The Service Hub Concept in Human Services Planning

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PERGAMON

Biographies

Michael Dear has been professor of geography at the University of Southern California since 1986. He received his BA degree (1966) in geography from the University of Birmingham, his Master of Philosophy degree (1969) in town planning from the University of London, and his MA and PhD degrees (1974) in regional science from the University of Pennsylvania. Professor Dear is heavily involved in public policy-related work. In 1992 he was retained by the Community Redevelopment Agency of the City of Los Angeles to assist in the preparation of a twenty year land-use plan to guide the future development of downtown Los Angeles. He also works with national and local voluntary organizations on behalf of the homeless and the mentally disabled, with emphases on the organization of community-based care and overcoming the NIMBY syndrome.

Professor Dear received a Guggenheim Fellowship and the Golden Key Honor Society universitywide award for excellence in research in 1988–89. In 1993, he was elected a fellow at the Center for Advanced Studies in the Behavioral Sciences in Palo Alto and received the University of Southern California's highest honor of creativity in research. He is the author or editor of six books and a great number of articles in academic journals. He is the founding editor of the journal *Society and Space*.

Jennifer Wolch is professor of geography and urban and regional planning at the University of Southern California, where she chairs the Department of Geography. She received her BA degree (1975) in anthropology, her MA degree (1976) in geography from California State, Hayward, and her PhD degree (1978) in urban planning from Princeton University. Her research focuses on the problems of service dependent and homeless people in American cities, social policy and human service delivery, and the role of the voluntary non-profit sector in the American welfare state. Since 1987, she has directed the Los Angeles Homelessness Project.

Professor Wolch is a winner of the Best Article of the Year Award from the American Planning Association (1985) and the Hagman Prize of the American Planning Association's Southern California Chapter (1984). In 1993, she was elected a fellow at the Center for Advanced Study in the Behavioral Sciences in

Palo Alto. Her books include *Landscapes of Despair: From Deinstitutionalization to Homelessness* (1987, with M. Dear), *The Power of Geography: How Territory Shapes Social Life* (1989, co-edited with M. Dear), and *The Shadow State: Government and Voluntary Sector in Transition* (1990). Professor Wolch is also actively engaged in urban planning practice, most recently serving as a consultant to the Los Angeles Downtown Strategic Plan with responsibility for the Skid Row area.

Robert Wilton is a graduate student in the Department of Geography at the University of Southern California where he is currently completing his MA. He received his BA (1991) from the University of Hull. His research interests currently include the experience of marginalized groups within society, including the homeless population, the mentally ill, and those with HIV and AIDS, as well as the practice of human service provision. The focus of his Master's thesis is the geographical dimensions of life following an HIV diagnosis.

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Contents

Abstract

This monograph examines how the concept of a 'service hub' could assist in the delivery of human services. This concept emphasizes and builds upon the networks that exist between human service clients and the facilities designed to help them and concludes that by co-location of facilities relative to groups in need, a more effective service delivery is achieved.

The problematic of human services focuses on the notion of service hubs, but also incorporates four other elements: assessing and assigning needy clients to appropriate treatment settings; facilitating the actual and potential social networks of clients; addressing the relationship between the service facility and its host community; and determining the socio-spatial goals of the service delivery system.

The principles of the service hub concept involve the co-location of a set of relatively small-scale, community-based facilities in such close physical proximity that interaction between them is feasible to the extent that the set of facilities functions as an integrated unit. Service hub interaction depends on the effectiveness of the assignment and referral process, as well as the hub's ability to capitalize on client-coping networks.

Two case studies of service hubs in Los Angeles underscore the significance of geography in service hub structure and in the lives of homeless people. A third case study demonstrates how service hubs are constructed by adding-on carefully selected facilities to existing community networks.

As any plan for the construction of a region-wide system of service hubs is likely to run into community opposition at the local level, such a plan should also include a community outreach program as part of its overall strategy. 'Fair-share' principles in regional human service systems are also considered, and the fundamental issue of overcoming stigma and discrimination based on disability and difference is highlighted in a future research agenda.

Acknowledgements

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CHAPTER 1

Introduction: The Problematic of Human Services Planning

The problematic of human services planning remains ill-defined. For some, it is simply a matter of efficiency in facility location to ensure client access; for others, it broadens to issues of the inherent inequality of medicine under capitalism. In this essay, we shall focus firmly on the geographical aspects of the problem, as well as the intrinsically spatial nature of planning solutions in human services delivery. Our approach is based on the concept of a 'service hub', although the overall problematic also takes into account the difficulties associated with effective client assessment and assignment; overcoming the opposition sentiments that commonly block human services provision; and questions associated with socio-spatial justice.

As a point of departure, it is useful to think about these challenges in terms of *networks* of clients and facilities as they exist in and through space and time. Client networks for the most part consist of peer group interaction and other forms of formal and informal contact with helping agencies. These networks can be characterized as distinct entities so that it becomes important to understand the interactions *between* two or more groups in close proximity (be they positive or negative). On the other hand, it is also vital to appreciate the activity which occurs *within* a network as individuals develop relationships and learn to function as one element of a communal group.

Interlinkages between facilities are also significant. In the same way that different groups of clients in close proximity may generate interaction, so too can facilities. One positive potential is for client referral. Where interaction is 'vertical' (i.e. where two or more facilities in close proximity represent linked stages in a client's sequence of treatment) proximity may be highly beneficial, facilitating smooth transitions between services for those on the road to recovery. But positive effects may also occur where interaction is 'horizontal', allowing facilities to benefit from their proximity even though they may not be linked programmatically. One example of this may be where the infrastructural base of one facility (e.g. street lighting, open space, etc.) is available to others at no extra cost.

Finally, interlinkages occur across the interface between client and facility. In many ways, these are the most important, since facilities must effectively engage their target populations if they are to achieve success. Errors by service providers, or mistrust of the facility and its surroundings by clients, can mean failure for even the best equipped program. In terms of geography, a poor facility location will clearly deter potential visitors whose daily routines and intricate social networks draw them to other locales. For many service dependent individuals (particularly the homeless) informal networks represent vital components of day-to-day existence; they are not easily sacrificed, regardless of the more formal programs and services on offer.

In terms of land-use planning, our general objective is to improve the positive interactions among the client and facility networks identified above. A specific focus must be to improve the general setting in which client–facility interaction occurs. Currently, human service facilities, especially for the poor, are often confined to settings which can best be described as marginal. Because of this, even where the fit between individual needs and facility services is highly effective, the conditions in which that interaction occurs may significantly hinder progress. Negative influences may include a dilapidated built environment, lack of appropriate neighborhood services, low numbers of affordable dwelling units, the absence of public transport, and a high crime rate.

1.1. THE SERVICE HUB CONCEPT

The task facing us is perplexing. Estimates of latent demand for a facility's programs may be sadly off-target if its design fails to successfully engage its potential clientele; resources expended with benign intent may thus have little tangible effect. One way to improve outreach and service effectiveness is through the use of the 'service hub' concept, which we define as the artful 'co-locational' siting of facilities that can create, and benefit from, an array of agglomeration economies. In simplest terms, the hub utilizes the fact of geographic proximity to create a highly functional and supportive service environment for clients. Because of their closeness, facilities are able to function as an integrated whole, offering comprehensive, yet flexible, programs of assistance. We hasten to add, however, that we are not advocates of a deliberate attempt to 'ghettoize' human services. Although this outcome has *de facto* arisen in certain localities, it will become clear that our design is for a *decentralized system* of service hubs, in which all communities share equally in the burdens and obligations of community care.

At first glance, it may appear that the costs involved in developing and maintaining an integrated system of human service may be prohibitive. In many instances this may be true, yet this need not dampen one's enthusiasm for the concept, since one of the main attractions of the service hub is its flexibility.

There will be no universal design for a service hub, and no attempt to install a pre-packaged collection of components. Instead, each hub will be locale-specific, its shape and content dictated largely by the nature of the host community and the needs of future clients. This specificity achieves two things. First, a sensitivity to the conditions and resources within any single community allows a hub design that emerges from already-existing community resources (although not necessarily targeted exclusively for use by the service dependent). Hence, small shopping malls, community centers, health clinics and the like may act as potential anchors for the addition of new client-specific facilities, thus contributing to the growth of a service hub. Secondly, an awareness of local conditions increases our ability to recognize the presence of existing coping networks developed by the service dependent population. These can be used to inform the design of the hub and thus ensure a good fit between client needs and service provision.

Stressing the need for a setting-specific approach does not disqualify us from making some general statements about the content of the service hub. Most importantly, any hub should attempt to develop a physical focus within the neighborhood. The emphasis here is on reaching a critical mass of service opportunities through geographic proximity. It also requires that we pay careful attention to the way in which these facilities are sited, and to the additional opportunities that may be required to transform them into a fully functioning service hub. Such additions may include the provision of generic facilities (i.e. available for all community members), including retail outlets and cafes, the creation of a pedestrian zone at the core of the hub, the setting up of a system of shuttle transportation, or the provision of childcare services. Hub success will crucially depend upon the existence of an adequate level of residential opportunities in close proximity. Typically, these opportunities will be provided in Single Room Occupancy (SRO) hotels as well as other forms of group homes or emergency shelters. Open space (both soft and hard) may also contribute to the operation of the hub, providing aesthetic as well as material support for community members.

1.2. PLANNING FOR HUMAN SERVICES

Much of this essay is devoted to illustrating the ways in which service hubs can improve the delivery of human services. We begin by outlining the assumptions and principles behind the concept (in Chapter 2), as well as several real-world examples of service hubs in practice (Chapter 3). However, effective service delivery also depends on other operational and contextual factors which must be incorporated into the overall human services problematic. These include: the client need/treatment setting assignment process; the actual and potential structure of

clients' social networks; relationships between service facility and host community; and the socio-spatial goals of the human services planning problem.

1.2.1. The assignment process

Despite the significance of geography in service delivery, a focus on the spatial configuration of clients and facilities is not sufficient in itself to guarantee access to needed services. Regardless of the overall spatial fit achieved by service providers, ineffectiveness in the client assignment system will continue to deny potential benefits to needy consumers. Whilst assignment occurs through space and time, it centers on the issues of resource availability and service coordination rather than geography *per se*. Three decisions comprise the assignment process: gaining knowledge of client needs; assessing the resources that may be available to meet these needs; and ensuring that needs and resources are properly and expeditiously matched (Chapter 2). Accuracy in assignment is crucial. Clients provided with incorrect or inadequate assignment (e.g. through lack of resources) may not be helped and may even deteriorate.

1.2.2. Client social networks

Just as the assignment process emphasizes the linkage between client and the formal service network, so does a focus on client social networks draw attention to the significance of informal peer-group support in client well-being. Such support networks are of vital significance in the coping abilities of most individuals, whether service-dependent or not. However, in the case of the service-dependent, the effectiveness of such informal supportive arrangements can literally mean the difference between life and death. Since service hubs are intended to strengthen client support networks, an important element in our health service problematic will be to highlight the structure and potential of such networks (Chapter 3).

1.2.3. Community acceptance and rejection of human services

Not all communities welcome human service facilities and their clients. The objective of achieving a decentralized system of service hubs may be seriously compromised by the NIMBY (for Not-In-My-Back-Yard) syndrome. Local opposition to community-based facilities for the service dependent has had a significant effect on facility geography, contributing for example to the ghettoization of human service facilities in downtown zones of dependence (Dear and Wolch, 1987). In this essay, we develop a fuller understanding of community

reaction and employ these insights to improve our strategies for dealing with opposition (Chapter 4). A central element in this scheme involves refining methods of communication and outreach. Since opposition towards facilities often emanates from a small vocal minority, a principal goal of any effective communications program would be to galvanize the silent majority into action on behalf of the facility.

1.2.4. Socio-spatial justice

The current concentrations of service-dependent individuals and facilities designed to serve them in degraded, resource-deficient zones in our cities is not only untenable, but also unjust. To achieve a degree of what can be called 'socio-spatial justice', every community within a given urban or regional setting should be prepared to accept a fair share of the service dependent burden and obligation (although the specific form of that burden may vary between communities). This is, we recognize, a controversial proposal, but it is one to which we are inevitably drawn as a fundamental element of any community-based human services plan (Chapter 5).

1.3. A NOTE ON TERMINOLOGY

We hope to keep the discussion in this essay as general as possible so that its principles may be applied to the different human service sectors in which others may interested. To this end, we have adopted the term 'service dependent' to refer to a wide range of client and consumer groups. However, the examples that we use must, by necessity, refer to particular places and situations involving distinct segments of the service dependent population. Our principal exemplars are the homeless and the mentally disabled populations in Los Angeles. In these situations, the generic relevance of our discussion for other service-dependent populations may be compromised. Nevertheless, we hope that the strategies suggested and the problems encountered will prove insightful to many human service sectors, including (for instance) the mentally retarded, dependent elderly, substance abusers, children's services, and physically disabled.

CHAPTER 2

The Service Hub Concept

We begin with a detailed exploration of the human services problematic outlined in the previous chapter. First, the concept of a service hub is defined, emphasizing how its principles may be applied to a wide variety of geographical settings. The mere presence of a facility set is no guarantee that it will be utilized by a population in need; service utilization also depends upon the presence of an effective process that assigns those in need to appropriate treatment settings. In the second section, the principles of such an assignment process are laid out. Finally, the role of social support networks in client well-being is demonstrated; first with respect to links between the client and the formal service providers, and second, in the case of informal linkages between peers in the client population.

2.1. THE SERVICE HUB: SOME DEFINITIONS

We approach the planning of community-based support networks for the service dependent by adopting the following principles:

- The human problems of disability, deprivation and need may (in part at least) be addressed through the direct provision of human services delivered from a set of physical facilities in geographically-favorable locations.
- Such facilities will tend to have associated with them a range of positive and negative external effects, which extend over a geographically-finite area.
- The well-being of the service dependent population may be improved if as many as possible of the positive external effects are 'captured' by siting the facilities such that they are geographically proximate.

In other words, to properly address the needs of the service dependent, facilities should not only provide direct care, but should also be located close enough to each other that localization and urbanization economies can be realized. The former refer to benefits that accrue to directly-related services in close proximity to each other (e.g. a transitional living shelter and a job referral center); the latter to more general benefits that unrelated services enjoy through proximity (e.g. better street lighting and security in the vicinity of a hospital).

A *service hub* is a diverse collection of facilities for aiding the service-dependent. It consists of relatively small-scale, community-based facilities which are in such close physical proximity that interaction between them is feasible, to the extent that the set of facilities functions as an integrated unit. The service hub will typically consist of a heterogenous group of services, including some generic community functions, and typically is capable of addressing the needs of a variety of client groups. In this essay, we use the term *service-hub approach* to designate those planning efforts that attempt such a proximate siting of facilities, and, in so doing, reap the benefits of the agglomeration economies identified above.

The fundamental planning objective associated with the service hub concept is to create decentralized service and housing opportunities throughout an urban area. This dispersal will have the dual effect of providing more choice in residential location, as well as encouraging a fair-share principle in the burden and obligation of caring for society's dependent populations. In essence, the hub approach calls for replicating the positive support features of the zone of dependence (usually confined to the downtown core) in other zones of the city. Such a duplication may be achieved by creating a totally new service infrastructure, or by 'adding-on' the basic elements of a support network to existing infrastructures. These could include centers of established activity where levels of existing services are already high, such as a shopping mall with good transportation connections, a community center, a library, etc. If specialized services, reflecting the needs of specific groups could be added-on to such centers (e.g., a sheltered workshop), then a wider range of supportive community-based networks could be quickly created to meet local needs.

The purpose of the service hub is everywhere the same. It is to provide the necessary level of support and choice in community-based care so that the disadvantaged are able (to the extent possible) to maintain themselves in independent living, and so that their quality-of-life is maximized. Needless to say, it is difficult to define a priori what each service hub will consist of. Resources and needs will vary according to many dimensions, including city size, availability of specialized care, structure of the voluntary sector, local government policy, etc. However, whatever the variation in local conditions, two key planning issues must be addressed:

- what should be the geographical configuration of the newly-created housing and service support network; and
- what is the minimum necessary level of add-ons which would be sufficient to create a functioning service hub?

Although these questions are utterly fundamental to the design of a successful decentralized system of community-based care, they have scarcely been addressed in the literature. One reason might be that they are extremely difficult to answer

in any definitive way. We cannot hope to provide comprehensive answers in what follows; but we do hope to demonstrate some of the directions in which this vital research issue might proceed.

Our task then is to develop a truly community-based support system. This involves the active creation of support networks in every community so that service-dependent individuals are able to live outside institutions and participate fully in the everyday life of their neighborhoods. Such a task requires urgent attention. Many regions already have well-developed hospital-based care networks. Some have begun to develop rudimentary community-based networks; others have yet to do so. However, all jurisdictions are currently facing a time of restraint and cutback. Under such constraints, how can we construct a caring community network quickly, efficiently and cheaply?

In our judgement, direct and immediate attention should be given to the creation of service hubs in every community, building upon existing social networks by adding on the basic elements of a coping network for the service-dependent group(s) in question. In each case, the exact characteristics of the individual service hub will depend upon the size of the population in need, available community resources, location, and so on.

It is important to emphasize that we are not advocating the development of specialized treatment centers for clients. On the contrary, we recommend that a decentralized system of specialized services be attached to existing service concentrations within the community. The service hub approach focuses on the following principles:

- developing the community-based, local-level elements of the caring hierarchy;
- decentralizing responsibility for care to local communities; and
- building local ecologies that will integrate and support the service-dependent population.

The goal of the service hub approach is to create totally integrated, decentralized networks of care and support on a region-wide basis. Such a network includes hospital and asylum as well as informal folk-support networks. It implies a fully coordinated system to address the needs of the individual person as he or she moves through the system.

Quite clearly, local needs will differ. The challenge is to design and develop a planning framework that will permit the nature and resources of each locale to inform the exact form of their respective hubs. In this way, each hub is tailored to efficiently meet local demand. The following are examples of how service hubs could be developed in three different types of setting.

Metropolitan area. Recent decades have seen an increasing concentration of service-dependent individuals in certain well-defined zones of the city, usually near the downtown. Yet even in the most deteriorated skid row area such 'ghettoes'

have been observed to possess many positive dimensions typical of community-like support networks. One objective in this case setting would be to replicate the positive aspects of these support networks throughout the city, especially in suburban areas. The lives of the service dependent could be integrated with established community support networks, and a broad range of new housing opportunities would thus be made available to those in need. In short, new communities to meet the residential and service requirements of the service dependent could be rapidly created by building on what already exists.

Small town. A common experience in many smaller towns lacking regional hospital facilities is the migration of their residents in need to cities that possess such facilities. Typically, once a person travels to the city for care, that person often remains in the city after treatment is completed. The application of the hubs concept in this case would facilitate the return of migrants to their home town. The planning principle is only slightly different: to use the hub to ensure the creation of local support networks for individuals who need to be reintegrated into their communities. In many instances, the most pressing need will be for housing. A group home or half-way house concept could be developed in every town where sufficient need can be demonstrated. Such a center could provide shelter, generate employment, and — very importantly — act as referral and coordination entry points into the regional caring network. Center personnel and clients may also act as advocates for the long-term needy (for example, the chronically mentally disabled).

Rural areas. In more isolated rural areas, the problem of social support and caring is somewhat different; population densities are low, and resources may be scarce. But again, the concept of the service hub proves to be versatile and applicable. The objective of the hub in a rural setting is to augment and coordinate existing 'folk-support' systems by increasing awareness of the problems and needs of local service-dependent populations. Especially important is the role of trained personnel and volunteers in the referral of clients to other facilities and care centers, and in assisting their reintegration after a period of absence. Service hub personnel would also call on other resources to ensure adequate income and housing for local clients. In this case, the hub is less likely to take the form of a physical structure; it may be based simply in a coordinated telephone network.

Many other examples could be developed to show how service hub solutions may be designed to meet different local needs. It is not necessary to demonstrate every case; it is more important to recognize the versatility of the concept and its potential for widespread application in community-based care. The approach can be applied to low density, dispersed rural populations as well as to dense urban populations.

2.2. THE ASSIGNMENT PROCESS IN HUMAN SERVICES DELIVERY

The geography of service provision is a crucial dimension of human services delivery. The distribution of service hubs throughout a given urban or regional environment, and the spatial configuration of proximate facilities within individual hubs are both important factors determining the efficiency of service delivery. However, an accurate patterning of services does not, in itself, provide a guarantee of success. Even given an optimal configuration of service hubs, the full benefits of the various facilities will only be accessible via an accurate system of client assessment and assignment. The design of such a system is predicated on three assumptions: first, that the care of the needy should, to the extent possible, always be provided in a community setting; second, that there will always be a need for an asylum (in the sense of a sanctuary, or place of refuge) for some people; and third, by extension, that certain service-dependent groups need continuing support and care over an extended period of time (even a lifetime). Based on these principles, the required assessment/assignment process may be characterized by three interrelated components: population characteristics; service characteristics; and operational principles.

2.2.1. Population characteristics

Service-dependent people have a range of needs which can be characterized in many ways. One of the more useful views is of a continuum or spectrum of client needs ranging from *autonomy* through to *dependency* (Fig. 1). For example, in the former case, a person may suffer only a transient emotional disturbance associated with (say) a bereavement. Such a disturbance may interfere only marginally over the short term in the activities of everyday living. On the other hand, a case of chronic schizophrenia may render an individual totally — even permanently — dependent on outside help. It is easy to imagine a graduated sequence of dependency through the continuum of need, representing varying degrees of client dependency. For instance, an increasingly disabled person may move from temporary emotional disturbance into a longer-term depressive state.

A significant emphasis in this conceptualization is that client needs and deficits are likely to change over time. Certain deficits are clearly modifiable (e.g. the lost ability to cook for oneself), while others are less tractable. A typical 'client career' envisages an individual making constant adjustments on the autonomy/dependence spectrum. Any adequate service system must be designed to allow for such adjustments to occur efficiently and economically. We must concede, however, that for groups like the long-term mentally disabled, with above-average dependency on the care-giving system, on-going support is often required for extended periods of time. For some unfortunate individuals, the best

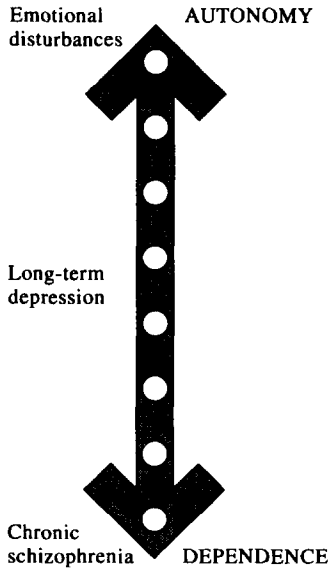

FIG. 1. The autonomy–dependence continuum of client needs.

that may ever be achieved is stabilization at relatively low levels of autonomy. Just like other people, they have every right to expect a rich and fulfilling life experience; it is simply that they may need greater help to enable them to enjoy their rights.

2.2.2. Service characteristics

Ideally, there ought to exist a sufficient range of services available to meet all possible client needs. Hence, in parallel to the spectrum of client needs, there would exist a continuum of service settings (Fig. 2). The dependent client requires what we shall call a closed or protected setting at one end of the continuum (for example, an asylum). On the other hand, relatively autonomous individuals may cope quite adequately in *open unrestricted* service settings (such as their own apartment or house), relying on conventional folk-support/informal networks.

As before, we envisage a variety of intermediate points along the service setting spectrum, representing varying degrees of openness and restriction in the service setting. Hence, increasing disability may be accompanied by movement from independent apartment living, through a group home, to a nursing home. At each stage, clients are being matched with a particular internal environment that is designed to promote treatment of, or coping with, their specific disabilities.

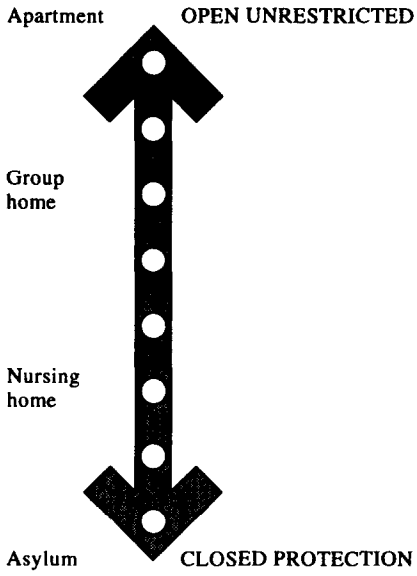

FIG. 2. The closed–open continuum of service settings.

One important aspect of service provision is that client needs are divisible into many different sectors or programmatic needs. Typically, the service dependent are observed to have needs in five different service sectors: social skills; vocational/employment skills; housing; income; and mental health care. It is important to recognize that an individual does not necessarily suffer the same degree of disability in all five sectors, and that individuals with similar deficits are not necessarily homogeneous in their needs. For instance, a psychiatrically-impaired individual may still be able to acquire sufficient social skills to be able to form enduring friendships; and one schizophrenic person may have more significant financial problems than another.

We can place the three dimensions of client needs, service settings and service sectors into a simple diagram that emphasizes the dynamic, interdependent nature of the client–service system (Fig. 3). The three dimensions of this space are defined by the autonomy/dependency client need axis (the vertical); the closed protected/open unrestricted service setting axis (the horizontal); and the five service–sector axis. It is possible for an individual to occupy literally any point within this needs–service space. For example, individual 1 is a person who is generally autonomous and capable of independent living in an open unrestricted setting; however, she has crucial deficits in social skills, making her relatively dependent in this sector. In contrast, individual 2 is a dependent person, requiring hospitalization, especially since he has no money or home. However, he continues to have high vocational and social skills. This concept of the client/service system

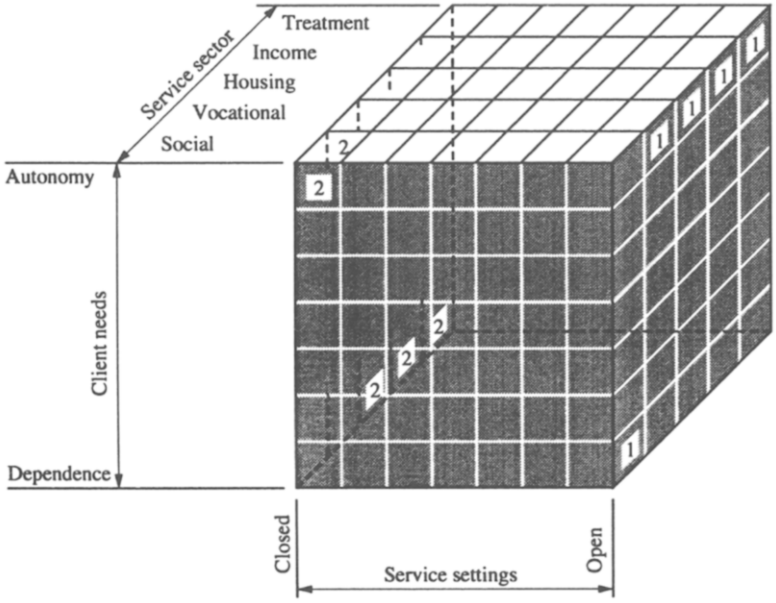

FIG. 3. An integrated view of the client assessment and assignment process.

(Fig. 3) makes it much easier to discuss the complex notions of *need* and the *level of support* inherent in any individual; the program recommended for individual care should address the three dimensions of client disability, service setting, and program needs.

From a spatial viewpoint, it is significant that client progress within the human service system also implies a progression through different community or geographical settings. Thus, the increasing envelopment of the disabled individual might involve movement through the various 'communities' of independent living, group home, nursing home and hospice. For many, and particularly for those living outside urban areas, migration to receive service in a city hospital also implies an uprooting of the individual to a new geographical community in order to obtain care. Such movements (involving a potential or real loss of community) are engendered because service systems (especially hospital networks) are not universally accessible; instead, they are organized hierarchically, both in sectoral and spatial terms. Thus, by definition, not all kinds of service are available everywhere. Typically, in any regional health care system, there are few higher-order specialized centers, such as psychiatric hospitals. These tend to be located in or near major population centers and to serve geographically-extensive market areas. Such higher-order services tend to be supported by many smaller, less-specialized centers such as community clinics. These have a much more

geographically-confined market areas, and are thus located in a dispersed manner, accessible to the local area they are intended to serve (Fig. 4). This geographical–functional hierarchy of service organization (typically referred to as 'regionalization') is characteristic of many sectors, including health care, retailing, and entertainment services. Its form is a response to the twin objectives of cost-effectiveness and accessibility. The former dictates that certain (presumably large) levels of client population and funding are necessary to support the efficient operation of bigger, more specialized centers; the latter argues for a decentralized system of smaller-scale service opportunities.

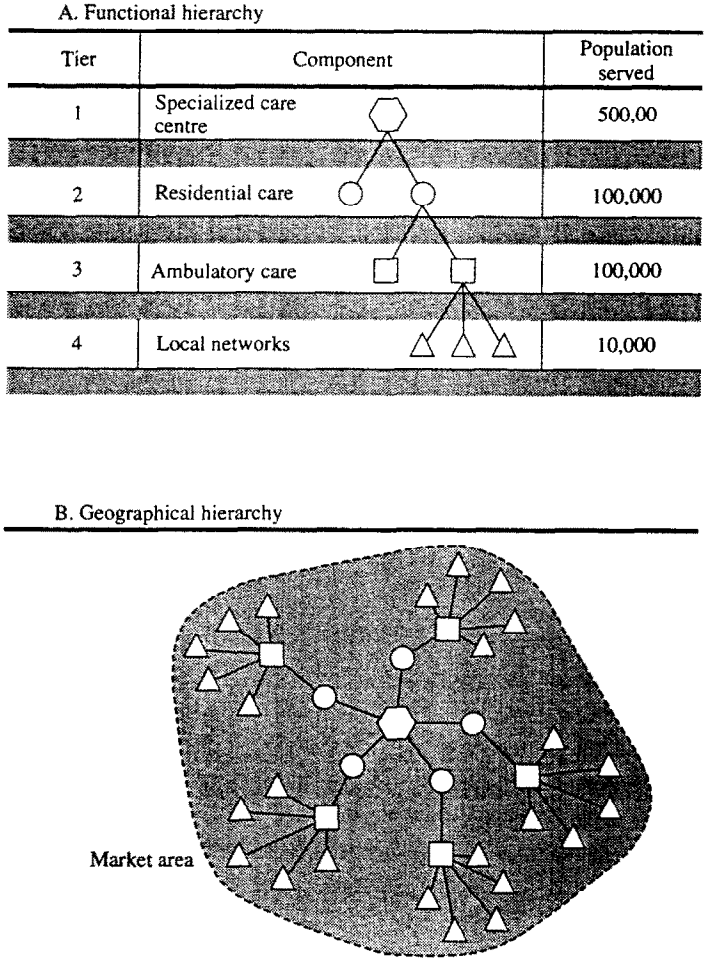

FIG. 4. A geographical–functional hierarchy of service operation (after Shannon and Dever, 1974).

The challenge then is to find the optimal balance between decentralization and centralization within a given context. Decentralization, both functionally and geographically, is in principle to be desired since it ensures access and equity. Yet it is not always feasible in economic or operational terms (e.g. due to available personnel), and a degree of centralization may be required to ensure a proper range of often-specialized services. Problems of remoteness can be overcome by developing an efficient referral system so that, when necessary, rapid access to the higher tiers of care is guaranteed.

2.2.3. Operational principles

The overall planning objective of the service hub system described above is to maximize the 'goodness of fit' between client needs and service setting. In theory, this is a simple exercise in efficient assessment and assignment: that is, to decide carefully what the client needs and allocate him/her to an appropriate service setting with an individualized program of care. However, it is easy for difficulties to arise in practice. For instance, ambiguities in diagnosis may lead to misallocation of a client to an unsuitable treatment setting; thus, a hospitalized person prematurely discharged to independent downtown living may find herself unable to cope with the variety in the setting and require rapid rehospitalization. Alternately, the absence of certain community-based facilities in the service spectrum may cause the assignment of a client to an overly-restricted environment, as when the absence of proper discharge facilities causes the client to remain unnecessarily in a hospital setting. In cases where the client–service fit is bad, client well-being may be jeopardized.

For the moment, let us ignore these practical difficulties, and assume that a comprehensive care system is fully in place. What, then, should be the operating principles of this system: Five objectives are paramount:

- *The principle of least envelopment.* Clients should be allocated to the least restrictive service setting, concomitant with their needs.
- *Progression toward autonomy.* A constant effort should be made to move clients toward the autonomy end of the spectrum.
- *Continuity of care and assessment.* The care system should facilitate, not hinder, the movement of clients through the system as their needs change. As a corollary, the system must ensure continuous assessment and reassessment of client needs.
- *Accessibility and availability.* Appropriate regionalizations should ensure that services are available and accessible in all areas concomitant with other principles of system organization.

- *Coordination.* The variety of needs of long-term service-dependent people require careful selection of the most effective method of coordination of services amongst the various responsible agencies.

2.2.4. The assessment and assignment process: summary

There exists a variety of client disabilities that can be characterized by a range from autonomy through to dependency, and a typical individual will progress into and out of this spectrum on frequent occasions. Consequently, there is a need for a concomitant range of service settings, from open/unrestricted through to closed/protected. Individual deficits may occur in any of five broadly-defined sectors: social skills, vocational/employment skills, housing, income, and psychiatric care. Assignment to an appropriate setting implies providing an internal treatment environment that will facilitate the solution of a client's difficulties. Service systems are organized in functional and geographical hierarchies. Access and equity in care is ensured through an appropriate regionalization of services; i.e. a decentralized system coupled with an efficient referral to and discharge from higher-order (specialized) centers. Operationally, the hub system should be designed to maximize the effectiveness of the assessment and assignment of clients to service settings, according to five principles: least envelopment, progression toward autonomy, continuity of care and assessment, access and availability, and coordination.

2.3. SERVICE HUBS AND SOCIAL SUPPORT NETWORKS

Needless to say, life consists of more than an assemblage of shelter and service opportunities (no matter how variegated these may be). A comprehensive view of the totality of needs of one prominent service-dependent (the homeless chronically mentally disabled) is reproduced in Table 1. For most marginalized, service-dependent people, the *formal* set of service-oriented facilities that helps them to survive is crucially supplemented by a range of *informal* networks associated with peer groups. Indeed, individual success (defined by exit from homelessness, control of symptomatic disorders, or whatever) will usually depend upon the successful integration of the support provided by both formal and informal networks.

An important (but usually neglected) point about support networks is that they must be geographically proximate in order to function effectively. A clear manifestation of the *de facto* importance of geography in defining coping ability is the spatial clustering of service-dependent populations, and the facilities designed to help them, in the core areas of our cities. This concentration has been called

TABLE 1. Summary of the basic and specialized needs of the homeless chronically mental ill

Basic need
Shelter
Food, clothing, household management
Income/Financial Management
Meaningful activities
Mobility/transportation
Special needs
Treatment services (general, mental health)
Rehabilitation
Vocational
Social service
Integrative services
Outreach
Assessment and planning
Case management
Advocacy
Information
Education

the 'zone of dependence' (Dear and Wolch, 1987). For the service-dependent population in these zones, the inner city has become a coping mechanism; within it, the mentally disabled, dependent elderly, physically disabled and others assist each other in finding jobs, accommodation, as well as providing friendship and support. It is possible, of course, that proximity also has deleterious effects; the fact of closeness is not always a positive thing. Thus, a treatment center for drug addicts or ex-offenders may not be the most appropriate neighbor for a home for runaway youths (see Fig. 5).

In what follows, we first examine the problems involved in linking clients with formal support networks, and then the structure of informal, peer group-based social networks.

2.3.1. Formal networks

One of the biggest mistakes that service providers can make is to assume that once they open their doors, the clients will come. In this regard, service-dependent people are just like purchasers of any other goods — they will not consume something that is not suitable for them. This explains, for example, the relatively

Facility type	SRO hotel	Children's home	Drug clinic	Job referral
SRO hotel	+			
Children's home	+	+		
Drug clinic	+	-	+	
Job referral	+	O	O	+

\+ = Positive interaction
\- = Negative interaction
O = Neutral interaction

FIG. 5. Facility interaction within a service hub.

high vacancy rates that occur in some emergency shelters at the same time as homeless people sleep on sidewalks outside; here, a clear choice is being made to avoid the hazards of the shelters (including communicable diseases, personal safety, intrusive regulations, etc.). In short, it is not enough simply to provide a service; that service has to be needed, useful, empathetic, and accessible. Hence, in many ways, the most important thing a service provider can do, at least initially, is to undertake outreach to a potential client community to ensure that the newly-available facility and its purposes are properly publicized. Only then is the facility likely to successfully hook into the networks of the service dependent and begin to provide useful assistance.

We shall use the term *formal networks* to refer to the linkages made between clients/consumers and providers in the human services sector. In order to identify some of the variables that place 'distance' between provider and client, we consider the experience of the community-based mentally disabled. Previous studies have demonstrated the influence of fifteen variables on the service utilization decision (Dear, 1977, 1978). These variables fall into three categories, relating to location, client characteristics, and service characteristics, and may be summarized as follows.

2.4. LOCATIONAL CHARACTERISTICS

- *Accessibility*: as measured by time travelled, physical distance, or cost.
- *Location as catchment*: referring to an administrative rule that places clients in one service jurisdiction but excludes them from others.

- *Social distance*: which emphasizes the behaviors that place distance between consumer and service, including referral patterns.
- *Relative location*: referring to the complexities in the utilization decision associated with a range of intervening consumption opportunities, such as the preference for a more distant facility based upon gender or racial considerations.

2.5. CLIENT CHARACTERISTICS

- *Demographic factors*: the significance of age, race, ethnicity, gender, family status, etc., in the utilization of human services has been well demonstrated.
- *Income*: it is an almost universal law that poorer people get worst service; even the slightest fee tends to act as a deterrent to consumption.
- *Education*: other things being equal, the better educated will receive superior service.
- *Religion*: although the effect of this variable is not always clear or consistent, certain religious groups are noteworthy for not becoming consumers of (for example) conventional mental health services.
- *Presenting symptoms*: some client groups have more than one immediate need; they have what are called 'multiple presenting symptoms' which may compromise the effectiveness of the assessment and assignment process.

2.6. SERVICE CHARACTERISTICS

- *Intake procedures*: these include opening times which can act to exclude certain groups, as well as deliberate policies of exclusion, such as the use of waiting lists to discourage potential consumers.
- *Quality and type of service*: reputation and sponsorship can play an important part in consumer perception and demand for a service.
- *Amenity*: architectural design and consumer convenience influence client well-being and recovery rates, and hence client choice of service.
- *Scale*: a larger facility will tend to have a greater range of convenient on-site services, yet its very size may also act to discourage potential consumers who prefer smaller, more user-friendly facilities.
- *Capacity*: actual and perceived congestion at any facility site will act to deter clients, while easy access encourages utilization.
- *Cost*: most services have some direct or indirect cost associated with them, and cost is always a factor in consumption practices.

Although this discussion has proceeded from the viewpoint of the consumer, it should be emphasized that many of the influential variables that we have identified are in fact controlled by the service providers. Frequently, these variables are deliberately manipulated by providers in order to control the flow of clients into the system.

2.6.1. Informal networks

The coping strategies and social networking that occur within groups often play a vital part in the day-to-day survival of service-dependent individuals and should therefore feature in any design for a service hub system. Such a concern will thus prevent service providers from unwittingly disrupting what may be an important, if fragile, part of a group's existence, and an appreciation of these informal strategies could prove to be a valuable resource for providers, helping them to target services more effectively. To illustrate, we consider the nature of the strategies employed by one service-dependent group: the homeless. By the very nature of their predicament, the homeless are forced to develop a wide range of strategies to cope with the loss of a homebase and the lack of everyday routine that this entails.

Two basic types of coping strategy among the homeless have been identified: adaptive and material (Wolch and Dear, 1993). Adaptive strategies are cognitive and psychological adjustments that help the homeless person adapt emotionally to the depredations of street life and other personal problems. Material strategies are adaptations to physical deprivation; they are directed toward obtaining the goods and services necessary for basic subsistence (Table 2). There is obviously

TABLE 2. Coping strategies among the homeless

Adaptive:
Social ties
Peer networks
Homed networks
Personal mobility
Use of drugs and alcohol
Altered physical appearance
Material:
Personal effects
Public assistance
Voluntary organizations
Work
Proximate urban resources
Social networks
Community of homeless
Mobility

TABLE 3. Characteristics of the social networks of the mentally disabled as compared to the general population

Smaller in size
Fewer ties with kin
Fewer members living far away
Fewer different sources of friends (i.e., work, school. . . etc)
Fewer long-term friends
Less interaction with family, friends, relatives
Fewer friends who know family members
Greater degree of change in terms of moves, deaths, . . etc
Greater feelings of loss of help from relationships

some overlap between the strategies, but maintaining the distinction between the two is useful, if only to emphasize the way in which individuals weave several qualitatively-different coping strategies together in order to survive, changing the exact mix as circumstances alter.

Adaptive strategies. These reduce the psychological pain inflicted by homelessness, and reduce the dangers inherent in life on the outside. The most important option is the use of *social ties* to provide emotional support (Wallace, 1965; Mitchell, 1987; Solarz and Bogat, 1990; Grigsby, Bauman, Gregorich and Roberts-Gray, 1990). The social networks of homeless people tend to be smaller and/or weaker than those of the homed community (see Table 3). For instance, homeless mothers have fewer adult supports than homed mothers (Bassuk and Rosenburg, 1988; Wood, Valdez, Hayashi and Shen, 1990); up to one half of the homeless have no contact with family members (Rossi, 1989; Cohen and Sokolovsky, 1983); and homeless men have smaller networks which they use less frequently than precariously-housed men. Small network size has been attributed to negative family backgrounds (such as a history of abuse) and to lower levels of service utilization (Passero, Zax and Zozus, 1991). Indeed, the absence of social support may have propelled some people into homelessness in the first place. Yet while their networks may be small, unstable, and resource-deficient, homeless people are rarely without any supportive relationships. And paradoxically, because their remaining social ties are fragile and limited, the few ties that they do possess take on even greater significance.

Social networks of the homeless have two basic components: peer networks and homed networks (Fig. 6; Rowe and Wolch, 1990). Within *peer networks*, homeless people share their locales with other homeless individuals, facilitating the formation of peer networks within the homeless population. Peer networks are comprised of homeless acquaintances, friends, family, lovers and spouses; some peers will live in informal street encampments or communities which often arise in vacant lots, parks and sidewalks in Skid Row. In many ways, these peer networks replace the function of the home-base in the maintenance of time–space

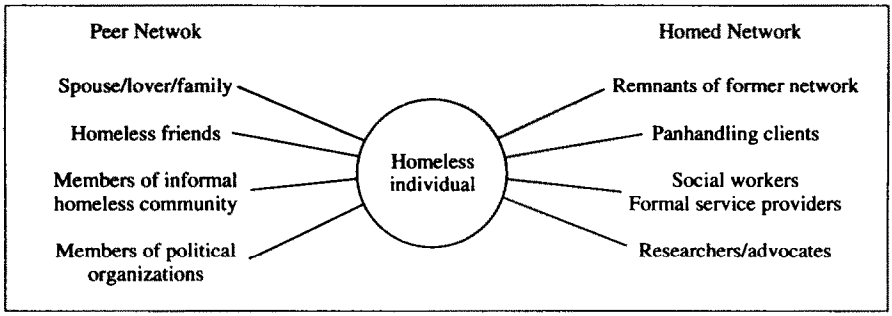

FIG. 6. The social networks of homeless people.

continuity, identity and self-esteem for the general homeless population. Although social interaction with the peer network may dominate the social network of the homeless individual, contacts with the homed community are also of vital importance. The activities that lead to the formation of *homed networks*, such as panhandling and obtaining formal welfare services, may replace those formed within the context of formal employment. The location of interactions with the homed community is typically fixed in time and space, allowing the homeless individual to re-establish some degree of continuity in the daily path. Also, institutionalized norms of behavior (acceptable panhandling sites, bureaucratic rules governing welfare recipient activities, etc.) tend to structure the interaction between homeless individuals and their homed network.

Both peer networks and homed networks can undermine identity and self-esteem. Components of an individual's supportive network can be ephemeral and frustrating, thwarting efforts to use the resources they provide for long-term planning. Friends within a peer network may respond to problems with mobility, encampments are often disturbed or broken up, panhandling contacts can disappear, and so on. Instability of this nature leads the individual to practice frequent substitution among available sources of support. This strategy in turn diverts attention and energies away from long-term goals with the result that homelessness is prolonged and one's identity and self-esteem are further transformed. However, despite these negative aspects of the homeless individual's social networks, the ongoing support that they provide stands in the way of total material and emotional devastation, and may represent the only brake on a downward-spiralling of personal value and identity. Homeless networks often prove so vital to material and emotional welfare that the adoption of an identity as 'homeless community member', 'panhandler', or as a service provider's 'favorite' is readily embraced. While the acceptance of these new identities works against the development of both the means and the will to execute long-term projects needed to re-enter the homed society, it also serves an essential function in meeting daily

needs and maintaining self-esteem within the geographic and social context of homelessness (Rowe and Wolch, 1990).

Homeless people also adapt through *personal mobility*. One of the most important manifestations of adaptive behavior through mobility takes the form of constant movement to avoid harassment or assault. By keeping on the move, people are less likely to be the target of mugging or theft. Equally significant are visits to another part of town for division in an otherwise boring day, or as a scanning strategy to assess alternative resource environments. For example, many of those who were observed leaving Los Angeles' Skid Row on a periodic basis were attempting to 'take a break' or get a 'change of scene', returning only when resources ran out (Wolch, Rahimian and Koegel, 1993).

Other adaptive strategies may be more dysfunctional. One very common response is the *use of drugs or alochol* to alter consciousness and detract from the pervasive worries of homelessness. About half the homeless use drugs and/or alcohol. Alcohol abuse is more common (Milburn, 1990; Fischer *et al.*, 1986; Rossi, 1989), but drug usage has been spiralling upward in recent years, especially with the advent of relatively inexpensive and highly addictive crack cocaine. The proportion of homeless using alcohol ranges from one quarter (Ladner *et al.*, 1986) to over one third of the population (Mulkern and Spence, 1984b; Fischer *et al.*, 1986; Robertson, Ropers and Boyer, 1985). Alcoholics are typically older, white males with conventional work histories. Younger homeless people, especially African–American and Latino males, are more likely to be involved with drugs, and have minimal or unstable work backgrounds. In general, homeless men are more apt to be chemically-dependent than women (Milburn, 1990), and substance abuse as a whole is less common among families. Some portion of the homeless mentally disabled use drugs as 'self-medication' to mitigate their symptoms. As a strategy of adaptive coping, substance abuse is short-term and illusory at best; drinking and doing drugs create serious health problems, increase the likelihood of arrest and jail, and often bar entry into shelters and other helping agencies.

Finally, some homeless people adapt by *altering their physical appearance* to deter unwanted attention. They dress and/or behave in an eccentric fashion to repel people who might otherwise threaten them. Of course, for many an unkempt appearance may be primarily the consequence of the lack of public hygiene facilities. In New York City's Bowery district, for example, the unavoidable outcome of street life is "matted hair, filthy clothes, skin crawling with lice, and an odor so offensive that some of the men brag that it is strong enough to ward off would-be muggers" (Cohen and Sokolovsky, 1989, pp. 102–103). For others, however, dressing in bizarre clothing, staying as dirty as possible, or talking loudly to oneself are indicative of a deliberate intent to deter contact. This is a particularly common tactic among women fearful of sexual assault (Bard, 1990).

Material strategies. The most important material resources available to the homeless are their *remaining personal effects*. Many homeless people retain a car,

van, or camper to sleep in and store possessions; any income can then be carefully budgeted for other necessities (Koegel, Burnam and Farr, 1990; see also Cohen and Burt, 1990). Suburban homeless people are more apt to have automobiles. Some homeless individuals in Los Angeles temporarily store possessions in the laundry rooms of apartment buildings, as well as making use of the laundry facilities. Others pool their resources to rent space in public storage facilities.

The central importance of money makes it imperative for the homeless to apply for and obtain some form of *public assistance*. The real value of welfare benefits has declined dramatically over the past decade, and eligibility rules have become more exclusionary. In addition, assistance programs vary considerably by locality, since States and municipalities are free to supplement federal programs or introduce their own benefit schemes; in Los Angeles, the County administers a State-mandated General Relief (GR) program, which (until it was reduced in 1992 to $293) paid $341 per month plus $65-worth of Food Stamps. Whatever the level of benefits, the fact is that in most cities, the proportion of homeless people receiving benefits is low (Wright, 1989; Rossi, 1989). In Los Angeles's Skid Row, only 16 percent of the homeless received a welfare entitlement, social security, or disability benefits (Koegel, Burnam and Farr, 1990).

The homeless often turn to *voluntary organizations* for material assistance. Such agencies serve food, distribute clothing, provide emergency shelter and a variety of other services (e.g. job counseling and medical examination). Emergency shelters and soup kitchens are perhaps the most widely-used services (Roth, 1989; Cohen and Sokolovsky, 1989; Burt and Cohen, 1990), although many are fearful of large shelters and stay away (Anonymous, 1988a; Koegel, Burnam and Farr, 1990). Voluntary-sector services may be utilized sporadically throughout the month, or (as in the case of public assistance recipients) predominantly at the end of the month when benefits run low; such services are usually visited in conjunction with other resource opportunities. Los Angeles' shelter system, for example, is not patronized continuously by the homeless, most of whom deliberately employ a variety of sleeping places, often three or more different places per month (Koegel, Burnam and Farr, 1990; such reports are consistent with other studies, including Rossi, 1989; Roth, 1989; Burt and Cohen, 1990). A national sample of community kitchens suggested that homeless people typically use other avenues to obtain food, mostly purchasing items at restaurants or grocery stores (Cohen and Burt, 1990).

Fourthly, homeless people *work*. Typically, between a quarter and a third of homeless people hold part- or full-time jobs, and many more are looking for work (Rossi, 1989). In some places, employment rates are higher, and up to half an individual's cash income may be derived from working (Wright, 1989; Koegel, Burnam and Farr, 1990, p. 97). Much of the work was casual day labor and other temporary employment, e.g. spot labor offered by the day, and paid for in cash. Typical jobs include posting bills, delivering fliers, loading/unloading trucks, and

labor at construction sites; the work is usually dirty, dangerous, and poorly paid (Weigand, 1990). Homeless people also engage in a variety of non-traditional occupations to earn money or in-kind payments. Bard (1990) described a wide range of entrepreneurial activities by homeless women to earn money, including collecting castoffs for street-corner sales and making craft items for sale (such as jewelry, clothing, or sketches). Recycling, selling blood plasma, and sale of personal items provided the principal incomes of 17 percent of the homeless people surveyed in 16 cities across the country (Wright, 1989). Other strategies involve illicit or illegal endeavors, thus exposing the homeless to the risk of criminalization (Lamb and Grant, 1982, 1983). Panhandling is one such activity. Contrary to popular wisdom, relatively few homeless people panhandle, and even fewer rely on panhandling as their primary source of income (Farr, Koegel and Burnam, 1986). Among homeless applicants for GR in Los Angeles, only 13 percent ever panhandled, while less than 3 percent panhandled for a substantial portion of their income (Husick and Wolch, 1990). Most homeless people consider panhandling demeaning and hence an unacceptable way to gain money. Other illegal occupations include drug dealing, subsistence prostitution, and petty thievery: 15 percent of 634 homeless arrests in Baltimore involved offenses against property; 10 percent were against persons; and the remaining three-quarters were victimless crimes, such as contempt of court, park rule violations, trespassing, disorderly conduct, or violation of liquor laws (Fischer, 1988). Of the offenses against property, many were linked to meeting subsistence needs, e.g. shoplifting for food.

Much material support derives from *proximate urban resources*, many of which are universally available in the community, including libraries and public parks (Bard, 1990). Other resources require the homeless to break local laws (e.g. against trespassing, sleeping in public places, or rifling through people's garbage) and may result in prosecution (Fischer, 1988). Garbage bins and trash dumpsters offer 'dumpster divers' a wide range of artifacts and food discarded by households and restaurants. Public or quasi-public facilities (such as libraries, transportation terminals, universities, museums, medical centers, or parks), private enterprises (all-night theaters, shopping malls, hotels, bowling alleys, food fairs, amusement parks), and religious institutions are commonly used by the homeless as places to sleep, relax, clean up, and meet people. Bus and subway systems are also important resources; many individuals spend nights on buses or subway cars (Reich and Wolch, 1988). Abandoned industrial or residential buildings offer shelter to those willing to trespass. Steam heat from municipal grates provides sought-after sleeping sites during cold weather. Give-aways by local businesses (especially restaurants or markets) supplement food offered in community kitchens.

Sixthly, the homeless rely on their *social networks* for material as well as emotional support (Solarz and Bogat, 1990; Cohen and Sokolovsky, 1989; Lee,

1989a; Rivlin and Imbimbo, 1989). For example, in Los Angeles' Skid Row, family or friends provided food to almost a third of homeless respondents; many others indicated that they had slept at the homes of family or friends during the month prior to their interview, on average for as much as half of the month (Koegel, Burnam and Farr, 1990). Material assistance also comes from homeless peers. Often, ties with other homeless people are rooted in exchange relations; trading involves material goods, emotional support and vital information on (for example) how to get public assistance, where to find work, or where to panhandle. Such relationships, driven by survival needs and predicated on resources, often fluctuate quickly as needs change and resources are depleted. The initiation of an exchange (through the provision of food or money) without an expectation of or need for reciprocity allows homeless people to express kindness and generosity, bolstering their self-esteem.

In some instances, the use of social networks to provide material (as well as adaptive) support leads to the formation of *communities of the homeless*, either tightly knit semi-permanent street encampments, or loosely-knit 'extended families'. Such encampments are sometimes able to establish a synergistic relationship with neighbors. For example, one community under a bridge over the Los Angeles River provided informal security services for a nearby business; in return, the owner permitted camp dwellers to dispose of trash in his dumpsters, and made occasional gifts of fresh food.

Geographic mobility is essential to material well-being. People travel to contact and receive resources from family and friends; they return to Skid Row in order to obtain assistance from social agencies. Thus, the pull of the welfare office, soup kitchen, drop-in center or mission motivates geographical mobility; as does the need to show up at a worksite, pandhandling spot, or garbage dumpster (Wolch, Rahimian, and Koegel, 1993). The typical mode of transportation is by foot, although public transport is used for longer trips, especially by those with bus passes. Mobility sometimes extends to permanent or semi-permanent migration, i.e. long-distance moves from one city or region to another. Most homeless people do not migrate from place to place, but those who do are typically in search of a job or resources that may be available from family or friends.

CHAPTER 3

*Service Hubs in Practice**

We turn now from a general discussion of the potentials and problems of the service hub concept to look in more detail at the way in which they operate in real-world situations. This chapter is divided into two main sections. In the first, we look at several service hubs currently operating within Los Angeles County communities. These examples clearly illustrate the effect of the locale on the development of the hub, as well as offering some important insights into the operation of the hubs, their ability to make use of the resources at hand, and the positive effects they have had on the service dependent populations that use them. In the second section, we turn to look in more detail at the actual process of constructing service hubs with an example from the Skid Row district of Los Angeles. This locale already has a strong hub base in place due to the efforts of the Single Room Occupancy Housing Corporation of Los Angeles (an organization created by the city's Community Redevelopment Agency).

Our focus in the following discussion again will be upon the homeless. Coping without a home is a stressful, time-consuming occupation. Every single day, homeless people are faced with the tasks of securing food, shelter, and other necessities of life. Frequently they are obliged to negotiate complex bureaucratic systems, endure alienating and dehumanizing service delivery routines, and risk arrest or jail. They live with the physical and psychological consequences of poor diet, inadequate rest, and lack of health care. In the face of such challenges, sometimes imposed by the very social programs designed to serve them, homeless people make remarkable, even heroic adaptations. They invent intricate sets of coping strategies, combining public assistance with wage income, offerings by voluntary agencies, material and emotional supports provided by family and friends, and the resources embedded in the public and private spaces of the streets where they live. Learning quickly to adapt to homelessness is quite literally a matter of life and death.

One insistent theme in the lives of the homeless is that *place matters*. Specifically, coping on the outside (the experience of homelessness, the probability

*This chapter was written with Gregg Wassmansdorf.

of exit, etc.) is inextricably linked to the qualities of local context. A resource-rich environment can accelerate the exit from homelessness; a resource-poor setting may significantly retard it, or worse. In this section, we describe two service locales in order to examine how variations in local setting and the nature of the support service influence the behavior and coping strategies of homeless people.

3.1. CASE STUDY 1: ROSE AVENUE, VENICE

Rose Avenue marks the northern limit of Venice beach and is the symbolic, if not the actual, dividing line between Venice and Santa Monica. And "in many ways the wide and well-travelled thoroughfare is a microcosm of Venice: a haphazard collection of houses, apartments, restaurants, businesses and shops where dissimilar people have lived and worked in relative harmony" (*L.A. Times*, November 22, 1987). Rose Avenue is an example of how a broad mix of land uses can be accommodated on a single street, and it has evolved into a major hub of activity for the local area homeless.

Rose Avenue is the home to the St. Joseph's Day Center, the Bread and Roses Cafe (also run by 'St. Joe's'), and the Venice Family Clinic; three critical nodes for the homeless, situated strategically between Santa Monica to the north and Venice to the south. Other resources in the immediate area include a wealth of additional services provided by the St. Joseph's Center; Public Storage lockers found across the street from the center; inexpensive motels along Lincoln Boulevard; and both public bathrooms and showers along the beach (see Fig. 7).

The St. Joseph Center is a non-profit, non-sectarian social service agency whose goals are to "assist individuals and families with meeting their basic needs while empowering them to cope with their own problems". The Center operates eleven programs for homeless and homed low-income persons and serves over 12,000 individuals each year. The most visible, and hence controversial, facility run by the Center is the Homeless Day Center located on Rose Avenue. Initiated over a decade ago due to a dramatic rise in the number of homeless seeking assistance, the drop-in center provides a comfortable atmosphere for homeless people to obtain clothing, receive advocacy and referral aid, take a shower, pick-up personal mail, do their laundry, use the phone, get a bus token, or to sit, relax and socialize. The Day Center is the hub around which many Venice and Santa Monica persons' daily routines revolve. Integrally linked with the daily activities of the Day Center is the Bread and Roses Cafe, located three blocks east. Operating since 1989, the Cafe serves free, hot meals every weekday to approximately 150 homeless patrons in a clean, stylish restaurant-like atmosphere. An aesthetically-pleasing environment, Bread and Roses lends much to homeless people's self-esteem. In addition, 1991 saw the introduction of a Food Services

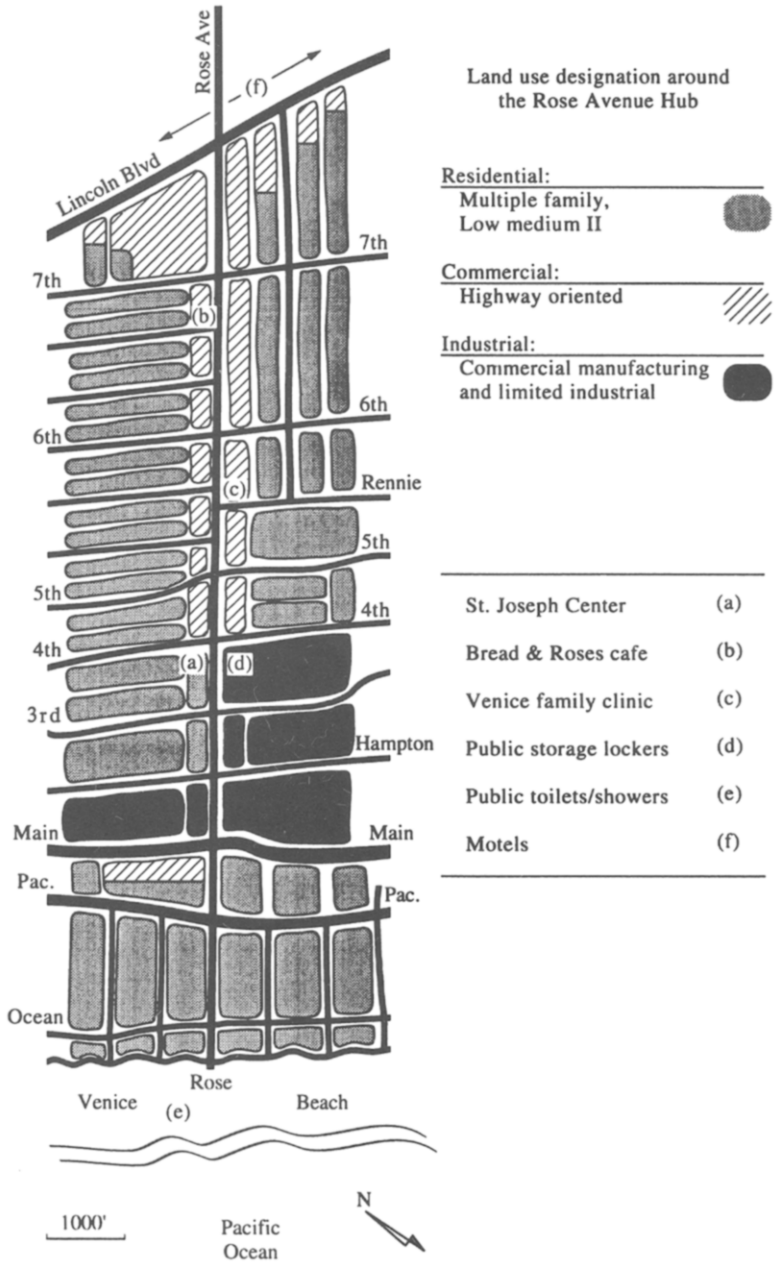

FIG. 7. Land-use designations around the Rose Avenue Hub.

Training Program at the Cafe to teach homeless participants food service skills, thereby assisting them in finding permanent employment.

St Joseph's also has several other valuable programs located a few blocks away on Hampton Avenue. The Family Center and the Food Pantry, in fact the first of all the programs to be created, have grown into a comprehensive advocacy referral and emergency assistance program providing over 375 bags of supplemental groceries each week. Established in 1986, Senior Outreach assists homebound older people by delivering groceries and providing service referrals, and the Listo Job Referral is an employment service for very low-income, monolingual Hispanic people in the area. As self-improvement through schooling or employment is made increasingly inaccessible for low-income people with childcare needs, St. Joseph's has developed the Child Care/Parenting Cooperative which provides no-cost quality care and instruction for children and also teaches parenting skills. Recent developments at St. Joseph's (on Hampton) include the addition in 1990 of a Section 8 (low income) Housing Program which helps homeless families and disabled persons find affordable housing. Also located within walking distance of the Rose Avenue and Hampton Avenue facilities is the Monetary Advisory Program (MAP) which is geared towards the homeless mentally ill and assists with money management, finding affordable housing and making use of community resources. Finally, the Thrift Shop, which opened in 1978 on Lincoln Boulevard at Flower, continues to provide the community with a wide variety of high-quality, low-cost clothing, furniture and household items.

Services provided by the St. Joseph's Center are not, however, the only strategic resources available to the local area homeless. Both north and south of Rose Avenue on Lincoln Boulevard are motels which are utilized by the economically marginal because of their low rental rates. Several blocks east of the St. Joseph Day Center is the Venice Family Clinic, a critical element in the Rose Avenue Hub. The Clinic has provided health care for the unemployed, working poor and homeless since 1970, and has occupied its Rose Avenue location since 1984. Of the greater than 10,000 patients seen last year, one quarter were homeless. The clinic represents one commonality (at least) between these 2,658 people. Additionally, directly across the street from the Day Center is a Public Storage facility, where over one hundred homeless individuals currently rent relatively low-cost storage space to protect what remains of their belongings. And at the end of Rose Avenue is Venice Beach. The presence here of public bathrooms and showers provide for the more pressing needs of the homeless on a 24-hour basis. Nor should the value of the sunshine, sand and surf be over-looked since they constitute a generally therapeutic environment.

3.2. CASE STUDY 2: RAYMOND AVENUE, PASADENA

The pattern of mixed land uses coupled with the small scale of homeless facilities in Venice is not replicated in Pasadena. In this instance, the homeless facility (Union Station) is both distinctive and conspicuous in its landscaping and building exterior, although it remains unobtrusive due to the relative scale and monotony of the surrounding land uses which are predominantly heavy commercial and light/medium industrial. The Raymond Avenue Hub is also distinct from the Rose Avenue example because Union Station is the only service provider in the central district area of Pasadena. The proximity of Central Park to the north, however, in addition to the presence of several local bus routes, provides valuable additional resources for the homeless patrons of Union Station (see Fig. 8).

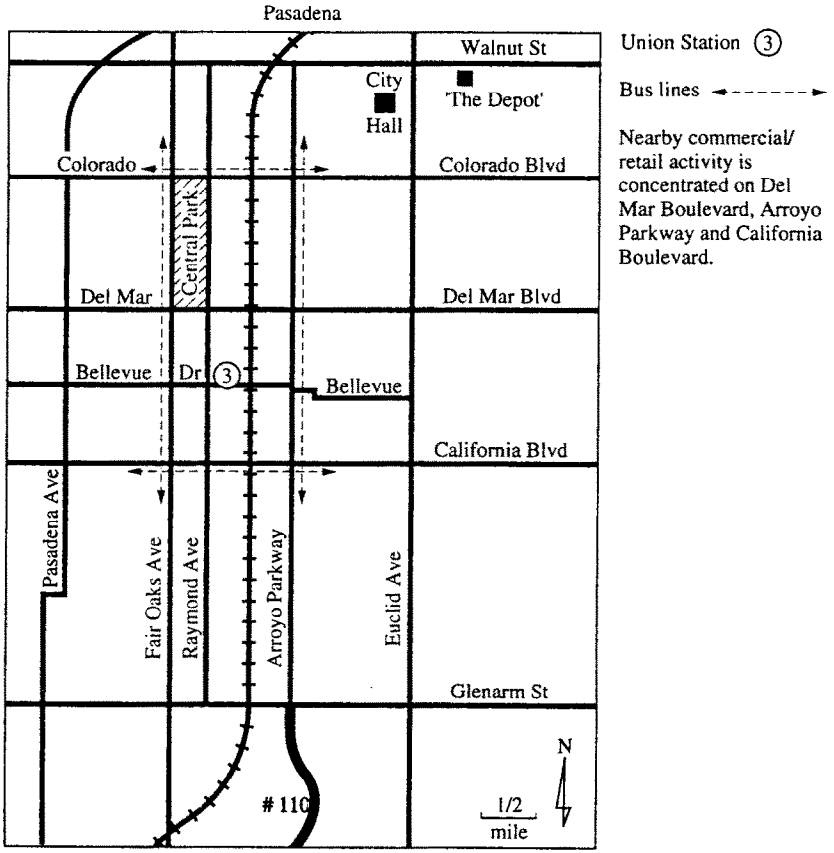

FIG. 8. Union Station, Pasadena.

Founded in 1973, Union Station began as a hospitality center in Pasadena's Old Town, and acted as an outreach ministry of the All Saints Episcopal Church. A majority of the patrons at that time came for food and friendship. An early victim of NIMBY, the facility was forced to move twice (in 1976 and again in 1980). Throughout the late seventies and early eighties, it became apparent that more of the Union Station patrons were seeking shelter in addition to food and companionship. This led to the creation of the Depot, a twenty bed shelter located at Pasadena's First Congregational Church. A year later, the Union Station Foundation was formed as a non-profit corporation, and over the next four years an intensive building campaign was undertaken. Over $1.2 million was raised from a variety of sources, subsequently allowing Union Station to move to its current facility at 412 Raymond Avenue. A workforce of 19 staff and 370 volunteers allows Union Station to serve thousands of patrons each year. Breakfast and lunch are served every day of the year (and dinner for overnight guests), thus providing nutrition for up to 225 individuals each day. In 1990, over 93,000 meals were served. Adult men and women in Union Station's Substance Abuse Recovery Program are able to enter the Shelter Program which provides a place to sleep for 56 persons every night. Guests are permitted to stay up to 60 days, and in 1990 almost 15,200 nights of shelter were provided. All shelter residents have access to clean bathrooms and showers.

In addition to addressing the immediate needs of the homeless, individualized Case Management Services strengthen the ability of Union Station to provide friendship, hospitality and begin to service the long-term needs of its patrons. Case managers provide physical, medical, social, financial, legal and psychological assessment and referral. This process assists in helping patrons to identify specific goals in order to achieve permanent housing and employment. Introduced in March 1988, the Substance Abuse Recovery Program provides individual counseling and referral services regarding rehabilitation as well as follow-up services to graduates of the program. Three 12-step meetings are held on-site every day. Long-term career and personal needs of patrons are further served through a Literacy/Learning Program which offers one-on-one tutoring and access to library materials, and Art Classes which offer all interested guests a creative opportunity to express themselves. The Health Screening Project brings volunteer doctors and nurses to Union Station on a weekly basis to provide preventative health care and emergency medical referral. Furthermore, Project Outreach enables a team of mental health professionals from Pacific Clinics to visit Union Station on a daily basis to provide assessment, medication, counseling and referral for the homeless mentally ill population.

Interaction between the homeless patrons of the facility and residents of the surrounding area is encouraged through several additional programs, including Adopt-A-Meal which allows families and community groups to prepare and serve an evening meal to an overnight shelter guest; a Monthly Car Wash which helps

homeless overnight shelter guests earn income and gain work experience; and the GRACE (Greater Raymond Avenue Connection Effort) team, an effort in which patrons assist in keeping the neighbourhood clean by picking up litter within 500 feet of Union Station.

3.3. THE SOCIAL STRUCTURE OF HOMELESS COMMUNITIES

As service hubs, St. Joseph's and Union Station are highly distinctive places. Newly-built, Union Station is architect-designed, landscaped and relatively spacious. Some of its design features are the result of extensive community opposition to the facility's siting and operations; for instance, the building is set back on the lot, and does not interact strongly with the street. St. Joseph's Center, on the other hand, is a tiny hole-in-the-wall, old and worn out, with no architectural distinction. The front door and yard gate open directly onto the sidewalk at a busy street corner. Yet despite the differences, both constitute vital service hubs for the homeless.

The two agencies differ markedly in terms of their service philosophy. Union Station is grounded in the belief that surroundings and rules should encourage people to make a concerted effort toward changing their lifestyles and behavior. As one client, Hazel Smith, said: "They didn't want us to get too comfortable down here . . . too lazy, not wanting to do anything for ourselves". For those homeless who have made a commitment to change by entering the agency's substance abuse program, Union Station provides short-term residential shelter, counseling, 12-Step Recovery meetings, and referral to longer-term rehabilitation programs operated by Los Angeles County. Graduates of the recovery program return to Union Station even after they have moved on to a permanent living situation; alumni attend 12-Step meetings and provide advice and support to current clients. For the facility's non-resident 'day' clients, Union Station offers case management, including emotional counseling and welfare advocacy, but not shelter. Day clients can also use Union Station to receive mail. There are two 90-minute periods in the morning and afternoon when all clients are allowed in the building and can access services. During the rest of the time, however, the facility is not open to day clients. Breakfast and lunch are served daily. Clients line up and plates of food are handed to them across a counter by volunteers. They are allowed twenty minutes to eat. In addition, structured activities (e.g. art and literacy classes), weekly health screenings and rap sessions are available to all. Volunteers interact with clients as tutors and health-care providers. They also aid caseworkers in the supervision of overnight guests and help out in the kitchen.

The St. Joseph's philosophy is somewhat different. The goal is to create an environment in which people retain their dignity as autonomous individuals. The only demand made of clients is that they observe minimal rules designed for the

security of staff and clients. The facility is open from 9 am to 5 pm three days per week, and for half-days during the remainder of the week. In addition to advocacy, clients can use the address to receive mail and the telephone number to receive messages (the latter is especially important for those needing to leave call-back numbers for potential employers). They can make phone calls. There is a shower facility, sinks for shaving, an ironing board, and a washer and dryer. People are free to come in and sit all day, and simply hang out. There is a small, sparsely furnished patio behind the building; coffee is served in the morning. Donated clothes and sundries are put out for people to take. Volunteers have constant interaction with clients.

The two localities are also strikingly different. Pasadena has a relatively stable, solidly middle-class population. It is one of a number of long-established urban nodes in Southern California, with venerable local institutions and quiet neighborhoods, although in recent years it has developed problems characteristic of older inner-ring suburbs (e.g. pockets of poverty, and gang behavior). The Venice/Santa Monica area presents a different picture. There are extremes of income and wealth; tattered beach cottages exist a block away from million-dollar homes. These are large Hispanic and African–American populations. An enormous daily and seasonal inflow of day-trippers and tourists are attracted to the beach.

Both locales offer much in the way of supportive infrastructure, e.g. libraries, malls, parks, thrift stores, and public conveniences. Venice/Santa Monica has extra advantages, mostly relating to the beach, with its public showers and bathrooms, shaded benches, and large crowds available for panhandling. One of the most interesting features of the Venice resource base is the storage lockers. Between the lockers and the Center, clients are able to replicate many home base functions; they can store their possessions securely, have a meeting place, and perform the basic tasks involved in everyday living. What is missing, of course, is shelter. So patrons sleep in cars, on the beach, in abandoned buildings, and on rooftops. Venice Family Clinic is two blocks from St. Joseph's, a store-front mental health clinic is nearby, and until recently evening meals were served daily in front of Santa Monica City Hall (about 1 mile north). A day-labor agency operates out of the local Economic Development Department (EDD) office, and a recycling operation is a few blocks from the Center. Two other major social service agencies in Santa Monica are also used occasionally by St. Joseph's clients.

How do the differences between the St. Joseph's and Union Station hubs, and between Venice and Pasadena, influence the formation of community among the homeless? An ethnographic study of the two hubs revealed important distinctions (Wolch and Dear, 1993). In Pasadena, clients enrolled in Union Station's 12-Step transitional substance abuse program had instant access to a community of sorts. They shared their lives with others at program meetings, and have a homed sponsor who sometimes offered rides or helped in other ways. Some 12-Step

clients spend time together and help keep each other sober, although, for the most part, the Union Station clients were relatively loosely-knit and transient. At the time of our study, there were a few couples; some groups lived in abandoned buildings not far from Union Station; three Hispanic men always arrived and departed together; and there was another small group camping alongside the railroad tracks. This last group, headed by David DeMay,* a Glendale-born Anglo man in his twenties, was stable for a period of about four months. Most of its members were working and trying to accumulate enough resources to obtain permanent housing. Another fairly stable group had turned an abandoned building into a squat. As Jet (a recovering substance abuser) said:

> "There used to be a hotel on Fair Oaks. It was abandoned a long time ago and we used to stay there. A lot of homeless people stayed there . . . The building's been renovated and it's no longer like it was. It was OK because we had mattresses and candles and it was fixed up real nice. In fact the police came up there one night and they commented on how nice and clean it was".

Apart from those enrolled in the substance abuse program, most people who used Union Station had dispersed and found secluded places to live, even though they socialized and maintained ties with the Station. Sara Miller, for instance, did temporary live-in care for recuperating elderly people; she ate regularly at Union Station, and claimed: "I've made a lot of friends [there]". She lived in her illegally-parked, defunct van on an Altadena street. Friends were discouraged from visiting because of her fear of being discovered. An intermittently employed 38-year old black man also indicated the importance of privacy and seclusion:

> "It's taken a while to develop the technique of staying somewhere where nobody will bother a guy in a sleeping bag . . . so if I'm staying inside or outside, for my own safety I would very rarely tell anybody where I live."

In contrast to Union Station, a chorus of voices told about the strength of social ties and community in Venice. St. Joseph's Center was *the* hub for the local homeless community. It was a place to meet friends and associates, make and receive telephone calls, and develop links with volunteers and staff. Many clients took ownership of the facility, acting as volunteers themselves and showing newcomers the ropes. When toiletries or towels were stolen from the supply closet, clients were angry, seeing theft as depleting the store of common goods available to their community. Sometimes, clients would spend their own funds to replace a stolen item.

The homeless community around St. Joseph's was not permanent, but could be quite stable for months and even years at a time. Many cohesive groups formed along lines defined by race/ethnicity, sexual preference, and substance abuse patterns. People often identified a group as their 'family'. This was encouraged

*Pseudonyms have been used in this text, except in the case of Diane Williams.

by Center staff who strove to achieve a family atmosphere. One such group of white gay men (mostly HIV-positive) was headed by Michael Rosenberg, a bright charismatic, car-ringed man in his mid-thirties; for a period of six months, they lived in a tent on a vacant beachfront lot and went everywhere together. Another was a large racially-mixed group with couples and singles, ranging from 7 to 20 or more persons. This group was kept in line by 'Mom', a small, dynamic 35-year old African–American woman, Diane Williams, a former hostess/dancer and mother of three. A third group clustered around a middle-aged African–American couple, Bill and Charlene, who were so stable that many people would crowd around them. The couple would move their personal camp to escape the attention and thus avoid problems with the police. Many Hispanic men also frequented St. Joseph's; one group did day-labor and maintained a loose but relatively stable network; another was younger, and included many undocumented and recently-arrived men who came and went together. Lastly, a number of older white male alcoholics, mostly Vietnam veterans, primarily used St. Joseph's for its restaurant service. It was customary for these 'families' to adopt newcomers, help them to obtain food, clothing, and medical care, and introduce them to the informal rules of community.

The differences between the agencies in Venice and Pasadena mattered in the lives of the homeless. The philosophies and policies of the two agencies strongly influence client notions about what successful coping entails. At Union Station, coping is essentially defined by sobriety; at St. Joseph's, a loosely-defined idea of autonomy-cum-survival prevails. In addition, the support provided by homeless peers tends to significantly improve coping ability. On this count, the St. Joseph's extended family appeared to be better off, having more material goods and being less socially isolated.

3.4. BUILDING SERVICE HUBS

The preceding case studies offered glimpses of the service hub in action, and how it makes a difference in the day-to-day lives of service-dependent individuals. Our next step is to consider how to build a service hub. We focus on one example of a hub in the making, located in the Skid Row area of Los Angeles. Again, the very nature of the hub concept implies that each service hub will develop differently, its specific form dictated by the nature of the surrounding community and the characteristics of its client population. Nevertheless, such an observation need not prevent us from identifying some of the more general tactics and strategies that we might apply.

Los Angeles' Skid Row, like others in the United States, developed during the late-nineteenth century as a migrant working men's neighbourhood. Its

location was largely a result of proximity to transportation terminals, and it quickly developed a suite of land uses including rooming houses, tenements, and commercial businesses. By 1920, several dozen SRO hotels had been constructed to serve the local transient population. During the Depression, public relief agencies began to congregate in the vicinity of Fifth and Main Streets, attracting additional indigent populations to the area. Public attention was drawn to Skid Row in the mid-1950s, when newspaper accounts exposed the dilapidated conditions of the area's housing. Consequent efforts to enforce building codes led to the demolition of over 5,000 hotel units and apartments. Yet the area continued to be a favored destination for transient populations.

Redevelopment pressures led to the loss of more than a quarter of Skid Row's housing units between 1969 and 1986. A City-wide moratorium on SRO demolitions in 1988 has slowed further losses. In addition, the remaining stock has been significantly upgraded by an initiative of the Los Angeles Community Redevelopment Agency (CRA). During the past eight years, over 25 SRO hotels have been renovated in the area (roughly one-third of the stock) and turned over to non-profit management. Considerable seismic upgrading has also been achieved.

Nevertheless, for many southern Californians, downtown Los Angeles remains an unattractive and threatening place. Part of this perception is due to the large numbers of poor people, homeless and substance abusers who congregate downtown, particularly in the Skid Row area. What cannot be forgotten, however, is that Skid Row plays a vital role in the lives of large numbers of Angelenos and in the economic health of the downtown as a whole. As the principal regional center for human services, downtown helps many thousands of people, including those in need of health, welfare, housing and other social services. As a downtown 'business', the human service sector is a multi-million dollar industry employing many hundreds of people through direct service delivery and the actions of voluntary agencies. In addition, Skid Row is part of a more extensive district known as Central City East (defined by Seventh, Alameda, Third, and Los Angeles Streets), which is one of the principal industrial districts in the City of Los Angeles.

The Single Room Occupancy Housing Corporation (SROHC) of Los Angeles was created in 1984 by the city's Community Redevelopment Agency (CRA). The SROHC has a complex mandate, reflecting the CRA's awareness of the interdependent, multi-dimensional nature of the Skid Row 'problem'. Its mandate included improving the current stock of SRO-type housing; managing that stock; providing technical assistance and training to SRO operators; representing SRO tenants; and implementing projects to improve the quality of life for SRO tenants and the surrounding neighborhoods. In practice, SROHC's first years have targeted three particular areas:

- a program of hotel acquisition, renovation, management and maintenance;

- a series of special projects, including quarterly neighborhood clean-up campaigns, graffiti removal, voter registration drives, and job fairs; and
- the management and maintenance of public open space.

Our interest in the SROHC project lies in the fact that these multiple policy initiatives are being undertaken in a highly circumscribed area within Los Angeles' Skid Row. A large proportion of the SROHC's activities are confined to a relatively small 3-block area identified by the CRA as a 'priority intervention area'. Within about 1/4-mile radius of the SRO's center-piece developments (the renovated Florence Hotel, and the vest-pocket park at 5th and San Julian Streets), land uses are developed as follows (figures are percentages of building floorspace):

- Industrial uses: 54% (including toy manufacture and seafood packaging)
- Parking: 17%
- SRO hotels: 11%
- Commercial/retail: 8%
- Services: 8%
- Open space: 2%.

The SROHC project is potentially valuable not only for its special combination of programs, but also for its self-conscious attempt to create an 'island of sanity' (a safe and humane hub environment) in the heart of Skid Row.

The *park* at 5th and San Julian Streets is at the heart of the SRO project. It opened in the summer of 1986, and now has a well-established pattern of usage. From its 8 am opening, the park's population grows steadily to an early afternoon peak of 70–80 patrons. The park population builds earlier in the day on weekends, because a significant proportion of potential users are either working or seeking casual employment during the morning. The build-up, rapid decline and re-inflation of the park population on weekends is associated with an organized free food distribution which occurs at this time on an adjacent site (a line of over 400 people typically forms by about 2 pm on Sundays).

The park is an inviting space which has areas for sitting, sheltered tables for games, seats, and grassed areas (Fig. 9). Park population is predominantly African–American (92%), and male (85%). The park is used mainly for meeting friends and talking, relaxation and game-playing, although the patterns of activity vary significantly during the day. The park is well-demarcated from its neighboring spaces. It is staffed and cleaned by SROHC personnel during the day, and by security guards during the night. The park also has formal rules which again act to demarcate the space from its surroundings. A significant proportion of self-policing is undertaken by park regulars. But the space is clearly alive, and well-regarded. The variety of common everyday daily activities is testimony to its value as a community asset (Table 4). In addition, there is a wide variety of 'irregular' activities which testify to a vital urban activity space (Fig. 10).

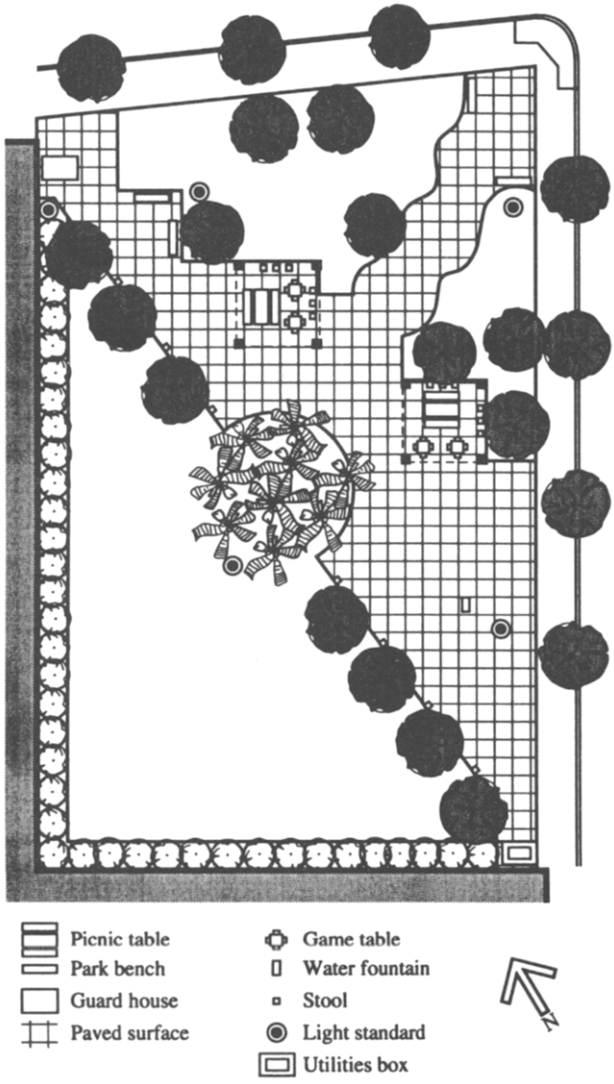

FIG. 9. Features of the 5th and San Julian Park.

The park's role in the coping network of Skid Row inhabitants (35% of our respondents were homeless, the rest lived in SRO hotels as permanent residents) begins to crystallize if we consider the frequency of regular visits by park patrons. Almost three-quarters of the sample visited the park more than 5 times per week; but hotel residents on average made much less use of the park (over half reported they never used it). The value of the park is further illustrated by respondent rating of the park's impact upon the neighborhood. Most felt that Skid Row was

TABLE 4. Park activities (October 19–25, 1986)

Conversing
Sleeping
Eating
Reading
Game playing
Maintenance
Bathing at the water fountain
Urinating
Hair styling
Washing and drying clothes
Vending – newspapers, cigarettes, lighters, ice creams
Preaching
Distributing pamphlets
Distributing food
Littering
Ball play by children
Assaulting
Arresting
Scavenging for recyclable material
Shooting
Knife sharpening
Filming of news program
Kissing (heterosexual and homosexual)
Soliciting for prostitution
Drug dealing from the curbside
Playing of stereo placed on sidewalk outside park boundary
Watching satellite T.V. provided by SRO staff

a bad place to live, with major concerns being crime and drugs/alcohol. Yet the neighborhood also had its good points, including its supportive atmosphere and service infrastructure (Table 5). According to 80% of the respondents, the opening of the park had improved things further (Table 6), especially providing a safe place to 'hang out'.

The acquisition of ten *hotels* on Skid Row has formed the other cornerstone of SROHC policy. Seven of these are clustered around the park. Over 85% of our respondents believed that the SRO renovations were helping the area, as well as providing better places to live. Over 60% of respondents reported using local *neighborhood services*, other than the park and hotels. These other services primarily related to shelter (55%) and food (23%).

The cumulative effects of SROHC policies in this part of Skid Row is vividly portrayed in a series of 'turf' maps which respondents prepared (Figs 11–13). The darkness of the shaded areas indicates the frequency with which a zone was cited by the respondents. Hotel residents (Fig. 14) portrayed a very limited safe zone around the Florence hotel/park apex; their concerns with unsafe zones focused on another park at 6th and Gladys Streets (a notorious crime center, since closed). Park users (predominantly homeless) have a much more complex, geographically

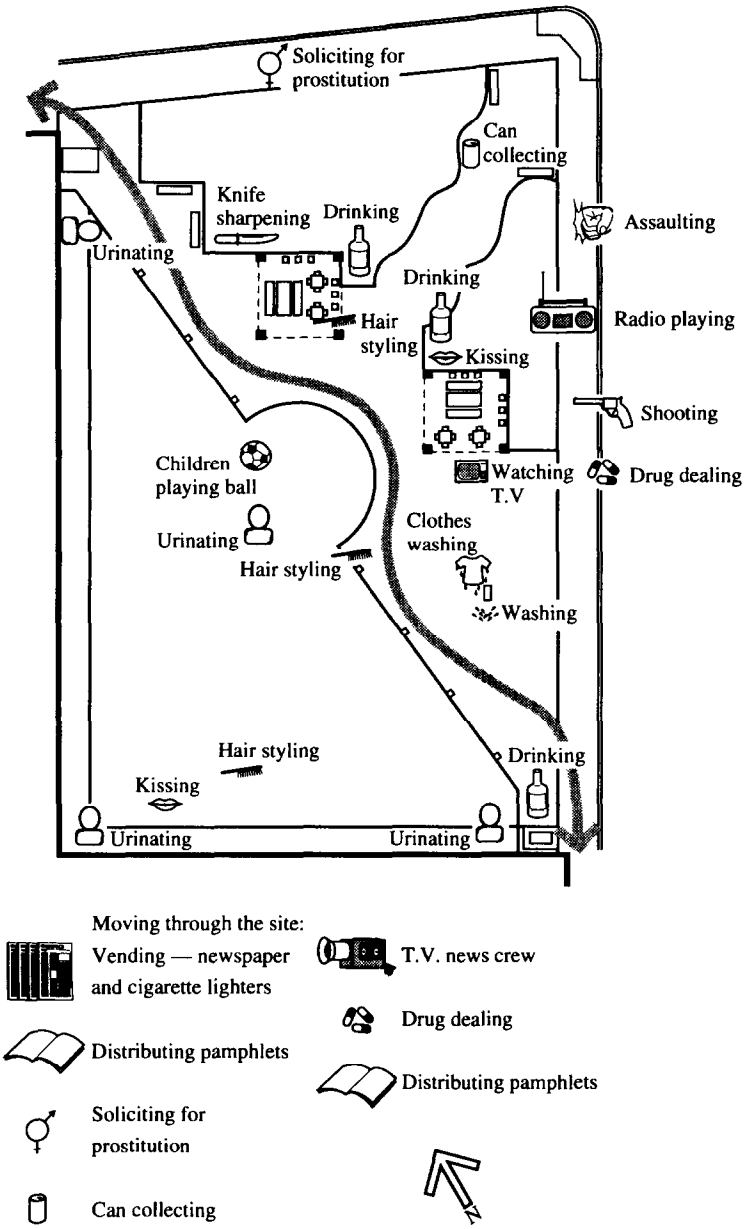

FIG. 10. Irregular activities at the 5th and San Julian Park.

TABLE 5. Best aspects of a neighborhood (percentages)

	Park users	Hotel residents	Total
Supportive environment	26.1	17.4	21.7
Good services	26.1	13	19.6
Park at 5th & San Julian	21.7	4.4	13
Tolerant neighborhood	4.4	17.4	10.9
Cheap shelter	4.4	17.4	10.9
Central location	0	13	6.5
Nothing	13	17.4	15.2
Other	4.4	0	2.2
Total	100	100	100
N	23	23	46

Multiple responses were permitted.

TABLE 6. Respondent assessment of how the park has helped the area

	Park users	Hotel residents	Total
Provided a place to hang out	21.9	9.7	23.3
Safe place	18.8	25.8	32.6
Clean	12.5	29	30.2
Place to meet friends	12.5	9.7	16.3
Provided a 'nicer' place	6.3	25.8	23.3
Place for recreation	6.3	0	4.7
Park workers and maintenance	3.1	0	2.3
Something to do	18.8	0	14
Total	100	100	100
N	31	31	43

Multiple responses were permitted.

extensive safe zone, which again centered on the hotel and park area (Fig. 12). The 6th and Gladys park was clearly a 'no-go' area. The shelter operators basically regarded the whole area as unsafe (Fig. 13); the hotel/park zone was included as one of the few safe zones, but (somewhat paradoxically) also sketched as a zone of some danger.

Overall, it is clear that the park users have a geographically more expansive safe turf than hotel residents or the shelter operators. In the lives of the homeless, the 'island of sanity' provided by the hotels and park plays a prominent role in their everyday lives. In fact, four well-defined relationships were illustrated by a canonical correlation analysis of coping ability and attitude to parks and hotels.

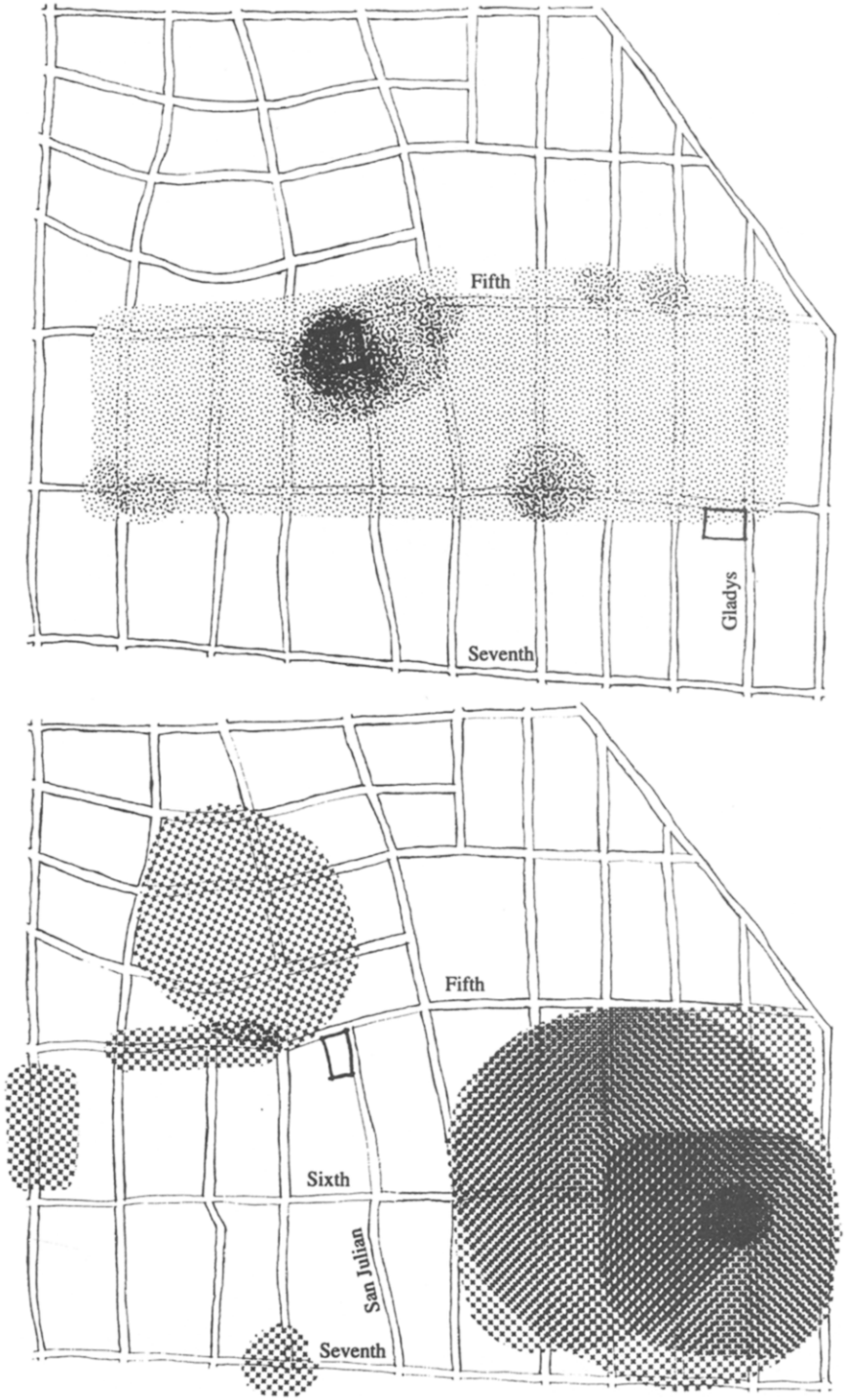

FIG. 11. (a) The safe zones of hotel residents. (b) The unsafe zones of hotel residents.

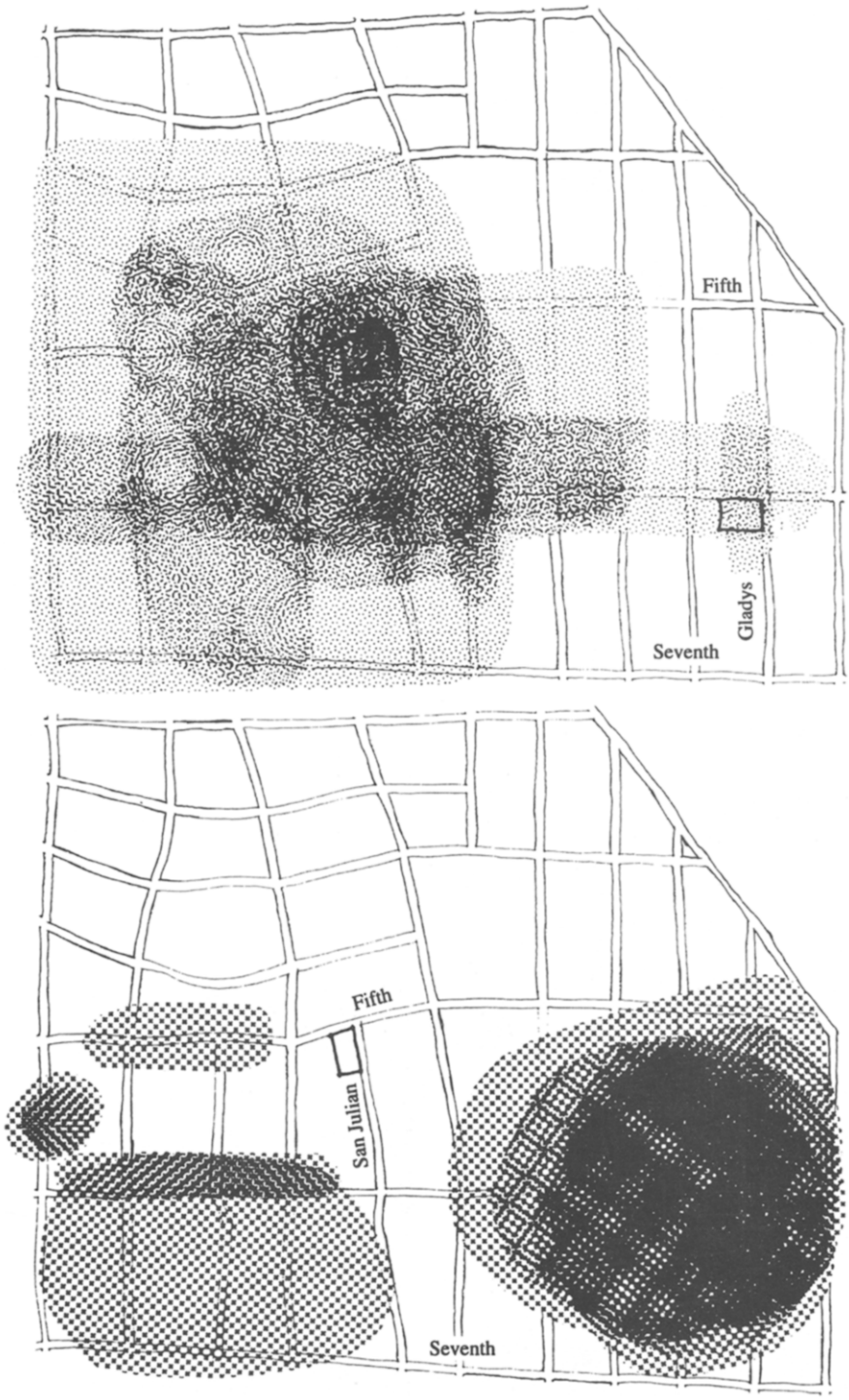

FIG. 12. (a) The safe zones of park users. (b) The unsafe zones of park users.

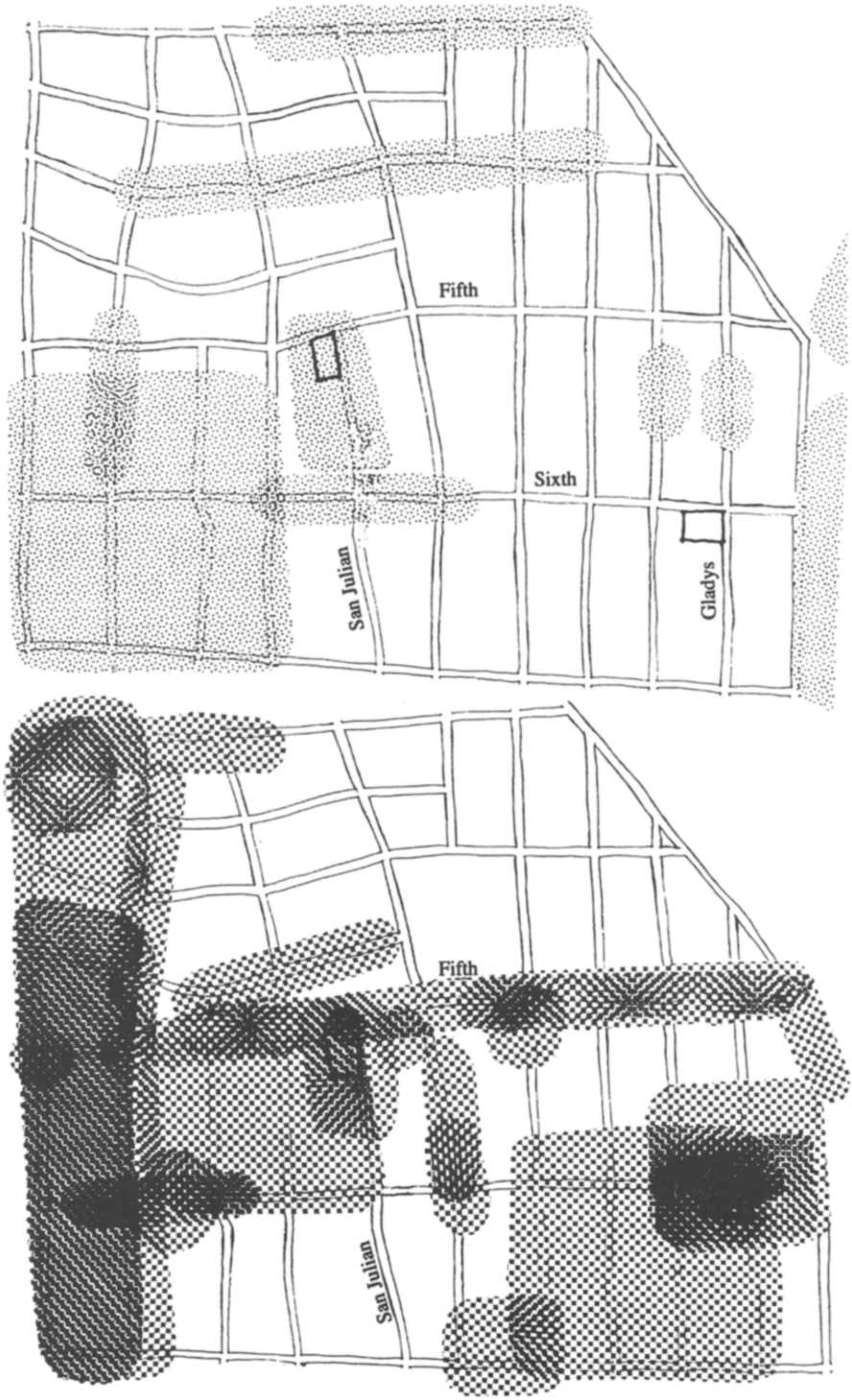

FIG. 13. (a) The safe zones of shelter operators. (b) The unsafe zones of shelter operators.

These may be summarized as follows:

- those who are black non-SRO residents, frequently using community services, tend to have lower coping ability and place a high value on the park;
- conversely, white SRO residents, making less use of community services, tend to cope better and rate the park as neutral or low impact;
- those who are young and cope well tend to value the park highly; and
- those older people using services less often tend to discount the park but have lower coping ability.

In summary, for those living on the street, the park plays a significant role in their coping ability; and for those living in the SRO hotels, the park is less significant than their status as a hotel-resident in their sense of well-being.

The SROHC/CRA attempt to create an 'island of sanity' on Los Angeles' Skid Row can be seen as an (albeit inadvertent) attempt to build a service hub. The several SRO actions (around park openings and hotel rehabilitation) represent add-ons to the existing social networks of Skid Row. The bolstering of these networks has had a significant effect on the quality of life for the local residents, as well as on the overall levels of amenity in the physical environment.

CHAPTER 4

Overcoming Community Opposition to Human Services

Since the late 1950s, community-based support systems for service-dependent people have been advocated as humane and effective settings for promoting rehabilitation and social integration of groups formerly relegated to institution-based care. More recently, the siting of community-based facilities for such groups as the mentally and physically handicapped, the dependent elderly, substance abusers, ex-offenders and the homeless has sparked a heated and often vociferous local opposition. The reasons for this opposition mostly center on the perceived negative effects arising from proximity to such facilities. Concern is frequently voiced that community service installations will, for instance, create excessive noise, traffic and parking problems. More often than not, opposition is grounded in fear and sometimes erroneous perceptions about service-dependent persons themselves. Residents are alarmed by possible threats to neighborhood amenity, personal safety, and increased exposure to unusual behavior. Concern is also expressed that the facilities will depress property values, though to date little or no evidence has been found to validate this claim. Neighborhood hostility has frequently been bolstered by local zoning ordinances which restrict community care facilities to commercial areas, or place excessive burdens upon facility operators as part of a conditional use permit process.

In this chapter, we shall explore the bases for community opposition to human service facilities. First, we document the common themes that appear to underlie most neighborhood disputes, and identify the factors that generate accepting and rejecting sentiments in various neighborhoods. Then we examine the range of approaches to community outreach available to service providers contemplating the establishment of a new facility. And finally, based on our many years experience, we offer a recommended blueprint for good neighborhood relations with a service provider's host community.

4.1. THE RISE OF NIMBY-ISM

In plain language, NIMBY (for 'Not-in-my-back-yard') is the motivation of residents who want to protect their turf. More formally, the term refers to the

protectionist attitudes of, and oppositional tactics adopted by, community groups facing an unwelcome development in their neighborhood. Such controversial developments encompass a wide range of land-use proposals, including many human service facilities, landfill sites, hazardous waste facilities, low-income housing, nuclear facilities, and airports. These facilities are usually conceded as being necessary but are not wanted by residents in proximity to any potential site; hence the term 'not-in-my-back-yard'.

The effect of NIMBY sentiments on the provision of human services can be devastating. They can lead to the withdrawal of tax dollars for needed programs or cause the closure of a facility. Consumers thus either have to do without service, or travel excessive distances to obtain service. At the very minimum, NIMBY sentiments can sour community–facility relations in ways which are detrimental to client well-being. Of course, not all opposition is counterproductive: neighborhood complaints can result in valuable improvements to proposed programs; and vocal, client-led opposition may cause adjustments to the program plans of human service providers. In the present context, however, we focus on the more self-interested, turf-protectionist behavior of facility opponents.

Prejudice and discrimination against 'different' people are nothing new. Latin manuscripts from the twelfth century identify homosexuals and Jews as non-conformists threatening to the social order (Boswell, 1980). In another time and place, opponents of a late-nineteenth century asylum in Canada listed the following concerns:

> The chief grounds on which the plaintiffs based their [opposition to the new asylum] were: that the erection of the building and the maintenance and carrying on of an asylum on the site chosen constituted a public nuisance, and was a source of injury and damage to them, decreasing the value of their property, especially as sites for villas and elegant dwellings; and that they, the plaintiffs, would be exposed to constant annoyance, inconvenience, and danger, with great risk of disease through the contamination of the air and the pollution of the Rivers St. Lawerence and St. Pierre by sewage from the hospital (Burgess 1988, 1986).

Although contemporary writers may not have referred to these incidents as instances of the NIMBY syndrome, it is evident that such sentiments abound in the historical record (Gilman, 1988). In the late-twentieth century, prejudice has once again been inflamed by the plague of AIDS and the crisis of homelessness.

From the viewpoint of the developer or public agency targeted by NIMBY activists, neighborhood opposition can amount to much more than a minor irritant on the way to project completion. Indeed, the effectiveness of community opposition has given rise to a new class of lawsuits, termed SLAPPs, or strategic lawsuits against public participation. These have been employed as a means of discouraging opposition, even though developers have lost the vast majority of suits filed since the SLAPP phenomenon surfaced around 1970 (Enos, 1991). Counter-suits by community groups (SLAPP-backs) are likely to deter future lawsuits; in one recent case, three Kern County, CA, farmers won a $13.5 million

award for malicious prosecution against an agribusiness giant that had previously SLAPPed them (Hager, 1991).

Many of these concerns seem far from the problems of human service delivery, and the role of NIMBY factors in this field is less well documented (notable exceptions include Lauber, 1990a; Smith, 1989; Takahashi, 1993). Yet although they may be less dramatic in their consequences, the problems of NIMBY responses to human services are increasingly present in land-use decisions. We are obliged to turn to other literatures for guidance in understanding the origins of prejudice and discrimination towards society's disabled and disadvantaged. Representative studies of stereotypes of race and gender are to be found in Gilman (1985), who has also examined the case of attitudes toward madness throughout history (Gilman, 1988). The NIMBY sentiments engendered by specific human service clients appear to vary widely. The case of the developmentally disabled is examined in Balukas and Baken (1985), Berdiansky and Parker (1977), Dudley (1988), Gale *et al.* (1988), and Kastner *et al.* (1979); of ex-offenders and substance abusers by Fattah (1984); of problem youth by Piper and Warner (1980), and Solomon (1983); and of the mentally disabled by Green *et al.* (1987), and Smith (1981). The special case of AIDS sufferers has recently begun to receive attention (see, for example, Bean *et al.*, 1989; Blendon and Donelan, 1989; Herek and Glunt, 1988; Page, 1989; Rogers and Ginzberg, 1989; Sontag, 1989). And as a final example, the case of the homeless has been examined by Birch (1985); Dear and Gleeson (1991); Laws and Lord (1990); Lee *et al.* (1990); Marin (1987); National Campaign to End Hunger and Homelessness (1988); National Coalition for the Homeless (1987); and Wolch *et. al* (1988).

Planners may be less concerned with the origins of NIMBY attitudes, but there is an increasing volume of publications devoted to understanding the consequences of land-use decision-making in an exclusionary environment. Good overviews of the general class of noxious facilities and the associated locational conflict are to be found in Massam (1993) and Lake (1987). Plotkin (1987) provides a thorough analysis of the land-use planning consequences of slow-growth-related NIMBY actions (see also Weber, 1978). Much recent attention has been directed toward conflict over low-income housing developments (e.g. State of California, 1988; Feld, 1986; U.S. Department of Housing and Urban Development, 1991), and hazardous-waste disposal sites (e.g. Armour, 1991; Heiman, 1990; Schwab, 1991). Many reports on opposition to service-dependent groups have been published by advocacy groups; those by HomeBase (1989) and CRISP (1976, 1989) are among the best-known. In addition, there is a burgeoning literature providing a more formal evaluation of local government's programmatic efforts to overcome the NIMBY syndrome. (For the example of New York, see Glazer, 1991; Olson, 1991; for the State of Illinois, see Lauber, 1990b; and for Toronto, Canada, see Dear and Laws, 1986.)

4.2. UNDERSTANDING THE NIMBY RESPONSE

To understand community opposition, it helps if we realize that there are certain patterns, or consistencies, in the way in which NIMBY battles arise and progress.

4.2.1. NIMBY sentiments go in cycles that reflect national, regional and local events

Community opposition tends to be cyclical in nature, with periods of intense activity (i.e., many disputes) followed by extended calms. In the field of human services, several important national events have formed a backdrop to local events during recent decades. These include: the deinstitutionalization movement; an extensive restructuring of federal social welfare programs; the collapse of federally-assisted affordable housing programs; a widespread restructuring of the U.S. economy toward a 'services' orientation; homelessness; and AIDS (see, for example, Bassuk, 1984; Dear and Wolch, 1987; Kamerman and Kahn, 1989; Phillips, 1990; Smith, 1989; Wolch, 1990; Wolch and Dear, 1993). The net effects of these developments have been that more people are demanding social welfare programs at a time when these programs are being reduced or eliminated; those who work are less well off, at the same time as the nation's wealth is increasingly concentrated in fewer hands; and decent, affordable housing is an increasingly scarce commodity. In addition, the 1980s have been labelled the 'Me Decade', reflecting the increasing self-absorption and loss of community among many Americans. In these less-than-tolerant times, the disabled and disadvantaged suffer not only increasing material hardship but also diminished public sympathy (Dear and Gleeson, 1991; Glass, 1989).

4.2.2. The pattern of community opposition and conflict has its own internal rhythm

Each incident of locational conflict tends to have its own internal rhythm, almost always revealing a three-stage cycle (Dear, 1976):

- **Youth:** In which news of the proposal breaks, and the fuse of conflict is lit. Opposition tends to be confined to a small vocal group in very close proximity to the proposed development. NIMBY sentiments are usually expressed in the rawest, bluntest of terms often reflecting an irrational, unthinking response by opponents.
- **Maturity:** Battle lines have solidified, and the two sides have assembled ranks of supporters and objectors. The debate has moved away from private complaints, and into a public forum. As a consequence, the rhetoric of opposition becomes more rational, and 'objective'. Less is heard of the

desire to 'throw the bums out' of the neighborhood; more measured voices express concerns about property value decline, increased traffic volumes, and the like.

- **Old age:** The period of conflict resolution is often long drawn-out and sometimes inconclusive. Victory tends to go to those with the persistence and stamina to last the course. Typically, at this stage, some kind of arbitration process is adopted, utilizing professional and/or political resources. Concessions are made by both sides. If positions become sufficiently entrenched, a stalemate can ensue; in this situation, victory again tends to fall to those with staying power.

4.2.3. Opposition arguments follow consistent patterns

If we exclude the angry, irrational outbursts characteristic of the initial/youthful phase of conflict, opposition arguments can usually be distilled into three specific concerns: property values; personal security; and neighborhood amenity.

In past decades, the principal concern voiced by opponents has been that property values in their neighborhood would decline. However, a large number of studies on real estate transactions in the vicinity of human service facilities have been conducted during this period (summarized in Dear and Taylor, 1982, Chapter 9; see also State of California, 1988). Not one of them has demonstrated a property-value decline that could clearly be linked to the facility in question. When market changes have been observed, they tend to be associated with broader neighborhood trends, e.g., fluctuating interest rates, or larger-scale local property developments nearby, such as a new shopping mall. In some instances, neighborhood property values have actually increased because the facility was so well-maintained or renovated that it had a beneficial effect on its neighbors.

Concerns about personal security are more common with certain client groups than others. The key variables in this category are the potential dangerousness and unpredictability of clients (Dear and Laws, 1986; Dear and Gleeson, 1991; Lee *et al.*, 1990). As one might expect, substance abusers (particularly drug addicts who might be associated with criminal behavior to support their habits) and ex-offenders (with manifest records of lawlessness) figure prominently in this category. But these factors also influence responses to the mentally disabled, who may display aberrant and/or aggressive public behavior. Neighborhood concerns about personal security often find expression as questions about facility operating procedures, especially supervision arrangements.

The potential decline of neighborhood quality also worries people close to a proposed facility. This applies equally to the anticipated impact on business as well as to residential amenity. Specific threats to overall neighborhood amenity

include: the physical appearance of clients, some of whom may appear dirty or unkempt; and anti-social behavior, such as loitering, public urination or defecation, and aggressive panhandling. Businesses complain that groups of undesirable people drive customers away; residents worry that the presence of clients detracts from their enjoyment, and that certain types of people provide a bad influence on children.

Apart from these three arguments, opponents also focus on the peculiarities of local situations. Increased traffic and availability of parking are commonly mentioned. More sophisticated opponents express their opposition in terms of the clients' needs. For example, the host neighborhood may be represented as unsuitable for the client group, or unsafe. This is "NIMBY with a caring face".

4.2.4. Opposition tactics are almost always the same

Strategies and tactics adopted by opposition groups vary, but in the past they have overwhelmingly focused on the zoning hearing. This is because, more often than not, human service facilities in residential districts have required a zoning variance (Dear and Wolch, 1987).

The need for a zoning variance arises because a proposed development does not comply with the land-use zoning category that has previously been established for the area in question. Group homes and similar facilities that bring together unrelated adults in a residential situation have usually been in clear breach of residential zoning codes; hence they require a 'variance' to allow them to operate. Exactly the same problem arises with non-residential facilities (such as counselling centers and clinics) which may be classified for zoning purposes as commercial, retail, or even industrial land uses. The variance procedure usually insists that the immediate neighbors be informed about the proposed change to a non-conforming land use. Public hearings may be held to deal with objections. These information and public meeting mechanisms have been the principal vehicles through which community opposition has been alerted and channelled (Lauber, 1990a, b).

Besides zoning hearings, other common pressure tactics adopted by opponents are: neighborhood petitions; letter-writing campaigns (usually targeting the facility and its sponsor, or local politicians, or the media); political pressure through elected representatives; media involvement; demonstrations; and formation of formal neighborhood opposition groups. Very often, these tactics are combined and even coordinated with the process of a zoning variance. In extreme cases, violent and/or illegal means are employed by opposition groups. This kind of vigilante action is relatively rare, but it can flare up at any time during a locational conflict. Such tactics include: damage to property; arson; and physical assaults on staff and clients (Dear, 1976).

4.2.5. Four factors typically determine the host community's response to a proposed facility

It is always difficult to predict exactly how community residents will respond to the proposal to open a facility in their midst, but four factors contribute to the formation of that response (see, inter alia, Dear and Taylor, 1982; Glass, 1989; Segal and Aviram, 1978; Takahashi, 1993; Weber, 1978). We shall mention them briefly here and then return to them in more detail in the following section.

- *Client characteristics,* including their demographic profile (age, sex, etc.), and their particular disability (e.g., mental handicap, addiction, and so on);
- *nature of the human services facility itself,* including its physical condition and appearance (such as the presences or absence of landscaping), and its operating procedures (e.g., opening times);
- *structure of the host community,* including its socio-economic composition (income, etc.), as well as the neighborhood's physical characteristics (such as density or land-use mix); and
- *local programmatic considerations,* which refer to administrative conditions affecting the siting process, including peculiarities of the local zoning ordinance, and the existing distribution of human service facilities (if any) within the community.

4.2.6. In the final analysis, NIMBY sentiments arise because of geographical proximity

There is one over-riding factor in the NIMBY syndrome: geographical proximity (Smith, 1981). The rule is simple: the closer you are to an unwanted facility, the more likely you are to oppose it. This is especially true if the facility is on your block. But somewhere within a radius of between two and six blocks, a neighbor's interest or awareness declines to the point of indifference (Dear *et al.*, 1977). This rule will be obvious to most, but it should never be underestimated simply because it is familiar.

4.3. FACTORS DETERMINING COMMUNITY ATTITUDES

We can never be certain about the response of a potential host community. But four factors play a consistent role in explaining how opposition arises; these were briefly mentioned in the preceding section, but they warrant fuller attention.

4.3.1. Client characteristics

Public attitudes toward difference tend to be organized in a hierarchical fashion (Tringo, 1970). At one end of the spectrum, certain differences are easily tolerated; at the other, difference provokes intense revulsion. Between these extremes lie many ambiguous cases, characterized by ambivalence on the part of the observer. A report by the Daniel Yankelovich Group (1990) suggests that atop a typical "good neighbor hierarchy" are those with physical disabilities and problems that most people will encounter at some point in their lives (old age, and terminal illness). In the middle of the acceptance ranking are mental disabilities. The fact that the mentally ill are twice as likely to be rejected than the mentally retarded is probably a reflection of culpability (i.e., the retarded can't be blamed for their condition). Finally, lowest in the acceptance hierarchy (the least desirable neighbors), are those with 'social diseases': crime, alcoholism and drugs (also see Takahashi, 1993).

Hierarchies of acceptance/rejection are not fixed. Instead, the pecking order changes over time, even quite quickly. The volatility in the acceptance hierarchy results from many factors. For instance, the development of new programs (such as deinstituitionalization) can introduce new client groups to previously unfamiliar communities. Equally important, the appearance of new groups in need have the potential to transform the hierarchy of acceptance. The 1980s have witnessed the dramatic appearance of two such groups: people with AIDS, and the homeless.

The case of people with AIDS (PWA) and those who are HIV-positive is especially poignant and revealing (Illingworth, 1990; Kinsella, 1989; Sabatier, 1988). The disease appeared out of nowhere, and quickly rose to prominence as a new world-wide plague. It was contagious, almost always deadly, and associated with mental as well as physical breakdown (up to two-thirds of PWAs suffer from dementia and other neurological disorders). Community response to the AIDS crisis has been complicated. Much misinformation was transmitted, either through an ill-prepared media or by public authorities (including, most notably, well-publicized arrests of AIDS demonstrators by police officers wearing yellow rubber gloves). Delayed response by federal government health authorities has further complicated matters. Finally, PWAs have to combat the notion that they are to blame for their illness because of their 'anti-social' behaviors, especially intravenous drug abuse and male homosexuality (Bean *et al.*, 1989; Blendon and Donelan, 1989; Herek and Glunt, 1988; Page, 1989; Sontag, 1989).

The case of the homeless is equally instructive. In the 1980s, much public sympathy and political mileage were engendered by lumping together all groups that qualified as homeless. The homeless not only included the traditional middle-aged male alcoholic, but also the mentally disabled, veterans, substance abusers, families, victims of domestic violence, and so on. Public attention was

grabbed as estimates of the number of homeless rose, even as high as 3 million nationally. Now, a decade later, many communities appear to be losing their compassion. In this harsher climate, all homeless people tend to become tainted with the characteristics of the worse-case homeless sub-groups; substance abuse, chronic mental disability, dangerousness and unpredictability, and complicity in creating their own difficulties (Dear and Gleeson, 1991; Lee *et al.*, 1990).

One of the most recent national surveys, by the Daniel Yankelovich Group (1990) provides valuable evidence of the hierarchy of acceptance in the era of homelessness and AIDS. Three tiers of acceptability were identified:

- Most welcome; school, day care center, nursing home, hospital, medical clinic.
- Mixed reviews; group home (mentally retarded), homeless shelter, Alcohol rehabilitation center, drug treatment center, chronic mentally ill facility.
- Absolutely unwelcome; shopping mall, group home (AIDS patients), factory, garbage landfill, prison.

We can summarize those key dimensions along which clients are likely to be judged by a potential host community (cf. Dear, 1990):

- Demographics; age, gender, race, ethnicity, social class.
- Type of disability; physical, mental, social.
- Severity of disability; contagious, life-threatening, chronic, mild.
- Visibility of disability; invisible, predominant.
- Culpability; blameless, blameworthy.

4.3.2. Facility characteristics

Facility characteristics are doubly significant in the acceptance/rejection equation: not only do they impact directly on community perceptions; but they also are one of the few areas over which service providers can exercise direct control. Next to the clients themselves, the service facility is the most important image that providers offer the host community. In general terms, six dimensions of the facility influence community perceptions: type, size, number, operations, appearance, and reputation (Dear and Taylor, 1982; Segal and Aviram, 1978; Weber, 1978).

Type: Human service facilities can be classified in a number of ways. The most important evaluative dimensions, from a community's viewpoint, are as follows:

- Residential vs non-residential: In the case of the former, clients will become part of the community on a 24-hour basis, as neighbors; in the latter case, users will tend to confine their presence to opening hours and usually anticipate a more limited community involvement.

- Local clients vs outsiders: Services intended for local residents are more likely to be accepted than services which are perceived as attracting strangers to a community.
- Provision-type vs dispatch-type facility: Some facilities dispatch their service to a client; others rely on the client to come to them for service.
- Acceptable vs non-acceptable clients: This is just a reminder that community response to the facility–client package will vary according to the client group's position in the hierarchy of disability acceptance. One revealing example of the significance of client/facility type occurred a few years ago in Metropolitan Toronto (Canada). Here, a new zoning law was passed to allow all kinds of group homes into residential neighborhoods as of right, with the exception of correctional facilities designed for rehabilitation of convicted offenders (Dear and Laws, 1986).

Size: Other things being equal, large-scale facility will be less acceptable than a small-scale facility, because the impacts of a large-scale facility are likely to be so much greater (e.g., more cars, more people, more activity). The main exception to this rule is the case where a large facility has a significant positive impact on local employment prospects (e.g., a prison in an isolated rural community).

Number: The number of human service facilities in a community becomes important in two different circumstances: (1) the introduction of the very first facility is often viewed with suspicion as the thin edge of the wedge. Opponents argue that if the initial facility is allowed, then the community will be targeted for further sitings; (2) the opposite circumstance occurs when a neighborhood perceives itself to be saturated with human services. Saturation is a relative concept: residents see themselves as overburdened in comparison with other neighborhoods. There is no absolute level at which saturation becomes identifiable.

Operating procedures: The operating procedures of a facility can dramatically influence the impression it creates in a community. Uppermost in people's minds is the question of supervision, which is associated with the problems of neighborhood security and personal safety. Hence, appropriate staffing to ensure client supervision can tip the balance toward community acceptance. Other factors that determine the facility's 'profile' in the community are: its opening times; the schedule of activities (e.g., scheduled recreation periods in the back yard); and the presence or absence of formal neighborhood outreach programs.

Reputation of the sponsoring agency: The reputation of the service sponsor often enhances the facility's chance of acceptance. It also helps to be able to refer opponents to other facilities that have been successfully introduced into neighboring communities. Note that the relevant sponsor could be the

funding source or the actual service provider. In other cases, less direct sponsorship is possible, as when a prominent personality (say, a politician or a celebrity) lends his or her name to support a particular venture. A spokesperson should be chosen carefully, however. When Nancy Reagan withdrew her sponsorship of a Southern Californian drug treatment center (following community protest), the facility never opened.

Appearance: A new or renovated, well-maintained facility, in good physical condition, can rapidly become a positive asset in most neighborhoods. It is not unusual for such facilities to boost property values in their vicinity. Even the name of a facility can influence opinion. It is also important that appearance and signage (if used) should avoid imparting an institutional atmosphere to the neighborhood. The facility should blend into its context, aiming to obtain a good fit between the facility and its setting. Neighborhood anger can be defused by careful attention to the design of internal and external spaces, by (for instance) enlarging the waiting room or internal courtyard so that clients congregate inside a building rather than on the sidewalk outside. Some may object to these cosmetic adjustments, which can have the effect of screening the facility and its clients from the surrounding community. But such design/architectural concessions seem a small price to pay in order to appease opponents.

4.3.3. Characteristics of the host community

Conventional wisdom suggests that suburban jurisdictions usually close ranks to prevent the incursion of human service facilities (or any other development perceived as a threat to the neighborhood). In contrast, inner cities are seen as more tolerant and accepting (Dear and Taylor, 1982). The key dimension underlying this difference is neighborhood homogeneity, both social and physical. Suburban areas tend to be composed predominantly of single-family homeowners living at relatively low densities. The inner city is a mix of land uses and social groups: industrial, commercial, and residential uses, often at high densities; owners, renters, singles, diverse social classes, and mixed racial/ethnic groups. Homogeneous suburbs, as a general rule, tend to reject difference; but in the inner city, one further addition is unlikely to be noticed (Segal and Aviram, 1978).

Typical community profiles of acceptance and rejection have been suggested. A recent U.S. national survey (Daniel Yankelovich Group, 1989) revealed the following profile of the typical NIMBY respondent: High income, male, well-educated, professional, married, homeowner, living in large city or its suburbs. According to this survey, the single best predictor of opposition is income: the more affluent tend to be less welcoming.

How does intolerance develop? Some researchers argue that individual psychology reveals a complex trade-off. On one hand, people harbor authoritarian and restrictive sentiments, believing that the disabled and disadvantaged require paternalistic care, and should be separated from the rest of society. On the other hand, benevolence is a strong motivator, and results in a humanitarian view of society's disadvantaged, largely derived from religious/humanistic values (Dear and Taylor, 1982, Chapter 10). The actual response depends on how these factors are balanced in an individual's mind. Particularly important are an individual's familiarity with, and awareness of the characteristics and the difficulties of the client group (e.g., the likely behaviors of schizophrenic adults); in this case, familiarity increases tolerance. These findings are consistent with the experiences of service providers in many human service sectors, such as those for the homeless (Anello and Shuster, 1985); the developmentally disabled (Bruni and O'Brien, 1970; Casrud *et al.*, 1986); correctional populations (Evans *et al.*, 1981; Fattah, 1984); the physically handicapped (Roth and Smith, 1983); troubled adolescents (Solomon, 1983); and foster care (Pierce and Hauk, 1981).

4.3.4. Programmatic considerations

Finally, it is important to remember that services do not exist in a vacuum, but occur within a particular programmatic setting. Two aspects of this context are especially important: (a) land-use planning strategies; and (b) the saturation question (Dear and Wolch, 1987, Chapters 5, 6 and 9).

During the past two to three decades, community relations programs developed in a piecemeal manner, often as a result of the pressures associated with the application for a zoning variance. Three phases in this history can be identified. In the early siting history, service providers typically adopted one of two locational strategies. The first has been called a *low profile* approach. In essence, a facility was established secretly; the hope was that, by the time its operation was discovered, it would already have demonstrated its successful integration into the neighborhood. Since this was a manifestly risky strategy, other operators adopted a *high profile* approach. This had, as its objective, the education and persuasion of the host neighborhood. Acceptance was pursued either via a general (i.e., community-wide) communications strategy or via a program specifically targeted at opinion leaders in the neighborhood. Unfortunately for the operators, the high profile approach also had the effect of alerting potential community opposition, so it too was a risky option.

Since neither strategy could guarantee a non-controversial siting, operators next responded by seeking out risk-free locations. Such *risk-aversion strategies* reinforced the tendency to favor inner-city locations with flexible zoning

classifications. The pattern of land-use zoning, when combined with other factors (such as suburban opposition, and the limited availability of properties suitable for conversion to community-based facilities) produced an inexorable force for ghettoization in the well-defined inner districts of major urban areas.

This unforeseen outcome (neighborhood saturation) gave impetus to the third phase in the development of siting strategies. This was manifest as pressure to prevent further saturation and to ensure a 'fair share' of the responsibility for providing services throughout urban areas. A number of jurisdictions have moved to develop minimum *distance-spacing standards* between facilities; others have advanced *fair-share principles* to ensure that other communities do their part in the burden and obligations of service provision. The effect of distance-spacing requirements has been to slow the process of ghettoization but fair-share ordinances are only now beginning to open up the suburbs. As we discuss in the final section, accepting the fair-share approach to human services planning demands a willingness to reformulate the principles which currently inform planning practice, a task that is clearly problematic.

Communities that perceive themselves as saturated with facilities require special consideration (Sundeen and Fiske, 1982). Since they are, by definition, already caring for needy clients, they are not susceptible to the same moral pressures that can be brought to bear on neighborhoods lacking such services. For these neighbors, facilities and clients are not abstract or hypothetical notions; they have direct, real knowledge of them. Hence, saturated communities expect to be (and should be) treated differently; and very special arguments will be needed to induce them to support the introduction of yet more services.

One very important argument in favor of saturation tends to be overlooked: that saturation can be a positive asset for clients and service operators (Dear and Wolch, 1987). Our reasoning here once again relates to geographical proximity. Quite clearly, a collection of proximate services can allow for positive interaction both between facilities and between clients.

4.4. ALTERNATIVE APPROACHES TO THE HOST COMMUNITY

As soon as service providers decide to commence operations, they must also choose one of two strategies: collaboration with the host community (high profile) or autonomous action independent of the host (low profile). The choice depends on whether the service operator places greater emphasis on the community's rights, or on clients' rights. It also depends on an operator's judgement concerning which strategy (or combination of strategies) is the most likely to succeed, given local circumstances.

- *Collaborative,* implying open cooperation between operator and host community; or
- *autonomous,* involving operator action independent of the host community.

These alternatives represent two totally different philosophies of community relations, so it is important to understand them in detail.

The collaborative approach assumes direct contact between the service provider and the host community or its representatives. Implicitly or explicitly, it grants relative priority to the community's rights to be made aware of, and participate in, decisions affecting their neighborhood. However, while acknowledging those rights, it also implies a community obligation to host services for the disabled. In essence, collaboration is about establishing a social contract between the provider and host community. Facility operators offer a useful service, openly and honestly, and anticipate community support in return.

The collaborative option is always indicated in those circumstances where good community relations are vital to the on-going success of a program. It is a sound policy in neighborhoods where community support is confidently anticipated, but makes greatest sense in neighborhoods where opposition is strong. Handled properly, collaboration promises long-term community support for facilities. Its principal drawback is that it risks alerting and provoking the opposition.

The autonomous approach accords priority to the rights of the clients. Generally speaking, operators (and others responsible for the service in question) reject the notion of difference, and insist on the clients' rights to live/work/play/receive care wherever they please, and under circumstances of their own choosing. In accordance with this principle, the autonomous approach presumes no direct contact with the host community prior to siting. When challenged by disgruntled opponents, the service providers, clients and their advocates usually reply simply: "You didn't seek permission to move into this neighborhood, so why should we?" This powerful argument ignores host community attitudes, being concerned mainly to avert opposition behavior by local residents.

To be successful, the autonomous approach has to be backed by good authority (even if this authority is never explicitly invoked). This usually means that the operator is acting with the mandate of governmental and/or legal rules. Two kinds of rules are important: those relating to the civil rights of clients and operators; and those pertaining to local land land-use zoning and licensing regulations. The opportunity for operators to act autonomously largely depends upon the legitimacy granted by these sources. The operator who invokes their authority without first checking on their application is obviously taking a risk.

How does the facility operator begin to decide between a collaborative or an autonomous approach? As before, a little bit of history can help us understand this choice.

In the early days of community-based care, during most of the 1960s,

enthusiastic operators tended not to worry too much about potential opposition. They adopted, usually quite unconsciously, an autonomous approach to facility siting. During the 1970s, as the community care movement took hold, opposition and conflict became more prominent. Sensitive operators engaged in community outreach, or avoided those neighborhoods where intense opposition was anticipated. Whenever opposition arose, operators invoked a wide variety of appeasement strategies. So that by the 1980s, most operators were aware of the negative potential of the NIMBY syndrome, and a rich body of case studies had grown up. Many manuals advising on siting procedures placed establishing good community relations somewhere near the top of their lists of recommendations for service planner. 'Outreach' had become the buzz-word for a successful siting.

At this time, there is a just-perceptible new trend, which we shall characterize as 'aggressive autonomy'. The approach is marked by independent siting actions on the part of operators and advocates who grant special prominence to the civil rights of client groups, and correspondingly diminished importance to community opponents. Such actions are bolstered by recent legislation at the federal level, but also by related state and local initiatives. A major impetus for aggressive autonomy was the passage of the U.S. Fair Housing Amendments Act in 1988, which outlawed discrimination toward the disabled. Further impetus has been provided by the passage of the Americans with Disabilities Act (1990), and by other local legislative initiatives (for example, in the States of Illinois and Massachusetts, and in New York City). Further discussion of the federal legislation will be found below.

On the face of it, the disabled and their advocates have learnt a lesson from previous civil rights struggles. However, history also shows us that mere enactment of a law does not guarantee compliance. Therefore, many advocates are currently promoting the civil rights of the disabled in many areas, in order to ensure the effective application of new legislation. This is primarily why the cutting edge, nation wide, in dealing with community relations is toward aggressive autonomy. But it takes time for new and relatively untested ideas to filter through to localities. For some time to come, most operators will continue to face a general 80s-originated climate of collaboration, even though the legislative authority exists to permit more autonomous action.

The important lesson from this history is that facility operators should determine which strategy is most suited to their local circumstances. We know what the crucial variables are, but there are many other local conditions that affect strategic choice, and we are unable to mention all of them in this survey. They include such issues as whether or not the facility operator is planning further siting efforts in the community (and hence, is likely to be just as concerned with future as well as present community reaction), and the potential for collective support for the local siting effort, especially the availability of technical/legal/advocacy back-up.

Before we go on to consider communication strategies in more detail, one thing

must be emphasized. *There is no way to confidently predict local responses to a siting initiative.* Even if good neighborhood support is guaranteed, something can still go wrong. A well-publicized murder by a 'crazy' person in New York City can the very same day jeopardize siting plans in Chicago and Los Angeles; a decision to close a major metropolitan institution can place new demands on suburban- and rural-based facilities; or prominent supporters can get 'cold feet', causing support to dissolve overnight.

Faced with the option (or need) to interact with the host community, human service operators have at their disposal what appears to be a bewildering array of alternative communications strategies. It may help to understand that these alternatives can be distilled into three basic approaches: community-based, government-based, and court-based strategies (Fig. 14)

The collaborative approach assumes direct outreach to the host community, thereby hoping to encourage positive response. If community relations go sour, then recourse to the courts or to government for action and/or adjudication is possible. In contrast, autonomous siting action relies on the authority of government-promulgated laws and regulations in order to legitimize the service provider's actions. The appeal to government can be explicit, as when the provider seeks appropriate licensing approval, or checks compliance with local zoning statutes. Or it may be implicit, as when operators assume that the authority of a particular statute covers their situation. In both cases, operators may be obliged, when challenged, to refer to the courts to justify their procedures.

Operators may proceed directly to a court-based strategy. For example, they may sue a community opposition group because of its obstruction of their plans

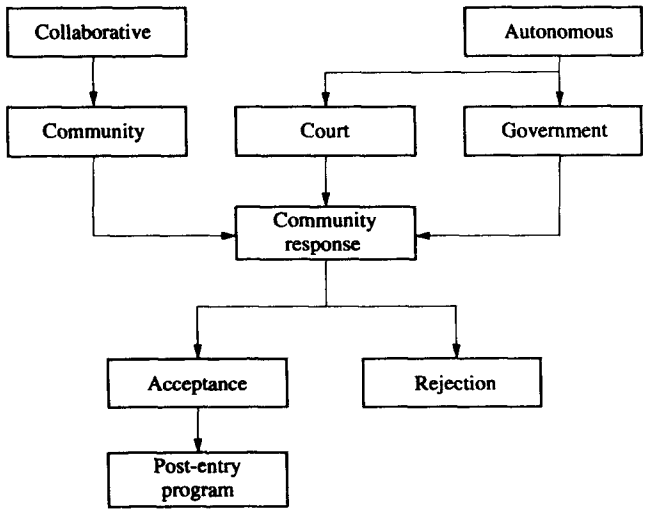

FIG. 14. A guide to communication strategies.

or activities. Operators may also prosecute a government body because of its impedance of an operator's objectives (e.g. the denial of an operating license because of community disapproval).

Once the service is accepted by the host community, the operator is faced with another decision: whether or not to engage in a post-entry program. This generally has two purposes: to ensure continued support; and (where applicable) to promote client integration. If a facility is rejected, operators may choose to abandon a siting effort, or to approach the community with a fresh initiative (presumably different from the strategy that had previously failed).

With this map of communications strategies in mind, we may now examine what exactly each of the community-, government-, and court-based alternatives has to offer.

4.4.1. Community-based strategies

Community education: This is the use of communications media (television, radio) print, general mailings, leafletting usually to increase public awareness and understanding of the client group and its problems. It is important because familiarity and understanding tends to increase tolerance and acceptance, although it is sometimes time-consuming (e.g. in establishing good media relations), and expensive (for mailings, or for resource materials). The strategy may be more effective and efficient when the service operator has links to a broadly-based national or local advocacy group possessing resources, experience and expertise. Community education is an indirect strategy, in the sense that it is general and untargeted (i.e. it is all but impossible to control who watches the TV spot, reads the ad, or opens the mail).

Community outreach: This refers to direct contact with a host community or its representatives, usually in the form of public or private meetings, in order to promote acceptance. Typically, the operator first approaches representatives of the community, hoping they will persuade their neighbors to accept the facility. A follow-up meeting with the community-at-large is also routinely planned, although it may be unnecessary. Outreach can be important at several stages of the siting process, especially in the early stages of planning in order to scope out likely host community responses; and later, as part of a mediation process. However, it can also be time-consuming, and risky because poorly-prepared meetings antagonize residents and may undermine public trust. ("If they can't run a proper meeting, why should we assume they'll operate their service as good neighbors?")

Community advisory boards: Creating an advisory board of prominent local leaders can be an effective way of: (a) legitimizing the activities of the proposed facility; (b) incorporating needed skills (both technical and advocacy); and (c)

defusing opponents (by, for instance, appointing the most vocal to the advisory board). A board should be appointed before opposition surfaces, otherwise certain local personalities (especially politicians) might be unwilling to stick their necks out. This is a low-cost, potentially highly effective strategy, although it depends very much on access to influential local networks.

Concessions and incentives to the community: There seems every reason to accede to host community demands if they do not compromise a facility's purpose, operations and effectiveness and if they lead to the withdrawal of community opposition. A little can go a long way in demonstrating the operator's willingness to listen and desire to be a good neighbor. Typically, operators offer concessions that relate to the design and operating characteristics of their facility. These include landscaping, property rehabilitation, parking arrangements and adjustments to operating procedures (e.g., levels of supervision, opening times, etc.). In addition, whenever possible, providers should identify those areas where the facility benefits the host community beyond direct service provision. These include: employment opportunities (hiring local staff persons); utilizing local contractors (for building renovation, food and linen supplies); the use of the facility for community purposes (e.g., local meetings); or obtaining other funding that will be spent in the host community.

4.4.2. Government-based strategies

Local licensing regulations: At a most elementary level, human service facilities must comply with local licensing codes relating to building, fire regulations, operations, parking, etc. This applies equally to operators anticipating a collaborative approach to the host community, but it acquires extra force for those electing to act autonomously. Any facility without the appropriate licensing authority presents an easy target for opponents, especially since government agencies can hardly be expected to defend a facility operating in breach of its regulations. For our purposes, licensing procedures only become important when they are ignored. Service operators in breach of these regulations must expect to be regarded as illegitimate by the host community.

Zoning: Land-use zoning is one example of the delegation of the state's police powers to local municipalities. It provides localities with authority to zone (i.e., define allowable uses by geographical area), and thereby regulate the use of land. Community-based facilities have consistently run into zoning problems because they are relatively new types of development, and are typically not mentioned in lists of allowable uses. Under such circumstances, a *condit' nal-use permit* or *zoning variance* must be obtained.

Some municipalities, under pressure to locate sites for facilities and seeking

to offset the constant demand for site-specific variances, have adopted *general amendments* to their zoning codes. These designate certain facilities as 'permitted uses' within existing zoning categories. Henceforth, all such facilities may locate as of right (i.e., without use permit or public hearing) within the designated districts.

A similar effect can be achieved through *overlay zoning*. The overlay zone defines alternative development regulations within a given zoning category, allowing certain kinds of development that meet the specified criteria. For instance, shelters for the homeless may be allowed within single-family residential zones so long as they meet certain standards of (say) size, appearance, and operations.

Another way for operators to shake free from local zoning constraints is to appeal to *pre-emptive state codes* (where they are available). A number of states have enacted policies that explicitly or implicitly support the establishment of community-based residences. Courts have upheld arguments that local zoning codes cannot contravene over-riding state policies.

Because some of their land-use control mechanisms are obsolete, some states and municipalities have begun to revise their regulations. In California, for example, state law requires that each city and county compile a *Housing Element* as part of their 'General Plan'. The Housing Element must incorporate an assessment of the community's housing needs, including emergency shelter and transitional housing. Experience has shown that such laws are not self-enforcing; indeed, the State of California currently lacks a mechanism to enforce this policy. Hence, much depends upon the willingness of local advocates to utilize such regulations where they exist.

What all these options boil down to is this: That facility operators must comply with local zoning laws; that when they do, they have the authority to act autonomously; and that many states and localities have made it easier for facilities to comply with zoning ordinances. Hence, whereas in the past facilities would generally qualify as non-conforming uses and operators would require a zoning variance, today's operators can find other ways to establish compliance with zoning ordinances, including general amendments to the zoning code, overlay zoning opportunities, pre-emptive state codes, and revisions to the Housing Element of the General Plan. A facility in compliance with zoning ordinances is much less likely to be challenged. And operators may prefer that the controversy focuses on land-use issues rather than other, more emotional concerns.

Civil rights: Even though they possess appropriate licensing and zoning authority, some operators seek further legitimacy by appeal to the civil rights of the client group. Such appeals can be based in local, informal practices. For instance, the Department of Mental Health in the State of Massachusetts pursued an aggressive, successful, year-long civil rights-based campaign on behalf of group homes in the Commonwealth. The approach had no specific legislative bases, but carried a powerful moral authority associated with historical civil rights

movements, and was backed by a 1989 State law prohibiting many local zoning requirements. The recourse to civil rights arguments is made easier, however, if formal legislation or public policy exists to back up a moral stance. Such legislation may be promulgated at any level of government. Thus, the State of Illinois in 1989 enacted a Community Residence Location Planning Act which requires every home-rule municipality to prepare plans to meet local needs for group homes. And the new Charter of New York City has explicit wording anticipating the 'fair share' of the burden of care for the disabled among its boroughs. An analogous statement, promoting a broad geographical distribution of facilities, has been developed by the Seattle Human Services Strategic Planning Office.

By far and away the greatest long-term potential in this category of rights-based strategies is afforded by three recent pieces of federal legislation on behalf of the disabled. The Americans with Disabilities Act (ADA) was signed into law on July 26, 1990. It extends the protection of the 1964 Civil Rights Act to people with disabilities, prohibiting discrimination in employment, public accommodations, transportation, communications and other services. At the moment, it is not possible to gauge the effect of this far-reaching legislation. Many of its most far-reaching provisions will not come into effect until two years after the bill's passage. In the meantime, regulations pertaining to the Act are being prepared.

The disabled are protected against discrimination in housing by another legislative milestone, the Fair Housing Amendments Act (FHAA). Effective from March 12, 1989, the FHAA extends to the handicapped the protection afforded by Title VIII of the Civil Rights Act of 1968 (popularly called the Fair Housing Act) against discrimination based on race, color, religion, gender and national origin. This has been interpreted to outlaw discrimination against the developmentally and physically disabled, people with mental disabilities, recovering alcoholics, and people suffering from AIDS and other diseases. More specifically, the FHAA makes it illegal to discriminate in housing sale or rental, or "otherwise make unavailable or deny", a dwelling to any renter or buyer because the applicant has a handicap, or is providing housing for people with handicaps. Moreover, the Act prohibits discriminatory *effects*, not simply intentional discrimination. The FHAA is particularly important, since it outlaws many local licensing and zoning requirements.

Several important test cases based on the Act are working their way through the courts, and it is not yet clear how effective the Act will be in facilitating siting. In one of the earliest cases (January, 1990), the City of Chicago Heights, under court direction, approved the construction of a home for retarded people, reversing its previous denial of the permit. The City also agreed to pay $45,000 in damages: $30,000 to the company for construction delays; and $1,000 to each of the fifteen people who will live in the home. The U.S. Department of Housing and Urban Development (HUD) is currently preparing FHAA-based guidelines for making

new multi-family housing available to people with disabilities. It is also worth noting that many State Attorney Generals have incorporated FHAA requirements into State law, thus making it even more effective in assisting facility sitings.

Finally, the 1990 National Affordable Housing Act entails changes in the Section 202 program, which henceforward will have two components: one on behalf of the frail elderly, and a second for people with disabilities. The latter remains a housing-oriented program. The former also offers funds for non-housing services (such as transportation, food, and social activities); these services may also be made available for non-elderly persons in the community.

Mediation: This is a form of assisted negotiation that utilizes a neutral third party to resolve disputes between parties. The non-partisan intermediary may be a public- or private-sector agent, although some public funding is usually necessary to defray the costs of mediation. Mediation is to be preferred over litigation, which tends to be more costly and time-consuming. Mediation is suggested in disputes that have become polarized. The mediator's task is to involve all parties in the dispute in a non-confrontational search for a mutually-agreeable solution. This includes: compiling the facts; maintaining ground rules; clarifying opposing views and areas of overlapping interest; and identifying new options that address the concerns of the conflicting parties.

4.4.3. Court-based strategies

As a general rule, recourse to the courts is to be avoided. Lawsuits can be expensive, time-consuming, and almost always counterproductive to the goal of community integration. They also tend to delay a facility's opening while a case is being considered. Operators utilizing either the collaborative or autonomous approaches can find themselves threatened by, or facing the need to adopt, legal proceedings. Even facility operators who elect a collaborative approach may quickly stir up a vocal opposition; their mediation efforts may fail or be rejected; finally, opponents engage lawyers to block the facility's opening. Independently-minded operators electing to take the autonomous route can also quickly encounter community-instigated legal challenges to the authority behind their siting actions. In these circumstances, the government (on whose legislative/regulatory authority the operator's claims are based) may find itself drawn into the dispute.

The law may be invoked not only in disputes between the service facility and host community, but also in circumstances where human service providers are dissatisfied with government. This is common, for instance, when municipalities are perceived as not responding to local services needs (as in providing shelters for the homeless, or hospices for AIDS sufferers). The courts may provide relief by establishing government's obligation to provide certain levels of service.

Planners and advocates have enjoyed significant success using the judicial process to advance the cause of community-based residences. To overturn local zoning decisions, for example, advocates have relied heavily on two arguments: (a) that community residences (i.e., group homes and the like) function as single housekeeping units, and hence should be regarded as families for zoning purposes; and (b) that restrictive local zoning ordinances may not contravene pre-emptive state legislation that supports community-based residences. Federal lawsuits, advanced by the U.S. Department of Justice in pursuit of the FHAA, have also been significant in adjusting local government decisions and rebuking community opposition. There is little doubt that court decisions on the FHAA, as well as the ADA legislation, will become increasingly prominent over the next decade.

One final point worth remembering is that the threat of legal proceedings can be as effective as pursuing a case right to the bench. It is not always necessary to go to court in order to make effective use of judicial authority and precedent. Sometimes the threat of court proceedings is enough to encourage opponents to seek an out-of-court compromise. However, people who back down from a threat, once their bluff is called, tend to lose credibility as a consequence.

4.4.4. Post-entry communications strategies

Once a service has been established in a neighborhood, operators must decide whether or not to continue communication with the host community. So-called 'post-entry' programs are indicated; (a) when it is necessary to maintain good relations with the local residents (after either a positive or a negative siting experience); and/or (b) when community support is vital to assist the process of client integration and socialization.

Most service providers are likely to favor post-entry community outreach, even those who earlier elected to go the autonomous route in facility siting. Two approaches are common. First, facility residents and clients participate in *community service*, including neighborhood clean-up days or flower planting. Such service is a gesture of goodwill, not an incentive or concession in the sense we explored earlier. Second, there are programs for post-entry *contact* between clients and the host community. These are especially important when client integration is a relevant objective, or when community education (about the client's needs and problems) is necessary. Contact can occur in many formal or informal ways: block parties, open houses, casual labor in the neighborhood, and so on.

In many cases, it will be beneficial to maintain a community advisory board after the facility has opened. Such boards are useful in liaising with the community-at-large, providing opportunities for contact, information sharing, as well as for channeling local grievances.

4.5. A BLUEPRINT FOR COMMUNITY OUTREACH

The recent upswing in the incidence of NIMBY cases reflects a community backlash against the disabled, and is based in 'compassion fatigue' (i.e., frustration at the persistence and volume of apparently intractable problems such as homelessness), plus an increasing suburbanization of facilities and clients into jurisdictions hitherto unaccustomed to their presence (often prompted by new legislation limiting the rights of opposition groups). It may also be related to the loss of community, and to the rise of more aggressively autonomous siting strategies on the part of service providers.

In the previous section, we outlined the structure of choices available to facility operators facing the prospect of dealing with a host community. None of the communications strategies was described in detail; our intention was, instead, to define the realm of the possible. Now we shall examine the *community outreach* option in more detail because (in some form or other) it is likely to be the most common strategy adopted by facility operators and advocates. Since this part of our study is specifically intended to benefit operators and advocates, we shall take the unusual step of addressing them directly in what follows.

We assume that by choice, or through force of circumstance, you are preparing for a dialog with your host community. Obviously, we are unable to present an outreach program for every circumstance. Instead, the outline that follows is intended to alert you to the concerns that should be uppermost in your mind in approaching the community, and to provide a blueprint (or template) by which you can determine the appropriate response. This may also be termed a 'modular' approach in that the pieces (or modules) of the suggested program can be retained, rejected, modified or preserved to suit your specific needs.

The program has three necessary facets: preparation, design for outreach, and implementation.

4.5.1. Preparation

Ensure that potential opponents have little or nothing to object to: You must comply with all local regulations relating to zoning and licensing. The physical appearance of the proposed facility (or that of the examples you invoke) should be exemplary. All manner of facility operations (supervision, emergency arrangements, etc.) must be adequate, appropriate, and fully thought-through. And, whenever possible and necessary, your clients must be prepared for their role in good community relations. If it would help, you may wish to phase the growth in your client population so as to minimize initial adjustments by both client and community.

Prepare access to necessary resources: Your task will be easier if you gain access to human and material resources that could sustain you in any dispute with the community. These include individuals and organizations (local and national) willing to act on your behalf either in an advocacy or an advisory capacity; plus the documentation necessary to counter opposition arguments (e.g., the facts about AIDS transmission, the property value myth, the dangerousness and criminal behavior of people with mental disabilities). Local, regional or national advocacy groups sometimes have on hand stocks of pamphlets and other materials that can be used in a community education campaign.

Know yourself: You must be able to show why your service is needed in the community, and be familiar with every little detail of its operations. If you have a good track record for service delivery, or a reputable sponsor, do not hesitate to let the community know about it. Also, know you clients, their problems and their capacities, plus what you expect your program to do for them. Finally, be prepared to make concessions to the host community without compromising the integrity of your service.

Know your host community: It is important to gain a rapid understanding of your host community. Ask the local librarian or a friendly bureaucrat to guide you to census sources or to other public documents that help you determine the demographic composition of the neighborhood. That way you can get some idea of how close your community matches the accepting/rejecting profiles we developed above. Two other pieces of intelligence are particularly useful: the host neighborhood setting; and the host's previous experiences with human service facilities.

There exists a variety of neighborhood settings (or contexts) into which facilities will need to be integrated. These include: high-density urban (typically inner-city zones with a highly variegated land-use pattern); low-density urban (typically suburban districts, or smaller towns); and rural areas (including small villages and essentially agricultural municipalities). The basis for these distinctions is the impact a facility might be expected to have in each neighborhood setting. In a high-density, mixed land-use urban area, a facility is likely to be lost in all the other activity; in a rural area, however, its presence is more likely to be widely noticed.

Contexts will also differ according to their degree of experience. Again, three basic types may be identified: neighborhoods with no experience of human service facilities; neighborhoods with a positive experience; and neighborhoods with a negative experience. If we combine the land-use and experience dimensions, we obtain a nine-fold (3×3) typology of different neighborhood contexts that we could expect to encounter in the process of facility siting (Table 7).

In most cases, your opposition will also form part of the host neighborhood. Needless to say, it is vitally important that you understand their motivations, objectives, and actions. Talk with neighbors, teachers, and other community

TABLE 7. Taxonomy of neighborhood settings

Experience with facility siting	Land-use setting: High-density urban	Low-density urban	Rural
None	1	2	3
Positive	4	5	6
Negative	7	8	9

leaders. Check past issues of local newspapers to find out the track record (if any) of the opposing group. In short, do all you can to know everything there is to know about the opposition before you try to engage them in dialog.

4.5.2. Design for community outreach

One theme figures prominently in community disputes over facility siting: the need for *communication*. It is almost an axiom of siting conflict that residents complain about the alleged secrecy surrounding the siting process (especially the choice of location). Now, most people like to be kept informed about what is happening in their neighborhood. This understandable curiosity creates serious ethical problems because, in principle, clients have the same rights to privacy and freedoms of association as other individuals. Moreover, an informed community is not necessarily an accepting community. We cannot assume that outreach will meet with a positive neighborhood response.

Under such circumstances, how do we construct a communications strategy to facilitate community acceptance? Many studies have shown that: (1) the general public reveals a high level of tolerance/acceptance of disabled persons; (2) awareness of and familiarity with various disabled groups tends to promote acceptance; (3) very close proximity to disabled groups tends to exaggerate worries; and (4) opposition is generally confined to a small, vocal minority.

Under these circumstances, the communications strategy that suggests itself is one which increases the familiarity and awareness of the few community opponents to such an extent that they become supportive of the facility, or (at minimum) their opposition is silenced. We assume that the ill-informed minority can be transformed into an informed, aware group that will be tolerant/supportive of community-based human service initiatives. At the same time, we shall want to reassure the silent majority that their basic supportive sentiments are well-founded.

Such a communications program could have five elements: target group; purpose; personnel; format; and materials.

Target group: The appropriate target group for our program is the community-at-large. This term refers to members of the host community within approximately 4–6 blocks of a facility (in an urban setting), or within approximately one mile (in a rural setting). Relevant community leaders are included in this designation, as well as any other individuals who express an interest in the service.

Theme and purposes: One general theme of the communications strategy could be A MIRROR ON OUR COMMUNITY. Its intent would be to allow a community to learn about itself from the way it reacts to other communities' experiences with human service facilities. Specific emphases in this strategic theme are: the promotion of community-based facilities as part of the solution, not part of a problem; emphasis on the human dimensions of client needs; and establishing the notion of a 'caring community'. The specific purposes of the communications strategy are: (1) to increase community awareness and understanding; and (2) to move through dialog to acceptance.

Personnel: Experience suggests that the communications program should be presented by a minimum of four personnel: a local chairperson capable of commanding community respect, and able to articulate the needs of facility users; a government representative; a representative of the sponsoring agency (who may also be the facility operator); and a client/consumer (who is preferably from the local area). Where necessary, and where available, two other participants could be added: a human services professional (for instance, according to circumstances, a psychiatrist, social worker, or planner); and a facility neighbor and/or community leader.

It is vital that such personnel work to legitimize the support mode of behavior at the meeting; i.e., advocates must make the silent majority comfortable about voicing their support for the proposed service. However, care should be taken to avoid giving the impression that outsiders are parachuting into a community to tell it how to behave.

Format: The community-based communications program is envisaged as a 2–3 hour evening meeting held in the neighborhood that will host the proposed facility. The meeting would be composed of a series of modular presentations. The selection and order of presentation of the modules will depend upon local need and resources. Four standard modules are likely to form the core of all meetings.

M-1. THE FACTS ABOUT COMMUNITY CARE: The meaning of community-based care, the process of deinstitutionalization, and other relevant concepts and policies (e.g., privatization). A description of need and related services in the region, and in the community.

M-2. COMMUNITY CARE AS SOLUTION: A brief account of how community-based care operates, its philosophy, together with personal stories of the benefits that residents enjoy, revealing positive examples of community acceptance.

M-3. THE MYTHS SURROUNDING COMMUNITY CARE: Demythologizing the practice of community care: the selection of individuals eligible for service; the referral process; supervision; unpredictable and dangerous behavior; the myth of property value decline, etc.

M-4. OUR COMMUNITY: A DIALOG: An open discussion about the community and its needs in light of the experiences reported in modules 1–3. This should lead (ideally) to a positive community response, plus a creative program of follow-up initiatives allowing citizens to participate actively in the facility's establishment and growth.

Other modules could be presented in communities with special needs or problems.

M-5. SATURATION/GHETTOIZATION: The special problems of communities which have a proliferation of human service agencies and service-dependent populations.

M-6. ZONING AND LICENSING PROCEDURES: This is likely to be useful in communities which need reassurance of human service facility compliance with siting and operations procedures.

M-7. FACILITY OPERATION: A detailed treatment of facility operating procedures, including: referral of residents; supervision; disposal of hazardous materials (as in the case of AIDS facilities); and problem residents. This may be especially needed in neighborhoods which are being asked to host residents low on the acceptance hierarchy.

Materials: As much information as possible should be made available to participants in the community dialog. Especially recommended is the use of visual materials that give some idea of what the facility will actually look like in the neighborhood (such as models, plans, and sketch renditions). More extensive summary material should be available on request. As well as creating an atmosphere of openness, this approach also facilitates recall and dissemination, and encourages follow-up and continued participation. All materials presented at the meetings should be of high quality, of the greatest possible accuracy, and should be designed to maximize communication and understanding.

4.5.3. Program implementation

The success of your communications program will depend upon four strategic considerations: government participation and leadership; the use of local

intelligence; flexibility in program design; and program sequencing (i.e., timing).

Government participation: Formal or informal government back-up will help establish the legitimacy of your program. If possible, a designated local government agency should be encouraged to accept a leadership role in a region-wide communications program. This would help because: (a) few individual operators will possess the resources, expertise or experience to mount an adequate program alone; (b) repeated duplication of program design at the local level is inefficient in terms of time, money and resources; and (c) a centralized responsibility is likely to mean that more operators will be encouraged to mount a communications strategy.

Of course, the exercise of responsibility by one level of government does not guarantee cooperation and participation by other levels of government, or other interested parties (such as the voluntary sector). Hence, whenever appropriate, effort has to be made to ensure such wider cooperation and participation.

Local intelligence: The value of local knowledge in the preparation and execution of the communications strategy cannot be overestimated. Such intelligence is necessary in: selecting appropriate participants; the choice of modules to meet local concerns; identifying local constituencies (including the opposition); activating support agents and mechanisms (e.g. service groups, church groups, available premises); and ensuring positive follow-up and outreach action after the program has been presented.

Flexibility in the modular approach: The communications program should be tailored to local circumstances. This need not imply that each individual program will be an eclectic jumble of diverse concerns. We have suggested that four modules are likely to form the core of all meetings:

M-1. Facts about community care.
M-2. Community care as a solution not a problem.
M-3. Myths surrounding community-based care.
M-4. Community dialog.

In addition, at least four program personnel are likely to be consistently utilized:

A. Local chairperson.
B. Government representative.
C. Representative of sponsoring agency.
D. Client/consumer.

Four other program modules and three supplementary program personnel have been identified. The precise manner in which these resources and personnel are combined will depend on local conditions. In some cases, new modules will have to be invented to take account of special local conditions.

The proper sequencing of a communications strategy: Success in community meetings is more likely if the community meeting is executed as part of a sequence

of strategic interventions. This should involve proper preparation for the public meeting, as well as plans for subsequent follow-up.

Following an initiative to open a community facility, the operator or sponsoring agency will typically begin the search for an appropriate location. This search should trigger commencement of the operator's training session. The purpose of this session is to alert facility staff of potential problems in the host community, and of ways to combat any opposition.

Once the staff is sensitized to the potential problem, the first contact with the host community is initiated. This is best achieved through an operator/agency meeting with representative community leaders. The communications program outlined in this section could serve to animate the necessary dialog between operator and community representatives. Such dialog might be used to identify possible sites for the proposed facility.

A meeting with the community-at-large should follow community leaders' acceptance of the proposed site. In the event of a negative community response at the meeting, members of the operator/community-leader coalition could be mobilized to persuade the dissenters to accept the facility. A follow-up community meeting may be required to resolve outstanding issues.

CHAPTER 5

Difference and Social Justice in Human Services Planning

> "Neighborhoods and political leaders are fighting with increased fervor to prevent unpopular projects from being sited in or near their communities. It's always hard to find places for jails, drug treatment centers, boarder babies, halfway houses, highways and sanitation trucks, incinerators and homeless shelters. But the NIMBY (Not in My Back Yard) syndrome now makes it almost impossible to build or locate vital facilities that the city needs to function.
>
> If executive and legislative leaders yield to fear and suspicion, we will regress into a new feudalism. At the very moment when barriers are coming down around the world, we will find ourselves marching backward toward the imaginary safety of feudal fiefdoms defended by NIMBY walls" (Edward R. Koch, Mayor of New York City between 1977 and 1989, on December 26, 1989, five days before he left office).

In this study, we have defined the problematic of human services planning as having four essential components: first, a need to understand and utilize geography in the design of service hubs; second, the importance of an efficient and appropriate assessment and placement of service clients; third, the central role of client and facility networks in effective service delivery; and, fourth, the ability to overcome community-based opposition to the construction of service hubs. The service hub concept, despite its flexibility in both urban and rural settings, is, by necessity, context-specific. As a consequence, many factors could diminish its potential effectiveness. Preparation, particularly a comprehensive knowledge of the locale and its needs, plus a willingness to endure setbacks, represent the best weapons in the arsenal of service providers. The current climate of welfare state restructuring, a growing service-dependent population, economic recession, a lack of affordable accommodation, and continuing adverse public reaction towards the service dependent all ensure that the service-hub goal is not easily achieved. Yet such exigencies also provide an unusual opportunity — to significantly expand the range of community-service options by simply adding-on carefully-selected programs in existing neighborhoods.

In this concluding chapter, we depart from the urgent present realities of providing for the service dependent and explore some visions of the future. First we discuss what has been commonly termed the *'fair-share' approach* to service provision. In essence, this requires that society as a whole take responsibility for the service-dependent population, with each region and each community therein,

called upon to do its part in the provision of adequate facilities and resources for its own population. This approach also implies a significant transformation in the geography of service delivery, since a planning program informed by a notion of socio-spatial justice would dramatically increase the number of locations impacted by the siting of service facilities. No longer would the majority of providers and clients be confined to inner-city zones of dependence. Second, we raise a more fundamental issue concerning the social status of service-dependent populations. Despite good intentions, society in general often perpetuates an image of the service-dependent individual as someone who, as a result of his/her 'problem', is *different* from 'regular' members of society. Such individuals are clearly marked as distinct from the majority of the population and thus endure the stigma of their difference; their service-dependency serves as ample justification for their silence within the social arena. They can be seen as long as they are not heard. Their very visibility serves an important function in society, demarcating the boundary between what is 'normal' and what can be labeled as the 'other' (see Gilman, 1988, especially pp. 12–13).

There is a need to further interrogate currently popular perceptions and representations of service-dependent people, and to re-evaluate them not as some form of inevitable and embarrassing social debris but as valued elements of the social corpus. Each individual deserves the opportunity to participate as fully as possible in social life. People with physical disabilities, the mentally disabled, the homeless, the aged, people with AIDS (PWAs) and many others all possess distinctive characteristics; the challenge is to examine these features in ways that do not automatically ascribe negative value to them. This may be achieved by exposing the unspoken norms that currently dictate social acceptability. Concomitantly, an attempt must be made to alter the norms of society itself, to move away from a primary focus on individual and group well-being and towards a concern with equality for all individuals and, with it, a recasting of the meaning of difference. Significantly, the ideal of community, often presented as the antithesis of competitive individualism, does not offer a suitable alternative. Following Young's (1992) work on the city life and difference, we present an alternative form of social justice.

5.1. A FAIR SHARE FRAMEWORK FOR HUMAN SERVICES PLANNING

The concentration of service facilities and clients in central cities creates several positive effects. including economies of scale in service delivery, and the development of agglomeration economies between different elements of the service system and between clients. However, more often than not, the consequent service facility distribution is deficient when measured against other criteria. Most

importantly, the ghettoization of service facilities and their clients fails to realize the primary objective of community-based service delivery: i.e., the integration of the service-dependent into society at large. In addition, civil liberties are infringed as clients are denied access to housing and facilities in suburban locations. And as a corollary, community-based service is inequitably distributed when suburban localities transfer their obligations to the low-income and politically-impotent neighborhoods in the central city.

We propose that a regional fair-share approach offers an efficient method for remedying these injustices (see Dear and Wolch, 1987, Chapter 9). Such a program would require that facility planning and administration be carried out concurrently at the regional level and at a local community level. The *regional structure*, overseen by local representatives and client advocates, could function independently or be constituted within the existing frameworks for metropolitan governance. In addition to numerous technical and coordinating functions, the core charge of this body would be to develop a fair-share plan for allocating to each local jurisdiction a portion of the region's total burden of support for its service-dependent populations. The regional burden is calculated on the basis of need and from community valuations of the impacts associated with various client/facility types. At the *local level*, community service boards would be created to supply the regional body with information on service-dependent populations, facilities and ancillary urban services; to work with local planning departments, developing appropriate land-use policies for community care installations; and to develop education programs to encourage the formation of positive attitudes towards service-dependent people. Most importantly, the local board would provide a forum for community participation whereby facility impacts may be evaluated and communicated to the regional body.

The precise content of the community-based services allocated to each community (e.g., the specific number and type of clients and facilities to be assigned) would be jointly determined by negotiations between communities and client advocates with the regional body brokering these interests. Such an arena would provide the formal mechanism, now absent, by which the goals of facility/client distribution may be identified and ranked, and mutually acceptable deviations from goals agreed upon. This process of conflict resolution is assisted to the extent that the 'victims' — whether service-dependent clients or the host communities — may be compensated for bearing the costs arising from unavoidable deviations from their own goals. As the following examples illustrate, these compensatory mechanisms can be used as bargaining tools in the negotiation of particular client assignments to specific communities.

- *Facilities packaging* offers the positive incentive of a side-payment in the forms of desirable facilities and/or public policy agreements concerning

program and facility development standards to induce communities to accept undesirable facilities.

- *Client/facility trade-offs* would allow communities to choose between more numerous but low-impact facilities or a smaller number of high-impact installations. Where the spatial dispersion of clients necessary to ensure socially integrative settings reduces access to needed support programs, services may be augmented through greater use of, (1) specialized transportation programs; (2) universal services which provide support to a wide range of client groups; (3) informal networks of community members to assist clients in coping with daily needs; and (4) a selective clustering of clients in regional sub-centers.
- *Transfer of facility rights* could be instituted to ensure that all communities shoulder their fair-share of community care whether a jurisdiction fulfills that obligation by accepting some number of specific client/facility types or by compensating another jurisdiction, either through cash or in-kind payment, for accepting more than its fair-share of installations. As we emphasized for the service hub concept itself, flexibility is often a crucial part of the service planning framework. Here also, the ability to modify a community care obligation provides a useful tool for dealing with instances where a blanket policy would prove inapplicable. However, the ability to convert a facility placement obligation into financial terms should not be equated with the opportunity for more wealthy locales to simply buy their way out of the human service framework. The regional planning body should ensure that the resulting distribution of facilities is one that protects clients rights to an integrative community and does not lead to another round of ghettoization. In instances where suitable sites are unavailable or where the community is far removed from client demand, other forms of contribution to the service system will ensure that the society as a whole remains involved.

These illustrative policies represent a significant departure from current methods for determining the distribution of community-based facilities. Their successful implementation will no doubt require that a number of awkward technical and political hurdles be overcome. Some planners may also object on ethical grounds to the negotiated approach offered here. However, the important point is that these policies prevent communities from escaping their responsibilities, reduce the current disparities that exist between locales, and hence erode the injustices that beset the geographical distribution of human services (cf. Brion, 1988).

5.2. INTERROGATING DIFFERENCE

A fair-share approach to human services planning has the potential to provide

a much greater level of socio-spatial justice to service consumers, giving them an opportunity to participate in the day-to-day life of a broader range of potential host communities. Once facilities are established within neighborhoods, local perceptions of the clients are often significantly improved over a relatively short period of time. This positive correlation between first-hand experience and acceptance of the consumers suggests that a successful regional network of service hubs may incidentally achieve a substantial rise in levels of community tolerance. However, a regional distribution of facilities may not in itself ensure a pervasive and lasting attitudinal change. Continued mass media reporting of adverse incidents involving service-dependent individuals, NIMBY-inspired conflicts where communities reject a facility, and the entrenched nature of stigma surrounding bodily disfigurement, unpredictable behavior, and disease represent ubiquitous and formidable obstacles. A more widespread and enduring change in the way that society perceives the service dependent requires a direct confrontation with *difference*.

Difference is a social construct. As Goffman (1963, p. 138) reminded us: "the normal and the stigmatized are not persons but perspectives . . . generated in social situations". This statement is not intended to deny the reality of an individual's experience of discrimination, but it underscores the distinction between the reality of any given disability and the social significance that is attached to it. Such a dichotomy has been all too evident in the history of the AIDS/HIV epidemic. In 1990, an ACLU study reported that individuals nation wide were suffering discrimination because they were *believed* to have the AIDS virus or were thought to have been in contact with someone who had. In these instances, the force of the fear surrounding AIDS was sufficient to sustain the effect of social stigma without the actual presence of the virus. For many service-dependent people, the existential reality of their diagnosis, disability, or deficit may not be easily alterable; however, the social meaning of their dependency is malleable and it is this interpretation that we seek to address.

Difference is, by necessity, a relative measure. Dominant norms and values are permitted to masquerade as universal standards by which everyone is judged. Since these norms are perceived and/or treated as immutable, the relative differences between them and other standards become visible signs of non-conformity (see Minow, 1990, for a detailed discussion of these implications). Hence, the deviation of (say) a mentally disabled woman from her 'normal' counterpart is of *identical magnitude* to the deviation of the latter from her. But endowing one of these two poles with absolute authority over the other may have a catastrophic effect on the life of the 'abnormal' person. To cite another example, the bodybuilder and the amputee have different capabilities, yet the physical distance separating them cannot be used to imply that one is a more worthwhile member of society. Each possesses different qualities; each has different needs. Bodybuilders expect that construction of a fitness center in their neighborhood

would not ignite community opposition; should amputees' expectations for a day-center be any lower? Yet the value that we attach to the aesthetics of physical appearance — and in particular to disability — dictates that the imperfect person is regarded with distaste. This may, of course, be related to the fact that reminders of our own vulnerability should be kept out of sight (cf. Hahn, 1986).

The fundamental challenge facing us is not to deny the existence of difference, but to ensure that its relative nature is made clear. Any attempt to modify beliefs about difference must necessarily include an imperative that everyone become more aware and tolerant of lifestyles and viewpoints that are not their own. As Minow states:

> *"It may be impossible to take the perspective of another completely, but the effort to do so can help us recognize that our own perspective is partial"* (1990, p. 68; see also Foucault, 1980, on the release of 'subjugated knowledge').

Yet neither liberal individualism nor its arch rival, the ideal of community, seem capable of incorporating such a demand. The former posits people as self-contained and separate, bound up in "the self-interested competitiveness of modern society" (Young, 1990, p. 227). The latter professes harmony and openness, its search for unity accompanied by the denial of ontological difference and the exclusion of those who do not fit (Cohen, 1985). We require an alternative vision, one that values rather than excludes difference. In her work on the politics of difference, Iris Marion Young (1992) suggests that an alternative to both individualism and community may be found in a normative ideal of city life.

5.3. EXTENDING THE PROBLEMATIC: CITY LIFE AND DIFFERENCE

Young (1992) warns that an ideal can only inspire change if it is grounded in the reality of our own experience. Thus, a transition may be accomplished, but not through a Utopian leap of faith, but by a restructuring of urban form (space) and function (institutions). Without these, we may achieve little more than a 'failed transition' (Lefebvre, 1991, p. 55). Young identifies four virtues of city life that may be concealed beneath current social ills: social differentiation without exclusion, variety, eroticism, and publicity.

1. Ideally, *differentiation* between groups in urban settings could occur without the formation of hard and fast boundaries, so that differences overlap and intermingle rather than exist in opposition.
2. *Variety* implies that the multi-use of urban space can function to create places that are both diverse and interesting, and that draw people from self-contained private spaces to an interactive public environment.
3. Drawing on Barthes' (1986) conceptualization of the *erotic*, Young suggests that city life also offers inhabitants difference as an escape from routine. The unfamiliar — the very opposite of the homogenous community — represents

a source of anxiety, but also produces a feeling of pleasure engendered by a questioning of established boundaries and categories.

4. Finally, *publicity* is used to suggest an arena where difference is encountered on a regular basis. As Young (1992, p. 242) states: "The public is heterogenous, plural and playful, a place where people witness and appreciate diverse cultural expressions that they do not share and do not fully understand".

These virtues represent an image of a metropolitan space far more tolerant of difference than that which we commonly experience. Yet, importantly, each quality may be found within an urban setting today, if only on a limited scale. Multi-ethnic neighborhoods, mixed-used zoning areas, eclectic public spaces filled with street vendors and side-walk cafes offer places that can potentially mix black with white, rich with poor, the conventional alongside the bizarre. According to Young, the task is to cultivate these qualities on a citywide basis.

The implementation of Young's ideals will necessitate a fundamental alteration of the structure of political authority. She contends that social justice "involving equality among groups that recognize and affirm one another in their specifity, can best be realized through large regional governments with mechanisms for representing immediate neighborhoods and towns" (Young, 1992, p. 248). Neighborhood assemblies, composed of a variety of local members, would form the base of this authority structure. Their purpose is to voice local priorities and opinions to representatives at the regional assembly who would, in turn, be answerable to their respective constituents. At the regional level, political representation is guaranteed by right, so that all groups are provided with a voice. Regional assemblies are responsible for legislation, taxation and regulation (including regional planning and human service provision). Their role would include the promotion of justice, both in the organization of urban space and the distribution of services. The authority structure of Young's model is informed by a principle that accords to any agent affected by an action the right to participate in the decision-making that regulates that action and its conditions. Such a stipulation does not favor the creation of local autonomies, but instead a form of local empowerment that avoids the feudalism that autonomy promises. Empowerment, guided by the difference principle, requires that individuals are sensitive to others in their actions.

The blurring of perceptual boundaries and the creation of a spatiality that encourages (rather than deters) the overlapping of distinct genders, cultures, classes, races, ages, *and abilities* without hierarchization is not a Utopian fantasy. In practical terms, we can readily draw parallels between Young's prototypical vision and the fair-share planning framework developed in the previous sections. Both schemes rely heavily on the use of a local coordinating body involving residents and other interested parties; both make use of a mediating regional authority to design and implement policy and to ensure that socio-spatial justice

is achieved; and both require sufficient flexibility to ensure that a multiplicity of interests is represented.

Needless to say, the attempt to create a heterogenous urban space involves the manipulation of time and space to combine generic and specialized facilities, and service-dependent and non-dependent people in public places. Our regional fair-share framework postulates that a decentralized geography of facility siting would introduce a greater degree of equality and choice into the lives of the service dependent, encouraging their more effective integration into community life. But the hub approach offers more than delivery of human services to a population in need; it also produces a first-hand knowledge and awareness that would cultivate understanding and tolerance between different populations within the commonwealth.

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