a licensed physician. The physician is also on-call on a 24-hour basis. This could also be considered a managed care program as described below.

Criminal Justice System provides medical service availability in case of physical difficulties experienced by an inmate who may be having symptoms of withdrawal related to alcohol/drug addiction while initially incarcerated.

Managed Care

Managed Care is a process which promotes cost containment of health services through a formal process of review and evaluation of subscribers of health insurance. It is a formal arrangement in which utilization review is a vital component. Utilization review is a monitoring process which insures appropriate utilization of services to control costs. It specifies if services are medically necessary as defined by quality care standards within utilization review programs.

Utilization review typically includes:

Preadmission Review: determines whether inpatient and/or outpatient treatment is medically necessary. This is also an assessment/referral process to designate appropriate modes of treatment based on pre-identified criteria.

Admission Review: determines appropriateness of unscheduled/emergency admissions.

Concurrent Review: determines if continued inpatient/outpatient services are medically necessary.

Review organizations have been given the authority, through third-party payers (i.e. insurance companies) and upon the recommendations of advising physicians on their review panels, to deny third-party payment on continued treatment. The belief and generalization is that patients should not be retained as inpatients and/or outpatients when they have reached the stage at which they can return to safe, drug-free living environments. This, in turn, impacts the patient. As currently shown in our sample survey population, the majority does not reside in safe, drug-free living environments. Research indicates the longer the period of sobriety, the lower the chances for relapse. Managed Care controls costs, thus one has a limited length of time of sobriety. Increasing the length of sobriety may be extended by providing a supportive environment for recovering people. Alternative models of treatment must be supported and expanded, as hospital-based treatment has its limitations.

Rehabilitation Service

Rehabilitation services are types of care which provide 24-hour daily services in a facility providing treatment programs for alcohol and other drug problems

and/or addiction. Individualized treatment is pursued to help the client recognize the seriousness of addiction and help to motivate the client to obtain and maintain a clean and drug-free lifestyle. Rehabilitation also focuses on teaching recovering persons how to prevent relapse and rebuild their lives without drugs/alcohol. A number of services fall under this category:

Hospital, Short-Term Rehabilitation refers to a 24-hour hospital, inpatient facility licensed by the state. These programs provide levels of care including professionally focused evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems and/or addiction occurs. The length of stay is typically 30 days or less.

Free Standing Short-Term Rehabilitation refers to non-acute care in a non-hospital treatment setting on an in-house, 24-hour basis. These programs include professionally directed evaluation, care and treatment for the restoration of functioning for persons with alcohol and other drug problems and/or addiction occurs. The length of stay is typically 30 days or less.

The Lucas County Corrections Center and the Regional Jail provide in-house treatment for inmates who desire and are motivated for recovery from chemical dependency. The programs promote rehabilitative services oriented toward development of independent living skills in adapting to clean and drug-free lifestyles, educational training, involvement in self help groups and group therapy/support.

Outpatient, Aftercare Services is a type of care providing services to persons in an alcohol and/or other drug treatment program which operates for at least three or more hours daily for three or more days per week. The client's participation is relative to an individualized treatment plan. Aftercare services is the provision of outpatient alcohol and/or drug services after discharge from a treatment program to help in maintaining or improving what was previously gained in treatment.

12 Step, Self-Help Groups are independent support groups or fellowships organized by and for drug abusers and alcoholics to help members achieve and maintain abstinence and/or cope with the effects of drugs and alcohol. Meetings consist of recovering addicts who voluntarily meet regularly to help one another achieve and maintain clean and drug-free lifestyles. Self-help groups provide an option of treatment for recovering people based on a philosophy of spiritual growth, increased self awareness, developing and improving interpersonal relationships with others and reliance on a higher power. Alcoholics Anonymous (AA) is the oldest, most widely known self help group. Others like Cocaine Anonymous (CA) and Narcotics Anonymous (NA) have evolved, based on the same concept.

Long-term Rehabilitation provides 24-hour, non-medical, non-acute care in a residential treatment setting that provides support to recovering people for more than 30 days. Clients served are those with alcohol and other drug problems and/or addiction. Long-term rehabilitation facilities include the following supported housing categories:

Transitional Residential, (up to six months in a residential setting) provides the means for transition from a period of being "dry" to a period of maintaining clean and drug-free living. It is a 24-hour, non-medical, non-acute care facility, most likely referred to as a halfway house.

Long-term Residential, (six to 18 months in a residential setting) provides the opportunity in either a 24-hour, supervised, non-medical facility or a semi-supervised (part-time) non-medical facility to change addictive lifestyles in a supportive, long-term facility which may also be referred to as a halfway house or a three-quarterway house.

Independent, Permanent Housing is a basic life need consistent throughout people's lives; for recovering people as well as the rest of the general population. It is the provision of permanent individual housing that is not treatment-based or considered a service setting, but is a place to live. It is a place to call home and thus the ultimate goal of residential care. Stable, decent, affordable housing is a life necessity which should be available to all individuals, including

recovering people. Insuring availability, access and equal choice according to individual preference is the responsibility of the public health systems, in addition to stimulating the preservation and development of housing. Public health systems should also assure the appropriate community resources, such as meaningful employment, education and opportunities for community participation, are insured regardless of living situations.

The opportunity to move within the Continuum of Supportive Housing from detoxification to independent, permanent housing requires long-term chemical-free environments to help recovering people develop the skills to remain substance-free in the community.

Increasing the number of continuum options, in conjunction with community resource agencies, will provide more residential opportunities for recovering people who lack a safe, drug-free home. The impact of increased alternatives will be measured by decreased levels of recidivism, specifically in regard to the chemically-dependent population within correctional institutions and substance abuse treatment agencies.

Primary Research - Needs Assessment

A needs assessment was conducted in order to obtain consumer generated data which may be used to support the development of supportive housing and treatment programs in Lucas County. Without such information, the accuracy of fulfilling the critical need may only be assumed.

An initial review of the secondary research revealed a number of factors related to substance abuse, including: environment, self control, demographics, cost, homelessness, crime and other related events. These statistics may be used to obtain a better understanding of the problem and its magnitude.

National Statistics

The following is a summary of the secondary research which highlighted specific national statistics. These trends may be used to illustrate the current impact substance abuse has upon our society.

- 5.2 million Americans (2% of the national population) are dependent on prescription sleeping pills, tranquilizers, stimulants, pain medication (Milhorn, 1990).
- 6 million people (2.4% of the national population) use cocaine (Milhorn, 1990).
- Alcohol and drug problems are more frequently reported in men, up to 80%, 61% respectively, compared to 63%, 26% respectively in women (Fischer, 1991, DHHS).
- Alcoholism in the homeless population is more clearly associated with males (Fischer, 1991).
- Age range of excessive drinking is between the early 20s and the late 50s; among females it mainly occurs in the early 30s (Glaser, 1978).
- Excessive drinking more prevalent in urban areas (Glaser, 1978).
- Based on national samples, between 4 and 9% of all adults are classified as excessive drinkers whose drinking has impaired their social, psychological and physical functioning (Glaser, 1978).
- Approximately 5700 public and nonprofit organizations provide inpatient/residential services to about 528,000 clients annually for recovery from alcohol and combined alcohol and other drug problems (Fischer, DHHS, 1991). Approximately 40% or 211,000 clients are served through inpatient or residential programs. The need for access to housing upon release has not been formally reported but informal reports from operating treatment programs suggest that only a small fraction are accommodated. If about one-third of clients are low-income homeless at time of release, then approximately 70,000 occupancies of housing per year could be utilized (Fischer, DHHS, 1991).
- Annual cost of alcoholism in U.S is estimated at 116.7 billion as related to reduced productivity and lost employment (Milhorn, 1990). Alcoholism has universally "found to be greater among males than females. Most studies show that black males have the greatest proportion of problem drinking, white males and black females are approximately equal and white females are by far the lowest prevalence" (Glaser, 1978).

- The annual cost of drug abuse is estimated at 177 billion in lost work time, accidents, treatment, legal assistance, law enforcement. Drug use is estimated to be 10-20% among homeless adults (Milhorn, 1990).

- There are a high prevalence of alcohol problems in the new homeless population. It is also noted to occur in a more severe form as measured by physiological and behavioral symptoms of the disease, e.g. blackouts, DTs early morning drinking and by experience of adverse social consequences, e.g. drinking-related arrests, family dissolution, loss of jobs and so forth (Fischer, 1991, DHHS).

- An estimated 35 to 45% of the homeless population have chronic alcohol problems, while 15 to 20% have chronic problems with other drugs (R.O.W. Sciences, Inc., 1991).

- Alcohol and other drug problems constitute the number one public health problem among this population. Studies show that a minimum of 30% of homeless people have alcohol problems and an additional 10% more have histories of other drug problems (Curtiss et al., 1991, Dept. of Health and Human Services).

- One-third or more of clients in publicly funded residential recovery programs are homeless most of the year before entry into treatment (Wittman and Dodd, 1987 in NIAAA).

- 75% of all crime is related to drug use, drug selling or related criminal activity (Milhorn, 1990).

Local Impact and Services

Assuming substance abuse in Lucas County is representative of national trends, it is possible to extrapolate the national statistics in order to obtain insight into the number of people affected locally. The 1990 Census results indicate that there were 462,361 residents in Lucas County. Based upon the national statistics reported above (pages 29 & 30), the following local calculations were generated for Lucas County.

> *9,250 citizens (2%) who have an addiction to prescription drugs;*
> *11,100 citizens (2.4%) are addicted to cocaine;*
> *18,500 to 41,600 residents (4 - 9%) suffer from alcohol abuse.*

Based upon prior research, the local cost attributed to substance abuse (alcohol and drug) due to reduced productivity, lost employment, accidents, treatment programs, legal assistance, law enforcement, and incarceration could *exceed $527,400,000 annually.*

The Toledo - Lucas County Council for Human Services housing study, "Needed: More Than a Place to Sleep" reported that there are approximately 3,000 homeless individuals in Lucas County. Based upon national research, 35 to 45 percent of the homeless population have a chronic alcohol problem while 15 to 20 percent have chronic problems with other drugs. Utilizing these statistics locally would result in between *1,050 and 1,350 people who are homeless and suffering from chronic alcohol problems and 450 to 600 homeless people with chronic drug problems.* These projected numbers

illustrate the need for additional supportive housing.

The following is a table of the number of transitional/supportive beds available in Lucas County. The Lucas County Jail was included only to illustrate system capacity.

	Men	Women	Shared
Public			
Aurora Project	--	9	--
Cherry St. Mission	--	--	21
COMPASS	--	--	40
F.O.R.W.A.R.D.	--	6	--
Idle Time	8	--	--
Lucas Co. Jail	30	--	--
Open Door	8	--	--
St. Paul's	--	--	44
Salvation Army	40	10	--
SASI	5	5	--
Toledo Rescue Mission	--	--	16
Volunteers of America	--	--	68
Subtotal:	91	30	189
Private			
Talbot Outpatient	--	--	12
Toledo Hospital	--	--	34
Tennyson Center	--	--	14
Subtotal:	--	--	60
TOTAL: **370**			

Based upon this inventory, there is one public or private bed available for every 1,359 residents of Lucas County (excluding Lucas County Jail). The table above is not intended to suggest that all facilities and services are equal. This summation would suggest that there is not adequate supportive residential environments to sufficiently meet the need as determined from national projections. Ten percent (10%) of these beds are located at the Lucas County Jail, which is not an option to be considered for continued residential support.

Local Needs Assessment

The purpose of the needs assessment was to determine the following features:

- past living situations of the respondents, all of whom are recovering substance abusers;
- the forces influencing their substance abuse relapse; and

- the type of housing and support services respondents believe is necessary for a permanent recovery from substance abuse.

The results of the needs assessment were tabulated and various factors were evaluated in relationship to each other. The individual identities of respondents used for the assessment will remain anonymous.

The 100 individuals who participated in this needs assessment came from nine community resource agencies, all of whom provide transitional housing and/or supportive services for recovering substance abusers. The following table illustrates the number of people interviewed and the associated agency.

Lucas Co. Jail*	26
COMPASS	22
SASI	11
Jerusalem Outreach Ctr.	11
Volunteers of America	9
Salvation Army	8
Aurora Project	6
F.O.R.W.A.R.D.	5
Idle Time	2
Total	100

* Sober Living Program

General Demographics

Age & Race

A total of 67 men and 33 women were surveyed. The age range for the participants was wide-spread, with the youngest individual at 20 years old and the oldest at 50. Average age was 31. The dominant race among the respondents was African-American (63 participants), followed by 33 Caucasians, three Hispanics and one American-Indian. Thus, the gender versus race breakdown of the participants is as follows:

	41	African-American Males
	22	Caucasian Males
	22	African-American Females
	11	Caucasian Females
	03	Hispanic Males
	01	American-Indian Male
Total:	100	Participants

Children

There were 73 respondents who stated that they have children. A total of 18

individuals (25 percent) indicated they had full custody of all of their children, and 19 respondents (26 percent stated that their ex-spouse had custody. There were five reported cases in which Lucas County Children's Services Board had full custody of the children and three cases where there was shared custody between CSB and the respondents. The custody breakdown of those respondents who had children is as follows:

Self has full custody	18	25 percent
Ex-spouse has custody	19	26 percent
Family has custody	15	20 percent
CSB involvement	08	11 percent
Husband/wife custody	08	11 percent
No response	05	07 percent

Out of the 47 people who did not have sole or joint custody, 27 people (57 percent) would like to regain custody once the recovering individuals become clean and drug-free. Of the 19 women who did not have custody of their children, all indicated a desire to regain custody. Only eight out of the 24 men (33 percent) who did not have custody would like to have their children back.

Legal Charges

There was a total of 65 respondents who had legal charges pending. More white respondents had legal charges pending than blacks, 76 percent to 59 percent respectively. All four of the combined Hispanic/American-Indian populations were incarcerated and had legal charges pending. From those participants who had legal charges pending, 89 percent indicated that the charges were drug related.

Relapse

A total of 57 respondents stated that they had relapsed, and 41 (72 percent) contributed their relapse due to their past living environment. The racial/gender breakdown of those who relapsed due to the environment is as follows:

14 Black Males
13 White Males
11 Black Females
03 White Females

None of the Hispanics nor the American-Indian claimed to have ever relapsed. Based upon the sample size of the Hispanic and American-Indian populations, it is not appropriate to draw conclusions from these results.

Environment

The highest number of participants who stated they had relapsed due to the environment fell into the 31-35 age range. In this age range, 72 percent of the relapsing respondents reported that their environment caused their relapse. All the respondents above the age of 35 who relapsed stated that their environment was the major contributing factor.

Many factors, inside and outside the realm of the environment, contributed to the respondents' relapse. Included within the environment that caused several of the individuals' relapses was the convenience of drugs and the presence of other substance abusers. The availability of drugs enhanced 36 respondents' relapse (63 percent). There was another 39 people who were either living with substance abusers or friends who contributed to their relapse.

Of those individuals living with active substance abusers, a total of 25 people (64 percent) relapsed, where only two out of eight people (25 percent) relapsed who were living with recovering substance abusers. There were 12 respondents, out of 40, who relapsed when they lived with relatives such as their mother, father and/or children (30 percent).

There were 25 people who stated they were very satisfied with their previous living situation. Of those satisfied, only seven (28 percent) relapsed. Contrary, 58 percent of the 33 people who stated that they were dissatisfied with their living environment relapsed.

Of those who said that their relapse was caused by the environment, it was necessary to determine what they did and did not like about their past living conditions. The majority of the participants said they did not like the area due to the high amount of drugs and crime in the neighborhood. The things that people did like about their last living arrangements were the location (close to stores, activities, etc.) and the proximity of their family and friends. Others said they liked having the privacy that they do not have in their present housing arrangements. The highest percentage given in this category, however, was that nine respondents did not like anything about their past living situation (22.5 percent).

Other Factors

Outside of their environment, eight individuals of the 57 people who relapsed stated that their reason for relapse was due to it being easier to drink than not to drink (14 percent), six people related it to not utilizing the tools of Alcoholics Anonymous and its subsidiaries (11 percent), and five contributed their relapse the outside pressure from work, deaths and family life (9 percent).

Past Living Environment

Even though 70 percent contributed the environment to their relapse, 45 out of 100 people considered their past living environment to be a safe and drug-free place to live. Although the percentage difference was small, 52 percent of the white population said that their past living condition was safe and drug-free, where only 41 percent of the black respondents said they lived in a clean and drug-free environment. Three out of the four Hispanic and American-Indian respondents would like to return to their past living environment.

Term of Occupancy

The amount of time one had lived in his or her previous residence was yet another factor of past living arrangement satisfaction. Of the 13 respondents who had been living at the same place for longer than five years, 9 or 69 percent indicated an intention to move back to their previous residence. However, 66 out of the 72 people who had been living in the homes for three years or less (92 percent) said they wanted to move elsewhere. Only two out of 15 respondents who lived in their previous home for three to five years wanted to return.

It was prevalent that several of the respondents had moved at least one time within the past three years. When comparing race and sex with the number of times an individual had moved, whites tended to be more mobile than blacks, and females moved more often than males. The survey showed that 35 percent of the black respondents had not moved once within the past three years. White participants had moved several times--24 percent moved once and 19 percent moved five times; percentages that were much higher than that of the black population.

Although results showed higher percentages among females than males who moved three times or more, only 18 percent of the women moved once. This number is low compared to the 31 percent of the men who moved one time.

Housing Cost

Yet another factor determining satisfaction depended upon the amount of money one paid monthly for their living arrangements. As the amount of monthly payments increased, the more satisfied respondents were. For example, 21 out of 31 people were very or somewhat satisfied with their housing if they paid $200 or more. On the contrary, 28 out of 41 people who paid $180 or less (68 percent) were dissatisfied with their housing.

Income

Only 26 percent of the respondents were or are presently employed--16 of the black respondents (33 percent), six whites (18 percent) and all of the Hispanic/American-Indian population. A majority of the individuals who

were not employed received their income from public assistance (30 percent white and 25 percent black). A total of 21 percent of the black population received income from Aid to Families with Dependent Children and food stamps, while 12 percent of the white respondents received money from SSDI and AFDC. Five of the 33 white participants and eight of the 63 black participants did not receive income of any kind.

Supportive Services

Participants were asked if they had utilized any of the 12 step, self-help programs such as Alcohol Anonymous, Narcotics Anonymous, and/or Cocaine Anonymous while residing at their previous residence. Of the 70 people who did use the self-help programs, 49 percent of the respondents were very satisfied with the programs and 39 percent were somewhat satisfied. Only six percent were not satisfied with the 12 step programs.

Future Needs

Type of Housing

A total of 17 respondents stated that they would like to return to their former place of residence. The 82 people who said they want to move had responded that they would like to move into independent living situation. There were 60 respondents (83 percent) who would like to live in their own house or apartment.

Several survey participants said they would like to live with other recovering substance abusers for support. More specifically, 52 percent of the men and 61 percent of the women would like to live with recovering substance abusers. More black than white participants would prefer living with recovering individuals; 62 percent and 46 percent respectively. The Hispanic and American-Indian respondents indicated that one person wanted to live with a recovering substance abuser and three did not want.

Supportive Services

Regarding supportive services, 95 percent of the recovering individuals stated they would most like to live a clean and drug-free life and ongoing contact with the 12 step, self-help groups. Other high scores in this category were help on obtaining housing (93 percent), access to treatment staff 24 hours per day (88 percent), and a specified number of hours for substance abuse counseling (85 percent).

Upon breaking down the respondents needs by gender and race, it was determined that females needed help in keeping in contact with self-help groups, as well as assistance in obtaining housing, furniture and other

household supplies. The lowest ranked items on their list was obtaining roommates, which scored 19 percent. Men stated that they also needed ongoing contact with the self-help groups, as well as guidance in housing and availability of a 24-hour treatment counseling staff. Although only 46 percent of the men said they would like assistance in finding a roommate, their need was considerably higher than that of the women.

When comparing the black and white populations, the black individuals rated contact with self-help groups first, followed by household supplies and help in obtaining housing. Household supplies was one of the lowest on the white individuals' list, however, more money for expenses, furniture and housing assistance ranked high.

Requirements within the Criminal Justice System

Because a number of respondents were either incarcerated at the Lucas County Corrections Center or on release/furlough through the criminal justice system at Volunteers of America, it is necessary to determine these individuals' specific needs in housing and supportive services. This survey did not take into account the number of times people have been incarcerated, length of jail term, original offense, or any specific data for people in the criminal justice system. As stated, such an assessment requires a more controlled and refined process and instrument to generate statistically valid results. It should be noted that all the respondents in this category were men.

Housing Preference

Of the 65 people who had legal charges pending (taking responses from all 100 participants), 89 percent (58 individuals) had charges that were drug-related. There were 31 of these 65 people (48 percent) who stated that their past living environment was safe and drug-free. And 29 of those respondents (45 percent), if given the chance to move, would like to live in their own house. Falling below that amount, 20 people (30 percent) would like to live in their own apartment, 15 individuals (23 percent) want to return to living with their family, and eight stated that they would like to live in a group home for recovering individuals. (These percentages add to a total higher than 100 percent due to multiple responses). A total of 35 of the 65 participants with legal charges pending (54 percent) indicated that they would like to live with recovering substance abusers either in a group home or independently.

Relapse of the individuals in the criminal justice system was only slightly higher than the general population at 60 percent (57 percent of the general population responded positively). However, only 46 percent (30 people) contributed their relapse to the environment, where 70 percent of the general population did. In addition, 28 percent (nine individuals) responded that they would want to return to their past living environment, while only 17 percent

of the general population would like to return to their previous neighborhood.

A total of 32 respondents currently reside in the jail or at VOA. Unlike the other participants, individuals within the criminal justice system are involuntarily placed into the substance abuse recovery programs. Thus, these responses may not be an accurate indication of the serious need for transitional housing and supportive services.

Supportive Services

These participants stated that two needs upon their release are getting access to a substance abuse treatment staff and having a specified number of hours designated for treatment counseling (both at 66 percent). The percentage for the general population was 88 percent and 83 percent respectively. These percentages for people in the criminal justice system may be lower for a number of reasons ranging from not wanting to receive assistance, to lack of assistance in the past, to the environment people previous lived in (no opportunity to move).

The group did rank high in requesting assistance upon release in locating housing (78 percent). However, 92 percent indicated they would like to receive aid from volunteer 12 step, self-help groups.

Conclusion - Needs Assessment

Based on the assessment of this survey, it has been determined that individuals who are recovering from substance abuse desire independent housing with correlating supportive services. It is not perceived that they are requesting a highly structured and controlled environment, but rather permanent housing with services as needed. While a common theme is independence, people reported the desire to live with other people in recovery for support.

Presently, there are not any agencies that provide independent, supportive housing. Individuals who are recovering from substance abuse would like to make their future residence permanent. Thus, housing units must be in a safe and clean environment, away from their past living environment--free of drugs, crime and individuals who are still abusing substances.

Supportive services necessary for the people who are recovering must include on-call treatment staff, assistance in finding household amenities including furniture. Ancillary services such as assistance in money management, stress control, improving family relationships, parenting classes, work/study programs and self-help groups are also needed.

The responses of people in the criminal justice system reflect a number of conflicting characteristics. People did not believe their environment

contributed to their relapse. But there was a strong desire not to return to their prior living environment. Individual responses could be a function of a person's lack of control over their drug treatment and present incarceration. These individuals are not participating in treatment by choice. Thus their responses may reflect hostility or lack of faith that there will be a viable alternative (substance abuse treatment, economic opportunity, employment, housing, etc.) for them upon release.

Although percentages somewhat differed between the four race groups, and among those in the criminal justice system, all populations basically desired the same housing and support conditions--ones that encourage and support total and permanent recovery.

Primary Research - Federal, State and Local Housing Regulations

Access to safe, decent, stable, affordable housing is a universal human requirement. The lack of this necessary resource will adversely impact a person's ability to establish additional basic needs such as employment, job training or eduction, social benefits, and interpersonal relationships. People recovering from substance abuse also require a drug and alcohol free environment. Historically, local land use regulations and state licensing requirements have not encouraged or facilitated the development of supportive living environments in residential settings. Housing opportunities for special populations (i.e. people with disabilities and illnesses) have been perceived and regulated in a fashion different than traditional single family housing.

The purpose of this section is to examine the present land use and regulatory requirements which will be encountered in the development of housing for people recovering from abuse of drugs or alcohol.

Federal Regulations

As a result of the civil rights protests during the 1960s and in the wake of Dr. Martin Luther King's assassination, Congress enacted the Civil Rights Act of 1968, popularly called the Fair Housing Act, to end racial segregation in housing (Mental Health Law Project, 1989). In 1988, congress amended the law to extend the principal of equal housing opportunity to people with disabilities, enacting the Fair Housing Amendments Act of 1988. The amendment became effective March 12, 1991.

This amendment made it unlawful for public and private entities to discriminate against people with disabilities in the sale, rental or advertising of dwellings, in the provision of brokerage services, in the availability of residential real-estate transactions, in the implementation of land-use and zoning laws and in the enforcement of restrictive covenants and deeds (Mental Health Law Project, 1989). This amendment provides people with disabilities with the same protection from discrimination as all other protected classes of people (e.g. minorities and women).

The Justice Department is charged with the responsibility of prosecuting state and local zoning or other land-use laws that affect people with disabilities. This includes investigating and prosecuting discriminatory land-use laws.

Local Housing Regulations

History

Modern land use regulation began in 1916 with the first comprehensive zoning plan, adopted by New York City. The premise of the initial zoning regulations were to prohibit "noxious" uses in residential neighborhoods (Mandelker, 1988). Today, zoning and planning regulations can be found

throughout the country. But a fundamental right of zoning has been the local control of land uses, within the legislative authority provided in each State enabling act. Thus, the State of Ohio adopted enabling legislation which establishes the structural requirements of municipal, county and township zoning. Each jurisdiction then has the authority to implement zoning regulations within the context of the enabling legislation.

Cities, counties and townships have the ability to enact specific land use controls with minimal professional planning or legal guidance due to the local control and administration of land use. Once enacted, these ordinances and resolutions are rarely challenged due to potential local repercussions and special interest groups. As a result, local ordinances and resolutions are being administered which may be in violation of the federal Fair Housing Act, as amended.

Restrictions

Housing regulations take the form of zoning and building codes in Lucas County. Adopted by cities, the county (building only) and townships (zoning only), the purpose of these regulations is to promote public health, safety and general welfare (State of Ohio, Department of Economic and Community Development, 1973). The general basis for zoning and land use regulation is to "maintain property values by assuring that incompatible uses will be kept apart... promote the public health and safety... and providing for more orderly development through lot size, set back lines, building height and population density" (Ohio Department of Development, 1986). Though not intended, it may be argued that these basic principals have worked to discourage the development of accessible, affordable housing in general, and for people with disabilities specifically. Through the guise of promoting public health and safety, and protecting property values, communities have denied people with disabilities housing opportunities simply based upon a perceived fear of people who are different.

Housing regulations within Lucas County are divided into city, county and township jurisdictions. Zoning and building codes are enforced in four cities: Maumee, Oregon, Sylvania and Toledo. Lucas County enforces a building code within the unincorporated areas, while all townships have adopted zoning resolutions (Providence Township is partially zoned). The Toledo - Lucas County Plan Commissions provide professional zoning and planning services within the City of Toledo and to all the townships.

Process for Building Occupancy

The establishment of a continuum of housing options providing a supported living environment will require compliance with specific governmental regulations. The use of a building will require careful consideration and evaluation prior to making a commitment to acquire or enter into a lease.

Building options or purchase agreements may be negotiated in order to investigate regulations and proposed sites in detail. In order to occupy a building three land use and building issues must be addressed: zoning compliance; building code requirements; and, occupancy permit. Resolution of these three issues may require extensive research, evaluation and project modification or may be only a formality depending upon the building, the proposed use and applicable codes.

Zoning Compliance

Written assurances, that the intended use of the building will be permitted under the existing zoning classification, should be received prior to committing to purchase or lease a building. This assurance should be provided by the local zoning official (Appendix A). Any contract to purchase or lease should include a stipulation that nullifies the contract if this assurance cannot be obtained in a timely fashion.

Building Code Requirements

A condition of purchasing or leasing a building should be that the physical building condition permits occupancy for the intended purpose. Because building code requirements vary with the intended use, size, age and condition of each building, it is not possible to provide a general list of code conditions which must be completed. A preliminary list of requirements are found in Appendix B. This stipulation may be satisfied by having a building inspector or licensed contractor or architect inspect the structure prior to waiving this condition. A building failing to meet code requirements may still be considered if the required site improvements are anticipated and completed as part of the rehabilitation process. It is essential to have a complete understanding of the costs to be incurred in rehabilitating or operating the building prior to consummating the purchase or lease.

Occupancy Permit

The final hurdle in establishing a supportive housing program is receiving the occupancy permit. This is the final validation that the zoning and building codes have been complied with and the structure may be operated as proposed. A temporary occupancy permit may be granted at the discression of the building inspector, while final improvements are being completed.

These elements of the building occupancy process may vary dependent upon the type of supportive housing program which is proposed. A general assessment may be that the more a program operates as a typical home and family, the less difficulty will be experienced in receiving the appropriate permits and making required building code improvements. The courts have

held that people living together in a group home constitute a "family" as defined by the zoning ordinances and that the application of a "family" definition to exclude a group home is unconstitutional (Mandelker, 1988).

The following is a brief review of the housing regulations found in Lucas County. An attempt is made to provide both historical and factual information when it is available. All relevant code citations are included in this Section. Actual regulations may have been amended without prior notification and it is recommended that each governmental jurisdiction be consulted regarding specific regulations.

It is important to note that while some conclusions are drawn regarding the validity of present regulations, each applicant is responsible to work with the existing code or take legislative or judicial steps to amend these requirements. This plan will not serve as a tool to obtain regulatory relief from a governmental entity.

Zoning - City of Maumee

The Codified Ordinances of Maumee (COM), Part 11 - Planning and Zoning Code addresses the establishment of a number of supported living environment. Chapter 1103 defines a **Halfway House** as,

> a "residential structure used to provide services or care for adolescents or adults who have been institutionalized and released, or who have alcohol or drug related problems and who require a group setting for rehabilitation."

The zoning code does not make any further reference to a halfway house. It can not be determined from reading the code, where such a structure may be located, or any specific requirements for establishing such a home.

The code defines an **Institution** as,

> a "building and/or land occupied by a nonprofit corporation to aid individuals in need of mental, therapeutic, rehabilitative counseling or other correctional services, intended wholly for public use."

The code does require that prior to establishing an "Institution" a Special Use Permit be received (COM, Chapter 1127.13(b)(3)). However, this regulation exempts or does not permit institutions for "criminals or the insane".

The ordinance defines **Family** as:

> "a group of one or more persons occupying premises and living as a single housekeeping unit, whether or not related to each other by birth or marriage, as distinguished from a group occupying a boarding house, lodging house or hotel.

This would appear to indicate that as long as a house is occupied by people who live as a family, sharing in responsibilities and household costs, it would be permitted in any residential district. Enforcement of the regulations will depend upon interpretation. The code does not limit the number of people who may live together as a family.

If services are provided to residents, such as meal preparation and building cleaning, then the zoning ordinance may interpret the use as a **Dwelling, rooming house, boarding house, lodging house or dormitory.** These uses are jointly defined as:

> "a dwelling or part thereof, other than a hotel,

> motel, motor inn or restaurant where meals and/or lodging are provided for compensation, for three or more unrelated persons where no cooking or dining facilities are provided in the individual rooms."

Again, no provisions could be found which would permit the establishment of a boarding house. But, Chapter 1131.06(a)(6) does require that all rooming and boarding homes have one parking space per bedroom or sleeping room.

The status of these residential regulations may limit the creation of a nontraditional family home within the City of Maumee. If such a proposal would be made, the current regulations are confusing enough to frustrate any potential development. The best alternative, in light of these restrictions, is to operate any program to coincide with the definition of a family, with supportive services available on an individual basis. This would appear to preclude the option of 24-hour professional staffing, etc.

Zoning - City of Oregon

The Codified Ordinances of Oregon (COO) includes a number of references to specialized residential facilities. This includes such terms as: Boarding House, Family, Group Home, Institutional Home, Lodging or Rooming House, and Nursing Home. While none of these terms specifically address the development of a supportive housing environment for recovering substance abusers, experience indicates that an attempt would be made to regulate such a use in accordance with the current regulations.

The COO defines a **Boarding House** as:

> "a building other than a hotel where lodging and meals for three or more persons are served for compensation."

The city could attempt to regulate a supportive housing program as a boarding house, if the residents do not participate in its operation by performing such activities as meal preparation or housekeeping. If paid staff performs these duties, then the city may have the option of treating the facility as a boarding home. Boarding homes are permitted in multifamily zoning districts (R-3 and R-4).

A **Family** is defined as:

> "one or more persons occupying a premises and living as a single housekeeping unit, whether or not related to each other by birth or marriage, as distinguished from persons occupying a boarding house, lodging house or hotel as herein defined."

The primary distinction between a boarding house and family appears to that a family must operate as a single housekeeping unit, such as sharing common meals, sharing the expenses of the house, sharing maintenance responsibilities around the house, etc. "Family" members could pool their resources to operate the home. As with any family, they could also contract for specific services as a single household or as individuals. This could include such items as lawn maintenance or personal health requirements.

The code defines **Group Home** as:

> "a residential facility that provides room and board, personal care, physical or mental rehabilitation services and supervision in a family setting; including, but not limited to, facilities licensed by the county, state or federal government, facilities providing rehabilitation services for the handicapped, the emotionally disturbed or the

developmentally disabled, or other similar facilities."

This definition is an attempt to regulate the development, placement and operation of residential programs for people with particular disabilities. The city could attempt to use this definition to regulate a supportive housing development. No further regulations could be found in the zoning ordinance to indicate the zoning district which would permit the development of a group home. Group homes are not regulated as a special or conditional use.

Institutional Home is defined in the code as:

> "a home or institutional facility for the care of babies, children, pensioners or elderly people, except those for correctional or mental cases."

As with a group home, no reference can be found for permitting the location and operation of a defined Institutional Home in Oregon. Again, this definition could be used to restrict the operation of a supportive housing program.

The code also defines a **Nursing Home** as:

> "a home for the aged, chronically ill or incurable persons in which three or more persons not of the immediate family are received, kept and provided with food, or shelter and care, for compensation; but not including hospitals, clinics or similar institutions devoted primarily to the diagnosis, treatment or care of the sick or injured."

This definition, may be used to restrict the location and operation of a supportive housing program that does require 24-hour staffing, and some personal assistance. The code limits such facilities to multifamily districts and requires the approval of a conditional use permit.

The common themes in Oregon's regulations are: operating a house as a single housekeeping unit; compensation for room and board; and the lack of permitted uses for specifically defined uses. If a program was operated as a family (sharing expenses and responsibilities) and with no permanent staff on site, then the opportunity would exist to locate the program in any single or multifamily zoning district, per these regulations. Otherwise, the code severely limits the opportunity to develop a continuum of housing options.

Zoning - City of Sylvania

The Codified Ordinances of Sylvania (COS) Part Eleven, describes the regulations for the operation of a few nontraditional housing options. Pertinent terms include: Family, Institution, Lodging House, and Nursing Home.

Family is defined as:

> "one or more persons occupying a single housekeeping unit and using common cooking facilities, provided that unless a majority of the members are related by blood or marriage, no such family shall contain over five persons."

This definition clearly limits the number of unrelated people that can live as a single housekeeping unit and constitute a family. This is the most restrictive definition of Family encountered in Lucas County. The validity of this definition is in question due to the 1988 Amendment of the Fair Housing Act of 1968. This issue will be discussed in the Federal regulations.

An **Institution** is defined as:

> "a building occupied by a nonprofit corporation or a nonprofit establishment for public use."

This definition may restrict the ownership of supportive housing by a nonprofit corporation if it is classified as an Institution. The establishment of an institution requires the approval of a special use permit (COS 1153.02 (j)). Section 1153.02 (v) also requires that any charitable or public service organization chartered as a nonprofit corporation, receive a Special Use Permit in order to be located in any residential zoning district or specific business districts (B-1 and B-2). This may require that the supportive housing option meet and exceed standard zoning issues (e.g. lot and yard area, building set backs, and parking).

A **Lodging House** is defined as:

> "a building where lodging for three or more persons is provided. A building or group of buildings having units containing sleeping accommodations which are available for temporary occupancy by automobile transients shall not be deemed a lodging house."

Based upon the definition, a Lodging House is to provide accommodations for three or more people. It does not address the issue of compensation or meals. Based upon the strict definition of Family and a very general definition for Lodging House, the city may attempt to regulate any supportive housing option as a Lodging House. This would restrict such housing to multifamily districts (R-3 and R-4).

Finally, the code also defines a **Nursing Home** as:

> "a home for the aged, chronically ill or incurable persons in which three or more persons not of the immediate family are received, kept and provided with food, or shelter and care, for compensation; but not including hospitals, clinics or similar institutions devoted primarily to the diagnosis, treatment or care of the sick or injured."

This is the same definition used by Oregon. As with Oregon's code, this definition may be used to restrict the location and operation of a supportive housing program that does require 24-hour staffing, and some personal assistance. The code limits such facilities to any residential zoning district with the approval of a Special Use Permit.

The major issues in Sylvania's regulations are the definitions of family and institution. These definitions and regulations appear to prevent more than five unrelated people from living as a single housekeeping unit. The definition of institution would also limit the options afforded to nonprofit housing corporations. These code requirements severely limit the opportunity to develop a continuum of housing options within Sylvania.

Zoning - City of Toledo

The present zoning regulations have evolved from years of administration. Specifically, the regulation of group living environments is a result of the increased development of such homes within specific neighborhoods over the past twenty years. Neighborhoods characterized by large, stately homes lent themselves to be used as housing for special populations. As a result of gentrification and the increase in housing costs, neighborhood associations have fought to require the distribution of such specialized housing throughout the city. Various distribution methods were created, including: defining the type of structures which may be used; defining supervision requirements; minimum site area requirements; minimum spacing requirements between similar facilities; maximum number of group homes and similar facilities within any one planning community; restricting the number of people who can live together in a supportive environment; required notification and continued contact with neighbors; preparation and approval of a site plan and optional review by the city after one year. Similar, though less sophisticated, requirements have been incorporated into the zoning resolutions for the townships.

These requirements are clearly established to reduce the ability to develop supported affordable housing options. Chapter 1117.01(i)(8) states:

> "In order to **reduce any negative impact of group homes and similar facilities** *(emphasis added)* on the planning community and on the adjacent area, both within a polysided block and as measured in linear fashion along a particular street, the following spacing standards shall be followed. No group home, or halfway house providing a rehabilitation program for persons reentering society upon discharge from a mental hygiene institution, or **for persons with drug or alcohol problems, or for persons on probation or parole for criminal offenses** *(emphasis added)*, shall be located within the following distance from such facility:
>
> A. Within 990 feet within the same block, as bounded by the perimeter streets or other natural or manmade boundary;
>
> B. Within 530 feet outside the block;
>
> C. Within 1,320 feet along the same street, on either side of such street, as measured along the right-of-way line of the street."

This clearly suggests prejudice against the establishment of a group home or

similar facility by stating that a negative impact will occur. Research has indicated that this is not true (City of Lansing Planning Department, 1976).

The Toledo zoning code defines the type and location of housing which may be developed, depending upon disability. The nomenclature for these housing environments was based upon the State of Ohio's regulations and licensing requirements. While all the types of housing provide shelter to groups of people (3 or more individuals), their placement within the community was not uniform. Thus, group homes for people who are mentally retarded are permitted in single family residential districts. Group living environments for the elderly are permitted within two family residential districts. Boarding homes and group homes for people who are mentally disabled are permitted in multi-family residential districts. Unlike the other disabilities or classifications, there are presently no specific regulations for facilities serving recovering substance abusers. This could be due to the fact that until recently, substance abuse services and housing was a part of the State and local mental health system. There is the inference that halfway homes and rehabilitation programs for persons with drug or alcohol problems, or for persons on probation or parole for criminal offenses are included in the spacing and distribution requirements (TMC, Chapter 1117.01(i)(8 & 9).

Assuming that a boarding home is the only permitted use for a supportive housing program, agencies providing services and/or housing to recovering substance abusers are not permitted within single and two family residential zoning districts. A **Boarding House** is defined as

> " a building other than a hotel, where lodging and meals, for three or more persons is served for compensation" (TMC, Chapter 1103.07).

As a result, such housing is restricted to areas which may not contribute to maintaining a safe, drug-free, living environment. Per the zoning code regulations, boarding homes are confined to high density residential (R-5), commercial or industrial zoning districts.

The Toledo Municipal Code defines **Family** as:

> "one or more persons occupying a premises and living as a single housekeeping unit, whether or not related to each other by birth or marriage, as distinguished from persons occupying a boarding house, lodging house or hotel as herein defined."

Again, the definition of family does not overtly discriminate against people wanting to live together as a single household. But, based upon the specific regulations for each type of population (mental retardation, mental health and elderly) it appears that the City does not wish to promote the expansion of supportive housing. Thus, establishing a supportive halfway house for

recovering substance abusers may not be viewed as a family, and permitted in any single family neighborhood.

Zoning - Townships in Lucas County

All eleven Townships in Lucas County have zoning regulations. Only a small portion of Providence Township is zoned. Due to the diversity of the Townships, their zoning regulations vary in complexity and requirements. The urban townships have adopted more rigorous regulations than the rural townships. All the townships receive professional zoning and planning assistance from the Lucas County Planning Commission. The staff of the Planning Commission has attempted to create uniform regulations for the townships. Thus, there may be some similarity in how the townships regulate group living environments.

The following is a brief outline of how each township regulates a group or supported living environment. Township zoning officials should be consulted prior to purchasing or leasing any building or land

Township	Definitions and Permitted Use
Harding	Family Group homes not mentioned. Nursing homes permitted as a Special Use. Lodging house permitted under C-2.
Jerusalem	Family Group homes permitted in R-1 District under Special Use. Nursing homes permitted under Special Use. Lodging house permitted under C-2.
Monclova	Family is defined as a any number of people living as a single housekeeping unit. Group homes permitted under A-3, R-A, R-1, and R-3 all under a Conditional Use Permit. Nursing homes permitted under A-3, R-3 and C-1 all under a Conditional Use Permit. Boarding house defined but not mentioned elsewhere.
Providence	Family is defined as a any number of people living as a single housekeeping unit. Group homes are permitted as a Special Use in any "A" District. Nursing homes are permitted as a Special Use in any "A" or "C" District. Boarding homes are defined but not mentioned elsewhere.
Richfield	Family is defined as a any number of people living as a single housekeeping unit. Group home mentioned in Planned Development as a Special Use. Nursing homes permitted under Special Use. Lodging house permitted under C-2.

Township	Definitions and Permitted Use
Spencer	Family Group homes not mentioned. Nursing homes permitted in "A" or "R" Districts under Special Use. Lodging house permitted under C-2.
Springfield	Family is defined as not more than five unrelated persons living together in a single housekeeping unit Group homes permitted "A" or "R" Districts under Special or Conditional Use. Nursing homes permitted as Institutional home and PUD (excludes "correctional or mental cases").
Swanton	Family is defined as not more than five unrelated persons living together in a single housekeeping unit Group homes not mentioned. Nursing homes permitted in "A" or "R" Districts under Special Use. Lodging houses permitted under C-2.
Sylvania	Family is defined as not more than five unrelated persons living together in a single housekeeping unit Group homes permitted un A-3, R-3, R-4 and R-5 Districts under Conditional Use. Nursing homes permitted in R-3 and R-4 Districts under Conditional Use. Boarding house and Rooming house have same definition. Boarding house mentioned under "Off Street Parking and Loading Requirements", but not elsewhere.
Washington	Family Group homes are not mentioned. Nursing homes permitted in R-3 and R-4 Districts under Conditional Use. Boarding house and Rooming house have same definition. Boarding house mentioned under "Off Street Parking and Loading Requirements", but not elsewhere.
Waterville	Family Group homes are mentioned under "planned Unit Development". Nursing homes are permitted in "A" or "R" Districts under Special Use. Lodging house is defined but not mentioned elsewhere.

While these individual township regulations are diverse in the approach used to regulate supportive living environments, the common focus is their attempt to restrict the development of such housing options. Many of the townships that require conditional or special use approvals require a separation or distance requirements apparently to minimize impact on "normal" housing. Some townships attempt to regulate the number of unrelated adults living together in a single household by using a restrictive definition of a family. Based upon changes in the Fair Housing Act of 1968, the validity of these present regulations are in question.

Zoning - Summary

The four cities and eleven townships in Lucas County all have zoning regulations which address in some manner the operation and location of group living environments. In an effort to develop a continuum of supportive housing for people in recovery from substance abuse, it is essential to have a clear understanding of the impact governmental land use regulations can have. While the enforcement of these local regulations may be contrary to newly adopted Federal regulations, jurisdictions will not likely amend these regulations unless legal action is pursued. The alternative to taking the legal route, is to work with the existing regulations, and design a residential program which will coincide with the definition of a family. This would permit housing operation and location within any single or multifamily neighborhood. This approach still runs the risk of creating concerns and fears from zoning officials and neighbors.

These regulations have evolved over the past years, but they have failed to keep pace with the present philosophy of supportive housing and with Amendments to the Fair Housing Act. Emphasis should be placed upon changing the regulations in order to provide increased housing options throughout the entire County, without necessitating individual legal challenges.

Data Analysis

Local Impact - Supply versus Demand

Within Lucas County there are a total of 370 detox/transitional/ supportive beds available (including the Lucas County Jail program). 16 percent (60) are private beds. Eight percent (30) of the beds are dedicated to women; while only nine adult beds are available to women and their children. The agency which serves this population, the Aurora Project, reports that they turn away an average of 27 women (plus children) per month because of insufficient housing resources. This dramatic illustration indicates that the existing supply of supportive housing is not meeting the need.

The impact of substance abuse upon residents in Lucas County may be extrapolated from national studies and statistics. All the current studies indicate that local substance abuse may be more significant than perceived. Estimated projections for Lucas County reveal that as many as:

9,250 citizens are addicted to prescription drugs;
11,100 citizens are addicted to cocaine; and,
18,500 - 41,600 residents suffer from alcohol abuse.

This summary does not reflect the total impact of substance abuse within Lucas County. The projected costs associated with this population exceeds $527,400,000 annually. This includes substance abuse services, lost employment, reduced productivity, child/foster care, accidents, insurance claims, legal assistance, law enforcement and incarceration.

The local impact of substance abuse, from human and economic perspective, indicates a deep rooted need for additional prevention and supportive services. The existing service providers do not presently offer the volume of services to adequately meet this growing demand. Due to the lack of long-term supportive housing, the "revolving door" process within the criminal justice system, and detox and treatment centers continues. For this to change, an increased financial commitment will be necessary to cement the relationship between treatment facilities/supportive services and housing providers.

Needs Assessment: Results for Creative Planning

Based upon the responses received from the housing and support service needs assessment, the following conclusions may be drawn in response to the impact environment has upon relapse, past living environments, identified future needs, and specific requirements for substance abusers within the criminal justice system. The data collection and analysis was completed in such a fashion, as to suggest broad, general characteristics and/or factors which impact people who have a history of substance abuse. Thus, these results should only be used to validate the urgency of

substance abuse problem, and not as a statistically accurate representation of specific issues.

Assessment: Relapse

Relapse, as defined, results when a drug-free lifestyle is not maintained, and a person enters or re-enters the substance abuse system. The preparation of this plan must include a cursory examination of relapse due to the demand upon limited resources within the substance abuse and criminal justice systems. It is also essential that new options be designed to reduce the relapse rate.

- 57 percent of the needs assessment participants indicated that they had relapsed. *(Actual relapse rate may be higher due to false responses received from people who had charges pending and where sobriety was a condition of parole).*

- Of the 57 respondents who admitted they had relapsed, 72 percent contributed their relapse to their past living environment.

- The highest percentage of relapse due to environmental factors occurred in people between the ages of 31 to 35 (72%) and those over 35 (100%).

- The environmental factors which enabled a persons relapse included the availability of drugs within the environment and living with people who actively abused drugs or accepted such behavior.

The data collected and evaluated on relapse indicates that the current residential treatment programs are not providing the amount of services necessary to impact the relapse rate. With forty-one respondents indicating that their environment stimulated their relapse, this would support the fact that additional safe, stable, drug-free supportive housing is required to be developed within similar neighborhood settings. Since residents are susceptible to the existing environment conditions, which may include drug dealing and public intoxication, new supportive housing should be located in neighborhood where the environment is perceived safe, stable and desirable by the general public. This location demand must be balanced with other factors including real estate cost, proximity to services and transportation.

Assessment: Past Living Environment

A significant number of respondents indicated that their prior living environment was a factor in their relapse. Thus, it is essential to evaluate the differences in the living environments to determine significant environmental factors influencing relapse.

- Approximately 50 percent of the white respondents and 59 percent of the black respondents considered their prior living environment not to be safe or drug-free.

- The amount of time a person lived at one location increases a persons' desire to return to the same residence. People residing in one location longer than five years, wanted to return; while those with less than three years of housing history in one location, wanted to move elsewhere.

- Respondents who paid more for housing indicated their intention of returning to their past living environment than those who paid less.

- 77 percent of the respondents indicated that they were satisfied or somewhat satisfied with self help support programs. Thus, such groups should be available to people in recovery.

The data indicates that after people complete detox and rehabilitation, their options for long term supportive housing are limited. It is clear that the majority of substance abusers are not satisfied with the housing which is available. People do not feel that upon their return to the community, there will be a safe, drug-free environment in which to continue rehab and learn to live substance free. Thus, in order to reduce the cycle of detox-rehab-relapse, additional supportive housing is essential.

The data indicates that the substance abuse population is highly transient, with a large majority (72 percent) of the people living in one location for less than three years. Reducing this behavior, may result in people acquiring the stability and empowerment to eliminate drugs and alcohol from their permanent environments.

Assessment: Identified Future Needs

The vast majority of the respondents (82 percent) stated that they wanted to live in an independent and permanent living situation. 83 percent of the people said that they wanted to live in their own home or apartment. This predominant response should not be surprising since shelter is a basic human need, and society promotes housing independence. While this response is certainly appropriate, it does not address the need for a structured, non-permanent, residential program that will permit recovering substance abusers the time required to learn to live in an independent drug-free environment.

When asked what it would require in order to live in the community and remain drug-free, the respondents listed receiving support services from a 12 step self-help program (95%); obtaining housing (93%); and, access to treatment staff 24 hours a day (88%). Thus, housing and structured, professional services are essential. The design of such a residential program depends upon funding and the ability to coordinate supportive services. The first initial step includes the creation of a transitional, supportive housing program, which will provide people with the foundation to become successful in their own home within six months to a year.

Assessment: Criminal Justice

The reported relapse rate among people in the criminal justice system and the general public was nearly the same, 60% to 57% respectively, but some significant differences did exist:

- 54% of the people within the criminal justice system indicated that they wished to live with other recovering people.
- 46% of the people within the criminal justice system indicated that the environment was the primary cause for their relapse, while 70% of the general population stated that environment was the significant cause for their relapse.
- 28% of the people within the criminal justice system indicated that they wanted to return to their prior environment, while only 17% of the general population wanted to return to their former environment.
- The criminal justice respondents also listed access to substance abuse treatment staff as less important than the general population - 66% to 88% respectively.

Based upon these responses, it is recommended that a highly structured, supportive living environment should be developed to meet the specific and difficult needs of people released from the criminal justice system. These individuals are still in need, or require daily monitoring and treatment for an extended period of time (six months to a year).

Regulatory Impact

Restrictions are placed upon the development of supportive housing options through the use of municipal and township zoning. The administrative and legislative creation and implementation of these laws have evolved from the premise to eliminate nontraditional single family housing from residential neighborhoods. Today, these regulations appear to conflict with the Fair Housing Act as amended.

The Fair Housing Act, as amended, prohibits:

- Regulatory land use controls to enforce special controls over housing for people with disabilities such as spacing or density requirements or special/conditional uses for group living environments for people with disabilities;
- Limiting the definition of the term "family" in order to restrict occupancy by relationship or number of people in single family neighborhoods.

Recommendations: Supportive Housing for Recovering People

Program Design

Improving the quality of life and aiding in prevention of relapse for recovering people is the intended goal of supportive housing. Objectives of supportive housing also include achievement of drug-free status for all members, developing a change of lifestyle for residents and preparation for reintegration in the community at large. Designing a program for recovering people requires assessing all supportive services within the framework of housing, in addition to the administrative tasks which must accommodate the organization of the housing and the residents who desire to live there. Review of the perspectives of all people involved in the development of housing and supportive services is necessary to insure the residential setting maintains the overall philosophy of substance abuse treatment and the process of recovery. There is a need to identify treatment provisions and activities as well as provide environments required for the effective implementation of these activities. Predictions of viability are relative to four basic requirements:

- "facility's space use program and related design requirements must be satisfied;
- housing must be economically stable and accessible;
- occupancy must be stable and predictable;
- site-control must be obtained" (Wittman, 1989).

The management and operation of the housing must insure all members maintain clean and drug-free living. All residents must abstain from all drugs/alcohol with the understanding that a return to the use of such means eviction. Monitoring and self-supervised arrangements among the residents themselves should be encouraged.

The need for on-site staff is dependent upon the source of funding, the clients served and the length of sobriety of residents. State funding is dependent upon following specific state-certifiable standards, published by the Ohio Department of Alcohol and Drug Abuse Services, for residential service categories. Other sources of private funding including community organizations, church affiliations and private donors may be sought and arranged on an independent basis. Owners may explore opportunities regarding financial acquisition through examples like the Department of Housing and Urban Development, and state and local resources. Owners seeking state licensure may contact the local Alcohol and Drug Addiction Services Board.

Specific criteria with regard to design of supportive services may be customized according to how services will benefit the residents involved. The following recommendations are based on literature review and may be helpful in designing therapeutic environments to benefit the recovering person who wishes to maintain clean and drug-free living in a supportive atmosphere, before reintegration into the larger community. The creation of a supportive residential environment requires consideration and planning of the following factors:

- Setting
- Occupancy Term and Size
- Policies and Procedures within Supportive Living Establishments

Setting

Quality of the setting is very important. A safe, physically secure, attractive, sociable and comfortable dwelling emphasizes the importance of maintaining drug-free, clean living. Easily monitored entrances/exits and controlled building boundaries; opportunities for socialization in specially designated rooms; sufficient storage space; areas for privacy; location away from communities consisting of high concentrations of drug/alcohol abuse, drug dealing activities; design for recreational activities, exercise and activity centers; access to public transportation, employment, shopping and medical/social service agencies are suggested guidelines to consider prior to developing a dwelling.

Assessment of the physical environment within the dwelling is necessary to evaluate private sleeping space; kitchen availability and proximity; adequate lavatory facilities, (number and accessibility); privacy which includes the availability of curtains and doors; and a stimulating, home-like environment with non-standard, decorative surroundings; good state of repair, cleanliness and modifications as necessary. All efforts should be focused upon creating a homelike environment.

Occupancy Term and Size

Length of stay must be a consideration in designing supportive housing options. Long-term, open-ended or multi-year housing options should be available. Longer stays will permit additional reinforcement of sober living tools and a greater chance for success. The smaller the number of residents, the more likely it is that the benefits and supports from within the residence become stronger and more effective. Smaller number of occupants encourage more interaction and participation.

Policies and Procedures within Supportive Housing Establishments

The physical and philosophical design of supportive housing program is dependent upon a number of related factors which are necessary for consideration before implementation or development. Policies and procedures in the daily workings of the household and new admission of individuals are the initial considerations to take into account before beginning a residence for recovering people. These documented, planned policies and procedures should be aimed at identifying, supporting and meeting the needs of people recovering from addiction. Considerable variation and creativity ranging from participation in household duties to the quality of interpersonal relations expected among residents should characterize the management of homes for recovering addicts. Without fiscal control over programs, it may be difficult to encourage proper program design and implementation. But, the following may be used

as guidelines for development of policies and procedures for all supportive service programs.

Admission Process

Policies and procedures should include a specific description of the selection process for recovering people who apply for admission into the supportive housing facility. Owners should establish a process which distinguishes clients who are motivated to accept the challenge of recovery. It may also be helpful to use the following guidelines in establishing admission criteria:

- gain other residents' input regarding what should be requested of applicants;
- current members' participation in the interview process may also be helpful;
- creating a good match between the residents and the management rules is a large part of the art of successful residences, therefore, it is necessary to get and evaluate applicant's responses to the requirements of living in the supportive housing establishment;
- criteria such as completion of at least a detoxification program is necessary and at very best, a 14 to 28 day treatment program, to insure freedom from medical problems for applicants who have not been clean from alcohol/drugs for a lengthy time period;
- ability to pay rent must be established;
- complete understanding of rules and regulations of the household is necessary to insure applicants admitted are willing to comply with such;
- applicant must openly take responsibility for thoughts, feelings and behaviors and be willing to take personal responsibility for recovery;
- re-evaluate the selection process after a 3 to 6 month period to determine whether changes should be made based on problems experienced.

Treatment

Owners must first decide if treatment will be provided within the residence and the nature of that treatment. This must also consider the ethical and legal implications of treatment provided. The treatment philosophy and goals for members of the household must be determined and should be compatible with the treatment philosophy of the substance abuse system. This includes consideration of the following:

- Treatment standards and regulations of state licensed facilities are specifically defined and may be pursued through contact with the local Alcohol and Drug Addiction Services Board. Specific requirements for state certification must be met.

- Optional treatment methods must be also considered in conjunction with the availability of funding for qualified staff to provide treatment activities and available.

Treatment options may include but are not limited to:

- group meetings to explore personal problems and the commitment to be clean and drug-free, to share emotional experiences in a family-like atmosphere;

- individualized counseling/therapy provided in-house by a qualified chemical dependency counselor, perhaps on a contractual arrangement with an area agency;

- 12-step self help group meetings which may take place on the premises, facilitated by a volunteer who is also recovering;

- outpatient and aftercare linkage for residents who can assume responsibility for obtaining the link and maintaining the contact with the community resource.

Expectations and Restrictions of Residents

Admission to the supportive housing residence should include a full description of what is expected of residents, prior to acceptance of the placement. The resident's understanding of the expectations of living within the home must be documented to insure that residing there to gain control over one's personal life, is the common goal of both the owner and the applicant. This may be done by arranging a list of requirements and expectations for members of the home which requires the applicant's signature upon acceptance of the residence. Owners must formulate goals and expectations of people who live within the home. This will provide a reasonable structure of living in order to give recovering people the chance to make productive lifestyle changes. Requirements of residence may include:

- participation in program(s) of recovery as devised by a professional, probation officer, parole officer or between the owner and the applicant which includes active participation in self-help groups;

- residents are required to remain drug and alcohol free with the consequence of immediate dismissal if one chooses not to comply;

- residents must be willing to accept personal responsibility for caring

for their own needs and the requirements of maintaining residency in the home;

- identification of household tasks required to make the house a comfortable place for all which may include cleaning, planning and cooking meals, grocery shopping, etc...;
- a code of conduct with defined standards of behavior, expectations regarding curfews, leaving the house, presence at meals, privileges, process of written warnings upon violation of rules, etc must be defined;
- participation in house meetings to discuss current issues of residing together as a household;
- visitor restrictions, i.e., visiting within designated areas and certain hours of the day only, sign-in sheets, etc;
- safety measures pertaining to fire and tornado procedures must be clear and understood;
- guidelines for use of the telephone;
- expectations of room upkeep, room monitoring/inspection activities pursued by owner/staff;
- method of resolution regarding issues resident would like to resolve, for example discussion with staff/owner and if decision is not satisfactory to resident, then 3rd party mediation committee is consulted with;
- written daily schedule of activities and expectations should be considered.

The opportunity to build self esteem and feelings of success may be achieved through an arranged system of "status" within the home. Giving the opportunity for one to achieve rank within the home may provide additional incentive to remain committed to the process of recovery. For example, the 414 House in Canada uses 4 levels of status: probationary (for newly admitted residents), junior residency (after 3 months of residence), senior residency (6 months residency) and finally reentry into the community. Recognizing a democratic process of voting on new issues or suggesting different ways of performing activities within the residence may also be helpful in building self esteem in each resident. The process which encourages input places value on what the residents have to contribute.

Expectations upon the Owner/Operator

Crisis Management

A process designed to intervene upon crisis situations may be helpful in teaching residents how to deal with life stressors. Previous sections of this plan for supportive housing reported relapse usually happens upon stressful events and is the result of resident's inability to cope. By providing a means for the residents to discuss stressful situations and divert the need for a return to drugs/alcohol, relapse may be prevented. The following are suggestions to address crisis as it arises:

- utilize and support the concept of 12 step self help groups, require individual residents participate on a regular basis;
- require the use of a sponsor within the community for residents to contact to crisis situations;
- post the telephone number for the local crisis agency in a visible place;
- encourage open communication between owner/staff/residents;
- encourage residents to learn to cope with problems and emotional pain in direct ways;
- positive attachments within the residence are important to create an atmosphere of support;
- assist residents in viewing a crisis as a growth process that can be converted into a positive constructive opportunity for life improvement;
- owners must be aware that crisis may reflect problems within the residence in need of attention and resolution.

Staff and Volunteers

The roles of staff and volunteers vary and overlap from supervising activities to rousing people in the morning. These individuals may provide any number or none of the following services: group counseling sessions; phone answering; coordinate case management activities; process employer's requests for assistance with a specific employee; monitor activities within the residence by taking charge of the door and documenting observations of resident's behavior; perform admission interviews; and act as an advisor or a companion.

The less perceived monitoring status that exist between staff and residents, the more effective communication and interaction between the two entities is likely to become.

A friendly, sociable climate is essential to provide a supportive atmosphere. Promotion of the residents' management of the home would likely be more effective in building the skills residents need to eventually live in a permanent, independent living situation. Residents' management of the household distinguishes it from what would otherwise be considered a residential treatment program or an institutional facility.

Supportive housing presents an opportunity for recovering people to receive support, feedback and insight from staff role models. This form of leadership though, must emphasize where decisions are made, who makes which decisions, which decisions are made by staff, which are made by residents and which are made by the owner. Supportive housing facilities need comprehensive guidelines and structure for participants and staff members to follow.

Ex-Offenders

Principles governing the rehabilitation of ex-offenders who are recovering are basically comparable to the overall concept of providing supportive housing to recovering people who are not involved with the criminal justice system. The main difference may be that admission is court-ordered instead of voluntary, thus impacting the success of the recovery process. If one is court ordered into treatment or rehabilitation the person may not have taken personal responsibility for the addiction. Thus, the recovery process will most likely be unsuccessful once released from the criminal justice system. Intervening upon release on a voluntary basis, increases the chances for success substantially and success becomes comparable with other recovering individuals not involved in the criminal justice system. Offenders typically have a difficult time keeping rules and abiding by regulations. Therefore, it is considered necessary to integrate them into a new environment which is socially acceptable (if them, and them with the environment) while dissolving their old ties to the environment that promoted addiction.

The following factors, in addition to all the previously noted information, should be considered upon devising a plan to accept ex-offenders who are recovering, into supportive housing establishments:

- the recovering person should be removed from common drug abusing groups into groups which encourage a clean and sober lifestyle, thus supportive housing establishments;

- people served should be those whose common goal is reformation and recovery from addiction with the willingness to abstain from drugs/alcohol/crime;

- a common goal must include taking personal responsibility for own behavior, that they are there to think about and focus on their own behavior;

- group cohesion and feelings of belonging are also important factors to achieve positive outcomes in recovery;

- status and/or rank within the residence to promote achievement and success and replace the desire to gain prestige within the environment of addiction is also recommended.

Community Resource Utilization

An important part of any plan of recovery are the primary services extended to residents to insure development of skills to help them function in independent living situations. Supports and services should be a primary consideration in developing a supportive housing model. A large number of recovering people lack basic skills which enable them to lead productive lifestyles including finding employment, coping, money management and recreation. Supportive services may refer to any number of services which address physical, social, economic and political supports. Addressing development of all these skills will lead the recovering person to a self-sufficient lifestyle with adequate social and economic skills to be successful in the transition from the supportive living arrangement to independent, permanent living. Living together in a supportive housing environment will help promote change and increase coping abilities and lifestyles in general to eventually enable residents to cope with their feelings and all environments.

The following guidelines are recommended in order to facilitate linkage with community resources to aid recovering individuals in developing basic living skills:

- collaboration between service providers and housing providers;

- establishment of links with health and social services providers and neighborhood supports;

- provide the opportunity for rewarding, productive activity. This may be accomplished through promoting vocational training, educational assistance, employment opportunities, etc... This may be achieved through meetings with local community agencies who provide these services and establishment of formal links between the residence and the agency. This may also be achieved through informing residents of the availability of possible resources, enabling residents to choose for themselves and take personal responsibility in improving current lifestyles.

- discourage isolated activities among newly admitted members, encourage newly admitted members find a long-term resident to lean on through the process of adjustment in a new environment;

- may consider using volunteers who have achieved long-term clean and drug-free living skills to coordinate groups and other activities within the home;

- continually point out the residence is an opportunity to change lifestyles and the common goal is to leave the home and live as productive member of society;

Housing Development

The creation of new supportive housing options for people in recovery from substance abuse requires consideration of typical real estate development factors. A central premise in all housing development is to create a product that will attract people. This concept is just as, or more, important for supportive housing, as it is for market rate, owner-occupied housing. People in recovery must feel that their housing is secure, safe, convenient to commercial services, affordable, and non-institutional in design and function. Aside from there site-specific factors, there are a number of organizational factors which also need to be considered including ownership, operation, management and funding. All of these must be considered when developing additional housing resources.

The following discussion highlights each factor. Recommendations for each housing development factors are based upon the experience of Planning Concepts in establishing housing programs and are solely intended to increase the availability of housing options.

Housing Ownership

Housing ownership and all types of corporate structure must be determined in order to access available funding, coordinate supportive services, and maintain long-term control over the housing.

An initial question is who should own supportive sites? The answers are many: existing treatment facilities, non-profit housing corporations, private for-profit corporation and individuals or all of the above. Presently, there are no standards or preference for housing ownership. It is a mixture of private and public programs. While there is no mandate to significantly change this situation, the following recommendations are intended to increase housing options.

- Housing should be owned by a non-profit corporation [501(c)(3)]. This corporation should have a contract or affiliation agreement with a provider(s) of supportive services.

    - A non-profit housing corporation will have the ability to use available private and public funding to increase all housing options.

- There may be a number of issues which are in conflict between tenant treatment and occupancy. Staff from a treatment program may not have the ability to enforce occupancy issues (i.e. rent payment, tenant behavior and expectations, etc.).

- If the decision is made not to own, but rather lease housing, then the corporate structure of the lease holder is less of an issue. There is still a need for a contract if supportive services are provided by a third party.

Operation and Management

A clearly defined operation and management plan must be prepared for a supportive housing environment. Since there is no special model for a successful supportive program, the following is a general list of issues which need to be determined.

- Structure of the housing operation and management. What are the responsibilities of the housing owner/lease holder versus the provider(s) of supportive services?

- Establish a tenant screening process. Who will administer this process? What criteria will be used for accepting or rejecting placements?

- Develop minimum tenant responsibilities within the home (i.e. cleaning, cooking, maintenance, etc.).

- Eviction criteria.

- Specific and detailed operational, maintenance and management costs.

Location

Successful supportive program must be located in safe, secure areas where people in recovery will be permitted to remain substance free. Philosophically, these locations should be in neighborhoods less impacted by drugs. Realistically, all neighborhoods are vulnerable to crime and drugs, but an effort should be made not to locate supportive housing in known neighborhoods with high crime and drug sales.

Aside from this general premise, there are a number of locational issues to be considered including:

- Housing should be integrated within the community in a non-intrusive fashion. No special events or identification should be made which will draw attention to the homes.

- The home should be accessible to commercial and community services including stores, restaurants, medical services, educational facilities, etc.

- Housing should be located within close proximity (less than one-quarter of a mile) to public transportation.

Summary

The development a supportive living environment requires the coordination of services and housing development. The recommendations are intended to provide the foundation for the development of additional housing and supportive service resources. These individual issues must be addressed on an individual site-by-site basis based uppon the intended tenants.

Conclusions

Why is a Therapeutic Environment Necessary?

Environments with a "combined special and physical designation for groups of people with a specific disability and type of place to treat the disability are identified as therapeutic. The definition of issues and an explanation of their etiology form the basis for the selection of experiences and setting that presumably will lead the disabled back to acceptable modes of behavior" (Canter and Canter, 1979). A therapeutic environment provides the services required to assist people with disabilities to live in the community. It has been the purpose of this plan to provide the foundation which may be used to create additional therapeutic environments, through supportive housing. A setting considered a therapeutic environment recognizes and supports the strengths and weaknesses in people, which may be physiological, psychological, social, economic or political. Strengths and weaknesses are recognized without applying stigma or isolation.

Housing for recovering people is insufficient, causing the homeless population to increase in this special population. The newly recovering population lacks coping skills to manage their lives in a functional manner. They lack economic and social resources to obtain and maintain clean and drug-free lifestyles. They lack environmental support which encourages value systems contrary to chemical use/dependency.

To incorporate change in people who desire to abstain from chemical use, it is necessary to first consider and evaluate the factors affecting the desire to be free of drugs/alcohol. If a person is willing to accept the facts that: the recovery process begins with the recognition of problems resulting from substance dependency; lifetime abstinence is required for a successful, functional life; participation in an individualized plan of recovery is required; development of skills to lead a functional life is necessary; and the acknowledgment of signs and symptoms of the disease to prevent relapse must be pursued, then the individual may be considered ready and able to accept the challenge of a supportive environment.

Motivational desire is required to impart a necessary change of lifestyle for success. The challenge of changing personality and lifestyles is met first through an individualized plan of recovery. Once detoxification is achieved, a person is able to proceed in obtaining clean and drug-free living through a plan devised by substance abuse treatment staff and/or through self identified goals with the support of 12 step self help groups. This is a relative process to achieve stability and is useful in defining problems and/or situations and stressful events that have the potential of reactivating self-defeating behaviors and chemical abuse.

Structure and predictability may be achieved through the provision of drug free environments, and supportive settings. Research has pointed out environmental risk factors are multiple and that residing within a drug saturated area within the first six months of drug-free, clean living may contribute to relapse. Environmental factors,

combined with poor coping skills encourage relapse. The relapse process is marked by symptoms such as depression, inability to manage painful thoughts/feelings and reactivation of the impulse/drive to use drugs/alcohol again as a way to cope. Every day experiences serve as triggers to drug-seeking and taking behavior, therefore, ties with fellow substance abusers, places of prior use and purchase of drugs/alcohol must be acknowledged with a commitment to refrain from these people and places.

Elimination of social contacts and peer groups, conditions which previously reinforced drug seeking/taking behavior will aid in supporting the individual toward productive change. Separating the addict from common places, people and rituals which accompany drug/alcohol use reinforces the opportunity for a change of lifestyle. Eliminating these factors can also cause the addiction to lose its appeal.

Removing the addict from the environment in which the addiction thrived must be met by a therapeutic setting which provides an atmosphere filled with support, structure, stability and predictability. The environment will serve as an instrument to aid the recovering person:

- in becoming aware of signs and symptoms of relapse;
- in providing self awareness of the need to accept personal responsibility to pursue behavioral change and personality change regarding beliefs about alcohol/drug use;
- will serve as a support by the presence of other recovering individuals who experience common situations and feelings;
- in formulating goals and expectations for self as well as for the residential setting to create socially acceptable value systems and behavioral expectations;
- will aid in establishing new social and economic supports in preparation for independent, permanent living.

Those who wish to maintain the process of recovery must also share common objectives. Recognition of the addiction as a disease and the need for lifetime abstinence from all drugs/alcohol must be consciously pursued. Clean and drug-free living will then offer healthy alternatives to all recovering people who are motivated to accept the challenge.

Utilization of community resources must be considered and be made a priority for recovering people living within supportive housing residences. More than just housing is necessary for effective, long-term recovery and community integration. Supportive environments which provide opportunities for changing lifestyles must be provided in conjunction with community resources to reinforce the need of residents to move away from fostering dependence upon the residence, but rather self-sufficiency in living an independent lifestyle, free from drugs/alcohol. Supportive housing facilities promote self-responsibility in maintaining drug-free lifestyles, while at the same time must consider promoting independent living, away from the supportive housing component. The intent of residing in a supportive housing environment must be identified as an opportunity to prepare recovering people for re-entry into the community as functional citizens who are able to contribute to society's needs.

Supportive housing facilities must establish links with community agencies who provide social, health or vocational services for the community. Recovering people often lack a number of self-sufficient independent living skills like money management, employment skills, interpersonal relationship skills, socialization skills, coping skills, etc... Breaking out of the world of addiction means achieving personal goals and re-defining values and expectations of self. To be effective in doing so, one must have the opportunity to invest in building and developing skills which are lacking to promote a change and accomplish goals. Community agencies which provide interventions to address development of these skills must be contacted to establish formal or informal links with the housing establishment. This will insure recovering people within the residence will have the opportunity to improve additional areas of their lives and alter their response patterns to cope more effectively, with the goal of living an independent lifestyle in mind.

APPENDIX

Appendix A

Planning and Zoning Telephone Numbers

Township Zoning		Municipal Zoning	
Harding	826-1456	Oregon	698-7077
Jerusalem	836-8134	Northwood	693-9329
Monclova	865-7857	Maumee	893-8751
Richfield	829-2114	Ottawa Hills	536-1111
Spencer	865-2883	Sylvania	882-7102
Springfield	865-0239	Holland	865-7104
Swanton	826-9914	Rossford	666-0210
Sylvania	885-5276	Whitehouse	877-5383
Washington	729-0853	Waterville	878-8107
Waterville	878-4746		
Providence	875-6100		

Building Code Information

City of Toledo Division of Inspection	245-1220
Lucas County Building Permit Department	245-4230

Appendix B

Preliminary Building Code Requirements (Ohio Basic Building Code) - City of Toledo
Furnished by the City of Toledo Plan Commission and Division of Inspection

Use Group Classification

I-1 Transient Occupancy (less than 30 days)

Characteristics

Six or more individuals, because of age, mental or physical disability or other reasons, must live in a supervised environment but are capable of responding to an emergency situation without personal assistance, such as:

residential care facilities
board and care facilities
half way houses
group homes
social rehab facilities
alcohol/drug centers
convalescent facilities

Building Limitations:

2 story/35 feet
4,200 square feet per floor for wood structures
2 means of egress with an interior stair enclosed by 1 hour rated walls.
No sprinkler system required for 2 stories or less and having an occupancy of less than 20, but sprinkler required for storage/workshop areas, furnace rooms and windowless basement.

R-2 Transient Occupancy (more than 30 days)

Characteristics

All boarding houses, adult group homes, dormitories, etc., for more than 5 individuals.

Building Limitations:

2 story/35 feet
4,800 square feet per floor for wood structures
For two story buildings, one means of egress with an interior walls rated 1 hour may be permitted if each floor is 3,500 square feet or less and the maximum travel distance to an exit is less than 50 feet
No sprinkler system required for buildings 75 feet or less in height except for storage/workshop areas, furnace rooms and windowless basement.

R-4 Detached 1, 2, 3 Family Dwellings (CABO Code Governs)

Characteristics

Two non related family members are permitted to occupy each dwelling unit.

BIBLIOGRAPHY

Allan, Carol A., "Characteristics and Help-seeking Patterns of Attenders at a Community-based Voluntary Agency and an Alcohol and Drug Treatment Unit", British Journal of Addiction, 1989, 84, 73-80.

Annis, Helen, "Relapse to Substance Abuse: Empirical Findings Within a Cognitive-Social Leaning Approach", Journal of Psychoactive Drugs, 22, (2), Apr-Jun, 1990.

Brochu, Serge, "Abstinence versus Nonabstinence, The Objectives of Alcoholism Rehabilitation Programs in Quebec", Journal of Psychoactive Drugs, 22, (1), Jan-Mar, 1990.

Brook, Robert and Whitehead, Paul, "Drug-Free Therapeutic Community", Human Sciences Press, 1980.

Caetano, Raul, "Concepts of Alcoholism among Whites, Blacks and Hispanics in the United States", Journal of Studies on Alcohol, 50, (6), 1989.

Canter and Canter, "Designing for Therapeutic Environments", Wiley & Sons, 1979.

City of Lansing Planning Department, "The Influence of Halfway Houses and Foster Care Facilities Upon Property Values", Lansing, Michigan, October 1976.

Codified Ordinances of Maumee, "Part Eleven - Planning and Zoning Code", 1990.

Codified Ordinances of Oregon, "Part Eleven - Planning and Zoning Code", 1990.

Codified Ordinances of Sylvania, "Part Eleven - Planning and Zoning Code", 1990.

Ditzler, Joyce and Ditzler, James, "Treatment At Farm Place", British Journal of Addiction, 1989, 84, 493-497.

Edwards, Griffith, "The Addiction Research Unit of the Institute of Psychiatry, The Work of the Unit's Drug and Alcohol Section, and General Issues", British Journal of Addiction, 1989, 84, 715-725.

Fram, David, "Group Methods in the Treatment of Substance Abusers", Psychiatric Annals, 20, (7), July, 1990.

Garrett, Gerald R., "Alcohol Problems and Homelessness: History and Research," Contemporary Drug Problems, Fall, 1989.

Gilbert, Francis, "The Effect of Type of Aftercare Follow-Up on Treatment Outcome among Alcoholics", Journal of Studies of Alcohol, 49, (2), 149-159.

Glaser, Frederick, "A Systems Approach to Alcohol Treatment", Addiction Research Foundation, 1978.

Gorski, Terence, "The Cenaps Model of Relapse Prevention: Basic Principles and Procedures, Journal of Psychoactive Drugs,k 22, (2), Apr-Jun, 1990.

Hall, Sharon et. al., "Commitment to Abstinence and Acute Stress in Relapse to Alcohol, Opiates and Nicotine", Journal of Consulting and Clinical Psychology, 58, (2), 175-181.

Herd, Denise, "Subgroup Differences in Drinking Patterns among Black and White Men: Results From a National Survey", Journal of Studies on Alcohol, 51, (3), 1990.

Jansen, Elly, (editor), The Therapeutic Community, Croom, Helm, London, 1980, The Phoenix House, by Mitchell Rosenthal, p.102-111; Therapeutic Communities, by Elizabeth Shoenberg, p. 64-71; The Halfway House as a Therapeutic Community, by Howard Hoffman, p. 72-85; A Theoretical Approach to the Halfway House, by Sue Harris, p. 121-131.

Kurtz, Ernest, "AA, The Story", Harper and Row Publishers, 1988.

Mandelker, Daniel R., "Land Use Law", second edition, The Michie Company, 1988.

Mandelker, Daniel R., "Land Use Law", second edition, The Michie Company, 1991, Cumulative Supplement.

Mental Health Law Project, "The Impact of the Fair Housing Amendments on Land-Use Regulations Affecting People with Disabilities", 1988.

Milhorn, Thomas Jr., "Chemical Dependence, Diagnosis, Treatment and Prevention, Springer-Verlag, 1990.

Mills, Kenneth et. al., "Handbook for Alcohol Education", Ballinger Publishing Company, 1983.

Ohio Department of Development, Office of Local Government Services, "Rural Zoning Handbook", State of Ohio, 1986.

Peele, Stanton, "The Meaning of Addiction", Lexington Books, 1985.

Rubington, Earl, "Alcohol Problems and Social Control", Merrill Publishing Co., 1973.

Rubington, Earl, "Relapse and the Chronic Drunkenness Offender", Connecticut Review on Alcoholism, November, 1960.

Rush, Brian, Ekdahl, Ardith, "Recent Trends in the Development of Alcohol and Drug Treatment Services in Ontario", Journal of Studies on Alcohol, 51, (6), 1990.

Sandoz, Inc., "From Theory to Practice: The Planned Treatment of Drug Users", The International Journal of the Addictions, 24, (7), 675-706, 1989.

Schecter, Arnold et al., (editors) "Drug Abuse", Marcel Dekker, 1978, pp. 785-796, 408-412.

State of Ohio, Department of Economic and Community Development, "Model Zoning Regulations, 2nd Edition", 1973.

Toledo Municipal Code, "Part Eleven, Planning and Zoning Code", 1991.

U.S. House of Representatives Report No. 771, 100th Congress, 2d Session 22, at 18, 1988.

Washton, Arnold, Stone-Washton, Nannette, "Abstinence and Relapse in Outpatient Cocaine Addicts", Journal of Psychoactive Drugs, 22, (2), Apr-Jun, 1990.

Weiner, Harvey, et. al., "Culture and Social Class as Intervening Variables in Relapse Prevention with Chemically Dependent Women", Journal of Psychoactive Drugs, 22, (2), Apr-Jun, 1990.

Wittman, Friedner D., "Housing Models for Alcohol Programs Serving Homeless People", Contemporary Drug Problems, Fall, 1989.

Yablonsky, Lewis, "The Therapeutic Community", Gardner Press, Inc., New York, 1989.

Zinberg, Norman, "Drug Set and Setting", Yale University Press, New Haven and London, 1984.