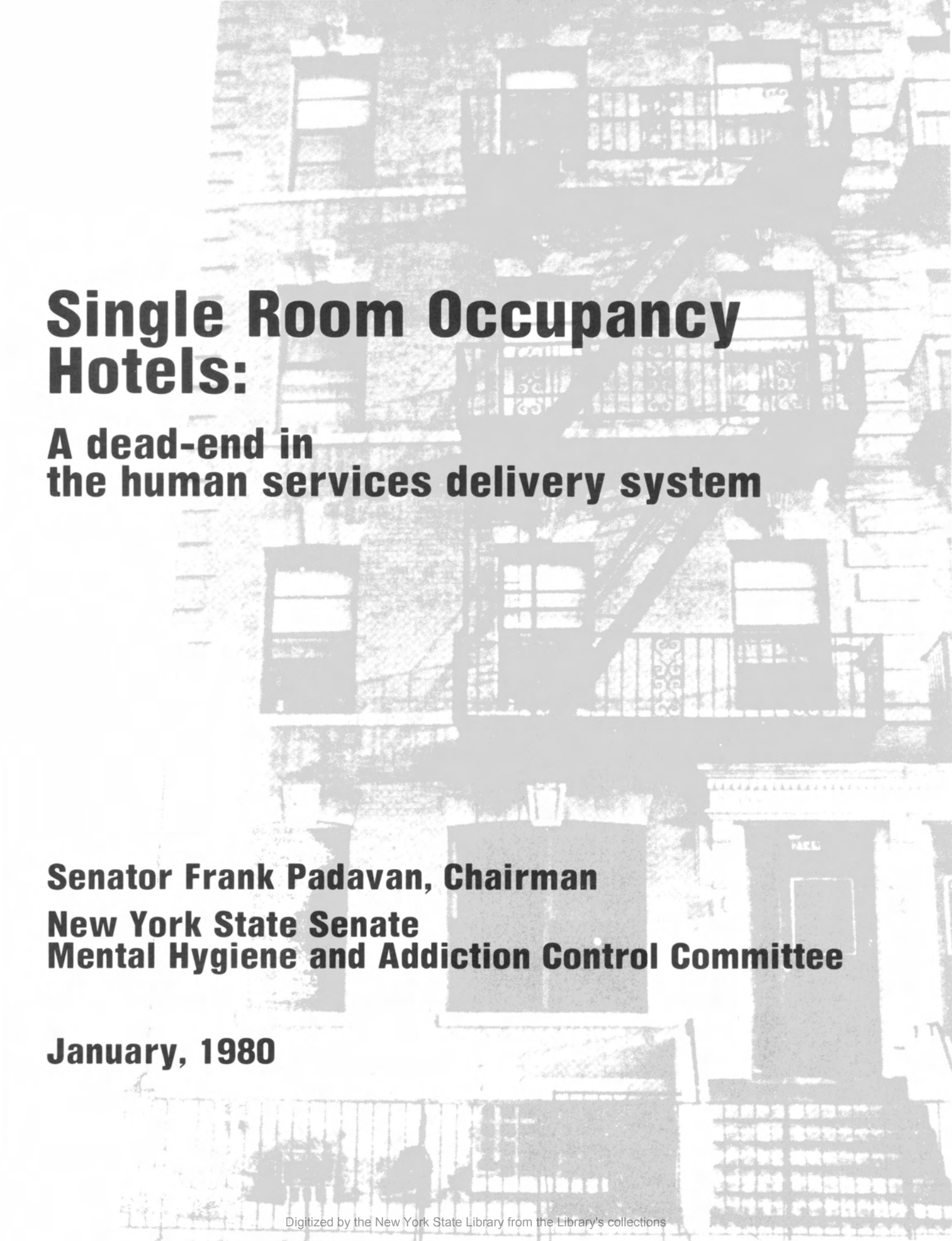

Single Room Occupancy Hotels:

A dead-end in the human services delivery system

Senator Frank Padavan, Chairman

New York State Senate
Mental Hygiene and Addiction Control Committee

January, 1980

News from

The Senate Committee on
Mental Hygiene and Addiction Control

Senator Frank Padavan, Chairman

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SRO's: DEAD END FOR MENTAL PATIENTS

The Senate Committee on Mental Hygiene and Addiction Control, chaired by Senator Frank Padavan (R,C, Queens), has just published a comprehensive report on the impact single room occupancy (SRO) hotels housing discharged mental patients in New York City have on the communities surrounding the hotels and on the patients themselves.

The report is entitled Single Room Occupancy Hotels: A Dead End in the Human Services Delivery System, and details the failure of state and NYC agencies to cope with the flood of mental patients sent to SRO housing under the policy of "deinstitutionalization" developed by mental health officials and supported by court mandates to provide patient treatment "...in the least restrictive environment."

The report is a compilation of testimony offered at public hearings before Padavan's committee by experts in the field of mental health, social services, housing and finance, and information gleaned through confidential interviews with former SRO residents.

Estimating an SRO tenancy in New York City between 30,000 and 70,000, the report cites the variance in accuracy of the population estimate to be the crux of the problem: "...the inability of government agencies to cope with the flood of patients discharged from mental hospitals, and the inefficiency of such agencies to keep track of those they are pledged to help."

According to the report, the SRO tenancy "is a cross section of mental, physical and social pathology" and that three-fourths of the residents suffer from chronic diseases, many are alcoholics and, in some hotels, sixty percent of the tenants have histories of psychiatric problems.

The committee report reveals that mental patients receive little, if any, follow-up psychiatric or medical care while living in SRO housing. "Mental patients wander the streets aimlessly and act-out in bizarre mannerisms, frightening local residents," the report points out.

(more)

The report states that the SRO's have contributed to the deterioration of neighborhoods socially and economically, and that the problem is further compounded by the diminishment of housing stock in the city due to overcrowding and a New York City policy of tax abatement for landlords who convert their SRO hotels to luxury hotels. "The SRO's have become a magnet for drug pushing, prostitution and loan sharking," the report says, "with the mentally ill the prime target of muggers, rapists and armed robbers."

The committee offers thirty five recommendations for initiating solutions to the SRO problems, ranging from streamlining policy, administration and discharge planning, to income support for the discharged mental patient, to more funds for community services, to offering tax breaks to landlords who upgrade their hotels for use by the elderly and the mentally disabled.

Committee chairman Padavan characterizes the problems SRO's present as now being at the crisis level. "The flood of people relegated to the SRO districts, landlords unable to pay fuel bills and abandoning buildings, the city's tax abatement for luxury conversion, the restriction on re-admitting patients to the hospital once they are discharged have all compounded the problems of deinstitutionalization and brought it to the crisis we face today," he said.

According to Senator Padavan, the committee will continue its study of the problem and will hold additional hearings and issue updated reports. Says Padavan, "This Committee has dedicated itself to a continued effort in this problem area. The State is shamefully behind in attending to its responsibility to the mentally disabled and to the public, and I intend to pursue solutions to these problems with all the diligence and with all the resources this committee can muster."

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SINGLE ROOM OCCUPANCY HOTELS:

A dead-end in the human services delivery system

A study of policy and procedures involved in placing and servicing the mentally disabled in SRO Hotels.

A Report by
the Chairman of the New York State Senate
Mental Hygiene and Addiction Control Committee

Senator Frank Padavan, Chairman

January, 1980

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Mental Hygiene and Addiction Control
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C O N T E N T S

APPENDICES

LIST OF WITNESSES
(in alphabetical order)

November 14, 1979 Public Hearing

Senate Mental Hygiene and Addiction Control Committee

Carol Bellamy, President, New York City Council

Barbara Blum, Commissioner, New York State Department of Social Services

Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center.

Kathy Clarkson, The Catholic Worker

Steve Coe, Community Access Program

Carl Cohen, M.D., New York University Medical Center, Office of Urban Health Affairs

Sarah Connell, New York City Regional Director, New York State Office of Mental Health

Deputy Inspector William Conroy, Commanding Officer, 24th Police Precinct

Richard Cromwell, Assistant Director, Crisis Intervention Services, New York City Human Resources Administration

Reverend Robert Davidson, West Park Presbyterian Church, New York City

Barbara Fox, Public Affairs Officer, Post Graduate Center for Mental Health

Michael Friedman, Co-Chairman of the Health Committee for Community Board #7

Charles Fuller, Alcoholism Program Coordinator at Staten Island Hospital

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation and Development

Reverend Ray Hand, E.N.T.E.R. Program

Fred Hartman, Member Board of Visitors, Manhattan Psychiatric Center, Director, Community Access Program

Robert Hayes, Esq., Legal Aid Society

Mary Karry, Community Access Program

Laurence A. Klein, Director, New York City Mayor's Office of Single Room Occupancy Housing

Carroll Kowall, Director, Mayor's Office for the Handicapped

Reverend Edward O'Brien, Director, Holy Name Center for Homeless Men

Christina Paul, Director, Community Support Services for Roosevelt Hospital

James A. Prevost, M.D., Commissioner, New York State Office of Mental Health

Stephen Reibel, M.D.,Director, Ambulatory Mental Health Services, Roosevelt Hospital

James Rice, New York City Department of Mental Health, Mental Retardation and Alcoholism Services

Joan Robbins, Director, Straub Hall

James Schmidt, Associate Director, Fountain House

Ethel Sheffer, SRO Project, Division for Adult Residential Care, New York State Department of Social Services

Elizabeth Strecker Trabony, Executive Director, Project Find-Aid for the Aged, Inc.

Robert Trobe, Associate Commissioner, Office of Family & Adult Services, NYC Human Resources Administration

Charles W. Williams, Psychiatric Social Worker

Steve Wobido, Vice-President, Consortium of SRO Service Providers

...A MESSAGE FROM THE CHAIRMAN

This report concerns the serious problem of the treatment and support of the mentally disabled released to the community from state institutions. Primarily, this report will concern itself with the operation of single room occupancy hotels housing the mentally disabled and how the operation of these hotels has affected the released patients and the communities surrounding the hotels.

The problems these sub-standard hotels present to the patients, and the patients' impact on the communities of the West Side of New York City have already received much public attention. The problems are the result of a state policy to return patients from the confinement of institutions to an unsupported way of life resulting in the proliferation of resident abuse, vice, economic community debilitation and official neglect.

The policy of deinstitutionalization has flooded tens of thousands of the mentally disabled into our midst. It is a policy which shuns the basic concept that while a patient may not need the facilities of a hospital, it does not necessarily indicate the patient is cured or that the patient does not need convalescent care and support.

There has been failure throughout the state system of agencies dealing with the mentally disabled to effectively solve the problems of deinstitutionalization. The complexities of the problem have been compounded by years of neglect, indecision and lack of official follow-through and concern. Whatever noble purpose the concept of deinstitutionalization was founded upon has disintegrated into the ashes of social disgrace.

Although we who concern ourselves today with improving the quality of care for the mentally disabled may have had no part in creating the problems associated with deinstitutionalization, we must necessarily and absolutely accept the responsibility to solve them.

I call upon all who are involved in providing delivery of services to the mentally disabled to help this Committee initiate the beginnings of positive action to erase the blot of inefficiency which has so far characterized the handling of the SRO problem in New York.

This Committee has dedicated itself to a continued effort in this problem area. The State is shamefully behind in attending to its responsibility to the mentally disabled and to the public, and I intend to pursue solutions to these problems with all the diligence and with all the resources this Committee can muster.

FRANK PADAVAN, CHAIRMAN

PART I

INTRODUCTION

It is estimated there are between 30,000 and 70,000 people living in single room occupancy hotels in New York City. The typical SRO hotel is a cross section of mental, physical and social pathology. Studies have indicated that at least three-fourths of the residents suffer from major chronic diseases such as heart disease, tuberculosis, cirrhosis of the liver, diabetes, and blindness. In some SRO hotels, over half the tenants are alcoholics and as many as sixty percent have histories of psychiatric problems.

The variance in the estimated number of SRO residents points graphically to the crux of the problem facing us today. There is inability of government agencies to cope with the flood of patients discharged from mental hospitals, and the inefficiency of such agencies to keep track of those they are pledged to help.

The inability of most discharged mental patients to help themselves in the community points to the other facet of the problem: improper discharge planning by hospital administrators in their haste to comply with the court mandated policy of deinstitutionalization adopted by the Office of Mental Health.

The problem is further compounded by the diminishment of housing stock in the city due to overcrowding and a city policy of tax abatement for landlords who convert their single room occupancy hotels to luxury apartments.

The SRO's have contributed to the deterioration of neighborhoods socially and economically. Mental patients wander the streets aimlessly, act-out in bizarre mannerisms which frighten neighborhood residents are generally shunned by the local population. The SRO's have become a magnet for drug pushing, prostitution and loan-sharking with

the mentally ill the prime target of muggers, rapists and armed robbers.

It is not exaggeration to characterize the problem the SRO's present by saying it has reached the crisis stage. The flood of people relegated to the SRO districts, landlords unable to pay fuel bills and abandoning buildings, the city's tax abatement for luxury apartment conversion, the restriction on readmitting patients to the hospital once they are discharged have all compounded the problems of deinstitutionalization and brought it to the crisis we face today.

This report makes 35 recommendations for solving these problems based upon expert testimony and advice offered this committee. Excerpts of testimony given before the committee as presented in the report represent the considered opinions and suggestions of experts in the field of mental health, social services, housing and finance.

The recommendations offered by this committee will be the subject of several public hearings in the future to implement, where possible, the beginnings of a definite solution to the problems.

PART II

RECOMMENDATIONS

POLICY PLANNING

It is imperative that consistent data be gathered concerning a number of mental health dischargees living in SRO's. Before any meaningful planning can take place, the numbers and level of care needed by individuals discharged from psychiatric facilities will have to be pinpointed. The recent publication of New York City Comptroller Goldin's report clearly indicated to the Committee that the statistics published by the state do not coincide with those gathered by New York City and voluntary providers of mental health services.

Recommendation #1

A comprehensive study is needed to determine the actual number of individuals living in SRO's as well as the number of individuals in need of aftercare services. The State Department of Social Services SRO project is embarking upon a pilot study of SRO hotels on the upper West Side. In addition, the New York State Quality of Care Commission is embarking in a related report on the discharge planning and housing arrangements of discharged Manhattan Psychiatric Center patients. It is imperative that these efforts be coordinated and, wherever possible, that they collect data in a uniform manner that will give policy-makers a firm data base on which to make their decisions.

Recommendation #2

That the State Office of Mental Health, the New York City Department of Mental Health, Mental Retardation and Alcoholism Services in conjunction with the New York City Housing Preservation and Development Department should assemble and disseminate information on housing for the mentally disabled. This information should contain a community roster of available apartments compiled on a monthly basis, requirements of various state and federal housing grants, along with available funding for each should be included.

This would be most helpful in attracting sponsors for alternative housing.

Recommendation #3

In-rem housing in New York City should be utilized. The cooperation of the Department of Real Property, New York City Planning Commission, HRA Special Housing, New York City Department of Mental Health, Mental Retardation and Alcoholism Services should be sought in identifying those buildings that have been classified as In-rem that are suitable for establishing model residences for the mentally disabled. The city could retain title to the property and the Office of Special Housing would provide and coordinate supportive social services. (i.e. Hotel Woodstock, Hotel Henry Hudson)

Recommendation #4

Upon completion of the above mentioned recommendations there should be a development of criteria or at least a workable understanding concerning the determination of an equitable and humane point at which a neighborhood would no longer be considered for referrals from psychiatric facilities.

ADMINISTRATION AND DISCHARGE PLANNING

Effective administration and discharge procedures offer the "first line of defense" in providing relief to the present SRO situation. Individuals presently in state and municipal psychiatric facilities present the opportunity to identify people in need of services and to plan for their return to the community. When an individual is improperly discharged from a psychiatric facility or unduly refused admission the ability to plan for a rational delivery of service is lost. Discharged patients, not going back to their families, cannot get a determination on where they will live until they go to welfare after being discharged from a state psychiatric facility. The state psychiatric facility, therefore, does not have an idea of where the patient will in fact be living. Furthermore, the patient's first out-patient visit after leaving a state psychiatric facility is usually scheduled three or four weeks away and the patient is given a supply of medication to hold him over until that visit occurs.

Recommendation #5

An official state inter-agency task force consisting of the Office of Mental Health, Department of Social Services, the Office of Vocational Rehabilitation, State Division of Housing and Community Renewal and State Health Department must be established to coordinate administrative policy and procedures concerning the delivery of services to the mentally ill.

Recommendation #6

The New York State Office of Mental Health shall develop a formal housing plan which will identify existing housing resources and the housing needs of discharged patients. Such a plan would set forth specific goals and objectives for development of future housing for the mentally ill, complete with a timetable for implementation.

Recommendation #7

A special agreement should be developed and signed by the Commissioner of Mental Health and Social Services on a city and state level. To insure a continuity of services to the discharged patient, this agreement should spell out the responsibilities of each agency with respect to determining where the individual will live and his income supports before the individual is discharged from a state facility.

Recommendation #8

A management information system needs to be established to identify where discharged patients are residing and what community treatment and support they will require. This sharing of information among various providers of services should reduce the cost of treating these individuals by elimination of duplicative paperwork and should provide better and more continuous service to the individual in need.

Recommendation #9

Discharge procedures should identify a domicile before the patient is discharged. A case manager should be available to help the dischargee in the application for welfare, SSI and securing housing. The case manager should insure that proper papers are secured (birth certificate, social security number, etc.) and complete as much paper work as possible before the client is discharged.

Recommendation #10

A dischargee's first visit after leaving a state psychiatric facility should be within the first week of release and medication, when leaving the hospital, should be only a one-week supply. Furthermore, hospitals, clinics and other mental health providers should be notified of patients leaving the facility so that there is a continuity of care.

Recommendation #11

The Office of Mental Health must develop a pre-discharge housing policy. Furthermore, the discharge procedures should include an investigative team that will be able to evaluate various living situations before referrals are made and a 24 hour (seven days a week) "hotline" number for discharged patients' assistance should be established.

Recommendation #12

Chapter 804 of the Laws of 1975 which mandated discharge planning should be amended to spell out in further detail the essential elements of the discharge process. An additional provision of this legislative amendment should require a report to the Legislature concerning the implementation of Chapter 804 and identify the funds, the number of personnel and the training of personnel needed to carry out this legislative mandate. Such a report should be written by the New York State Commission on Quality of Care for the Mentally Disabled and with the participation of other agencies that the Commission deems appropriate.

Recommendation #13

An expansion to Chapter 804 of the Laws of 1975 to require all hospitals, as defined in Article 28 of the Public Health Law which admits a patient for psychiatric treatment complete a discharge plan.

Presently Chapter 804 applies only to State operated psychiatric centers although the majority of psychiatric admissions are received by hospitals outside of the state system.

Recommendation #14

The New York State Office of Mental Health must develop a training manual for employees engaged in discharge planning. There should be a report to the Legislature regarding the implementation of this training and the utilization of Title XX funds and other resources needed to carry out an effective discharge training.

INCOME SUPPORT FOR THE DISCHARGED MENTAL PATIENTS

Individuals discharged from psychiatric facilities face trying if not traumatic moments in adjusting to transition of community living. The crux of many of their problems is financial insecurity as well as the lack of financial management skills to best utilize the meager resources they may possess. The money problems faced by these individuals add to their fears of failure which many times leads to decompensation and a return to an institution. Indeed, there is a clear correlation between hospital admissions and the time period of each month when the last of the entitlement is spent (as noted by Dr. June Christmas and Martin Bergun, Deinstitutionalization and the Community, July 17, 1978).

There are certain measures, listed below, which would greatly assist the discharged patients with their finances and which would substantially reduce the current 60% recividism rate experienced by our state psychiatric centers.

Recommendation #15

A centralized Income Maintenance Center should be established in each borough of New York City to expedite the granting of home relief to state department of mental health dischargees. (HRA should designate such a center). The Office of Mental Health should place a discharge review and placement team in each center to review the adequacy of the discharge plan and link the patient to a service provider.

Recommendation #16

Income maintenance staff should be stationed at all hospitals providing information referral and assistance in applying for entitlements and benefits.

Recommendation #17

Through state and local coordination medicaid cards should be issued at the point of discharge to eliminate confusion, duplication and loss of this benefit to the individual in need.

Recommendation #18

A new category should be authorized through legislation for providing funds needed during the transition to civilian living.

An equitable system should be set up to provide adequate one-time start up grants for rent security and furnishings for former patients. The Department of Social Services Emergency Assistance to Adults regulations provide for meeting some of these needs, but implementation is erratic and unpredictable. Coordination among various human service agencies could meet this need.

Recommendation #19

State Legislative Resolution memoralizing Congress to change the requirement of the Supplemental Security Income Program which reduces the income when an individual pools his or her limited resources with others in a shared apartment.

Recommendation #20

The State Department of Health Handicapped should be revised so that proposed changes do not continue to hamper medicaid reimbursement for "functional maintenance" programs. This currently discontinued coverage should be reinstated in clear unambiguous terms.

Recommendation #21

A handbook of benefits and entitlements should be prepared by the State Department of Social Services. This handbook should be concise and written with the consumer in mind; each grant and increment to which people are either entitled or which they may request, should be appropriately detailed.

Additional information and/or suggestions could be included which will assist the individual making the transition to community life. This handbook should be disseminated at hospitals, clinics, human services centers and made available to hospital discharge staff, consumer advocacy groups, and distributed to all Income Maintenance Centers, Community Boards and district legislative offices.

Recommendation #22

Welfare check disbursement system should be changed to curtail the amount of lost or stolen checks. The Legislature enacted legislation which allowed for the establishment of a demonstration project in one of the five boroughs, where public assistance grants would be forwarded directly to banking institutions, approved by the Commissioner of Social Services, and participating public assistance recipients would have access to their grant without having to pay a service charge to the Banking Institution. The program was to be implemented by the Commissioner of Social Services in conjunction with New York City Human Resources Administrator. (Chapter 759, 1977)

FUNDING OF COMMUNITY SERVICES

The issue of discharged mental patients living in SRO's must be recognized and addressed through a coordinated effort by all the human service agencies at the state and local level. It became clear at Senate Committee hearings that state, local and voluntary providers of human services to the SRO population are in substantial agreement on a number of directions to be taken. However, confusion and gaps in services are caused by the myriad of rules, regulations and directives which eminate from the various agencies concerned with the SRO population. Despite benevolent efforts in this area, there remains a serious lack of coordination and clarity of thought. Therefore, funding priorities must be established, complete with timetables for program implementation, if the state is, in fact, serious about improving the quality of life of the discharged patient living in SRO's.

Recommendation #23

A continuum of aftercare facilities must be established. The New York State Office of Mental Health must follow through on its verbalized housing plan by crystalizing such a policy into a meaningful plan. Specific goals and objectives, with a timetable for implementation must be established. The number and types of facilities to be developed must be indicated in the central plan, in order to establish funding priorities.

Recommendation #24

The Governor's $13 million funding commitment to the Manhattan West Side SRO's be maintained but that the provisions under which this money is to be spent should be rethought in light of the testimony and revelations presented at the November 14th Senate Hearing.

The Governor's budget envisioned using these funds in transferring SRO residents to "enriched housing". The $13 million which would have gone to the increased cost of public assistance for residents so transferred when in fact, not one resident received "enriched housing" and the money lay dormant. Clearly, there is no "enriched housing" available and these needed funds could be better used to develop on-site services to the SRO's and a range of alternative housing.

Recommendation #25

Single room occupancy hotels, which are City Housing Code-complying and meet standards for substantial supplementary on-site services for tenants, should be designated as supportive residences. A higher rate of SSI should be authorized for eligible recipients living in such supportive residences thus enabling (through higher rents) improvements in services and conditions. This would also make it easier for programs to gain access to the SRO's. It would also provide leverage/incentives to upgrade the SRO.

Recommendation #26

Intermediate care facility for the mentally impaired should be established. The intermediate care facility for the mentally impaired would be a facility exclusively for ambulatory mentally impaired over age 65 who are not a danger to themselves or others. Qualified staff would provide the specialized services and sheltered environment needed by these individuals. Services would include those of a psychiatric nurse to monitor and administer the use of drugs.

A number of other states have established this category which would improve services to a segment (over age 65) of the SRO population, plus maximumizing funding through federal participation.

Recommendation #27

The eligibility requirement for 100% state funding for the mentally disabled in the community, under Chapters 620 and 621, should be reduced from five continuous years to two continuous years in a state facility in order to cover a greater number of individuals in need. Such a proposal has passed the New York State Senate in the last two legislative sessions.

Furthermore, N.Y.C. Comptroller Goldin's report, entitled Performance Analysis of Programs of New York State Assistance to New York City Agencies Serving Deinstitutionalized Psychiatric Patients, indicated that Chapter 621 funds reach 87% of those eligible while Chapter 620 funds are utilized by only 18% of those eligible. Through proper administration of Chapter 620, the utilization of these funds should more closely resemble that of 621.

Recommendation #28

C.S.S. Funding should take into consideration the time and staff needed to develop linkages among systems (i.e. mental health, social services, housing, etc.).

Recommendation #29

The Office of Mental Health Case Management Program must be substantially expanded and upgraded in order to insure the discharged patient's successful return to the community.

OWNERSHIP OF SRO'S

The single most controlling factor concerning the viability of an SRO hotel as a living arrangement for the mentally disabled, is the hotel management. While the existence of programs in a hotel may tend to improve management practices, it must be recognized that no on-site services could exist without the cooperation of management and that in general effective, responsible management is usually the key to a well run SRO. A quote from the West Side Community Task Force on single room occupancy housing illustrates this point:

> "The program is utterly dependent upon the good will of the individual building manager. If he declines to permit the social workers to be in the building, there is no program. Finally, it must be noted that where a service program has been withdrawn from a building, the pre-existing apathy and anarchy have reoccurred within a year."

Coupled with the deinstitutionalization policy, there is the fact of an increasingly older deteriorated housing stock, generally unregulated buildings, which are more and more run by irresponsible, sometimes absentee landlords, who are unable to engage in minimum maintenance because of a guaranteed public assistance rent. The lack of sanctions in the housing law leads to a failure to compel managements to upgrade their hotels or to run them properly.

Recommendation #30

There is a need for disclosure of the ownership of these hotels so that on-site services may be brought in and conditions improved. Until the ownership question is unravelled, we can expect conditions to remain virtually unchanged. Taxpayer's dollars are being siphoned off for profits by the landlords while the tenants, many who are fragile, are sentenced to a substandard existence.

Recommendation #31

In addition to more strictly enforcing existing housing codes, the provisions of the State Social Services Law, which allows rent to be placed in escrow until certain maintenance takes place, should also be utilized. An arrangement must be established which will utilize the taxpayer's money going for rent in SRO hotels in order to insure that certain improvements are made to the hotel.

Recommendation #32

Standards should also be codified which would mandate that: rooms must be cleaned weekly and that if towels and linens are provided, they must be changed weekly, extermination services must be provided by the owner once a month and continuously in case of infestation, laundry, clothes drying, cooking and refrigeration equipment must be maintained in a safe and sanitary condition if they are provided. Under rent control and rent stablization laws, the services which are provided to tenants in hotels cannot be withdrawn. If extra SRO services such as laundry and cooking facilities are provided, and can't be removed, they must be decent. These maintenance standards would be under a single section of the City's Administrative Code clearly designated for SRO's.

J-51 TAX ABATEMENT PROGRAMS

The number of SRO housing units has declined. This decline is expected to continue, due to the J-51 Tax Abatement Program. Efforts to improve the environment of SRO's will be meaningless if there will be no SRO's available to upgrade. The decline of SRO

housing units has also reduced the vacancy rate to proportions where present SRO hotels are virtually at full occupancy. This situation further reduces any leverage governmental bodies may have possessed by refusing to refer individuals to certain badly run SRO's, simply because there is no where else to go, due to the housing shortage. Furthermore, the J-51 Tax Abatement Program has no established standard for acceptable relocation of residents nor any effective restraints on landlord tactics.

Recommendation #33

We must offer incentives similar to J-51 for the upgrading of SRO's, possibly reserving a certain percentage of these buildings for use by the elderly and mentally disabled population.

Recommendation #34

Provide tax incentives for those who lease apartments to discharged mentally disabled in order to provide better, more healthy living conditions and to discourage the current concentrations of the deinstitutionalized.

Recommendation #35

Make landlords who have been convicted of unlawful tactics and practices ineligible for J-51 tax benefits.

PART III

EXCERPTS FROM STATEMENTS PRESENTED AT NEW YORK STATE SENATE MENTAL HYGIENE AND ADDICTION CONTROL COMMITTEE'S NOVEMBER 14, 1979 HEARING ON SINGLE ROOM OCCUPANCY

Thirty-four speakers, representing State and New York City human service agencies, consumers advocates, community associations impacted by SRO's, voluntary and public providers of services to the SRO population, medical and social work professionals, presented testimony to the Committee. Excerpts from the hearing follow:

1. DESCRIPTIONS AND CHARACTERISTICS OF SRO'S

A. The SRO Population

Mr. Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center:

Many SRO residents are ex-offenders, past-hospitalized mental health patients, alcoholic and drug abusers. Ex-offenders, the mentally ill and the chronically addicted who reside in SRO's obviously need a wide variety of social and human services, if they are to successfully adjust to community life. Such services have not been made available to them. The result is the perpetuation of the SRO's, with the City paying the rent bills and the residents feeling greater alienation and degradation.

They are fearful and distrustful of institutions; they are jobless with no prospects of employment; they are isolated from family and friends; they are much more victims than victimizers. They are a population which is approximately 75% Black and Hispanic (as opposed to the general Westside population which is 35% minority) and whose median age is between 40 to 50 years.

This overwhelming isolation is the hallmark of the SRO resident. As the numbers of discharged mental patients and released ex-offenders continues to rise, SRO's grow while community attitudes harden. In her study of SRO residents, Shapiro described the vicious cycle of SRO life:

> "Unattached single individuals constitute a group of the poor population characterized by marked social and psychological maladaptation and chronic physical disease; they are

neither sick nor deviant enough to be institutionalized nor well enough to use health, social, and welfare services effectively. Many cluster in urban rooming houses....where untreated illness, hunger, loneliness, and sporadic violence are unrelieved concomitance of existence".

Thus, the typical SRO resident is either too ill physically or emotionally to effectively use whatever services in the community might be available to break the cycle of SRO living. The resulting alienation has been reinforced in many instances by the questionable practice of many SRO landlords. Documented cases have shown that some landlords routinely hold the residents' welfare checks and give them only a portion which they decide upon. Building upkeep is often poor with unsanitary and unliveable conditions commonplace. Building owners have been criticized for allowing prostitutes and gamblers to prey upon residents and for their failure to maintain adequate security arrangements.

The alienation of SRO residents makes the task of helping agencies particularly difficult. The conditioned response of the residents is to trust no one. Thus, typically, Shapiro described an attempt by a social worker to meet with a group of SRO residents to begin to respond to their overwhelming needs:

"The worker met by appointment with a small group of tenants ...The atmosphere was alive with hostile undercurrents, both among those gathered and toward the worker. The tenants present had simultaneously unrealistic expectations of the worker's professional role and passive sullen suspiciousness ...The worker was obviously being challenged and tested... and it was difficult to switch the focus from interrogation of the worker...to the problems of the tenant".

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation & Development:

It is the troubling SRO hotel issue which, I believe, has been one of the focuses of today's hearing. The Human Resources Administration has identified 215 SRO Hotels, whose catering to low income persons house 33,000 residents. SRO hotels, tend to concentrate those tenants with a serious range of social problems. According to a random sample conducted for the Mayor's SRO office, the typical SRO hotel is composed of 32% psychiatric patients, 25% alcoholic, 5% drug abusers, 18% elderly, 9% physically handicapped and 6% ex-offenders (5% others). Undeniably, concentration of this nature lead to problems of fear and crimes by both the SRO tenant and the community at large. Elderly tenants in SRO hotels should not have to become "lock-ins" in their rooms. Neighborhood residents should not have to fear for the security of their children and themselves.

Charles Fuller, Alcoholism Program Coordinator at Staten Island Hospital:

Those people renting rooms in the single occupancy hotels often suffer feelings of hopelessness, unwanted, lost and most important, still sick. They are preyed upon by those who are even sicker.

The impact of the SRO hotel upon a person who had recently been discharged from a structured environment, such as a hospital, is great. No wonder relapses and hospitalization occurs again. Alcohol, and other substances are available for sale in the SRO hotel, seven days a week.

B. SRO ENVIRONMENT

*See appendix #1 - Interviews with SRO residents

Charles Fuller, Alcoholism Program Coordinator at Staten Island Hospital

Most single room occupancy hotels (SRO's) are not viable as community living arrangements. They are usually located in run-down neighborhoods, (waterfront, West Side, East Side, Mid-town). They are inhabited by alcoholics, addicts, the elderly, and last but not least, the mentally disabled. They appear to arrive at these SRO's via agencies and institutions, some of which do not, it seems, investigate where they are referring these people for lodging.

The deplorable living conditions existing in too many SRO's are degrading to the inhabitants, i.e. filthy, depressing, poor heating and lighting, improper cooking and refrigeration facilities (the window sill will do in winter). Rarely are they furnished properly. Clean bedding is another problem. All this, plus a high weekly rent, for a run-down rattrap.

In SRO's one can expect to be robbed after cashing one's check on check day (a big day in SRO's). Rooms are broken into and pitiful possessons stolen, not to mention the beatings a drunken guest in SRO's takes, fighting to hold onto his money or other valuables. (Women didn't stand a chance). If you are alcoholic or mentally disabled, no one believes that these events took place, nor does anyone care. You must pay the rent no matter, or try to leave the SRO hotel on check day, by asking for your check. It's two weeks rent up front, before you leave (whether you stay or not). It's hard to walk away.

Barbara Fox, Post Graduate Center for Mental Health:

SRO hotels constitute the only housing for many of our patients. The problem of housing is a constant crisis intervention issue. The SRO creates problems for these patients who often find themselves victimized, exploited and intimidated by other residents and the management and staff. The sicker patients are often unable to negotiate for themselves, and live under constant threat of being thrown out if they stand up to their tormentors.

Despite the horrible conditions, the SRO's are frequently the only places to house the mentally ill. When no SRO space can be found, patients have no other choice but the men's shelter or a room somewhere which may be worse than an SRO hotel. The short supply of only 28,000 units allows the SRO hotel owners to pick and choose their residents, and the mental patient is often excluded from the better facilities. Those in which they are accepted are also frequently the places which house hardened criminals, drug addicts, and alcoholics.

Aside from the problems of disrepair and filth, the SRO's are not conducive to practicing skills associated with independent living. There are seldom cooking facilities, and few provide meals to residents. Mental patients can ill afford to eat in restaurants on the meal allowance which they receive.

C. Community Acceptance/Response

Richard Cromwell, Assistant Director, Crisis Intervention Services, New York City Human Resources Administration:

Our experiences with communities in which there are SRO's has varied. It ranges from absolute community concern over the well being of those living there along with an inspired desire to help them, to a total rejection. Most often it falls some place in between. Where the SRO or hotel is the only one in a community area and the number of more obviously dysfunctional people seen on the streets are limited, communities generally tend to be more sensitive and accepting. By contrast, where many SRO's are in an area and the number of people with problems are perceived as threatening, outright rejection and negative attitudes surface in parts of the general community. Communities are not ready to accept the alcoholic, mentally disabled, or addicted persons in their midst. For the most part, the community shuns them. It appears to me that educating the communities should be a priority for facilities referring persons to the communities. Most people leaving a facility are not aware of the community resources and services. Community involvement and cooperation are essential in my opinion.

Reverend Edward O'Brien, Director, Holy Name Center for Homeless Men:

We continue to be dismayed by the large numbers of mentally ill people in our communities who are not in qualified adult homes or family care homes. The lack of proper support services coupled with denial of medical attention has caused these patients to slip and slide, totally lost to the department, and, in many cases, living on the streets in our cities.

Reverend Robert Davidson, West Park Presbyterian Church:

Clergy, merchants, building superintendents are ministering to the needs of mentally disabled persons without compensation, without training and with inadequate knowledge of where to refer. Community mental health treatment needs community participation in strategy, program design and in partnership with professionals. Continued

ignoring of the community will intensify legitimate rage and increase alienation from professionals.

2. SERVICE NEEDS AND UTILIZATION

A. Linking Up with Essential Services

Mr. Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center:

Perhaps the most important element in the life of an SRO resident that we see at Ryan Health Center is their isolation. This isolation is compounded by a variety of factors: marked social and psychological maladaption, chronic physical disease, victimization by SRO landlords, hardening negative community attitudes and distrust of institutions.

The SRO Team working out of the Ryan Health Center has focused on the health/mental health needs of the SRO resident and in that context the catalog of chronic illnesses is overwhelming. The major medical problems we have encountered are active tuberculosis (in increasing numbers), hypertension, diabetes, malnutrition, dehydration, various respiratory infections most particularly pneumonia, arteriosclerostic heart disease, chronic leg ulcers, lice and maggot infestation and chronic skin infections due to poor hygiene. In addition to this litany of medical problems the Team is also seeing patients from the SRO's suffering from residual schizophrenia, retardation and organic brain syndrome associated with aging and/or substance abuse.

Our efforts to deal with these medical/mental health problems are complicated by the isolation, frustration and distrust typical of the SRO resident. One of the first problems a member of the SRO Team from Ryan encounters is helping the SRO resident/patient realize and articulate that they are ill. Many times the Team sees patients who simply cannot identify the source of their problem and the worker with great patience must be able to help the patient isolate the source of their concern and identify the nature of their complaint. Many times this process uncovers that the patient does not have a physical complaint but one associated with their living conditions, or the delay of a welfare check, etc. In any case the worker must be able to deal with any and all problems the patient presents and assist the patient in finding a satisfactory solution. Second, the patient must know where they can go to seek help for their particular complaint and must also be able to deal with the ancillary problems connected with that issue, i.e., how are they going to pay for the service they need, do they have a valid medicaid card, do they have carfare, etc. For many SRO residents these are insurmountable problems and whatever ailment the individual has goes untreated and may develop into a much more serious problem.

In the instances the SRO resident does manage to get to a health care facility, she/he must (because of the bureaucratic nature of

these facilities) be prepared to articulte clearly and concisely the nature of their problem and in turn the facility must be willing to provide the care as the patient presents him/herself-dirty, smelly, with lice, drinking and psychotic. In both instances a vast number of SRO residents find that they are unable to get the care they need or are treated in such a manner that they probably will never return to that or any other health care facility.

In those miraculous instances when the SRO resident is able to overcome all these obstacles, there remains what proves to be the most difficult problem - understanding what the medical practitioner is telling him/her, getting the medication prescribed and following either a medication program or other treatment modality prescribed.

Clearly, SRO residents require a coordinated network of services from a wide variety of agencies to begin to break the cycle of alienation and frustration. Basic medical and psychiatric services are the first priority. Achieving physical and emotional well-being is a necessary pre-requisite to improving the quality of life. Advocacy with the City Social Services Department (given the large number of residents on welfare) and a host of other agencies from employment to the Board of Education is also required. An improvement in physical living conditions must also be achieved by working closely with landlords and building managers.

Of course, the most important goal must initially be to gain the trust of residents by setting realistic goals and achieving them. Once this trust is established, residents will become accessible attitudinally to accept the servces provided by the SRO Service Team.

B. Admissions & Discharge Planning

The Committee heard from various speakers concerning the inadequacies of admission and discharge procedures as practiced by the state psychiatric centers. The testimony clearly indicated that it is becoming increasingly difficult to gain admittance to a state psychiatric center. Even when a bonafide case for inpatient treatment is present, the state facility appears to be reluctant to treat the individual and a referral to a municipal hospital takes place. This practice of "shuffling" the individual between the state and city mental health systems occurs even if the individual had previously been an inpatient in the state psychiatric facility. This practice causes an overloading of the municipal hospitals psychiatric wards.

For those individuals in a state psychiatric center, the lack of proper discharge planning prior to their return to the community in-

creases their likelihood of needing inpatient treatment in the future. The viciousness of the cycle becomes readily apparent.

The major deficiencies described in discharge planning were:

- Some patients were discharged without a plan. This is particularly true of individuals who leave the psychiatric center without consent who are declared "officially" discharged if they do not return within 72 hours.

- Lack of contact or input from New York City Social Services, New York City Mental Health, and other potential providers of service, in drafting the plan. In essence, making the plan and its process pro-forma and of little meaning.

- Patients are discharged undomiciled. Discharged patients, not going back to their families, often cannot get a determination on where they will live until they go to welfare after being discharged from a state facility. The state facility therefore, has no idea where the patient will be living.

- Lack of continuity of care assurances and case management services. There is no one assigned to assist with housing needs, income support, clothing, food and the bureaucratic maze of agencies facing the discharged client. Even if an excellent discharge plan has been put on paper there are no assurances that it will be followed once the client is discharged from the psychiatric center.

- The first outpatient visit is often times not scheduled until the third or fourth week after discharge. This occurs even though the time immediately following discharge is recognized as most crucial in determining the patients successful transition to community life.

° Medication in sufficient supply to last until the first outpatient visit is dispensed (3 - 4 weeks) thus leading to abuses and overmedication.

° There is a significant time lapse between the time the first outpatient visit is missed and attempts, if any, are initiated to locate the individul. Considering the first outpatient visit is not scheduled until the third or fourth week after discharge, six weeks or longer may ensue before the state facility notifies a local provider or services regarding the missing client.

These deficiencies in discharge planning exist even though specific communication with local agencies, appropriate housing and on going monitoring are mandated by §29.15 of the New York State Mental Hygiene Law and §36.4 of the New York State Codes, Rules and Regulations.

MHL §29.15 (f) (g) (h)

(f) The discharge or conditional release of all patients shall be in accordance with a written service plan prepared by staff familiar with the case history of the patient to be discharged or conditionally released and in cooperation with appropriate social services officials and directors of local governmental units. In causing such plan to be prepared, the director shall take steps to assure that the patient to be discharged or conditionally released is interviewed, provided an opportunity to actively participate in the development of such plan and advised of whatever services might be available to him through the mental health information service.

(g) A written service plan prepared pursuant to this section shall include, but shall not be limited to the following:

1. a statement of the patient's need, if any, for supervision, medication, aftercare services, and assistance in finding employment following discharge or conditional release, and

2. a specific recommendation of the type of residence in which the patient is to live and a listing of the services available to the patient in such residence.

(h) It shall also be the responsibility of the director of any department facility from which a patient has been discharged or conditionally released, in collaboration with appropriate social services officials and directors of local governmental units, to prepare, to cause to be implemented, and to monitor a comprehensive program designed:

1. to determine whether the residence in which such patient is living is adequate and appropriate for the needs of such patient;

2. to verify that such patient is receiving the services specified in such patients written service plan; and

3. to recommend, and to take steps to assure the provision of any additional services.

14 NYCRR §36.4

(a) The goal of community placement shall be to provide the most independent residential accommodation which is also physically safe and convenient and appropriate to the needs of the patient.

(1) The facility, in cooperation with county departments of social services and community mental hygiene services and other public and private community agencies or individuals shall take all necessary steps to obtain an adequate supply of safe, convenient and appropriate housing for patients to be discharged or conditionally released.

(2) In some cases, this goal can be met by organization and arrangement of physical facilities and property of the facility when appropriate placement resources in the community are inadquate.

(b) The placement of choice for many patients is in the home with family which preceded inpatient service. It is recognized that for some patients such a situation never existed, for others no longer exists, and for still others would not be appropriate to the needs of the patient. In these instances, other placement may be appropriate under the following conditions:

(1) If the place of residence is subject to licensure, certification or approval by the Department of Mental Hygiene or other State agency such place of residence shall be currently and validly licensed, certified or approved.

(2) If groups of patients are placed in homes or apartments with no full-time on-site supervision by staff of a provider of services, the placing facility shall consult appropriate local agencies to determine that the building complies with local zoning, building, fire and safety codes, ordinances and regulations.

(3) If a patient is placed alone in a home, apartment, or room the placing facility shall take care that he is capable of daily living without assistance. This care shall include but not be limited to regular and frequent visits to the patient by facility staff or staff of cooperating agencies to review adjustment during the initial period of community placement.

(c) The individual service plan of each patient to be placed in the community shall include plans for placement and placement shall be made in accordance with such plans. Such planning shall include, but not be limited to:

(1) review of the patient's physical, psychiatric, social and vocational conditions, disabilities and strengths, with particular attention to those related to his or her placement potential;

(2) services to overcome disabilities and capitalize on strengths to enable the least restrictive community placement possible;

(3) consideration of post-release supervision of the patient in the placement residence in addition to the plan for outpatient services to overcome mental disability;

(4) evidence of the patient's participation and that of the patient's family and friends, when appropriate, in the establishment of the placement plan and selection of the placement residence and

(5) evidence of participation by staff of other agencies in the establishment of the placement plan, the plan for outpatient services and the means of assuring continuity of care, if services and supervision are to be provided by another agency in whole or in part.

Two illustrative examples of the inadequacies of discharge planning were related to the Committee by

Kathy Clarkson of the Catholic Worker:

A women I know tells me she is living on a fire escape in the West Village. She wandered away from Manhattan State last June, and ended up at the Women's Shelter where she hit the Shelter's nurse who was attempting to examine her. She was barefoot by the time she found our house. Her only request was to come indoors and rest for awhile, because, she told me, she was tired from being raped so many times. After numerous calls to the state hospital, I was informed that she could not return there. Manhattan State had discharged her even though the hospital staff had not seen her since the day she left the

hospital grounds without consent. I met with officials at the state hospital and I was told that anywhere from 50 to 100 patients wander away from the hospital each month. No one, it seems, checks the passes of patients, boarding buses to all parts of the City. I was told it was OMH policy to discharge voluntary patients within 48-72 hours after they are noted missing. It did not seem to trouble the hospital authorities that these often severely mentally ill people have no place to live, no income, no medication.

Another practice of Manhattan State recently came to light in conversation with officials at Bellevue Psychiatric. According to Dr. Steven Katz, 40% of the patients Bellevue sends to Manhattan State for continued care are refused at the door. Some are returned to Bellevue, but others are released on the spot. On January 24 of this year, for example, Manhattan State refused to accept a man sent there for care by two Bellevue psychiatrists. Admission's staff accepted his statement, which had no basis in fact, that he had a place to live. That man returned to the streets. This is not to excuse Bellevue's responsibility for the chronic mentally ill. It is also difficult to get seriously disturbed people admitted and treated at Bellevue.

I would like to read to you from a report from a social worker on one of the psychiatric wards at Bellevue about what happened with one woman: "The state hospital often refused to admit patients whom we have transferred as dangerous in the community. We have one woman now who has had about five or six admissions in six months and has not been out of the hospital for longer than nine days at one time. Yet she has misused her SSI check every month. On 12/20/78 the court agreed to her state hospital commitment over her objections because of the evidence of repeated destructive and dangerous behavior immediately following every hospital discharge - on probation for having thrown lye in the face of one woman, she was arrested for grabbing away the purse of another after breaking the interior of a neighborhood candy store and having to be removed by police, she threw an apartment door out of a sixth floor window. She broke all the lights in the building hallways, disturbed the residents throughout the night with noise and ethnic insults, and terrorized patients in a neighborhood clinic as she broke windows with a stick. The state hospital released her on 1/8/79. Later that same week she set a fire in the same neighborhood clinic and threatened the life of one of the workers who has tried consistently to help her. Finally she came to Bellevue and caused sufficient breakage and disturbance in public areas that one security guard brought her to the admitting office on 1/17/79. This concluded her nine days out of the hospital. The state hospital had kept her for 18 days and had released her with a totally inadequate discharge plan. She had been given no help in using her January SSI to pay rent on her apartment or have the lights and gas turned back on. She used the check to gamble in the neighborhood chug-a-lug game."

Carol Bellamy, President of the New York City Council:

On February 23, 1979, George Freeman was discharged from Manhattan State Hospital and transported to the Times Plaza Hotel in Brooklyn. Unlike most local residential facilities housing ex-mental patients, the Times Plaza has both State and City social workers stationed on-site to assist hotel residents. Moreover, at the time of Mr. Freeman's placement at the hotel, the State and City had a written agreement with the hotel management to screen all referrals from State hospitals to guarantee appropriate placements of ex-mental patients at the hotel.

Tragically, Mr. Freeman's referral to and placement at the Times Plaza was made by a Manhattan State social worker on Friday evening, thereby circumventing the screening procedure. In fact, if the on-site social service staff has been given a chance to screen Mr. Freeman, he would have been rejected, because he had no legs, and was confined to a wheelchair. The doorways at the hotel are too narrow to accommodate a wheelchair.

Mr. Freeman was brought over to the hotel by a state worker, taken up to his room and left there sometime Friday evening. No one bothered to check whether the chair would fit through the door. Early Monday morning, a resident of the hotel saw Mr. Freeman trying to crawl down the hall to the bathroom. An hour later, at 8:30 a.m., he threw himself out his six-story window to his death.

I have found that state hospitals in New York City are able to circumvent the Mental Hygiene Law in four ways;

First, because of poor security, 50 to 100 patients are allowed to wander away from Manhattan State every month, and this is the case at other state hospitals in the city. Two to three days after a patient is discovered missing, he or she is officially discharged. As a result, approximately 600 ex-patients return every year from Manhattan State to the community, many with no place to live and no public assistance benefits.

Second, even when a Manhattan State social worker has prepared a discharge plan, a patient can still end up at the Men's Shelter or on the street. It happens this way: Prior to discharge, the social worker fills out a welfare and SSI application. On the day of the discharge, the patient is given bus fare and sent from Manhattan State to the East Harlem Welfare Center. If everything goes well, that patient will get his or her first check that day. But if no housing is available, the patient will not get his check. Instead he is given a subway token to get to the Men's or Women's Shelter. The patient is not permitted to return to the hospital. If the dischargee returns to the welfare center the next day, a room may be available and the welfare check will be turned over. But many of these ex-patients never make their way back uptown and simply join the ranks of the homeless.

Third, patients who are lucky enough to find a room at an SRO hotel sometimes do not last in the residence for very long. With no support or aftercare services from the state hospital of discharge, ex-patients may lose their rooms and/or their public benefits, and are often incapable of finding another place to live. They, too, drift onto the streets.

Finally, state hospitals, particularly in New York City, can avoid the obligation of finding appropriate community placement for mentally disabled people by simply refusing to admit them in the first place. A recent study completed at Bellevue shows that 36% of all patients referred to Manhattan State from municipal, voluntary, and proprietary hospitals are refused admission. Elderly people, in particular, who pose a greater risk of becoming long-stay patients, are virtually barred admission to state hospitals in New York City. As a result, acute care hospitals, particularly over-crowded municipal hospitals, are forced to release patients who still need inpatient treatment. Or they must keep elderly patients on their wards for up to a year waiting a nursing home placement, thereby limiting their ability to treat short-stay, acutely ill individuals.

The Committee heard further from Sarah Connell, Regional Director, New York State Office of Mental Health regarding her Department's efforts with respect to discharge planning and the problems they have encountered.

Sarah Connell, N.Y.C. Regional Director, N.Y.S. Office of Mental Health:

Manhattan Psychiatric Center probably has the greatest percentage of discharges to SRO placement of all our facilities. Manhattan Psychiatric Center admits 450 undomiciled persons annually. A random sample of discharges from Manhattan, as part of Dr. Schwartz's study of deinstitutionalization showed that approximately 20% went to SRO's, 45% went back to families and 35% chose to return to their own apartments or to live with friends. Thus, the number of patients placed in SRO's citywide in a year is probably near or less than 10%.

As you may know, a discharge plan (filled out on a standardized OMH form the DMH-6) is required by law for all patients prior to discharge. Compliance with this requirement, however, does not insure that the necessary connections with these people will be maintained once they leave. I will return to this point later.

Steps are taken in each of our facilities to connect the discharged patient with the appropriate Outpatient Department (OPD). Practices vary from facility to facility: At Facility A, when the OPD and the inpatient unit are in the same catchment area, the patient is taken to the clinic for a visit prior to discharge; at Facility B, the patient is given a clinic appointment upon discharge and the clinic is

made aware of this appointment. In most cases, if the patient does not show up for his clinic appointment, telephone contact and/or home visits are made.

Every attempt is made to return the patient to the family whenever possible. Often this is not possible because the patient either has no family or the family does not wish to have the patient in their care. An alternative, such as an SRO, adult home, community residence, etc., must then be found. And here is where the problem begins.

As I mentioned earlier, discharge planning not withstanding patients can and do leave hospitals without consent. A second group of patients, much smaller in number, refuse further treatment. These two groups together comprise roughly 10% to 20% of the discharges per year. Exactly what percentage of these wind up in SRO's is unknown to us. Thirdly, undomiciled patients for whom we must seek DSS assistance in placement, can at times be particularly difficult to follow.

Let me give you two examples of the kinds of problems we encounter. When New York City DSS places an undomiciled patient in an SRO hotel, they are limited by what is available. The patient may wish to be placed in one location, but because of availability of a room, the patient must be placed elsewhere. This secondary placement may be inconvenient to the outpatient supports we had envisioned and it thus becomes difficult to keep the patient in our sphere of influence. Another consequence of these secondary placements is that the patient will accept the arrangement and then quickly move to another location. Again, he is likely to get lost to us.

A second problem we encounter is that some DSS centers require that the patient be formally discharged before they will process the necessary eligibility papers for the patient. As a consequence, we sometimes need to discharge the patient before they can go to DSS for placement. If the process were streamlined, we could send a staff person with the discharged patient to see him through the eligibility and placement process and arrange for appropriate aftercare. This is not often possible, and again some patients may be lost to us.

Recommendations

The Committee received recommendations to improve discharge procedures, covering the areas of inter-agency coordination, case management services, housing needs and the concentration of dischargees in one community:

Inter-Agency Coordination

James A. Prevost, M.D., Commissioner, New York State Office of Mental Health:

We have set for ourselves a number of objectives. We must assure the effective implementation of comprehensive discharge plans now required of state centers and extend that requirement to the psychiatric units of municipal and voluntary hospitals.

Crisis intervention services must be more available to this high risk population.

Sheltered work programs providing vocational training and meaningful employment must be developed.

Adequate nutrition and general health measures must be enhanced.

Better housing of all types linked to psycosocial supports must be sought.

Conversion of excess state hospital space to supportive living arrangements for those who will accept these placements must proceed in order to augment the meager city housing stock.

Resources must be realigned to these high priority tasks from all levels of government and the voluntary sector, including physical plants. It is imperative that human service agencies, whether health, social, or housing, whether sponsored by voluntary, city, state or federal auspice, work cooperatively and coordinate their efforts if we are to succeed.

Barbara Blum, Commissioner New York State Department of Social Services:

While there may be some shortcomings in our statutory authority to act in particular circumstances, the most obvious shortcomings are in available resources and in cooperative efforts to fully utilize those resources. What I would hope is that we could direct our energies to finding more efficient ways to provide the necessary care and services, and that all suggestions will be evaluated with close attention to the cost and administrative feasibility of implementation.

It is hoped that the suggestions we might elicit in this forum will not be directed exclusively at possible statutory amendments, but will also attempt to address specific administrative changes under current statutes that the State Department of Social Services, or the Office of Mental Health, or other state or local agencies might adopt to expand our ability to meet the needs of this group.

Joan Robbins, Director, Straub Hall:

The state should look into the possibility of adapting the federal model of having disability and/or retirement checks mailed directly to a bank. At the present time welfare checks are mailed to

individual's homes, and sometimes result in life-threatening situations for the recipients, as well as presenting logistic problems in cashing the checks. Part of the client's discharge planning and pre-discharge training should include procedures for community banking. Client's on welfare will then be able to bank and receive food stamps at one central location. This training in banking and money management would also help develop realistic spending plans each month, instead of spending at the beginning of the month, and then running out of money before the end of the month.

Mr. Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center:

The entire question of coordination and comprehensive advance discharge planning is in many ways at the crux of many of the problems faced by deinstitutionalized persons living in the SRO's. We, at Ryan, are particularly concerned that this discharge planning covers in addition to escort services areas such as identified housing, public assistance services with the appropriate documentation available upon discharge, availability of programs that can provide training in activities of daily living, health care services and other services needed by the individual patient.

We would strongly recommend that an integrated medical/mental health service most particularly for those discharged chronic psychotic patients (i.e. patients who have spent 10 to 40 years of their lives in state hospitals) be a cornerstone of any complex of services for SRO's. Our experience in the SRO Outreach Team has led us to believe this approach in conjunction with social and housing services, ADL services (activities of daily living) and realistic and appropriate employment training offer the greatest and most consistent hope for deinstitutionalized persons living in SRO's to maintain themselves in the community.

Christina Paul, Director of Community Support Service for Roosevelt Hospital:

In the New York City area there are numerous voluntary provider agencies in addition to the state and city run facilities. Patients often utilize all three systems. Each system has features which are unique and under proper circumstances can offer the patient the comprehensive care he needs. What is missing is the overall coordination by the agencies themselves. To attempt to place the blame for this situation in any one area would be unfair and unrealistic. Often the demands of daily work loads make it impossible to engage in the kind of long term planning and exploration of resources necessary to overcome this problem. In addition, funding is based on direct service provision and time spent in developing linkages among systems is, in essence, not funded. As part of the Community Support System program, emphasis is placed on the development of such linkages but this must be extended beyond Community Support Systems programs in order to be effective.

Michael Friedman, Co-Chairman of the Health Committee for Community Board #7:

We continue to believe that an Interagency Coordinating Council can be an effective mechanism for coordinated planning and service, but it now seems clear that its effectiveness will depend upon the City Department of Mental Health assuming the leadership role. There must be a full-time coordinator whose role extends beyond contract management and monitoring. This coordinator must play a dominant role in program planning and development.

Sarah Connell, Regional Director, New York State Office of Mental Health:

We recommend that the New York City Department of Social Services and OHM more actively coordinate their efforts for patients who are undomiciled. We are suggesting that the Human Resources Administration (HRA) develop single points of entry to the social services system in each borough. We are requesting that HRA designate a single income maintenance center for each borough to which all mentally disabled persons being discharged from state, city and voluntary hospitals would be referred. OMH is prepared to place discharge review and placement teams in each center to review the adequacy of the discharge plan and link the patient to a service provider.

We are also very concerned about our capacity to do adequate discharge planning and to this end we have instituted a major inservice training program with Title XX funds to train psychiatric center staff to do quality discharge planning.

Case Management

Mr. Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center:

A continual problem has been the dramatic no-show rate at the established aftercare services (50% no-show rate). This means that patients discharged from state hospitals who are in need of medication and other therapuetic services are not getting them. One possible solution to this problem is a more coordinated and comprehensive discharge planning effort by the state institutions which would include the development of escort services for patients recently discharged until the patient becomes familiar with the aftercare facility and can realistically be expected to assume responsibility for their own aftercare services.

Mary Karry, Community Access Program:

I strongly recommend that discharged patients be intensively followed by staff with whom they are familiar at closely-spaced intervals, during the period immediately following their discharge. For this is the critical time for outpatients, during which they decompensate without strong support.

Richard Cromwell, Assistant Director, Crisis Intervention Services, New York City Human Resource Administration:

What often is the difference between appropriate placement in and SRO setting and inappropriate placement is the discharge process from the hospital. If patients are given some participation in their discharge plan and visit the SRO before discharge; are introduced to their aftercare facilities, and introduced to the service team at the SRO and are given assurance and reassurance that they are not alone in their struggle to adjust, then they have a chance of making it in the community. It is particularly important that they develop survival skills and have certain necessary tools. These include proper identification and credentials. They must also generate a halfway enlightened expectation of the adjustment they face. It is sad to say that much of the time, perhaps most of the time in our experience, patients arrive without this minimal preparation.

Housing

Ethel Sheffer, Director, SRO Project, Division for Adult Residential Care, NYS Department of Social Services:

Currently, discharge planning policies of both the Office of Mental Health and the prisons system are insufficient to ensure that releasees will be housed suitably and in appropriate communities. We seek a commitment to a thorough and consistent pre-discharge housing planning policy.

Charles Fuller, Alcoholism Program Coordinator at Staten Island Hospital:

I think part of the discharge procedure should be such that the living situation and environment be scrutinized by an investigative team, before the person is referred to the living situation. I feel this would help the person in the recovery process. Further, facilities would do well to allow the person to see the living situation and area, before accepting the referral. At the very least, the person would be prepared.

Concentration

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation & Development:

Discharge procedures from state institutions must be closely scrutinized. Concentrations such as on 94th Street and 95th Street in Manhattan where 1,300 tenants are occupants of SRO hotels and 1,000 are residents should not be encouraged by the discharge procedures of state institutions.

Reverend Robert Davidson, West Park Presbyterian Church, NYC:

The West Side has a disproportionate share of mentally handicapped persons.

Hospitals, state and city, have no reliable pre-release guidance to steer people to other areas.

Remedies:

An agreement in writing that no more mentally disabled persons will be advised by hospital personnel to move to the West Side. (Self-directed mentally disabled persons would, of course, not be limited in their choice of living areas.)

A promise today from Commissioner Prevost that he will enforce such an agreement.

A meaningful monitoring system to be certain that the agreement is being honored.

C. Housing

Despite the bleak picture of the SRO environment, SRO's are a valuable housing resource for many that would have virtually no other places to live. For some, SRO's and the lifestyle contained therewithin is a residence of choice, for others however, it is a choice of last resort in the absence of alternative living accommodations. The denouncement of all SRO's is unfair and unrealistic because it does not take into account that some SRO's are relatively well run and that SRO's are a preferred residence for a segment of the population. The goals in forging SRO policy, as heard by the Committee are twofold: 1) to upgrade the existing SRO's to provide a better environment; 2) to develop alternative housing for those who are inappropriate for SRO housing.

The Committee learned through testimony, of factors blocking the accomplishment of these two goals. First, the number of SRO housing units has declined and that this decline is expected to continue, due to the J-51 tax abatement program. This J-51 program has produced a number of spin-off effects concerning the SRO issue:

° Efforts to upgrade SRO's are not meaningful if the current trend of J-51 conversions of SRO's is allowed to continue unchecked. There will be virtually nothing left to upgrade.

° J-51 contains no effective restraints on landlords tactics and has not established standard for acceptable relocation of residents which has allowed owners and developers to create a panic, especially among the elderly and handicapped intimidating the clientele into leaving the hotel without due process. The relocation of former SRO residents presents an immediate problem to be addressed.

° The decline of SRO housing units has reduced the vacancy rate to the point where present SRO hotels are virtually at full occupancy. This phenomenon has further reduced any leverage governmental bodies might have possessed by refusing to refer individuals to certain badly run SRO's. This is simply nowhere else for these individuals to go.

° The single most controlling factor concerning the viability of an SRO hotel as a living arrangement, is the hotel management. Due to the low vacancy rate, the management/owner can be selective in determining the clientele of the SRO and may refuse on-site programs to exist because they prefer the vulnerable, alienated residents as they are. The management/owner might not desire the presence of service personnel which will disrupt their lucrative business.

° The vacancy rate decline also means that there is competition

for every available space that could be rented in the hotel, thus making the management/owner very reluctant to give up rentable space (i.e. profit) to on-site programs.

Secondly, the most promising alternative to SRO's, the surrogate landlord programs, is not appropriate for everyone and like the development of other alternative housing, takes times to develop. Therefore, we cannot expect the surrogate landlord program or other alternative housing to significantly relieve the impact of the relocation of an SRO resident if the J-51 tax abatement program is allowed to continue without amendments.

The Committee heard specific observations and recommendations concerning the areas of: amendments to J-51, upgrading SRO's, owner's control of programs, access to the SRO, and the relocation of SRO residents.

J-51

Bruce Gould, Executive Director, Office of Program Management, Analysis, Department of Housing Preservation & Development:

We will be proposing legislation to allow J-51 type benefits for SRO housing arrangements. The aim of this tax exemption and abatement legislation is to provide incentives for moderate rehabilitation of more than 7,000 buildings (7,428) and over 200,000 (200,733) rooming units.

Michael Holder, Brooklyn Association for Mental Health:

That tax incentive programs be initiated for SRO hotel owners desirous of making well needed renovations and repairs.

Reverend Robert Davidson, West Park Presbyterian Church:

The J-51 Law as it subsidizes the rich and penalizes the poor, encourages reduction of SRO housing spaces without providing new housing opportunities.

Remedies:

A moratorium on SRO conversions while efforts are made to provide alternate housing.

UPGRADING SRO'S

Ethel Sheffer, Director SRO Project, Division for Adult Residential Care, NYS Department of Social Services:

To maintain some well run SRO's for those who choose to live in them, managed by responsible non-profit making groups. Instead of shifting populations, it is high time - this is the commitment we seek - to plan for housing them. One part of this plan must be incentives to upgrade hotels as hotels - not exclusively to shut them down.

Joan Robbins, Director, Straub Hall:

One possibility might be for both state and city to combine their resources, and to do an in-depth study of the real estate holdings of New York City. This study should include among other things, the actual number of rooms or apartments available, the rental rates, the incomes and the amount of money necessary to rehabilitate any buildings that do not meet with current city and state housing standards. The state may encourage non-profit agencies to apply for state grants to rehabilitate these dwellings and rent them to clients as they leave mental hospitals. As opposed to halfway houses, where clients usually live for a maximum amount of time, individuals living in these residences would be permitted to live there indefinitely. There would be no pressure for an individual to find another residence after a certain amount of time has passed.

Reverend Robert Davidson, West Park Presbyterian Church, NYC:

SRO housing is inadequate in many, not all, instances. Yet it is no solution to merely throw out the current residents and replace them with new wealthier tenants. We have many studies calling for upgrading of living conditions within SRO's, the provision of social services, the creation of new housing and the use of existing housing stock. The Department of Social Services SRO Project is trying hard to move in these directions.

Remedies:

State Funding for hotel renovations;

Recruitment of non-profit SRO sponsors, and assistance for them in tackling bureaucratic blockades;

Amendments of rigid bureaucratic standards concerning eligibility for social service programs.

Reverend Edward O'Brien, Director, Holy Name Center for Homeless Men:

We recognize the inadequacy of using SRO facilities for deinstitutionalized patients and we urge a total revamping of state policy to provide more adequate community care for these patients. Until more adequate arrangements are made, and because we doubt that the state will ever make such arrangements, it is our view that the use of SRO facilities must be continued as a poor but necessary means of housing these patients.

Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center:

We are concerned with the current trends which seem to be towards removal of the SRO hotels without any kind of provision for alternate housing. This trend is particularly discouraging because it follows the age-old simplistic approach to problem solving, remove or hide the problem somewhere out of immediate sight and you have resolved it.

Caroll Kowal, Director Mayor's Office for the Handicapped:

Before presenting a shopping list of recommendations to facilitate the development of a spectrum of residential alternatives, it is necessary to present the case for SRO's as a necessary link in the continuum and a viable residential alternative for the handicapped population who live alone and are not able or do not choose to maintain households.

In addition to the fact that alternative housing such as community residences or apartment programs do not yet exist in sufficient supply, these housing types will never satisfy the needs of those individuals currently living in SRO's who prefer the more autonomous living arrangements of rented rooms. The result is that hundreds of handicapped persons being displaced by SRO conversions are being forced into the most deteriorated SRO's, or into illegal occupancy or unlicensed boarding homes and unregistered rooming houses, or into alternative housing types that are less appropriate to their needs and more costly to society. Added to these considerations is the factor of sheer numbers. Currently the City has three community residences for the mentally ill in planning which are funded by the federal 202 direct loan program as demonstration projects for the mentally ill. Considering the fact that it takes two years at a minimum to develop such residences and the cost of the facilities, the supportive ser-

vices and the staff time of city, state, federal and voluntary agencies to process such projects, the net result of housing for approximately 50 persons is indeed costly. Similarly when we consider the alternatives of individual or group apartments which require agency time and public funds to find and furnish apartments for 1 to 3 persons at a time, the expenditures of time and money are disproportional to the thousands of persons currently living in SRO's plus those being discharged daily from institutional care.

The reality therefore is that we must move quickly to preserve, upgrade and license some of the better SRO buildings as a permanent part of the city's housing resources, and as an essential part of the spectrum of a full range of housing options.

Our primary recommendation therefore is that the state establish another category of residential facilities which would be licensed SRO's. SRO-type buildings which meet physical and social standards to be established by state agencies would be licensed as "supportive residences." Handicapped persons for whom such living accommodations are most appropriate would be eligible for a higher rate of payment under the Supplemental Security Income in order to cover the higher cost of improved and well maintained furnished room facilities with on-site supportive services. Title 6 of the Social Services Law which provides for additional state payments for eligible aged, blind and disabled persons should be amended to include a level of payment for eligible individuals living in licensed SRO's. In this way some SRO's could be preserved and upgraded as a viable community living arrangement for the mentally disabled as well as other handicapped persons.

Owner's Control Over Access to SRO

Stephen Reibel, M.D., Director, Ambulatory Mental Health Services, the Roosevelt Hospital:

In regard to SRO's our major problem seems to me to be the ability to gain access. The history of our CSS team documents that problem. Despite the efforts of block associations, mayoral offices, hospital community liaison, etc., we were unable to gain access. One of our other teams was, in the last year, ejected from an SRO because the landlord felt the team was infringing on his prerogative and was not sufficiently cooperative with him. That team was able to re-enter after extensive negotiations and with the help of Mr. L. Klein, Director, Mayor's Office on SRO housing.

Arnold Braithwaite, Chairman, Board of Director, William F. Ryan Community Health Center:

A problem is a lack of cooperation from hotel owners in providing space for an on-going clinic.

Michael Holder, Brooklyn Association for Mental Health:

That there be tighter controls initiating stiffer fines for those SRO owners who continue to leave their buildings with numerous health and safety violations;

That there be the creation of an agency with human services experience to provide standards and regulations for SRO hotels.

Richard Cromwell, Assistant Director, Crisis Intervention Services, New York City Human Resources Administration:

A few hotels and SRO Managements willing either to accept or provide space for programs. We in C.I.S. are experiencing heavy resistance to new programs and a stiffened reluctance to continue present programs on the part of many landlords. Cooperation is particularly absent if it means providing any service space which is otherwise rentable. The acceptance of an on-site program which was appealing to SRO managements because it could mean increased referrals has disappeared because such referrals are no longer needed. Many SRO hotel managements are skimping on maintenance because of full occupancy and there is little incentive for better maintenance.

Relocation of SRO Residents

Ethel Sheffer, Director, SRO Project, Division for Adult Residential Care, NYS Department of Social Services:

To develop guidelines and procedures to ensure humane, orderly relocation of tenants displaced in cases of hotel shutdowns and conversions. To promote fair and humane relocation we need the development of a system of equitable displacement and relocation benefits, based on an index of tenant needs, and legal and/or administrative provisions to insure and enforce a humane relocation in the cases of hotel closing and conversions.

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation & Development:

We will be seeking legislation to provide for relocation benefits to those who are to be displaced by the rehabilitation and conversion of SRO's into apartment living.

Reverend Robert Davidson, West Park Presbyterian Church, NYC:

Relocation with few exceptions is ruthless and detrimental to the mentally disabled and older persons. They are dispatched with inadequate (if any) compensation to other SRO's which will also soon

close. The more ruthless the developer, the quicker his building is emptied. The more compassionate the owner, the more slowly he has the building cleared.

Remedies:

A plan for relocation.

Standards for relocation which force the developers to provide adequate notice, adequate compensation, and an effort to locate people in suitable new homes.

A system of rewards for developers who have a heart and penalties for the most gross violators of human dignity including denial of J-51 benefits to them.

3. SERVICE MODELS

The Committee heard testimony regarding efforts that presently address the needs of the SRO population through a variety of on-site services and alternative living arrangements. This testimony describes successful programs which should serve as models to be encouraged and replicated as governmental policy in this area is developed. Outlined, also, are the obstacles confronting the establishment of these programs with recommendations on the reduction and/or elimination of these obstacles.

A. Examples of Successful Programs

Elizabeth Strecker Trabony, Executive Director of Project Find - Aid for the Aged, Inc., which operates the only not-for-profit SRO in the City of New York, the 300 room Hotel Woodstock:

> Properly managed and in good repair, a hotel offers excellent accommodations for elderly and disabled people who require some help - maid service, linens, switchboard telephone service, elevator service and the availability of building service workers during illness and emergencies. There can be no question that as a lifestyle for persons with limited income and limited ability to care for themselves in self-contained apartments, hotels will always be a superior lifestyle to nursing home and state hospital confinement, superior both for the person and for the state because subsistence cost is less.
>
> The threatened luxury conversion of additional hotels on the West Side under the J-51 program in the immediate future and the monumental job of relocation of thousands of senior citizens and disabled persons, occuring on a smaller scale in Times Square five years ago, drove Project FIND, with representation on its Board of Directors of prominent community leaders and the pastors of Catholic and Protestant Churches into the monumental job of taking over the management of the Hotel Woodstock as a non-profit community venture. The situation was entirely different from today's situation, though, as far as putting together a viable financial package. In September 1975, the building had fallen behind about three years in the payment of City Real Estate Taxes; with a succession of owners and leasees, the property had been milked for private gain with virtually none of the building receipts having been spent for building maintenance and repair. Fires had gutted two floors, with water damage to the floors below and these and other rooms which required even minor repair or painting were sealed up and withheld from rental.
>
> In 1975, with Vacancy De-Control in effect in the State and hotels closed in the Times Square area, not so much because of sub-

standard conditions but because the Times Square business community wanted to rid the area of unwanted persons - mainly in an effort to curtail prostitution and drug traffic, which were flourishing businesses in the area. But here at that time and now in all of the West Side hotels presently under luxury development, elderly and disabled persons lived in the hotels, the majority of whom were long-term residents of the area, former theatre people, cabaret dancers and singers and persons, before retirement, who had been in trades allied to the entertainment industry.

In order to house displaced persons immediately - rather than obtain an empty building and do a "gut rehab", a process for which resources are available, requiring several years of work - we obtained a ten-year lease on the Woodstock with an option to buy. With help from the City of New York Department of Employment, which funded us with a U.S. Department of Labor CETA Title I (now called Title IIB) grant, we established a maintenance training program, employing young people being paid minimum wage in an Adult Work Experience Program. Every six months our work force was changed and jobs had to be found for those completing their work experience.

The building is a sound structure, fireproof, with systems at that time not requiring total overhaul. We began to rehabilitate rooms, and with 80 in shape for occupancy when we started, 200 have now been moderately repaired, made suitable for tenancy at what could be called basic subsistence. In other words, a tenant has a clean room, basically furnished with second-hand furniture donated by several East Side hotels being refurbished, in a safe, secure building.

With assistance from the New York City Department for the Aging and a Title VII Administration on Aging Nutrition grant, a senior citizen center was constructed in 1977 on the entire second floor in a 13,500 sq.-ft. community space set aside by our Board of Directors as permanent community space.

An exciting community of elderly and disabled persons is emerging joined together, many helping one another. Tenants volunteer in the senior center and for security work. Roosevelt Hospital has stationed several times a week through its Ambulatory Mental Health Services and its Alcoholism Service, a Social Worker, a Community Mental Health Nurse and several paraprofessionals for service to those requiring help. A Social Worker is also available 20 hours per week funded through the New York City Department for the Aging in a program called "The Frail Elderly Team," supervised by the Community Service Society.

The average monthly income of tenants is $282, and they spend an average of 43% of income for rent at the Woodstock; 70% are men and the median age is 69 years old. Thirty-seven percent of the men are Veterans of World War II, who, by the way, are receiving average Veteran's pensions of $315 a month, only $40 higher than the $270 which is the current average of combined Social Security and Supplemental Security Income (SSI). Ninety-seven percent of the tenants (excluding 4 or 3% working men) pay more than 1/3rd of their income for rent.

Rents are being held to an average of $130 per month at the present time. It took over three years to achieve a rent roll which could be projected to show financial ability to support a Purchase Money Mortgage with the owner of the property (totalling $900,000) and a conventional Bank Mortgage to pay back taxes. The story is like a Catch-22 situation: the building continued to accrue real estate tax arrearage, amounting to $84,000 a year, while we paid a total of $270,000 in three and a half years (with a moratorium for 12 months), which he paid to the City of New York toward tax arrears, an arrangement he made to keep the building out of In-Rem.

Our intention was to apply for Real Estate Tax Exemption as a non-profit organization housing low-income people, at least until the building was self-sufficient with any excess of rent receipts over operating costs to be applied to upgrading the building. Yet, we could not apply for a tax exemption until we held the title to the building, and the owner would not transfer the title until our financial projections could show the ability to pay the Purchase Money Mortgage, a conventional Bank Mortgage for whatever back taxes were still owing at the time of transfer of title, and a condition of the bank, show the ability also to finance a low-cost 3% mortgage for 15 years through the City of New York under the Article VIIIA Loan Division (for systems repairs).

The financial position was finally achieved in January 1979 in time to apply for exemption for the 1979-80 fiscal year. Ironically, when we were granted Tax Exemption by the City of New York (with the help of the Director of the Mayor's office on SRO Housing) on July 1, 1979 and the mortgage arranged with the New York Bank for Savings to cover the back taxes, the tax arrearage amounted to $593,000 dating back to September 1975, the month we started. In other words, we had paid the owner some $320,000, which he had mostly paid toward tax arrearage prior to our take-over of non-profit management of the building, and the mortgage we undertook with the Bank was for taxes accrued throughout some 47 1/2 months of desperate struggle to rehabilitate rooms and accommodate 200 tenants!

Finding a building now on the West Side to replicate our experience at the Hotel is impossible: the real estate market is booming and with tax abatement and exemption being granted developers under J-51 conversion to luxury housing, it is well worth it to hotel owners to devise other means than our painful struggle to meet their real estate taxes and keep the building out of In-Rem. There is no question that other community groups on the West Side as well as any neighborhood in New York could successfully lease or acquire hotels if they were granted tax exemption at the onset of their management. But, this would mean that the City of New York was assuming total responsibility for housing elderly and disabled persons, the majority of whom have such low SSI incomes through Federal and State subsidies as to be unable to pay rents, even a non-profit organization would have to charge for a minimally subsistence living standard.

We still have 100 rooms left to renovate and the majority of these require major repair. We have applied for and are relying on

the granting of Community Development (CD) funds through the City's Housing, Preservation and Development Administration, order to complete these renovations and meet our own projected mortgage commitments.

Granting tax exemption to the Woodstock is not exactly a precedent-setting, policy decision by the City: in effect, our community corporation lifted the hotel out of In-Rem Proceedings such that the City of New York after our four years of effort has gained close to $1,000,000 in real estate taxes and has stipulated that each year our financial status will be reviewed with the implication that as soon as the building achieves financial self-sufficiency and an improved living standard, it could likely return onto the tax rolls.

A solution immediately to the problems we are encountering at the Woodstock: obtaining the financing for up-lifting the standard of living in the building and to complete renovations, would be the granting of Section 8 Rent Subsidy to eligible tenants. As I was shown yesterday, paragraph 888.111 of HUD's Guidelines for Section 8 does contain the following sentence: "Single room occupant housing planned specifically as a relocation resource for eligible single persons may also be developed." This needs to be investigated as well as the process of identifying our housing crisis to qualify.

Low-cost mortgages through Article VIIIA as granted to the Hotel Woodstock, is also an important resource. Non-profit community groups, sponsoring the management and upgrading of existing SRO's with tenants in place, are vital if we are to halt the mass displacement of elderly and disabled persons threatened in the months ahead with no satisfactory places for relocation. The only way to attract such sponsors is by opening the doors to existing financial resources for development of SRO's as an acceptable lifestyle.

The major obstacle is simply the lack of money. There are no mortgage assistance programs nor rent subsidy programs which are applicable to the preservation and upgrading of existing SRO's. Hotels and rooming houses in New York City have been for the past 25 years the major housing resources for low-income elderly people and for the mentally and physically disabled in larger numbers during the past 10 years; yet, there still seems to be questions in people's minds that this is a viable lifestyle.

The City of New York has begun to examine its In-rem property (city owned property acquired through non-payment of taxes) to be operated as not-for-profit housing for the recently discharged patient.

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation and Development:

There has been a fair amount of discussion of in-rem housing as a resource for those living in SRO's. To that end, our office of Alternative Management has been working with the Mayor's SRO Office to link Community Management groups with SRO tenants. Through the Community Management Program we expect to place at least a small number of recently deinstitutionalized patients in community-managed, in-rem buildings. In addition, the Alternative Management Program has recently taken jurisdiction of the Hudson Hotel at 142nd Street and Amsterdam Avenue in Manhattan. This hotel, had been taken in-rem and was ordered vacated prior to our involvement. Under the HPD Alternative Management Program, the Hudson Hotel has been placed under the management of a neighborhood Community Management group. The Hotel income is being placed back into the building for operation and maintenance. In addition, HPD has committed several hundred thousands of dollars for the renovation of the Hudson Hotel. Criminal elements in the hotel have been removed and social services are being provided by a local mental health center. Under careful supervision, this hotel will serve as a demonstration of what can be accomplished under non-profit management of an SRO hotel.

In the absence of a self-contained program such as the one provided at the Hotel Woodstock, outreach services are needed.

Arnold Braithwaite, Chairman, Board of Directors, William F. Ryan Community Health Center:

One of the first problems a member of the SRO team from Ryan encounters is helping the SRO resident/patient realize and articulate that they are ill. Many times the Team sees patients who simply cannot identify the source of their problem and the worker with great patience must be able to help the patient isolate the source of their concern and identify the nature of their complaint. Many times this process uncovers that the patient does not have a physical complaint but one associated with their living conditions, or the delay of a welfare check, etc. In any case the worker must be able to deal with any and all the problems the patient presents and assist the patient in finding a satisfactory solution. Second, the patient must know where they can go to seek help for their particular complaint and must also be able to deal with the ancillary problems connected with that issue, i.e., how are they going to pay for the service they need, do they have a valid medicaid card, do they have carfare, etc. For many SRO residents these are insurmountable problems and whatever ailment the individual has goes untreated and may develop into a much more serious problem.

In those miraculous instances when the SRO resident is able to overcome all these obstacles, there remains what proves to be the most

difficult problem-understanding what the medical practitioner is telling him/her, getting the medication prescribed and following either a medication program or other treatment modality prescribed.

Given the nature of the problem confronted by SRO residents in seeking health care services, the Ryan Health Center nine years ago began an outreach effort to provide services for SRO residents in the setting most comfortable and accessible to the residents-the SRO hotel. Over the years through diligence, persistence and a fair degree of arm twisting, the health center has managed to establish regular weekly clinical sessions at these hotels (the Continental, Pennington and Capitol Hall) as well as an established presence in abut 20 to 30 other SRO hotels. It was felt by workers at the Ryan Center that clinical sessions on a regular basis in the hotels would begin to break down the barriers of distrust and fear that gradually with the confidence and relationships developed with members of the SRO Team, SRO residents would eventually begin to avail themselves of the larger array of services available at the health facility on 100th Street. In fact, this has been our experience.

The SRO Team currently consists of the following individuals - a medical nurse practitioner who serves as the team leader, two part-time internists, a psychiatric nurse practitioner and three family health coordinators. The medical nurse practitioner supervises the flow of work and has been the key in gaining access to many of the hotels. The family health coordinators play a particularly important role in the team's success. It is through their work that the SRO residents have gained confidence and trust in Ryan as a health facility. It is through the efforts of all the Team members that for the first time some SRO residents are receiving comprehensive ambulatory health care services (as well as effectively monitored psychiatric medication services)in a way that allows the SRO resident to maintain him/herself in a community setting. In addition the SRO Team provides easy access for the SRO resident to a variety of other services at the health center's main building at 160 West 100th Street including dental care, on-going out-patient psychiatric services, gynecological and social services.

The SRO Team's success is based on several very simple premises - bring the health services to the resident thereby breaking down several barriers of frustration and alienation, use the staff in as flexible a manner as possible, allow staff to use their own initiatives in trying to find ways to meet the patient's needs and finally, provide the consistency and follow-up that on the one had reassures the patient that someone really cares and on the other hand insures that the patient is following a prescribed treatment plan. This latter aspect of the SRO Team's work has been the particular function of the Family Health Coordinators who can be found even on weekends delivering medications to an SRO resident who needs it.

The Ryan Center would like to expand the number of weekly clinical sessions it runs to a larger numbers of SRO hotels. However, there are several problems which first might be overcome. First and foremost, there is the problem of money--we do not have funds to expand

our effort and what is even more relevant our funding source, HEW, has made clear that services such as the SRO Team are no longer eligible for continued funding. We face the devastating prospect of eliminating the SRO Team.

Richard Cromwell, Assistant Director, Crisis Intervention Services, New York City Human Resources Administration:

The particular focus of the Crisis Intervention Services Program is to provide social services to SRO residents. This is accomplished primarily by the establishment of on-site service projects with workers out stationed in specific SRO's and hotels. We feel these programs overall have worked particularly well. I would cite the Aberdeen, the Stratford Arms, and lately the Continental as programs which are dealing with larger numbers of residents suffering mental or emotional disability. It is our experience that no single agency can provide all services needed in an SRO. Therefore, we have a team approach and each project is serviced by more than one agency.

We work to meet the overall needs of the SRO residents. With regard to the mentally disabled, these needs include not only adequate follow-up psychiatric services and a stabilized medication regimen -- if the patient is taking medication -- but also such basics as assistance with: money management, nutrition (the patient often seems unaware that food will not automatically be provided in the community setting), negotiating with complex social and health systems, development of socialization abilities, recreational activities (the patient's budget allows for little or none).

We consider that the provision of this kind of service has both improved the quality for the patient in the SRO and in the community. Significantly, it also reduces the risk of reinstitutionalization. This program requires not only cooperation among agencies but also from the SRO management. In particular, SRO managements must screen out the more threatening members of the general SRO population who might seek housing with them. They thus assure a less victimizing group. The patients well being in an SRO depends not only on the provision of support services but on an understanding management and a non-threatening environment. Even then, the patient's life is dificult.

Two service models focusing on the needs of the alcoholic were described by:

Charles Fuller, Alcoholism Program Coordinator, Staten Island Hospital:

Better utilization of Camp LaGuardia, a 1,050 bed facility, located in Chester, New York. This facility in my opinion and knowledge, is underutilized. It is my very strong feeling that an appropriate long term treatment program for homeless alcoholics should be

developed. The homeless alcoholic, (in terms of dollars and cents) is costing the City and State of New York millions of dollars in welfare, hospital, police and court costs. This is just a big revolving door. However, the homeless alcoholic can become a responsible, tax paying member of the community.

Hart's Island (a former workhouse for public intoxicants) could be utilized. A community of several half-way house type facilities could be developed for persons leaving psychiatric facilities, etc. A community such as this would provide a wholesome environment which would contribute to the person's gradual adjustment to living in the "real community". Many of the City and State tax dollars are now going to single room occupancy hotels, to simply provide shelter.

B. Recommendations

Specific recommendations on models of service were given. In general these recommendations concerned the need for a variety of spectrum of services, the importance of on-site services, the surrogate landlord program as offering the most promising and immediate achievable alternative to SRO's and advocacy services.

1. The Need for a Spectrum of Services

Carl Cohen, M.D., New York University Medical Center, Office of Urban Health Affairs:

SRO hotels are not for everybody. A continuum of aftercare facilities - for example, halfway houses, group apartments - must be established which will enable the more capable ex-patient the opportunity to develop the requisite skills for independent community living. Presently, many of these individuals are not identified, and eventually they succumb to the low-expectation ethos.

Ethel Sheffer, Director, SRO Project, Division for Adult Residential Care, NYS Department of Social Services:

We need to incite development of a variety of alternative housing in enough variety to suit vastly differing levels of needs and desires for independent living of current SRO residents; this housing should be sized and suited so that it can be tolerated by the community.

Currently, the types of alternative housing which exist for the single poor, and especially the disabled, which are funded or subsidized by government, are not sufficient for the varied needs of a varied population. We seek a commitment to rechannel funding, to rethink rigid categories, and to open the doors for diverse kinds of housing.

To encourage the development of housing alternative:

*A redefinition of levels of SSI funding, so that new types of supportive housing, matching people's specific needs, may be made available to them.

*The development of a system for combining money from separate sources - for example, community development funds for participation loans, to produce packages of money resources for nonprofit housing sponsors and developers.

*The release of funding from agencies with responsibilities in the areas of SRO's and their tenants, so that alternative housing can be built, upgraded, and maintained, and related services can be provided.

Carroll Kowal, Director, Mayor's Office for the Handicapped:

It is the position of the Mayor's Office for the Handicapped that a total spectrum of housing types are needed to accommodate persons with disabilities, from the most independent living to highly supervised semi-institutional facilities. The goal should be to provide a continuum of alternatives so that individuals may have choices, not only at the time of discharge from institutional care but as their lives in the community change and their needs for more or less services fluctuate. The full spectrum should include individual apartments, group apartments, family care facilities, community residences, licensed SRO's, emergency shelters, and semi-institutional care-type facilities.

The Mayor's Office for the Handicapped is presenting here very briefly a list of recommendations for the Committee's consideration.

A. Individual apartments;

1. The protection afforded senior citizens under the City's Rent Increase Exemption Program must be extended to the non-elderly handicapped with State reimbursement to the City for such rent relief granted to handicapped citizens. Similarly the protection afforded senior citizens by State laws governing co-op conversions must be extended to non-elderly handicapped. Without these protections, disabled persons who are now living independently on fixed or marginal incomes will be forced out of their apartment.

2. The Section 8 program of federal rent assistance for new construction should be utilized for the mentally ill. There are currently over 8,500 units of elderly and handicapped housing in the pipeline for new con-

struction or substantial rehabilitation in New York City. None of these Section 8 units will be available to the mentally ill. Specific policies and procedures for back-up services should be worked out to ensure a "fair share" of such housing for those former mental patients who are now able to live independently.

B. Group apartments;

1. Restrictions in the City's Housing Maintenance Code and the State's Multiple Dwelling Law regarding the number of unrelated persons who can live together in apartments should be modified to allow the expansion of shared housing in order that people who cannot live alone can pool their financial and personal resources to live together in social units that foster mutual support and self help.

2. The Section 8 rental assistance program for existing housing should be more fully utilized under the recent changes in federal regulations to allow the use of this program for Independent Group Residences. The State's surrogate landlord program should be expanded and funds should be made available to supplement the Section 8 rental assistance in order to meet the high housing costs of certain areas of the City where apartments cannot be obtained within the Fair Market Rents established by the federal government for New York City.

C. Family Care Facilities. The Family Care Program, widely used upstate for the mentally ill should be modified to be more applicable to New York City's stock of rooming houses. Those rooming houses which are owner occupied already provide natural family-type settings for thousands of low-income single persons. The mentally ill could be included in the Family Care program.

D. Community Residences. An amendment to the City's Administrative Code is required to facilitate the expansion of community residences under a residential occupancy classification of the Building Code. Legislation is currently being drafted for submission to the State Legislature which hopefully will havethe full support of the Committee on Mental Hygiene and Addiction Control.

E. Emergency Shelter. Facilities should be set up in each borough of the City to provide emergency facilities for elderly and handicapped persons. Such facilities could serve as a resource for crisis intervention or respite housing for mentally ill persons as a way of avoiding unnecessary reinstitutionalization.

F. Semi-institutional care-type facilities. Adult residences, health related facilities, and nursing homes should all have expanded mental health services. But in addition some care-type facilities should be operated specifically for the mentally ill in order to provide more complete on-site psychiatric rehabilitation services. SRO-type buildings are an excellent resource of existing buildings to utilize for such purposes.

The Mayor's Office for the Handicapped stands ready to cooperate with the State in any way we can to further clarify and implement these recommendations to accomplish the goal of continuum of community based housing alternatives for the city's disabled population.

Barbara B. Fox, Public Affairs Officer, Post Graduate Center for Mental Health:

The President's Commission on Mental Health of 1978: "If chronically mentally ill people are to be cared for in their own communities, living arrangements must be available that are adequate and affordable. Some will want, and be able, to live alone. Others might prefer to live with their families. Still others will need structured and protected environments. These options have been widely available in the past. They are not widely available now."

These options are still not available now. We at Postgraduate Center for Mental Health want to see it happen.

Sarah Connell, Regional Director, NYS Office of Mental Health:

There is a serious shortage of low and moderate priced housing stock in NewYork City for those who are able-bodied and functioning in the community. For the mentally disabled, this shortage is exacerbated and almost hopeless. Therefore, we need to use whatever skill and ingenuity we have to make better use of what housing is available. To this end, OMH has established alternative housing as the major program priority in New York City, and has allocated $3.23 million from 1979-80. This includes program development grants, community residence operating contracts, crisis residence on state facility grounds, and surrogate landlords programs through Community Support System funding.

2. On-Site Services

Carl Cohen, M.D., New York University Medical Center, Office of Urban Health Affairs:

On-site staffing must be increased greatly. In addition to the need for a more social service and psychiatric staffing, there should also be more personnel trained in social and vocational rehabilitation.

Barbara B. Fox, Public Affairs Officer, Post Graduate Center for Mental Health:

We feel that special housing related to the problems of psychiatric patients is needed - an SRO where psychiatric services are available, a place which provides a support system to assist the mentally ill toward independent living, a place where the effect of a therapeutic program could be carried into everyday living, a place where social relationships and exchange between residents would be encouraged and a place that was safe.

We would like to operate an SRO which would be used as a training model, where studies of cost effectiveness could be made, where psychiatric services could be easily available, where new concepts and procedures could be evaluated, and where research could be conducted on outcome. We know of no existing model of this kind.

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation & Development:

One important goal throughout our efforts has been to combine a suitable living environment with supportive social services. The agency resources have been made available to all concerned. There have been constant contacts with the Mayor's Office of SRO Housing, the New York State Department of Social Services SRO Project and both the City and State Offices of Mental Health. Initially, we have been able to provide to all appropriate agencies a comprehensive computer list of all SRO and SRO type housing in the City.

3. The Surrogate Landlord Program

James Rice, New York City Department of Mental Health, Mental Retardation & Alcoholism Services:

The surrogate landlord component of CSS holds considerable promise for those SRO residents with a history of psychiatric hospitalization who have the aptitude and inclination to share an apartment while enrolled in a rehabilitation program. Surrogate landlord scatter site apartments are not subject to State Operating Certificate requirements. Apartment occupants may come and go as they please, provided that they are able to sustain relationships with community based rehabilitation services. A case manager looks in on the apartment dwellers from time to time, insuring that personal adjustment problems are dealt with as they arise. This unique CSS component affords current SRO residents a choice of leaving the SRO environs, thereby relinquishing the privacy of a single room, in return for the ambiance of more spacious surroundings and the development of social competence. Allow me to state a word of caution. The Surrogate Landlord CSS component should not be expected to assist in the wholesale relocation of SRO residents but rather, may prove to be a

boon for selected residents who wish to expand their horizons in the community.

In this Community District, there are seven CSS provider agencies under contract to the City Department serving SRO residents and disaffiliated people. In addition to CSS, there are several non-CSS health and mental health programs operated by voluntary, municipal and state agencies which have served SRO residents for a number of years prior to the advent of CSS. The majority of these programs are operated on-site in SRO hotels for the benefit of residents who are either unable or unwilling to use community based services on a regular basis. The chief thrust of these programs is to reach out to and engage individuals living in SRO's who do not avail themselves of off-site services, to maximize residents' levels of functioning and to enable those residents who are so inclined to become assimilated into the natural support systems of the surrounding community.

Bruce Gould, Executive Director, Office of Program Management Analysis, Department of Housing Preservation & Development:

We support the concept of community residential and surrogate landlord programs. Programs of this type allow social service agencies to support the needs of the deinstitutionalized individual and ease their transition to an independent living situation. We urge that programs of this nature be expanded. They serve to assist not only the individual client but help to provide a better climate in the community as a whole.

We are aware of the recent involvement of the Office of Mental Health in the housing field and are encouraged by it. Providing a satisfactory living environment for the SRO tenant will not be accomplished by providing only better social services, or by only providing better housing, but rather, by providing both adequate housing and adequate social services in neighborhood environments that make possible the further human development of all segments of our population. We must not allow ourselves or our community to shrink from the difficult task that faces us.

Sarah Connell, Regional Director, NYS Office of Mental Health:

We have just completed a needs assessment, and plan to develop 1,000 slots by March 1981. Included in this effort are two projects in Manhattan to upgrade two SRO's and provide appropriate on and off site programs.

Our commitment to providing meaningful services to mentally disabled persons in SRO's is demonstrated by the initiatives of the Community Support System Programs and new funding of on-site rehabilitation programs in SRO's at an annual cost of $1,239,216.

We have some question about the effectiveness of these on-site programs, but recognize that people in this environment do not readily respond or participate in the regular human service system. What may be needed is a mix of on-site programs and multi-service centers located in SRO neighborhoods. We will be evaluating these models.

4. Advocacy

Charles Fuller, Alcoholism Program Coordinator at Staten Island Hospital:

A support system for the person leaving a facility is most important. There are existing, some SRO hotels where professional staff are present and supportive to persons recently discharged from a facility. Adjusting to living in a community present different crisis situations. This staff would monitor and have some control over the SRO hotel environment. The Committee on Mental Hygiene and Addiction Control might consider appointing a special advocate for the alcoholic, mentally disabled, and addicted person, living in single room occupancy hotels.

Mary Karry, Community Access Program:

The quality of life of discharged patients should be greatly improved by the Advocate working alongside of the professional. Community Residences, run by Advocates, staffed by carefully selected professionals and paraprofessionals through shared staffing agreements, proprietary homes and SRO's.

We propose that professional liaisons be assigned to all community residences for the purpose of arranging and providing clinical services at the time these services are first needed.

Joan Robbins, Director, Straub Hall:

Aftercare services, including social services and advocacy services should be available, either through the SRO's themselves, depending on the size of the facility, or through neighborhood advocacy service centers, which may be storefront operations.

"Tenants Associations" should be encouraged in SRO's so that individual tenants will have the opportunity to meet together and discuss common problems and propose solutions to them. Representatives of ity Human Services Agencies should be present at these Tenants Association meetings. Just as new condominiums are offering more services to those who elect to live in them, including meeting rooms, recreational facilities, and convenient on-site shopping, SRO's should be encouraged to do the same. Clients living there are those who are least inclined to seek out recreational facilities for themselves. If there were rooms available in the SRO with trained support

services available to encourage socialization, re-socialization and constructive use of leisure time, then we would be doing for our mental patients at least what we would like to be doing for ourselves.

APPENDICES

Appendix I

Interviews with seven SRO residents conducted by the Senate Mental Hygiene and Addiction Control Committee describes the conditions and environment present in SRO hotels.

The deplorable physical conditions of SRO's is well documented. However, these conditons can and do work to the financial benefit of the owners. Testimony indicates that access to the buildings is controlled; that dispossession of non-paying tenants is swift and extralegal. In such an environment, it is hard to believe that the criminal activities carried on within the SRO are not approved by the operator of the SRO, for financial gain.

Q. When he'd want your room did you see anyone whose room he took over?

A. Mr. R: Oh yea, I seen plenty.

Q. What did he do?

A. Mr. R: Block the -- you know where you stick the key in.

Q. Is that called plugging the door?

A. Mr. R: Yea, plugging the door, you know, and when he wants to get in he would just take the whole lock off.

Q. So the tenant couldn't get into his room with the plug?

A. Mr. R: If he catch you in there him and his goon squad they came you know--

Q. Mr. W. back to you for a minute - you mentioned plugging the door also. Did you see any tenants in the building while you were there have themselves locked out in that fashion, and do you know why that was done to them?

A. Mr. W: Sure, their check would be delayed from Welfare or whatever and these cats didn't want to wait. Those people out there they use the little power that they do have, I feel they use it as a sword over people's head. He plugged the door; he would move all his stuff out and put it in the basement and then when the person does

come home with the money to get his room back he's gonna be charged for storing his stuff inside the basement or in his room, and thats terrible.

Q. All during the time you were in this hotel did you ever see any city marshalls, sheriffs or anybody do any eviction work? Was it official evictions or was it just the manager plugging the door?

A. Mr. W: Just the manager.

Q. And nobody ever went to court or had a change to go to court or anything like that?

A. Mr. W: No, no you don't talk about going to court. Those people they are anti, against the law, if you talk about going to court on them they'll bust you in your head. If they don't do it they'll have someone else do it.

Q. Mr. T: Well, what about the things people hide inside their rooms? The guy plugs your room, and what about your things?

A. Mr. W: You just don't get them back. All my belongings, when I left this hotel, all my belongings, I don't know if they're there. I just didn't care. I just left them there.

Q. If you went back to get them how much storage would you have to pay? Do you know what the rate was?

A. Mr. W: No, I don't know.

Q. But you'd have to pay to get them back?

A. Mr. W: Yea. But what I'm saying when I say pay to get them back, to show you what I mean about how they use people; if you go and stay away a year that stuff is all but forgotten about, but what he was doing, if your check was due on the 16th he plugs your door on the 17th and then by the 18th you came up with the money for your room in time to get back in, he would charge then for the time that you have let the stuff stay in your room.

Q. So he'd charge you two days storage on the 18th, in addition to the rent?

A. Mr. W: Yeah, right.

Q. So you had to pay more money?

A. Mr. W: Right, if you wanted to get your stuff back. My room wasn't any bigger than a cell at Sing Sing, you know and it had a leak right by the electrical appliance plug. I came from the Bronx one day at night and I just come to open the door somebody had just kicked the whole door in and a lucky thing I didn't have nothing in there for them to steal, but the point is that they just kicked the door in and I slept in that room, it took the man at least three or four weeks, four weeks to be exact, for them to fix the door. But you wouldn't have a room.

While the dispossession of non-paying tenants is swift, special arrangements are made for those individuals who are deemed "desirable" by the hotel management - as described by one witness:

A. Mr. R: When I got there they was telling me about this brother that slept over the top of me in that room up above me. This dude, man, I know it sounds funny but five years ago he had killed a broad, cut her head off and put her in a tub and they gave him 5 years and do you know that the hotel held his room for him again.

What's happening is that wherever there's a hotel with welfare recipients you're gonna find loan sharks, you're gonna find drugs, you're gonna find prostitution. It's the addict, the alcoholic and the whole slew of derelicts that they prey upon.

Further indications of the hotel management's control of the tenants and activities contained therein were related by the witness' experience:

A. Mr. R: Why I left was because, well, I had missed an appointment with welfare, I was picking my checks up at the welfare office. I had missed a check so about a week later he called me down, Mr. Blue, that's the name of the man called me down. He had a tire iron in his hand and he tells me, what happened to your check? Listen, so I said, listen, welfare cut me off temporarily but it will be straightened out if you just give me time. Now he had this crow bar in his hand and he's patting it up against his leg and he's telling me well you got till Thursday to get the check or we gonna want your room. I'm looking at this crow bar and the manager Mr. Blue is a big dude, man, what happened was I moved there Tuesday, and I moved Wednesday, Wednesday night I packed my stuff gave it to a young lady in the building on the same floor with me but I'm scared to go back and get it. A pretty good amount of money, I got

pictures of my mother, my father and important papers, my birth certificate, her death certificate and stuff like that. They like threatened me they got, like, a guard a security joint on one side of the building of the hotel, the hotel stretches a whole block, but on the bottom floor they have stores and what not. It has like one of his sons owns the security where they hire guards and stuff like that. When you first come in the building they got a big gate. They say its for security reasons but in order for you to come down the stairs you got to have a key and its just them that has the keys.

Q. Do the tenants have keys? If you rent a room do you have a key?

A. Mr. R: Oh yea, you have a key to your room.

Q. How about to that security gate?

A. Mr. R: No, not at all. You have to wake the dude up in that little office and tell him you want to go upstairs because he's supposed to ride you up in the elevator but half the time he's high so he'll just open the gate and let you run up the stairs. On your way down you got to bang the gate with a key or something cause he's in that little office he can't hear you.

Q. Mr. R: With this security gate locked, what would you have done if there had been a fire, would you have been able to get out?

A. Mr. R: Jump through the window.

Q. And was this security gate open at any time during the day?

A. Mr. R: No time -- always locked. At all times because they claim that people was coming in and ripping off other people but it was people in the building that was doing it you know - people in the building.

Q. Mr. R: You never saw any evidence that the gate kept out anybody?

A. Mr. R: No.

Q. Mr. R., when did you stay in this hotel?

A. I stayed in there from October to January.

Q. So you're talking October of 1978 to January 1979?

Q. If you wanted to obtain drugs from anybody could you have gotten them in the hotel?

A. Mr. R: You could do anything in there, every day it was constantly police going in there, in and out of that building. OD victims or they busted somebody.

Q. There was no trouble getting any alcohol or drugs or --

A. Mr. R: No, they had bootleggers that was competing against each other. They would buy it from the liquor store by the case and on Sundays they would open up a business on each floor, except on the third floor, the third floor was where the welfare officer was supposed to be but he was never in.

Q. Was liquor more expensive to buy in the hotel than if you went out and bought it yourself?

A. Mr. R: Well, you see, the stores would be closed on Sunday and you couldn't get no booze so they would charge, well on the fourth floor they were charging $1.25 for a pint and on the second floor they were charging $1.15 you know and it was always like a clash between them - you dirty sone of a you know.

Additional testimony received by another witness indicates that in-house sales of this type were not limited to Sundays or just liquor;

A. Mr. W: The hotel I'm gonna be in you don't even have to go out in the street. I know people who stay in the hotel for months on end and didn't know what day it was because they wake up and just go upstairs and buy a pint of wine and go to the next floor and buy a joint and they go back to their room and this is a big thing, people live right in that hotel and they, well, dope and everything.

The lifeblood of the SRO system is the welfare recipient tenant. Recognizing the shortage of housing in New York City, SRO operators are secure in the expectation of an unending supply of tenants. Without exception, the witnesses arrived in the SRO hotels via welfare referral.

Q. How did you come to live in an SRO?

A. Mr. W: I got into the hotel because I had suffered some facial injuries and I couldn't work so I had to have an income and I had to go to welfare so I didn't have a place to stay because I didn't want to live with

my family. The mere fact that I'm on parole and my parole officer helped me go to welfare and when I went to welfare, the welfare they told me that I'd have to sleep in the men's shelter so that was the house and I went and told my parole officer that I refuse to go down there and sleep with a bunch of derelicts and if you want me to go back to jail just keep on what you're doing to me and not giving me your help and you'll just have to send me back. So things went on and went on until I got a letter from my parole officer and they recognized the letter and they sent me to the welfare and they moved me into the hotel and the social worker told me the day they gave me the check and everything to go to the hotel and they told me you don't have to stay here. All you do is just stay until you get yourself together and when you get ready to move take your check.

A. Mr. X: The facts are when the welfare send people to those hotels I'm not sure if they really know the vice that they are involved in, how easy it is for these people to be exploited from the groups in the hotels. When I say groups, I mean the dope pusher, the loan shark. Loan sharking has to do with the checks from my experience for an instance, a junkie comes out of a program or just come out in the street from the hotel, just come out of the welfare department, the person involved is so glad to get a place to live they're not going to ask many questions about formalities, about signing checks, what kind of rooms they got. Welfare, I'm assuming, has already checked with this hotel to see that they do have the proper facilities for the people to live in so when the manager calls down to the welfare department and says he's got a furnished room or furnished apartment with cooking facilities, I believe they take that at face value that that's what it is. The facts are quite different.

A. Mr. R. I have only experienced one SRO hotel and that is the Hudson Hotel, 146th Street and Amsterdam Avenue. The welfare recommended me to go to this hotel.

A financial sub-culture has evolved out of the SRO hotel system, involving public monies. Witness have testified about six arrangement (described in I-VI) involving welfare checks and SSI check. The following are some typical examples:

I. The endorsement control system. The manager of the SRO obtains possession of checks by control of mail in the building. Tenants must endorse the check in the managers presence in order to receive the balance of their check. An example of this arrangement is apparent from the testimony of a witness referred to an SRO hotel by welfare. He testified the social worker told him he only had to stay until something better is available. But that day never arrives, as we see.

A. Mr. W. By her telling me that I accepted the fact that I would stay there until everything worked out. But there was a trick to it. Even though the check came in my name and everything, the hotel manager took it upon himself to cash checks; to cash everybody's check in the hotel. And if they thought you was going to move he'd give you a hassle about getting your check.

Q. Mr. W., does this check you're getting come with your name on it and the hotel's name on it?

A. Mr. W: My name.

Q. Just your name?

A. Mr. W: Just my name.

Q. Was the manager cashing the check without your signing it at all?

A. Mr. W: No, you have to sign it.

Q. How did he make you sign it? (Did it come to you or did it come to the manager?)

A. Mr. W: It come to the manager in the mail.

Q. He controlled the mail box?

A. Mr. W: Yea, the mailman would bring in all the mail and when it was time for you to pay your rent you to to the - when your check day come you go downstairs to the office to the window and he give you the check and a pen to sign your name. If you didn't want to sign your name on the check he give you a hard time. Or he tell you if you didn't pay your rent you just as well go along and I (the manager) put a plug in your key, in your door, and everything, and you have no place to go. This is pressure cause if you have no place to go you haven't prepared to get no place to go and this guy put pressure on you, you have no choice but to pay your rent and to hope that it will get better or that you will find another place.

Q. Mr. W., you got a check from welfare that covered your rent. Did you get just one check that included rent and your personal living allowance?

A. Mr. W: Yea, just one check.

Q. So that when you'd go to endorse your check, the manager would have to give you some money back wouldn't he?

A. Mr. W: Yea, he would give me $47 back.

This control made moving nearly impossible for the tenant. When asked about moving, a witness described the problems.

Q. What if you want to leave, and the manager has your check. Would he give you a whole check? Suppose you owed him two weeks rent?

A. Mr. W: Oh no, you wouldn't get no cash.

Q. Were you paying your rent in advance usually? If you get a check on the 16th, were you paying for the 1st through the 16th or the 17th through the 30th?

A. Mr. W: Yea, semi-monthly.

Q. I know it's semi-monthly but, if you sign your check on the 16th, is it for the next two weeks or the past two weeks?

A. Mr. W: It's for the past two weeks.

Q. So if you went down to get your check he'd be looking for a piece of it all the time?

A. Mr. W: Right.

Q. And if you wanted to leave he wasn't going to give it to you?

A. Mr. W: Right.

Q. How much was your rent?

A. Mr. W: I was paying $75.00 every two weeks.

Q. O.K., $37.50 a week?

A. Mr. W: Right.

Q. If your check was for more than that, would he keep the whole check and not give you anything back? If you were moving you'd just have to leave?

A. Mr. W: What he would do, he would send your check back, anything spiteful and you can't get no place because the other hotels want their rent money.

Q. Do you know for sure that he was sending it back? Is it possible that he kept it and cashed it?

A. Mr. W: Well in my case I assume he sent mine back.

Q. But you don't know one way or another if he really did?

A. Mr. W: No I don't know what he did.

A. Mr. X: If the welfare knew what was happening to their checks as far as their checks being cashed, and its not the person that they sent the check to, they would find some means to put some security on it to see that the person the check belongs to got the check. Often times these junkies in these buildings never see their check, I know this to be a fact because I had females in the same building that when you're pushing drugs you get involved with, ok; and females mainly, like, you hear them crying a lot, particularly the prostitutes. "This 'so and so' got my check and he won't give it to me."

Q. Are they referring to the manager?

A. Mr. X: They're referring to the manager's office, where they pick up their mail.

Q. Whoever is there?

A. Mr. X: Right, I was late two days, my check was late coming and I had to pay for this. What I mean, they had to pay. For I'm talking about what I heard females that work in my group, I hear them say things like this.

II. The forged endorsement - A variation of the first scheme, where the manager takes the added step of signing the check. This is common with SSI checks. Testimony of a witness indicated that some people didn't have to endorse checks, that the SRO manager just gave them their change (Note - this is most likely the personal living allowance of SSI).

Q. Did you observe other tenants at the manager's office on check day?

A. Mr. W: I do know that, like, the older people, that they used to get their checks; that the hotel that I used to live in that the landlord would, all I'd ever see him do, was just give them their change. The rent and everything was taken out and he just give them the change and I never see them endorse no checks.

Q. Would that be somebody getting SSI as far as you know?

A. Mr. W: Social Security, something like that. And you couldn't miss seeing because, like I say, whenever, in order to pay your rent everybody come down to the lobby or in the front, when check day is, and everybody there he call to the window, they were standing around watching who they gonna rob or how much money so and so got; and he's there just giving people change and I never see them endorse those checks. I even asked the guy one time why do you sign and I don't. Well that's all taken care of, he said.

A. Mr. Z: Some time back when I was in the program when you were here last time I had an incident with a fellow that was here, he had left the hotel for three days because he got drunk and he wound up here and he was due for a check so I had to escort him down there and when I got there (to the SRO) his room was locked and they wouldn't let him up in the elevator and the guy had his TV behind the desk. I asked the manager, I said, "I am escorting this man and I would like his property". The guy says "Well, all you have is food stamps, his check didn't come in for a couple of days you know, it didn't come in." I went back with the guy to welfare and welfare says "the check came, you cashed the check", and this guy is going crazy so he says the hell with it, nobody cares so he just left.

Q. So he just gives up but his check went to where he was living and was possibly cashed by somebody there?

A. Mr. Z: That is what it looks like, that is what welfare told you, that it had been cashed. They said that the man signed it. But, he said "what check, I was in Brooklyn all the time".

III. The "Lost Check" situation. The tenant is told the check didn't arrive, but he still must pay rent. This frequently involved referral to a loan shark.

A. Mr. X: There is a group in the hotel, junkies usually that crashed mail boxes they'll go out on check day and crack mail boxes.

Q. When you say crack mail boxes, are they cracking the common mail box in the hotel?

A. Mr. X: No, no.

Q. Through the community out to private homes, two and three family houses?

A. Mr. X: That's right, they walk up with screwdrivers in their pockets, a man and a woman, junkies, and they come back to the hotel with the checks. I was in the office at that time for my money, that's how I know that this happens and that there is a lot of welfare fence going on in the hotel, drug connections.

Q. If we were to take a hypothetical case, a mail crack team, a man and a woman come back, would they come to the manager and give him a series of checks or someone in the office?

A. Mr. X: Someone in the office, usually there's a guy in the office that's the manager's assistant and he's well known in the neighborhood to all of us. This is the same guy that I probably deal with, they would give him the checks and he will give them a third. If it's a $100 check they get $25.

Q. Is that the going rate?

A. Mr. X: That's it, any person that you go to that will take these types of checks will pay this.

Q. Do you have any knowledge what that guy will do with the checks from there?

A. Mr. X: I don't know.

Q. What would you think if you were to make a guess?

A. Mr. X: I haven't the slightest idea because I got involved in that awhile at that time, I'm talking about a period of years from 1958 to 1970 and I've seen the teams come back, man, they got checks like the mailman.

A. Mr. Y: One thing that happens with those checks when the landlord, not the landlord, but the manager, the manager's assistant or representative he generally is a

loan shark and he has or he does all his business with people, legitimate people who receive welfare checks and he has a way of laundering it through the businesses that owe him money, so its really not very difficult for him to get rid of them at all.

Q. So in paying a bill he can distribute a stolen welfare check?

A. Mr. Y: Checking account.

Q. In his checking account and pay it out and of course as a manager he carries a lot of these checks.

A. Mr. X: I couldn't pick that up because I think they get something for it because there are a lot of checks going on, that's right, laundering is going on right now. There's hotels right now, particularly since heroin is sorta back up out of sight off the scene. Now it's coke and it's still the hotels. As long as the junkie and the alcoholic is more or less tunnelled into the hotels, you are going to find people there that will exploit.

Q. Or provide services to them these...

A. Mr. X: Illegal services. As a matter of fact, a friend of mine, we communicate often, we play chess together, as a matter of fact we were up last night till 5:00 this morning playing chess, he got caught in a laundry situation with this check.

Q. Do you know the basic mechanics of this laundry situation? Could you describe it to us?

A. Mr. X: It has to do with a checking account, if you have a legitimate business like a hotel or if you are a hotel owner and I am working for you then you don't want to put the hotel up front, it is easy enough for you to finance me a candy store.

Q. And the welfare person takes his check or the stolen check is sent to the candy store and they deposit it in their account as if they cashed it and pass it on through the system but nobody every checks back as far as you know?

A. Mr. X: No, no the way that they laundry the check is clean otherwise they couldn't keep operating and I am sure they are not, whoever is responsible when I say they, they are not weak enough, they are not slow enough to blow it wide open otherwise they couldn't operate.

Q. Mr. Y. In other words it wouldn't be a candy store unless it were a legitimate outlet, I mean like a grocery store or something where it could be legitimately explained?

Q. Or somewhere that handles these checks regularly?

A. Mr. Y: So if the question was asked, it couldn't be proven.

A. Mr. X: What's happening is, how this can be stopped is somebody, somehow must take an interest in the junkie, the prostitute, and the alcoholic and the derelicts in that particular hotel because this is where the sharks gather, where the welfare recipients are being tunnelled, this is where, all you've got to do is just be there.

A. Mr. Z: I used to work for a check cashing system, I worked for several in Brooklyn and in the Bronx and I used to count the checks that were deposited on welfare and I would just look at the number, never at the name, just the amount and then I would put those in the mail stack after I added them up, put them in the mail sack, tie them up and deposit them at the bank and that was it, in other words they went into the accounts of those I worked for, into his account. They didn't question that. Maybe let us say weekly, a 100,000 checks, you think people are going to spot just one, two, three, four checks.

A. Mr. Z: The dope fiends and the alcoholics, they were just glad to get 1% or just enough to drink or shoot up one time you know and they don't give a damn if the check if for $300 or $400 as long as they get $20 or $30, just enough to get them by.

A. Mr. X: I believe that just about any body here who did not get their check goes down to the welfare office and says I didn't get my check. You know, and they go through the procedure waiting a few days whatever and

they issue you another check. From what I heard about this check situation is that if I bring a check for $300, I get $150.

Q. When a manager claims your check is lost, is he setting the tenant up with a loan shark?

A. Mr. Y: That's what he's trying to do, he's trying to set you up with a shark or the bootlegger.

Q. Why does the loan shark make the loan?

A. Mr. X: They will make a loan because sure they know they're hustling, they'll pay the money back but in the meantime, to stay on the system they head to the welfare department and the welfare will tell them the guy on the desk tells them no, there could be a mix-up, just wait three days and you'll get another check all you've got to do is go down and get an emergency check. They wait three days and they back down.

IV. The Device of "paying" for an address by splitting the check with the manager. This gives the recipient more money - he receives the personal grant plus part of the rent in cash.

A. Mr. Q: In '76 I took a dope bust on 16th Street and I was sent away for five months because I copped out from an A Felony to an A Misdemeanor and I got out and I hoped that welfare, they sent me to this hotel on 80th Street. Now I knew this hotel because I used to transact narcotics out of the hotel so it was easy for me, the people in there knew me so they were giving me a little consideration other than people that they didn't know. The thing was that if I didn't want to live there, all I did is, like I would let him sign it, what he would do is that he would cover my back by calling the people at welfare to say yea, Mr. Q is still here. They check. I'd go to some other spot and be selling drugs, be making money so that I could live to get a decent crib. What happened is that he wasn't there one day and this girl, she made a mistake and she bopped the whole thing. No only did they trace but they found out I was back around my neighborhood. Welfare and then the police and the detectives and then I messed up because I was supposed to pay a fine because as soon as I came back - I got back here too late to transact, I got picked up again. Now I was supposed to pay, I got

hung up at the hotel, so what they did they brought both bees because I jammed welfare and plus I got another jam so I went back to jail again.

Q. Mr. T: Let me ask you Mr. Q. what happened to the check? I mean, you, said that he would say that you were living there?

A. Mr. Q: Yeah, well he was getting a piece off my check. And he was a loan shark.

Q. What would he take?

A. Mr. Q: Say my check was $40 something, right, he would take $15 but he would hold my money because he knew me, as a matter of fact he was raised up around my old neighborhood, and he know me well so he did me favors.

Q. Do you think he would do this for anybody or just as a special favor for you?

A. Mr. Q: Special favor because he knew me as a kid.

Q. Mr. T: You would be saying that he would do this with people that he knew that he felt safe with?

A. Mr. Q: Yeah, but being that he knew me he felt that he didn't want to take anything from me but I did say, hey man, it is not my debt I know you are trying to make a hustle too so that I can keep my slate clean because I had cocaine and dope in there and plus he helped me get clientele selling my drugs so, I gave him just as much as he needed to a certain extent.

Q. How did he help you get clientele, did he refer people to you? Ones he thought were safe?

A. Mr. Q: Yeah, and plus when people found out that my party wasn't bad stuff and he trusted me, he billed from me, all I had to do was keep my thing together.

V. Part of the Financial sub-culture involves the use of loan sharks. Many sources of referral exist. The following is an example.

In response to a question about check control by the manager, a witness indicated that he was given the excess of his welfare check after the manager deducted the rent.

Q. Would he always give it back to you or would he hold out any more?

A. Mr. W: No he would always give me mine because I never borrowed any money from him.

Q. Did he loan money to other tenants?

A. Mr. W: Sure.

Q. Mr. R. can you add to this? (Another witness describes his experience when welfare was late.)

A. Mr. R: Well this Hudson Hotel where I was staying, a few people their checks would be delayed and Mr. Blue (referring to the security person) there was a loan shark office right next door.

Q. Right next door to the security office?

A. Mr. R: Right next door. Everything was in its proper place for this guy, man, you know he would recommend that you go to this loan shark and borrow money.

Q. And he knew the loan shark?

A. Mr. R: He knew the loan shark, I don't know how much he was charging, $.50 on the dollar something like that.

Q. $.50 on the dollar, do you think do you have any suspicion that Mr. Blue was receiving -

A. Mr. R: They were hooked up.

Q. There was a kickback of some kind?

A. Mr. R: Definitely, definitely, because he would, actually, he would force you to go to him you know, you go there or I want your room, knowing that you don't have no place to go.

VI. Some of the Witnesses showed how the predators prey on the helpless, particularly released mental patients. In response to questions about the obtaining of replacement welfare checks and loan sharking, the following statement was made:

A. Mr. Y: They do that, a lot of places, I won't say a lot of places, I know of two myself, where guys have girls out in the streets, pimps in other words do it. Particularly, if a woman comes in, let's say she comes out of a mental health situation and she happens to be reasonably good looking, you know attractive. They would play games like that, where she would go into welfare and they would tell her to wait three days and that's because they would get their statements back from the bank: they would maybe hold the check for a week and you get an emergency check to pay the rent and they would pull it again and the second time she goes down whether they did it or not, she wouldn't get her check so she would be strapped for money. All right she might go to a loan shark, and he might give her the money, but he would make it in such a way that she won't be able to pay without, well, she would starve to death unless she does something and eventually he's gonna get her out on the street to make money afterwards.

During the testimony, it became apparent that mentally ill residents of SRO's were being used by other residents:

Q. Do you know either of your own knowledge or from talking to other people of persons who obtain their drugs from mental health clinics or the mental hospitals?

A. Mr. Y: I think I mentioned when you were here before as long as I got a Medicaid card I can go into any hospital here in the City that will accept Medicaid and I can come out like with some pills, tranquilizers and soforth. Anybody could do that at least that's my opinion.

Q. As often as you wanted and to different clinics with the same card?

A. Mr. Y: Well I would say it would probably be little... we're dealing strictly supervised under most clinics because they have to answer to government officials and to the state and they use a little more tact, but that don't make it difficult. I mean I could use my card let's say to every hospital in the City and when I wanted to go around next week maybe I'd borrow somebody elses card. I wouldn't have to use my card. Its really simple because most people that do have Medicaid cards very rarely use them for purposes that they were meant to be used for.

In the first place most people who come out of mental institutions are usually on some kind of drug or tranquilizers or something because of the environment. It makes it easy for them to pass these drugs on to people who don't even have any background that would require them to take these as a matter of necessity. They just use them to get high and they are people who use other people to go and get drugs and they resell them for whatever amount of dollars and this is their livelihood.

Q. When you say they use other people, you're saying non-mental patients use the mental patients to get their drug allotment and then take it from them or buy it from them as a source?

A. Mr. Y: From my experience it's a situation where a guy, say he's fairly decent looking, and he pick some girls, particularly if they come out of mental institutions, and he uses them as prostitutes. They get pills. He gives them enough to maintain their being docile and to be able to be used and the remainder he just sells and continues to send them back to the hospitals and to doctors who give them prescriptions. Especially because she has a background in mental illness and they're aware of it and they can prove it and they set up a string of doctors and just keep on going and getting prescriptions. A woman I knew supplied enough pills to open a drug store of her own.

Q. When you say they have a string of doctors writing prescriptions, would a patient have more than one doctor prescribing to them?

A. Mr. Y: Yes sir.

Q. Do you think those doctors know about each other?

A. Mr. Y: Whether they knew about each other or not I can't say. But I do know that anytime a doctor sees one patient uses a months supply of pills in two or three weeks he gots to know something is wrong.

A. Mr. R: I've know dudes who have had experience with them selling pills. What they would do is recommend you or me to go to the doctor and act nervous, gittery, and tell him you're gonna do something, that you're gonna hurt somebody and tell him that you need something to calm you down and its just that simple. You go to him and he writes out your prescription, says to come back in a month and I recommend you to him and you recommend this brother to him and you know its a cycle.

A. Mr. Y: It goes on in many different forms. I know one particular person his speciality is picking up fat women because you can get ups, amphetamines, to diet with and they sell for quite a bit of money. I mean, this guy he just get a fat woman to go out with because he knows he can send her around to different doctors to get these diet pills and that's his scam.

There is an emerging picture of the SRO which reveals the probability that operators receive two or more rentals for the same rooms simultaneously. For example, a tenant lives in a particular room, which is also "rented" as an address for someone who doesn't reside there (but pays for the address - see IV above). In addition, testimony has shown that the room can produce a third "rent" for short term use.

Q. Do some hotels cater to people who use drugs for that reason?

A. Mr. X: Most of the hotels with welfare recipients that welfare send the people to is where you find the groups that exploit these people. This is what they're looking for because they know how easy it is to exploit them by pushing. Naturally, the hotel manager knows because they are sent directly to him. I can't say actually the hotel manager, I don't know where the

responsibility lies but I do know we all feed into the hotel. Wherever it goes from there I don't know. Yes, there's money involved as far as he's concerned but I don't put it in his hand, you don't put it in his hand you give it to some people that you have confidence in that it will get to the right person.

Q. But he never throws you out?

A. Mr. X: No, he wants you to take the cash out, you come in and you walk in and out of the place. Often times I had a little room where I cut my stuff up and I didn't pay no room. I'm telling you in and out I'm working because he's already taken care of that as far as drug pushers are concerned.

A. Mr. X: You don't give directly to him, he's got people in the hotel, he's got different squads around him, he's got loan shark, he's got people that you can talk to. I walk up to this strange hotel I haven't been in before. If I got the bag I'll find out the easiest way to see if they got room for me to put another bag in and I'll catch one of the guys who seems to be standing around the office a lot, I don't know if he's with the loan sharks or whoever, the idea is I'm trying to get to know somebody, I'm hustling now. How easy it is to get an in, who I have to see.

Q. Mr. Y: It's like renting a store?

A. Mr. X: Right, because the drugs bring about money in his picket for the drug users, the junkies in the hotel that's generally what's there.

SRO Managers are able to increase the income from a room by renting it to more than one tenant.

A. Mr. Y: I have the experience of being sent to a hotel, on 39th Street, I believe it was, and I went away for a weekend. When I came back to the room, there was someone else in the room occupying the bed. I went downstairs to the management and I said, "What the hell is this, you're renting this room to me, I've got a receipt and I've paid X amount of dollars for this room and somebody else is in there". Well, the manager proceeds to tell me that he was sorry there was somebody in the room, that the guy on the desk didn't know it

was already rented and I said "Bullshit, you know, I've got the key". He says, we're gonna move this guy to another room. Hey, he asks, somebody says, no they're not home. They put him in someone else's room for the same amount of rent he paid for the room that I already paid for and this is going on throughout the hotel. I left when I found out that it was a hotel where there was a great deal of prostitution going on and the people on the desk have a duplicate key. Anybody who goes out for an hour, a prostitute going to turn a quick trick, like and somebody comes back to dirty sheets. This is, like, a practice that goes on you know, widespread.

Laurence A. Klein, Director, New York City Mayor's Office of Single Room Occupancy Housing, a listing of City agencies servicing the SRO population.

The following is a description of the Mayor's Office of Single Room Occupancy Housing, including general background information, specific programs and referral sources.

BACKGROUND INFORMATION

The SRO population includes elderly; physically, emotionally or mentally handicapped; ex-offenders; and those with problems of drug addiction and alcoholism. Many of the SRO residents are vulnerable and helpless in an atmosphere which may include sub-standard living conditions, drug dealing, prostitution and criminal activity. They are unable to reach out individually for the services they require, and are also generally unable to organize as a group to improve their living conditions, or even advocate on their own behalf for the social service entitlements and legal protections they are due.

The areas of New York City with the greatest concentrations of SROs are the Upper West Side, Times Square, East Midtown (20's to 40's), the Bowery, Harlem, Downtown Brooklyn and Greenwich Village. The high concentration of problem populations in these neighborhoods has resulted in deteriorated and unsafe living conditions which have led to a reduction in viable housing stock. In addition, the bizarre or dangerous behavior exhibited by some SRO tenants threatens both community residents and the vulnerable population within the SROs. In these neighborhoods, it has become difficult for the stable community to co-exist with the SRO problem.

This situation has been greatly compounded in recent months by the conversion of more and more SRO buildings through J-51 tax abatements. After the emotional upheaval of forced relocations, SRO tenants usually end up paying higher rents for generally poorer living

conditions they encounter in new quarters. Relocations are usually made to less desirable areas which already have a high concentration of SRO problems, and both the SRO tenants and the surrounding community suffer as a result.

THE MAYOR'S OFFICE OF SRO HOUSING

The Mayor's Office of SRO Housing with only a Director, Administrative Assistant and Secretary, coordinates, monitors and evaluates the work of all City agencies providing health care, housing maintenance and social services in SRO facilities, and maintains cooperative relationships with private and voluntary agencies also working in the field. The activities of the Mayor's Office of SRO Housing include:

- developing coordinated and effective programs of service delivery in areas of medical and mental health, tenants' legal rights, housing maintenance, social services, and the specific problems of the aging, the ex-offender and the substance abuser.
- determining housing planning policy for SROs and alternative residences which will recognize both the needs of the tenants in SROs and the members of the communities in which they are located.
- providing advocacy for tenants in order to implement appropriate legislation, increase funding, improve service delivery and obtain acceptance and support from the community at large.
- serving in an informational and educational capacity to tenants, public and private service providers, funding agencies, legislators and the community.
- providing limited individual casework and referral service to SRO residents.
- participating in the SRO Service Providers Consortium, an organization composed of public, private and voluntary agencies providing services to SRO tenants.
- conducting inspections of SRO facilities.

RELATED CITY AGENCIES

The Mayor's Office of SRO Housing works closely with Crisis Intervention Services of the Human Resources Administration. The following two units at Crisis Intervention Services work directly with the SRO population:

- The Special Housing Services Unit provides on-site services in thirteen hotels. To the residents of these buildings, the unit provides direct service in the areas of counseling, housing improvement, systems negotiation, nutrition, recreation and advocacy. Referrals, when necessary, are made to various health and social service agencies. The unit also works in close conjunction with neighborhood organizations and other provider agencies to bring a wider range of services to each site.

- The Crisis and Assessment Unit makes social assessments of all lower priced hotels and many SROs and rooming houses, examining social conditions within the structures and their impact on the community. This unit also attempts to provide crisis intervention services to all Public Assistance and Supplemental Security Income clients living in SRO facilities throughout the city, but is necessarily limited in this capacity by the constraints of time and manpower.

The Mayor's Office of SRO Housing also works closely with the following divisions of Housing Preservation and Development:

- The Department of Rent and Housing Maintenance, at the request of the Mayor's Office, conducts complete cellar-to-roof inspections of SRO facilities, and where necessary participates in Interagency inspections which include the Police, Building, Health and Fire Departments and the Crisis and Assessment Unit.

- The Office of Evaluation and Compliance accepts referrals of problem buildings in an attempt to obtain voluntary compliance with housing codes and correction of violations.

- The Housing Litigation Bureau begins legal action against owners/lessees of buildings when attempts at voluntary compliance fail.

- The Office of Rent Control advises rent controlled tenants of their rights, and processes complaints regarding harassment, lack of services and overcharge.

REFERRAL SOURCES

HOUSING MAINTENANCE

Department of Rent and Housing Maintenance
Fire Deprtment
Buildings Department
Health Department
Sanitation Department

REGULATORY AGENCIES

Metropolitan Hotel Stabilization Association
Conciliation and Appeals Board
Office of Rent Control-HPD

TENANT ADVOCACY AND COUNSELING GROUPS

Metropolitan Council on Housing
West Side Tenants Union
West Side Crisis Unit
Jewish Guild for the Blind
West Side Legislative Center

LEGAL ASSISTANCE

MFY Legal Services
Metropolitan Council on Housing

EX- OFFENDERS

Project Greenhope
Project Refound

Pre-Release/Community Resource Services-N.Y.S. Department of Corrections
Aftercare Department-N.Y.C. Department of Corrections

ADDICTION AND ALCOHOLISM PROBLEMS

Beth Israel Hosptal
Smithers Alcoholism Center-The Roosevelt Hospital
Manhattan Bowery Project
STEP I, STEP II
St. Vincent's Hospital
Washington Heights-Inwood-West Harlem Community Mental Helth Center

MEDICAL AND MENTAL HEALTH SERVICES

The Roosevelt Hospital
St. Vincent's Hospital
St. Luke's Hospital
William F. Ryan Health Center
Kingsboro Psychiatric Center
South Beach Psychiatric Center
NYU-Bellevue Medical Center
Fountain House
The Bridge
Washington Heights-Inwood-West Harlem Community Mental Health Center

SOCIAL SERVICES

Crisis Intervention Services, HRA
Emergency Assistance Unit, HRA
Income Maintenance Centers, HRA
Adult Services Division, HRA
Food Stamp Centers, HRA
Social Security Administration
Veteran's Administration
Mayor's Office for the Handicapped

SERVICES FOR THE ELDERLY

Department for the Aging
Social Security Administration
Senior Citizens Rent Increase Exemption Program
Meals-on-Wheels Services
Half-Fare Transportation Program
Senior Centers
Murray Hill SRO Project for Older People
Heights and Hill Community Council
West Side Ecumenical Ministry to the Elderly
Encore at St. Malachy's Church
New York Service Program for Older People
Mobile Geriatric Team
Project FIND
Project Pilot I and II
FISH
JASA

Appendix III

Charles W. William Psychiatric Social Worker/Coordinator, Proposed Liaison Services between Washington Heights West Harlem Community Mental Health Center and Manhattan State Psychiatric Hospital.

Once a week a worker from Washington Heights West Harlem Community Mental Health Center could travel to Meyer Manhattan State Hospital to confer with team leaders there, concerning psychiatric in-patients whose home addresses are in our catchment area. Most of these patients will require after-care service at WHCMHC when they are discharged from Manhattan State. Others may have to go to Health Related Facilities, DIPHA homes, (Division of Institutional Proprietary Home for the Aged) Forster Homes for Adults, Nursing Homes or Halfway Houses. The liaison worker would have input with team leaders and social workers and others to determine which patients are appropriate for such facilities and which should return to their homes in the community.

For those returning to the community, cases will be discussed, anticipated date of discharge will be established, and a referral statement will be devised by Manhattan State indicating patient identity, chief problem, psychosocial background, diagnosis, and recommendations. When the patient is to be actually discharged the worker at WHCMHC will be contacted and will confirm with the worker at Manhattan State the appointment date for screening at CMHC. If the patient is already known to WHCMHC and has a worker, that worker will be alerted by the liaison worker so as to avoid conflicting appointment schedules.

The purpose of a liaison affiliation is to foster more continuity of service, to monitor patient progress, and to avoid patient decompensation and rehospitalization. Without this liaison worker, often times the patient is discharged and the community mental health center is unaware. The patient then returns to the community without an adequate follow-up plan and service. He may have received a two

week (or one week) supply of medication and when that runs out - leaving him/her without either chemo - or psycho-therapy - he may begin to experience renewed stress and the cycle of hospitalization - discharge - hospitalization (the revolving door) begins anew, at an exorbitant financial cost to the state and an inordinate human cost to the patient.

In the case meetings at Manhattan State between liaison worker and team leaders, psychiatrists, psychologists and social workers of Manhattan State, clinical dynamics can be shared and considered in making an appraisal as to when a patient should be discharged. With this inter-disciplinary/interorganizational approach the decision for discharge is a more informed one and indeed, a more pragmatic one.

I have mentioned once a week meetings because of staff limitations, but ideally this could happen at least twice a week. This would be conducive to a more viable, on-going monitoring of patient care and needs, with the patient's optimum well-being as a core consideration.

Charles E. Williams, A.C.S.W.
Psychiatric Social Worker/Coordinator

CEW/gw

APPENDIX #3

Charles W. William, Psychiatric Social Worker/Coordinator, Proposed Liaison Services Between Washington Heights West Harlem Community Mental Health Center and Manhattan State Psychiatric Hospital.

APPENDIX IV

Deputy Inspector William Conroy, Commanding Officer, 24th Precinct, SRO Crime Statistics, Upper West Side of Manhattan

As the Commanding Officer of the 24th Precinct, I have the duty of providing the service to approximately 100,000 people who reside in the area of West 86th Street to West 110th Street to the Hudson River and Central Park.

In 1978, 200 police officers were then assigned to the 24th Precinct, answered 41,000 calls for emergency assistance. They investigated 1,300 robberies. They gave first aid to and called ambulances for 4,000 people who were sick and injured and performed a multitude of other duties to improve quality of life in this neighborhood.

In the same area, there are forty-one SRO, single room occupancy hotels and rooming houses where approximately 7,000 people reside. Twenty-nine of these buildings are concentrated in the area of 93rd Street to 103rd Street from Riverside Drive to Broadway. On West 94th Street, West 95th Street, there are nine SROs alone and they house over 1,100 persons.

And I do not mean to infer that living in an SRO is a blanket indictment of any particular class of people. Many of these are poor, others are being housed temporarily awaiting housing after losing their homes to fire or other tragedy.

The ones causing my problem, the police problems, are the released mental patients, the drug addicts, alcoholics, ex-convicts and others who are unable to cope with life.

Of the 732 robberies committed inside the buildings last year, one-third of them for 244 were committed in an SRO.

You have to understand these 732 robberies were committed by residents of the SROs on the other weaker or sicker or elderly residents of these areas. Forty percent of the 1,200 outstanding warrants that I received last year were from SRO residents.

There were 446 reported crimes in the forty-one SROs in this precinct so far this year, which I believe is only the tip of the iceberg.

As some of the other speakers indicated, the alcoholic women that are residing there, they don't report the rapes, the wino who is beaten up, his wine stolen doesn't report the assault, the robbery. The man who has a door kicked in and his few possessions stolen, he doesn't even report the burglary.

What I am saying, the statistics indicate a very large amount of crimes being committed in the SROs. I don't think it is actually reported, what is actually happening inside there.

The other impact that Iwould have to indicate, the things I have had to do is to institute special patrols on Broadway because of the disorderly SROs. I have to institute a prostitute detail for those who live in SROs.

Last week the Narcotics Unit arrested a person selling marijuana to ten-year-olds. They had day-to-day walked fifteen blocks from the school on the lunch hour because they knew they could always get grass at Hudson Mall on West 92nd Street. These are kids from the private school on 72nd Street because they knew grass was being sold, we knew it also and made the arrest.

I would estimate that the impact of the SROs is at least thirty-five percent of the radio ones, I am saying one-third of the police

manpower of the 24th Precinct is directed at or in the vicinity of the SRO hotels.

Eighteen percent of the total arrests that we have made in the precinct last year, that was at or close to 3,300 arrested, almost 600 or eighteen percent of these people resided in the SRO hotels in this area.

What I am saying is that a small segment of the population of the 24th Precinct is receiving a disproportionate amount of police service provided to the detriment of the variety of people that live and work in this precinct.