To the Graduate Council:

I am submitting herewith a thesis written by Martin S. Jacobs entitled "Neighborhood Revitalization and the Development of Knoxville Neighborhood Housing Services, Inc." I recommend that it be accepted for the degree of Master of Science in Planning.

Judith Stoloff, Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:

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NEIGHBORHOOD REVITALIZATION AND THE DEVELOPMENT OF KNOXVILLE NEIGHBORHOOD HOUSING SERVICES, INC.

A Thesis

Presented for the

Master of Science

Degree

The University of Tennessee, Knoxville

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ABSTRACT

America's cities are facing a serious problem. The neighborhoods, one of the building blocks of our cities, are in various stages of decline. Throughout the years a variety of methods, at both the Federal and local levels, have been attempted to stem the decline of these older, urban neighborhoods. Urban renewal, Model Cities, and the current Community Development Block Grant Program have all tried to deal with the problem of neighborhood revitalization. In recent years local governments, with Federal funding, have been developing neighborhood revitalization efforts. These programs often involve a partnership of the public and private sector.

The partnership approach is the cornerstone of one such neighborhood revitalization program, Neighborhood Housing Services, Inc. Begun in Pittsburgh in 1968 the program is now operated by the Neighborhood Reinvestment Corporation, a public, nonprofit, tax-exempt corporation with direct funding from Congressional appropriations. There are currently more than seventy programs in operation with 10-15 more in the developmental stage.

It is the developmental stage which is very important in the long run of an NHS program. A great deal of time is spent forming and developing a partnership of local residents, local government, and representatives of lending institutions. Through a series of meetings and workshops often lasting twelve months or more, the Neighborhood

Reinvestment Corporation assembles a local nonprofit corporation armed to combat neighborhood decline.

The developmental process stresses communication, cooperation, and commitment. Its function is to build a base upon which a neighborhood rehabilitation program can stand and operate. The program is predicated upon the involvement of the three partners in stemming neighborhood decline.

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CHAPTER I

INTRODUCTION

Urban America is facing a serious problem. Many of the building blocks of our cities, the neighborhoods, especially the older inner-city neighborhoods, are in various stages of decline. To stem this decline and prevent further deterioration of our housing stock, something must be done.

> Numerous housing programs have been introduced with the objective of revitalizing deteriorating city neighborhoods. After years of urban renewal projects that razed existing housing stock and displaced residents, the problem is being approached from a different perspective.[1]

Often one of the major obstacles to neighborhood revitalization is the absence of a coordinated effort by the government, financial institutions, and neighborhood residents. All too frequently neighborhood revitalization programs, even some successful ones, proceed with only one of these groups taking an active role. The other actors are relegated to minor roles. Most often it has been the neighborhood residents that have been left out of the revitalization programs, but the past decade has exhibited marked change in this area.

> Organized neighborhoods are becoming a major focus of the national urban policy debate. In cities across the nation, people representing a wide variety of incomes and ethnic and racial compositions are organizing to struggle against severe social, physical and economic problems related to neighborhood

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[1]Mary B. Stupnik, "Neighborhood Housing Services: An Approach to Urban Renewal," Economic Commentary, May 2, 1977, p. 2.

> deterioration. In many cases they are struggling simply to maintain their neighborhood's vitality. Neighborhood residents are learning the need for comprehensive programs which deal with both the cause of the problem in the neighborhood and its relationship with external institutions and forces which affect the neighborhood. Politicians, policy makers and public officials are now recognizing that the neighborhood is the basic building block of a city, that survival of both neighborhoods and cities is interdependent.[2]

In recognition of this realization of the importance of maintaining the viability of our neighborhoods there has been recent emphasis on the partnership approach toward neighborhood revitalization.

> What is essential to neighborhood preservation and revitalization is involvement and cooperation among those who live in the neighborhood and others whose activities impinge importantly on the upkeep and improvement decisions these residents make.[3]

The partnership approach has been attempted before, notably in Hartford, Connecticut, and Baltimore, Maryland, and is now receiving widespread support from all areas as a means of stemming decline in inner-city neighborhoods.

> Neighborhood revitalization means the coordination and channeling of public, private and community resources into neighborhoods experiencing or threatened by decline. Financial investment is crucial for successful revitalization, but past lessons show that simply more money does not guarantee healthy neighborhoods. City resources for overall improvements and service delivery are also necessary, and what binds these efforts together, supports them and provides additional activity as well, is the commitment and organization of neighborhood residents.[4]

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[2]Jerold S. Nachison, "Neighborhood Development—The Urban Future," HUD Challenge, March 1978, p. 12.

[3]Carol Braddock and Alan R. Winger, "Neighborhood Housing Services," Quarterly Review, First Quarter, 1976, p. 2.

[4]Karen Kollias, "Neighborhood Revitalization: An Overview," HUD Challenge, March 1978, p. 2.

The cooperation and interaction of these three actors—city government, neighborhood leaders and representatives of the private sector—constitutes a partnership.

A major attempt at the partnership approach which has been receiving enthusiastic support, and recently statutory standing through the Neighborhood Reinvestment Corporation Act, is Neighborhood Housing Services. The program was originated in the Central North Side neighborhood of Pittsburgh, Pennsylvania, in 1968.

> Prior to the formal organization of Neighborhood Housing services, Mrs. Dorothy Richardson, a neighborhood resident, spearheaded a group of citizens under the name of CASH (Citizens Against Slum Housing). It was their desire to save their neighborhood and improve the quality of life. They met with local government and lending institutions to develop a plan, which marked the beginning of the partnership between neighborhood residents, local government and lenders. Financial institutions, who were initially wary of lending in the area, agreed to try it. (The city agreed to provide the code enforcement program and give attention to public services as needed.) A high-risk revolving loan fund was established with a $125,000 grant from the Sarah Mellon-Sciafe Foundation to help all residents in the area who were unable to qualify for loans at local lending institutions. To tie together these elements—the city's contribution, the lenders' involvement, and the citizens' access to help—a staff was hired.[5]

The program was originally implemented on the national level by the Urban Reinvestment Task Force, a partnership between the Federal Home Loan Bank Board and the Department of Housing and Urban Development. Neighborhood Housing Services is now a product of the Neighborhood Reinvestment Corporation, a public, nonprofit, tax exempt corporation with direct funding from Congressional appropriations. Congress decided

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[5]Braddock and Winger, p. 3.

that the Neighborhood Housing Services program of the Urban Reinvestment Task Force had proven itself as a successful vehicle for revitalizing older urban neighborhoods through the involvement of public, private and community resources at the neighborhood level. The Senate Committee on Banking, Housing and Urban Affairs issued a report commenting on the work of the Task Force.

> There is no doubt that the NHS program has been a remarkable success. Far beyond the number of loans that have been provided by each high risk revolving loan fund, each local NHS seems to engender confidence that declining neighborhoods can be turned around.[6]

Further, Congress has found that the demand and interest in numerous cities throughout the United States warranted the creation of a public corporation to institutionalize the Neighborhood Housing Services program and other programs of the Urban Reinvestment Task Force.

Although Neighborhood Housing Services has yet to prove itself conclusively as a successful vehicle for stemming neighborhood decline, much promise can be seen. This can be attributed to the fact that NHS focuses on the crux of the problem of neighborhood decline.

> The long run viability of a neighborhood depends upon the desire of residents to remain and the willingness of financial institutions to make mortgage and home improvement loans in the area. Without these two conditions, it is almost impossible for government to succeed in upgrading the neighborhood housing market and encouraging private investment over the longer term.[7]

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[6] Urban Reinvestment Task Force Annual Report, 1977, p. 10.

[7] Paul S. Ahlbrandt and Paul C. Brophy, "Neighborhood Housing Services: A Unique Formula Proves Itself in Turning Around Declining Neighborhoods," HUD Challenge, January 1976, p. 36.

These conditions, plus the addition of meaningful community involvement, separate a successful Neighborhood Housing Services program from less successful governmental attempts at neighborhood revitalization.

Neighborhood Housing Services describes itself as a program comprised of the following characteristics. NHS is a local program. While this aspect of NHS might undergo some changes due to the changing of the Urban Reinvestment Task Force to the Neighborhood Reinvestment Corporation, experience has shown this feature to raise the level of trust and confidence of the participants.

NHS is not a give-away program. None of the partnership groups are asked to compromise any self interests such as sound underwriting of loans by financial institutions, reasonable public improvements by local government, or community advocacy on the part of the neighborhood residents. Also, all loans, even those from the high risk revolving loan fund, are made with the prospect of repayment.

NHS targets specific neighborhoods. These neighborhoods are carefully selected by members of the three partnership groups following basic guidelines. (Much greater detail will be given to this process of neighborhood selection in Chapter III.)

A final important feature of Neighborhood Housing Services is the use of code enforcement. A flexible, sensitive code enforcement program is crucial, causing citizens to invest in housing rehabilitation when otherwise the motivation might not be present. The key here is flexibility, allowing people adequate and reasonable time to respond, and making available home improvement loans that would not cause personal financial burdens.

There are presently about seventy Neighborhood Housing Services programs in operation throughout the United States with a dozen or so more in the developmental stage. It is this developmental stage which is so crucial to the effective operation of NHS programs. The thorough background work throughout the development process and the careful scrutiny given each applicant has resulted in a large number of programs being made operational in a relatively short period of time. A thorough description of the Neighborhood Housing Services program will be found in both the literature search (Chapter II) and in the case study (Chapter III) of the Knoxville experience.

Problem Statement

Census Bureau data from 1970 show that growth in older metropolitan areas of our country is slowing, and in many older inner-city areas the population is actually dropping. This trend is exemplified by the decline and fall of some inner-city neighborhoods. Increasing concern has been exhibited by government officials, lenders, realtors, planners and neighborhood residents to reverse this trend. All have a real stake in the continued viability of our urban neighborhoods. Much time, effort and thought has been devoted to develop alternatives and solutions to this crucial problem facing our urban centers. An alternative that seems to be attacting greater attention and wider credence is the process of neighborhood revitalization, rehabilitation or conservation. Planning literature and activity throughout the past few years has brought to light this importance of neighborhoods and neighborhood revitalization. Planners have developed a keener interest and higher priority for

maintaining neighborhood stability. Accompanying this growing interest is an increasing body of literature documenting and analyzing the creation, implementation and evaluation of various neighborhood revitalization efforts throughout the United States. These include government sponsored attempts and also efforts by the private sector and those by neighborhood residents themselves.

> Viewed against the broader perspective of changing settlement patterns, neighborhood conservation emerges as one of several new responses to shifts in demographics, economics, resource constraints, social trends, personal aspirations and psychological needs.[8]

One such program of neighborhood conservation, Neighborhood Housing Services, is the subject of this thesis.

The purpose of the thesis is to investigate the development of a particular Neighborhood Housing Services program. The study will examine the developmental process from Knoxville's earliest interest in obtaining and establishing a Neighborhood Housing Services program through the election of a Board of Directors, thus completing the developmental process. The study will examine the developmental process from Knoxville's earliest interest in obtaining and establishing a Neighborhood Housing Services program through Workshop V, the final workshop.

> The last workshop occurs after the neighborhood has been selected, the structure of the corporation agreed upon, and operating funds raised. The last workshop is the first

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[8]Phyllis Myers and Gordon Binder, Neighborhood Conservation: Lessons from Three Cities, (Washington, D.C.: The Conservation Foundation), p. 2.

> meeting of the newly formed NHS corporation. The workshop participants become members of the corporation, and, at the meeting, elect a board of directors. This marks the transition from the developmental to the operating phase.[9]

There is a need for a study of this type because of the lack of information in the current literature which focuses on this aspect of Neighborhood Housing Services. HUD provides a short, almost outdated model of an NHS program. All other relevant literature concentrates on operational NHS programs and the role in stemming neighborhood decline. There is very little mention in the literature of the developmental process.

It is the author's contention that this developmental process is of paramount importance to the subsequent operation and effectiveness of a Neighborhood Housing Services program. Thorough preparation is given to developing the partnership approach, a significant characteristic of the program, as well as making sure, through workshops and meetings, that there is an adequate and stable foundation upon which a successful neighborhood revitalization program can be built.

Emphasis will be placed on the organization of the program and the roles of various actors throughout the process. Additional importance will be given to the circumstances that actually transpired, what, if any, benefits were realized by the participants and an analysis of the entire process.

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[9]Action-Housing, Inc., The Neighborhood Housing Services Model: A Progress Assessment of the Related Activities of the Urban Reinvestment Task Force (under HUD contract), p. 35.

Neighborhood Housing Services is touted by many as a successful program aimed at preventing the further decline of selected inner-city neighborhoods. The research will examine the NHS record nationwide and carefully consider the development of one such program in Knoxville. It is hoped that this research will give a better understanding as to why Neighborhood Housing Services has such a reported high level of success compared to other attempts at stemming neighborhood decline and determine the importance of the developmental process in achieving this level of success.

Methodology

The thesis will utilize the case study method as the basic research technique. A literature search will be undertaken to examine the area of neighborhood revitalization. Included in the literature search will be approaches and case studies of neighborhood revitalization efforts, a history of Neighborhood Housing Services supplemented with cases, and a look at citizen participation and organization with respect to neighborhood revitalization.

Also to be used is the participant observation method. Participant observation refers to

> . . . a characteristic blend or combination of methods and techniques that is employed in studying certain types of subject matter: primitive societies, complex organizations, social movements, communities and social groups. This characteristic blend of techniques involves some amount of genuinely social interaction in the field with the subjects of the study, some direct observation of relevant events, some formal and a

> great deal of informal interviewing, some systematic counting and some collection of documents and artifacts.[10]

The degree of participation may vary widely in this type of research. Researchers may take a major participatory role as their vantage point. Conversely, participation may be minimal with the researcher occupying a distant-observer role. The author's choice was to keep participation to a minimum. This vantage point will limit the possibility of influencing or being influenced by the group. The participant observation approach involved the researcher in a majority of group and committee meetings (see Appendix) from NHS's introduction through the election of a Board of Directors. It is hoped that the nature of this observation method will lead to a better understanding of the mechanics and development of a Neighborhood Housing Services program.

A final method of data collection was the use of personal interviews. The interviews were conducted in both a formal and informal manner. The persons interviewed include a broad range of actors involved in the development of the NHS program. Some of those interviewed were involved in Knoxville's application to be considered for a Neighborhood Housing Services program while others have been active participants in the program's organization and development. Additional interviews were conducted with personnel of the Federal Home Loan Bank of Cincinnati and the Neighborhood Reinvestment Corporation.

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[10]George McCall and J. L. Simmons, Issues in Participant Observation, (Reading, Mass.: Addison-Wesley, 1969), p. 1.

The informal interviewing occurred throughout the development process at the various meetings at which the author was present. This informal approach provided an opportunity for the author to obtain the opinions of the participants during all stages of the development process.

The formal interviews were conducted following the conclusion of the development process. This was done to obtain the views of the participants after they had time to reflect upon what had transpired. The interviewees selected for the formal interviews were those persons considered by the author to be key participants in the development process.

Throughout all the interviews all respondents were assured by the author of his confidentiality. For this reason information from these interviews cannot be attributed to an individual. When possible an interview date will be provided.

Much of the information for the interviewing process is presented in Chapter III. In those places where the response from an interview or interviews is the basis for that statement an asterisk (*) will follow. This will hopefully clarify the author's views from those of the participants in the development process.

Interviewees

Gloria Neel, Local Coordinator, Knoxville Neighborhood Housing Services, Inc.

Mike Haviland, Housing Coordinator, Federal Home Loan Bank, Cincinnati

Reynell Parkins, Director, Housing Research and Development Center, The University of Tennessee

Bill Murrah, Fourth and Gill Neighborhood Association

Keith Richardson, Housing Planner, East Tennessee Development District

David Sharp, President, Home Federal Savings and Loan Association

Judy Stoloff, Assistant Professor, Graduate School of Planning, The University of Tennessee

Annette Anderson, Coordinator, East Tennessee Community Design Center

Ray Kuchling, Mid-West Regional Supervisor, Neighborhood Reinvestment Corporation

Carl Eshbaugh, Director, Legal Clinic, The University of Tennessee

John Webber, former Director, Office of Community Development, City of Knoxville

Leslie Cavada, former Housing Rehabilitation Director, City of Knoxville

David Prisock, Director of Housing Rehabilitation, City of Knoxville

CHAPTER II

A REVIEW OF NEIGHBORHOOD REVITALIZATION EFFORTS

This chapter reviews the literature in the area of neighborhood rehabilitation, revitalization and conservation. The research will examine the role of the Federal and local governments in the development and operation of programs aimed at maintaining our declining inner-city neighborhoods. Also included will be a discussion of the importance and extent of citizen participation present in governmental attempts at neighborhood conservation.

Examination of the federal role will focus on the Housing Act of 1949 and subsequent legislation introducing and expanding the concept of urban renewal. Emphasis will also be given to those sections of federal legislation which deal most directly with housing and neighborhood rehabilitation.

The role of local government will be looked at through a series of brief discussions of a variety of attempts by individual communities in dealing with declining and deteriorated residential neighborhoods. A look at an early (1940) and innovative neighborhood conservation program in Baltimore, Maryland, will also be included. A final aspect of local neighborhood conservation programs which will be covered is that of Neighborhood Housing Services. Included will be information regarding the background, operation, and current status of NHS.

Federal Attempts at Neighborhood Rehabilitation

The federal government's involvement in the area of housing and neighborhood conservation began as early as 1892 with a Congressional expenditure of $20,000 to investigate slums of over 200,000 persons. Another early venture of the federal government's involvement in this area includes the Housing Act of 1937.

The United States Housing Act of 1937 was the government's first major step towards the removal of slum housing. Loans and annual contributions to local public housing agencies were provided for the construction of low-rent housing and some slum clearance. The 1937 Act also required the elimination of one slum dwelling for every new unit to be built under the program.

While the Housing Act of 1937 marked the beginning of a new era of federal aid to cities for the improvement of older, rundown neighborhoods, it was not until 1949 that this aid began to reach sizeable proportions. The first major program addressed to the needs of our cities' declining and deteriorated neighborhoods was the Housing Act of 1949. A Congressional study of housing problems and the related problems of slums and blighted areas during and following World War II found that:

> In large measure, the growth and persistence of urban blight has its roots in the inability of private enterprise to rebuild without aid the deteriorating parts of the city's structure and to meet changing needs and functions of urban areas.[1]

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[1]James Q. Wilson, Urban Renewal, (Cambridge, Mass.: The M.I.T. Press), p. 191.

Two major obstacles were found to prevent private development from succeeding. First, the developer must cope with the problem of assembling many parcels of land under diverse ownerships to create one tract large enough for his project. Failure to get all of the desired parcels may result in loss of time and higher development costs. The developer must also be prepared to withstand the effects of adjacent blight.

The second obstacle to private redevelopment efforts is high land acquisition costs.

> The acquisition costs to a private developer would often reflect inflated, speculative values. They would also include the costs of existing structures which, though deteriorating and obsolete, do have economic value that becomes a significant item of cost when they are demolished to make way for new buildings.[2]

The Housing Act of 1949 developed remedies aimed at overcoming these two obstacles preventing the participation of private developers in urban redevelopment. These remedies became a major part of the concepts found in Title I of the 1949 legislation.

> Under the procedures established by Title I, a community acquires and assembles properties in a blighted area, using its power of eminent domain where necessary. The procedure also requires the local and federal governments to pay the net costs of urban renewal, which is the difference between the cost of acquiring and clearing slum properties and the income received when the land is sold or leased for public and private redevelopment.[3]

Title I and the Housing Act of 1949 exhibited the high level of national importance given to the clearance and redevelopment of the slum

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[2]Ibid.

[3]Ibid.

areas of our cities. It further recognized that the participation of the private sector was crucial, but that private enterprise would fail to become an active, involved partner without public aid. Public power and public monies would be necessary, not only to ensure the participation of private enterprise, but to augment its work as well. This marked the beginning of public-private cooperation in urban redevelopment programs. This partnership, although greatly modified, is still the basis for a great many neighborhood rehabilitation programs.

The legislation of 1949 contained elements of what came to be known as urban renewal. While much legislation was introduced in the following years, amending and modifying the slum clearance program of 1949, the goals, roles of the actors, and the basic process and operation have their roots in the Housing Act of 1949. There was a basic change about to take place.

> A 1953 evaluation of the program found that the cost of demolishing and rebuilding the country's slums was so high that available resources were insufficient to permit renewal of the nation's cities in this fashion. In addition, the extensive relocation made necessary by total clearance projects had created major social and logistic problems, arousing substantial opposition to the federal program.[4]

By accepting the recommendations of the President's Advisory Committee on Government Housing Policies and Programs, Congress changed the focus of Title I of the Housing Act of 1949 from slum clearance to urban renewal. Maintenance and conservation of the existing housing stock was given increased priority.

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[4]"Citizen Participation in Urban Renewal," Columbia Law Review, March 1966, p. 490.

In response to this new emphasis on rehabilitation of existing housing, new FHA programs were introduced. There were new forms of FHA assistance for rehabilitation and the construction of new housing in urban renewal areas. Federal demonstration grants were made available to test and report on these new techniques. It was also hoped that these demonstration grants would encourage residents to begin considering rehabilitation on their own.

Another pertinent modification was the termination of the original requirement that the redevelopment project be predominantly residential. Urban renewal projects could now use 10 percent of the federal grant funds for nonresidential development. This was later increased to 20 percent in 1959 and again to 30 percent in 1961. This increase in the allowance of nonresidential development reflected a growing propensity of municipalities to use urban renewal as a means of increasing the city's tax base. It also marked the point where urban renewal began to branch into two directions, one aimed at the revitalization of downtowns and another aimed at rehabilitating older residential neighborhoods.

> Those who initiated the slum clearance program emphasized improving the central city tax base by attracting middle-class families and business back from the suburbs. They also emphasized improving the face of the central city through construction of public buildings, commercial centers, centers for arts, and even sports stadia. Another quite different objective, of urban redevelopment—improving slum conditions and providing better housing for the poor—was given less emphasis and sometimes forgotten during the early years of the program administration.[5]

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[5]M. Carter McFarland, Federal Government and Urban Problems, (Boulder, Colo.: Westview Press), p. 77.

Numerous federal programs emphasizing inner city residential rehabilitation were introduced in the years following passage of the Housing Act of 1954. They were a result of, and in response to, a constantly changing approach towards dealing with urban blight. There was an increasing realization that "vast areas of our cities are marked by blight and deterioration that was still susceptible to corrective action short of wholesale clearance."[6] This opportunity for residential rehabilitation was, and still is, present in practically every city in the United States. Housing which is basically sound in structure can be made to endure many more years through proper maintenance and treatment. It is this segment of our housing stock which forms the greatest resource of low and middle income housing.

In 1961 with President Kennedy's appointment of Robert Weaver as head of the Housing and Home Finance Administration (HHFA) the urban renewal program placed more reliance on rehabilitation and less dependence on the bulldozer and clearance. Clearance was primarily used for industrial and commercial sites rather than in residential neighborhoods.

The popularization of residential rehabilitation can be seen as occurring in four stages. The first stage took place in the early 1960's. The Urban Renewal Administration and the FHA jointly undertook several experimental programs designed to overcome the obstacles to neighborhood rehabilitation. These experiments resulted in modification or urban renewal administration policies and FHA guidelines. A major consequence of the experiments was the provision

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[6]Wilson, p. 214.

of below-market interest rate loans and rehabilitation grants. Prior to this action, rehabilitation financing through FHA was available only at full market interest rates.

The second stage, in the mid-1960's, dealt with the problem of absentee ownership. The FHA initiated experiments aimed at bringing about the rehabilitation of absentee owned rental properties in declining neighborhoods. The outcome of the experiments was mixed; some succeeded while others failed, but a better understanding of the obstacles to residential rehabilitation was realized.

The third stage occurred in 1969 with the advent of Project Rehab. Project Rehab was an effort to encourage large scale rehabilitation of absentee-owned properties. Through 1972 about 20,000 units had been rehabilitated in about two dozen cities. The Department of Housing and Urban Development was satisfied with the results and concluded that Project Rehab had proved that massive rehabilitation was possible. Long-term results of the program, however, had proved less successful. This points out an important facet of neighborhood rehabilitation.

> The success of residential rehabilitation depends not only on the number of units completed but also on the long term improvement of the housing, the living conditions of the people affected, and conditions in the neighborhood.[7]

Another important federal project in this stage was the Neighborhood Development Program (NDP). NDP modified the urban renewal program to allow a speedier and more flexible execution of urban renewal plans within particular neighborhoods. This permitted communities to proceed

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[7]McFarland, p. 81.

with the renewal of individual neighborhoods (contiguous or otherwise) which needed urgent action, while at the same time planning for the total redevelopment of the area. NDP provided $2.8 billion in funding for 430 communities prior to being superseded by the CDBG program.[8]

The fourth stage is now in progress in the many cities using Community Development Block Grant (CDBG) funds for rehabilitation. A variety of financing techniques and approaches are being used. Two other approaches which have gained increased HUD support as part of neighborhood rehabilitation programs are urban homesteading and increased participation of neighborhood residents.

Two notably successful residential rehabilitation programs during the urban renewal program took place in Boston, Massachusetts, and New Haven, Connecticut. While neither of these programs were typical of urban renewal activities, they did exhibit what could be accomplished.

> In medium-sized New Haven, the Wooster Square project of the 1960's managed to renew the housing stock, provide new public facilities and services, and build a stable, socially mixed community out of historic and new structures. In other words, it successfully achieved conservation through renewal. But will such a renewal approach travel? At Wooster Square, there were ample renewal funds, creative design approaches, a high proportion of homeowners, and a politically savvy and committee mayor and redevelopment agency director. The effort was concentrated on a single district. In other New Haven districts, where activities were less focused, where the ratio of absentee landlords was higher, and where opposition to the alleged paternalism of the redevelopment agency began to emerge, the renewal approach fared less well.[9]

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[8]U. S. Department of Housing and Urban Development, HUD Program Catalog, 1977 (Washington, D.C.: U. S. Government Printing Office), p. 8.

[9]Robert H. McNulty and Stephen A. Klimont, Neighborhood Conservation, (New York: Whitney Library of Design), p. 64.

In Boston, the Boston Rehabilitation Program (BURP) emerged as a response to HUD's increasing dependence on rehabilitation as a means of revitalizing urban neighborhoods. The FHA 221 (d) (3) program of moderate income residential rehabilitation had yet to make a significant impact and officials wanted to develop a successful rehabilitation program.

In BURP clustering of residential projects was used to reduce expenses. This clustering was done with more flexibility than had previously been allowed. In addition, BURP concentrated on speedy processing techniques and short construction periods. This dealt directly with two widespread problems of urban renewal, huge amounts of red tape and long periods before construction was completed.

> The tools of urban renewal worked as limited, physical tools for conserving neighborhoods. They could not be expected to solve major economic and social problems—declining employment, crime, lagging quality of public schools. Moreover, renewal activity always tended to come off better in commercial rather than residential districts.[10]

It was recognized early that federal aid in one form or another would be needed to maintain our low and moderate income housing. In addition, the federal government wanted to enlarge the role of the private sector in subsidized housing, and to stimulate activity in homebuilding and related industries. As a response to these goals Section 221 (d) (3) emerged.

> To provide new housing assistance to families of low and moderate income, the Housing Act of 1961 conferred on that general category the special mortgage insurance advantages previously available only to families displaced by urban

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[10] Ibid.

> renewal or other government action (Section 221), and added substantially greater benefits for all low and moderate income families. Subsection (d) (3) was part of the revised 221 which established the new subsidy program for rental housing.[11]

Section 221 (d) (3) introduced an expanded concept of below-market interest rates. Essentially what Section 221 (d) (3) did was to develop a program whereby nonprofit or limited profit sponsors could obtain long term (up to 40 years), low interest rate mortgages (as low as 1 percent) for the rehabilitation or construction of multifamily (5 or more units) rental housing for low or moderate income families. Also 221 (d) (3) housing could not be built unless the city had adopted an official plan of action. Similar to the workable program concept of urban renewal, the plan should deal with the elimination of urban slums and blight and establish and preserve well-organized neighborhoods of decent homes and suitable living environments.

Nearly identical to Section 221 (d) (3) is that of 221 (d) (4). Both programs provide for mortgage insurance to finance multifamily rental housing for low and moderate income families. The basic differences are that HUD may insure 100 percent of a project under Section 221 (d) (3) but only 90 percent under 211 (d) (4). Also, the mortgage limit per unit is less under Section 221 (d) (3).

Section 221 also dealt with rehabilitation and construction of both owner-occupied and rental housing.

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[11] U. S. Department of Housing and Urban Development, Housing in the Seventies Working Papers, (Washington, D.C.: U. S. Government Printing Office), p. 117.

> A part of the new legislation (Section 221 (d) (2)) consisted of special mortgage insurance on very liberal terms for home purchasers, but without provision of overt subsidy.[12]

In this attempt to increase homeownership opportunities for low and moderate income families, HUD would guarantee mortgage loans for the purchase, construction, or rehabilitation of low cost housing.

Through September 1977, the Section 221 (d) (2) program had insured 837,092 units with an insured value of over $11 billion. The Section 221 (d) (3) program has resulted in 1595 projects encompassing 132,858 units with an insured value of nearly $2 billion. The Section 221 (d) (4) program has produced 2331 projects with 281,731 units with an insured value of more than $4.5 billion.[13]

In examining individual housing rehabilitation programs of the federal government this research is more concerned with the nature and scope of each program rather than attempt to judge whether each program is successful or not. The above and other similar figures are provided to show that these were active federal programs aimed at neighborhood rehabilitation.

Another federal program aimed at curing the ills of declining and deteriorating neighborhoods was established by Section 312 of the Housing Act of 1964. It is known as the Section 312 loan program. The Section 312 loan program provides direct loans to finance the rehabilitation of residential, mixed-use, and nonresidential properties. The

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[12] Ibid.

[13] U. S. Department of Housing and Urban Development, Housing in The Seventies Working Papers, (Washington, D.C.: U. S. Government Printing Office), p. 117.

312 program operates in conjunction with other HUD programs. This results in restricting 312 loans to CDBG, Urban Renewal, Urban Homesteading, and Code Enforcement areas.

Under the Section 312 loan program owner-occupants of properties can obtain a loan not exceeding $27,000 per dwelling unit or $50,000 for nonresidential properties at an interest rate of 3 percent for a maximum of 20 years. "By financing rehabilitation to bring the property up to applicable code, project, or plan standards, the loans prevent unnecessary demolition of basically sound structures."[14]

From the program's inception in 1964 through 1977 rehabilitation loan reservations aggregated about $471 million with $85 million in reservation for fiscal year 1977.[15]

The next major federal aid program was the Demonstration Cities and Metropolitan Development Act of 1966. This became known as the Model Cities program. Although many of the principles of the Model Cities program were a natural extension of previous urban aid programs, there was a new twist.

Model Cities attempted to mount a comprehensive attack on social, economic, and physical problems in selected slum and blighted areas.

> Cities were required to use and coordinate existing Federal grant-in-aid programs and State, local, and private resources, and to involve neighborhood residents in planning, monitoring, and evaluating comprehensive five-year plans.[16]

In addition to coordinating financial resources from all levels the Model Cities concept stressed that urban blight could best be dealt with

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[14] Ibid., p. 5. [15] Ibid. [16] Ibid., p. 8.

through a comprehensive program including both physical rehabilitation and improvement of the social service delivery system. This approach increased the scope of activities eligible for funding. Included as eligible activities in the Model Cities program were those for improving educational facilities, combatting disease, reducing crime and delinquency, and providing needed social services.

The strategy of the Model Cities program had five basic ingredients: (1) concentration of all federal resources on a target area; (2) coordination of the complex array of urban aids; (3) mobilization of local leadership; (4) local initiative in molding and implementing its efforts; and (5) experimentation and innovation. In addition, Model Cities expanded previous federal attempts at organizing citizen participation.

Grants were used to cover up to 80 percent of the cost of the planning and development of comprehensive city-wide demonstration projects and 80 percent of the costs to administer such programs.

From its inception in 1966, through passage of the Housing and Community Development Act of 1964 which superseded it, the Model Cities program funded projects in 145 communities. Total expenditure in technical assistance, planning, and operating funds was approximately $2.5 billion.

Perhaps the most notable achievement of the Model Cities program was that it recognized that slums and urban blight were a result of social as well as physical problems and should be treated in such a manner.

The Model Cities program was also responsible for introducing another federal program of below-market interest rate loans. Section 221 (h) of the Demonstration Cities and Metropolitan Development Act of 1966 provided for direct below-market interest rate loans to be made to nonprofit sponsors. The loans are used for the purchase of, or rehabilitation of, low and moderate income housing. The properties are then sold to families with incomes not exceeding 135 percent of the limits required for eligibility for local public housing. The families could then obtain long term (up to 40 years) loans with an interest rate as low as 1 percent. The 221 (h) program was phased out shortly after its introduction and was replaced by the nearly identical Section 235 (j) program of the Housing Act of 1968.

Two other programs provided for under the Housing Act of 1968 are the Section 235 and 236 programs. These programs provided housing assistance to both low and moderate income homeowners and renters.

The Section 235 program is aimed at increasing homeownership opportunities for low and moderate income families. HUD insures mortgages and provides interest subsidies, in the form of monthly payments to lenders, which reduce the interest rate to as low as 1 percent. The homeowner must make a downpayment equal to at least 3 percent of the acquisition price and contribute 20 percent of his adjusted income to monthly mortgage payments. Eligibility is limited to families with incomes not exceeding 135 percent of the limit required

for public housing. Through September 1977, 478,553 units have been insured with a value of about $8.6 billion.[17]

Section 236 of the 1968 Housing Act provided mortgage insurance, interest subsidies, and operating subsidies in an attempt to reduce rents for low-income families. Original HUD participation was limited to insuring mortgages and providing interest subsidies to lenders which allowed the mortgage to be paid off by the project owner at an interest rate as low as 1 percent. The reduction in the interest rate was designed to produce lower monthly rents and increase the available supply of housing for low income families. Later HUD participation was increased to include subsidies which made up the difference between actual operating costs of the project and the revenue produced by the tenants.

Through June 1977, 4217 projects with 460,188 units and an insured value of nearly $8 billion were financed under Section 236.[18]

Another housing or neighborhood strategy program enacted by the federal government is Section 223 (e) of the Housing and Urban Development Act of 1968. Section 223 (e) addresses the problem of housing in older, urban areas.

Section 223 (e) authorizes the FHA to insure mortgages financing the repair and rehabilitation, construction, or purchase of housing in these older, declining urban areas. The program attempts to target areas

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[17] Ibid., p. 17.

[18] Ibid., p. 31.

> . . . where conditions are such that certain normal eligibility requirements for mortgage insurance under a particular program cannot be met. Normal economic soundness and economic life requirements in such areas may be waived, and decisions concerning location eligibility may be based on individual merit and the need for housing low and moderate income families. No property will be rejected for FHA insurance solely on the basis of its being in an older neighborhood.[19]

The most recent major federal program for aid to urban areas is the Community Development Block Grant program of the Housing and Community Development Act of 1974.

> The primary objective of this new program is the development of viable urban communities by providing decent housing, a suitable living environment, and expanded economic opportunities, particularly for persons of low and moderate income. Seven specific objectives include conservation and expansion of the nation's housing stock, and historic preservation.[20]

Although spending priorities are determined at the local level, there are basic guidelines which must be followed. Each community that wants CDBG funds must prepare a program outlining projects and costs, including a housing assistance program.

> In selecting locations for assisted housing, the act requires "furthering the revitalization of the community, including the restoration and rehabilitation of stable neighborhoods to the maximum extent possible." What is more, citizens must participate in deciding program priorities. Thus the cities and their citizens have a flexible resource which can be tailored to meet neighborhood conservation objectives.[21]

Community development block grant funding is based on a formula with population, extent of poverty, and extent of housing overcrowding

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[19] Housing in the Seventies, Working Papers, p. 1172.

[20] McNulty and Klimont, p. 40.

[21] Ibid.

determining the amount of funds available to the local jurisdiction. The CDBG program could now cover 100 percent of the project cost, unlike previous federal programs which required some percentage of local funding.

In the first two years of operation the CDBG program funded projects in more than 18,000 communities. The program has been authorized for three additional years (through fiscal year 1980) with funding of $10.95 billion for the three year period.[22]

Federal programs aimed at neighborhood conservation or rehabilitation have met with less than widespread success. Urban renewal did little for inner city neighborhoods. Through the years the central business district received increased focus in urban renewal programs. Slums and deteriorating residential neighborhoods were often not rehabilitated, they were cleared and relocated.

The Model Cities program provided a more holistic approach to our urban problems but did little to stem the decline of older, inner city neighborhoods. What Model Cities did introduce was an expanded concept of citizen participation. One of the major complaints of previous federal programs had been the lack of participation by impacted persons. Model Cities sought to remedy this problem. Too often, however, minimum guidelines and requirements became the maximum and citizen participation remained at the level of previous programs.

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[22] HUD Program Catalog, 1977, p. 3.

The Community Development Block Grant program is the federal government's latest approach to urban problems. The most significant contribution of the CDBG program is the increased autonomy given local governments. Local governments may now use CDBG funds at their own discretion within broad federal guidelines. The result has been the availability of CDBG funds for more local neighborhood conservation and rehabilitation programs. The local programs have an advantage over federal programs in that they are better equipped to concentrate efforts in a smaller area. This has attempted to improve upon the scattered approach of the federal government.

Bureaucratic red tape resulting in many unnecessary and costly delays, sometimes inadequate and often erratic funding, and a lack of a certain sensitivity have all prevented the federal government from adequately dealing with declining inner-city neighborhoods.

> The preservation focus of the 1960's usually found its initiative in the private sector. As the focus began to shift, it is clear that the complex economic, legal, social, and administrative policies and mechanisms needed to make conservation work, and the growing role of neighborhood groups of all backgrounds applying pressure through their elected representatives, will inevitably move the major responsibility to local government.[23]

Local Attempts at Neighborhood Rehabilitation

Local government, in many communities, has recognized the responsibility to involve itself in the area of neighborhood rehabilitation. In many instances local governments, with financial

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[23]Ibid., p. 57.

support from CDBG funds, have enacted a wide range of programs dealing with this problem. These programs take on different characteristics depending upon the circumstances present in that community.

> In neighborhood preservation, for example, many cities are using intensive code enforcement in residential areas where maintenance is beginning to slip. Others are shoring up confidence in older, stable neighborhoods by resurfacing streets, landscaping boulevards, adding or repairing curbs and gutters, or improving street lighting. Such demonstrations of public commitment generally spur owners to maintain their properties and thus reassure the inhabitants that the neighborhoods have long lives ahead of them. In areas with more serious problems—deferred maintenance and limited discretionary income among property owners—loan and grant programs are necessary when code enforcement is used to prompt rehabilitation, and some spot clearance may be required to generate new investment.[24]

The partnership approach. In many instances local government becomes involved in a partnership with the private sector. These partnerships are developing in response to the realization that although public policy might be well-conceived, the investments and decisions of the private sector ultimately determine the extent to which neighborhood revitalization programs are successful. In nearly all cities, however, comprehensive efforts from neighborhoods up have engendered a new need for close cooperation between public agencies and private business, labor, and civic interests.

With the termination or cut back of federal rehabilitation loan programs a few years ago, many cities began in earnest to develop new, local methods for financing residential rehabilitation programs. Local

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[24]Donald S. Cannon, et al., "Identifying Neighborhoods for Preservation and Renewal," Growth and Change, January 1977, p. 35.

rehabilitation efforts had long been hindered by limited or erratic federal funding, such as the Section 312 loan programs. Many cities developed neighborhood conservation programs using a wide variety of funding sources; city revenues, bonds, conventional loans, and foundation monies.

> Because these local efforts often featured public-private cooperation and more local decision making and control than earlier programs, they held far more promise for neighborhood preservation than federal programs had.[25]

A review of the literature has shown that among the more sophisticated of these local neighborhood conservation programs are those in Pittsburgh, Baltimore, and Seattle. These cities have pioneered numerous innovative partnerships and loan financing schemes aimed at stemming the decline in older inner-city neighborhoods. Some specific programs will be mentioned later in this chapter.

As mentioned, Baltimore has been a leader in the development of local neighborhood conservation programs. It is interesting to note that Baltimore, specifically the Waverly area, was the focus of an innovative conservation program as early as 1940. The program was authorized by the Federal Home Loan Bank Board (FHLBB) in an attempt to discern the major underlying causes of blight in the Waverly area, and to develop a general remedy which could be applied successfully in similar situations throughout the United States. The results of the Waverly study can be found in Waverly: A Study in Neighborhood Conservation by Donald McNeal and Arthur Goodwille.

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[25]Maxine Mitchell, "Municipal Rehabilitation Loan Funds: What Type Works Where?," Journal of Housing, June 1975, p. 280.

The Waverly study holds much interest and relevance because of a number of striking similarities to today's trend in neighborhood conservation and the present Neighborhood Housing Services program. The similarities include basic realizations, goals, operations, and the involvement of lending institutions, specifically the FHLBB.

The Waverly area was not a hopelessly depressed neighborhood. It was basically a sound neighborhood, structurally, economically, and socially, which was being threatened by decline. It was a neighborhood worth saving. The area was comprised mostly of single-family homes with a high percentage of owner-occupants. It was an inner city neighborhood, about two miles from the central business district. These qualities are similar to the criteria used in selecting a neighborhood for participation in an NHS program.

The general remedy of the Waverly study is also similar to, although less sophisticated than, the mechanics of Neighborhood Housing Services. The Waverly study recognized the importance of cooperation by all parts of the community. It stressed public-private cooperation, especially by those portions of the private sector involved in home financing. Also stressed as an integral part of the program was a sharply increased level of participation by neighborhood residents.

A final similarity is the involvement of the Federal Home Loan Bank Board. The FHLBB, which authorized the Waverly study, also played an important part in the development of the current Neighborhood Housing Services program. It was an original partner in the Urban

Reinvestment Task Force, of which NHS was a part. The following is a statement from the FHLBB found in the Waverly study of thirty years ago.

> The Board is deeply concerned with the terrific eventual losses which will be occasioned by neighborhood blight, decay, and final slum development, if that insidious process is not halted. It has, therefore, long sought a simple and practical preventive program by means of which vigilant groups of homeowners can reverse community disintegration before it attains a definitely destructive momentum.[26]

It can be seen that there is little change in the FHLBB's concern with neighborhood conservation. A good question might be why the FHLBB did not maintain this involvement during the interim.

The Waverly study was a very early attempt at examining the problems of neighborhood conservation. Emphasis was placed on methods of arresting blight in a declining neighborhood rather than trying to revitalize a deteriorated or slum area. The study concentrated on preventive remedies, a very novel approach at the time. It was this idea of preventive remedies which makes the Waverly study important. The study recognized that the life of residential neighborhoods need not end in widespread decay and eventual demolition and clearance. Neighborhoods experiencing the first signs of decline should adopt a conservation program. The conservation program suggested in the Waverly study places the majority of the burden on citizen participation and a public-private partnership. The study advanced goals, ideas, and remedies which thirty years later are the basis for many local neighborhood conservation programs.

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[26]Federal Home Loan Bank Board, Waverly: A Study in Neighborhood Conservation (Washington, D.C.: Federal Home Loan Bank Board), p. viii.

As was pointed out more than thirty years ago in the Waverly study, among the most important components of a local rehabilitation program are active citizen participation and a public-private partnership. Many communities have incorporated these concepts into their current neighborhood conservation programs.

The notion of an expanded public-private partnership, although not a new one, is an idea which is gaining increasing popularity and acceptance. Commercial banks and savings and loans are playing a larger part in the development of these partnerships. "Private financial institutions appear to be working with local government on an unprecedented level in order to protect their mutual interest in older neighborhoods."[27]

It should be understood that there is a certain amount of pressure being placed upon these financial institutions to become involved in urban problem solving.

> Increasingly, throughout the country, financial institutions are facing considerable pressure to demonstrate that they are serving the purpose for which, under law, they were originally established: to serve the public.[28]

Since 1975 Congress has passed two pieces of legislation aimed at halting disinvestment in older urban neighborhoods and encouraging community development participation by lending institutions. The Home Mortgage Disclosure Act of 1975 discourages redlining by private lending

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[27]"Rehabilitating the City," Practicing Planner, June 1976, p. 14.

[28]May Long, "Community Groups, Banks Work Together to Fight Neighborhood Disinvestment: Philadelphia Plan Works," Journal of Housing, January 1977, p. 25.

institutions and develops a greater "public awareness of the relationship between housing and community development programs and the availability of credit from the lending community."[29]

The Community Reinvestment Act was enacted as Title VIII of the Housing and Community Development Act of 1977. The FHLBB, the Federal Deposit Insurance Corporation, and other regulators make sure that financial institutions are assuming a continuous and positive obligation to meet the credit needs of the community. This is done through an assessment of the lending institution's history of meeting the credit needs of the entire community, including low and moderate income neighborhoods, within the bounds of sound lending practices.

Whether lending institutions have been pressured into involvement in neighborhood conservation programs, or whether they possess a sincere interest in the preservation of inner-city neighborhoods is not important. What is important is that all parties have realized that such participation is vital to the future of many urban neighborhoods.

> The shift in lending practices is neither easy or natural for the home finance institutions, for it will require a complete reversal of long-held industry beliefs about the age of the property and the homogeneity of the neighborhood in determining the value of the property. The process is far from complete, but even the most skeptical observers agree that it has begun.[30]

There are many instances throughout the United States where financial institutions are playing a major part in local neighborhood

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[29]William Witte, "Community Reinvestment Act," Journal of Housing, June 1978, p. 291.

[30]Rochelle Stanfield, "Savings and Loans Discover the City," National Journal, December 1977, p. 1962.

conservation programs. In Philadelphia, a meeting of twenty-six business and civic leaders seeking innovative approaches to urban and regional problems, resulted in the Philadelphia Mortgage Plan (PMP) in 1975. Staring with the participation of three local lending institutions the PMP had soon attracted the involvement of ten other lenders. The program has been successful in bringing about an increased flow of conventional mortgage financing into Philadelphia's residential neighborhoods. About 2400 applications representing $25.7 million and 1260 settlements worth $13.1 million have resulted.[31] Bank standards for loan eligibility were expanded so as to better reflect the city's housing needs. Decisions were made on a case-by-case basis rather than on generalized and many times ill-founded perceptions.

Norfolk, Virginia, initiated a local conservation loan program in 1973 to eliminate dependence on erratic federal funding. The city designated four conservation areas where rehabilitation loans would be made at below-market interest rates. Local banks are used as funding sources. Through this local conservation loan program the four target areas have been able to stem the blight and deterioration which had threatened the older neighborhoods of the city.

> The local program has several advantages over the federally funded program. First, there is very little delay in processing applications and paying funds. This fast action serves to increase citizen confidence in local agencies in general and the Norfolk Redevelopment and Housing Authority (NRHA) in particular. And local funding has improved the cooperation of contractors working in conservation areas to

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[31] Long, p. 25.

> a significant degree: they know that funds are readily available and that bid estimates won't be invalidated by inflation during lengthy processing. Lending institutions, who now know that there is local financial support for the neighborhood, are more willing to lend purchase money to buyers interested in the area. And, by teaming up with local financial institutions, the NRHA strengthens the local economy, while achieving its conservation objectives, free from dependency on federal funding.[32]

Another Virginia city, Hampton, has also developed its own local rehabilitation program in conjunction with local lending institutions. The Hampton program is concentrated in three target areas. Through an agreement with one bank and two savings and loans, the city has a $400,000 open-line account to fund temporary rehabilitation loans. This is guaranteed by $175,000 in CDBG funds. Effects have been felt in two areas which showed a sharp rise in building permits for rehabilitation work.[33]

Seattle, a leader in neighborhood conservation, has also enlisted the cooperation and involvement of local lenders in one of their conservation programs.

> The City of Seattle and seven financial institutions have recently announced the establishment of a Residential Review Process, whereby the banks agree to provide mortgages and loans throughout the city without regard to a neighborhood's economic condition or racial composition. It also provides for an appeal procedure for homeowners who are denied loans, with an assurance of a loan if the appeal is approved.[34]

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[32]J. H. Shiver, "Norfolk Has Successful Experience with Local Loans for Rehabilitation and Conservation," Journal of Housing, May 1974, p. 225.

[33]Andrew M. Ham, "Hampton Rehabilitation Program," Journal of Housing, October 1978, p. 472.

[34]Community and Economic Development Task Force of the Urban Consortium, Disinvestment in Urban Neighborhoods, (Washington, D.C.: Public Technology, Inc.), p. 15.

A final example of the public-private partnership approach to neighborhood conservation is a program operating in Pittsburgh, Pennsylvania. The city operates a below-market interest rate home repair loan program for homeowners with annual incomes of less than $15,000. Loans made through the program carry an interest rate of 3 percent. Funding is through the city's community development funds, $18 million over a three-year period. Additional monies are also secured from the city and state. The program is aimed at specified target areas encompassing approximately half of the city's neighborhoods.

> The relationship with the bank is the key factor in the Pittsburgh program. From the outset, the feeling was that the city should take maximum advantage of the expertise and experience that exists in the local banking community rather than try and duplicate those abilities on the staff of the Urban Redevelopment Authority. Furthermore, it was felt that many Pittsburghers would prefer to deal with a bank rather than with a public agency, as many homeowners are too proud to become involved in a "welfare program."[35]

Experience has shown that for every city dollar invested in the program the banks will loan 2.7 dollars, leveraging the limited public funds.

Local rehabilitation programs. Many cities are attempting to develop their own programs aimed at revitalizing and conserving older neighborhoods. Communities are using a wide range of funding sources to provide rebates, revolving loan funds, and rent and interest

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[35]"Pittsburgh's 3% Rehab Loans Are Handled by Major Bank," Practicing Planner, June 1976, p. 18.

subsidies. It is hoped that these tools can make more rehabilitation and mortgage money available to residents of declining inner city neighborhoods.

> In many cities today, CD funds are offering a major catalyst for forming new relationships among citizens, banks, and government agencies. The purpose is somehow to define neighborhood preservation and come up with workable and realistic programs with the very limited dollars.[36]

Among the many cities developing funding programs for their limited dollars is Pittsburgh. Pittsburgh has long been a pioneer in housing and neighborhood programs. In addition to Neighborhood Housing Services, Pittsburgh has also developed a new home subsidy program designed to replace the Section 235 sales program. The city, working together with developers and a local bank, Equibank, essentially expanded the local housing market.

> The market is created by making the cost of the housing affordable, with downpayments as low as $640. The city simply pays the difference between the actual costs of the housing unit and the amount the buyer pays through a mortgage with Equibank.[37]

The program has a very high cost effectiveness as compared to other programs but the city views this money spent as though on capital improvements. In the first two years of the program 110 houses had been built.

Louisville, Kentucky, has developed a subsidized loan program which uses community development funds as a major funding source. The city has

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[36]"Rehabilitating the City," p. 14.

[37]Robert Paternoster, "Pittsburgh Subsidizes New Home Mortgages," Practicing Planner, June 1976, p. 18.

committed $900,000 in CDBG funds to the program. Additional funding is obtained through the sale of $7.4 million worth of bonds by the Kentucky Housing Corporation, the state housing finance agency.[38]

After bad experiences with the Section 312 loan program, Louisville sought to develop its own rehabilitation loan program. City, state, and federal money was used to develop a subsidized loan program reducing the interest rate to 3 percent. The public money is used to make up the difference between the 3 percent loans and the current commercial rate. Outright grants are also provided through the program. Eligibility for the program closely follows HUD guidelines established for the Section 8 low-income assistance program. The city provides technical assistance through its neighborhood conservation staff. As is the case in most local rehabilitation programs, the efforts are concentrated in a few areas. Louisville has targeted six neighborhoods for improvements from a list of twenty areas.[39]

Schenectady, New York, has also developed a locally financed neighborhood conservation program. Development of this program was again in reaction to excessive federal red tape and lengthy processing periods. The city also wanted to end its reliance on FHA funds for rehabilitation of deteriorating housing. The FHA money was also slow and erratic.

The result was the development of the Better Neighborhoods program. "The Better Neighborhoods program buys two-family houses and rehabilitates

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[38]"Rehabilitating the City," p. 20.

[39]Ibid., p. 21.

and rents the apartments to medium and large families who are unable to find decent housing."[40] The program was organized by civic, religious, and business leaders. Initial capital was raised through the sale of two types of bonds, one which pays no interest and another which returns 4 percent. Bonds were sold to the Industrial Development Council of the local Chamber of Commerce, the local Board of Churches, and individual purchasers. Although the program is small in scope it has already aided 100 families and 500 persons in finding better housing.

Boston is another city which has long been active in the area of neighborhood conservation. It has developed many renewal, restoration, and preservation programs. A current program provides direct cash rebates for housing rehabilitation to help pay for necessary repairs.

Homeowners apply to the city for participation in the program. The city then sends a housing inspector to write up an estimate of needed repairs. The city also provides technical assistance and aids in locating contractors. When the work is completed a code inspector returns to make sure that it meets code standards. Approximately one month later the homeowner receives a check for 20 percent of the value of the work, whether he did some of the work himself or contracted it all out. A letter of intent to participate in the program can be used to obtain a rehabilitation loan from a bank if the repairs are major.

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[40]Robert G. Dyment, "Do-It-Yourself Rehabilitation: Schenectady Frustrated by Federal Red Tape, Used Local Financing for Housing Program," Nation's Cities, December 1970, p. 13.

Rehabilitation work is not limited to repairs necessary to bring the structure up to code standards but there are some criteria. Fifteen basic types of repairs are eligible under the rebate program. In the program's first full year of operation 7000 homeowners took advantage of the program repairing about 14 percent of the eligible housing stock. Eligibility is limited to persons with a taxable income of less than $16,000 the previous year. The city uses community development funds to support the $5.5 million budget of the rehabilitation rebate program.

As evidenced by the preceding examples, an increasing number of cities are focusing attention on housing rehabilitation and neighborhood conservation. Local programs vary in the way they are funded, the goals they strive for, and their methods of operation, but all seem to include code enforcement as part of the overall package. The housing code is the legal basis for municipal involvement in residential rehabilitation. Examples of local residential rehabilitation programs stressing code enforcement as part of their strategy can be seen in Charlotte, North Carolina, and Kansas City, Missouri.

In Charlotte, the city initiated a code enforcement and neighborhood conservation program, Neighborhood Assistance Program (NAP), following termination in 1974 of the FACE program. NAP uses local funds to extend the federal program and improve public services. Presently the program is operating in two neighborhoods near the central business district but it was designed for city wide application.

> The program can be applied to any of the city's neighborhoods that have not substantially deteriorated. NAP areas, selected by a city-appointed task force composed

> of representatives of five city departments, are to have a predominance of owner-occupied structures. At least a fifth of the structures must be sound, with the rest containing only minor violations of the city's housing code. After residents and owners are notified of the pending selection, and their approval obtained, a final selection is made by the city council.[41]

In place of the Section 312 loans, a local lending institution provides below-market interest rate loans at 8 percent. Property owners use the loans to correct code violations.

The program is administered by the Urban Redevelopment Department which assists in loan application processing; informs neighborhood residents of possible selection for the program; and coordinates the efforts of other departments which directly or indirectly affect operation of the program. Improved physical and social services and increased leniency in lending practices by local banks have resulted from the NAP.

Kansas City, Missouri, has begun a Neighborhood Property Conservation Program using housing code enforcement as its primary ingredient.

> Deterioration was occurring in Kansas City's residential neighborhoods at levels varying from minor decline that resulted from delayed housing maintenance to rapid decay and abandonment. The program, which began in 1973, was designed to increase the effectiveness of property codes by adjusting code enforcement standards to different levels of neighborhood stability or decline. Four different emphases within a single housing code were developed for use depending upon the condition of the neighborhood.[42]

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[41]Real Estate Research Corporation, Neighborhood Conservation: A Catalog of Local Programs, (Washington, D.C.: U. S. Government Printing Office), p. 20.

[42]Real Estate Research Corporation, p. 9.

This program is an innovative one because, although only one housing code is used, different application is provided depending upon the area and its condition. Neighborhoods are selected for the program only if they solicit or approve the program. Prior to the initiation of the program in a neighborhood, much work is done with citizens' groups, preparing and laying the groundwork for operation of the program.

Citizen Participation in Neighborhood Rehabilitation

Another trend evident in local housing rehabilitation and neighborhood conservation programs is the increasing participation of citizens and neighborhood groups.

> There is a recognition that local people must be increasingly involved in decisions that affect their lives since their commitment to a specific place spurs personal investment, as well as that of the larger community and its institutions.[43]

Citizen participation, in one form or another, has been present in most governmental attempts at stemming the decline of our inner city neighborhoods. The nature and extent of this participation has varied widely depending upon the particular program.

During the first 15-20 years of the urban renewal program, citizen participation was limited to the activities of community-wide citizens' advisory committees. Functions of the citizens' advisory committees, according to HUD guidelines, were to learn about the nature and extent of

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[43]Marcia C. Kaptur, "Neighborhoods and Urban Policy," Practicing Planner, September 1978, p. 5.

critical problems and means for alleviating them; to make recommendations for improvement; and to aid in informing other citizens about problems and planned improvements. It was hoped that these committees would bring about a community-wide understanding about present conditions and future solutions.

> These committees were often so broadly constituted that urban renewal area residents were only a weak voice compared with the more powerful articulations of business, labor, organized religion, social welfare, industry and education.[44]

For the most part, the local urban renewal program was created, adopted, operated, and controlled by the local renewal agency with approval from the local governing body and federal representatives.

The extent of citizen participation in urban renewal depended greatly upon the intended impact area. Some redevelopment projects were doomed to failure because of a high level of opposition from within the development area. Others, notably Cooper Square in New York City and the Kenwood-Hyde Park area of Chicago, thrived and flourished because of active and productive citizen participation.

> The best way to insure support at the solution level is to secure full participation at the problem-defining and decision-making level. When there is citizen participation in the planning stages of a renewal program, plans can be formulated which reflect the desires and needs of residents as they perceive them. Moreover, having a hand in the planning, residents are already predisposed to accept the plans which they feel they have helped create, even though the plans finally involve changes in the neighborhood they would not have agreed to without prior discussion and change of their attitudes.[45]

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[44]Hans B. C. Spiegel, Citizen Participation in Urban Development, (Washington, D.C.: Center for Community Affairs), p. 21.

[45]Ibid., pp. 32-33.

It was hoped that citizen participation in urban renewal, through the citizens' advisory committees, would facilitate acceptance of the program. Area residents were often co-opted into the renewal planning process in hopes of ensuring later success. This notion resulted in citizen participation becoming more than a democratic procedure, it was also a self-justifying end.

> The significance of the distinction between citizen participation advocated as a necessary condition to the success of the urban renewal program and citizen participation advocated as the right and proper mode of procedure is, of course, the distinction between means and ends. In the one case procedure may be evaluated in terms of efficiency and effectiveness, that is to say, pragmatically. In the second case, only consistency with other values may be invoked for evaluation.[46]

Citizen participation during the administration of the urban renewal program underwent many modifications and expansions as the federal government responded to criticisms concerning lack of substantive citizen participation.

> The 1969 revisions in citizen participation requirements in urban renewal reflected another strategy of citizen participation; namely, consultation, which is based on the premise that the educational background and life style of many planners and policy makers tend to make them unable to understand the problems of low-income people. Thus, these revisions attempted to obtain increased citizen participation in Urban Renewal Projects calling for the establishment of a Project Area Committee made up of residents of the project area for each urban renewal project in which residential rehabilitation activities are contemplated. The purpose of the PAC is to enable area representatives to participate in developing and executing plans for the renwal of the area.[47]

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[46] Ibid., p. 35.

[47] McFarland, p. 93.

The Model Cities program continued to expand and shift the strategy of citizen participation in the federal categorical grants program. The approach toward citizen participation shifted from the co-optation strategy frequently present during urban renewal to the development of community power strategy.

Citizen participation increased during the evolution of the urban renewal program and was viewed as a significant element of the Model Cities program. The legislation creating the Model Cities program authorized "widespread citizen participation and maximum opportunity for employing residents of the area in all phases of the program."[48]

The Model Cities program stressed a human solution to the problem of urban decay and decline rather than the physical remedies which were so prevalent in previous federal programs. Increased involvement of area residents seems to be a natural extension of the human solution offered by the Model Cities program.

The vehicles for citizen participation during the Model Cities program were called citizen participation groups. There were six types of citizen participation groups with varying roles and responsibilities. Some were composed of a broad-based constituency while others were dominated by residents of a target neighborhood. Some of the groups dealt with the very broad application of the Model Cities program and others concentrated upon one specific area of concern.

During the limited experiences of the Model Cities program a number of realizations about neighborhood conservation and citizen participation

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[48]Ibid., p. 101.

surfaced. Most prominent of these realizations dealt with a general strategy attacking urban decline and the extent of involvement within federal programs.

Many categorical grant programs of the federal government, including Urban Renewal and Model Cities, were replaced by the Housing and Community Development Act of 1974. The CDBG program provided local governments wider authority in determining how the federal money could be spent. While local officials were given primary responsibility for all aspects of the CDBG program, citizen participation seemed to be taking one step foward and two steps backward. The trend mandating increased citizen involvement began to stall. The depth and breadth of citizen participation, as set forth by federal guidelines, has been left largely to the local jurisdiction.

HUD regulations require that any jurisdiction requesting community development funds comply with their citizen participation guidelines. The local government is responsible for providing information regarding the amount of funds available and the types of programs that may be undertaken. Also required are a minimum of two public hearings to solicit citizen input as to the housing and community development needs of the locality, and the opportunity for local residents to participate in the development of the program and any changes or amendments pertaining to it.

While HUD regulations require the solicitation of citizen participation, local officials are under no obligation to heed the suggestions and recommendations. In the CDBG program, as with other

major federal urban aid programs, citizen participation at the local level is mandated through broad guidelines. It is up to the local jurisdiction to determine the role citizens will play in an urban redevelopment program. Some localities develop programs with an active, concerned citizen participation component while other localities keep citizen involvement to a minimum.

Citizen participation must come from within the neighborhood or community. It is not easily mandated through federal regulations and guidelines. Successful neighborhood conservation programs exist throughout the country which are built from citizen involvement. Programs which are built from the bottom upwards, rather than the federal notion of mandating citizen participation from above, seem to have a better track record. This trend has not gone unnoticed by the federal government. Current urban policy reflects this awareness of locally initiated programs.

> President Carter's urban policy is a milestone. It addresses the people of our cities as responsible citizens. For the first time, they are called upon, through their neighborhoods and voluntary associations, to become partners in urban revitalization and in the entire urban process, along with mayors, governors, businesspersons, and federal officials.[49]

An example of the effective role citizens can achieve in a local neighborhood revitalization program can be seen in St. Louis, Missouri. The Hill is an ethnic neighborhood in St. Louis which had been undergoing

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[49]Milton Kotler, "A Neighborhood Advocate," Journal of Housing, June 1978, p. 284.

some physical decline and outmigration. The neighborhood decided to organize to deal with these and other community problems.

In 1970 neighborhood residents formed Hill 2000, a neighborhood improvement association. The program was initiated to eliminate apathy and reverse the deterioration which was affecting the community.

> The objective of the program is to maintain a close-knit community and create an environment that will attract and retain young families. Ongoing services include home social workers, free hospital beds, high school courses, rental applications, senior citizen bus passes, free transportation to medical services for the elderly, and a neighborhood newspaper. A new program is under study to build an eight-story apartment building for the elderly, hopefully with some federal assistance, thereby freeing single-family homes for the young.[50]

The Hill 2000 neighborhood association shows what can be accomplished through organized citizen participation. Although the neighborhood derives a certain advantage from the presence of a single ethnic group and strong religious ties within the community, similar neighborhood associations hold very real possibilities.

Neighborhood Housing Services

Another instance of citizen involvement and concern becoming the catalyst for a neighborhood revitalization effort took place in Pittsburgh in 1966. Citizens in the Central North Side neighborhood attempted to organize in hopes of saving their neighborhood from urban renewal. Renewal and highway projects had already affected three adjoining neighborhoods, and a 1954 plan had designated the Central North Side as an urban renewal area.

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[50]Real Estate Research Corporation, p. 37.

> In 1966 the Central North Side was obviously declining. Its 3900 housing units were aging and in disrepair. The incomes of many of the residents in the area were low, and the population was increasingly elderly. The investment mentality in the area was pessimistic. Slum clearance seemed inevitable.[51]

Local leadership, recognizing the crisis at hand, swung into action. It is important to note that a substantial amount of local organization was already in existence. Neighborhood organizations began to pressure local officials to consider alternative plans, and a written commitment to keep the area residential was obtained from the mayor. Within one year the neighborhood was designated a code enforcement area by the city.

At the same time that neighborhood committees had been working with local government, meetings with local lending institutions were underway. There was a desire among some lenders to increase lending practices in older inner city neighborhoods.

> As the mutual interests of the neighborhood group and the banks become clearer, thirteen lending institutions verbally committed themselves to remove any red lines around the neighborhood by making loans available to property owners who qualified for conventional loans.[52]

It was soon realized that involvement of the lending institutions would have little impact unless other loan sources could be secured. Many residents of the Central North Side, due to fixed and low incomes, would be unable to qualify for conventional financing for rehabilitation loans. "The citizens groups began to seek additional resources—

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[51]Roger S. Ahlbrandt and Paul C. Brophy, Neighborhood Revitalization, (Lexington, Mass.: D. C. Health Co.), p. 127.

[52]Ibid., p. 128.

financing, counseling, and technical assistance—that would be required to make a home improvement succeed."[53]

> With help from the mayor's office a committee of citizens prepared a proposal for a $125,000 loan fund for high-risk nonbankable residents, particularly elderly, low-income, and poor credit residents, to be used in connection with the code enforcement program and for general housing improvement. The proposal was submitted to the Sarah-Sciafe Foundation in early 1968.[54]

The Sarah-Sciafe Foundation was interested in such a proposal for a number of reasons. The program is oriented toward minorities and the elderly. It is also a self-help effort which was supported by a broad base of community actors. Citizens, bankers, homebuilders, architects, and other civic minded organizations stood behind the proposal. Foundation trustees voted to fund the proposal.

Involvement of financial institutions expanded during 1968. The participating lenders had committed funds to operate the high-risk revolving loan fund and to provide technical assistance. Financial commitment of the lending institutions was based upon each bank's deposits.

> On July 3, 1968, the Central North Side Improvement Fund—a few months later to be renamed Neighborhood Housing Services, Inc.—was born. Its incorporators were three North Side residents (the President of CASH [Citizens Against Slum Housing] and two members of the Central North Side Neighborhood Council) and two bankers.[55]

The original Board of Directors consisted of a majority of residents, a requirement which would become an integral part of the NHS concept. The program is ultimately controlled by the residents.

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[53]Ibid. [54]Ibid. [55]Ibid., p. 129.

Through action initiated by a group of concerned neighborhood residents, the Central North Side was able to develop a partnership of residents, financial institutions, and local government working together to stem neighborhood decline. All three partners had a greater municipal concern as well as their own best interests at hand in embarking on this venture.

> NHS's formation was the result of three groups working closely together: (1) CASH and North Side Residents wanted neighborhood preservation as an alternative to urban renewal and relocation; (2) the banking community was looking for ways to increase its lending in lower-income areas (they began to see the need to pay attention to city neighborhoods and not just suburban areas); and (3) the city was interested in working with neighborhood groups to get needed programs going in order to meet HUD's Workable Program requirements.[56]

Following incorporation and the hiring of an Executive Director and other administrative personnel, NHS began operations. The Board was concerned that the program be flexible and responsive to the needs of the residents. Numerous deadlines and complicated and elaborate procedures were replaced by individuality and flexibility. Problems would be dealt with on a case-by-case basis.

NHS is not just a loan program. It provides an extensive array of housing related services:

> Long term, low interest rate loans to families considered high risk;
> Assistance in obtaining loans for home repair from participating financial institutions;
> Assistance in obtaining personal loans;
> Assistance in obtaining business loans;
> Financial counseling for budgets and bill consolidation;
> Assistance in obtaining reputable contractors;

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[56] Ibid.

Assistance in preparing plans and specifications;
Assistance in preparing contracts;
Review of bids for home improvements;
Inspection during construction to ensure that work is performed well;
Architectural assistance;
Liaison between code inspectors and residents;
Assistance to families in obtaining mortgages;
Advice on the purchase of homes;
Help families to locate housing;
Information on all housing for neighborhood residents;
Information on providing homes available for purchase and rehabilitation;
Assistance to neighborhood contractors on bidding and financing;
Assistance in organizing new block clubs;
Complaint center for residents;
Referrals of families with social problems.[57]

Among the major characteristics of the NHS program which warrant further discussion are the involvement of financial institutions, the code enforcement program, and the revolving loan fund.

A major component of the NHS program was the establishment of a high-risk revolving loan fund. Individuals, who for one reason or another cannot obtain conventional funancing, may apply for a loan from the NHS loan fund. Following an interview with an NHS staff member, the applicant fills out a loan application form with an estimate of the amount of money needed. After receiving a loan application the property is inspected by the NHS Staff and a code inspection is made. Specifications for the required work are then written up by NHS staff members. Bids for the rehabilitation work are solicited, received, and reviewed by NHS staff. Interest rates and the term of the loan are then established, varying from case to case. The loan application is

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[57]Ibid., p. 131.

submitted to the Loan Committee, composed of a majority of residents, for approval. All NHS loans are made with the prospect of repayment and a lien is attached to the property to help insure payment.

During the actual rehabilitation of structures NHS maintains a strong degree of supervision.

> In 1973, NHS began acting as the general contractor for rehabilitation and specific work elements were subcontracted to local contractors. NHS guarantees all work for one year and the subcontractors, in turn, make the same guarantee; this ensures quality rehabilitation work for residents. NHS retains 10 percent of each contractor's payment for one year after completion of repairs; this withholding encourages subcontractors to perform high quality work and to provide necessary follow-up repairs.[58]

In addition, NHS has also instituted a systematic maintenance service to make sure rehabilitated homes stay in good repair. Homeowners pay a set rate into a central fund for an annual inspection and needed repairs. Until this program obtains sufficient membership to make it self-sufficient, financing is through a foundation grant.

Code enforcement is another critical facet in the NHS program. In any neighborhood conservation program there is an important, delicate relationship with a concentrated effort in that area. Code enforcement, by causing structures to be brought up to code standards, results in increased loan activity.

> While NHS's success in making loans is partly the result of the code enforcement program, the reverse is also true; the code enforcement program's success is, in part, due to the NHS program.[59]

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[58]Real Estate Research Corporation, pp. 45-46.

[59]Ahlbrandt and Brophy, p. 140.

The NHS code enforcement program was administered jointly by the Pittsburgh Bureau of Building Inspection and the Allegheny County Health Department. The program divided the Central North Side neighborhood into seven areas for easier manageability and increased concentration. Focus was placed on owner-occupied structures. Code violations in rental structures were dealt with by having tenants withhold rental payments until repairs were made. This forced landlords to act; either they let the property further deteriorate, sold it, or brought it up to code standards.

Prior to enactment of the code enforcement program, NHS organized community meetings to explain the program and alternative financing plans for needed rehabilitation. The NHS code enforcement program had cooperation from the city and the residents, and various means for financing the necessary repairs.

The code enforcement program performed an important function in the rehabilitation of the physical structure of the neighborhood. A survey in 1968 showed 1485 structures with violations, about half minor and half major. By 1974, 1261 structures had been brought to code standards. The NHS loan fund and conventional financing were used to finance improvements.

A third feature, significant to the operation of NHS, is the involvement of local lending institutions. Public-private partnership in neighborhood rehabilitation is still in the development stage and the NHS program has contributed much to this development. It provided local financial institutions with an opportunity to become an involved,

active partner in the redevelopment of inner city neighborhoods and not compromise any of their self-interests.

Local financial institutions were given numerous responsibilities in the development and operation of NHS. They were asked to make conventional loans in this declining neighborhood as they would in a sound one. Redlining practices were eliminated. The bankers were also asked to underwrite the operating budget through contributions, based on deposits. In addition, the lenders were asked to participate in the program by serving on the NHS board of directors and various committees. In the years following NHS's inception, there has been an increase in the number of lending institutions involved in the program.

NHS did much towards turning around the Central North Side neighborhood.

> The Central North Side has been "turned around" according to NHS director Thomas Jones. Sections of the neighborhood were 90 percent of the houses had serious code violations now show that 90 percent of the houses comply with the housing code.[60]

Shortly after NHS began operating in Pittsburgh the Federal Home Loan Bank Board began to develop an interest in the program. Interested in using the money power of their savings and loan associations to meet the urban challenge, the FHLBB set up a special unit to duplicate the program in four other cities. One of the programs, Madisonville Housing Services in Cincinnati, has become a model itself.

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[60]Robert Cassidy, "Neighborhood Housing Services," Inland Architect, January 1976, p. 15.

The NHS program in Madisonville incorporated in December 1972. Madisonville is an older community located on the outskirts of Cincinnati. It was chosen as a target area due to its problems and its strengths.

Madisonville's strengths include a high percentage of single-family dwellings, a high percentage of homeownership, and an active neighborhood organization. Problems included recent racial change, lack of private lending in the neighborhood, and surfacing physical decline. In addition, the commercial district had declined rapidly in recent years. The deterioration of the commercial area apparently had some effect in the decline of some residences. Confidence in the neighborhood was uncertain at the time.

Program objectives were aimed at stemming residential and neighborhood decline. Little emphasis was given to revitalization of the commercial district (although some work is presently being done). Other objectives included increasing the involvement of local financial institutions and agencies of local government.

A total of 29 commercial banks and savings and loans involved themselves in the Madisonville program. The banks contributed money for the operating fund. A high-risk revolving loan fund was established with a $100,000 grant from the Edna McConnel Clark Foundation and was matched by local grants. The city contributed $1.4 million in capital

improvements for the neighborhood including street and curb repair, code inspection, and improved public services.[61]

The Madisonville NHS program was developed in a manner very similar to the Pittsburgh experience. Organization, operation, and administration followed closely what had been done in the Central North Side.

The Madisonville Housing Services program started slowly but by July 1975 an estimated $2.5 million had been invested in housing rehabilitation. The revolving loan fund was used by only about 1 percent of the area residents. The program has proved to be an effective vehicle in stemming decline within the neighborhood. Lending institutions are now actively involved in the rehabilitation process.[62]

> Mrs. Jeanne Davis, assistant director of the Madisonville NHS, says, "We're particularly pleased that the program is having a ripple effect. It's sort of a happy disease. Ladders go up on one building, then they go up across the street. I think it's beginning to turn Madisonville around, primarily because we see so much involvement and spirit. People are saying, 'something is finally happening in Madisonville.'"[63]

Another early attempt at duplicating the Pittsburgh NHS program occurred in Dallas. The target area chosen was Love Field-North Park, a multiracial community of 7000 persons. Love Field-North Park was a slowly deteriorating area of small, wood-frame houses which had a high

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[61] ACTION-Housing, Inc., The Neighborhood Housing Services Model: A Progress Assessment of the Related Activities of the Urban Reinvestment Task Force (under HUD contract), p. A-120.

[62] Ibid.

[63] Dudley Lynch, "New Life for Old Neighborhoods," Dallas, July 1974, no page.

(above 50 percent) degree of owner-occupancy. In addition, the neighborhood had been struggling to save itself for about eight years through the Love Field-North Park Civic League, a strong community organization.

The problems faced by the Love Field-North Park area were similar to problems present in Pittsburgh and numerous other older, inner city neighborhoods.

> It is suffering from middle-class abandonment, since its frame and brick homes, built mostly in the 1940's and 1950's, have lost their charm for climbers on the socioeconomic ladder. Too, the area has attracted a large number of minority families, and "white flight" has developed. This has brought about the spreading cancer of absentee ownership, although Love Field-North Park has fared far better than some inner city areas. Along with the aging of the housing structures has come the need for repairs, some of them major, but with modest incomes, most residents have found repairs out of the question. They need home repair loans, and these—usually—they cannot get. When normal lending guidelines have been applied, the risks have invariably been too high for financial institutions.[64]

The city of Dallas has actively supported the NHS program. The city committed $1.2 million for public improvement in the Love Field-North Park neighborhood for the first three years of the program's operation. Also, the city is providing housing code enforcement for the area.[65]

Local banks and savings and loans (46 are involved) have provided contributions for operating expenses. The Ford Foundation has contributed a $100,000 grant for the revolving loan fund on the condition that local organizations contribute $2 for every $1 put up by the Foundation.[66]

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[64]Dudley Lynch, no page. [65]Ibid. [66]Ibid.

Shortly after incorporation much rehabilitation activity could be seen in the neighborhood. Residents had a positive feeling about their neighborhood and believed that NHS helped them communicate with the city to improve conditions.

> In all, the NHS development process and subsequent operations have generated significant enthusiasm among those involved with the program. There is also evidence that cooperative relationships between representatives of financial institutions and city staff through NHS have spun off other joint efforts.[67]

Pleased with the early results of duplicating the Pittsburgh NHS program, the FHLBB and the Department of Housing and Urban Development created the Urban Reinvestment Task Force in 1974 to administer and oversee the program. HUD committed $12 million in research funds to aid in the demonstration. From five model programs in 1974, the number grew to 45 operational programs by the end of 1977. During 1978 fourteen more programs become operational and another fourteen were in the developmental stage. There are currently more than 70 NHS programs in operation throughout the United States. About a dozen others are in some stage of development.

Neighborhood Housing Services is now administered by the Neighborhood Reinvestment Corporation, a newly created public, nonprofit, tax exempt corporation with direct funding from Congressional appropriations. NHS is now independent of both HUD and the FHLBB although the Secretary of HUD and the Chairman of the FHLBB are on the board of directors of the new Neighborhood Reinvestment Corporation.

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[67]ACTION-Housing, Inc., p. A-124.

The current Neighborhood Housing Services program has retained much of the original approach pioneered in Pittsburgh. NHS programs are based on working relationships of neighborhood residents and representatives of local government and local financial institutions. The programs work to halt further deterioration of neighborhoods which have gegun to show signs of decline, but are basically sound, livable places.

A more detailed account of a Neighborhood Housing Services program, especially the developmental process, will be contained in the following chapter.

Summary

The concept of neighborhood rehabilitation and conservation as practiced by Neighborhood Housing Services has evolved slowly since the early days of urban renewal. Federal categorical grant programs and local conservation efforts have all contributed to the urban revitalization process. Some programs have resulted in the introduction of new concepts and others have provided needed modifications of existing concepts.

Urban renewal introduced the public-private partnership approach and citizen participation to the rehabilitation process. These concepts are still important components of neighborhood conservation although they have undergone major changes in reaching their present state of application. Also introduced during the urban renewal era was the idea of below-market interest rate loans. Subsidized loans still play an important role in plans to stem neighborhood decline.

The Model Cities program added a more comprehensive look at urban decline. The focus became concerned with more than the physical problems. In addition, the Model Cities program provided advancing levels of citizen participation in the redevelopment process. This emphasis on citizen involvement is present in many current neighborhood conservation programs.

The CDBG program provided increased local autonomy in decision-making and the notion of concentrated target areas to the redevelopment package. CDBG funds also became very important in funding local conservation programs.

These local neighborhood conservation efforts modified many concepts introduced by federal grant programs to meet local needs. Important components of many local programs include below-market interest rate loans (from urban renewal), concentrated code enforcement efforts (from the FACE program), high levels of citizen participation (from urban renewal and Model Cities), a public-private partnership (from urban renewal) and a concentrated geographic effort (from the CDBG program).

Neighborhood Housing Services has also taken a page from many of the federal and local programs in developing its current approach to neighborhood revitalization. NHS has incorporated many previous neighborhood conservation tools into one package which is presented as a means for stemming decline in certain inner-city neighborhoods.

CHAPTER III

THE DEVELOPMENT OF KNOXVILLE NEIGHBORHOOD HOUSING SERVICES, INC.

Introduction

On April 17, 1979, in a meeting at the Hyatt Regency, Knoxville Neighborhood Housing Services, Inc., elected its first Board of Directors and became a state chartered corporation. Knoxville Neighborhood Housing Services, Inc., is another example of the growing number of Neighborhood Housing Services programs in existence throughout the United States.

This meeting, known as Workshop V, was the culmination of approximately sixteen months of extensive planning and preparation. Upon the election of the Board of Directors, Workshop V became the first meeting of the newly formed NHS corporation. This point marks the transition from the developmental phase to the operating phase of the program.

Neighborhood Housing Services programs have two distinct phases; the developmental and the operating phase. This chapter will focus on the developmental process of one NHS program, Knoxville Neighborhood Housing Services, Inc.

According to The Neighborhood Housing Services Model: A Progress Assessment of the Related Activities of the Urban Reinvestment Task Force (HUD, Office of Policy Development and Research),

> . . . the developmental process has three distinct steps. The first is a determination of the feasibility of the NHS effort, the second is the ground work leading up to the first workshop, and the third is the workshop process itself.[1]

While this is accurate as far as it goes, it appears to be a much too simplistic assessment of the developmental process. It ignores a most important aspect, the selection of a target neighborhood for the NHS program, and considers the entire workshop process rather than the importance of individual workshops. In addition, the development of the Knoxville NHS program was faced with an extra step, the recognition and organization of potential neighborhood leaders.

Therefore, it is the author's view that the developmental process for the Knoxville NHS was composed of seven distinct and significant steps; (1) the determination of the feasibility of an NHS program; (2) ground work in preparation for Workshop I; (3) Workshop I; (4) the site selection process; (5) the organization of potential leadership within the target neighborhood; (6) Workshop III; and (7) Workshop V. A detailed explanation and discussion of these and other components of the developmental process will be provided throughout this chapter.

Feasibility of an NHS Program in Knoxville

Earliest interest in obtaining a Neighborhood Housing Services program for Knoxville occurred in the mid 1970's. At that time,

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[1] ACTION-Housing, Inc., The Neighborhood Housing Services Model: A Progress Assessment of the Related Activities of the Urban Reinvestment Task Force, (under HUD contract), p. 38.

Dr. Reynell Parkins of the Housing Research and Development Center at The University of Tennessee invited a representative from the Federal Home Loan Bank in Cincinnati to assess the feasibility of developing an NHS program in Knoxville. A representative of the Federal Home Loan Bank, Ms. Carol Braddock, met with a group of ten to fifteen persons. The group was composed primarily of community leaders from inner city neighborhoods. Ms. Braddock asked the group to develop a list of needs for the different geographic areas of the city.

At nearly the same time, city officials were becoming aware of Neighborhood Housing Services at various conferences throughout the country. In January 1978 the city of Knoxville, through its Office of Community Development initiated contact with the Urban Reinvestment Task Force (URTF) in Washington. An application to the URTF for assistance in developing an NHS program was being prepared.

The city's application for developmental assistance was sent to Ms. Winnie D. Morton, Special Assistant for Field and Program Development of the URTF, on February 2, 1978. The application was prepared by the Community Development Office and was accompanied by a letter from Mayor Tyree committing the city to the NHS concept.

Applications for developmental assistance are accepted by the URTF on an ongoing basis. Priority is given to those applicants showing the greatest potential for an NHS program. The application requires a narrative describing to what degree the following elements exist:

1. Local government capacity and willingness to participate with a sensitive and appropriate housing inspection program, and to provide capital improvements and increased service levels where needed.

2. Financial institution support and leadership—current or potential.

3. Neighborhood support and leadership—current or potential.

4. Foundation/industrial/civic/local governmental resources to support a growing Revolving Loan Fund.

5. Interest of federal, state, and other agencies in assisting and/or cooperating.

In addition, the city must identify its funding source of the $30,000 to $50,000 cost of the developmental program.

It should be noted that the city's application and the mayor's cover letter both mention a specific neighborhood, the Fourth and Gill area, as appropriate for an NHS program. The application states,

> Contacts have been established with several neighborhood groups by the Community Development Office of the City of Knoxville. The dialogue with these citizens has also helped the staff to identify appropriate housing programs. Because of the physical conditions of the area, existing commitments from various organizations and agencies, and due to the outstanding performance and capabilities of its neighborhood committee, the Fourth and Gill area is an ideal candidate for an NHS program.[2]

This advocacy position taken by the city in its application was to cause problems. The recommendation of an area or neighborhood for an NHS program is a function of the site selection committee, composed of representatives from the city, local financial institutions, and community organizations. The recommended site must then be approved by

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[2]City of Knoxville, Department of Community Development, "Application to the Urban Reinvestment Task Force for Assistance in Developing a Neighborhood Housing Services Program," February 1978, no page.

all the participants. This occurs much later in the developmental process. It was not the place of the city to apply for developmental assistance to establish an NHS program in a particular neighborhood. The application is for developmental assistance for establishing a program in that city. The NHS process will determine the selection of an appropriate neighborhood.

The city's application was thorough and extensive. It provided tables, maps, and additional data regarding possible inner-city neighborhoods appropriate for an NHS program. The application detailed municipal concern for housing rehabilitation through an explanation of current programs. A letter of support from Rev. Bill Murrah, a community leader in the Fourth and Gill neighborhood, was included to underscore the interest of local residents in obtaining an NHS program. Support from local lending institutions was based largely upon a newly developing cooperation between local banks and the Office of Community Development. Funding for developmental assistance was to come from CDBG funds.

Knoxville's application for assistance in developing an NHS program was accepted. The URTF was most impressed with the thoroughness of the application and current programs and potential present. Specific programs which gave the application a positive flavor were the city's housing rehabilitation program, social service delivery, and a flexible code enforcement program.

Prior to entering into a developmental agreement with the city, the URTF conducted a series of visits and meetings to assess the prospects for

creating an NHS program in Knoxville. These meetings are known as preassessment visits.

The preassessment visits are sessions with city officials, representatives of savings and loans and commercial banks, and community representatives. The purpose of these sessions is to discuss NHS with these groups or individuals and assess the feasibility of establishing an NHS program. Generally, the URTF is concerned whether ingredients for a successful program are present, whether the three partners are interested, and whether the necessary resources are available. In addition, the preassessment visits, through intensive interviewing, attempt to bring about a clearer understanding of the situation present in a particular city. Decisions regarding the potential present for creation of an NHS program are made on a qualitative rather than quantitative basis.

> If the initial contacts are encouraging, and if local commitment is strong enough to fund the developmental process, the Task Force enters into a developmental contract with a local funding source and hires a local coordinator.[3]

The preassessment visits are very much a reciprocal information process. Representatives of the URTF have an opportunity to learn about a locality and assess the possibility of establishing an NHS program and the local participants are given a chance to become more familiar with NHS.

The task of conducting the preassessment visits in Knoxville was initially done by Ms. Carol Braddock of the FHLB of Cincinnati and

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[3]ACTION-Housing, Inc., p. 39.

Mr. Ray Kuchling of the URTF. They were later joined by Mr. Mike Haviland, also of the FHLB. The preassessment visits officially began shortly after the city's application for developmental assistance was submitted in February 1978 and continued through the hiring of a local coordinator and the signing of a developmental contract on July 17, 1978.

While representatives of the URTF had begun their series of preassessment visits, the Office of Community Development had initiated an informal educational program aimed at the three partners in the NHS program. Members of the URTF and the CD office worked together in many instances in arranging and conducting meetings and information sessions.

The CD office had been in the process of communicating with several local banks in hopes of creating a climate of mutual concern and cooperation. Mr. Leslie Cavada, then Director of Housing Rehabilitation, met with representatives of local financial institutions and outlined the city's commitment to inner-city rehabilitation and explained specific municipal programs and policies. During these talks between the city and the banks some interest developed in beginning a local program whereby the city would cover the remaining 10 percent on FHA loans and would also lower the interest rate. Both parties felt that NHS would provide a better vehicle for achieving housing rehabilitation goals. Through meetings with the city and preassessment visits from the URTF, representatives of local lending institutions were made aware of NHS and exhibited early support and interest in developing such a program in Knoxville.

Meetings were also conducted to acquaint representatives of inner-city neighborhoods with NHS. The city had been meeting with neighborhood residents on an ongoing basis and received encouragement to further investigate the chances of obtaining an NHS program for Knoxville.

There were at least two occasions when Mr. Kuchling of the URTF was present at meetings of neighborhood residents to explain Neighborhood Housing Services. The first meeting occurred in February 1978. At this time the city envisioned the Fourth and Gill neighborhood as the place for an NHS program in Knoxville. Mr. Cavada of the CD office arranged a meeting of Mr. Kuchling and residents of the Fourth and Gill neighborhood. The meeting, held in the neighborhood, was used to explain NHS and answer questions about the program.

In the spring of 1978 another meeting was held to acquaint neighborhood leaders with NHS. This meeting was held at the Knoxville Community Development Corporation. Again Mr. Kuchling was present to present the NHS concept and answer questions. The audience at this meeting had a much broader base of community representatives than the previous meeting with Fourth and Gill residents. Present were representatives from the Inner-City Neighborhood Coalition (INC) and other inner-city neighborhood organizations.

The other partner, city government, was also involved in an educational and information program. Mr. John Webber, then CD Director, met with Mayor Tyree and members of city council in an attempt to explain NHS and enlist support for the development of a program in

Knoxville. Mr. Webber was aided by Mr. Kuchling of the URTF, who through his preassessment visits provided the mayor and council with needed information and answers to any questions they had.

City council members learned more about NHS through presentations at council work sessions. It was felt by representatives of the CD office that NHS should be presented to council thoroughly and carefully to insure their involvement and to obtain the necessary financial commitment to get the program off the ground.

Mayor Tyree was interested and involved from the beginning. The program was attractive for a number of reasons. Politically speaking, the program was desirable and was viewed as a logical step in any inner-city rehabilitation scheme. It fit well with the city's housing rehabilitation program and appeared to be a step closer to the city's desire to involve local financial institutions in inner-city development. The program received wholehearted support from the mayor through oral and written communication to various groups, e.g., council, neighborhood groups.

The preassessment visits continued through the spring of 1978 and led to council's passage of a resolution to participate in housing rehabilitation under the NHS program. The resolution was adopted May 2, 1978.

The resolution addresses a number of issues crucial to the development of an NHS program. It identifies the presence of substandard and deteriorated housing in the city and the need to develop a program based on a unified public-private partnership to

combat this problem. Responsibility for the development of such a partnership is given to the URTF. The resolution also identifies the city's commitments to the program. They are as follows: provide the financial resources to establish a high risk revolving loan fund for the next three years through CDBG funds in an amount not to exceed $300,000; provide $35,000 for the development process; provide a sensitive, systematic, flexible code compliance program in the NHS neighborhood; provide appropriate public improvements and services to the selected neighborhood as needed; and attempt to place Section 8 rental housing assistance in the selected neighborhood.

Preparation for Workshop I

Following council's passage of the resolution the preassessment visits continued, but with a slightly different purpose. The purpose is now to identify key individuals within the community. The URTF was looking for interested and responsible persons who could become involved in the development of an NHS program. The responsibility for the URTF at this point is to identify approximately 50-75 persons as participants for the first NHS workshop. Although the visits are not conducted around the individual's potential as a workshop participant, it is from these preassessment visits that most workshop participants emerged.

The preassessment visits are used to develop an increased understanding of the situation and to better grasp the resources and commitments the three partners are willing to provide. There is a

concern with personalities and commitments. While the nature of these interviews varied from person to person, the following are typical of questions that might have been asked. Could NHS work in Knoxville? Describe the three partners and their potential contributions and problems. Which partner might present the most difficulty? Why?

The preassessment visits conducted by the URTF were most thorough in their attempt to reach individuals with a possible interest in NHS, housing rehabilitation, or reinvestment in the inner city. Representatives from all three partners were contacted. The president or chief executive officers of every savings and loan and commercial bank doing business in the city were approached about their interest and potential participation in an NHS program. Representatives from a wide range of governmental agencies were also contacted, as were neighborhood and community leaders.

In an attempt to reach the widest possible audience, the URTF representatives relied on the pyramidal technique when necessary. During the course of the preassessment visits names of other individuals were often mentioned by the interviewee. If an individual's name was mentioned often enough, or he appeared to be an appropriate contact, he too was approached. Names of other individuals were often solicited by URTF members in an effort to expedite the process.

The preassessment visits concluded with the signing of a developmental agreement by the city and the URTF. The developmental agreement is a contract identifying the responsibilities of the city and the URTF in the development and subsequent operation of the NHS program. It was signed on July 17, 1978.

The extensive series of preassessment visits is an integral part in the continuing development and eventual operation of an NHS program. A key function of the preassessment visits is to develop a working relationship between local government and representatives of local financial institutions and community organizations. It is from these visits that the NHS concept and program are built upon. It is important that this first building block be sturdy enough to support and withstand later additions. For this reason, great care was used in developing this working relationship. The time required was approximately five months. This extended time requirement is necessary to develop in a careful and thorough manner a base upon whcih an NHS program can operate.

Around the time the preassessment visits were concluding and a developmental agreement was being signed, the URTF was in the process of hiring a local coordinator.

> The local coordinator identifies key leaders in the community (citizens, financial institutions, local government), contacts these individuals, explains the NHS concept, and arranges a workshop to present the NHS program in more detail. The local coordinator is assisted by the Task Force regional coordinator with backup from Washington when necessary.[4]

People contacted during the preassessment visits were also asked to suggest individuals for the position of local coordinator. Ms. Gloria Neel was chosen as local coordinator for the development of the Knoxville NHS.

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[4] Ibid.

The first task facing Ms. Neel was the organization of Workshop I. Much of the work in identifying key leaders had laready been accomplished through the preassessment visits. From the larger list of persons contacted through the preassessment visits, a smaller list of potential workshop participants was needed. Approximately sixty persons were identified by the URTF and the local coordinator as being desirable participants in Workshop I and the ensuing NHS development process. The sixty participants were divided nearly equally among the three partners. Nearly all those invited to participate in the workshop accepted.

Approximately six weeks prior to Workshop I there was a final attempt at presenting and explaining NHS. This meeting was aimed at representatives of local lending institutions. The "Lenders Luncheon" was held July 31, 1978, following the preassessment visits, signing of a developmental agreement and the hiring of a local coordinator.

The "Lenders Luncheon" was another example of the "dog and pony show" used by the URTF in presenting and marketing the NHS concept. The luncheon included a presentation of "Turning Around," a film documenting an NHS program at work. Also included were statements by Mayor Tyree; Mr. Charles Thiemann, President of the FHLB of Cincinnati; Mr. Jeffrey Wells, Vice-President, Federal Reserve Bank of Atlanta-Nashville Branch; Mr. Bernard M. Ganzfried, Regional Director, National Credit Union Administration; and representatives of the URTF.

Although the representatives of local lending institutions had already shown a positive interest and commitment to the development of

an NHS program, this luncheon had a purpose. The purpose was to reassure representatives of local banks and savings and loans that NHS was indeed a program that warranted their interest and involvement. Participation by high-ranking officials of the FHLB and the Federal Reserve Bank was intended to aid in this reassurance.

Workshop I

Workshop I took place at Fairfield Glade, a resort community about 75 miles from Knoxville. Fairfield Glade provided the retreat-like atmosphere necessary for conducting Workshop I. This environment is an important ingredient of the workshop format. The retreat-like setting is advantageous because it places the individual in a neutral setting, far removed from his office. There are no phone calls and no interruptions to distract the participant. For two days the UTRF has the undivided attention of workshop participants.

Workshop I began Monday, September 11, 1978, with a luncheon at the Hyatt Regency in Knoxville. Following comments by the Mayor, who restated the city's commitment and his personal enthusiasm for NHS, the participants left by bus for Fairfield Glade.

Following registration and dinner, the first scheduled activity is a communications session conducted by a psychologist hired by the URTF. The purpose of the communications session is to break down or weaken any barriers that might prevent constructive communication between the three partners.

Through a series of dynamic psychological techniques the group is forced to communicate with each other. One of the techniques used

involved the tasting of strips of paper. Unknown to the participants, the paper had been treated with a substance which tasted differently to different individuals. Some people tasted sweet, some sour, some bitter, some nothing at all. Discussing what the paper tasted like was instrumental in pointing out that similar differences might exist among the participants. This stressed the point that perception is closely related to perspective. A person should be aware that another individual's perception is an important function of his perspective, and there are many different perspectives. No one person's perception is absolute, but rather it is colored by who we are.

Another of the psychological techniques involves dividing the large group into smaller groups of 8-10 persons. Individuals were then instructed to turn either to their right or left and communicate a negative comment. Individuals receiving these comments were told to try to understand the other person before responding; to put his remark into perspective.

All of the psychological techniques were designed to illustrate how individuals, given the same set of circumstances and experiences, can end up with different conclusions and perceptions. The communications session is used to develop an increased awareness which will last through the remainder of the workshop and hopefully throughout the developmental process.

There was a wide variety of reactions regarding the effectiveness of the communications session. Some viewed the psychological techniques as "a bag of tricks" or "a product of the '60's." Some thought they

were most effective mechanisms for breaking down stereotypes and increasing the avenues of communication. The interviews revealed that there were some individuals present who felt that the communications session was effective, but only for one or both of the other two partners—not themselves. Interestingly, this response came from all three of the partners involved in the workshop process.

Despite the diverse reactions to the psychologist and the communications session, it is fair to say that it at least got the participants thinking. For some the time was more valuable than to others, but even in an indirect way most everyone benefitted from the process.

The participants were given a hospitality party following the communications session and the communicating increased greatly at this time. Many individuals felt that the informal social sessions were as productive as any other part of the workshop in developing a sense of partnership. It was at these times that people got an opportunity to get to know one another and realize that there wasn't as much that separated them as they had thought.

The morning session of the second day consisted of a presentation by URTF representatives. This included an oral presentation, the film "Turning Around," and time for questions and answers.

The afternoon session centered around a presentation by representatives from the NHS program in Little Rock, Arkansas. They related the experience in developing their program. Representatives from each of the three partners told of the apprehensiveness, enthusiasm,

problems, and highlights which occurred throughout the developmental process. There was an opportunity for the workshop participants to question the delegation from Little Rock in both a formal and informal atmosphere.

The presentation by participants in the Little Rock NHS program was most beneficial in providing actual experiences in the development of an NHS program. Their presentation added realism, an insight into the site selection process, and an idea of how long the development process lasts. These real people telling real stories provided increased enthusiasm among the workshop participants.* (See page 11 for an explanation of asterisk.) There was an eagerness to get on with the process of developing an NHS program for Knoxville.

It did not take long for this eagerness to be transformed into action. Following dinner, the workshop participants were divided into groups representing the three partner (city, lenders, and community). The groups were asked to consider what they could bring to the program and what they expected the other partners to contribute. Each group caucused to discuss these questions.

The evening session ended with a report from the three groups. A caucus leader was chosen to moderate the caucus and report their findings. The results from the caucus gave an indication whether there was strong enough commitment to return to Knoxville and begin the process of developing a program. The caucus results indicated there was sufficient support for NHS. Each of the three partners returned a report similar to that of the others. The commitment the lenders

were willing to make was nearly identical to the commitment the city and community felt was required. The same held true for city and community commitments. In fact, more often than not, groups required more from themselves than the other partners were requiring of them.

Following the group sessions was another hospitality party. Enthusiasm and commitments were at very high levels at this point. The groups had demonstrated to themselves and to others that they were capable of working together towards a given goal. The workshop participants had developed an understanding about NHS and what was needed to make it work.

The next morning Workshop I concluded with the creation and staffing of committees. The committees included site selection, fund raising, governmental relations, structure and organization, community relations, and personnel and administration. A cross-section of the three partners was sought in the composition of all committees. All workshop participants eagerly joined at least one committee, many participated in two. More will be discussed regarding specific committee functions later in this chapter.

Although there was some criticism regarding the time and cost involved, all the participants were enthused with the outcome of Workshop I.* The time necessary and the retreat-like atmosphere were critical to the effective development of a working partnership.

Workshop I brought these diverse elements of the community together in one place, likely for the first time. It provided an opportunity for all the participants to get to know one another through numerous

meetings and informal discussions. A feeling of mutual care and concern developed. The occasion to meet and discuss issues relating to inner-city investment, housing rehabilitation, and neighborhood conservation resulted in increased respect among the partners and a realization that there were a large number who cared about their neighborhood and were willing to work toward that end. The entire workshop process was a learning experience; learning about Neighborhood Housing Services, learning about the other partners, and learning about yourself.

Though not present at Workshop I, the author has developed a good sense about what took place through a series of interviews and participation in the remainder of the developmental process. It is apparent to the author as it was to many workshop participants, that Workshop I was part of a very sophisticated marketing program. There was a product to sell, Neighborhood Housing Services, and it was packaged and presented in a most effective manner. The result was a great deal of enthusiasm and momentum.

The workshop process led up to the caucuses when the partners identified their commitment and what they expected from the other partners. There was some surprise among the participants that the commitments required by other partners were nearly identical to what they had felt their own commitment should be. In actuality the participants had been led, even manipulated, to reach these conclusions. If the desired conclusions had not resulted, it would have seemed obvious that the commitment to develop an NHS program was not present. It was thought, even by those persons who were cognizant of a leading

technique throughout the process, that the quality of Workshop I was very high. Though it might have appeared staged, it was a constructive and effective mechanism to reinforce commitments, build enthusiasm, and develop and strengthen a working relationship necessary for an NHS program.

The Site Selection Process

Upon returning to Knoxville the first order of business for the workshop participants was to begin work in their respective committees. The most pressing responsibility was the selection of a target neighborhood for the NHS program. This was the job of the site selection committee. The site selection committee, probably because of its importance, was the largest of all the committees. It possessed a nearly equal distribution of representatives from the three partners.

The site selection committee first met September 27, 1978. It was chaired by Mr. Keith Richardson of the East Tennessee Development District. The first item on the agenda was to determine the responsibilities of the committee. After deciding that the committee's responsibility was to recommend to the larger group a neighborhood suitable for an NHS, clarification of the site selection process was needed.

It was decided that the site selection process have five basic steps. They were (1) determine criteria crucial for neighborhood selection; (2) gather and analyze data; (3) narrow the selection to

a few sites; (4) tour the final neighborhoods; and (5) choose a demonstration neighborhood for recommendation and rank the remaining choices.

The first meeting also began to establish criteria for neighborhood selection. A subcommittee was established to develop criteria and report back to the whole committee. The subcommittee recommended to the full committee the following set of criteria for selection of the NHS neighborhood:

1. Neighborhood median income around 80 percent of the city-wide median.

2. A neighborhood with housing needing moderate repair.

3. A neighborhood of not less than 300 structures.

4. A neighborhood typified by predominantly (51 percent) owner-occupied structures.

5. A neighborhood having an existing neighborhood organization.

6. A neighborhood or neighborhoods of a contiguous nature, uninterrupted by an impenetrable boundary.

While defining criteria it was realized that the availability of current or relevant data would be a problem. For instance, no reliable information was provided on a city-wide basis on housing quality. (Criteria No. 2.) Information for Criteria 3 and 4 was available only by units and not structures. In determining the size of a neighborhood, estimates were used to convert units to structures. In determining percentage of owner-occupied structures it was decided to take a closer look at those neighborhoods where significant changes in owner-occupancy might have occurred since 1970.

In establishing the criteria there was much discussion as to the appropriateness of some specific criteria. Neighborhood leaders questioned such criteria as income level, owner-occupancy ratio, and size of the neighborhood in hopes of keeping their neighborhood in contention for selection as the target area. While the neighborhood leaders made periodic attempts at objectivity, there was a great deal of self-concern. There were times when the concept and purpose of Neighborhood Housing Services became clouded by other issues. The advocacy position adopted by some community leaders resulted in additional and some unnecessary dialogue regarding site selection criteria.*

The set of criteria eventually decided upon bears a striking resemblance to the guidelines supplied by the URTF as necessary for the development of a successful NHS program. URTF guidelines are those which, if followed, give the greatest opportunity for a successful NHS program. Deviation from the guidelines could result in problems and/or delays in the developmental process.

After establishing the criteria for neighborhood selection a motion was made to compile a manageable list of recommended neighborhoods to be visited by the site selection committee. A bus tour of seven neighborhoods was arranged for October 15. The seven neighborhoods were Lonsdale, Vestal, Fourth and Gill, Old North Knoxville, Oakwood, Park City, and Beaumont.

Members of the site selection committee visited the seven neighborhoods during the afternoon bus tour. Committee members

were given an information package with relevant (to the criteria) data about each of the neighborhoods. In addition a representative from each of the neighborhoods narrated that part of the tour. The representatives pointed out what was being done in the neighborhood, what needed to be done, and invariably, why their neighborhood would be an appropriate selection for an NHS program.

The bus tour provided an opportunity to see and hear about all the recommended neighborhoods in a relatively short period of time. This helped the committee members to compare and contrast the seven areas. It seemed that the visual inspection, via the bus tour, had considerable impact in determining the site selection. The visual exposure was equally as important as numerous pages of data and previous impressions. This is not to say that the bus tour determined the site selection, rather that it was a most influential determinant.

The site selection committee met the following day to vote on a target neighborhood for recommendation to the larger group. The meeting began with an explanation of the city's current commitment in the seven neighborhoods being considered. This was viewed as an important consideration regarding each neighborhood's potential for revitalization.

Following an explanation of the city's involvement each committee member was given an opportunity to express feelings about the neighborhoods visited on the bus tour. They were asked to describe which neighborhoods were appealing, which might house a successful NHS program, and why.

The discussion brought out some good points. Many persons used this opportunity to speak as self-proclaimed advocates for their neighborhood. Others reminded the group what they felt was the purpose of an NHS program and that the target neighborhood should be best suited to that purpose. Other issues brought up included racial composition of the target area, the size of homes within an area, income levels high enough to ensure a large percentage of bankable loans, and placing the program in a neighborhood which provided the greatest guarantee for success.

After everyone had been given an opportunity to voice an opinion, a vote was taken. Committee members were asked to list two choices from the list of seven neighborhoods. The top three choices were Park City, Lonsdale, and a combination of neighborhoods, Fourth and Gill, Oakwood, and North Knoxville. Another vote was taken, this time limiting the voting to one choice from the top three neighborhoods. The result was a tie between Park City and the combination of Fourth and Gill, Oakwood, and Old North Knoxville. After some discussion a motion was made to break the tie with a final vote between the top two areas. The Park City area was chosen as the neigborhood which would be recommended to the larger group at Workshop II.

The Park City choice was a surprise to many people involved in the site selection process.* The primary reason for such surprise was the fact that Park City lacked any semblance of community organization. Throughout the developmental process it had been stressed that NHS is a partnership of the city, financial institutions,

and neighborhood residents. The lack of community organization was seen as a weakness in the committee's recommendation. Many persons had been led to believe that the NHS target area would be a neighborhood where there was an existing community organization, as this would be an asset to the development and operation of the program.

During the period between the final meeting of the site selection committee and Workshop II, when the recommendation was presented to the larger group, there was a great deal of concern among NHS participants as to whether the right decision had been made. Community leaders from other inner-city neighborhoods become disillusioned and began to drift away from the program. This is a natural step in the developmental process. The unlikely selection of Park City helped to expedite this attrition.

Workshop II was a luncheon meeting held on October 24, 1978. The main purpose of this workshop is to vote on the recommendation of the site selection committee and to bring the group up to date on the work of the other committees.

The site selection committee's recommendation was presented by committee chairman Keith Richardson. Included was a geographic explanation of the area's boundaries and why they were chosen. Also included was a slide presentation showing what had been done in the neighborhood, what was currently being done, and what was needed to revitalize the Park City area.

An opportunity was given to all present to voice any objections to the recommended site. In light of the level of dissent and

dissatisfaction following the final meeting of the site selection committee, there was little discussion as to the appropriateness of the recommended site. Some issues raised were the high percentage of elderly residents and the low owner-occupancy ratio in the neighborhood. The major objection was the lack of an existing community organization. This last question was raised by other inner-city neighborhood leaders.

Ms. Carol Braddock explained quite clearly that the program would work with or without an existing neighborhood organization, and while the assistance of other community leaders would be welcomed, it too was not a necessary ingredient to the development of a successful NHS program. Ms. Braddock's comments further alienated those neighborhood representatives whose neighborhood had not been chosen.

At the time Ms. Braddock's remarks seemed inappropriate and uncalled for. Perhaps they were, but in retrospect it can been seen that there was much validity in what she said. A neighborhood organization is in the process of developing in the Park City area. Leadership has emerged, and it appears that NHS is strong enough to generate a high level of neighborhood interest and support, at least on a temporary basis.

Workshop II concluded with the larger group adopting the site selection committee's recommendation of Park City as the target area for Knoxville NHS program. The site selection committee, its job now complete, was merged with the community relations committee whose work is just beginning.

The selection of a target neighborhood for the NHS program was a low point in the development process. As objective as some participants

(particularly neighborhood leaders) attempted to be there was a high level of advocacy in their remarks. This led to some temporary bitter and hurt feelings when the Park City neighborhood was chosen.

This weak point in the development process is a direct result of the emphasis on people and personal involvement in the NHS program. The strength of NHS, personal involvement and commitment, is also the cause of most of the problems throughout the development process. At this particular point in the development process there was much discussion regarding an appropriate site for the target neighborhood. Given 20 persons, from three different interests, some lack of consensus may be expected. In addition the advocacy position of some individuals slowed the process and aided in dampening the harmony created at Workshop I. Again, it should be stressed that this is a natural phenomenon when twenty persons are called upon to decide anything.

Committees in the Development Process

Following Workshop I all committees commenced working, some charged with more immediate responsibilities than others. Of all the committees the site selection committee had the most urgent task. The other committees had less pressing responsibilities and waited until a site was selected or moved slowly toward their appointed task.

One committee that went right to work was the Finance or Fund Raising Committee, chaired by Mr. David Sharp, President of Home Federal Savings and Loan Association. In the two meetings between Workshop I and Workshop II, the Finance Committee secured an agreement with local

financial institutions to support the operating budget of the NHS program. Actual pledges were to be obtained following the selection of a site and the establishment of an operating budget. The Finance Committee was composed of approximately 50 percent bankers and dealt with business in a most orderly and professional manner. This was a result of the composition of the committee and the nature of their work.

The Personnel and Administration Committee, chaired by Ms. Annette Anderson, Director of the East Tennessee Community Design Center, met three times between Workshop I and II. Major responsibilities of the committee at this time included drafting job descriptions for NHS staff positions, a preliminary budget for the first year of operation, and outlining recruitment procedures for the NHS Executive Director. The Personnel and Administration Committee increased in importance and responsibility towards the end of the developmental process as selection of an Executive Director neared.

The Government Relations Committee was chaired by Mr. David Farr, Vice-President of the Park National Bank. The committee focused immediately on the necessity of a flexible code enforcement program and determining whether capital improvement and code enforcement money could be spent in all the neighborhoods being considered as target areas. The committee met with representatives from the city's CD office and Code Inspection office in clarifying the above issues. There was an early concern that city involvement was not significant enough.* This was remedied through the addition to the committee of Mr. Tom Mattingly (CD) and Mr. Ken Flynn (Code Enforcement).

The Structure and Organization Committee chaired by Mr. Carl Eshbaugh, Director of The University of Tennessee Legal Clinic, met to prepare preliminary rough drafts of applications for tax exempt status. This committee developed increased importance later in the development process when the articles of incorporation and by-laws were drafted.

The Community Relations Committee was chaired by Mr. John Harshaw, President of Magnolia Federal Savings and Loan Association. The committee met three times between Workshops I and II in an effort to develop as broad a base of community support as possible. One hundred letters were sent to individuals and organizations not currently involved in the NHS process. These individuals were invited to a "catch-up" workshop. Support at this meeting was minimal. The Community Relations Committee also organized a presentation before the monthly meeting of the Knoxville Board of Realtors in hopes of enlisting their support and assistance. The committee, aside from dispensing public information, developed an increased responsibility after the site was selected. At that time the committee began to introduce the NHS program in the target neighborhood and sought support and leadership for its further development.

Each of the committees formed at Workshop I had an important function in the development of the NHS program. The point in the developmental process at which each committee achieves the bulk of their responsibility varies. The Site Selection Committee had the most immediate task, that of selecting a target neighborhood for the NHS program. The Government Relations Committee also began working quickly in establishing a rapport and working relationship with the many city departments and individuals

involved in neighborhood revitalization, housing rehabilitation, and capital improvements. Other committees such as Structure and Organization and Personnel and Administration faced less pressing responsibilities early in the development process.

Organization of Community Leadership

Following Workshop II and approval of the recommended site, the next major step in the developmental process was the organizing of residents in the Park City neighborhood. An active, concerned, and involved neighborhood is necessary to the further development and operation of any NHS program. The program was approaching a point at which NHS becomes "their" program, meaning the neighborhood residents. The period between Workshops II and III is a transition period, at least in the Knoxville example, where residents of the target area are brought into the NHS process. Ms. Neel, who was responsible for involving the Park City residents explained that the task was not to organize the community but to locate potential leaders for community organization. The task of recruiting residents for involvement was slowed temporarily by the lack of much existing community or neighborhood organization.

It was at this point in the developmental process that the Community Relations Committee increased its activity. After a short period of uncertainty with regard to individual responsibility the search for, and organization of community leadership commenced. Ms. Neel, with help from members of the Community Relations Committee, divided Park City into nine sections and began a door-to-door canvas.

The purpose of the door-to-door canvas was to locate neighborhood residents who would be receptive to NHS. The pyramidal technique was used to reach the greatest number of people.

A wide range of help was enlisted to assist in locating residents who might be interested enough to become involved in the program. Names of individuals who had recently bought homes in the neighborhood were gotten from realtors; Councilman Casey Jones was asked to recommend individuals with potential for participation; churches were used as a source for names; and the city supplied the names of individuals who had participated in their housing rehabilitation program and block clubs organized during a CD public improvement program.

From the names received and the door-to-door canvas a meeting was held at the Fifth Avenue Baptist Church. In addition, notices were placed in neighborhood church bulletins and all persons on the church register living in Park City were contacted.

The meeting, held on January 10, 1979, produced a much greater turnout than expected and a great deal of enthusiasm.* The residents were provided with a description and background information regarding NHS. There was a slide show illustrating the potential impact an NHS program might have in their neighborhood. The residents were also given an opportunity to speak and express their feelings regarding their neighborhood, themselves, and NHS.

The first neighborhood meeting demonstrated there was indeed a base for neighborhood leadership and support present in Park City. It was a yet untapped resource. Perhaps NHS, or a similar program, was

all that was needed to get the area residents active in making themselves heard and their neighborhood a better place to live.

This meeting was followed by additional contacting of neighborhood residents and follow-up contacts with those present at the first meeting who possessed potential for community leadership. A second meeting was planned for two weeks hence to make sure everyone had an opportunity to hear about the program and attend one of the meetings.

The second meeting, as evidenced by such a strong turnout, proved conclusively that the interest necessary to support an NHS program was present. Ms. Neel could now begin to think ahead to Workshop III which marks the beginning of resident involvement in the program.

The organization of community leadership was a weak point in the developmental process. Immediately following the selection of Park City as the target area the program's momentum seemed to slow. There was a period (4-6 weeks) of indecision among the NHS organizers about how to go about locating and organizing community leadership. This was compounded by the temporary alienation of other neighborhood leaders whose assistance would be most valuable.

The cause of this weakness in the development process can best be attributed to professional and personal differences among the actors. These conflicts merely slowed the process and did not cause irreparable harm.

Workshop III

Workshop III, also called the "resident inclusion" workshop, was held February 1 and 2 in Nashville, Tennessee. Participants included

representatives of local financial institutions, city government, the community-at-large, and Park City residents. The Park City residents making the trip were chosen from the two neighborhood meetings on the basis of potential involvement and leadership in the NHS program. Most other participants had been involved in the developmental process since Workshop I.

The workshop participants left Knoxville by bus early on the morning of February 1. After checking in at the hotel, there was a luncheon. The luncheon and the bus trip were the first opportunities for this particular group of people to get together.

Following lunch the afternoon session began. From the very beginning it was stressed that the neighborhood residents must be willing to provide the leadership role in the development and operation of the NHS program. Their participation is crucial for a successful venture. All the participants were then asked to rise, identify themselves, and state why they are interested in the program.

A further explanation of the NHS concept and program was provided by URTF representatives and a movie, "Turning Around," was shown. "Turning Around" is the NHS film. It documents the development and operation of one of the earliest NHS ventures, Madisonville Housing Services in Cincinnati. All participants by this point have seen the movie once, some two or more times. It is an effective vehicle used in the first stages of marketing an NHS program.

After the movie Mr. Anderson Hewitt, Executive Director of the Nashville NHS program was introduced. He candidly described his feelings

about NHS and explained what was being done and what was planned for in the operation of the Nashville NHS.

Mr. Hewitt's presentation dealt with community organization techniques, free paint programs, and loan financing and availability in the Nashville program. He continued to stress the theme that NHS is a corporation and operates as such. The corporation can use its funds at its own discretion. Decisions are up to the local residents who comprise a majority on the Board of Directors and Loan Committee. "The program belongs to you, the residents, and you must make it work."

Following Mr. Hewitt's presentation and a short recess, there was an opportunity for the workshop participants to engage Mr. Hewitt in a question and answer session. There was much concern about loan applications, eligibility for loans from the revolving loan fund, the Loan Committee, the extent of local government involvement, availability of qualified contractors, and an assessment of the program's impact.

Mr. Hewitt painted a frank and optimistic picture of the Nashville NHS program. The program has had its share of problems. He told the participants, especially the Park City residents, that the NHS concept is a good one and that it can be used to stem decline in their neighborhood and turn it around. He explained the partnership approach as an effective yet unnatural method of dealing with municipal problems of this type. There is a great deal of "tightrope walking" and politics involved. The walls preventing effective communication and interaction among the three partners are still present, but NHS

provides a small door in these walls. It is the function of the NHS Executive Director to patrol these walls to see that the door stays open. Mr. Hewitt's remarks concluded with the overriding theme of Workshop III, that the primary responsibility in NHS lies with the neighborhood residents. The other partners, city government and local financial institutions, can only provide assistance.

The question and answer session ran late due to the amount of interest and questions generated by the workshop participants, especially the Park City residents. After dinner the workshop resumed with a presentation concerning the NHS partnership. A panel composed of board members of the Nashville NHS and a representative from the Loan Committee gave presentations and answered questions. Board members included representatives from city government, a commercial bank, a savings and loan, and the NHS neighborhood. Each person related what they felt they brought to the partnership and what the necessary contribution from the other partners was. It was stressed again that the government and the lenders have only a supportive role and the residents have the active role. The speakers stressed the concept of commitment. Commitment is necessary through time, money, or support. A personal commitment of lenders and government was viewed by one board member as important.

The workshop participants were given an opportunity to question the panel members. Bankers were able to ask their counterparts in the Nashville NHS more technical and specialized questions as were representatives of local government. The residents dealt mainly with

general questions and concepts. Much of the questioning by the Park City residents dealt with the revolving loan fund and eligibility for it.

Following the discussion of the NHS partnership, the workshop proceeded to a lengthy presentation on the role of the resident in the NHS program. The presentation was conducted through two panel discussions; one dealing with the involvement and organization of block clubs, and the other dealing with a broader view of neighborhood involvement and participation. The group from Knoxville was divided into two smaller groups for participation in the panel discussions. After about an hour the groups switched rooms.

To present the role of the residents in an NHS program two panels composed of the most active and involved residents were formed. Many were block club presidents or board members of the Nashville NHS. One panel discussed a broad view of neighborhood participation and the other a narrower conception of neighborhood involvement, e.g., the organization and function of neighborhood block clubs.

Most of the discussion and interaction at this point in the developmental process had shifted to the Park City residents. They were reaching a better understanding of the NHS concept and process and had many questions ready for the residents of the Nashville NHS. These panel discussions provided an opportunity for the Park City residents to learn more about what they felt was important. They could share experiences and hopes with the Nashville residents regarding their respective neighborhoods—the problems, their desire to maintain it, and the work necessary to accomplish their goals.

The Park City residents related well to the residents on the panel, they were "people like us." The evening session, from the view of the Park City residents, was most informative, harmonious, and productive.*

The overriding theme throughout these panel discussions was the importance of resident activity and involvement. This was stressed again and again. Most comments and remarks led back to this crucial concept of resident participation. The panel discussion, as was the entire format of Workshop III, was designed to heighten the enthusiasm and interest of the Park City residents. They were relentless in their questioning, and their eagerness to learn more about the Nashville experience conveyed their interest and enthusiasm. The Park City residents seemed to embrace and accept the concept of neighborhood involvement, cooperation, and participation. The enthusiasm was nearing its zenith, the Park City residents and the whole group were eager to begin their own NHS.

Following the panel discussion was a reception. This provided an excellent opportunity for workshop participants to get residents and staff members of the Nashville NHS on a one-to-one basis and get a better understanding of what may be important to each individual. This informal sessions was very conducive to developing enthusiasm among the residents and continued to stress the importance of the partnership concept and the idea that the program and its destiny is in the hands of the neighborhood residents.

The entire first day of Workshop III was conducted in an atmosphere which lent itself to a learning process, both formal and informal, with

a built-in mechanism designed to solidify and strengthen the personal commitment of the Park City residents to the NHS program. The process and program of Workshop III gave the Park City residents a chance to communicate with, and learn from, people similar to themselves. This facilitated the communication process and helped the residents to relate to and understand much better the concepts which are crucial to the success of their NHS program. Some Park City residents seemed to be rising to the challenge of increased involvement and became more and more interested and active in the program. Leaders and potential neighborhood leaders emerged throughout the workshop process.

Day two of Workshop III began with breakfast and departure from the hotel. The second day provided the group with an opportunity to tour the Nashville NHS neighborhood. For most of the group this was the first look at an operating NHS program. The tour included a visit to the NHS office, a tour of much of the neighborhood, and a reception at the home of one of the neighborhood residents.

The workshop participants had a chance to see much of what they heard about the night before. Seeing the neighborhood, what was being done, and what needs to be done provided a good illustration of what the Park City residents may face in the stabilization and improvement of their neighborhood. The residents were able to tour the neighborhood and discuss among themselves what they saw, question Mr. Hewitt, Ms. Neel, and URTF representatives, and decide to what extent they were willing to commit themselves to see the program succeed in their neighborhood.

Following the tour the workshop participants had a final meeting at the Progressive Baptist Church. The purpose of this meeting, the final phase in Workshop III, was to decide where the program in Knoxville would proceed from here. The meeting began with a statement from Ms. Neel. She explained to the Park City residents why they were chosen to participate in the development process. The residents represented a broad cross-section of the community, diverse in nature, and possessed an interest in NHS and saving the neighborhood in which they lived.

All participants then rose and told the group their feelings and what they had learned after a day and a half of participating in Workshop III. The responses from all the participants were extremely positive. They reflected an enormous amount of interest, involvement, and personal commitment to ensure the success of an NHS program in Knoxville. Some people could not wait to return to begin the work of organizing the neighborhood and their block.

Enthusiasm was built throughout the workshop process to its peak at this final meeting. There existed among all the participants a belief, a belief in the program, the concepts, and in themselves to make the program work. At this point the residents were asked to sign up for committee participation. The purpose and function of each committee was explained and all the individuals were encouraged to become involved in at least one. Everyone signed up for one committee; many chose to participate on two.

The residents were told that their job begins as soon as they returned to Knoxville. They were to spread the word about NHS among their friends and neighbors. Most important was to explain the program and encourage others to become involved. The meeting ended with a prayer and group returned home.

The length of the development process poses a problem in keeping the interest and enthusiasm of all the participants at a high level. This waning of interest is natural and is harmful only when it becomes irreversible. For this reason the development phases contains five workshop sessions, some more important than others, but each designed to keep pumping enthusiasm and momentum into the program. Workshop III did much to rejuvenate interest in the continued development of the NHS program in Knoxville.

It was felt by the participants interviewed that the trip to Nashville was the highlight of the development process. Being able to see what was being done, how it was being done, and that the program could work did much to renew the interest and enthusiasm of those who had been involved since Fairfield Glade. It was also felt that Workshop III, the trip to Nashville, was informative and productive as compared to the more social atmosphere surrounding Workshop I.

Workshop III must be considered a most successful step in the development process. While there was a great deal of work yet to be done, much has already been accomplished. The partnership had been formed and firmed. There existed a personal commitment from the city, the bankers, and the neighborhood residents to do everything in their

power to ensure the program's success. A foundation had been constructed on which a neighborhood rehabilitation program, NHS, can be built.

Workshop IV and Committee Involvement

Following the return to Knoxville about one month passed before the group met again. The next meeting, Workshop IV, was for the purpose of organizing the committees formed at Workshop III and to ratify the articles of incorporation and the corporation by-laws. New participants were also brought up to date in the development process.

Workshop IV was held on March 8, 1979, at the Fifth Avenue Baptist Church. Workshop IV, as was the case with the previous workshops, elicited a strong turnout. There was an opportunity for everyone to get together and talk informally for about thirty minutes prior to the start of the meeting.

The business portion of the meeting included discussion of the articles of incorporation and the by-laws. After a brief discussion both were adopted. The articles of incorporation and the by-laws were the work of the Structure and Organization Committee chaired by Mr. Carl Eshbaugh. The committee was fairly specialized and had a strong representation of the legal profession. The resulting articles of incorporation were a common structure for a nonprofit community based organization.

Following adoption of the by-laws and articles of incorporation any new participants were brought up to date by a presentation of a summary of Workshops I and III.

The next order of business was a presentation by Rev. Bill Murrah speaking for the Inner-City Neighborhood Coalition (INC). He stated that INC has been active in trying to get an NHS program for Knoxville since the fall of 1977. It was important that there be an NHS program in Knoxville, not just in the neighborhood you represented. Rev. Murrah pledged the cooperation and assistance of INC and the Fourth and Gill Neighborhood Association in doing whatever was necessary for NHS to function effectively. This is an important gesture since it marked the return of a broader base of community support to NHS. Later, another neighborhood leader returned to engage in a low level of participation.

After a period of some bad feeling following the site selection any broad base of community support evaporated. This is a natural attrition; there are other things that need to be done and it is to be expected that individuals involved in community work will first work to improve their immediate environment. Some of the neighborhood leaders who drifted away from the program came to realize that if they wanted an NHS program in their neighborhood, it must first work in Park City. For this reason, as well as city-wide improvement, the program can be expected to achieve a broader base of community support and a good relationship with other inner-city neighborhoods.

Workshop IV concluded with committee meetings. This was the first opportunity for the committees to meet following Workshop III. Since that time many new members, the Park City residents, had been added to the programs. The purpose of these meetings was for old committee members to meet new committee members and to establish a mutually

acceptable meeting time and location. The Fifth Avenue Baptist Church was made avilable for NHS meetings and due to its location in the Park City neighborhood and meeting facilities, most of the committees chose to meet there.

It should be mentioned that the church has played an important role in the development process, specifically in locating potential neighborhood leaders and in providing meeting facilities.

Following Workshop IV the committee with the most immediate responsibility was the Community Relations Committee. One of the first orders of business was the organization of block clubs. The decision to organize the Park City neighborhood through the use of block clubs was a result of Workshop III. Residents in the Nashville NHS neighborhood had used block clubs and the approach appealed to many persons present at Workshop III. It was felt that block clubs would provide the strongest base of support for the operation of an NHS program. This is especially true in Park City which had little previous community organization.

To provide incentive for the organization of these block clubs, it was decided that the first area to become organized will likely be the area where rehabilitation work begins. The Park City area, as mentioned earlier, had been divided into nine sectors.

The Community Relations Committee also had the responsibility for obtaining office space for the NHS staff when the program becomes operational. Shortly after the site selection was made, a search began for office space in the neighborhood. One house in particular was

immediately eyed as the potential NHS office. The house, a large home, is located at the corner of E. Fifth Avenue and Cruze in the heart of the target area. In addition, the house needed rehabilitation work. It was thought that by rehabilitating the house through volunteer work it could provide a good illustration of the program's potential. The Community Relations Committee has obtained the money to transfer the title to the newly incorporated NHS program and has begun to solicit volunteers for the rehabilitation project.

Other committees with immediate responsibilities following Workshop IV were the Government Relations Committee and the Personnel and Administration Committee. The Government Relations Committee began meetings with the director and staff members from the Metropolitan Planning Commission (MPC). The purpose of this meeting was to investigate the possibility for MPC doing a small area plan for Park City. This would be a plus for the neighborhood and the NHS program. It would provide much needed data regarding income, housing quality, number and type of structures, etc. It was also hoped that the city's public improvements would be based on the results of this small area study.

Other responsibilities of the Government Relations Committee were concerned with code enforcement. The city code enforcement director, Mr. Ken Flynn, again provided assurance that the city would participate in a flexible and sensitive code enforcement program in Park City. The possibility of the code officer assigned to the NHS neighborhood having his office in the NHS office was also discussed.

The assignment of one code enforcement officer to the NHS neighborhood is a great help in developing the trust and confidence of area residents. By having the code enforcement responsibilities assigned to one person, the possibility of confusion is diminished and the avenues of effective communication are increased. For the code enforcement officer to have his office in the NHS office would help to increase accessibility and trust. It also illustrates the partnership concept in an operational context.

The final committee facing prompt action was the Personnel and Administration Committee. The sole task of this committee is to solicit applications for the position of Executive Director and narrow the choices for eventual interviewing and selection by the Board of Directors.

To attract the greatest amount of applicants advertisements were placed nationally, regionally, and locally. Approximately sixty responses were received. In an attempt to narrow this to a more manageable number, qualifications were ranked as to their importance. Of the seven criteria considered crucial, three skills emerged as the most important; administrative skills, experience in housing, and experience in community organization. This narrowed the list to twenty-five persons. The list of twenty-five applicants was reviewed again, using much the same criteria, and the number was reduced to twelve. The seven criteria were then weighed, 1-5, and the twelve remaining applicants were then ranked on this basis. Of the twelve remaining applicants, five were ultimately invited to interview for the

position. The Board of Directors was responsible for the interviewing and for recommending to the larger group an Executive Director. On July 5, 1979, Mr. Keith Richardson, then housing planner at the East Tennessee Development District, was named Executive Director of Knoxville Neighborhood Services, Inc.

Workshop V

The final stage of the development process is Workshop V. Held April 17, 1979, this meeting marked the end of the development process. By this time the group that first met at Fairfield Glade eight months ago had incorporated and elected its first Board of Directors. Although the corporation cannot begin the rehabilitation process until an Executive Director and staff have been hired, for all intents and purposes the development process has concluded.

Workshop V began with an introduction from Ms. Neel, the local coordinator. It was followed by a statement from Mayor Tyree expressing optimism for the NHS program and for the revitalization of other inner-city neighborhoods. Committee reports followed the Mayor's remarks. Committee heads used this opportunity to bring the group up to date on their committee's work. The next item on the agenda, and the highlight of Workshop V, was the election of the Board of Directors.

The Board of Directors has ultimate control over all decisions made by the new corporation, Knoxville Neighborhood Housing Services, Inc. The Board is composed of seventeen members, nine of whom are

residents of Park City. The majority of neighborhood residents is to assure community control of the program. It has been stated all along that the program belongs to the neighborhood residents, majority control of the Board of Directors assures this.

Of the seventeen positions on the Board of Directors, nine were allotted to neighborhood residents, four to representatives of local lending institutions, two to representatives of city government, and two at-large positions. The bankers decided among themselves who to nominate. The Mayor was responsible for nominating the two city representatives. Ms. Neel presented the nominations of a nominating committee for the at-large candidates and the Park City residents. Additional nominations were taken from the floor.

The results from the election of the Board of Directors were very satisfying to all involved in the development process.* The bankers on the Board included the President of the largest savings and loan and a Vice-President of the largest commercial bank. The city representatives were the Director of Housing Rehabilitation and the Code Enforcement Administrator. The at-large representatives are the Coordinator of the East Tennessee Community Design Center and an employee of the Knoxville Urban Ministry. Listed below is the Board of Directors.

Knoxville Neighborhood Housing Services—
Board of Directors

Lenders

David Sharp

John Harshaw

David Farr

Joe Adams

City Government

David Prisock

Ken Flynn

At-Large

Annette Anderson

Anna Dirl

Park City Residents

Chuck Anderton

Bennie Battle

Mildred Gerkin

Robert Hamilton

Reba Jenkins

Rick Mallory

Malinda Mostella

George Wyatt

Mel Betcher

The development process had been completed and all the individuals present, pleased with what had already been accomplished, were ready to begin the work at hand and make the program operational.*

Summary

Neighborhood Housing Services is a neighborhood rehabilitation program that has been receiving much attention as a vehicle for stemming

the decline of older, inner-city neighborhoods. NHS programs have experienced a rapid growth in recent years as many local governments have sought and received assistance to develop a program in their city. The city of Knoxville was one of these local governments interested in developing and operating an NHS program in one of its older inner-city neighborhoods. The result of the city's interest and desire is Knoxville Neighborhood Housing Services, Inc.

Knoxville applied for developmental assistance in beginning an NHS program in February 1978. The process was completed in April 1979. The fourteen months required for completion of the developmental phase is about average. The developmental process requires a period of time often exceeding one year.

The seemingly long time period required for the development of an NHS program is due to the careful, thorough, and extensive preparation given to the entire process. The developmental process builds a foundation upon which an operating NHS program can be placed. The foundation is constructed with this in mind. It strives to develop a strong working relationship among the city, neighborhood residents, and local lending institutions. This partnership is a fundamental part of Neighborhood Housing Services.

Organization, coordination, and growth of the partnership and the entire development process is the responsibility of the Urban Reinvestment Task Force (now the Neighborhood Reinvestment Corporation). The URTF later hires a local coordinator who shares this responsibility.

Early in the developmental process the URTF conducted an extensive series of preassessment visits aimed at determining the feasibility of an NHS program in Knoxville. These visits to local community leaders, city officials, and ranking representatives of local lending institutions determines whether there are adequate levels of resources and support from all partners for the continued developmental and eventual operation of an NHS program.

The preassessment visits in Knoxville revealed sufficient resources and support for an NHS program. The next step was for the city to enter into a developmental contract with the URTF. The agreement outlines the responsibilities of both parties in the development process. It is in this agreement that the city provides the funds ($30,000-$50,000) for the development of an NHS program. The city's contribution is returned by the URTF when the program becomes operational.

The developmental process from the preassessment visits through Workshop I stress the need for neighborhood conservation and rehabilitation through the partnership approach of Neighborhood Housing Services. There must be a strong working relationship between the three partners for the program to function effectively. All the partners were eager to meet the challenge of working together for the good of all.

Following the preassessment visits the developmental process is highlighted by a series of five workshops. Workshop I was a two-day meeting held at Fairfield Glade, a resort community. The retreat-like

atmosphere is an essential ingredient of Workshop I. Workshop I is used to strengthen the partnership approach to NHS. Much of the time was spent in a fairly social environment. The three partners were given numerous opportunities to interact and hopefully begin to break down any stereotypes that might have previously existed.

Workshop II followed Workshop I by about six weeks. The interim was spent selecting a site as the target neighborhood for the NHS program. Workshop II included a presentation of the recommended site by the site selection committee and a vote approving the committee's recommendation.

Workshop III is known as the resident inclusion workshop and for the first time included residents of Park City, the target neighborhood. This is probably the single most important step in the workshop process. It was viewed by nearly all of the participants interviewed as the highlight of the development process. Workshop III was held over a two-day period in Nashville. The thrust of Workshop III is that the NHS program belongs to the neighborhood residents. The other partners can only play supportive roles. The importance of an active, concerned, and involved neighborhood is reinforced through numerous presentations. The most effective of these being a panel discussion with residents involved in the Nashville NHS program. The enthusiasm of the participants reached its highest point following completion of Workshop III.

Workshop IV was basically an organizational meeting which followed Workshop III by about four weeks. The purpose is to reorganize

committees which had been functioning since Workshop I but are now receiving many new members in the form of Park City residents. Other business included adoption of the articles of incorporation and by-laws.

Workshop V concluded the developmental process. This meeting, held approximately seven months after Workshop I was primarily for the election of a Board of Directors. The final workshop became the first meeting of the newly formed NHS corporation.

The work of the URTF and the local coordinator is a most crucial factor in the development process. They provided an underlying strength to the program. They insured the fact that the program developed with a strong foundation so it is able to stand after the developmental process has been completed.

CHAPTER IV

SUMMARY AND CONCLUSIONS

In this, the final chapter, the author will present a summary of the research and additional analysis of the literature search and the case study. The final conclusions and areas for further research will also be presented in this chapter.

The purpose of this thesis has been to contribute to the body of knowledge regarding neighborhood conservation and rehabilitation, specifically the Neighborhood Housing Services program. In order to obtain a better understanding of NHS it was necessary to develop an historical perspective. This was accomplished by reviewing and analyzing, through a literature search, the many federal and local attempts at neighborhood rehabilitation. This analysis revealed numerous weaknesses in federal programs and much innovation by local governments.

Federal programs aimed at stemming the decline in older, urban neighborhoods have undergone many modifications and changes since the introduction of the Urban Renewal program in 1949. Throughout the years, however, the federal government has failed to come to terms with some major problems in neighborhood rehabilitation. These are involvement of the private market, specifically the lending industry, adequate levels of citizen participation, and concentrating program efforts in a workable area.

The federal programs have attempted, although not with great success, to deal with all the above problems. Urban renewal stressed involvement of the private sector and the myriad of federal grant programs mandated some degree of citizen involvement. Recently the CDBG program has given local governments increased decision-making authority in the spending of federal money. This has resulted in some local governments developing neighborhood rehabilitation programs concentrated in a few target areas.

From the 1930's to the present, government, both at the federal and local levels, has been involved in a myriad of programs which can be broadly characterized as "urban renewal." The direction of this massive financial involvement by the public sector has been modified and expanded numerous times since passage of the Housing Act of 1934 in hopes of developing a solution, or solutions for our urban ills. We have learned much through the experimentation and implementation of the many urban aid programs about how to attack the problem of urban decline.

Of the many problems facing urban American in the 1970's the area of neighborhood rehabilitation and conservation has attracted a growing amount of attention. This is true for a number of reasons. Urban neighborhoods are one of the building blocks of the city. The future of the city is closely linked to the future of its neighborhoods. The inner-city neighborhoods possess a great resource of our housing stock and home ownership opportunities for the next generation. This is especially true for lower and middle-income families unable to afford

new housing. Their character, individuality, and heritage have proven to be values worth preserving. In the face of an energy shortage and a changing lifestyle, inner-city neighborhoods are enjoying increased popularity due to their proximity to shopping, schools, jobs, entertainment and mass transit. In addition it has been found that neighborhood rehabilitation is a problem that we are able to come to grips with. Obviously not all the answers have been found. It is unlikely that they ever will be. Much progress, however, has been made in the last decade with regard to neighborhood rehabilitation and conservation.

The strategies involved in neighborhood conservation programs include active participation of the private sector, leveraging of public funds, and strong, organized citizen participation. These strategies, still in the process of development, are primarily a result of locally initiated neighborhood conservation programs funded in part through CDBG funds.

Many of the local programs are characterized by a strong sense of community and are given strength through active citizen participation and leadership. The local programs are also able to add a certain degree of sensitivity and flexibility not found in previous federal grant programs. The local programs have also relied on leveraging limited public funds to expand, but not water down their effectiveness. It is apparent to the author that neighborhood revitalization, rehabilitation, and conservation programs stand a greater chance for invoking positive changes in the community than the federal urban aid

programs of the past. It is for this reason that Neighborhood Housing Services is important.

Neighborhood Housing Services is a recent attempt to stem decline in older, urban neighborhoods. The program focuses on the physical rehabilitation of a target neighborhood and utilizes increased investment opportunities offered by local lending institutions to facilitate the redevelopment. Increased capital improvements and service delivery, a high level of citizen participation, and a high-risk revolving loan fund are the other ingredients in the NHS approach to neighborhood rehabilitation.

Begun in Pittsburgh in 1968, the program has grown rapidly. There are now more than 70 programs in operation with about a dozen more in the developmental stage. Assistance in developing an NHS program for cities nationwide is offered by the Neighborhood Reinvestment Corporation.

Chapter III of this thesis is a case study of the developmental process of Knoxville Neighborhood Housing Services, Inc. It is based upon the author's observations of the developmental process through attendance at workshops and meetings. Additional research was in the form of interviews with participants in the process.

This thesis has shown that the developmental process of an NHS program is thorough and intensive, often lasting more than a year. The Knoxville NHS required a period of fourteen months to complete the developmental process. The developmental process is crucial to the future operation of the NHS program for it provides a foundation

for the program's later activities. The program is built from the bottom up.

The thesis has shown the importance of the involvement of both the public and private sectors and the need for citizen participation in neighborhood conservation programs. Neighborhood Housing Services is a neighborhood conservation program which is built around this involvement of the public and private sectors and the neighborhood residents. It focuses on the shortcomings of earlier neighborhood conservation programs.

The development process is crucial to the subsequent operation of the NHS program because it devotes a great deal of time and effort to the development of a working relationship among the city, the local lending institutions, and the neighborhood residents. This partnership is the cornerstone of an NHS program.

The development process distinguishes NHS from other federal attempts at neighborhood conservation. Involvement of the private sector has been attempted before, notably during urban renewal. There was not, however, much emphasis or consideration given to the development of a partnership of that type. NHS has recognized the differences inherent in working with three diverse groups. It devotes much time to developing the partnership concept. Through much interaction at workshops and meetings preconceived notions and communication barriers are slowly broken down. By the conclusion of the development process a feeling of unity among the three partners has begun to take hold. They have become a Neighborhood Services Corporation and are no longer simply bankers, neighborhood residents, or city officials.

The NHS development process is dominated by a sophisticated marketing strategy. In Marketing for Nonprofit Organizations, author Philip Kotler defines marketing as,

> . . . the analysis, planning, implementation, and control of a carefully formulated program designed to bring about voluntary exchanges of values with target markets for the purpose of achieving organizational objectives. It relies heavily on designing the organization's offering in terms of the target market's needs and desires, and on using effective pricing, communication, and distribution to inform, motivate, and service the market.[1]

The "selling" of NHS throughout the developmental process bears a striking resemblance to much of the above definition. The developmental process as constructed by the URTF is carefully formulated and strives for voluntary exchanges in developing the NHS partnership. The program is effectively tailored to the organizational needs of the Task Force, and to the needs of its clients; the city, the bankers, and the neighborhood residents.

The developmental process stressed communication for information and motivation. The process was highlighted by a series of five workshops varying in emphasis and importance.

Workshop I stressed communication among the partners and has the primary purpose of organizing the three partners into a working relationship. Workshop I was an emotional high point in the developmental process.

Workshop II was the nadir of the development process in the Knoxville case study. There was much doubt regarding the site

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[1]Philip Kotler, Marketing for Nonprofit Organizations, (Englewood Cliffs, N.J.: Prentice-Hall, 1974, p. 4.

selection and the level of citizen involvement within the neighborhood. It is the author's contention that the importance of the developmental process can be seen at this point. The prior work of the Task Force and the local coordinator in the developmental process gave the program the necessary strength and enthusiasm to overcome this low point in the developmental process and continue with the most difficult task of organizing potential leadership in the Park City neighborhood.

Following the organization of potential leaders in the target neighborhood came Workshop III. It was felt by most of the participants interviewed by the author that this was the highlight of the developmental process. It was at this time that pieces of the puzzle began to fall into place and a clearer picture of NHS could be seen. Workshop III marked the initiation of the neighborhood residents into the developmental process. It was at this point that the program's responsibility and direction shifted to the neighborhood residents. The overriding purpose of Workshop III was to solidify the commitment and involvement of the neighborhood residents.

Workshop III, as did Workshop I, attempted to generate a great deal of enthusiasm in the NHS concept and approach to neighborhood conservation. Through the marketing strategy involved in the workshops and the individual workshop format sufficient enthusiasm and commitment is created to sustain the participants through the remainder of the development process. The format of Workshop III built slowly, peaked at the end of the first day, and maintained and channeled this enthusiasm into commitments and involvement from the Park City residents.

Workshop IV was basically a business and organizational meeting. The marketing approach is at a low level at this point. Workshop IV had little importance in the developmental process other than to make the neighborhood residents more comfortable in the NHS organization.

Workshop V culminated the developmental process with the election of the Board of Directors. This final highlight in the developmental process was designed to generate sufficient enthusiasm until an Executive Director was hired and the program can begin to operate within the neighborhood.

This thesis has shown the importance of the developmental process to the subsequent operation of an NHS program. The developmental process provides the program with the involvement of the private sector (local lending institutions), a working relationship of the city, the banks, and the neighborhood residents, and the financial commitments necessary for the first year's operation.

The thesis has also shown the existence of a sophisticated and intensive marketing strategy throughout the developmental process. This marketing strategy is effective in involving the participants, obtaining and solidifying commitments, and in developing a working relationship among the three partners. It is this relationship that is the key to the development and future operation of the program.

The Neighborhood Housing Services approach to neighborhood revitalization stresses the development of a partnership as the cornerstone of the program. While the NHS approach is stronger than other planning programs in ground work, communication, and personal

psychology there is a lack of planning and a programmatic approach following the selection of a target neighborhood. For example, no studies are conducted to determine the number and types of structural repairs needed in the area. No analysis of other neighborhood problems is conducted. No plans or targets are established for the operational phase of the project. The emphasis is on forming, selling, and marketing the partnership and has little immediate concern with the future operation of the program.

Areas for Further Research

The author visualizes two possible areas for further research. One would be to undertake a similar study of the developmental process of another NHS program. Contrast and comparison of similar case studies may provide useful information in a further analysis of Neighborhood Housing Services.

The other area for further research would be to research the operation and impact of Knoxville Neighborhood Housing Services, Inc. Research of this type would be useful in two ways. It would critique the author's conclusion that the developmental process is critical to the future operation of an NHS program and it would provide additional information to the sparse body of literature of Neighborhood Housing Services.

In closing the author would like to include some final observations about the developmental process of a Neighborhood Housing Services program. The author has little doubt that the developmental process is of paramount importance to the future operation of an NHS program.

The time spent developing the partnership is time well spent. Throughout the development process communication barriers are broken and the three groups slowly unite towards one goal, stemming decline in the target neighborhood.

It is interesting to note that the developmental process derives its strength and weakness from the same source, the participants. The strength of the program is derived from the partnership of three diverse groups working in one direction. The weakness evident in the development process comes from these same participants. As often happens, an individual's goal, or his goal for a small group can seem greater than the goal of the whole group. On at least two occasions during the development of Knoxville Neighborhood Housing Services, Inc., this was the case.

It is the author's belief that the strength of the participants far exceeds their weaknesses. Problems of the nature experienced in the Knoxville case study are a natural phenomena. The partnership is the program and the development of the partnership is a most important factor in the ultimate direction of the program.

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APPENDIX

NHS COMMITTEE MEETINGS ATTENDED BY THE AUTHOR

September 21, 1978.	Governmental Affairs Committee, East Tennessee Community Design Center.
September 22, 1978.	Fund Raising Committee, Home Federal Savings and Loan.
September 25, 1978.	Personnel and Administration Committee, Green's Restaurant.
September 27, 1978.	Site Selection Committee, Valley Fidelity Bank.
September 28, 1978.	Community Relations Committee, Magnolia Federal Savings and Loan.
October 4, 1978.	Site Selection Committee, Valley Fidelity Bank.
October 5, 1978.	Governmental Affairs Committee, East Tennessee Community Design Center.
October 5, 1978.	Community Relations Committee, East Tennessee Community Design Center.
October 6, 1978.	Fund Raising Committee, Home Federal Savings and Loan.
October 11, 1978.	Personnel and Administration Committee, Green's Restaurant.
October 12, 1978.	Community Relations Committee, Magnolia Federal Savings and Loan.
October 12, 1978.	Code Enforcement Subcommittee, East Tennessee Community Design Center.
October 15, 1978.	Bus tour of neighborhoods.
October 16, 1978.	Site Selection Committee; vote on site for recommendation to ad hoc committee, Valley Fidelity Bank.
October 18, 1978.	Personnel and Administration Committee, Green's Restaurant.
October 19, 1978.	Governmental Affairs Committee, East Tennessee Community Design Center.
October 24, 1978.	Workshop II, Faculty Club.
October 27, 1978.	Fund Raising Committee, Home Federal Savings and Loan.
October 31, 1978.	Community Relations Committee, Magnolia Federal Savings and Loan.
February 1-2, 1979.	Workshop III, Nashville, Tennessee.
March 8, 1979.	Workshop IV, Fifth Avenue Baptist Church.
March 29, 1979.	NHS Committee Meetings (all), Fifth Avenue Baptist Church.
April 17, 1979.	Workshop V, Hyatt Regency, Knoxville.

VITA

Martin Stuart Jacobs was born in Boston, Massachusetts, on June 19, 1952. He attended elementary school in Yonkers, New York, and high school in Cincinnati, Ohio, graduating in 1970. Upon graduation from high school he entered Ohio University where he received his B.A. degree in government in 1974.

After a brief residence in Cincinnati he entered the Graduate School of Planning at The University of Tennessee, Knoxville, in 1975. He was graduated in 1979 with the Master of Science in Planning.