JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

HOMELESSNESS IN PENNSYLVANIA: CAUSES, IMPACTS, AND SOLUTIONS

A TASK FORCE AND ADVISORY COMMITTEE REPORT

APRIL 2016

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REPORT

Homelessness in Pennsylvania: Causes, Impacts, and Solutions
A Task Force and Advisory Committee Report

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The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.[1]

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.[2] Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

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[1] Act of July 1, 1937 (P.L.2460, No.459) (46 P.S. § 65), amended by the act of June 26, 1939 (P.L.1084, No.380); the act of March 8, 1943 (P.L.13, No.4); the act of May 15, 1956 (1955 P.L.1605, No.535); the act of December 8, 1959 (P.L.1740, No.646); and the act of November 20, 1969 (P.L.301, No.128).

[2] Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. However, it does, at a minimum, reflect the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth of Pennsylvania receives the financial benefit of such volunteerism, along with the expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used in determining the intent of the General Assembly.[3]

Since its inception, the Commission has published more than 350 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

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[3] 1 Pa.C.S. § 1939 ("The comments or report of the commission . . . which drafted a statute may be consulted in the construction or application of the original provisions of the statute if such comments or report were published or otherwise generally available prior to the consideration of the statute by the General Assembly").

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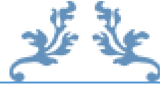

In Memory of
Dr. Staci Perlman

During our work on this project, the advisory committee sustained a tragic loss: one of the advisory committee members, Dr. Staci Perlman, passed away in the summer of 2015.

Dr. Perlman was a prominent scholar and a dedicated advocate of homeless children and families. She was known nationwide for her research on early childhood education, homeless youth, and parenting in the context of homelessness. She served on numerous boards and commissions seeking solutions to the problem of child homelessness. Her partnership with the People's Emergency Center in Philadelphia facilitated application of the latest scientific discoveries to policy and practice.

Dr. Perlman made a valuable contribution to this report. The advisory committee and the Joint State Government Commission express their profound appreciation of her efforts and hope this report will promote the cause of combatting homelessness that inspired Dr. Perlman's prolific work.

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April 2016

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To the Members of the General Assembly of Pennsylvania:

House Resolution No. 550 of 2014 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to conduct a study of the occurrence, effects, and trends of homelessness in Pennsylvania and to report its findings and recommendations.

The Commission is pleased to announce the release of **Homelessness in Pennsylvania: Causes, Impacts, and Solutions: A Task Force and Advisory Committee Report.**

The report presents a comprehensive review of impacts of homelessness on various populations and discusses public and private agencies' actions to mitigate those impacts and to secure safe and stable housing for people in need. The report includes the task force and advisory committee's recommendations for effective, efficient, and compassionate means for ending homelessness in the Commonwealth.

The report is available at http://jsg.legis.state.pa.us/.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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EXECUTIVE SUMMARY

House Resolution 550 of 2014 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to conduct a study of the occurrence, effects, and trends of homelessness in Pennsylvania and to report its findings and recommendations to the House of Representatives.

Shelter is a basic human need. As the Resolution states, "a stable, quality, affordable home promotes family stability, physical and mental health and enhances both adults' and children's ability to be productive. Conversely, the lack of a stable, quality, affordable home increases the risk of illness, failure at school, inability to find or hold a job, incarceration and nursing home placement, often at public expense." When homelessness is experienced in childhood, it can have a dramatic, ongoing impact on the individual's life. The adverse effects of childhood homelessness on children's health, development, and well-being are also associated with both short-term and long-term societal costs and impose a costly toll on society. Prevention and early intervention are critical.

Guided by the Resolution, the advisory committee undertook a comprehensive analysis of Pennsylvania's homelessness problem and developed a set of recommendations that would move the Commonwealth toward permanently reducing and eliminating homelessness.

Study Process

The advisory committee held five general meetings and numerous subcommittee teleconferences, from August 21, 2014 to December 17, 2015. The advisory committee members and the Joint State Government Commission staff conducted extensive research and reviewed studies on various aspects of homelessness from around the country.

In order to obtain direct input from families and individuals throughout the state who have experienced homelessness, the Joint State Government Commission conducted a survey of people utilizing housing services throughout the Commonwealth. The survey results and analysis are presented in the report.

Definition, Occurrence, and Presently Available Resources

The definition of homelessness is as complex as the issue itself. The advisory committee and the task force developed a broad and inclusive definition of homelessness, based on the fundamental problem faced by those who are "homeless," which is that they are without a permanent and stable living arrangement.

The very nature of homelessness makes accurate identification and count difficult. The report contains statistical data on homelessness in Pennsylvania collected by multiple methods. Data on homelessness collected by various methods should be analyzed in their totality as they complement each other and each of them illuminates one aspect of the problem not identified by others.

Multiple federal and state programs currently exist to serve people experiencing homelessness. The report contains a review of the state and federal resources, along with local, privately-funded programs assisting the homeless.

Causes, Impacts, and Promising Strategies to Address Them

Homelessness is a complex and multi-faceted phenomenon with many causes. It affects many populations as it has various complex pathways. Homelessness requires a holistic approach. Solutions to the problem will be as varied and comprehensive as the problem itself.

For a particular individual or family, homelessness typically comes as a result of a combination of macro- and micro-level circumstances. The list of causative factors of homelessness includes the lack of affordable housing, domestic violence, unemployment, insufficient job training, poverty, mental illness and the lack of needed services, substance abuse and the lack of needed services, and others.

Housing Affordability

The lack of affordable housing is an overarching cause of homelessness, affecting all categories of people who are at risk of homelessness or finally slip into homelessness. Rental affordability has grown as a challenge in recent years due to a number of factors, including increasing demand, a relative lack of rental construction lately in comparison to past cycles, and stagnant wage growth. Numerous households experience excessive housing cost burdens. These burdens are highly more prevalent among low-income households.

Traditionally, the discussion of housing cost burden focused on renters as they are more likely than homeowners to face those. However, in the past few years, the number of homeowners with severe cost burdens also increased significantly, even in the moderate-income category.

An analysis of recent trends leads to an alarming conclusion that housing affordability problems have worsened almost continuously for the past three decades. The housing bubble collapse in 2007 and the Great Recession are perceived as the leading economic cause of a vast increase in the number of households, both renters and homeowners, with severe housing cost burdens.

Expanding the supply of appropriately priced housing, increasing renters' income, and rental assistance are all required to resolve the affordability problem.

Domestic Violence

One of the leading causes of homelessness for women and children is domestic violence. Domestic violence is linked to homelessness in multiple ways. Women are often pushed into homelessness when they finally decide to leave their abuser, sometimes in fear for their life. Others stay in the abusive environment because of the lack of housing options.

The relationship between experiencing abuse from partners and homelessness is not linear but rather complex and multifaceted. It involves more than running away from home after a direct act of violence and finding refuge at a shelter. Research has corroborated links between domestic violence and housing instability.

Though various forms of domestic abuse can contribute to homelessness, one of particular importance is economic abuse, such as manipulating household accounts in ways detrimental to women, preventing women from getting or keeping a job, and limiting or denying them access to family income.

Safety remains a primary concern for some domestic violence survivors and must take priority.

Local domestic programs in Pennsylvania help significant numbers of victims of domestic violence. However, a portion of requests remain unmet because the programs do not have the resources to provide requested services.

The report contains the analysis of the effectiveness of various housing and service models in helping families experiencing homelessness establish and maintain residential stability and self-sufficiency.

Housing alone is insufficient to ensure long-term housing stability; all housing and shelter programs for families need to be enhanced by a tailored mix of supports and services based on the trauma-informed approach.

Trauma is a key predictor of long-term residential instability for victims of domestic violence, which is why trauma-informed care is the cornerstone to any approach addressing family homelessness.

A tiered system of housing services for families, dependent on the causes of their homeless condition and their needs, appears to be most beneficial and most cost-effective.

Some of the currently existing policies and programs may inadvertently make it more difficult for victims of domestic abuse to secure stable housing after leaving an abusive partner; they need to be modified.

Former Inmates

One of the essential ways to curb homelessness is to identify its immediate causes and intervene early to prevent people from becoming homeless, a strategy described as “turning off the tap.” Providers are well aware of several “feeder” systems that supply clients to shelters on a regular basis. These are correctional facilities, drug treatment centers, and sometimes hospitals. Young men and women leaving the foster care system constitute another high-risk group. Offering help to individuals from these groups at a critical time of transition may stop their descent into homelessness and many additional problems associated with it. Critical time intervention is acquiring more and more attention from experts.

Former inmates constitute one of the groups at a high risk of homelessness. Unless they have a family to return to, they face numerous challenges to securing safe and affordable housing. These barriers mostly fall into two categories: the scarcity of the housing stock in the affordable price range and formal and informal regulations and prejudices that restrict tenancy.

The interrelationship between homelessness and incarceration is complex. They constitute mutual risks for each other: homelessness contributes to a higher risk for incarceration, and, inversely, incarceration contributes to an increased risk of homelessness. Bidirectional association between homelessness and incarceration may result in cycling of a group of individuals between prisons and jails, public psychiatric hospitals, homeless shelter, or the street. Breaking this cycle would be a major achievement in curbing chronic homelessness. Researchers contend that efforts to prevent homelessness among released prisoners should focus on the transitional period occurring right after prison and should focus on persons who demonstrate a history of unstable housing.

In the past few years, housing has been acknowledged as a critical component in successful reentry. Realizing the critical role that housing plays in successful recovery as well as the increased risk of reoffending that is associated with homelessness, agencies of the criminal justice system try to connect prisoners to housing, yet these efforts are fraught with problems and limitations.

Successful programs connect formerly incarcerated individuals with stable housing, along with clinical and support services, to break the cycles of chronic homelessness and recidivism.
The report details efforts undertaken by the Pennsylvania Department of Corrections, the Pennsylvania Board of Probation and Parole, and some Pennsylvania counties to assist former inmates in finding appropriate housing arrangements.

Collaboration between correctional institutions and local community housing programs is required for success.

Mental Health and Substance Use Disorders

A significant segment of people who end up homeless suffer from mental health problems or substance use disorders. They represent a majority among those defined as chronically homeless. High prevalence of homelessness among mentally ill people and the especially high risks they face once they become homeless can be explained by a number of reasons, which are discussed in the report.

People who are homeless and have co-occurring mental health and substance use disorders often cycle through the criminal justice and homeless systems, moving from the street, to the shelter, to jail or prison, and back. Housing stability has been proven a key to long-term recovery. However, securing housing for individuals with mental illness may present additional challenges compared to the general population.

Experts and providers agree that housing alone is not enough, that support services must be provided with housing. Permanent supportive housing – permanent housing coupled with supportive services as needed – has been increasingly recognized as an effective strategy to assist people suffering from mental illness and experiencing homelessness. This model and its implementation are analyzed in detail in the report.

The report contains information on the SOAR program and the Homeless 2 Home Behavioral Health Project for Pennsylvania, along with other successful supportive housing programs for people with psychiatric disabilities in the Commonwealth.

Rural Homelessness

Homelessness was traditionally conceptualized as an urban issue. In the past few years, however, there has been a growing understanding that homelessness is pervasive in rural communities due to high rates of poverty, unemployment, lack of affordable housing, and geographic isolation.

Specific barriers to accessing and providing homeless services in rural areas include limited access to services, large service areas, dispersed populations, and a lack of transportation. The lack of affordable housing, which is a major cause of homelessness anywhere, may be exacerbated in rural areas where a newly-developed high-paying industry like gas or oil exploration has recently set in. Shortage of affordable housing in rural areas is often combined with the poor quality of housing, with some buildings lacking plumbing or heat.

Local providers in rural areas often struggle with additional administrative burdens and challenges in applying for various grants in part due to their limited staff, and in part due to the difficulty of providing data to demonstrate resource needs that are required by many grant programs.

A major challenge to the study of rural homelessness is the inability to accurately identify and quantify the population. It can be attributed to a number of factors, including inconsistent and, at times, competing definitions of "rural" and "homeless"; insufficiency of the urban methodology

when applied to rural populations; and lack of awareness or recognition of homelessness. Individuals experiencing homelessness in rural areas are also believed to be more transient, which makes it much less likely to encounter them unless you know exactly where they are. Rural landscapes camouflage homelessness through expansive geography with low population density; unstably housed individuals reside in less visible locations than in urban areas (wilderness, substandard housing, or doubling-up with family or friends).

The patterns in which homelessness unfolds in rural areas differ from urban settings, necessitating tailored approaches in public policy and service design.

The report contains a list of promising practices and a review of a successful model of outreach and service delivery in one of the Pennsylvania counties.

Veterans

There are higher levels of homelessness among veterans compared to both general and low-income populations. Some of the causal factors are shared with non-veterans; others are specific to this group.

Due to concerted efforts, the numbers of homeless veterans have fallen significantly in the past five years. The decrease in Pennsylvania has been most pronounced in the number of veterans who remained unsheltered.

The Commonwealth has shown a thorough commitment to ending veteran homelessness. In September of 2015, Governor Tom Wolf announced Pennsylvania's participation in a 100-day challenge to serve 550 homeless veterans throughout the end of 2015. Pennsylvania exceeded its goal and has permanently housed over 900 homeless veterans from the end of September until the end of January.

Numerous Pennsylvania cities have taken up the Mayors' Challenge to end veteran homelessness in their communities, and several cities have already succeeded in achieving this goal. They have reached functional zero, which means they have the capacity and infrastructure in place to house more people than are currently in the system. Increased outreach to homeless veterans and working with the community to combine resources are frequently cited as central components to ending veteran homelessness.

It is hoped that the successful process used by these communities to end veteran homelessness can serve as a guide for housing other groups of individuals and families experiencing homelessness statewide.

Homeless Survey Results and Analysis

The survey questionnaire was distributed to local providers across the state. Completed survey data was received from twenty-seven agencies representing sixteen geographically diverse counties. The total of respondents was 255. Though limited in scope, the study was important because it provided a random, brief, snapshot analysis of the current landscape of homelessness in

the state and allowed those individuals who are currently experiencing homelessness to express their opinion directly and to share their concerns.

The survey results illustrate significant diversity of the homeless population. They also reveal several notable facts that are discussed in the report and should be considered in policy-making.

Children and Youth

In the past few years, the number of children and youth experiencing homelessness has reached historic highs, and there is growing awareness of the need to increase attention to this problem.

The report contains a review of the national and state prevalence of children and youth homelessness and an analysis of its trends.

Homelessness affects children in many ways. One of the critically important negative impacts is on the child's general health. Homelessness can cause illness and aggravate existing medical problems; homeless children tend to be in poorer health than their housed counterparts. Poor health for homeless children begins at birth and even before birth. Homeless women face numerous obstacles to healthy pregnancies. Their babies have lower birth weights and more often need specialty care immediately after birth as compared with housed children. From infancy through childhood, homeless children have significantly higher levels of acute and chronic illness. They have poorer access to both medical and dental care; often they do not get required vaccinations.

Poor health outcomes mean greater health care utilization, which, in its turn, involves significant financial costs, most of which are born by public health insurance.

Longer periods of homelessness are associated with worse health outcomes, along with other detrimental consequences. Researchers have concluded that the younger and longer a child experiences homelessness, the greater the cumulative toll of negative health outcomes, which can have lifelong effects on the child, the family, and the community.

Interventions that focus on preventing child and family homelessness can be especially effective before birth. Provision of supported housing and case management to pregnant women who are homeless and have existing medical risks may prevent long-term negative health outcomes for both women and their children and bring cost savings to the Commonwealth by eliminating the need in extensive healthcare later.

In addition to multiple adverse impacts on children's physical health, homelessness negatively affects their emotional and behavioral development. When children are homeless, they are confronted with stressful and traumatic events, which causes severe emotional distress. Homelessness presents a kind of chronic or extreme adversity that can lead to "toxic stress." Experienced by a very young child, it can disrupt normal brain development, which in turn can

have a life-long negative impact on the child’s physical and mental health and on his or her ability to function, to learn, and to work in adulthood.

Homelessness has a major influence on children’s education. The stress of homelessness, frequent disruptions, and school change may all jeopardize homeless children’s academic success. Many of the negative impacts of homelessness can, however, be mitigated or even eliminated by specially designed policies and interventions.

In Pennsylvania, the Education for Children and Youth Experiencing Homelessness (ECYEH) Program was developed to ensure that all children and youth experiencing homelessness could enroll, participate, and have an opportunity to succeed in school. The report contains a detailed description of the ECYEH program, of the barriers homeless children face, and of the measures the Department of Education has been taking to remove these barriers.

Various subgroups of children face different challenges and have different needs that should be properly addressed.

Preschool-age children exposed to homelessness are subjected to multiple risk factors. To mitigate negative impacts of homelessness and to provide them with a chance at academic success, interventions often need to start early. Early education programs may play a big part in the life of these children and should be made accessible to them.

Another subgroup of children that requires special attention is “unaccompanied youth,” individuals under the age of eighteen who are experiencing homelessness alone, without their families. Unaccompanied youth are believed to be under-identified to a higher degree than the rest of youth experiencing homelessness for a number of reasons. They commonly avoid seeking services and, in fact, make a special effort to remain invisible. Some of the “runaway” or “throwaway” youth are very young, below the age of fourteen. Many of them have been physically, emotionally or sexually abused by a family or a household member. Religious and sexual orientation differences constitute a common reason for youth being thrown out of the house. It is widely acknowledged that gay, lesbian, bisexual, transgender, or questioning (LGBTQ) youth tend to be overrepresented in the homeless population. In addition to family rejection, harassment in schools continues to drive elevated rates of homelessness among LGBTQ youths and needs to be addressed.

Youth aging out of the foster care system often have little or no income support and limited housing options and are at high risk to end up on the streets. Youth who have lived in residential or institutional facilities frequently become homeless upon discharge.

Children and youth who find themselves on the streets alone face a daunting range of risks and dangers. Consequences of life on the street include not only poor health and nutrition, greater risk of severe anxiety and depression, and difficulty attending school, but also increased likelihood of high-risk behaviors such as participating in intravenous drug use and engaging in unprotected sex, often with multiple partners. Youth can be driven to “survival” sex, exchanging sex for food, clothing, or a place to spend the night. Unaccompanied homeless youth often become victims or perpetrators of crime. Homeless LGBTQ youth are more likely to exchange sex for housing, are

abused more often at homeless shelters, and experience more violence on the streets than homeless heterosexual youths.

The longer a young individual has been homeless, the more likely he or she is to be in multiple kinds of trouble, and there is a higher likelihood that this person will end up as a chronically homeless adult. Youth homelessness should be prevented whenever possible, and usually the earlier intervention occurs, the more effective it is.

Innovative tools to measure unaccompanied youth homelessness and promising ways to address and finally eradicate it are discussed in the report.

Pennsylvania has made significant progress in addressing children homelessness in the past several years, which is reflected by its ranking in the State Report Card on Child Homelessness published by the National Center on Family Homelessness. The progress made indicates that the efforts the Commonwealth has been applying to reduce children's risk of homelessness have brought positive results and should continue as no child should be homeless in Pennsylvania.

RECOMMENDATIONS

Pursuant to HR 550, the Advisory Committee and the Task Force on Homelessness have made multiple recommendations that would move Pennsylvania towards permanently reducing and eliminating homelessness. The goal is to reduce the number of people who are homeless in Pennsylvania and to ensure that when homelessness does occur in the Commonwealth, it is rare, brief and non-recurring.

GUIDING PRINCIPLES AND GENERAL APPROACHES

Permanently reducing and eliminating homelessness requires

- Joint efforts of state, local, and federal authorities and the community at large;
- An approach that is holistic and client-centered;
- Addressing all of the many facets of homelessness including different demographics, causes, geographic areas, forms, and levels;
- The aggressive expansion of affordable housing opportunities;
- A clear focus on homelessness prevention;
- Embracing the philosophy of Housing First;
- The use of best practices in data gathering and strategic planning.

ORGANIZATION AND PLANNING RECOMMENDATIONS

The Commonwealth and its agencies must be organized and function in a way that will maximize coordination and collaboration between federal, state, and local agencies and utilize available funds in the most efficient way to strengthen the delivery of services for people experiencing homelessness.

It is recommended that the Governor's Office

- Issue an executive order to end homelessness in Pennsylvania, accompanied by mandates to relevant state agencies to provide leadership and participate in the planning and implementation of the Commonwealth's goals and objectives.

- Reconfigure the PA Interagency Council to End Homelessness so that it would function as an independent body that
    - includes executive-level participation and support from
        - the Governor's Office
        - the General Assembly
        - all relevant Commonwealth departments

        - local Continuums of Care (CoCs)
        - private sector;
    - meets on a regular basis (at least quarterly), with a pre-determined agenda that presents key issues for discussion and resolution;
    - includes standing subcommittees focused on various homeless subgroups;
    - appoints ad hoc committees as needed to bring in expertise to address targeted issues;
    - identifies and addresses key statewide policy issues for discussion and resolution;
    - assesses current and potential state-administered programs and resources addressing homelessness in order to
        - determine how resources are being used;
        - identify and disseminate best practices; and if necessary,
        - recommend policy, regulatory and/or legislative changes to increase their effectiveness;
    - facilitates state-level systems' integration and interagency coordination needed for successful plan implementation; and
    - ensures designation and alignment of state and federal resources towards achieving the goals in the Plan to End Homelessness in Pennsylvania.
- Develop a new Plan to End Homelessness in Pennsylvania that is in alignment with the federal plan and has clear, measurable goals, timelines and the necessary commitments to implement the Plan. The Plan would
    - include key initiatives for ending homelessness, prominently among them discharge planning and permanent supportive housing production;
    - identify responsible parties and deadlines for each activity;
    - include a mechanism for monitoring and updating progress toward achieving the goals in the Plan on a regular basis; and
    - serve as basis for the agenda for the PA Interagency Council meetings.
- Appoint a full-time Chair of the PA Interagency Council to End Homelessness, who will have clear accountability and responsibility for
    - interfacing with the U.S. Interagency Council on Homelessness and other relevant national entities;
    - providing leadership to the PA Interagency Council on Homelessness including
        - ensuring consistent representation by all stakeholders;
        - preparing, facilitating, and following-up Council meetings;
        - identifying and addressing training and technical assistance needs of the Council;
    - creating, implementing, monitoring, and updating the Plan to End Homelessness in Pennsylvania and ensuring that its goals and objectives are accomplished;
    - serving as a liaison to stakeholders and practitioners at the local level, including staffing a formal committee composed of local homeless program administrators and providers from all Commonwealth Continuums of Care to discuss common policy and program implementation issues, share best practices and identify their technical assistance and training needs and resources;
    - making recommendations on how and to whom the Department of Human Services (DHS) dispenses its Homeless Assistance Program (HAP) funds and the

Department of Community and Economic Development (DCED) dispenses its Emergency Solutions Grant (ESG) funds to counties;
  - releasing annual homeless assessment reports for each of Pennsylvania counties and Continuums of Care.

DATA RECOMMENDATIONS

The Commonwealth must incorporate best practices in data gathering in addressing homelessness.

It is recommended that the Commonwealth

- Create an integrated data system that links records across all homeless, justice, healthcare, social service, public and private subsidized housing systems that is user-friendly and produces regular reports on progress in ending homelessness that are made available to state agencies and other interested stakeholders.
- Pilot integrated data systems in strategic locations (urban, rural, suburban) in order to test the impact on public policy and ultimately, program outcomes.
- Implement a validated data model such as the Actionable Intelligence Social Policy so as to identify heavy services users and provide them with intensive services that facilitate better outcomes and generate net cost savings.
- Encourage all the major state agencies that compare and manage data to agree to a shared definition of terms (such as “homeless,” “at risk for homelessness,” and “service”), or, when not feasible, to the clear indication of the scope of their definition, and to core methodological practices in order to allow for analyses that cross datasets and for seamless data integration.
- Improve collection of statewide data on the number, characteristics, and needs of elderly homeless in anticipation of projected increases in elderly homelessness (due both to the aging of long-term homeless and to seniors falling into homelessness).
- Take actions to increase dialogue between data collection organizations and homeless service providers.
- Educate service providers about the value of high-quality data.
- Review state policies, rules, and regulations regarding data release, data privacy, and data sharing.

HOMELESSNESS PREVENTION

Homelessness prevention efforts must be a key component of the Commonwealth’s strategies to end homelessness.

It is recommended that the Commonwealth

- Aggressively assess and upgrade its discharge planning policies in order to prevent exit from institutions into homelessness

- Establish and empower separate ad hoc committees to formulate effective discharge policies for each of the following at-risk subpopulations; these committees should include members of the targeted subpopulation as well as other as other key stakeholders:
    - Youth exiting child welfare and juvenile justice systems;
    - Individuals exiting from federal, state, and local correctional institutions;
    - Individuals being discharged from state hospitals; and
    - Individuals being discharged from community hospitals and substance abuse treatment programs.
- Review all state-administered sources of prevention funding (ESG, HAP, PHARE, ESA, PATH, et cetera) and assign priority to the above "feeder" systems based on the effective policies formulated.
- Take into consideration local market conditions in formulating state policies, specifically, consider modification of state ESG allocation criteria to permit communities affected by factors restricting the availability of affordable rental housing to increase the percentage of ESG dollars devoted to prevention as opposed to Rapid Rehousing.
- Encourage innovative approaches to preventing homelessness such as creative case management and colocation of services.

STATE HOUSING POLICY

It is critical that Pennsylvania homeless programs and activities be guided by clear goals, objectives, and policies for ending homelessness. Therefore, it is recommended that the Commonwealth adopt policies that

- Establish needs-based priorities and employ data-driven best practices and techniques such as set-asides for the use of state housing resources to benefit homeless families and individuals, especially those who are frequent users of public resources. This should include funds both for the production of affordable rental housing and for rental assistance. Policies should apply to at least the following resources:
    - State and federal housing trust funds;
    - Low Income Housing Tax Credits (LIHTC);
    - Home Investment Partnerships Programs (HOME) funds; and
    - Section 811 vouchers through the Pennsylvania Housing Finance Agency for non-elderly in non-LIHTC projects serving homeless individuals and families with disabilities.
- Develop and support a comprehensive range of both traditional and non-traditional affordable housing options for various subpopulation groups. This will require a review of current state and local policies and regulations in order to remove obstacles that might prevent viable implementation of these options.
- Ensure adequate resources for combatting homelessness.
- Increase and sustain funds for permanent and permanent supportive housing, including resources for services for people in permanent supportive housing.

- Designate pilot funding and operating subsidies for smaller projects for defined population groups.
- Provide administrative fees and other incentives to local public housing authorities that establish preferences in their public housing and housing choice voucher programs for homeless families and individuals. This should include both tenant-based vouchers and project-based vouchers dedicated to housing developments using LIHTC and other state-and federal-funded programs.
- Create incentives for state-funded homeless providers to coordinate formally on the local level with other homeless providers (i.e., integrate HAP, ESG, and other state-funded homeless programs with PATH and HUD CoC programs and resources).
- Establish a statewide cross-system initiative to develop policies, protocols, and programs to address the unique permanent supportive housing needs of the elderly who are homeless or at-risk of homelessness.
- Create a bridge program to provide for basic needs of those individuals that have applied for SSDI but are waiting for a decision.
- Develop public awareness campaigns at the state and local levels to facilitate better understanding of homelessness as a social and economic phenomenon in general and to address specific concerns local communities may have regarding special housing or local policies.
- Continuously review and measure outcomes of the programs used.

BEST PRACTICES INTERVENTIONS

Communities throughout Pennsylvania and the nation have identified best practices for preventing and ending homelessness. It is recommended that the Commonwealth continue to support the testing and expansion of best practices and innovative approaches to ending homelessness in Pennsylvania and

- Increase the use of Critical Time Intervention practices for individuals with serious mental illness, co-occurring disorders, and ex-offenders as well as other homeless populations.
- Evaluate the TANF-funded Rapid Rehousing Demonstration program in Philadelphia and, if it demonstrates positive outcomes, make necessary modifications to expand it to other parts of the state.
- Consider re-establishment of the Homeless Liaison positions in each county assistance office.
- Examine the possibility of the PA Medicaid expansion to provide services to people experiencing homelessness.
- Maximize local discretion and flexibility in the use of state and federal funds to address homelessness in communities (for example, for building modifications to make them accessible for the disabled or the elderly, for providing transportation that would enable a homeless person to get to work, et cetera).
- Utilize innovative, creative case management and person-centered approaches.
- Encourage all communities to identify a lead agency to administer SOAR that will receive SOAR training and provide SOAR services.

- Expand employment programs and services for homeless individuals including the following:
    - PA Workforce Development Boards that should specifically target homeless persons for services, including skill development programs;
    - Increase in job training programs for homeless;
    - Establishment of workforce programs for TANF recipients who are homeless, including public service employment programs.
- Incorporate a trauma-informed approach for adults and children experiencing homelessness as a result of domestic violence as well as other populations who have been subjected to trauma.
- Utilize Housing First approach for specific populations such as the chronically homeless.
- Implement coordinated entry in order to facilitate services, avoid duplication, and maximize use of funds.

SUBPOPULATIONS

There are a number of homeless subpopulations in Pennsylvania that were studied for this report and that can benefit from the implementation of the following recommendations.

VICTIMS OF DOMESTIC VIOLENCE

- Ensure a full continuum of care for victims of domestic violence who are experiencing homelessness with services and supports uniquely matched to their safety and housing needs.
- Explore a tiered model that provides longer/greater assistance to families experiencing multiple/significant barriers.
- In prioritizing services, recognize that for domestic violence victims that are still in danger, safety comes first and long-term housing is secondary.
- Establish close collaboration between domestic violence victims' advocates and homeless shelters' personnel. Where feasible, implement a domestic violence specialist co-location with mainstream systems/community institutions to provide universal screening, cross-training and intervention to prevent homelessness and address the root issue (in this case, family violence).
- Increase emphasis on client-driven care, including client-driven goal-setting and housing placement based on client needs/safety assessments, and flexible financial assistance (allowing advocates to address victims' self-identified needs, including transportation, child care, et cetera).
- When appropriate, recognize the potential and enhance the possibility for victims to stay in their homes while their abuser leaves.
- Examine and improve long-term outcomes for domestic violence victims by going beyond immediate homelessness to housing instability.

- Review and adjust current housing policies that may inadvertently make it more difficult for victims of domestic violence to secure stable housing after leaving an abusive partner.
- Focus on violence prevention as a strategy for ending homelessness for women and children as a result of domestic violence (both locally and on the state level).

FORMER INMATES

- Strengthen the partnerships between the Department of Corrections (DOC) Bureau of Reentry, the Pennsylvania Board of Probation and Parole (PBPP), county probation and parole, and housing providers throughout the Commonwealth.
- Expand the number of effective Reentry Management Organizations throughout the Commonwealth that bring together government agencies, faith community, and business representatives with criminal justice, mental health, housing and human service agencies to address reentry on the local level.
- Legislate reforms in criminal justice systems, including the revision of the "get tough" statutes and related policies to take into account the need for supervised release.
- Increase pre-release activities to facilitate obtaining and maintaining stable housing, including the following:
    - Encourage DOC and county jails to provide pre-release housing training that would include the application and appeal process for applying to PHAs and other subsidized housing providers;
    - Enhance collaboration between PBPP and local CoCs in order to optimize the use of funds available for reentry housing;
    - Facilitate access to public benefits at the county level immediately upon release.
- Make housing a key component of streamlined reentry. Facilitate the availability of various housing options to ex-offenders by:
    - Providing education to dispel myths about restrictions to public and Section 8 housing;
    - Providing incentives such as increased administrative fees for PHAs that flex their policies with regard to admission of individuals with criminal histories, including unification with families living in public housing and other assisted units;
    - Providing incentives (for example, rent vouchers or tax credits) to landlords who house formerly incarcerated or ex-offenders;
    - Combining housing with supportive services when necessary;
    - Modifying one-strike housing regulations so discretion is not used to target ex-offenders with minor offenses or offenses that occurred far in the past.
- Focus on a limited group of persons who demonstrate a history of unstable housing and/or are frequent users of public services including jails, emergency shelters, state hospitals, and community hospital emergency rooms.
- Increase DOC and county jail coordination with the Social Security Administration and employment initiatives.

INDIVIDUALS WITH MENTAL HEALTH AND/OR SUBSTANCE USE DISORDERS

- Expand cross-training of staff in the behavioral health, housing, and criminal justice systems.
- Promote housing stability as it is a key to long-term recovery.
- Expand permanent supportive housing for individuals who need it utilizing all available resources including Health Choices reinvestment funds.
- Provide housing with access to treatment and recovery support services to reduce relapse and improve outcomes.
- Facilitate access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are homeless or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.
- Enhance employment training and employment opportunities for individuals with serious mental illness and co-occurring disorders.
- Utilize certified peer specialists and other peer supports and peer navigation to assist persons who experience homelessness with substance use disorders or co-occurring substance use and mental health disorders.
- Implement evidence-based models of providing comprehensive and flexible treatment and support to individuals who live with serious mental illness such as Assertive Community Treatment (ACT).
- Increase collaboration and coordination between providers of mental health/substance abuse services, housing authorities, the DHS Office of Mental Health and Substance Abuse, CoCs, and homeless advocacy projects under the leadership of the Department of Drug and Alcohol Programs.
- At the county level, increase collaboration between county behavioral health personnel and CoCs in various areas, including the use of funds.
- Develop a network of Recovery Community Centers, ensuring a proper accreditation system and supervision.

RURAL HOMELESSNESS

- Improve the methodology for the identification of homeless families and individuals in rural areas, and increase the ability to accurately identify and quantify the population.
- Create a unified, comprehensive system that addresses the needs of the unsheltered and those in danger of losing their homes. Combine funding and programming under one roof to allow for a more comprehensive, preventative approach.
- Recognize and address the special problems of addressing homelessness in rural communities such as low population density, levels of perceived visibility, unique local dynamics, limited availability of resources, and lack of public transportation.
- Examine the special relationship between health and homelessness in rural areas; explore various ways of broadening access to physical and mental health care, including via telemedicine and regional conglomerates.

- Provide funding for advanced dental care realizing that oral health has a significant impact on the ability to secure housing and employment.
- Develop a comprehensive employment program for homeless in rural areas that would include training, physical, and behavioral health supports, and transportation.
- Introduce financial incentives for communities that want to bring the services together that address the needs of the identified population, for example, tax incentives to purchase abandoned, foreclosed, or economically feasible buildings to retrofit for homeless services such as agencies, emergency shelter, job training, et cetera, under one roof or on one campus.

CHILDREN AND YOUTH

Families

- Emphasize family preservation. Prevent children's placement into foster care due solely to homelessness or unstable housing by providing housing assistance to families, in addition to intensive wraparound services such as income supports, job training, health care, trauma-specific services, parental supports, programs for children.
- Prioritize families with young children and pregnant women for housing placement as it has been shown that the younger and longer a child experiences homelessness, the greater the cumulative toll of negative health outcomes, which can have lifelong effects on the child, the family and the community.
- Ensure that pregnant women experiencing homelessness have access to early and consistent prenatal care.
- Explore and pursue various ways of increasing access to physical and mental health care for children experiencing homelessness.
- Expand cross-training opportunities for homeless service providers and early childhood agencies/providers.
- Take steps to reduce overall risk levels for children who face homelessness, in addition to boosting resources and adaptive capacity.
- Increase support for children in supported housing.
- Offer parental support and training to homeless parents so that they could be emotionally responsive and supportive of their children even in the midst of adversity and/or transient and stressful living environments.
- As shelter and street youth are at much higher risk of having been pregnant than housed youth, provide them with comprehensive services, including pregnancy prevention, family planning, and prenatal and parenting services.
- Connect all infants and toddlers experiencing homelessness to evidence-based early childhood home visiting programs and parenting interventions that promote positive early parent-child relationships, such as those funded through the Maternal, Infant, and Early Childhood Home Visiting Program.
- Ensure that all HUD-funded family shelters are safe environments for young children, that they provide appropriate play spaces designed specifically for young children, and that they fully implement the new Early Childhood Self-Assessment Tool for Family Shelters.

- Ensure that all HUD-funded family shelters meet HUD prohibition against family separation, keeping children below eighteen years of age with their families.
- Continuously assess all programs' outcomes for both parents and children.

Education

- Continue and improve the Educating Children and Youth Experiencing Homelessness (ECYEH) program, with specific attention to identification and outreach as well as to academic achievement.
- Educate teachers about the signs of homelessness and homeless students' rights and instruct them to refer homeless students to the ECYEH office for services.
- Prioritize access and increase outreach to expand the high-quality early learning opportunities available to young children experiencing homelessness.
- Head Start, Early Head Start and Pre-K Counts should "save slots" for children who are homeless and should not be penalized when a child moves out of the program.
- Consistently apply Act 143 requirements that children who are homeless be automatically screened and, if appropriate, evaluated for Early Intervention (EI) services. Homelessness has been added to the list of "automatic qualifiers" for screening.
- Quality early learning programs should be strategically located to serve at-risk children and offer expanded hours and transportation. Not only should high-quality learning centers be located in close proximity to shelters and transitional housing, but shelters themselves and transitional housing programs should offer learning opportunities on site.
- In order to expand access to early education programs, allow the mother's GED training as well as working to be considered a qualifying criterion.
- Offer resources to encourage Head Start grantees and housing service providers to work together to expand services for children experiencing homelessness or at-risk for homelessness.
- Provide cross-training opportunities for homeless service providers and early childhood agencies/providers.
- Connect all infants and toddlers with the national universal developmental screening system and ensure all infants and toddlers with identified needs receive services according to the federal Individuals with Disabilities Education Act (IDEA), Part C system.
- Encourage secondary schools to explore opportunities for teaching financial literacy.

Child Care

- Modify Child Care Information Services (CCIS) eligibility criteria for homeless families, including waiver of child care co-payments and other expenses for those families.
- Prioritize homeless families' access to subsidized child care.

- Eliminate bureaucratic barriers in part by designating a CCIS representative at TANF offices to assist families applying for CCIS subsidies.
- Offer higher reimbursement rates to providers who serve homeless children.
- Train child care staff on the impact of trauma and trauma-informed care to improve outcomes for children.

Unaccompanied Youth

- Use special, innovative practices to facilitate identification and engagement of homeless youth:
    - Engage youth service providers
    - Engage LGBTQ partners
    - Involve youth as outreach workers, as advisers on the survey design, and as guides to find homeless youth
    - Hold magnet events
    - Use social media to raise awareness and outreach

- Explore the feasibility of opening a drop-in center for youth in/near downtown, or open shelters during the day to serve as drop-in centers. A drop-in center for youth would combine many of the services and supports that youth need, under one roof, including
    - a service coordinator who knows about resources and can help young people access them;
    - a place where a young person who is without a home can come to take a shower, have some food, use a phone or a computer with Internet access, receive mail, do his or her laundry, get bus tickets to key destinations, et cetera;
    - It could also serve as a house base where nurses, employers, schools, and job training agencies can come to engage young people.

- Initiate a pilot project with CoCs collaborating with federal, state and local governments, private agencies, and with homeless and formerly homeless youth. The lead agency could be the Department of Human Services Office of Children, Youth and Families, with project activities consisting of
    - Identification and engagement of homeless youth
    - Homeless prevention, including
        - Transition and life skills
        - Discharge planning from child welfare and juvenile justice institutions
        - Counseling for family and “kin” reunification
    - Services for homeless youth including
        - Emergency/short term interventions
        - Models for longer-term housing and supports
        - Public education and awareness

STATUTORY RECOMMENDATIONS

- To amend Act 153 of 2012 by adding a homelessness component.

Act 153 provides for the establishment of "land banks." Under this proposal, where a land bank is established, if there is residential reuse, a certain percentage of the properties it acquires should be made available for housing of homeless and formerly homeless persons. This could be accomplished by the land bank conveying the properties to a non-profit development corporation under the stipulation that such properties will be rehabbed for use by homeless persons.

- To amend Act 49 of 2005 (Appendix C).

The proposed amendments allow counties, at their option, to increase the amount of money collected for the county's Optional Affordable Housing Fund. The amendments specifically allow use of the funds for programs or projects to prevent or reduce homelessness. The funds may also be used to expand the availability of affordable homes, including permanent rental homes and supportive housing, which will help Pennsylvanians experiencing homelessness to find stable, affordable places to live.

INTRODUCTION: STUDY PROCESS

In March 2014, House Resolution No. 550 directed the Joint State Government Commission to establish a bipartisan legislative task force and an advisory committee to conduct a study of the occurrence, effects and trends of homelessness in Pennsylvania and to report its findings and recommendations to the House of Representatives.

Shelter is a basic human need. As the Resolution states, "a stable, quality, affordable home promotes family stability, physical and mental health and enhances both adults' and children's ability to be productive. Conversely, the lack of a stable, quality, affordable home increases the risk of illness, failure at school, inability to find or hold a job, incarceration and nursing home placement, often at public expense." When homelessness is experienced in childhood, it can have a dramatic, ongoing impact on the individual's life. The adverse effects of childhood homelessness on children's health, development and well-being are also associated with both short-term and long-term societal costs and create a costly toll on society. Accordingly, children became one of the focal points of the Resolution.

The advisory committee created to assist the legislative task force in its study and recommendations was comprised of over thirty individuals including the staff from several departments: the Department of Community and Economic Development, the Department of Human Services, the Department of Education, the Department of Corrections, the Department of Labor and Industry, the Department of Drug and Alcohol Programs, and the Pennsylvania Board of Probation and Parole. Other advisory committee members were researchers, housing services providers, county officials, advocates representing diverse homeless populations, community development specialists, and people who have experienced homelessness themselves at some point in their lives. Diana Myers served as the advisory committee chair.

The advisory committee held its organizational meeting on August 21, 2014, and met again on January 21, 2015; May 15, 2015; September 1, 2015; and December 17, 2015.

To accomplish its purpose of investigating and reviewing causes and impacts of homelessness in Pennsylvania and subsequently developing policy recommendations that would move the Commonwealth toward permanently reducing and eliminating homelessness, the advisory committee divided into the following five subcommittees, each representing a cross-section of the full committee:

1. Definition of Homelessness and Data Collection
2. Causes, Occurrence, and Effects of Homelessness
3. Impacts of Homelessness on Children and Youth
4. State and Federal Resources for Addressing Homelessness (Housing and Services)

5. Strategies and Solutions for Reducing and Eliminating Homelessness in Pennsylvania

The subcommittees met several times by teleconference and reported the results of their work to the full advisory committee for further consideration of the issues and general discussion.

In addition to these meetings, the Urban Affairs Committee of the House of Representatives, directed by the Resolution to provide assistance to the task force and the advisory committee in their endeavor, held an informational meeting on current governmental resources for addressing homelessness. The HR 550 informational meeting was held on November 13, 2014, in conjunction with the ongoing study of homelessness conducted by the Joint State Government Commission.

The Urban Affairs Committee members and the public heard testimonies prepared by the staff of County Commissioners Association of Pennsylvania, the Center for Rural Pennsylvania, the Department of Community and Economic Development, the Department of Corrections, the Department of Drug and Alcohol Programs, the Pennsylvania Association of Housing and Redevelopment Agencies, and the Pennsylvania Housing Finance Agency. Testimonies on programs addressing homelessness run by the Department of Public Welfare (now called the Department of Human Services) and the Department of Education were submitted later. The speakers described key programs and tools their agencies use to address homelessness; some of them also offered a series of recommendations for further progress in this area, including consolidation of the state data under one roof and better education on available resources and data collection for service providers. Several presenters highlighted the importance of both funding targeted for immediate relief of those currently without housing and funding aimed at homelessness prevention.

An important part of the study was to obtain input from families and individuals throughout the state who have experienced homelessness. To achieve this goal, the advisory committee selected a consumer survey as one of the methods to examine homelessness in Pennsylvania. The advisory committee and the Joint State Government Commission developed the survey parameters to ensure voluntary participation and maintain confidentiality of participants. Members of the advisory committee reached out to their local constituents who provide services to the homeless and invited them to participate in the survey. The questions could be either posed to participants as part of a facilitated focus group, or asked in a one-on-one interview, or offered as a written survey. Completed survey data was received from twenty-seven agencies representing sixteen counties. The Joint State Government Commission received over two hundred individually completed surveys and six focus group responses, with forty-two people participating in focus group discussions. That means the total of respondents was 255. The survey results and analysis are presented later in this report.

DEFINITION OF HOMELESSNESS, OCCURRENCE, AND EXISTING RESOURCES FOR ADDRESSING HOMELESSNESS IN PENNSYLVANIA

DEFINITION OF HOMELESSNESS

One of the first challenges the advisory committee had to address was developing a proper definition to use throughout the research process and in the final report. There exists no universal definition, as the term is as complex as the issue itself. The common-man definitions, the provider definitions, and the resource allocation definitions serve different roles, as each of them is formulated to identify particular members of the homeless community. Focusing on any one aspect of the definition would inevitably lead to the exclusion of one or more subsets of the homeless population. The advisory committee is aware that an excessively expansive definition of homelessness for specific programs may drain or decrease the available resources to those most in need. At the same time, the task of the advisory committee and the task force is to present to the General Assembly the full landscape of the homeless population in Pennsylvania and to provide a comprehensive picture of the causes of homelessness and multiple problems resulting from it. Specific programs and resources may have more narrow provisions, but the legislators need a full view of the current scope of the problem in order to make appropriate policy decisions. A helpful definition should contain a clear distinction between those who are truly homeless – without a roof over their head, and those who are at-risk of homelessness. It is obvious that people who are already living on the street or in an emergency shelter are in the most detrimental situation and require the most intensive resources. However, people who are at risk of falling into homelessness should also be identified because there is value in analyzing current policies and practices that support this faction of the population or hinder them from becoming homeless. The legislators need to be able to compare the costs and benefits of preventative services versus providing emergency care later. It was determined that a definition should be crafted by the advisory committee to maintain consistency throughout the report. The intent of the advisory committee was to create a broad and inclusive definition, based on the fundamental problem faced by those who are "homeless," which is that they are without a permanent and stable living arrangement.

For years, the term "homeless" has been defined in various ways in federal and state statutes. The lack of a unified and clear definition has resulted in certain classes of people being excluded from relief typically afforded by federal and state agencies, in muddled data collection and analysis, and also resulted in unnecessary litigation. The HUD definition is narrow; it defines "homeless" as those who are residing overnight in a temporary shelter or those who are spending the night without shelter. The reason for such a narrow definition is that HUD is specifically charged with providing accommodations for individuals and families that are homeless and meet one of the two criteria. To make its task achievable and manageable, HUD needed to purposely narrow the provisions. The McKinney-Vento definition is significantly broader. As the purpose of

the McKinney-Vento Homeless Education Improvements Act[4] is to ensure that every child or youth who is experiencing homelessness can have access to the same free and appropriate public education as all other children, its definition of "homeless" is broader in scope and includes those individuals who live "doubled-up", sharing residence with their family members or friends. This broader definition gives a vast additional group of children and youth an opportunity to receive needed support and services. The following definition, developed by one of the subcommittees and subsequently approved by the entire advisory committee, is an effort to define "homeless" in a manner which can offer guidance to the Pennsylvania General Assembly and the various state agencies providing services for the homeless.

Definition:

1. The terms "homeless", "homeless individual", and "homeless person" shall mean an individual or family who lacks a fixed, regular, and adequate nighttime residence, including but not limited to:

    a. an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including parks, cars or other vehicles, public spaces, abandoned buildings, condemned buildings, bus or train stations, temporary shelters provided to migrant workers and their children on farm sites, hallways, lobbies, airports, camping grounds, tents, or similar settings;

    b. an individual or family who has a primary nighttime residence that is a publicly or privately operated shelter designated to provide temporary living arrangements, including congregate, transitional, emergency, domestic violence, or runaway shelters; transitional housing; welfare hotels; homes for adolescent mothers; mental health, drug, or alcohol facilities; and hotels and motels paid for by federal, state, or local government programs for low-income individuals or by charitable organizations;

    c. an individual who is exiting an institution, correctional facility, or hospital where he or she resided for 90 days or less and who was homeless immediately before entering that institution and has no primary nighttime residence to return to;

    d. an individual remaining in an institution, correctional facility, or hospital because the individual has no primary nighttime residence;

    e. an individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that has either taken place within, or has made the individual or family afraid to return to, their primary nighttime residence, including where the health and safety of children are jeopardized;

[4] 42 U.S.C.A. §§ 11431-11435.

f. an individual or family who has a primary nighttime residence in the residence of another due to loss of housing, economic hardship, or similar reason; [5]

g. an individual or family who has been deemed eligible as "homeless" under Federal or State law or regulation.

2. The term "at risk of homelessness" shall mean an individual or family who:

   a. will imminently lose their primary nighttime residence, provided that:

      i. the primary nighttime residence will be lost within 30 days;
      ii. no subsequent residence has been identified; and
      iii. the individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

   b. has experienced persistent instability as measured by two moves or more during the immediately preceding 60-day period;

   c. lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

   d. lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

   e. is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, a drug or alcohol facility, foster care or other youth facility, or correction program or institution); or

   f. otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness.

The above-listed definition has informed the work of the advisory committee and the task force in their deliberations and should be kept in mind by those considering the final recommendations presented in the report.

[5] It is acknowledged that some statutes place a time limitation on this category.

OCCURRENCE AND DATA COLLECTION

Data collection is universally recognized as one of the challenges to addressing homelessness. The very nature of homelessness makes accurate identification and count difficult. The U.S. Department of Housing and Urban Development (HUD) collects significant, relevant data to understand the nature and extent of homelessness. However, it is widely believed that the actual number of people experiencing homelessness is higher than indicated by any of the utilized methods. There are several methods used to collect information about the number of homeless people, the demographics, and their needs. Each of these methods has its strengths and weaknesses.

The Annual Homeless Assessment Report (AHAR) is a HUD report to the U.S. Congress that provides nationwide estimates of homelessness, including information about the demographic characteristics of homeless persons, service use patterns, and the capacity to house people who are homeless. The report is based primarily on Homeless Management Information Systems (HMIS) data about persons who use homeless shelters during a 12-month period. Seventeen of eighteen Communities of Care in Pennsylvania (CoCs) collect and submit data for AHAR. AHAR's strengths are that it provides year-round numbers, bed turnover rates, and age breakdowns. Its weaknesses are that data sets are submitted by housing type; data quality review is stringent, so not all data is deemed "usable" by HUD, making comparisons across year or in the aggregate difficult; and that AHAR numbers based on HMIS statistics do not include domestic violence and runaway/homeless youth shelters or individuals living on the street or doubled-up. Additionally, one Pennsylvania CoC does not participate in the data submission.

The Point-in-Time (PIT) is a count of sheltered and unsheltered homeless persons on a single night in January. It includes homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens (shelters for victims of domestic violence) on that particular night. It also includes people who spend the night on the street or under bridges. Each count is planned, coordinated, and carried out locally. PIT's strengths are that it gives estimate of the number of homeless persons on a single day and that it identifies street population. Its main weakness is that it is done in January and the weather can cause major fluctuations in numbers.

The Housing Inventory Count (HIC) is a point-in-time inventory of provider programs within a Continuum of Care that provide beds and units dedicated to serve persons who are homeless. They are categorized by five program types. HIC's main strength is that it reports system capacity. Some people consider it the most ambitious and comprehensive count we have over a long period of time. HIC's weaknesses are that it is driven in part by inventory rather than need or demand and that it is based on self-reporting in confined parameters.

The Education for Children and Youth Experiencing Homelessness State Evaluation Report (ECYEH) indicates the number of children who experience homelessness. Its purpose is to maximize school participation and eliminate barriers preventing homeless children and youth from attending school. ECYEH's chief strengths are that it is based on the broader definition (includes children and youth who are doubled-up) and indicates that homelessness is a larger problem than what is manifested by the housing system; that it identifies children and youth not identified by the homeless system; and that it collects school district-level data, including academic

achievement. ECYEH's weaknesses are that it does not offer student-level data or data about the family situation; that the broader definition creates conflicting responses at the local level and a disconnect between housing, child welfare, and education systems; and that youth, in particular, tend to avoid self-reporting, so they remain undercounted.

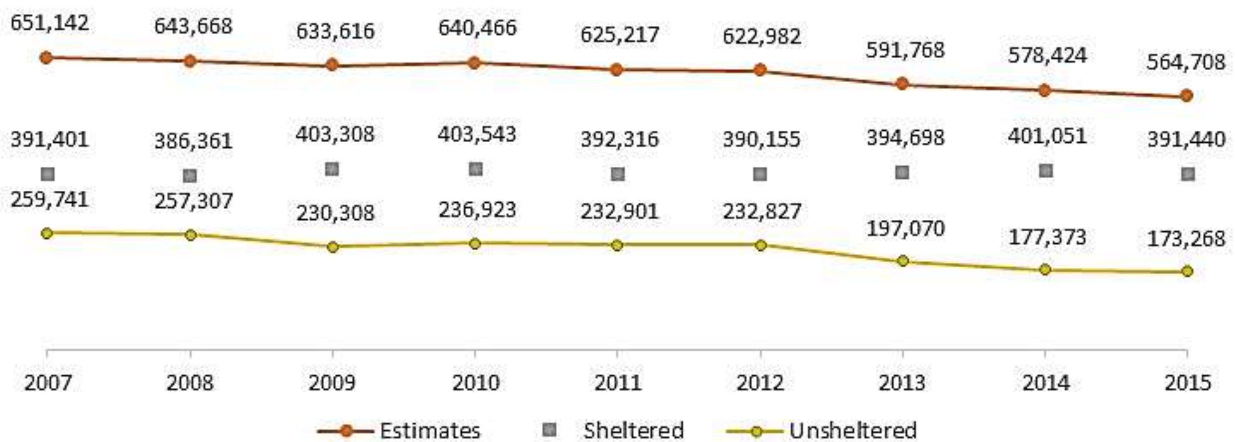
Data on homelessness collected by various methods should be analyzed in their totality as they complement each other and each of them illuminates one aspect of the problem not identified by others.

The Annual Homelessness Assessment Report

Much of the information collected on homelessness across the country by the CoCs is compiled in the Annual Homelessness Assessment Report to Congress (AHAR). Since 2007, HUD has reported the results of local PIT counts, as well as estimates of the number, characteristics, and service patterns of all people who used residential programs for homeless people.

In 2015, there were over 564,708 people experiencing homelessness across the country on a single night.[6] Of those counted, just under 70 percent were staying in emergency shelters or transitional housing programs. The remaining 31 percent were found in unsheltered locations such as under bridges, cars, or abandoned buildings. Close to two-thirds of the people recorded in 2015 were individuals experiencing homelessness alone, and the remaining third were homeless as a family.

Estimates of Homeless People by Shelter Status[7]

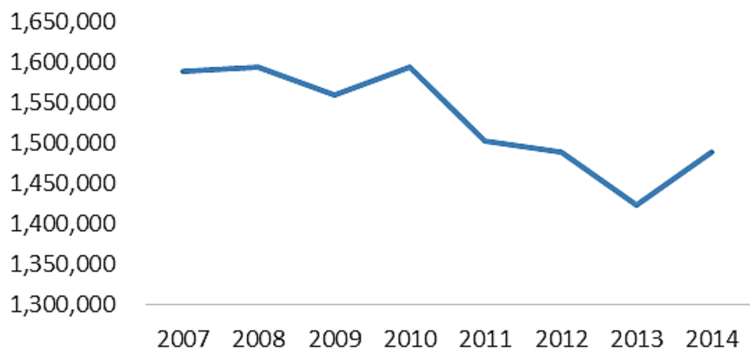


[6] Henry, Meghan et al. *The 2015 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 – PIT Estimates of Homelessness in the U.S.* Washington, D.C.: U.S. Department of Housing and Urban Development, November 2015, P. 10, available at https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf (accessed December 27, 2015).
[7] Ibid.

Comparing homelessness estimates in 2015 to previous years gives an indication on the progress made by the country in reducing homelessness. Over the last seven years, there has been a steady decline in total levels of homelessness while in general the rate of sheltered persons has remained constant.[8] The number of homeless people counted has decreased by 82,550 people, or 12.7 percent, since 2007.[9] In the same time period levels of unsheltered homelessness lowered by 32 percent.[10]

PIT counts are only one way of assessing the amount of homelessness. Each year HMIS data from participating communities on the use of emergency shelter, transitional housing, and permanent supportive housing programs is reported to HUD. HMIS is an electronic database which stores information on people who access the homeless service system. These data are adjusted to produce national estimates. As shown in the figure below, there were nearly 1.49 million people who used a shelter program at least once in 2014, a 4.6 percent increase from the previous year. Despite the recent increase, levels of homelessness have been trending downward, and overall homelessness is down by 6 percent since 2007.

One-Year Homelessness Estimate[11]



The 2014 AHAR uses HMIS data to demonstrate how the characteristics of sheltered homeless individuals differ from that of sheltered persons in families. Sheltered Individuals are more likely to be white men, over 30 years old, with a 50 percent chance of a disability.[12] Individual homeless persons were more likely to be homeless before arriving at a shelter and on average stayed 22 nights.[13] Adults with children in shelters were more likely to be younger African-American women in urban locations, without a reported disability. Over sixty percent of

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[8] Ibid.
[9] Ibid.
[10] Ibid.
[11] Solari, Claudia D. et al. *The 2015 Annual Homeless Assessment Report (AHAR) to Congress: Part 2 – Estimates of Homelessness in the United States*. Washington, D.C.: U.S. Department of Housing and Urban Development, December 2015, P. XII-XIII, available at https://www.hudexchange.info/onecpd/assets/File/2014-AHAR-Part-2.pdf (accessed January 7, 2016).
[12] Ibid. Pp. 2-6.
[13] Ibid. Pp. 3-6.

these family members had some other form of housing before using a shelter an average of 37 nights.[14]

Pennsylvania Point-in-Time Counts

A point-in-time count (PIT) is an unduplicated sum of the people experiencing homelessness including both sheltered and unsheltered populations. The count takes place on a single night during the final week of January. Each PIT count is conducted by one of 16 local planning bodies across the state responsible for coordinating homelessness services within their communities called Continuums of Care (CoC). The U.S. Department of Housing and Urban Development requires that all communities which receive federal grants through the McKinney-Vento Homeless Assistance Act conduct a PIT count of shelters annually and unsheltered homeless biennially.[15]

The PIT count is one of the most important tools used to estimate levels of homelessness in the United States. Through the count, communities gather data on the general homeless population and the numerous subpopulations. Every person counted is designated as an individual, a member of a family. Additionally, communities record if someone belongs to a particular subpopulation such as veteran, an unaccompanied youth, or chronically homeless, indicating long-time or repeated homelessness and the presence of a disability. Collecting this data helps inform both federal and local agencies on progress being made towards reducing homelessness and where future focus is required.

The 2015 PIT count found 15,421 people experiencing homelessness in Pennsylvania, representing 2.7 percent of the national total.[16] Since the homelessness figures were first reported by HUD, Pennsylvania's homeless population has dropped by 4.9 percent. Pennsylvania's lowest PIT count occurred in 2010 with 14,516 people and has increased by 6.2 percent over the last five years.[17] Between 2014 and 2015 there was a gradual .6 percent increase in homelessness.

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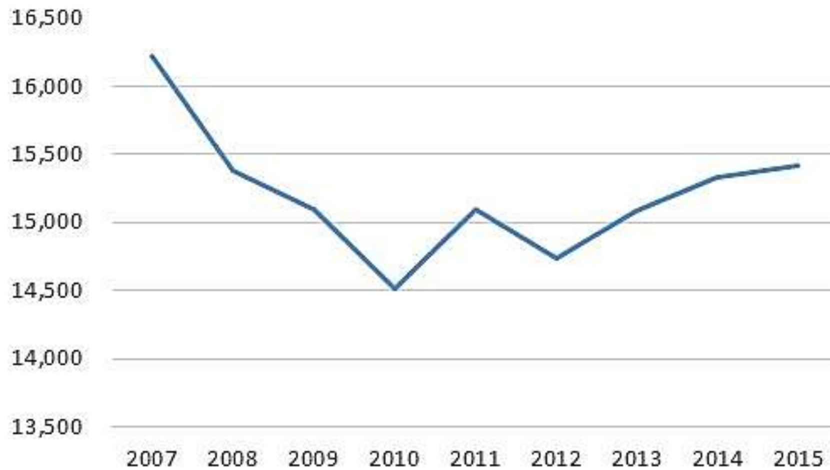
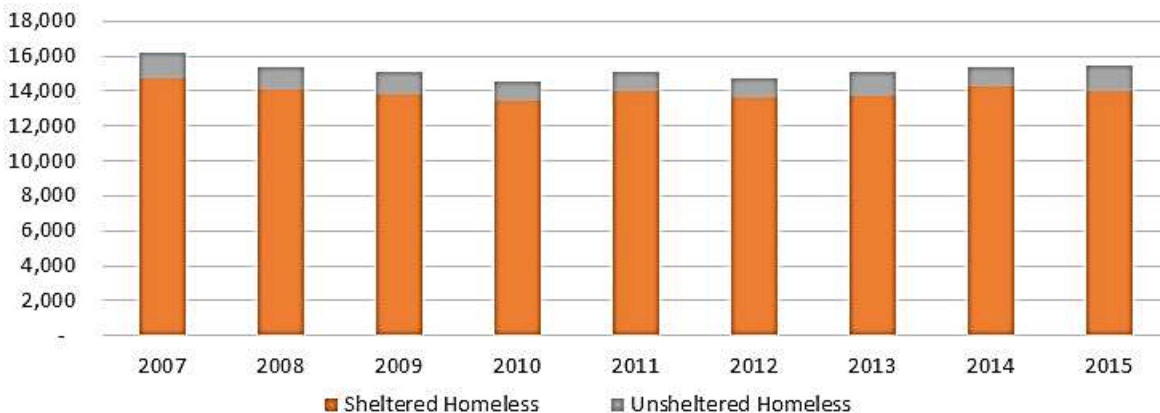
[14] Ibid. Pp. 3-6.
[15] "Homelessness Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program; Interim Final Rule." Federal Register 77 (31 July 2012): 45445-45446, available at https://www.hudexchange.info/resources/documents/CoCProgramInterimRule.pdf (accessed December 27, 2015).
[16] U.S. Department of Housing and Urban Development. *2007 – 2015 PIT Data by State*. 2015, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed December 27, 2015).
[17] Ibid.

PIT Count of Homeless Pennsylvanians[18]



On a single night in January 2015, there were nearly 14,000 people staying in shelters across the state.[19] This figure makes up over 90 percent of the state's total homeless population. The remaining 1,428 people were found in unsheltered locations.[20] The state's proportion of unsheltered homeless persons has not changed dramatically over the last 8 years, hovering around 10 percent of the total homeless population. Between 2013 and 2014 Pennsylvania's unsheltered homeless population rose by 28 percent, an increase of just under 400 people.[21]

Number of Homeless Pennsylvanians by Shelter Status[22]



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[18] Ibid.

[19] U.S. Department of Housing and Urban Development. *2007 – 2015 PIT Data by State*. 2015, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed December 27, 2015).

[20] Ibid.

[21] Ibid.

[22] Ibid.

Adults without children accounted for over 55 percent of the total homeless population and 92 percent of the unsheltered homeless population.[23] In Pennsylvania, a homeless person is more likely to be male, which make up 55 percent of the state's total homeless population and 70 percent of the unsheltered persons. Adults over the age of 24 accounted for 65 percent of homeless persons and a large portion of unsheltered population. African Americans comprised over half of the state's total homeless population, though 92 percent were staying in shelter.[24] Pennsylvania's unsheltered homeless population was predominately white.

Overall, there were 10,757 homeless households recorded in Pennsylvania during 2015.[25] The table below shows individual people which comprise these households, along with their shelter status. Of the 2,299 households with children, only 1 percent were unsheltered.[26] Households comprised solely of children were the most uncommon household type and made up about only 0.2 percent of the state's homeless population. Over the last five years homeless people in families have declined by 7 percent, while the number of homeless individuals has grown by 30 percent.

Homeless Households by Shelter Status in 2015[27]

Description	Emergency Shelter	Transitional Housing/Safe Haven	Unsheltered	Total
Persons in households without children	4,573	2,672	1,320	8,565
Persons in households with children	2,980	3,737	99	6,816
Persons in child-only households	23	8	9	40
Total Homeless Persons	**7,576**	**6,417**	**1,428**	**15,421**
Total Homeless Households	**5,565**	**3,870**	**1,322**	**10,757**

[23] U.S. Department of Housing and Urban Development. 2015 *CoC Homeless Assistance Programs Homeless Populations and Subpopulations: Pennsylvania.* Published October 29, 2015, available at https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_PA_2015.pdf (accessed December 27, 2015).
[24] Ibid.
[25] Ibid.
[26] U.S. Department of Housing and Urban Development. *CoC Homeless Assistance Programs Homeless Populations and Subpopulations: Pennsylvania*, November 2015, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed November 30, 2015)
[27] U.S. Department of Housing and Urban Development. 2015 *CoC Homeless Assistance Programs Homeless Populations and Subpopulations: Pennsylvania.* Published October 29, 2015, available at https://www.hudexchange.info/resource/reportmanagement/published/CoC_PopSub_State_PA_2015.pdf (accessed December 27, 2015).

4,312 children 17 or younger made up 28 percent of the total homeless population in Pennsylvania while 1592 adults under the age of 25 accounted for 10 percent.[28] In the 2015, there were 871 homeless unaccompanied young adults and children in Pennsylvania, of which 85 percent were sheltered.[29] Of those unsheltered, only 9 were children under the age of 18.[30] There were also 573 parenting youth under 25 recorded along with their 792 children; however, all were sheltered.

Homeless Subpopulation by Shelter Status in 2015[31]			
Description	**Sheltered**	**Unsheltered**	**Total Populations**
Chronically Homeless	1040	550	1590
Severely Mentally Ill	3022	533	3555
Chronic Substance Abuse	2902	551	3453
Veterans	1295	80	1375
HIV/AIDS	219	44	263
Victims of Domestic Violence	1611	84	1695
Unaccompanied Youth	745	126	871
Parenting Youth	573	0	573
Children of Parenting Youth	792	0	792

The rate of unsheltered homeless veterans was also low, due in part to the concerted effort made by the state and federal government to eliminate veteran homelessness. Since 2010, the number of homeless veterans has shrunk by 4.5 percent in Pennsylvania, and the number of unsheltered veterans has been cut by half.[32] Similarly, 95 percent of homeless domestic violence victims were staying in shelters. The count of unsheltered individuals who have been chronically homeless, have a severe mental illness, or substance use disorders remains high compared with other homeless subpopulations.

There have been numerous changes in the state of homelessness over the last five years, as shown in the table below. Total homelessness has increased by 900 people since 2010, despite the progress made at reducing homelessness among veterans, families, and the chronically homeless. This growth was driven by increasing levels of homeless individuals who are unsheltered. How the state reports homelessness has also changed in the last five years as more effort has been made to recognize unaccompanied homeless children and youth.

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[28] Ibid.
[29] Ibid.
[30] Ibid.
[31] Ibid.
[32] U.S. Department of Housing and Urban Development. *2007 – 2015 PIT Data by State*. 2015, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed December 27, 2015).

Pennsylvania Homelessness 2010-2015[33]							
Year	**Total Homeless**	**Sheltered Homeless**	**Unsheltered Homeless**	**Homeless Individuals**	**Homeless People in Families**	**Chronically Homeless**	**Homeless Veterans**
2015	15,421	13,993	1,428	8,605	6,816	1,040	1,375
2014	15,333	14,301	1,032	8,359	6,974	1,607	1,411
2013	15,086	13,727	1,359	7,973	7,113	1,681	1,462
2012	14,736	13,660	1,076	7,295	7,441	2,106	1,456
2011	15,096	14,036	1,060	7,867	7,229	1,719	1,392
2010	14,516	13,418	1,098	7,191	7,325	1,524	1,441

The Housing Inventory Count

While the PIT count is a useful method of gauging the size of the homelessness population in a given location, the Housing Inventory Count (HIC) is a way of assessing how equipped a community is to provide housing services to that area's homeless people. CoCs are required to provide housing inventories to HUD annually on the number of homeless assistance programs and beds in their community. The HIC is broken down into five categories based on the program type: emergency shelter, transitional housing, Rapid Rehousing, Safe Haven, and permanent supportive housing.

In addition to providing information on the housing capacity to HUD, the HIC has several other purposes. The HIC is used along with the PIT count to determine bed utilization rates and adjust the amount of beds based on system capacity and usage. Local communities can use this information to determine if there are any gaps in their services and if the needs of homeless subpopulations are being met. Throughout the year HUD compares the information in the HIC against the actual housing usage information, which is a major component of the AHAR report. The HIC is also required to complete the application for HUD's Homeless Assistance Funding.

In 2015, there were 33,441 temporary and permanent housing beds across the state in programs aimed at serving homeless populations.[34] Over half of these beds were reserved for families. Among the temporary housing programs, emergency shelter had the largest amount of adult-only and child-only beds, while transitional housing programs had the most beds devoted to families with children.

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[33] U.S. Department of Housing and Urban Development. *2007 – 2015 PIT Data by State*. 2015, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed December 27, 2015).

[34] HUD. *HIC Data 2015*, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed December 27, 2015).

HIC Data 2015 [35]					
Description	**Family Units**	**Family Beds**	**Adult-Only Beds**	**Child-Only Beds**	**Total Year-Round Beds**
Total Temporary Housing	**2,754**	**8,699**	**7,386**	**55**	**16,140**
Emergency Shelter	1,161	3,994	4,412	46	8,452
Transitional Housing	1,593	4,705	2,706	9	7,420
Safe Haven	0	0	268	NA	268
Total Permanent Housing	**2,887**	**9,170**	**8,131**	**0**	**17,301**
Permanent Supportive Housing	2,112	6,665	6,945	NA	13,610
Rapid Rehousing	475	1,605	999	NA	2,604
Other Permanent Housing	300	900	187	NA	1,087
Grand Total	**5,641**	**17,869**	**15,517**	**55**	**33,441**

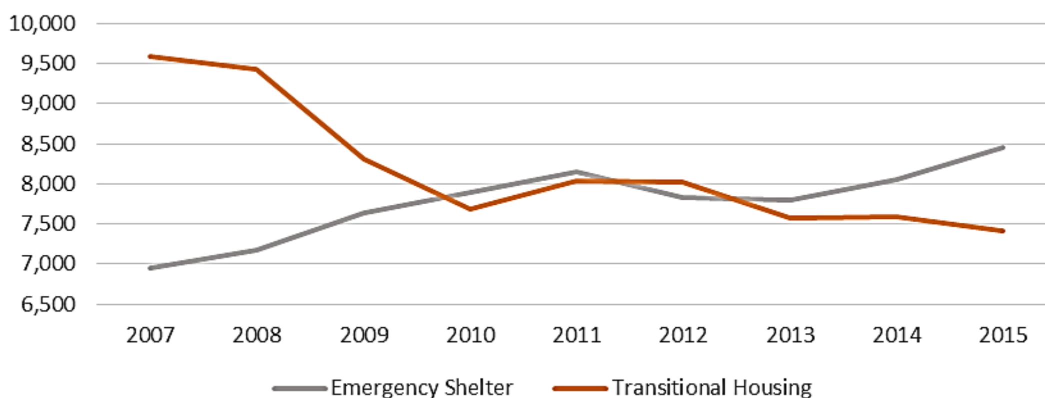
Overall, there has been an increase in the number of beds in the HIC over the last five years. Comparison of the most recent HIC with previous years shows that there has been a 2.5 percent growth in temporary year-round beds since 2010 driven by the growth in emergency shelter beds. Since 2010 there has been an addition of 560 year-round emergency shelter beds, a seven-percent increase.[36] In addition to the year-round emergency shelter beds, there were 1,135 seasonal beds and 317 overflow beds in 2015.[37]

Pennsylvania HIC of Year-Round Beds[38]						
Year	**Total Year-Round Beds**	**Emergency Shelter**	**Transitional Housing**	**Safe Havens**	**Permanent Supportive Housing**	**Rapid Rehousing**
2015	16,140	8,452	7,420	268	13,610	2,604
2014	15,922	8,053	7,587	282	11,862	1,544
2013	16,370	7,793	7,565	254	12,304	758
2012	16,050	7,825	8,016	209	10,857	n/a
2011	16,363	8,148	8,042	173	9,895	n/a
2010	15,745	7,889	7,683	173	8,300	n/a

[35] Ibid.
[36] Ibid.
[38] Ibid.

Permanent supportive housing saw the largest amount of bed expansion during this time growing by over 5000 beds or 39 percent.[39] While the Safe Haven program is much smaller, its beds increased by 50 percent in the same five year time span. The only exception to the program bed growth is the shrinking number of transitional housing beds, which have decreased by 20 percent since 2007. The decline is in part due to the high cost of the programs and in part a result of more communities moving to adopt Rapid Rehousing programs, which now provide 2,604 beds throughout the state.

Year-Round Beds of Emergency Shelter and Transitional Housing*[40]*



Pennsylvania Education for Children and Youth Experiencing Homelessness State Evaluation Report

While AHAR contains nationwide statistics relating to children and youth experiencing homelessness, Pennsylvania also provides services to these children aimed at increasing access to education. These efforts are detailed in the Education for Children and Youth Experiencing Homelessness (ECYEH) report that contains information on the state plan for enacting the McKinney-Vento Act Education Assistance Improvements Act of 2001.[41] The report gathers additional statistics about how homeless children and youth access services from the state. Throughout the report, distinctions are made between homeless students who are enrolled in a local education agency and all homeless children and youth who benefit directly or indirectly from state programs (those are categorized as "served").

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[38] Ibid.
[39] Ibid.
[40] Ibid.
[41] Pennsylvania Department of Education. *Education for Children and Youth Experiencing Homelessness Program 2013-2014 State Evaluation Report.* Harrisburg: Pennsylvania. 2015 Pp. 6-7, available at http://www.education.pa.gov/Documents/K-12/Homeless%20Education/2013-14%20ECYEH%20Counts%20by%20Region%20County%20State.pdf (accessed November 4, 2015).

Number of Homeless Children in Pennsylvania[42]		
Year	**Served**	**Enrolled**
2013-14	24,540	20,785
2012-13	22,618	19,459
2011-12	19,914	18,231
2010-11	20,556	18,621

During 2013 to 2014 program year, a total of 24,540 children and youth experiencing homelessness were served by Pennsylvania programs.[43] Of those served, 20,785 children and youth, or 85 percent, were enrolled in school.[44] These enrolled children make up just 1 percent of total school population in Pennsylvania. The report also noted that homeless children were spread across the state as 96 percent of school districts and 72 percent of charter schools had at least one homeless child.[45] The majority of homeless students were enrolled in schools located in either a city or suburban area. The children and youth who are not enrolled by the state include 412 youth out of school and the nearly 3,000 children age 0-5 who were not enrolled in a pre-kindergarten services.[46]

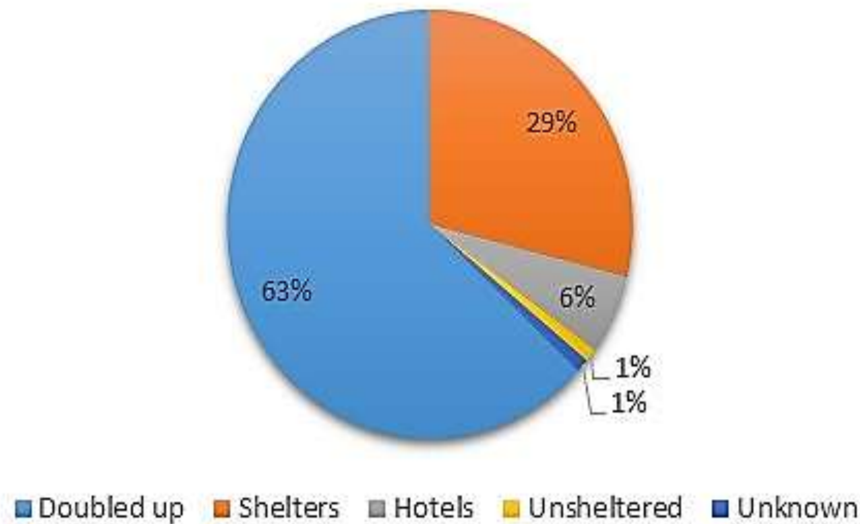
The 2013-2014 ECYEH also highlighted several other important characteristics of Pennsylvania's homeless children and youth:

- 20 percent of the enrolled students were listed as having some form of disability.
- Unaccompanied youth made up 10 percent of those served by state programs.
- 22 percent were identified as experiencing homelessness the prior year.
- 77 percent of homeless children served were classified as economically disadvantaged.

The night-time status of enrolled children and youth is the determining factor in whether they are designated as homeless. For the purposes of the ECYEH, the definition of homelessness includes children from families who are "doubled up" by living with extended relatives, friends, or nonrelatives due to financial hardship. Children in doubled-up families make up 13,120 students, more than half of all enrolled students.[47] The next largest category children were the 6,056 children living in temporary conditions such as shelters, waiting for foster care placement.[48] The final two percent were split between children living unsheltered or whose nighttime status was unknown.[49]

[42] Ibid. P. 24.
[43] Ibid. P. 23.
[44] Ibid. P. 24.
[45] Ibid. P. 2.
[46] Ibid. P. 25.
[47] Ibid. P. 26.
[48] Ibid. P. 26.
[49] Ibid. P. 26.

Enrolled Students Nighttime Status 2013-2014[50]



Many homeless children and youth face additional obstacles which prevent them from enrolling, attending, or attaining educational success at school. The ECYEH identified 12 percent of enrolled, or 2,104 children, facing educational barriers.[51] The most common barriers to education included transportation to school and determining whether a student was eligible for homelessness services. The report noted that the number of students facing transportation barriers had increased from previous years. While the report did not list the root causes of transportation barriers, it noted that the problem is difficult to solve due to the financial limitations of schools and the logistical challenges associated with arranging transportation.

In the 2013-2014 reporting period, Pennsylvania's ECYEH program had multiple successes. Close to 70 percent of homeless students stayed in their school of origin, and 81 percent of homeless children received state services at an individual level.[52] Tutoring or other instructional support was by far the most offered service to children/youth, making up 77 percent of services accessed by students.[53] Other important services provided included school-agency coordination, transportation, providing school supplies and school-required clothing. Additionally, over half of the schools with homeless students offered free or reduced priced lunches.[54]

Pennsylvania's ECYEH program and other efforts to assist homeless children are discussed in more detail in a separate section of this report.

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[50] Ibid. P. 27.
[51] Ibid. P. 40.
[52] Ibid. P. 40.
[53] Ibid. P. 40.
[54] Ibid. P. 11.

FEDERAL, STATE, AND PRIVATE RESOURCES FOR ADDRESSING HOMELESSNESS

Federal Government Homelessness Resources

Homelessness has been a priority for the federal government for the past few years. The ambitious federal strategic plan to prevent and end homelessness, *Opening Doors*, released in 2010 and amended in 2015, is inspired by the humane and noble vision: "No one should experience homelessness – no one should be without a safe, stable place to call home."[55] The amended plan sets up the goals to

- Prevent and end homelessness among Veterans in 2015
- Finish the job of ending chronic homelessness in 2017
- Prevent and end homelessness for families, youth, and children in 2020
- Set a path to ending all types of homelessness.[56]

The United States Interagency Council on Homelessness estimates that since the start of *Opening Doors* in 2010, the amount of federal funding on social programs specifically targeting homelessness has reached over 5.1 billion dollars.[57]

<u>Department of Housing and Urban Development (HUD)</u>

In 2009, the McKinney-Vento Homeless Education Improvements Act was reauthorized by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.[58] Under this act, the HUD awards funding to local communities through the Continuum of Care program and the Emergency Solution Grant, two of the largest homeless assistance programs in the country. Through these programs, the federal government distributes funds to states, and the funds are then granted to local communities through a competitive process. In 2014, through these two programs combined, Pennsylvania received over 107 million dollars from HUD, a 17-percent increase from 2010.[59]

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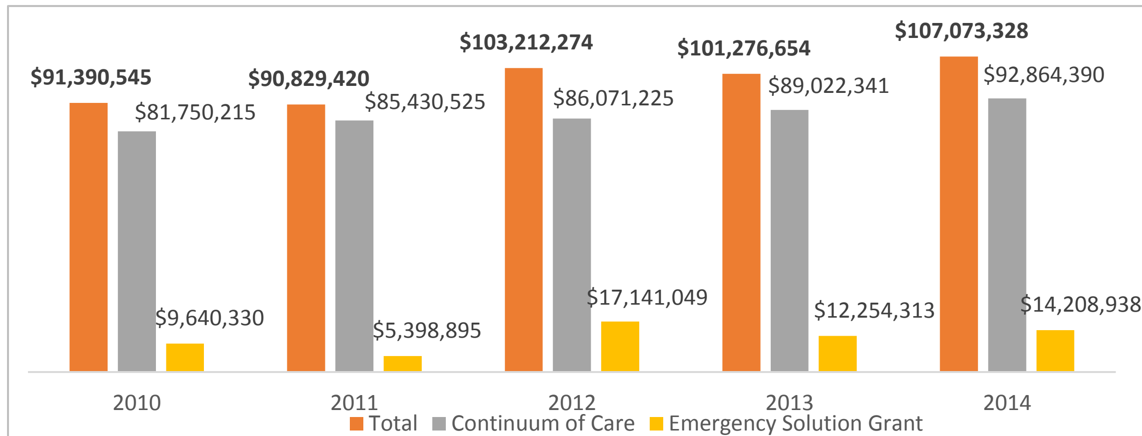
[55] U.S. Interagency Council on Homelessness. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness*, as Amended in 2015. Washington, D.C., June 2015, available at https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors-Amendment2015_FINA (accessed March 1, 2016).
[56] Ibid.
[57] U.S. Interagency Council on Homelessness. *The President's 2016 Budget: Fact Sheet on Homeless Assistance*. 2015, P. 1, available at https://www.usich.gov/resources/uploads/asset_library/2016_Budget_Fact_Sheet_on_Homelessness_Assistance.pdf (assessed January 7, 2016).
[58] U.S. Department of Housing and Urban Development. *HEARTH-Act 2014*, available at https://www.hudexchange.info/homelessness-assistance/hearth-act/ (assessed January 7, 2016).
[59] U.S. Department of Housing and Urban Development. *CPD Allocations and Awards*. 2015, available at https://www.hudexchange.info/grantees/cpd-allocations-awards/ (accessed January 7, 2016).

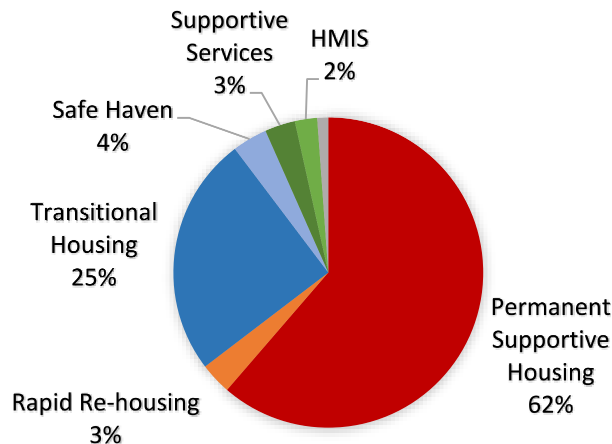
Pennsylvania Homeless Assistance Funding Awards, 2010-2014[60]



The Continuum of Care (CoC) Program

The Continuum of Care Program is HUD's largest program to serve individuals and families experiencing homelessness. The purpose of this program is to provide services to help place individuals and families on a path to stable long-term housing. To promote this goal, CoC programs provide funding for evidence-based programs and approaches like permanent supportive housing, Rapid Rehousing, and Housing First. CoCs have the dual role of planning and operating programs, and use data collected through HMIS to inform planning decisions and track performance at both the project and systems levels.

HUD 2014 Continuum of Care Program Funding Awards[61]



[60] Ibid.

[61] U.S. Department of Housing and Urban Development. *HUD's 2014 Continuum of Care Program Funding Awards: Pennsylvania*. March 19, 2015, available at https://www.hudexchange.info/resource/reportmanagement/published/CoC_AwardComp_State_PA_2014.pdf (accessed January 7, 2016).

In 2014, HUD dispersed over $92 million dollars to Pennsylvania's 18 CoC programs.[62] How these collective funds were utilized is explained in the chart above. Programs dedicated to permanent housing programs made up the largest portion of these CoC funds with 65 percent, while temporary housing made up 29 percent of the funds spent.[63] The remaining 10 percent of the funds were spent on programs that offer supportive services only, funding the housing management information system, and planning CoC activities.[64] Of the money CoC programs spent on housing projects, 98.7 percent was used to renew preexisting housing programs, while 1.3 percent of the funds were awarded to the development of new permanent housing projects.[65]

CoC Program Awards by PA Region[66]

County	2011	2012	2013	2014	$ Change 2011-14
Allegheny	$10,141,881	$13,583,191	$14,474,702	$15,524,687	$5,382,806
Beaver	1,035,049	1,380,850	1,387,350	1,587,100	552,051
Berks	1,958,279	2,757,595	2,610,244	2,624,111	665,832
Bucks	601,933	960,756	840,708	902,215	300,282
Central PA	3,899,879	4,312,293	4,992,351	5,722,465	1,822,586
Chester	1,428,812	1,551,258	1,411,830	1,538,508	109,696
Delaware	3,816,719	4,332,127	4,404,288	4,581,158	764,439
Erie	1,913,315	2,194,681	2,142,963	2,301,957	388,642
Harrisburg	985,938	1,076,667	1,612,657	1,587,502	601,564
Lackawanna	2,068,496	2,538,942	2,363,946	2,615,255	546,759
Lancaster	1,224,407	1,455,820	2,012,908	1,916,917	692,510
Luzerne	3,315,133	3,467,716	3,368,966	3,826,687	511,554
Montgomery	2,342,946	2,348,321	2,199,442	2,555,725	212,779
NE PA	4,281,299	5,281,166	5,398,867	5,440,115	1,158,816
NW PA	2,241,389	2,619,134	2,635,655	2,739,662	498,273
Philadelphia	26,312,466	30,384,189	29,767,783	30,800,341	4,487,875
SW PA	4,423,192	5,056,771	5,042,434	5,148,459	725,267
York	711,188	769,748	1,011,954	1,012,925	301,737
Total	**$72,702,321**	**$86,071,225**	**$87,679,048**	**$92,425,789**	**$19,723,468**

[62] Ibid.
[63] Ibid.
[64] Ibid.
[65] Ibid.
[66] U.S. Department of Housing and Urban Development. *CPD Allocations and Awards*. 2015, available at https://www.hudexchange.info/grantees/cpd-allocations-awards/ (accessed January 7, 2016).

The Emergency Solutions Grant Program (ESG)

The ESG program, formerly the Emergency Shelter Grant, was authorized by Subtitle B of Title IV of Chapter 119 of the McKinney-Vento Homeless Assistance Act.[67] The ESG program was later amended and reauthorized by the HEARTH Act in 2009. During this time the focus of the program expanded from providing services to homeless persons in shelter to assisting individuals and families quickly regain permanent housing stability after experiencing a housing crisis. The program requirements are designed to encourage state and local governments to use all available resources, consult closely with local communities, and evaluate progress in accordance with federal plans. ESG funds can be used to pay for many shelter- and rehousing-related activities including the following:

- Engaging homeless individuals and families living on the street by providing essential services necessary to reach out to unsheltered homeless people, connect them with emergency shelter, housing or critical services, and provide non-facility based care to unsheltered homeless people who are unwilling or unable to access an appropriate health facility.
- Improving the number and quality of emergency shelters for homeless individuals and families; helping operate these shelters; providing essential services to shelter residents;
- Rapidly Rehousing homeless individuals and families; and
- Preventing families and individuals from becoming homeless through housing relocation and stabilization services and temporary rental assistance necessary to prevent an individual or family from moving into an emergency shelter.

In 2015, over $15 million dollars of ESG funds were allocated to Pennsylvania. The majority of ESG funds are distributed directly to counties and cities throughout the Commonwealth by HUD. DCED administers the remaining ESG funds (approximately one-third of the total amount) and awards them competitively to mostly rural counties known as the Balance of State. Older state ESG allocations are shown in the following chart.

ESG Funds Allocated to Pennsylvania[68]

Year	Dispersed by State	County and City Allocations	Total ESG Funding
2012	$5,816,323	$11,324,726	$17,141,049
2013	4,470,452	7,783,861	12,254,313
2014	5,049,113	9,159,825	14,208,938
2015	5,435,602	9,867,735	15,303,337

[67] U.S. Department of Housing and Urban Development. *Emergency Solutions Grants (ESG) Program Fact Sheet 2014*, available at https://www.hudexchange.info/resources/documents/EmergencySolutionsGrantsProgramFactSheet.pdf (accessed January 7, 2016).

[68] U.S. Department of Housing and Urban Development. *CPD Allocations and Awards*. 2015, available at https:\\www.hudexchange.info/grantees/cpd-allocations-awards/ (accessed January 7, 2016)

HOME Investment Partnerships Program

The HOME program is an example of a program that benefits formerly homeless individuals and families and aids them in finding stable permanent housing. HOME provides formula grants to states and localities annually which are used by communities to fund many activities.[69] HOME is the largest federal block grant to state and local governments designed exclusively to create affordable housing for low-income households.[70] The program's flexibility allows states and local governments to use HOME funds for grants, direct loans, loan guarantees or other forms of credit enhancements, rental assistance, or security deposits. Eligible uses of funds include tenant-based rental assistance, housing rehabilitation, assistance to homebuyers, and new construction of housing. HOME funding may also be used for site acquisition and improvements, and other necessary and reasonable activities related to the development of non-luxury housing. HOME requires that participating jurisdictions match 25 cents of every dollar in program funds, thus mobilizing community resources in support of affordable housing.[71]

In Pennsylvania, HOME funds not granted directly to local communities are administered by DCED. To pay for its administrative costs, DCED earmarks a small percent of the total funds awarded and allocates at least 35 percent of the available funds to the PA Housing Finance Agency for rental projects and homebuyer projects.[72] DCED sub-grants the remaining funds to local government grantees. These grant funds are commonly used for homeowner rehabilitation projects for low-income individuals and families.[73]

HOME Funds Allocated to Pennsylvania[74]			
Year	**Dispersed by State**	**County Allocations**	**PA Allocation**
2013	$13,994,674	$26,946,774	$40,941,448
2014	15,212,519	28,091,845	43,304,364
2015	13,441,532	25,176,590	38,618,122

[69] U.S. Department of Housing and Urban Development. *HOME Program Overview*, available at http://portal.hud.gov/hudportal/documents/huddoc?id=19790_Overview.pdf (accessed January 7, 2016)
[70] U.S. Department of Housing and Urban Development. *HOME Investment Partnerships Program*, available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/programs/home/ (accessed January 7, 2016)
[71] Ibid.
[72] Commonwealth of Pennsylvania Department of the Auditor General. *Performance Audit Report Department of Community and Economic Development*. Page 6. December 2015, available at http://www.paauditor.gov/Media/Default/Reports/Performance%20Audit%20of%20the%20Pennsylvania%20Department%20of%20Community%20and%20Economic%20Development.pdf (accessed January 20, 2016).
[73] Ibid.
[74] U.S. Department of Housing and Urban Development. *CPD Allocations and Awards.* 2015, available at https://www.hudexchange.info/grantees/cpd-allocations-awards/ (accessed January 7, 2016).

*Housing Opportunities for Persons with AIDS (HOPWA***)**

Housing Opportunities for Persons with AIDS is an example of a homelessness assistance program specifically designed to meet the needs of a small subset of the nation's homeless population. Through this program, HUD makes grants to local communities, states, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families. HOPWA funds can be used for a wide range of purposes including housing, social services, program planning, and development costs.[75]

Pennsylvania HOPWA Allocation[76]	
Year	**PA Allocation**
2013	$11,422,560
2014	12,606,281
2015	11,413,347

There are two ways HOPWA funds are distributed to states and cities: a statutory formula for areas with higher homeless populations and a competitive grant program.[77] The competitive grants are usually awarded to either innovative programs of special national significance or new long-term projects, for areas of the county which did not qualify for formula allocations.

Several other mainstream HUD programs may also benefit homeless individuals and families:

- Public Housing
- Project Based Rental Assistance
- Community Development Block Grant
- Choice Neighbors Initiative
- Section 202 Housing for Elderly
- Section 811 Housing for People with Disabilities
- National Housing Trust Fund

[75] U.S. Department of Housing and Urban Development. *HOPWA Eligibility Requirements.* 2014, available at https://www.hudexchange.info/programs/hopwa/hopwa-eligibility-requirements/ (accessed January 7, 2016).
[76] U.S. Department of Housing and Urban Development. *CPD Allocations and Awards.* 2015, available at https://www.hudexchange.info/grantees/cpd-allocations-awards/ (accessed January 7, 2016).
[77] U.S. Department of Housing and Urban Development. *HOPWA Eligibility Requirements*. 2014, available at https://www.hudexchange.info/programs/hopwa/hopwa-eligibility-requirements/ (accessed January 7, 2016).

Department of Health and Human Services (HHS)

The Health Care for the Homeless Program is an offshoot of the Community Health Center program, authorized under section 330 of the Public Health Services Act.[78] The purpose of the Health Care for the Homeless Program is to provide primary health care, substance use treatment, emergency care with referrals to hospitals for in-patient care services and/or other needed services, outreach services to assist difficult-to-reach people experiencing homelessness in accessing care, and assistance in establishing eligibility for entitlement programs and housing. Nationally, the Health Care for Homeless Program was funded at 366 million in 2015, a 19-percent increase from 2014.[79]

The six Pennsylvania Community Health Centers which had the highest percentage of homeless patients in 2014 received a total of 15.8 million dollars in health center funds and served approximately 17,712 homeless patients.[80] Health Center funds covered only 32 percent of the cost to operate these clinics; other funding sources included PATH funding, Mental Health/Substance Abuse block grants, Ryan White Funding, Medicaid, Medicare, and private dollars.[81]

Pennsylvania Community Health Centers Serving Homeless Patients

Program Name	Location	Total Operating Cost	Health Center Grant Funds	Patients Served	Percent Homeless
Community Health Net	Erie	$9,403,417	$1,789,430	15047	6.9%
North Side Christian Health Center	Pittsburgh	3,085,517	1,099,811	4786	1.1
Primary Care Health Services, Inc.	Pittsburgh	12,253,307	5,549,291	17914	28.2
Project Home	Philadelphia	1512751	570,533	541	33.8
Public Health Management Corp.	Philadelphia	16,172,074	4,261,870	16974	54.7
Rural Health Corp. of NE PA McKinney Clinic	Wilkes-Barre	7,024,867	2,531,265	17374	12.1
	Total	$49,451,933	$15,802,200	72,636	--

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[78] National Health Care for the Homeless Council. *Fact Sheet 2013*, available at http://www.nhchc.org/wp-content/uploads/2011/09/hch-fact-sheet-2013.pdf (assessed January 7, 2016).

[79] U.S. Interagency Council on Homelessness. *The President's 2016 Budget: Fact Sheet on Homeless Assistance*. 2015, P. 1, available at https://www.usich.gov/resources/uploads/asset_library/2016_Budget_Fact_Sheet_on_Homelessness_Assistance.pdf (accessed January 7, 2016).

[80] U.S. Department of Health and Human Services. *2014 Health Center Data: Pennsylvania Program Grantee Data,* available at http://bphc.hrsa.gov/uds/datacenter.aspx?year=2014&state=PA (accessed January 7, 2015).

[81] National Health Care for the Homeless Council. *Fact Sheet 2013*, available at http://www.nhchc.org/wp-content/uploads/2011/09/hch-fact-sheet-2013.pdf (accessed January 7, 2015).

SAMHSA Grants

The Projects for Assistance in Transition from Homelessness (PATH) program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration (SAMHSA). It provides services to people with serious mental health illness, including those with co-occurring substance use disorders, who are experiencing homelessness or are at risk of becoming homeless. In addition to PATH funds, SAMHSA also offers discretionary grants which benefit homeless persons with substance use or mental health problems. The Treatment Systems for Homelessness Programs in SAMHSA's Center for Substance Abuse Treatment enable communities to expand and strengthen their treatment services for individuals experiencing homelessness with substance abuse disorders and mental illness. These programs have been funded at 41 million dollars during 2014 and 2015. One example of SAMHSA's Treatment Systems grants includes the Cooperative Agreement to Benefit Homeless Individuals grant received in 2015 by Pennsylvania's Department of Drug and Alcohol Programs for 1.8 million dollars.[82] Once awarded, grants can be used to enhance statewide planning and infrastructure development; deliver behavioral health, housing support, peer and other recovery oriented services; and engage and enroll individuals in Medicaid and other mainstream benefits.[83]

Other programs include 33 million dollars spent on the Homeless Prevention and Housing programs in SAMHSA's Center for Mental Health Services, which funds services for individuals and families experiencing homelessness while living with severe mental illness or co-occurring mental and substance disorders.[84] The programs address the need for treatment and support service provision to individuals and families.

The Runaway and Homeless Youth Act

The Runaway and Homeless Youth Act (RHYA) funds hundreds of community and faith-based organizations through three grant programs that serve the runaway and homeless youth population: the Basic Center Program, the Street Outreach Program, and the Transitional Living Program. Across the country, over 114 million dollars was allocated to these programs in 2015.[85]

The Basic Center Program (BCP) aids local community programs that address the immediate needs of runaway and homeless youth under 18 years old. Basic Centers provide youth with up to 21 days of temporary emergency shelter, food, clothing and referrals for health care.[86] Other types of assistance provided to youth and their families may include individual, group, and

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[82] Substance Abuse and Mental Health Services Administration. *Fiscal Year 2015 Discretionary Funds*, available at http://www.samhsa.gov/grants-awards-by-state/details/Pennsylvania (accessed February 10, 2016).
[83] Substance Abuse and Mental Health Services Administration. *Cooperative Agreement to Benefit Homeless Individuals-States Initial Announcement*. February 2014, available at http://www.samhsa.gov/grants/grant-announcements/sm-14-010 (accessed February 10, 2016).
[84] U.S. Department of Housing and Urban Development. *CPD Allocations and Awards*. 2015, available at https://www.hudexchange.info/grantees/cpd-allocations-awards/ (accessed January 7, 2016).
[85] Ibid.
[86] Family & Youth Services Bureau. *Basic Center Program Fact Sheet*, available at http://www.acf.hhs.gov/programs/fysb/resource/bcp-fact-sheet (accessed January 29, 2016).

family counseling, recreation programs, and aftercare services for youth once they leave the shelter. As of 2015, Pennsylvania had eight BCP centers with a total of $1,679,275 in active awards.[87]

RHYA's Transitional Living Program provides shelter, skills training and support services to homeless youth between the ages of 16 and 22 for a continuous period of 540 days, or 635 days in exceptional circumstances.[88] Youth are provided with stable, safe living accommodations and services that help them develop the skills necessary to move to independence. Living accommodations may be host family homes, group homes, or supervised apartments. Since 2012, five grantees have been awarded a total of $913,238 in transitional living grants.[89]

The Street Outreach Program provides educational and prevention services to runaway and street youth subjected to or at risk of sexual exploitation or abuse. This competitive grant program works to establish and build relationships between youth and program outreach staff in order to help youth leave the streets.[90] Grantees also provide support services that aim to move youth into stable housing and prepare them for independence. In 2015, two Pennsylvania grantees received a total of $342,547.[91]

Family Violence Prevention and Services Grant Program

Family Violence Prevention and Services Grant Program administered by the Family Youth and Services Bureau is the only source of dedicated funding for domestic violence shelter and supportive services since 1984.[92] These grants are provided to assist state agencies in the provision of shelter to victims of family violence and their dependents, and for related services, such as emergency transportation and child care. In 2015, Pennsylvania grantees were allocated $3,107,268.[93]

Other mainstream HHS Programs benefiting homeless families and individuals include the following:

- Community Service Block Grant

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[87] Family & Youth Services Bureau. *2015 Basic Center Program Awards*. September 2015, available at http://www.acf.hhs.gov/programs/fysb/resource/2015-bcp-awards (accessed January 29, 2016).
[88] Family & Youth Services Bureau. *Transitional Living Program Fact Sheet.* October 2015, available at http://www.acf.hhs.gov/programs/fysb/resource/tlp-fact-sheet (accessed January 29, 2016).
[89] Family & Youth Services Bureau. *FYSB Resources available at* https://www.acf.hhs.gov/programs/fysb/resource-library/search?keyword[0]=awards&area[1952]=1952&type[5168]=5168&sort=recent (accessed January 29, 2016)
[90] Family & Youth Services Bureau. *Street Outreach Program*. January 2015, available at http://www.acf.hhs.gov/programs/fysb/programs/runaway-homeless-youth/programs/street-outreach (accessed January 29, 2016).
[91] Family & Youth Services Bureau. *2015 Street Outreach Program Grant Awards*. September 2015, available at http://www.acf.hhs.gov/programs/fysb/resource/2015-sop-awards (accessed March 1, 2016).
[92] Family & Youth Services Bureau. *Family Violence Prevention and Services Program Overview, available at* http://www.acf.hhs.gov/sites/default/files/fysb/fvpsa_overview_20150731.pdf (accessed March 1, 2016).
[93] Family & Youth Services Bureau. 2015 *Family Violence Prevention & Services Act Grant Awards to States and Territories.* April 2015, available at http://www.acf.hhs.gov/programs/fysb/resource/fy2015-state-grant-awards (accessed March 1, 2016).

- Child Care and Development Block Grant
- Maternal and Child Health Services Block Grant
- Children's Health Insurance Program
- Ryan White HIV/AIDs Program
- Head Start
- TANF

<u>Department of Labor</u>

Homeless Veterans' Reintegration Program

The Homeless Veterans' Reintegration Program (HVRP) provides services to help veterans experiencing homelessness obtain meaningful employment and to improve effective service delivery systems to address problems facing homeless veterans. HVRP is the only nationwide program exclusively focused on helping veterans experiencing homelessness reintegrate into the workforce. Funds are awarded through a competitive grant process. The program also includes funds specifically for grantees providing specialized services to female veterans experiencing homelessness and veterans with families experiencing homelessness. In 2015, six Pennsylvania grantees were awarded 1.3 million dollars, with individual grants ranging between $100,000 to $300,000.[94]

<u>Department of Veterans Affairs (VA)</u>

The HUD Veterans Affairs Supportive Housing Program (HUD-VASH)

HUD-VASH is a joint program between HUD and the U. S. Department of Veterans Affairs designed to reduce the number of homeless veterans by combining rental assistance vouchers with case management and outreach from VA care centers.[95] To provide rental assistance, a housing subsidy is paid to the landlord on behalf of the participating veteran. The veteran then pays the difference between the actual rent charged by the landlord and the amount subsidized by the program. In 2015, veterans across Pennsylvania received 243 housing choice vouchers worth a total of 1,585,207 dollars.[96]

Supportive Services for Veteran Families (SSVF)

The SSVF program is funded by the VA and administered locally by homeless service providers. This program provides supportive services to very low-income veteran families in or

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[94] U.S. Department of Labor. *Program Year 2015 Homeless Veterans Reintegration Program Grantees*. June 23 2015, available at http://www.dol.gov/newsroom/releases/vets/vets20151203 (accessed February 22, 2016).
[95] U.S. Department of Housing and Urban Development. HUD-VASH Vouchers, available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/public_indian_housing/programs/hcv/vash (accessed February 22, 2016).
[96] U.S. Department of Housing and Urban Development. *Fiscal Year 2015 HUD-VASH Voucher Awards, available at* http://portal.hud.gov/hudportal/documents/huddoc?id=FY2015HUDVASH.pdf (accessed February 22, 2016).

transitioning to permanent housing. Funds are provided through grants to private non-profit organizations and consumer cooperatives that will assist very low-income veterans' families by providing a range of supportive services designed to promote housing stability. Through the SSVF Program, the VA aims to prevent veterans from falling into homelessness whenever possible and to Rapidly Rehouse veterans' families who become homeless, improving housing stability for very low-income veterans' families.

Grants can be used to fund many services including outreach, case management, assistance in obtaining VA benefits, and providing time-limited payments to third parties (for example, landlords) to help the families of veterans stay in or acquire permanent housing on a sustainable basis. In 2016, the VA renewed the funding of fifteen organizations across Pennsylvania, awarding a total of 16,661,671 dollars to these programs.[97]

Other VA programs beneficial to homeless veterans include

- Healthcare for Homeless Veterans Program
- Homeless Providers Grant and Per Diem Program
- The Domiciliary Care for Homeless Veterans Program
- Homelessness Prevention: Healthcare for Reentry Veterans
- Veteran's Justice Outreach

Department of Justice

Transitional Housing Assistance Grants for the Victims of Sexual Assault, Domestic Violence, Dating Violence, or Stalking Program

The Department of Justice administers this transitional housing program which focuses on holistic, survivor-centered approaches to transitioning individuals into permanent housing. Over the last five years the Department of Justice has awarded eight Pennsylvania grantees a combined total of 2,597,373 dollars spread over nine grants.[98] Average grant amount per organization was approximately $300,000. These grants support programs that provide assistance to survivors of sexual assault, domestic violence, dating violence, and/or stalking who are in need of transitional housing, short-term housing assistance, and related support services.[99] Transitional housing programs may offer individualized services such as counseling, support groups, safety planning, and advocacy services as well as practical services such as licensed child care, employment services, transportation vouchers, telephones, and referrals to other agencies.

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[97] U.S. Department of Veterans Affairs. *2016 Supportive Services for Veteran Families Awards List, available at* http://www.va.gov/HOMELESS/ssvf/docs/SSVF_Awards_List_Final_September14.pdf (accessed February 22, 2016).

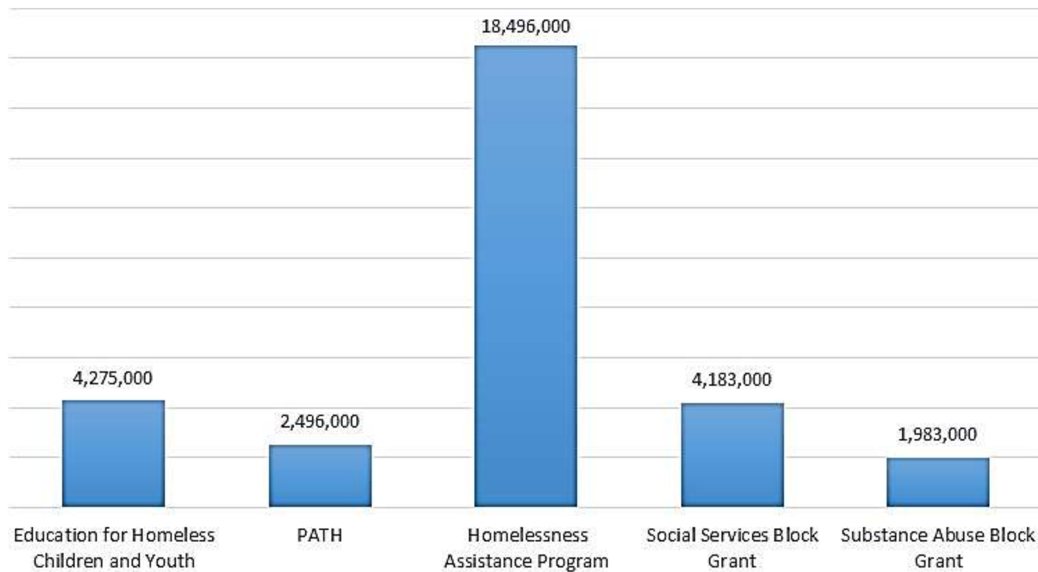
[98] U.S. Department of Justice. *Grant Awards by Program*. December 2015, available at https://www.justice.gov/ovw/awards (accessed February 22, 2016).

[99] U.S. Department of Justice. *Office of Violence Against Women Fiscal Year 2016 Transitional Housing Assistance Grants for Victims of Sexual Assault, Domestic Violence, Dating Violence, and Stalking Solicitation* December 21, 2015. P. 1-2 available at https://www.justice.gov/ovw/file/800641/download (accessed February 22, 2016).

State Resources

While Pennsylvania provides close to 18.5 million dollars in homeless assistance from the general fund, when combined with federal aid available to the Commonwealth, there was a total of 31.4 million dollars spent on homelessness programs in the 2014-15 fiscal year. The Pennsylvania Department of Human Services estimated that in the 2014-15 fiscal year 28,621 children and 47,293 adults accessed housing services for a total of 75,914 people.[100] Additionally, 104,297 adults and 239,246 children received protective services.[101] There are five main sources the state uses to fund its homelessness assistance programs. Pennsylvania's Education for Homeless Children and Youth program provides services to school age children while Projects for Assistance in Transition from Homelessness assists homeless individuals who have mental illness.

Pennsylvania Homeless Assistance Program
Appropriations for 2014-15



The Education for Homeless Children and Youth Program

The Education for Homeless Children and Youth Program was created to ensure that all children and youth experiencing homelessness have equal access to the same free, appropriate public education available to other children. To further this goal, the U.S. Department of Education allocates federal McKinney-Vento funding to the states. In 2015 the U.S. Department of Education

[100] Pennsylvania Department of Human Services. *Post Expenditure Report For the 2014-2015 Social Services Block Grant*. January 2016. P. 3, available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/report/c_121244.pdf (accessed February 22, 2016).
[101] Ibid. P. 4.

sent 65 million dollars of McKinney-Vento funding to the states.[102] Of that amount. $2.4 million dollars in funding was allocated to Pennsylvania to provide services to children and youth who experience family homelessness and to unaccompanied youth.[103]

In accordance with federal requirements, twenty-five percent ($600,474, FY 2015-16) of those funds are retained by Pennsylvania Department of Education for state-level activities, which include program coordination and management, technical assistance, program evaluation, and federal reporting. The remaining 75 percent ($1,801,422 FY 2015-16) of the funds are sub-granted to local education agencies to provide services across the state.[104]

In 2014, the Commonwealth of Pennsylvania Task Force on Homeless Children's Education wrote a report which examined federal and state spending on the Education for Homeless Children and Youth Program. The task force expressed concerns about the funding:

Fiscal Year	USDOE Funding	Funding Awarded to PA EHCYP
2009-10	$65,427,000	$1,719,278
1010-11	65,427,000	2,578,809
2011-12	65,296,146	2,384,170
2012-13	65,172,591	2,592,529
2013-14	61,771,052	2,345,862
2014-15	65,042,000	2,452,072
2015-16	65,042,000	2,401,896

The amount allocated to Pennsylvania has decreased over the past several years due to federal budget constraints. Pennsylvania currently budgets no state funds for state level activities or to expand the federal funding base it receives to provide services to children experiencing homelessness and unaccompanied youth. Most states provide additional supportive services to meet the needs of children and youth experiencing homelessness beyond the services implemented through McKinney-Vento. The Commonwealth of Massachusetts has taken an additional step of

[102] U.S. Interagency Council on Homelessness. *The President's 2016 Budget: Fact Sheet on Homeless Assistance*. 2015, P.1, available at https://www.usich.gov/resources/uploads/asset_library/2016_Budget_Fact_Sheet_on_Homelessness_Assistance.pdf (assessed January 7, 2016).

[103] U.S. Department of Education. *Funds for State Formula-Allocated and Selected Student Aid Programs*. 2015. P. 87, available at http://www2.ed.gov/about/overview/budget/statetables/17stbystate.pdf (accessed January 29, 2016).

[104] U.S. Department of Education. *Guidance for the Education for Homeless Children and Youth Program.* Washington D.C., July 2004. P. 5, available at http://www2.ed.gov/programs/homeless/guidance.pdf (accessed January 29, 2016).

supplementing its federal McKinney-Vento allocation with a state appropriation. Historically, other states have also provided state funding.[105]

Projects for Assistance in Transition from Homelessness

PATH is a formula grant program that provides financial assistance to states to support services for individuals who are experiencing homelessness and who have serious mental illness or co-occurring mental illness and substance abuse disorders. PATH was authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990.[106] The PATH grants can be used to pay for a large number of services including outreach, health, and treatment services in additional to assisting individuals in identifying and securing housing.[107] PATH also funds programs to assist the recovery of homeless individuals with mental health and substance use disorders. At the federal level, the program is administered by the Center for Mental Health Services, a component of the SAMSHA.

The amount of PATH funds Pennsylvania receives from SAMHSA is a set amount based on a legislatively determined formula. Pennsylvania's PATH allocation for 2014 was $2,353,000 while the state matched $1,217,092 to these services.[108] At the state level, Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) offers technical assistance and coordinates the efforts of county PATH programs.

OMHSAS receives PATH funds and then redistributes these funds out to county Mental Health and Intellectual Disability offices annually. Pennsylvania allocates a substantial amount of PATH funds to areas with the highest concentration of individuals who are homeless with serious mental illness. Once a county establishes a PATH program or adds PATH-funded services to an existing program, funding to that county continues as long as the program complies with PATH requirements. As of April 30, 2015, OMHSAS has contracted with 24 County Mental Health/Intellectual Disability offices to receive PATH funds and administer PATH services.[109] These 24 county offices encompass 36 of Pennsylvania's 67 counties.[110]

Homeless Assistance Program

The Homeless Assistance Program (HAP) is a county-directed program that offers a variety of supportive services to individuals and families who are experiencing or at risk for homelessness and who can demonstrate that, with HAP intervention, they will be able to meet their basic housing needs in the near future. The Commonwealth of Pennsylvania funds HAP through an annual state-

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[105] Pennsylvania Department of Education. *Meeting the Educational Needs of Pennsylvania's Homeless Children and Youth: Commonwealth of Pennsylvania Task Force on Homeless Children's Education Report to the Governor and General Assembly of Pennsylvania.* Harrisburg, PA, 2014. P. 13, available at http://www.elc-pa.org/wp-content/uploads/2014/06/HomelessTaskForceReport_1_31_14.pdf (accessed March 21, 2016).
[106] McVey, Johnathan. Presentation to the advisory committee at the general meeting on December 17, 2015.
[107] Ibid.
[108] PATH Data Exchange. *2014 State Profile: Pennsylvania*, available at http://pathpdx.org/Report/AnnualProfileReport/?annualPeriodId=5&stateId=&stateName=Pennsylvania (accessed March 3, 2016).
[109] McVey, Johnathan. Presentation to the advisory committee at the general meeting on December 17, 2015.
[110] Ibid.

funded appropriation. The Budget for Homeless Assistance Appropriation is $18,496,000 for the 2015-2016 fiscal year and has been flat-funded since 2012, when it was reduced by 10 percent.[111]

There are five service components included in HAP: case management, rental assistance, bridge housing, emergency shelter, and innovative supportive housing. Each county determines how and for which of the five service components the funds are utilized. This process allows counties the flexibility needed to design a comprehensive homeless program that will address the housing issues specific to clients in their community and assist them in reaching self-sufficiency.

Social Services Block Grant

Social Services Block Grant (SSBG) is managed by the Pennsylvania Department of Human Services and assists states in delivering social services directed toward the needs of children and adults. Funds are allocated to the states on the basis of population. Funds support outcomes across the human service spectrum and are associated with strategic goals and objectives such as employment, child care, child welfare, adoptions, and youth services. States have flexibility to use their funds for a range of services, depending on state and local priorities. Pennsylvania dedicated $4,183,000 of these funds for housing services in 2013 and 2014.[112]

Substance Abuse Prevention and Treatment Block Grant

Substance Abuse Prevention and Treatment Block Grant is used to assist individuals who are suffering from serious mental illness or substance abuse and who are homeless or have an imminent risk of becoming homeless**.** In Pennsylvania a portion of this block grant is used to augment the state HAP funds allocated to counties and is managed by the Department of Human Services. Since 2013, Pennsylvania has devoted $1,983,000 of this block grant to homelessness assistance.[113]

County Allocations 2014-15

County	State Homeless Assistance Program	Office of Mental Health	Social Services Block Grant	Substance Abuse Block Grant	Total
Adams	$93,894				$93,894
Allegheny	2,358,084	$308,904		$731,200	3,398,188
Armstrong	196,405				196,405
Beaver	116,549				116,549
Bedford	28,173				28,173
Berks	455,873				455,873

[111] PA Office of the Budget. *2012-2-13 Enacted Budget General Fund.* P. 8, available at http://www.budget.pa.gov/PublicationsAndReports/Documents/2012-13%20Enacted%20Budget%20Line%20Item%20Appropriations.pdf (accessed March 21, 2016).
[112] Ibid.
[113] Ibid.

County Allocations 2014-15					
County	**State Homeless Assistance Program**	**Office of Mental Health**	**Social Services Block Grant**	**Substance Abuse Block Grant**	**Total**
Blair	263,017				263,017
Bradford	45,398				45,398
Bucks	401,196				401,196
Butler	133,931				133,931
Cambria	176,450				176,450
Cameron	6,477				6,477
Carbon	27,359				27,359
Centre	353,498				353,498
Chester	275,643				275,643
Clarion	106,439				106,439
Clearfield	57,920				57,920
Clinton	23,818				23,818
Columbia	29,460				29,460
Crawford	203,076				203,076
Cumberland	301,058				301,058
Dauphin	703,274	80,154			783,428
Delaware	838,684	91,410			930,094
Elk	27,817				27,817
Erie	606,765	167,099			773,864
Fayette	452,568				452,568
Forest	4,635				4,635
Franklin	113,658				113,658
Fulton	14,389				14,389
Greene	53,572				53,572
Huntingdon	24,518				24,518
Indiana	223,106				223,106
Jefferson	29,664				29,664
Juniata	19,097				19,097
Lackawanna	243,257	76,333			319,590
Lancaster	370,361				370,361
Lawrence	120,502				120,502
Lebanon	146,289				146,289
Lehigh	418,721				418,721
Luzerne	753,690				753,690
Lycoming	153,114				153,114
McKean	36,192				36,192
Mercer	112,794				112,794
Mifflin	27,491				27,491
Monroe	50,195				50,195
Montgomery	479,154				479,154
Montour	10,812				10,812
Northampton	319,424				319,424
Northumberland	50,319				50,319
Perry	46,937				46,937

County Allocations 2014-15					
County	**State Homeless Assistance Program**	**Office of Mental Health**	**Social Services Block Grant**	**Substance Abuse Block Grant**	**Total**
Philadelphia	2,535,571	930,058	4,183,000	1,251,800	8,900,429
Pike	15,327				15,327
Potter	26,111				26,111
Schuylkill	128,172				128,172
Snyder	36,375				36,375
Somerset	48,764				48,764
Sullivan	10,571				10,571
Susquehanna	32,140				32,140
Tioga	103,031				103,031
Union	37,830				37,830
Venango	45,179				45,179
Warren	58,058				58,058
Washington	224,501				224,501
Wayne	28,969	14,260			43,229
Westmoreland	496,294				496,294
Wyoming	18,784				18,784
York	877,388				877,388
Total	**$16,590,782**	**$1,668,218**	**$4,183,000**	**$1,983,000**	**$24,662,000**

Local Resources

While the collaboration of national and state governments has led to a sharp reduction in individuals and families experiencing homelessness, the efforts of local communities can also have a large impact. There are numerous private foundations and for-profit organizations that contribute to homeless assistance programs. Examples include the United Way, which has a longstanding reputation as a leader in eliminating homelessness at a national and local level and the John D. and Catherine T. MacArthur Foundation, which makes grants for community development and affordable housing projects. Local aid can come from numerous sources including community programs, nonprofits, and faith-based organizations. When necessary items and services are provided locally, more state and national resources are freed up and made available to others, increasing the number of people helped. The table below includes a sampling of Pennsylvania programs which benefit homeless persons in their communities.

This table is not intended to present a comprehensive picture of existing programs; it offers some examples to illustrate a variety of services offered to people experiencing homelessness by local organizations in various parts of the Commonwealth.

A Sampling of Local Homeless Resources in Pennsylvania[114]		
Name	**Location**	**Description**
Safe Harbour	Carlisle	Operates an emergency shelter for families and single females; a bridge housing program; and single-room-occupancy (SRO) permanent housing facilities
Haven Ministry Inc.	Central Susquehanna Valley	Provides emergency shelter, food, referral help, and life skills education to homeless families and individuals. Transitional housing program also offered.
The Community of Caring	Erie	Temporary emergency shelter. There is also referral for case management, mental health treatment, health care and housing contacts
The Employment Project	Philadelphia	Nonprofit employment service for homeless and disadvantaged people
Housing Association of Delaware Valley	Philadelphia	Operates programs to assist low income families gain and retain decent affordable housing.
Project H.O.M.E.	Philadelphia	Provides housing and services to chronically homeless persons.
HSP of Pittsburgh	Pittsburgh	Helps to bring food, clothing, blankets and medical staff to homeless persons
Operation Safety Net	Pittsburgh	Delivers medical, mental health, and drug and alcohol services. Also provides employment opportunities to the street homeless population.
St. Francis of Assisi Kitchen	Scranton	Soup kitchen that serves lunch to homeless people and others in need.
Interfaith Hospitality Network	Washington/ Allegheny	Serves area with shelter and social services to promote independence.
Helping Hand for the Homeless	York	Provides hot meals, sleeping bags, clothing, hygiene kits, and access to temporary day work.

While some local organizations are dedicated towards providing a continuum of services, others focus on very specific needs, such as ensuring that homeless individuals and families are fed. Within Pennsylvania there are nine food banks, large warehouses that distribute food and other necessary items to communities.[115] Additionally, there are over 246 local food pantries in Pennsylvania which are usually independently run programs sponsored by churches and community coalitions that help feed the homeless.[116]

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[114] National Coalition of the Homeless. *Directory of Local Homeless Service Organizations, a*vailable at http://www.nationalhomeless.org/directories/directory_local.pdf (accessed March 3, 2016).
[115] Feeding America. *Find York Local Food Bank: Pennsylvania*, available at http://www.feedingamerica.org/find-your-local-foodbank/?zip=&state=PA (accessed March 3, 2016).
[116] FoodPantries.org. *Pennsylvania Food Pantries*, available at http://www.foodpantries.org/st/pennsylvania (accessed March 3, 2016).

Some food pantries offer additional services important to people experiencing homelessness. A good example is the Downtown Daily Bread in Harrisburg. It states its mission as "Feed the hungry and provide services for the homeless." In addition to serving over 40,000 nutritious, hot meals a year, the Downtown Daily Bread offers such essential services as phone and mail service, showers, transportation, lockers, clothing for men and women, housing and employment references and even helps with resume preparation and job interview coaching.[117] These additional services are highly appreciated by the Downtown Daily Bread's customers and were mentioned in many of their reviews.

Many churches and communities also offer drug and alcohol programs designed to help homeless individuals achieve and maintain sobriety. Similarly, local branches of Alcoholics Anonymous and its sister organization Narcotics Anonymous act as support network for homeless individuals with substance use disorders.

Many faith-based organizations have mission statements dedicated to aiding the homelessness through the provision of necessary services such as temporary housing, food, and overnight lodging as well as counseling and educational opportunities for homeless individuals. Some of the organizations include the Association of Gospel Rescue Missions, which operates a large network of work-based rehabilitation programs in North America, and the Salvation Army, which is known for its street outreach and assistance.

In some cases federal and local efforts to reduce homelessness intersect. The Emergency Food and Shelter Program (EFSP) was created by Congress in 1983 to help meet the needs of homeless people throughout the United States.[118] This program allocates federal funds to supplement the work of non-profit and government-run local social service organizations that provide services to the hungry and homeless. Funds from EFSP can be used to provide food and shelter as well as homelessness prevention through rent, utilities, and mortgage assistance.[119] Providers can also use these funds to purchase necessary equipment to shelter and feed people. During its 28 years of operation, the program has disbursed over 3.7 billion dollars to over 13,000 local providers in more than 2,500 counties and cities.[120] In 2014, Pennsylvania was awarded 4.5 million dollars by the EFSP.[121]

The EFSP is governed by a National Board, chaired by the Federal Emergency Management Agency (FEMA), and comprised of representatives from the American Red Cross; Catholic Charities, USA; The Jewish Federations of North America; National Council of the

[117] Information provided to the Joint State Government Commission by Ms. Elaine Strokoff, Executive Director of the Downtown Daily Bread, on June 10, 2015.
[118] U.S. Department of Homeland Security. *Emergency Food and Shelter Program Fact Sheet*. March 2015, available at https://www.fema.gov/media-library-data/1434644639179-72fee075871519bcf84b530a5d1227fb/EFSP_FactSheet_final508.pdf (accessed February 7, 2016).
[119] Ibid.
[120] Ibid.
[121] Emergency Food and Shelter National Board Program. *State Award History,* available at https://www.efsp.unitedway.org/efsp/website/websiteContents/index.cfm?template=EFSPAwardByPhase.cfm (accessed February 7, 2016).

Churches of Christ in the USA; The Salvation Army; and United Way Worldwide.[122] The National Board dedicates EFSP funds to local cities and counties based on an allocation formula using national population, unemployment, and poverty statistics. There are also local EFSP boards that decide which local social service organizations in a jurisdiction are to receive program funds through an application process reviewed by the national board.

In many Pennsylvania counties, community foundations provide support to local shelters and other housing programs. For example, Community Foundation of Western Pennsylvania and Eastern Ohio maintains the Joshua's Haven Endowment Fund, which supports an eight-bed men's homeless shelter in Sharon.[123] The Erie Community Foundation donates funds to Mercy Center for Women, which serves homeless women in the community, and St. Patrick's Haven, which provides emergency shelter to homeless men.[124] In 2014, the First Community Foundation Partnership of Pennsylvania donated to By Grace Women's Transitional Home, located in Middleburg, PA, and housing young homeless women and their children; to Susquehanna Valley Women in Transition, offering emergency shelter for families who have been displaced as a result of domestic violence or sexual assault; and to the Good Samaritan Mission, which is a men's homeless shelter in Danville, PA.[125] The Foundation for Enhancing Communities in Harrisburg, PA, through its Women's Fund and its Whitaker Fund, granted money to Lebanon Rescue Mission, Inc. Project Agape Family Shelter Security System and to the Shalom House Empowerment by Design Program, which offers emergency sheltering for homeless women and children, transitional housing for homeless women veterans and their children, and permanent housing for disabled, chronically homeless low-income women.[126] The Lehigh Valley Community Foundation donated to the PROGRAM for Women and Families for the Transitional Residence Continuum of Care, serving women who are transitioning out of the criminal justice system or who are at risk of criminal behavior, and have children; to Safe Harbor Easton for the emergency shelter; and to several other similar projects.[127] In 2014, the Pittsburgh Foundation facilitated a program campaign to aid individuals and families experiencing homelessness or housing insecurity in the area. In one day, the campaign raised $450,000 in local donations, which the foundation then matched, totaling $900,000.[128]

[122] U.S. Department of Homeland Security. *Emergency Food and Shelter Program Fact Sheet*. March 2015, available at https://www.fema.gov/media-library-data/1434644639179-72fee075871519bcf84b530a5d1227fb/EFSP_FactSheet_final508.pdf (accessed February 7, 2016)
[123] Community Foundation of Western Pennsylvania and Eastern Ohio. *2014 Endowment Funds Listing*, available at http://www.comm-foundation.org/affiliates-2/shenango-valley-j-l/ (accessed March 25, 2015).
[124] Erie Community Foundation. *2013 Annual Report*, available at http://www.eriecommunityfoundation.org/files/publications-videos/2013-annual.pdf (accessed March 25, 2015).
[125] First Community Foundation Partnership of Pennsylvania. *2014 Raise the Region Grantees*, available at http://www.wlfoundation.org/file/grant-results/2014-Raise-the Region.pdf (accessed March 25, 2015).
[126] Foundation for Enhancing Communities. *2014 Women's Fund Grantees,* available at http://www.tfec,org/index.cfm?act=womens_fund (accessed March 3, 2015).
[127] Lehigh Valley Community Foundation. *2014-2015 Community Partnership Grants*, available at http://www.lehighvalleyfoundation.org/news/press-releases/lehigh-valley-community-foundation-awards-almost-300000-2014-2015-community (accessed March 3, 2015).
[128] Pittsburgh Foundation. *December 2014: Critical Needs Alert Program*, available at http://www.pittsburghfoundation.org/sites/default/files/2014%20Winter%20Forum.pdf (accessed March 25, 2015).

Some of private faith-based organizations are very small and rely entirely on local resources and volunteers. Bridge of Hope is a good example of a faith-based program for single mothers and children who are homeless or facing homelessness. It has a very specific target population: mostly young women, with one or two children, who clearly demonstrate the potential to become gainfully employed and attain self-sufficiency.[129] The program focuses on single women with children for whom homelessness comes as a result of acute crisis. It purports to help families who face eviction due to low-wage jobs or sudden loss of income or who are forced out of their former residence by domestic violence. Some of the program clients may have income that is slightly too high to make them eligible for state programs. Others feel they would rather find a quick solution to their problems than enter the state system. Some of them feel the state rules and regulations may force them to choose between employment and affordable childcare. Bridge of Hope selects its clients among women who want to be proactive in changing their lives, who are able and willing to find employment that would make them independent in a comparatively short period of time.

The program mission statement describes its goals in the following way:

> Bridge of Hope brings together professional staff and trained church-based mentoring groups to empower homeless and at-risk single mothers to attain
>
> - permanent housing
> - financial stability through employment
> - life-changing friendships
> - increased self-esteem and growth in areas of holistic living[130]

As a church-based approach to ending and preventing family homelessness, the Bridge of Hope program relies on a three-way partnership: single mothers, case managers, and church-based mentoring groups. Single mothers are expected to attain financial stability through employment and budgeting, to work toward personal goals, and to build friendship with mentors. Social workers who provide case management enhance strengths of the family to build a positive future; they teach budgeting and life skills, assist the mother with finding possibilities for training and employment, and allocate rental assistance for Rapid Rehousing. Bridge of Hope identifies local landlords who are willing to work with the program and provides rental assistance on a descending scale: more in the first six months, less in the following three, et cetera. There are no strict time limits that a family can remain with the program; it depends on a particular family's needs and abilities and varies from several months to two years. Another responsibility of the social worker is to train and support mentors. Would-be mentors receive four and one-half hours of training prior to meeting the family they will mentor and constant support while they are working with the mentee. Trained mentoring groups within congregations are a key component of Bridge of Hope. Mentoring groups consist of eight to twelve church members who volunteer to provide practical assistance and emotional support to the mother and child. They invite the formerly homeless family to social gatherings and visit on a regular basis. They model positive parenting and nurture spiritual

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[129] Information provided to the Joint State Government Commission by Johanna Fessenden, Executive Director of the Bridge of Hope Harrisburg Area, on May 19, 2015.

[130] *Bridge of Hope: Our Mission and Values,* available at http://bridgeofhopeinc.org/our-model/our-mission-and-values/ (accessed May 21, 2015).

growth. In essence, they try to become friends. Volunteer mentors must commit to the task for the period of 12 to 24 months, for the entire length of the family participation in the program, but often the relationship lasts much longer. Mentoring groups are critically important because they provide the support network; people experiencing homelessness often indicate the lack of such a network as a cause of their homelessness. Establishing such a support network not only helps women who found themselves without a home to overcome their current difficulties and the sense of loneliness and abandonment that homelessness often brings, but also reduces their risks of becoming homeless again.

Bridge of Hope, thus, seeks a holistic, long-term solution to family homelessness. Bridge of Hope claims an 80-percent success rate: the program site and brochures state that 80 percent of the women they serve successfully graduate their program with permanent housing, a circle of friends, and a plan for financial stability.[131]

An additional benefit of a program like Bridge to Hope is educational: because it involves so many volunteers, it changes the public perception of homelessness, enhances the awareness of multiple faces of homelessness, and increases empathy to those going through this difficult experience.

Bridge of Hope is a truly grass-roots organization. It is worth noting that it was born in Pennsylvania. It originated in March 1987, when 37 people gathered in a church basement in Lancaster to hear three homeless women share their stories. The first homeless single mother and her child were matched with a mentoring group in December 1989. The program spread from Lancaster and Chester Counties to Bucks and Montgomery Counties in Pennsylvania, and later to thirteen other states and one Canadian province.[132] Currently, there is a national board that coordinates the effort and convenes annual conferences.

It should be noted that the program outcomes require further independent verification and analysis and that it currently operates on a very small scale, is tailored for a very specific subset of the homeless population, and, thus, can help only a very limited number of people. Nonetheless, the history and practice of an organization like Bridge of Hope contain useful lessons in understanding how small-scale local efforts can contribute to the fight against homelessness and what specific approaches may work when carefully targeted to specific population groups.

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[131] *The Bridge of Hope Model*, available at http://bridgeofhopeinc.org/our-model/the-brdige-of-hope-model/ (accessed May 21, 2015).

[132] *Bridge of Hope: Our History*, available at http://bridgeofhopeinc.org/about-us/-our-history/ (accessed May 21, 2015).

CAUSES AND EFFECTS OF HOMELESSNESS AND PROMISING STRATEGIES TO ADDRESS THEM

HOUSING AFFORDABILITY

Homelessness is a complex and multi-faceted phenomenon with many causes. It was first recognized as a major social problem in the 1980s, in part due to increasing discrepancies in income between classes. Since the income gap has continued to increase in the past thirty years, effectively addressing homelessness has remained difficult. It is also worth noting that this issue affects many populations as homelessness has various complex pathways. Homelessness requires a holistic approach. Solutions to the problem will be as varied and comprehensive as the problem itself.

As a homeless service provider insisted in her opinion piece published in "The New York Times" at the beginning of this year, an important initial step is "a recognition that homelessness is not an isolated problem; it interacts with, and is a consequence of, a maelstrom of factors – inaffordable rents, insufficient job training, lack of accessible child care, untreated mental illness and substance abuse, and too few stable work opportunities."[133] It is not by accident that inaffordable rents took the first place on the provider's list.

The latest "Status Report on Hunger and Homelessness in America's Cities," a 25-city survey produced by the Unites States Conference of Mayors, established that the leading cause of homelessness among families with children is lack of affordable housing, followed by unemployment, poverty, and low-paying jobs.[134] Lack of affordable housing "also topped the list of causes of homelessness among unaccompanied individuals. This was followed by unemployment, poverty, mental illness and the lack of needed services, and substance abuse and the lack of needed services."[135] It is worth noting that Philadelphia was one of the cities responding to the survey in 2014.

One of the major causes of homelessness, affecting all categories of people who are at risk for homelessness or finally slip into homelessness, is the lack of affordable housing. For a particular individual or family, homelessness typically comes as a result of a combination of macro- and micro-level circumstances. Housing affordability is, however, one underlying economic factor that is common for most cases of homelessness. A recent review of homelessness literature reveals "an emerging consensus in the sociological research community that

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[133] Quinn, Christine C. "Let's Rethink Our Homeless Shelters." *The New York Times.* January 02, 2016, available at http://www.newyorktimes.com/2016/01/02/opinion/lets-rethink-our-homeless-shelters.html?_r=0 (Accessed January 5, 2016).

[134] U.S. Conference of Mayors. *2014 Status Report on Hunger and Homelessness*. Washington, D.C. December 2014, available at http://www.usmayors.org/pressreleases/uploads/2014/1211-report-hh.pdf (accessed May 14, 2015.

[135] Ibid.

homelessness is, fundamentally, a structural problem rooted in the larger political economy: too many poor people competing for too few low-income housing units."[136]

Analysts concur that "rental affordability has grown as a challenge in recent years due to a number of factors, including increasing demand as more people choose to rent or are forced to because they can't get mortgages, a relative lack of rental construction in recent years in comparison to past cycles, and stagnant wage growth."[137]

Housing Cost Burden

Affordability has replaced physical deficiency and substandard quality of the housing stock as the main housing problem. According to Alex F. Schwartz, the author of the definitive guide to American housing policy, "the affordability of housing is today of far greater concern than physical condition or crowding."[138] Schwartz cites illuminating numbers to corroborate his statement: "Whereas less than 2% of all households reside in severely deficient housing and less than 4% confront overcrowded conditions, more than 18% spend half or more of their income on housing expenses, including nearly 27% of all renters."[139]

Spending more than 50 percent of their income on housing expenses puts these families and individuals in the category of those with severe housing cost burdens. When housing costs amount to 30 percent or more of households' pre-tax income, they are defined as excessive housing cost burden. Though these thresholds have changed historically, today 30 percent of income is the most common standard of housing affordability in the United States.[140]

The U.S. Department of Housing and Economic Development (HUD) offers the following description of housing affordability: "Families who pay more than 30 percent of their income for housing are considered cost burdened and may have difficulty affording necessities such as food, clothing, transportation and medical care. An estimated 12 million renter and homeowner households now pay more than 50 percent of their annual incomes for housing."[141]

According to Schwartz, "nearly one-third of all homeowners (31%) and half of all renters (50%) spent 30% or more of their income on housing in 2011."[142] Though the share of cost-burdened households decreased slightly from a record-high 37.2 percent in 2010 to 35.3 percent in 2012, the number, however, is still high: "based on the traditional affordability standard

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[136] Lee, Barrett A.; Tyler, Kimberly A.; and James D. Wright. "The New Homelessness Revisited." *Annual Review of Sociology.* Book 36. 2010, available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4045444/ (accessed April 14, 2015).
[137] Kusisto, Laura. "Minimum Wage in U.S. Cities Not Enough to Afford Rent, Report Says." *The Wall Street Journal.* June 1, 2015, available at http://blogs.wsj.com/economics/2015/05/19/report-minimum-wage-in-u-s-cities-not-enough-to-afford-rent/ (accessed June 1, 2015).
[138] Schwartz, Alex F. *Housing Policy in the United States*. Third Edition. New York; London: Routledge, 2015. P. 32.
[139] Ibid.
[140] Ibid.
[141] U.S. Department of Housing and Economic Development. *Affordable Housing*, available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing (accessed April 14, 2015).
[142] Schwartz, Alex F. Op. cit. P. 34.

(housing costs of no more than 30 percent of income), more than a third of US households live in housing that exceeds their means."[143]

Not surprisingly, these burdens are highly more prevalent among low-income households. The numbers present a dramatic picture: "nearly two-thirds of all renters (64%) and homeowners (63%) earning less than 30% of their area median family income (AMI) spent more than half their income on housing, as did about one-third of all homeowners (31%) and renters (29%) earning 30% to 50% of AMI."[144] Analyzing the existing crisis of affordability for renters, the authors of the 2014 report "The State of the Nation's Housing" by the Joint Center for Housing Studies of Howard University also established that "lower-income households are especially likely to be cost-burdened."[145] In 2012, 82 percent of those earning less than $15,000 a year paid more than 30 percent of income for housing and 69 percent paid more than half.[146]

Schwartz's thorough analysis of the recent trends leads him to an alarming conclusion: "Housing affordability problems have worsened almost continuously over the past three decades. From 1999 to 2011 alone, the number of households with severe housing costs burdens increased by 71% to nearly 21 million."[147] The housing bubble collapse in 2007 and the Great Recession were the leading economic cause of a vast increase in the number of households, both renters and homeowners, confronting severe housing costs burdens: "In total, households with severe housing cost burdens increased by more than 5 million, or 31%, from 2007 to 2011."[148]

Traditionally, the discussion of housing cost burdens focused on renters as they are more likely than homeowners to face those. However, in the past few years, the number of homeowners with severe cost burdens increased significantly, even in a moderate-income category. Today, as Schwartz points out, "homeowners account for a large share of households with cost burdens. In 2011, more than 10.3 million homeowners spent more than half of their income on housing – 49 % of all households with severe cost burdens."[149] The Joint Center states in its report that the share of homeowners with cost burdens crested in 2008 at 30.4 percent; then it declined slightly, partly due to the number of homeowners dropping as a result of the foreclosure crisis, but "even after two years of declines, the share of cost-burdened homeowners stands well above levels at the start of the last decade."[150] In 2012, "more than a quarter of homeowners (27 percent) still had cost burdens, including more than one in ten with severe burdens."[151] Excessive cost burdens, understandably, increase the risk of mortgage default and foreclosure, which, in extreme cases, may lead to homelessness.

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[143] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2014*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/sonhr14-color-full.pdf (accessed April 15, 2015).
[144] Schwartz, Alex F. Op. cit. P. 34.
[145] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2014*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/sonhr14-color-full.pdf (accessed April 15, 2015).
[146] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2014*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/sonhr14-color-full.pdf (accessed April 15, 2015).
[147] Schwartz, Alex F. Op. cit. P. 36.
[148] Ibid. P. 38.
[149] Schwartz, Alex F. Op. cit. P. 36.
[150] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2014*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/sonhr14-color-full.pdf (accessed April 15, 2015).
[151] Ibid.

According to the Center's 2014 report, the share of cost-burdened renters increased in all but one year from 2001 to 2011, to just above 50 percent. More than a quarter of renter households (28 percent) had severe burdens (paid more than half their incomes for housing). In 2012, the share of cost-burdened renters improved slightly but their numbers held steady as more households entered the rental market."[152] Despite the slight decline, the share of renters with cost burdens "still remained close to 50 percent. Moreover, more than one in four renters (27 percent) were severely housing cost burdened."[153]

The Joint Center's 2012 report "The State of the Nation's Housing" asserts that "the housing bust and Great Recession helped to swell the ranks of low-income renters in the 2000s, increasing the already intense competition for a diminishing supply of low-cost units."[154] The gap between the number of low-income renters and the supply of affordable, available and adequate units widened: "In 2001, 8.1 million low-income renters competed for 5.7 million affordable units, leaving a gap of 2.4 million units. By 2010, the shortfall had more than doubled to 5.1 million units. Moreover, of these affordable units more than 40 percent were occupied by higher-income renters."[155] Various statistical approaches demonstrate that "the lowest income renters confront the most severe shortages of affordable housing."[156] With affordable housing in short supply, low-income renters have to occupy housing that costs more than they can afford and accept perilous housing cost burdens.

Though the number of households with housing cost burdens appears to have moderated over the past two years, it remains high. The consequence is an obvious negative impact on the way of living. When such a significant portion of the household income as almost one-third or even one half is consumed by housing costs, it dramatically constricts the household's ability to spend adequate amount of money on health care, education, and sometimes even food. Moreover, it also puts the household at risk of losing the residence in case of any unexpected additional expenses or loss of income such as severe illness or temporary unemployment as these overwhelming housing costs become unsustainable. The family or the individual may become homeless.

Housing Affordability and Employment

It comes as no surprise that "trends in housing cost burdens coincide with joblessness patterns."[157] The Joint Center for Housing Studies of Harvard University has established that "in 2010, 22 percent of those reporting short-term unemployment and 36 percent of those facing long-term unemployment were severely housing-cost burdened, compared with just 10 percent of fully

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[152] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2014*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/sonhr14-color-full.pdf (accessed April 15, 2015).
[153] Ibid.
[154] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2012*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/son2012.pdf (accessed April 15, 2015).
[155] Ibid.
[156] Schwartz, Alex F. Op. cit. P. 47.
[157] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2012*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/son2012.pdf (accessed April 15, 2015).

employed householders," with the amount of unemployed, severely burdened householders reaching 5.8 million in 2010.[158]

However, in the consideration of housing affordability, it is important to recognize that employment does not guarantee freedom from housing cost burdens. Economists point to a notable mismatch between housing costs and wages and salaries. According to the Joint Center for Housing Studies, in 2010, fully employed heads of households constituted over 20 percent of all households with severe housing burdens, with their number increasing by 63 percent from 3.9 million in 2001 to 6.2 million in 2010.[159] Obviously, households with one employed worker are more likely to face severe housing cost burdens than those with two or more workers. In 2013, the National Low Income Housing Coalition (NLIHC) reported that "in no state can a minimum wage worker afford a two-bedroom unit at Fair Market Rent, working a standard 40-hour work week."[160] Similarly, "among those reliant on SSI, there is not a single county in the U.S. where even a modest efficiency apartment, priced according to the FMR, is affordable."[161] The NLIHC's 2015 report confirms the situation has remained essentially the same: "In no state can a person working full-time at minimum wage afford a one-bedroom apartment at the Fair Market Rent."[162]

The NLICH calculated the annual income that is necessary to earn in order to afford the national average two-bedroom apartment at Fair Market Rent (FMR) and compared it to the average renter wage. The results were discouraging: in 2012, the housing wage[163] in the United States exceeded the average renter wage by over four dollars and was nearly three times the minimum wage.[164] According to the "Out of Reach 2015" data, a renter earning the federal minimum wage of $7.25 per hour would need to work 85 hours per week to afford a one-bedroom rent at the Fair Market Rent and 102 hours per week to afford a two-bedroom Fair Market Rent.[165]

In Pennsylvania, by the NLIHC's estimates for 2012 and 2014, the discrepancy between the housing wage (at $16.06 and $17.57 respectively) and the average renter wage (at $12.86 and $13.66 respectively) is close to the national level.[166] As for the number of hours at minimum wage a person needs to work per week in order to afford a two-bedroom FMR apartment, in Pennsylvania, it was 89 hours in 2012 and 97 hours in 2014.[167]

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[158] Ibid.
[159] The Joint Center for Housing Studies of Harvard University. *State of the Nation's Housing 2012*. Cambridge, MA, available at www.jchs.harvard.edu/sites/jchs.harvard.edu/files/son2012.pdf (accessed April 15, 2015).
[160] National Low Income Housing Coalition. *Out of Reach 2013: America's Forgotten Housing Crisis*. Washington, D.C. March 2013, available at http://nlihc.org/sites/default/files/oor/2012-OOR.pdf (accessed April 15, 2015).
[161] Ibid.
[162] National Low Income Housing Coalition. *Out of Reach 2015.* Washington, D.C., available at http://nlihc.org/oor (accessed June 1, 2015).
[163] The housing wage is the estimated full-time hourly wage a household must earn to afford a rental unit at Fair Market Rate while spending no more than 30 percent of the monthly income on housing costs.
[164] National Low Income Housing Coalition. *Out of Reach 2013: America's Forgotten Housing Crisis*. Washington, D.C. March 2013, available at http://nlihc.org/sites/default/files/oor/2012-OOR.pdf (accessed April 15, 2015).
[165] National Low Income Housing Coalition. *Out of Reach 2015.* Washington, D.C., available at http://nlihc.org/oor (accessed June 1, 2015).
[166] National Low Income Housing Coalition. *Out of Reach 2013: America's Forgotten Housing Crisis*. Washington, D.C. March 2013, available at http://nlihc.org/sites/default/files/oor/2012-OOR.pdf (accessed April 15, 2015).
National Low Income Housing Coalition. *Out of Reach 2015.* Washington, D.C., available at http://nlihc.org/oor (accessed June 1, 2015).
[167] Ibid.

Worst-Case Housing Needs

A useful category to gauge housing problems of low-income renters is the worst-case housing needs, defined as "renters with very low incomes – below 50 percent of the Area Median Income (AMI) – who do not receive government housing assistance and who pay more than one-half of their income for rent, live in severely inadequate conditions, or both."[168] HUD's estimates of worst-case needs are based on the biennial American Housing Survey. Though "homeless individuals and families clearly have worst case needs for affordable or assisted housing," they are not included in official estimates of worst-case needs because the American Housing Survey covers only housing units and the households that live in them.[169] For over thirty years, HUD has submitted periodic reports on worst-case housing needs to Congress tracing their causes and trends.

After dramatic increases during the 2007-2011 period, the extent of worst-case needs in 2011 was very high: "regardless of household type, one-third to one-half of very low-income renters of each type experienced worst case needs in 2011."[170] In 2015, HUD found that "the number of renter households with worst case needs decreased to 7.7 million in 2013 from the record high of 8.5 million in 2011, ending a sustained period of large increases."[171] While this is certainly a positive development, the number still remains high, and it is also important to keep it in perspective: "The number of worst case needs in 2013 is 9 percent lower than in 2011, yet it remains 9 percent greater than in 2009 and 49 percent greater than in 2003."[172] Worst-case housing needs affect very low-income renters across racial and ethnic groups, age groups, and types of households, including, in 2013, 2.8 million families with children and 1.5 elderly households without children.[173] A subgroup that clearly requires a special attention and help is people with disabilities. It is disconcerting that "about one in seven renters with worst case needs – 14 percent – included a nonelderly person with disabilities. The 1.1 million of such households are 17 percent fewer than in 2011 but remain 10 percent above the 2009 estimate."[174] The vast majority (97 percent) of worst-case needs are caused by severe housing burdens (paying more than one-half of income for rent); only 3 percent are caused by inadequate housing.[175]

The "Worst Case Housing Needs: 2015 Report to Congress" attests to positive changes, noting that from 2011 to 2013 worst-case needs "decreased modestly but significantly"; the report, however, concludes that "substantial unmet needs for affordable rental housing remain even as economic conditions are improving" and that "even with rental assistance, 6 of 10 extremely low

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[168] U.S. Department of Housing and Urban Development. *Worst Case Housing Needs 2015 Report to Congress: Executive Summary.* Washington, D.C., February 2015, available at http://www.huduser.org/portal/Publications/pdf/WorstCase2015_summary.pdf (accessed April 17, 2015).
[169] Steffen, Barry L. et al. *Worst Case Housing Needs 2011: Report to Congress.* Washington, D.C.: U.S. Department of Housing and Urban Development, August 2013, available at http://www.huduser.org/portal/publications/affhsg/wc_HsgNeeds11_report.html (accessed April 22, 2015).
[170] Ibid.
[171] U.S. Department of Housing and Urban Development. *Worst Case Housing Needs: 2015 Report to Congress: Executive Summary.* Washington, D.C., February 2015, available at http://www.huduser.org/portal/Publications/pdf/WorstCase2015_summary.pdf (accessed April 17, 2015).
[172] Ibid.
[173] Ibid.
[174] Ibid.
[175] Ibid.

income renters and 3 of 10 very low income renters do not have access to affordable and available housing units."[176] Consequently, "a broad strategy at the federal, state, and local levels is needed to continue to rebuild the economy, strengthen the market, and provide assistance to those families most in need."[177] Expanding the supply of appropriately priced housing, increasing renters' income, and rental assistance are all required to resolve the affordability problem.

Housing Resources in Pennsylvania

The status of housing resources in Pennsylvania is similar to that on the national level though slightly more moderate. The Pennsylvania Housing Finance Agency (PHFA), which plays an important role in the Commonwealth by facilitating the development of affordable rental housing and by providing mortgage products for low- and moderate-income households, prepared a report on housing availability and affordability. The evaluation of homeownership and rental trends at the county and state levels led the authors to the conclusion that "what we see in Pennsylvania are shifts mirroring what has been reported about housing on the national level, but shifts that generally are less extreme than seen in some other states."[178] The PHFA report identified the following changes in the marketplace:

- A trend toward lower homeownership rates
- Data showing that more people are renting
- Indicators that rents are increasing due to greater market demand, and
- Evidence of an increasing need to provide affordable housing options for the state's residents – of particular importance for an aging population and for households in the Marcellus Shale region (running along the northern tier and western half of the state).[179]

According to the PHFA data, from 2000 to 2010 the number of renter-occupied households in Pennsylvania increased from 1,370,666 to 1,527,182 – an increase of 156,516 renter households.[180] With more families moving into rental housing, "the estimated gross rent for a two-bedroom apartment ("fair market rent") in Pennsylvania rose from $507 to $650 – a 28 percent jump."[181]

The PHFA's examination of the data for Pennsylvania indicated that "rental costs in an increasing number of counties have risen to the point that they now exceed 30 percent of a household's income, which is generally accepted as the maximum level for maintaining affordability."[182] In 2000, there were only twelve counties with fair market rents exceeding 30 percent of the median renter income. The data collected from 2006 to 2010 showed that the number of such counties more than doubled, reaching thirty-two.[183] The authors of the report characterized

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[176] Ibid.
[177] Ibid.
[178] Pennsylvania Housing Finance Agency. *Pennsylvania Housing Availability and Affordability Report.* Harrisburg, PA. September 2012, available at http://www.phfa.org/forms/housing_study/reports/aar2012.pdf (accessed April 22, 2015).
[179] Ibid.
[180] Ibid.
[181] Ibid.
[182] Ibid.
[183] Ibid.

this as “a disturbing trend being fueled by a combination of the housing and economic downturn occurring simultaneously, with market demand driving up rents at a time when some family incomes have leveled off or are declining.”[184] The PHFA experts believe that “this dramatic decrease in affordable rental housing in 32 Pennsylvania counties should be of concern” until a strengthening economy and, possibly, increasing rate of homeownership, which would relieve pressure on the rental housing market, improve the situation.[185]

The PHFA findings on the homeownership front were more positive, with the median home value within the affordable cost of a home. Homeownership, however, still remains unaffordable for some occupations, and the homeownership maps reveal that in some areas, specifically in the eastern line of counties that run along New York-New Jersey border, homeownership has become no longer affordable at the median household income.[186]

In view of the PHFA experts, counties of particular concern are those where both housing options (renting or owning) are becoming unaffordable. In 2000, there was only one such county – Centre County. In 2006-2010, there were seven, mostly in the eastern part of the state. As the natural gas industry places growing demand on available housing stock in the Marcellus Shale region, more counties in the northern and western parts of the state may be expected to follow the trend.[187] Proactive measures by the General Assembly and PHFA endeavor to prevent this from happening.

The PHFA report highlights two trends that deserve attention in regards to affordable housing. One is the aging of the state’s population, and the other is the impact of the natural gas industry on housing in Pennsylvania. We can expect a dramatic shift in the percent of the population over the age of 65: from 15.5 percent in 2010 to an estimated 22.5 percent in 2030.[188] PHFA believes that “state programs, such as those that help people adapt their homes so they can live independently longer into their senior years, will be critical for keeping housing affordable for this segment of the population.”[189] Notably, the shift to an older population will be more pronounced in the Marcellus Shale region – “precisely where changes to the economy already are putting pressure on housing affordability.”[190] As the size of the natural gas industry in the Commonwealth is expected to increase in the next few decades, so will its impact on housing affordability and availability. Both trends require serious attention.

An elucidative report on affordability and availability of rental housing in Pennsylvania was recently completed by the Federal Reserve Bank of Philadelphia. The report, covering the entire Third Federal Reserve District, affirms that “the demand for rental housing has increased substantially in recent years,” mostly as a result of declining homeownership rates in the aftermath of the Great Recession.[191] The recession “expanded the pool of lower-income households for

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[184] Ibid.
[185] Ibid.
[186] Ibid.
[187] Ibid.
[188] Ibid.
[189] Ibid.
[190] Ibid.
[191] Divringi, Eileen. *Affordability and Availability of Rental Housing in the Third Federal Reserve District: 2015.* Federal Reserve Bank of Philadelphia. *Cascade Focus.* February 2015, available at

which renting may be the only feasible option, with a predictable effect on the already low vacancy rates for low-cost units."[192] According to the Federal Reserve Bank's analysts, the shortage of the affordable units in the Third District became "increasingly acute for renter households making 50 percent or less of the median family income (MFI) in their area."[193]

For its assessment of rental affordability by income level, the Federal Reserve Bank of Philadelphia subdivided households into four categories. It defined a household low-income (LI) if its income is 51-80 percent of the median family income (MFI) in its region, very low income (VLI) if its income constitutes 31-50 percent of the MFI, or extremely low income (ELI) if its income is equal or less than 30 percent of the median family income in its area.[194] Additional adjustments were made to reflect the number of people in each household.

To determine how challenging it is to find suitable, affordable rental housing in a given area, the Federal Reserve Bank analysts calculated the rate of housing cost burden for renter households at different income levels. As they expected, "ELI households had the greatest difficulty finding rental housing within their means."[195] The Federal Reserve Bank's findings indicate that in each metropolitan statistical area (MSA) in the Commonwealth, the vast majority of households at the extremely low income level was "severely housing-cost burdened in all of the time periods examined."[196] The level of cost burden can be exceptionally high – up to 95 percent - in State College and East Stroudsburg or close to 90 percent in Lancaster, but even in metropolitan areas with comparatively low cost burdens such as Pittsburgh and the Allentown-Bethlehem-Easton area, rates of ELI housing cost burden exceeded 80 percent.[197] This means that the housing costs paid by many ELI households "substantially exceeded the maximum that would be considered affordable."[198] In 2008-2012, many families and individuals at the lowest end of the income scale paid several hundred dollars more in gross rent than they could afford.

According to the Bank's estimates, roughly two-thirds of renters in the very-low income category also experienced some level of housing costs burden though the gaps between affordable and actual gross rents were typically smaller than those of ELI households. In 2012, the median gap between affordable and actual gross rent for cost-burdened households was estimated at $475 for extremely low-income renters, $277 for very low-income renters, and $192 for low-income renters.[199] The analysis performed by the Federal Reserve Bank of Philadelphia indicates unequivocally that "burdensome housing costs disproportionately affected renters in these bottom two income categories. Though ELI and VLI households constituted 47 percent of all renter

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https://www.philadelphiafed.org/community-development/publications/cascade-focus/cascade-focus_4.pdf (accessed April 24, 2015).

[192] Ibid.

[193] Ibid.

[194] Ibid.

[195] Divringi, Eileen. *Affordability and Availability of Rental Housing in the Third Federal Reserve District: 2015.* Federal Reserve Bank of Philadelphia. *Cascade Focus.* February 2015, available at https://www.philadelphiafed.org/community-development/publications/cascade-focus/cascade-focus_4.pdf (accessed April 24, 2015).

[196] Ibid.

[197] Ibid.

[198] Ibid.

[199] Ibid.

households in the Third District in 2012, they accounted for 77 percent of those that were cost burdened."[200]

The report also notes growth in the proportion of cost-burdened renters in the low-income category. In Pennsylvania in 2012, it was 37 percent, with considerable differences between geographical areas. From 2007 to 2012, significant increase was discovered in the city of Philadelphia and in the Allentown-Bethlehem-Easton area, with the final figures reaching 42 percent and nearly 50 percent respectively.[201]

Overall, the Federal Reserve Bank's analysis revealed that "a growing percentage of lower-income renters in the region are facing burdensome housing costs. For Third District renters at each income level specified in this report, both the overall percentage of cost-burdened renter households and the proportion for which these burdens were severe significantly increased between 2007 and 2012."[202]

Alongside the housing cost burden, the Federal Reserve Bank of Philadelphia assessed the supply of affordable rental housing. Its findings in this area confirmed that "affordability challenges are largely concentrated among the lower-income renters," and the situation is getting worse: "In both Pennsylvania and New Jersey, the number of affordable and available rental units per 100 renter households declined significantly for households at or below 50 percent of MFI from 2007 to 2012. Additionally, over this period, Pennsylvania saw a significant decrease in the ratio of units that were affordable and available to renter households making 30 percent or less of MFI."[203] In 2010-2012, the number of affordable and available units per 100 ELI renter households was sufficient to meet less than one-half of the demand in the Harrisburg-Carlisle area and in Pittsburgh and only one-quarter of demand in Lancaster.[204] In the City of Philadelphia, from 2007 to 2012, the proportion of vacant units affordable to ELI renters declined by almost half.[205] Vacancy and house quality issues were also prevalent among lower-income renters.

Most of the data included in the report have been calculated for metropolitan statistical areas. It is important to recognize that the distribution of lower-income renters varies across more localized housing markets and some of these markets require more close attention. For example, while the metropolitan statistical area that includes Philadelphia did not see a significant change in its rental vacancy rate between 2007 and 2012, "the city's rate declined from 12 percent to 9 percent. Since the city is home to a disproportionate share of lower-income renters, changes in its housing market affect affordability in ways that might not be immediately obvious at the MSA level."[206]

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[200] Divringi, Eileen. *Affordability and Availability of Rental Housing in the Third Federal Reserve District: 2015.* Federal Reserve Bank of Philadelphia. *Cascade Focus.* February 2015, available at https://www.philadelphiafed.org/community-development/publications/cascade-focus/cascade-focus_4.pdf (accessed April 24, 2015).
[201] Ibid.
[202] Ibid.
[203] Ibid.
[204] Ibid.
[205] Ibid.
[206] Ibid.

In the view of the Federal Reserve Bank experts, the most prominent finding of their report is that "unmet affordable housing needs are overwhelmingly concentrated among VLI and ELI renters and appear to have worsened over the study period."[207] Eileen Divringi, a community development research analyst who wrote the report, points out that "even in relatively affordable MSAs such as Pittsburgh, Harrisburg-Carlisle, and Dover, the vast majority of renters making 50 percent or less of MFI experienced some level of cost burden. For many of these households, the burdens were severe."[208] Considering policy-making implications of its assessment, the Federal Reserve Bank of Philadelphia came to the following conclusion: "Ultimately, the findings of this report speak to persistent and growing deficits of rental housing affordable and available to the most economically vulnerable households in the Third District. It suggests that affordable housing resources would be most effectively targeted toward ELI and VLI households in many of the region's metropolitan areas."[209] To successfully address the affordable housing shortages identified in the report, its authors recommend collaboration on the regional, state and federal levels.

An informative set of data on Pennsylvania's affordable housing problems was aggregated in the report prepared by a local consulting firm for the Pennsylvania Association of Area Agencies on Aging. Confirming that low- and moderate-income families and individuals in the Commonwealth "are paying far in excess of the HUD and industry standard of 30% of their income for housing," and noting a worrisome share of households with severe cost burdens, the report focused on two especially vulnerable population subgroups: the elderly and the disabled:

- The percentage of persons experiencing severe housing cost burden is higher for persons with disabilities and the elderly: 37% of renters with disabilities, 28.4% of renters aged 75 to 84 and 39% of renter-occupied households headed by persons 85 years old or older are severely cost burdened.
- The discrepancy between the cost of housing and a person's income is especially problematic for an individual with a disability in Pennsylvania living on Supplemental Security Income (SSI), who on average has to pay 87.9% of his/her income for an efficiency apartment and 100% of his/her income for a one-bedroom apartment. Even in Johnstown, the state's most affordable housing market, an individual on SSI is severely cost burdened, needing to pay 66% of his/her income for an efficiency apartment.[210]

The authors of this report also point to an additional important factor: affordability is not the only problem this group of people may face when looking for housing. Renters who are elderly or have disabilities may need wheelchair-accessible housing; or housing with features to address other impairments, for example, visual; or they may require access to specific supports and

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[207] Ibid.
[208] Divringi, Eileen. *Affordability and Availability of Rental Housing in the Third Federal Reserve District: 2015.* Federal Reserve Bank of Philadelphia. *Cascade Focus.* February 2015, available at https://www.philadelphiafed.org/community-development/publications/cascade-focus/cascade-focus_4.pdf (accessed April 24, 2015).
[209] Ibid.
[210] Diana T. Myers and Associates, Inc. *Ten Ways to Boost Housing Opportunities: Working with Private Housing Providers*, available at http://www.pahousingchoices.org/documents/10_ways_private_housing.pdf (accessed April 27, 2015).

services. The report postulates that "despite requirements for a percentage of new publicly funded housing units to meet federal and state accessibility standards (5% and 10% respectively), obtaining affordable accessible housing in most communities is a daunting challenge."[211]

Based on their research and on the input from focus groups from over twenty private housing providers in Cumberland and Bradford Counties, Diana T. Myers and Associates listed specific strategies that may enhance housing opportunities for the elderly and the disabled through partnerships between agencies and private housing providers.[212] Such strategies include creating a local inventory of resources, linking private housing providers to sources of tenant-based rental subsidies, promoting the use of other subsidies to enhance affordability, enhancing units with assistive technology and accessible features, developing protocols for interventions, and developing master lease programs for hard-to-serve populations.[213]

Other states initiated programs to prevent elderly homeowners from becoming homeless through state and local collaboration. For example, in Florida, the Elderly Mortgage Assistance Program (ELMORE) is a program to provide financial assistance to elderly homeowners, with reverse mortgage commitments, to keep them from losing their homes. It is targeted to elderly homeowners who are at extreme risk of foreclosure because they are in significant arrears in paying their homeowners' insurance, property taxes, or homeowners' association fees. The funding for the ELMORE program comes from a combination of federal, state, and local resources.[214]

Researchers identified two major pathways to homelessness for the elderly and recommended the basic strategies to address both.[215] With limited fixed incomes and increasing housing cost burdens, some elderly individuals can be pushed into first-time homelessness. To prevent this, a policy recommendation is "to increase the supply of subsidized affordable housing on which economically vulnerable elderly persons rely."[216] For the second pathway, those who are over the age of fifty and chronically homeless, researchers recommend permanent supportive housing to address housing and service needs to break the cycle of homelessness.

Recommendations

- Establish needs-based priorities and employ data-driven best practices and techniques such as set-asides for the use of state housing resources to benefit homeless families and individuals, especially those who are frequent users of public resources. This should include funds both for the production of affordable rental housing and for rental assistance. Policies should apply to at least the following resources:

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[211] Ibid.
[212] Ibid.
[213] Ibid.
[214] *Florida Elderly Mortgage Assistance (ELMORE) Program,* available at http://www.floridaelmore.org/ (accessed March 29, 2016).
[215] Sermons, M. William and Meghan Henry. *Demographics of Homelessness Series: The Rising Elderly Population*. Washington, D.C.: Homelessness Research Institute, 2010, available at http://www.endhomelessness.org/page/-/files/2698_file_Aging_Report.pdf (accessed March 23, 2016).
[216] Ibid.

    - State and federal housing trust funds;
    - Low Income Housing Tax Credits;
    - HOME funds; and
    - Section 811 vouchers through PHFA for non-elderly in non-LIHTC projects serving homeless individuals and families with disabilities.
- Develop and support a comprehensive range of both traditional and non-traditional affordable housing options for various subpopulation groups. This will require a review of current state and local policies and regulations in order to remove obstacles that might prevent viable implementation of these options.
- Ensure adequate resources for combatting homelessness.
- Increase and sustain funds for permanent and permanent supportive housing, including resources for services for people in permanent supportive housing.
- Designate pilot funding and operating subsidies for smaller projects for defined population groups.
- Provide administrative fees and other incentives to local public housing authorities that establish preferences in their public housing and housing choice voucher programs for homeless families and individuals. This should include both tenant-based vouchers and project-based vouchers dedicated to housing developed using LIHTC and other state- and federal-funded programs.
- Create incentives for state-funded homeless providers to coordinate formally on the local level with other homeless providers (i.e., integrate HAP, ESG, and other state-funded homeless programs with PATH and HUD CoC programs and resources).
- Establish a statewide cross-system initiative to develop policies, protocols, and programs to address the unique permanent supportive housing needs of the elderly who are homeless or at-risk of homelessness.
- Create a bridge program to provide for basic needs of those individuals that have applied for SSDI but are waiting for a decision.
- Develop public awareness campaigns at the state and local levels to facilitate better understanding of homelessness as a social and economic phenomenon in general and to address specific concerns local communities may have regarding special housing or local policies.
- Continuously review and measure outcomes of the programs used.

DOMESTIC VIOLENCE

Domestic violence is one of the leading causes of homelessness for women and children. It is also one that presents special difficulties to address. This is indicated by a number of counts and studies. Based upon its review of many of those, the National Law Center on Homelessness and Poverty (the Law Center) asserts that "for women in particular, domestic violence is a leading cause of homelessness."[217] In its recent report, the Law Center states that "in some areas of the country 1 in 4 adults reported that domestic violence was a cause of their homelessness, and between 50% and 100% of homeless women have experienced domestic or sexual violence at some point in their lives."[218] The National Center on Family Homelessness estimated the prevalence of domestic violence among homeless women at 60 percent – twice as high as among the general population; it also points out that "compared to the general population, violence among homeless women is usually more severe and often accompanied by economic domination and threats."[219] It is known that women are not the only victims of domestic abuse; men can also be victimized in their homes. Women, however, constitute a vast majority of victims of domestic violence. When they have young children and are forced to leave their homes, both women and their children often become homeless.

Domestic violence is linked to homelessness in multiple ways. Women are often pushed into homelessness when they finally decide to leave their abuser, sometimes in fear for their life. Others stay in the abusive environment because of the lack of alternative housing options. It is important to understand that "the relationship between experiencing abuse from partners and homelessness among women is not linear but rather complex and multifaceted."[220] It involves more than running away from home after a direct act of violence and finding refuge at the shelter. Illuminating recent studies have corroborated links between domestic violence and housing instability. For example, a large cross-sectional study of women in California (over 300 women) examined the relationship between recent intimate partner violence (IPV) and housing instability as evidenced by late rent or mortgage, frequent moves because of difficulty obtaining affordable housing, and/or being left without their own housing.[221] The researchers established that after adjusting for all covariates such as age, race/ethnicity, education, poverty status, marital status, and having children in the household, "women who experienced IPV in the last year had almost four times the odds of reporting housing instability than women who did not experience IPV."[222]

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[217] National Law Center on Homelessness & Poverty. *Homelessness in America: Overview of Data and Causes*, available at http://nlchp.org/documents/Homeless_Stats_Fact_Sheet (accessed August 5, 2015).
[218] National Law Center on Homelessness & Poverty. *There's No Place Like Home: State Laws that Protect Housing Rights for Survivors of Domestic and Sexual Violence.* Washington, D.C. October 2012, available at http://www.nlchp.org/documents/Theres_No_Place_Like_Home (accessed August 5, 2015).
[219] DeCandia, Carmela, Corey Anne Beach, and Rosenie Clervil. *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness*. Needham, MA: The National Center on Family Homelessness, 2013, available at http://www.familyhomelessness.org/media/371.pdf (accessed August 11. 2015).
[220] Tutty, Leslie M. et al. *"I Built My House of Hope:" Best Practices to Safely House Abused and Homeless Women*: Report Prepared for the Homelessness Knowledge Development Program, Homeless Partnering Secretariat, Human Resources and Social Development, Canada. September 2009, available at http://www.ucalgary.ca/resolve-static/reports/2009/2009-01.pdf (accessed July 23, 2015).
[221] Pavao J. et al. "Intimate Partner Violence and Housing Instability." *American Journal of Preventative Medicine.* 2007. Vol. 32. No. 2 (February). Pp.143-146.
[222] Ibid.

The findings confirmed that women who had experienced violence at the hands of their intimate partners were at increased risk for housing instability. The nature and direction of the relationship between intimate partner violence and housing instability require further research.

Prevalence

To assess the prevalence of domestic violence in the United States and the availability of services, the National Network to End Domestic Violence (NNEDV) conducts an annual National Census of Domestic Violence Services, which is a one-day, unduplicated snapshot of the number of people who accessed domestic violence services, the types of services they requested, and experiences of victims and advocates.

According to the NNEDV census, on September 17, 2013, local domestic programs in Pennsylvania served 2,424 victims of domestic violence; 1,168 of them (618 children and 550 adults) found refuge in emergency shelters or transitional housing provided by local domestic violence programs.[223] As these numbers testify, the programs helped significant numbers of people. However, a portion of requests remained unmet because the programs did not have the resources to provide requested services. On one day in Pennsylvania, 364 of those requests were unmet; 60 percent (218) of them were for housing,[224] which is comparable to the national level.[225] In 2014, out of 2,498 served on September 10, 1,373 received residential assistance at emergency shelters or transitional housing; 713 of them were children and 660 were adults.[226] 184 requests for housing remained unmet, due to lack of resources.[227] This constitutes 73 percent of the total number of unmet requests (252), which is higher than the national level, where this number is 56 percent.[228]

According to the data provided by Women Against Abuse, two domestic violence shelters in Philadelphia, with 100 beds each, serve approximately 1,200 people per year, 60 percent of them children.[229] In 2014, over 12,000 requests for shelter (women and children included) were turned away due to a shortage of beds.[230]

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[223] The National Network to End Domestic Violence. *'13 Domestic Violence Counts: Pennsylvania Summary*. Washington, D.C., 2014, available at http://nnedv.org/downloads/Census/DVCounts2013/State_Summaries/DVCounts13_StateSummary_PA.pdf (accessed July 15, 2015).
[224] Ibid.
[225] The National Network to End Domestic Violence. *Domestic Violence Counts 2013: A 24-Hour Census of Domestic Violence Shelters and Services*. Washington, D.C., 2014, available at http://nnedv.org/downloads/Census/DVCounts2013/Census13_FullReport_forweb_smallestFileSizeWhiteMargins.pdf (accessed July 15, 2015).
[226] The National Network to End Domestic Violence. *'14 Domestic Violence Counts: Pennsylvania Summary*. Washington, D.C., 2015, available at http://nnedv.org/downloads/Census/DVCounts2014/2014_StateSummaries_FINAL.pdf (accessed July 15, 2015).
[227] Ibid.
[228] The National Network to End Domestic Violence. *Domestic Violence Counts 2014: A 24-Hour Census of Domestic Violence Shelters and Services*. Washington, D.C., 2015, available at http://nnedv.org/downloads/Census/DVCounts2014/DVCounts14_NatlReport_web.pdf (accessed July 15, 2015).
[229] Lisitski, Jeannine L., Sarah Janicki, and Elise Scioscia. *Research and Practices Related to Domestic Violence and Homelessness*: Presentation to the Subcommittee on Causes, Occurrence, and Effects of Homelessness on July 1, 2015.
[230] Ibid.

When the program employee has to inform a person soliciting services that they are unavailable, she or he does not always know what happens to the person in need afterwards. However, based on the information they have, in 2013, 60 percent of the programs nationwide reported that victims returned to the abuser, 27 percent reported that victims became homeless, and 11 percent reported that victims ended up living in their cars.[231] Obviously, none of those solutions can be deemed acceptable.

Though various forms of domestic abuse can contribute to homelessness, one of particular importance is economic abuse, such as manipulating household accounts in ways detrimental to women, preventing women from getting or keeping a job, and limiting or denying them access to family income. "All forms of abuse, in combination with isolation, lead survivors to have limited support systems. With nowhere else to turn, the choice becomes continued violence or homelessness."[232]

A safe place to stay is one of the most immediate needs of a woman or a man escaping domestic violence. Emergency shelters provide a temporary safe refuge in crisis. Many domestic violence survivors need help in their transition to permanent housing and long-term self-sufficiency. Transitional housing serves as such a temporary accommodation. "Moreover, while in transitional housing, many survivors benefit from additional services as they work to rebuild their lives."[233] The common stay in an emergency shelter is 30 to 60 days: sometimes, it is just one night. The length of stay in transitional housing varies but is not supposed to exceed 24 months. Despite the success of transitional housing in helping women who flee domestic violence find stability for themselves and their children, due to funding cuts, many programs had to reduce or eliminate their transitional housing services in the past year, which means that "far too many victims leave shelter without a stable place to go."[234]

Various Housing and Service Models

A longitudinal national study, "The Service and Housing Interventions for Families in Transition" (SHIFT), examined the effectiveness of different housing and service models in helping families experiencing homelessness establish and maintain residential stability and self-sufficiency, with the focus on the needs and characteristics of homeless mothers and children and the corresponding support and services necessary to ensure residential stability among various subgroups of families.[235] The SHIFT study identified mothers in emergency shelter, transitional

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[231] The National Network to End Domestic Violence. *Domestic Violence Counts 2013: A 24-Hour Census of Domestic Violence Shelters and Services*. Washington, D.C., 2014, available at http://nnedv.org/downloads/Census/DVCounts2013/Census13_FullReport_forweb_smallestFileSizeWhiteMargins.pdf (accessed July 15, 2015).
[232] Lisitski, Jeannine L. et al. Op. cit.
[233] The National Network to End Domestic Violence. *Domestic Violence Counts 2014: A 24-Hour Census of Domestic Violence Shelters and Services*. Washington, D.C., 2015, available at http://nnedv.org/downloads/Census/DVCounts2014/DVCounts14_NatlReport_web.pdf (accessed July 15, 2015).
[234] Ibid.
[235] Hayes, Maureen A., Megan Zonneville, and Ellen Bassuk. *The SHIFT Study: Final Report. Service and Housing Interventions for Families in Transition.* The National Center on Family Homelessness, 2015, available at http://www.familyhomelessness.org/shift.php?p=sm (accessed July 17, 2015).

housing, and permanent supportive housing programs in four cities in upstate New York and interviewed them three times during a 30-month period.

An unsettling finding was that "about half of families across the three housing/service program models remained residentially unstable over time."[236] Improvement in women's employment status, though it remained low, had the most salutary effect on residential stability. The SHIFT study also confirmed "the necessity of implementing a housing model that stabilizes families in long-term housing as quickly as possible."[237] It is important to add, however, that "regardless of the housing model that is used, the results of this study indicate that housing – including Rapid Re-Housing – must be aligned and linked with tailored services and supports to ensure residential stability over time."[238] A factor of particular gravity for this subpopulation is the impact of trauma and maternal mental health.

The Impact of Trauma and the Importance of Trauma-Informed Care

While trauma had been previously recognized as a characteristic of mothers in homeless families, the SHIFT study indicated that it is "not merely a characteristic, but in fact is a key factor predicting long-term residential instability."[239] The SHIFT researchers' "examination of predictors of residential instability revealed a new – and critical – finding: trauma symptom severity predicted residential instability."[240] The SHIFT report describes mothers' histories of trauma as "striking," with 93 percent of mothers having experienced at least one trauma, 81 percent multiple traumas, and 79 percent having been traumatized as children.[241] The most common traumatic events involved interpersonal violence such as physical assaults and sexual abuse. Half of the mothers met diagnostic post-traumatic stress disorder (PTSD) criteria at baseline, and 40 percent were still having symptoms thirty months later.[242] The SHIFT authors underscore that "PTSD among survivors of interpersonal violence impacts all aspects of functioning – cognitive, affective, relational – and can result in severe impairment and loss of resources including an inability to establish safety, residential instability and employment difficulties, compromised ability to be responsive to children's developmental needs, and use of negative parenting practices."[243]

The new data led the SHIFT researchers to the paramount conclusion that "the cornerstone to any approach addressing family homelessness must address the impact of trauma and maternal mental health of these mothers and their families."[244] The SHIFT authors strongly recommend implementing trauma-informed care in all family housing programs; they maintain that trauma-

[236] Ibid.
[237] Ibid.
[238] Ibid.
[239] Ibid.
[240] Ibid.
[241] Ibid.
[242] Ibid.
[243] Ibid.
[244] Hayes, Maureen A., Megan Zonneville, and Ellen Bassuk. *The SHIFT Study: Final Report. Service and Housing Interventions for Families in Transition.* The National Center on Family Homelessness, 2015, available at http://www.familyhomelessness.org/shift.php?p=sm (accessed July 17, 2015).

informed care is “a cost-effective strategy to provide an appropriate environment to support these mothers and families on the path towards residential stability.”[245]

According to the SHIFT findings, “Housing First has shown significantly higher rates of residential stability than any of the models” in this study.[246] However, to be effective all housing programs will have to address the trauma-induced and other mental health needs of mothers. The SHIFT study strongly asserts that “housing alone is insufficient to ensure long-term housing stability” and that all housing and shelter programs for families need “to be enhanced by a tailored mix of supports and services” based on the trauma-informed approach.[247] In addition to addressing maternal mental health, specifically depression and PTSD, the SHIFT authors recommend that all housing and shelter programs “support parenting and address the needs of the children to ensure their healthy development and long-term success.”[248]

The SHIFT study was not solely focused on victims of domestic violence; the programs that participated in that study were general housing programs providing assistance to homeless families. Very high rates of abuse among women in these programs confirmed the conclusion made by other researchers that “although we have tended to treat homeless women and abused women as separate and distinct populations,” there are “considerable overlaps in both their experiences and their needs, housing being a key consideration.”[249] Policy implications of this realization include added emphasis on safety at regular shelters, expansion of training on the trauma-informed approach to all housing providers, and a broadened range of supports and services for homeless women and children.

Safety Needs and Ways to Address Them

An authoritative Canadian study by Leslie M. Tutty and her colleagues highlighted “the unique safety needs of abused women, especially those whose partners remain threats.”[250] The authors of this study, along with many other researchers and service providers, contend that safety “must be the core issue when considering housing” for victims of domestic violence.[251] At the same time, they remind policymakers and service providers of the need to consider the entire population of abused women, including those who have never accessed specialized emergency shelters, and to find housing options appropriate for women with fewer safety risks and for women whose partners have been brutally violent.

In agreement with the SHIFT study and other publications, the authors of the Canadian report recommend that given the fact than there are many more similarities than differences between women with children in homeless shelters and their counterparts in domestic violence

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[245] Ibid.
[246] Ibid.
[247] Ibid.
[248] Ibid.
[249] Tutty, Leslie M. et al. *“I Built My House of Hope:” Best Practices to Safely House Abused and Homeless Women*: Report Prepared for the Homelessness Knowledge Development Program, Homeless Partnering Secretariat, Human Resources and Social Development, Canada. September 2009, available at http://www.ucalgary.ca/resolve-static/reports/2009/2009-01.pdf (accessed July 23, 2015).
[250] Ibid.
[251] Ibid.

shelters, "families in homeless shelters be provided with the same degree of support as those in domestic violence facilities."[252]

Tutty and her colleagues also recommend close collaboration between domestic violence victims' advocates and homeless shelters' personnel and changes in policies of child protection agencies as well as other agencies based on a better understanding of the abused women's circumstances.[253]

Domestic Violence Shelters

A representative study of 3,410 clients in 215 domestic violence shelters in eight states investigated residents' needs and services provided by shelters.[254] The report was prepared by the National Center on Domestic Violence for the United States Department of Justice. The results demonstrated that "domestic violence shelters address compelling needs that survivors cannot meet elsewhere," that shelter programs "offer more than safe places for survivors and their children to stay" but also provide a wide range of services for parents and children such as support groups, crisis counseling, individual counseling, as well as advocacy related to a number of issues.[255] The vast majority of clients rated the outcomes of their shelter stay quite highly though they also indicated some difficulties, usually involving other residents rather than staff.[256]

In their discussion of policy implications, the authors of the study strongly state that "domestic violence shelters serve a critical need for people who have experienced abuse" and they bring "a wide variety of educational, emotional, psychological, attitudinal and concrete benefits to residents, including their understanding of what they need in order to live safer and more fulfilling lives."[257] Longer-term outcomes were beyond the scope of this report, but they certainly deserve further attention.

Long-Term Outcomes: Domestic Violence and Housing Instability

Examination of long-term outcomes for battered women requires broadening the discussion by going beyond immediate homelessness to housing instability. Housing instability, which can include multiple unwanted moves, not paying other bills in order to pay rent, being threatened with eviction, or experiencing rental or credit problems, "is not only a precursor to homelessness, but is also a significant stressor in women's and children's lives."[258] Recent research has suggested that the association between domestic violence and housing instability may be caused by a variety of factors. In addition to complications arising from women's traumatic

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[252] Ibid.
[253] Ibid.
[254] Lyon, Eleanor, Shannon Lane, and Anne Menard. *Meeting Survivors' Needs: A Multi-State Study of Domestic Violence Shelter Experiences, Final Report.* Washington, D.C. The United States Department of Justice. October 2008, available at http://www.ncjrs.gov/pdffiles1/nij/grants/225025.pdf (accessed July 23, 2015).
[255] Ibid.
[256] Ibid.
[257] Ibid.
[258] Baker, Charlene K. et al. "Domestic Violence, Housing Instability, and Homelessness: A Review of Housing Policies and Program Practices for Meeting the Needs of Survivors." *Aggression and Violent Behavior*. 2010. Vol. 15. Pp.430-439, available at http://b.3cdn.net/naeh/416990124d53c2f67d_72m6b5uib.pdf (accessed July 28, 2015).

experiences with domestic violence that hinder their ability to secure stable housing after leaving their abuser, the situation may be further exacerbated by current housing policies and practices.[259] After women leave their violent partners, they face significant barriers in obtaining and maintaining stable and safe housing for themselves and their children. These barriers may be "insufficient income to live independently, limited availability of affordable housing, potential housing discrimination against them as domestic violence survivors, histories of credit or rental problems, a criminal history, or ongoing harassment and assaults by the ex-intimate partner."[260] Poor rental history may result from women's multiple moves while trying to elude a persistent abuser or because of evictions that arise from the abuser's actions.[261] In other cases, after separating from their abusive partners, "women may have difficulty paying rent on their own, which may lead to evictions and subsequent credit problems, thus reducing their ability to access alternate housing."[262]

Based on recent studies, the National Center on Family Homelessness posits that domestic violence "contributes significantly to repeat episodes of homelessness by decreasing a survivor's chance of receiving a housing voucher, decreasing job stability, and interfering with women's abilities to form supportive relationships."[263]

Housing Options and Changing Policies

The analysis of the types of housing options available to women and men upon their separation from an abuser (various kinds of emergency shelters; motel vouchers; two main transitional housing models: facility-based and temporary rental subsidy programs; and subsidized permanent housing programs) allows researchers to identify specific advantages and disadvantages these programs may present to domestic abuse victims compared to other homeless subpopulation groups. It has been observed that some of the currently existing policies and programs may inadvertently make it more difficult for victims of domestic abuse to secure stable housing after leaving an abusive partner.

Certain changes in federal housing policies recognize these difficulties and include measures to obviate them. The 2005 re-authorization of the Violence Against Women Act (VAWA) added important housing provisions, such as the prohibition of evictions based on real or perceived domestic violence (unless having the victim remain would pose an "actual and imminent threat" to staff or other tenants) and portability (allowing women to move during the first year of tenancy, often prohibited by voucher and public housing programs, if moving is

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[259] Ibid.
[260] Ibid.
[261] National Law Center on Homelessness & Poverty. *Lost Housing, Lost Safety: Survivors of Domestic Violence Experience Housing Details and Evictions Across the Country.* Washington, D.C., 2007, available at http://www.nlchp.org/content/pubs/NNEDV-NLCHP_Joint_Stories%20_February_20072.pdf (accessed July 9, 2014).
[262] Baker, Charlene K. et al. "Domestic Violence, Housing Instability, and Homelessness: A Review of Housing Policies and Program Practices for Meeting the Needs of Survivors." *Aggression and Violent Behavior*. 2010. Vol. 15. Pp.430-439, available at http://b.3cdn.net/naeh/416990124d53c2f67d_72m6b5uib.pdf (accessed July 28, 2015).
[263] DeCandia, Carmela, Corey Anne Beach, and Rosenie Clervil. *Closing the Gap: Integrating Services for Survivors of Domestic Violence Experiencing Homelessness*. Needham, MA: The National Center on Family Homelessness, 2013, available at http://www.familyhomelessness.org/media/371.pdf (accessed August 11. 2015).

motivated by an attempt to protect the health or safety of the victim). VAWA 2005 also gives Public Housing Authorities (PHAs) flexibility that can help domestic violence survivors. PHAs now have an opportunity to remove the abusive partner from the lease and retain the victim, turn the voucher or apartment over to the victim even if she was not on the original lease but was a household member, and grant emergency transfers. It is important that PHAs personnel are aware of the new regulations and understand their intent. The VAWA protections, however, are limited as VAWA does not cover private housing or federally subsidized housing other than Public Housing and Section 8.[264]

As federal housing protections provided by VAWA are limited, most states have enacted legislation designed to counteract some of the common housing problems faced by victims of domestic violence. Pennsylvania has passed laws providing relocation assistance and rights to emergency shelter,[265] protecting rights of battered tenants on appeal,[266] and guarding confidentiality of housing records.[267]

It is essential to remember that whether battered women are utilizing emergency shelter, transitional housing or permanent subsidized housing, they need an array of services, including interventions specific to domestic violence, such as safety planning, advocacy, and referrals to other services. Lack of these interventions may compromise their ability to maintain stable housing.[268]

A critical factor in helping women obtain stable housing is coordination and cooperation between domestic violence and housing systems. Charlene K. Baker and her colleagues clearly delineated different approaches of these two systems and the possible impact on victims of domestic abuse:

> Domestic violence programs are focused on safety planning and crisis intervention, and offer a wide array of advocacy services that victims need and want, including assistance in obtaining emergency and/or other types of housing (although they may not know the range of housing options and programs or work-related resources in their community). Housing and homeless service providers are focused on a move to stable housing and improved financial stability, but may have little knowledge or expertise in providing services to survivors. Because of differences in history, philosophy, and practices between these two systems, women, who are often faced with a variety of barriers after separating from an abusive partner, may not fit perfectly into either system, and therefore, receive insufficient or inappropriate services.[269]

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[264] Baker, Charlene K. et al. "Domestic Violence, Housing Instability, and Homelessness: A Review of Housing Policies and Program Practices for Meeting the Needs of Survivors." *Aggression and Violent Behavior*. 2010. Vol. 15. Pp.430-439, available at http://b.3cdn.net/naeh/416990124d53c2f67d_72m6b5uib.pdf (accessed July 28, 2015).
[265] 23 Pa.C.S. § 6365 (a).
[266] Act of Apr. 6, 1951 (P.L.69, No.20), § 513(b); 68 Pa. Stat. Ann. § 250.513 (b).
[267] 23 Pa.C.S. §§ 6112, 6703, 6705.
[268] Baker, Charlene K. et al. Op. cit.
[269] Ibid.

Closer collaboration between these two systems, mutual training, and adding a domestic violence victim advocate to the housing agency staff are perceived as possible ways to improve outcomes for women who have experienced domestic violence and homelessness.

Promising Approaches and Beneficial Policy Changes

These women may benefit from several recent changes in funding agencies' policies such as reducing or eliminating mandatory service requirements as a condition of entering or remaining in a transitional housing program, or emphasizing the development of long-term housing programs. To provide good outcomes, long-term housing programs need to assist domestic violence survivors in finding an appropriate home and then, after housing is established, to continue working with the family to help address their other needs to order to optimize the chance of lasting stabilization. An example of such a program is Volunteers of America *Home Free* program in Oregon. It addresses the family's barriers to obtaining permanent housing by supporting a rapid return to stable housing. *Home Free* services include active advocacy with landlords and helping each survivor obtain a home for which she can realistically expect to assume the costs following a period of up to two years of subsidization."[270] Highlighting its differences from other domestic violence services agencies, *Home Free* claims that "rather than provide a facility or temporary apartments for individuals and families fleeing domestic violence," it helps survivors "secure their own housing and assists them in staying there -- safely and independently."[271]

A similar program, the District Alliance for Safe Housing (DASH), was created in Washington, DC. It is a scattered-site, transitional-to-permanent housing program that gives families an opportunity to sign a lease on an apartment of their choosing, with the program offering a rental subsidy for two years. After two years, the family can take on the rent and remain in the apartment permanently.[272] DASH provides home-based community advocacy and emphasizes economic empowerment.[273]

Other recent changes in offering housing services that are especially beneficial to battered women due to their unique needs include a shift towards shelters based on an apartment-style model rather than a community-living model and an attempt to increase women's autonomy by offering more flexibility in service offerings. For example, the program called AWARE (Assisting Women with Advocacy, Resources, and Education) in Missouri "provides women with an option to stay in their own homes (once the abuser has vacated) rather than having to flee, enter a shelter, and eventually search for another home."[274] For two years, the program pays a gradually declining portion of rent and utilities in order to move its clients towards self-sufficiency. This model attracts growing attention nationwide, as it has the potential of securing long-term solutions and increasing the women's and children's sense of stability due to staying in their own home.

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[270] Ibid.
[271] Volunteers of America Oregon. *Children and Families*, available at http://www.voaor.org/children-and-family (accessed August 5, 2015).
[272] Women Against Abuse. *Research and Best Practices Related to Housing and Domestic Violence*: *Spring 2015*. Information provided to the Joint State Government Commission by Ms. Jeannine Lisitski on June 2, 2015.
[273] Ibid.
[274] Baker, Charlene K. et al. Op. cit.

Researchers recommend addressing domestic violence and housing instability simultaneously, emphasizing safety and stability for women who have experienced domestic violence and their children, expanding and innovating existing models of service delivery to provide a broader range of options for survivors, increasing awareness among housing agencies' staff of the dynamics of domestic violence and the range of its victims' needs, and adjusting policies to adequately respond to those needs.[275]

All policies and program practices need to be informed by the knowledge that domestic violence and housing instability are inextricably linked, and that a holistic approach is required to achieve safety and stability and to mitigate the negative economic, social, and health outcomes brought about and exacerbated by both experiences of domestic violence and housing instability.[276]

A good example of this type of a program that attempts to address domestic violence and housing instability is a pilot called *The Home to Stay*. It was launched in New York City in 2010.

Home to Stay

- Targets chronically and episodically homeless families who return to shelter from subsidized and unsubsidized housing
- Provides support services targeting families while in shelter and providing individualized, strengths-based case management
- Uses the evidence-based practices Critical Time Intervention and Motivational Interviewing[277]

The program goals are for the clients to remain stably housed and not to return to the city's shelter system. The program assists them in connecting to community-based resources they need and to increase income to 200 percent of rent and/or to obtain a housing subsidy if they are eligible for it and if it is available. The clients are expected to exit from the program within 9 months of moving into permanent housing.[278] The program managers report that the pilot has demonstrated better outcomes than standard service outcomes, with return to shelter less than 20 percent; in addition, those families who do return to shelter remain housed for an average of 414 days before reentry.[279] Based on the promising results presented by *Home to Stay* research pilot, this practice will be broadly applied now.

Advantages of the Tiered Approach

A New Path: An Immediate Plan to Reduce Family Homelessness, a recent comprehensive study performed by the Institute for Children, Poverty, and Homelessness (ICPH), contains a comprehensive analysis of the emerging trends in serving the needs of homeless families in New

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[275] Ibid.
[276] Ibid.
[277] Kenton, M. *Living in Communities: The Power of Housing and Time-Limited Case Management Support*. CUCS Institute, February 2015, available at http://b.3cdn.net/naeh/2d0f973e9393aa5b27_olm6bxkk4.pdf (accessed August 15, 2015).
[278] Ibid.
[279] Ibid.

York City and proposes significant changes in programs and service delivery. The authors acknowledge that families become homeless for a variety of reasons, but "they can often be identified as families who are experiencing different kinds of poverty: situational poverty and generational poverty."[280] These two different kinds of poverty require different approaches in regard to the ensuing family homelessness.

According to the ICPH definition, "situational poverty is created by an event or temporary condition that impacts a family, i.e. job loss, divorce, or illness."[281] For such families, a brief stay in a shelter, along with the minimal attending services, is sufficient to allow them "to regroup and regain permanent housing."[282]

However, as the ICPH researchers point out, a recidivism rate of almost 50% clearly indicates that there is another group of families, whose long-term problems the current system fails to resolve. "This group of families that are served repeatedly by the homelessness services system often come from generational poverty situations, and have greater needs and challenges to being able to obtain and maintain permanent housing and create safe, stable, thriving households for themselves and their children"; their obstacles to stability may include little or no educational attainment or work histories, domestic violence, physical and mental health concerns, involvement with child welfare agencies, or substance abuse, and they require "a comprehensive, intensive program" that would help them address the numerous challenges they face.[283] In order to address the needs of these families, along with others, the ICPH outlined "a new path to stability," making a special effort to utilize the tools that already exist in the current system while also putting in place additions that would address the needs of those living in generational poverty.[284] The ICPH's claim is that "the end goal of all of these proposed changes is to improve the way that public funds and systems are used to serve those most in need, by those most able to do so."[285]

The essence of the ICPH's proposal is creating a three-tier system of housing services for families, dependent on the causes of their homeless condition and their needs.

Tier I is intended for families who, at the time, need only a short stay in a shelter (less than 30 days), when their eligibility and needs are assessed and temporary shelter is provided. In the ICPH's estimate, this level of service will suffice for approximately one half of all families.

Tier II, involving a stay between two and twelve months, will offer families the help of case managers and housing specialists in finding new or better employment and housing options they can afford.

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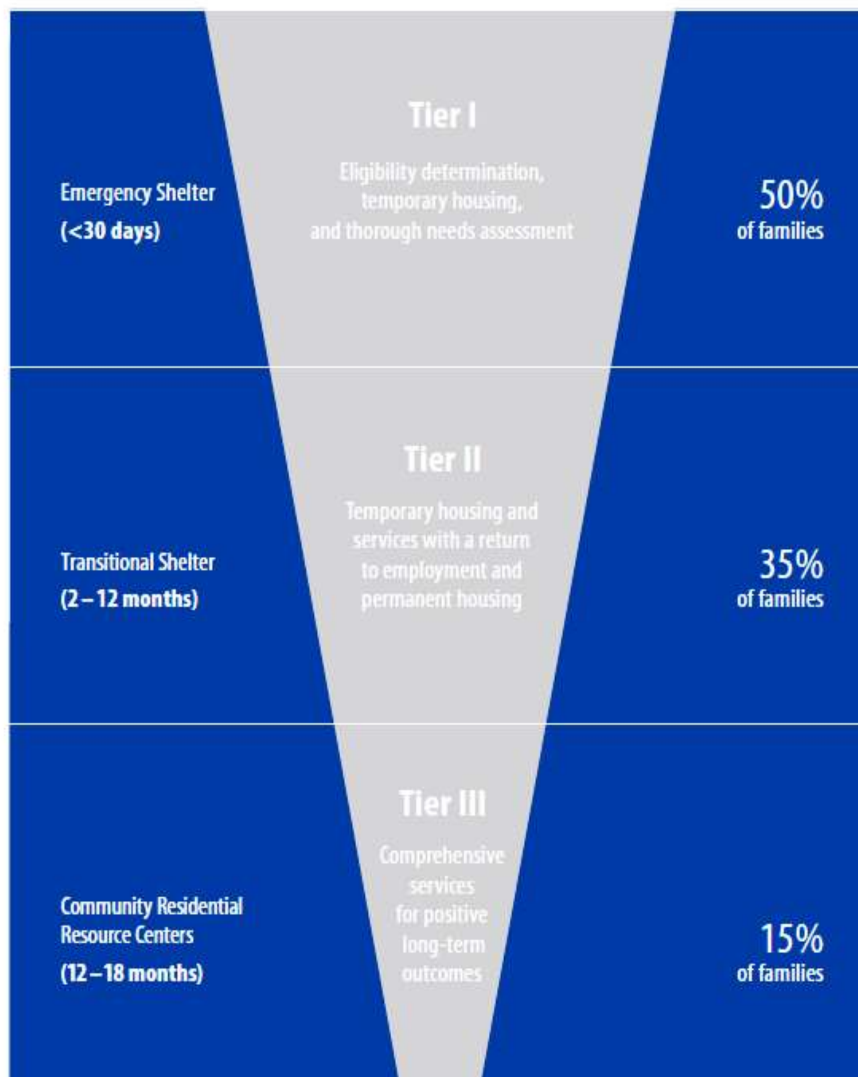
[280] Institute for Children, Poverty, and Homelessness. *A New Path: An Immediate Plan to Reduce Family Homelessness*. New York, N.Y. February, 2012, available at http://www.icphusa.org/filelibrary/ICPH_ANewPath_021312.pdf (accessed August 11, 2015).
[281] Ibid.
[282] Ibid.
[283] Ibid.
[284] Ibid.
[285] Ibid.

Tier III program, or Community Residential Resource Center (CRRC), is designed for "families who identify more complex needs and have higher barriers to maintaining permanent housing."[286]



[286] Institute for Children, Poverty, and Homelessness. *A New Path: An Immediate Plan to Reduce Family Homelessness*. New York, N.Y. February, 2012, available at http://www.icphusa.org/filelibrary/ICPH_ANewPath_021312.pdf (accessed August 11, 2015).

Tier I and Tier II, capable of addressing the needs of the majority if families, are very similar to the currently existing system. Tier III, which would be required to serve only a comparatively small number of families (15%), would offer specialized programs with specific outcomes. The authors underline that this model is not targeted to all homeless families that seek help; instead, "this model is meant to address a specific subset within that group who have a prescribed set of characteristics."[287]

Community Residential Resource Centers will target specific obstacles a particular subset of families face: women and children with verified safety concerns related to domestic violence will find safety in Tier III Safety First Residences; those for whom lack of education and work experience present the biggest barrier will be able to take advantage of job-skill development and work experience opportunities in Tier III Advancing Employment Residences; families involved with child welfare agencies will be referred to Tier III Child Wellness Residences, focused on child safety in family preservations; and families with histories of mental health or substance abuse will be offered enrollment in a Tier III Health and Recovery Residence.

ICPH expresses a certain concern regarding what they perceive as "an increasingly single-minded focus on rapid rehousing initiatives" and the simultaneous elimination of "the services originally designed to target the significant obstacles faced by homeless families."[288] They contend that "to help families move toward growing stability, the weight of the underlying problems faced by these families must be acknowledged and addressed" and recommend utilizing targeted support services in addition to rent subsidies: "To deemphasize these critical services is to forego critical opportunities for putting families on a long-term path toward stable housing."[289]

While specific components of "A New Path" model designed by ICPH for New York may be different in other communities and while it requires further testing, its key elements appear to be attractive and deserve attention. These elements include its general philosophy (family-oriented, strength-based, trauma-informed approach); acknowledgement of two significantly different kinds of poverty and ensuing homelessness that require different responses; and specific program structure including a strong employment-development component and continuity of aftercare. This model may be considered one of the most promising practices that have recently emerged.

"The Road Home"

One of the trends that can be perceived as best practice in providing assistance to victims of abuse is "helping women and children who experience domestic violence to stay safely in the family home."[290] As domestic violence is one of the leading causes of female homelessness and as fleeing the home to avoid assault often results in most dramatic, abrupt loss of shelter and in severe disruptions in the woman's and children's life, finding a way for the victim to stay safely at her home, with the abuser vacating it, can be considered a desirable and fair solution. This approach is one of the ways to prevent homelessness actively facilitated by the Australian Government in

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[287] Ibid.
[288] Ibid.
[289] Ibid.
[290] *The Road Home: A National Approach to Reducing Homelessness*, available at http://www.cshisc.com.au/media/150400/the_road_home.pdf (accessed August 13, 2015).

its comprehensive effort to combat homelessness. It is also being actively explored by service providers in the United States.

The Australian Government's White Paper called "The Road Home: A National Approach to Reducing Homelessness" contains other valuable features that attract growing attention in the U.S. The White Paper, published in 2008, outlines the causes of homelessness and an ambitious but specific plan to halve homelessness in the country by 2020 and to offer supported accommodation to all unsheltered people who need it. "The Road Home" provides "a framework for preventing homelessness from occurring in the first place" (what the authors call "turning off the tap").[291] The White Paper unequivocally states, "Whenever possible, homelessness should be prevented."[292] To make this possible, "prevention strategies should focus on key transition points and life events."[293] Specific initiatives include increasing support for people in public and private rental housing to maintain their tenancies, assisting additional young people between 12 and 18 years old to remain connected with their families, helping women and children who experience domestic violence to stay safely in the family home, and, notably, "'No exits into homelessness' from statutory, custodial care, health, mental health and drug and alcohol services."[294] "The Road Home" plan involves building up additional public and community housing for low-income households, allocating aged-care places and capital funds for specialized facilities for older people who are homeless, and generally improving services for older people experiencing homelessness.[295] Focus on older people as a particularly important subset of the homeless is another aspect of "The Road Home" that deserves particular attention in Pennsylvania, with its aging population and alarming expectations that older adults will constitute a bigger share of the homeless in the near future.

"The Road Home" states that the response to homelessness will be implemented through three strategies:

1. *Turning off the tap*: services will intervene early to prevent homelessness
2. *Improving and expanding services*: services will be more connected and responsive to achieve sustainable housing, improve economic and social participation and end homelessness for their clients.
3. *Breaking the cycle*: people who become homeless will move quickly through the crisis system to stable housing with the support they need so that homelessness does not recur.[296]

The plan sets out clear goals and targets to be achieved by specific dates.

Strong focus on prevention and early intervention, recognition of the complexity of homelessness and the needs of different groups within the focus population, and increasing access to safe, affordable housing linked to appropriate support services are features of "The Road Home" approach that attract American researchers' attention and should be considered by policymakers.

[291] Ibid.
[292] Ibid.
[293] Ibid.
[294] Ibid.
[295] Ibid.
[296] Ibid.

Proposals from Women Against Abuse

Based on its review of available research, Women Against Abuse highlights "the need for a continuum of care for survivors of domestic violence who are experiencing homelessness with a comprehensive toolkit of available housing resources that can be uniquely matched to a survivor's housing, safety, and trauma needs."[297] Women Against Abuse also emphasizes "the importance of services to address the trauma experience of domestic violence for both adults and children, and the need for client-centered and client-driven housing advocacy."[298] In addition, citing several recent studies, Women Against Abuse recommends more flexibility in funding, focus on prevention, shared learning among homelessness and domestic violence service providers (including potential co-location of staff and/or services), and, "importantly, a holistic, coordinated community response to address both homelessness and domestic violence."[299]

Recommendations

- Ensure a full continuum of care for victims of domestic violence who are experiencing homelessness with services and supports uniquely matched to their safety and housing needs.
- Explore a tiered model that provides longer/greater assistance to families experiencing multiple/significant barriers.
- In prioritizing services, recognize that for domestic violence victims that are still in danger, safety comes first and long-term housing is secondary.
- Establish close collaboration between domestic violence victims' advocates and homeless shelters' personnel. Where feasible, implement a domestic violence specialist co-location with mainstream systems/community institutions to provide universal screening, cross-training and intervention to prevent homelessness and address the root issue (in this case, family violence).
- Increase emphasis on client-driven care, including client-driven goal-setting and housing placement based on client needs/safety assessments, and flexible financial assistance (allowing advocates to address victims' self-identified needs, including transportation, child care, et cetera).
- When appropriate, recognize the potential and enhance the possibility for victims to stay in their homes while their abuser leaves.
- Examine and improve long-term outcomes for domestic violence victims by going beyond immediate homelessness to housing instability.
- Review and adjust current housing policies that may inadvertently make it more difficult for victims of domestic violence to secure stable housing after leaving an abusive partner.
- Focus on violence prevention as a strategy for ending homelessness for women and children as a result of domestic violence (both locally and on the state level).

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[297] Women Against Abuse. *Research and Best Practices Related to Housing and Domestic Violence*: *Spring 2015*. Information provided to the Joint State Government Commission by Ms. Jeannine Lisitski on June 2, 2015.
[298] Ibid.
[299] Ibid.

FORMER INMATES

One of the essential ways to curb homelessness is to identify its immediate causes and intervene early to prevent people from becoming homeless, a strategy that the highly acclaimed Australian national plan to reduce homelessness describes as "turning off the tap."[300] Critical time intervention is acquiring more and more attention among experts. Both of the prominent speakers at one of the advisory committee meetings, national-level experts with many years of research and practical experience, Dr. Dennis Culhane and Dr. Martha Burt, highlighted it as a most promising strategy.

Providers are well aware of several "feeder" systems that supply clients to shelters on a regular basis. These are correctional facilities and drug treatment centers. When people are released from one of those and have no family members willing to accept them, they often end up in shelters. The same can be true about patients released from hospitals with nowhere to go. Young men and women leaving the foster care system constitute another high-risk group. Many of them have no resources or skills for independent living and end up homeless. Offering help to individuals from these groups at a critical time of transition may stop their descent into homelessness and many additional problems associated with it.

Housing Challenges for Former Inmates

Formerly incarcerated constitute one of the groups at a high risk for homelessness. Leaving prison with a very small amount of "gate money," some of them can spend their first nights with a family member or friend. Not many have sufficient resources for renting an apartment on their own, especially with the addition of a security deposit and first and last months' rent. Many private landlords are wary of allowing an ex-offender into their housing. Public housing is often not an option for criminal offenders due to the existing regulations and local policies. Housing authorities commonly deny public housing to people with a history of violence and those with felony drug convictions. Ex-prisoners have high rates of mental health, substance abuse and public health issues such as HIV and AIDS infections, which may further reduce their chances for finding housing. Women who are released from prison or jail may have special needs, and they often must find a home not only for themselves but also for their children, which presents an additional challenge.[301] Many newly released prisoners find themselves facing a choice between spending their first night of freedom on the street or in the shelter.

[300] *The Road Home: A National Approach to Reducing Homelessness*, available at http://www.cshisc.com.au/media/150400/the_road_home.pdf (accessed August 13, 2015).
[301] Roman, Caterina Gouvis and Jeremy Travis. *Taking Stock: Housing, Homelessness, and Prisoner Reentry*: Final Report. Washington, D.C.: Urban Institute Justice Policy Center, March 2004, available at http://www.urban.org/Uploadedpdf/411096_taking_stock.pdf (accessed August 5, 2015).

In the past few years, housing has been acknowledged as a critical component in successful reentry. In their review of existing data, experts at the Urban Institute assert that "studies indicate that parole violation and rearrest may be more likely for those prisoners with no place to go upon release."[302] In fact, according to one exploratory study, "38 percent of the people who reported during the study's pre-release interviews that they were going to live in a shelter absconded from parole supervision, compared to only 5 percent of the individuals who reported they were not going to a shelter."[303] Multiple studies have demonstrated that "among released inmates, those who do not have stable housing arrangements are more likely to return to prison than those with stable housing arrangements."[304] Recent research into the intersection of housing, homelessness, and reentry, as well as the formidable barriers that returning inmates face in securing safe and affordable housing, led to the understanding of need for "coordinated reentry housing mechanisms," involving cooperation of correctional facilities, housing and homeless assistance agencies, community and faith-based organizations, local residents, and private businesses.[305]

Realizing a critical role that safe housing plays in successful recovery as well as the increased risk of reoffending associated with homelessness, "agencies of the criminal justice system traditionally seek to connect prisoners to housing, yet these efforts are fraught with problems and limitations. Such efforts include implementing prerelease programming, requiring a verified address to be released, and using transitional centers (halfway houses)."[306] Only a very small percentage of offenders are placed in transitional centers. Preparation for release, including housing arrangements, has not been a priority for the correctional system. In addition, the criminal justice system's emphasis on public safety may lead to restrictions and limitations on a newly released prisoner's housing options and, consequently, become an obstacle to finding a suitable residence.

The realities of the housing market, housing practices and policies present their own difficulties. According to researchers and practitioners, "for returning prisoners, the barriers arising from housing policies and practices generally fall into two categories: (1) the scarcity of the housing stock and (2) formal and informal regulations and prejudices that restrict tenancy."[307] Community obstacles, primarily the so-called NIMBY ("not in my backyard") factor exacerbate the situation.

Fragmentation across service systems makes the problem resolution more challenging. Correctional counselors are unfamiliar with their clients' neighborhoods, housing options or local housing policies. Neither correctional nor parole officers are trained to be specialists in housing

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[302] Roman, Caterina Gouvis and Jeremy Travis. *Taking Stock: Housing, Homelessness, and Prisoner Reentry*: Final Report. Washington, D.C.: Urban Institute Justice Policy Center, March 2004, available at http://www.urban.org/Uploadedpdf/411096_taking_stock.pdf (accessed August 5, 2015).
[303] Ibid.
[304] Solomon, Amy et al. *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, D.C.: Urban Institute, 2008, available at https://www.ncjrs.gov/pdffiles1/bja/220095.pdf (accessed October 7, 2015).
[305] Roman, Caterina Gouvis and Jeremy Travis. "Where Will I Sleep Tomorrow? Housing, Homelessness, and the Returning Prisoner." *Housing Policy Debate*. 2006. Vol. 17. Issue 2. P. 390.
[306] Roman, Caterina Gouvis and Jeremy Travis. "Where Will I Sleep Tomorrow? Housing, Homelessness, and the Returning Prisoner." *Housing Policy Debate*. 2006. Vol. 17. Issue 2. P. 399.
[307] Roman, Caterina Gouvis and Jeremy Travis. "Where Will I Sleep Tomorrow? Housing, Homelessness, and the Returning Prisoner." *Housing Policy Debate*. 2006. Vol. 17. Issue 2. P. 401.

services. On the other hand, "housing service providers may not be equipped to handle the additional needs that returning prisoners typically present."[308] Coordination of efforts is required in this process.

Complex Interrelationship between Homelessness and Incarceration

Continuing research into the correlation between homelessness, incarceration and recidivism has unraveled multiple ties between these phenomena. The interrelationship between homelessness and incarceration is complex. Multiple studies indicate that incarceration and homelessness are mutual risks for each other. A review of existing studies prepared by "In Focus," a publication of the National Health Care for the Homeless (HCH) Council, says that "researchers generally estimate that 25-50% of the homeless population has a history of incarceration."[309] Studies also show that "compared to adults in the general population, a greater percentage of inmates have been previously homeless (5% of general population versus 15% of incarcerated population with history of homelessness), illustrating that homelessness often precipitates incarceration."[310]

According to a comprehensive national study, homelessness was 7.5 to 11.3 times more prevalent among jail inmates than the general population.[311] Other findings of that study were that "in comparison with other inmates, those who had been homeless were more likely to be currently incarcerated for a property crime, but they were also more likely to have past criminal justice involvement for both violent and nonviolent offenses, to have mental health and substance abuse problems, to be less educated, and to be unemployed."[312] The authors concluded that "homelessness and incarceration appear to increase the risk of each other, and these factors seem to be mediated by mental health and substance abuse, as well as by disadvantageous sociodemographic characteristics."[313] Based on their analysis of homeless inmates' age and their criminal histories, the authors also surmised that "past incarceration, even before they became homeless, may have been a major risk of subsequent homelessness."[314] Similar to other researchers, Greg Greenberg and Robert Rosenheck suggest that "this bidirectional association between homelessness and incarceration may result in a certain amount of cycling between public psychiatric hospitals, jails and prisons, and homeless shelters or the street."[315]

This cycling of a group of individuals between jail, shelter and mental health and substance abuse services has been observed by several researchers. Findings that multiple social systems get involved with chronic offenders have been confirmed in a number of states. An analysis of chronic offenders in Allegheny County, Pennsylvania, found that 72 percent of chronic offenders – those

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[308] Ibid.
[309] "Incarceration & Homelessness: A Revolving Door of Risk." *In Focus: A Quarterly Review if the National HCH Council*. Vol. 2. No. 2. Nov. 2013, available at http://www.nhchc.org/wp-content/uploads/2011/09/infocus_incarceration_nov2013.pdf (accessed September 2, 2015).
[310] Ibid.
[311] Greenberg, Greg A. and Robert A. Rosenheck. *Jail Incarceration, Homelessness, and Mental Health: A National Study,* available at http://pathprogram.samhsa.gov/ResourceFiles/Greenberg.pdf (accessed October 1, 2015).
[312] Ibid.
[313] Ibid.
[314] Ibid.
[315] Ibid.

arrested five or more times over the period of two years – also accessed the county's Department of Human Services for homelessness services and substance abuse or mental health treatment at some point before or after incarceration, "compared with 46 percent of all individuals booked by the jail."[316] In New York City, a program targeting frequent users of the city's jail and shelter systems, called The Frequent Users of Jail and Shelter Initiative (FUSE), matched the records of the city's Department of Homeless Services and Department of Correction and Probation and identified "a relatively small number of individuals cycling through both of these systems, at least four times in each system, over a five-year period."[317] Another study, designed to identify risk factors for long-term homelessness, established that one in seven participating men and women who were admitted to New York City shelters was a jail or prison inmate before shelter entry. The authors argue that "this finding, coupled with the importance of arrest history in predicting a longer duration of homelessness, underscores the association of the criminal justice system with the problem of homelessness. This association is ripe for the development of programs that involve prerelease planning for services, including housing, and the creation of interventions that prevent unnecessary incarceration of individuals who have serious mental illnesses and chemical dependences and who come into contact with the police."[318]

An illuminating study that focused specifically on homeless shelter use and reincarceration following prison release was performed by Dennis P. Culhane and Stephen Metraux. The researchers examined the incidence and interrelationships between shelter use and reincarceration among a vast cohort of almost fifty thousand persons who were released from New York State prisons to New York City in the late 1990s. The results showed that "within two years of release, 11.4% of the study group entered a New York City shelter and 32.8% of this group was again imprisoned."[319] The findings demonstrated that "prior prison and shelter use were significantly associated with the hazard (i.e., risk) of subsequently using these institutions."[320] Using survival analysis methods, the authors concluded that "time since prison release and history of residential instability were the most salient factors related to shelter use, and shelter use increased the risk of subsequent reincarcerations."[321] That increase was found to be significant: "The hazard ratio (HR) of experiencing a shelter stay increased by a magnitude of 4.9 (with a history of prior shelter use, and increased more than fivefold (HR = 5.28) upon release from a reincarceration during the risk period."[322] The age factor had a strong impact, with the hazard of experiencing a shelter stay increasing by 4 percent (HR = 1.04) with each year of increased age and the hazard of reincarceration decreasing by almost the same amount: 3 percent (HR = 0.97).[323]

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[316] Dalton, unpublished data. Qtd. in Solomon, Amy et al. *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, D.C.: Urban Institute, 2008, available at https://www.ncjrs.gov/pdffiles1/bja/220095.pdf (accessed October 7, 2015).
[317] Fisher, C., M. White, and N. Jacobs. *FUSE Outputs and Outcomes: Presentation to New York City Department of Correction*, July 3, 2007. Qtd. in Solomon, Amy et al. Op. cit.
[318] Caton C.L. et al. "Risk Factors for Long-Term Homelessness: Findings from a Longitudinal Study of First-Time Homeless Single Adults." *American Journal of Public Health*. October 2005. Vol. 95. No. 10, available at http://www.ncbi.nlm.gov/pubmed/16131638 (accessed January 19, 2016).
[319] Metraux, Shephen and Dennis P. Culhane. "Homeless Shelter Use and Reincarceration Following Prison Release." *Criminology and Public Policy*. Vol. 3. No. 2. 2004, available at http://works.bepress.com/cgi/viewcontent.cgi?article=1028&context=dennis_culhane (accessed July 17, 2015).
[320] Ibid.
[321] Ibid.
[322] Ibid.
[323] Ibid.

Effective Interventions

In addition to augmenting the existing body of evidence suggesting that "homelessness contributes to a higher risk for incarceration and that, inversely, incarceration contributes to an increased risk of homelessness," Culhane and Metraux revealed several specific trends and correlatives that allowed them to make valuable policy recommendations.[324] Based on their findings, the authors strongly suggest that "efforts to prevent homelessness among released prisoners should focus on the transitional period occurring right after prison and should focus on persons who demonstrate a history of unstable housing."[325] The researchers note that "the limited nature of such a process, where screening persons would considerably narrow the identified risk group and services would be concentrated in the initial months after release, should render the intervention as relatively practical to implement."[326] Culhane and Metraux underscore that "the key intervention point appears to be at the time of release."[327] They also highlight the need for an integrated approach that would combine housing assistance to newly released prisoners with help in other areas such as obtaining identification, applying for Medicaid and other benefits, securing employment, and receiving treatment for mental illness if necessary.[328] The most important practical policy implications of this study consist in the suggestion that "enhanced housing and related services, when targeted to a relatively small at-risk group among this population, have the potential to substantially reduce the overall risk for homelessness in the group."[329]

As mental health and substance abuse issues are known to further exacerbate risks of arrest and reincarceration for former inmates who lack reliable housing, several new reentry programs include this factor while selecting their target populations. The National HCH Council's review contains examples of successful programs that "connect formerly incarcerated individuals with stable housing, clinical and support services to break the cycle of recidivism."[330]

One of these programs is the Jail Inreach Project, operated by Healthcare for the Homeless-Houston (Texas). It provides intensive medical case management to individuals with behavioral health diagnoses. Eligibility for the program is contingent upon being incarcerated in the Harris County Jail, having a behavioral health diagnosis, expecting to be homeless upon release, and being a "frequent flyer," meaning high arrest rates and utilization of mental health services while incarcerated. Jail inreach programs build relationships with inmates at risk of homelessness prior to their release, thus laying the groundwork for continuity of care. The Harris County project emphasizes developing patient-centered release plans with clients and making services immediately available, often with case managers accompanying clients directly to the clinic. The program analysts believe that immediate linkage reduces missed first appointment and overall loss

[324] Ibid.
[325] Ibid.
[326] Ibid.
[327] Ibid.
[328] Ibid.
[329] Ibid.
[330] "Incarceration & Homelessness: A Revolving Door of Risk." *In Focus: A Quarterly Review if the National HCH Council*. Vol. 2. No. 2. Nov. 2013, available at http://www.nhchc.org/wp-content/uploads/2011/09/infocus_incarceration_nov2013.pdf (accessed September 2, 2015).

of clients, which, in its turn, reduces arrests rates, number of days in jail, and costs of incarceration to the community.[331]

Another program highlighted in the National HCH Council's review is the Re-Entry Collaborative (REC), facilitated by the Albuquerque Health Care for the Homeless (AHCH). REC is a collaborative among the New Mexico Department of Health, Bernadillo County Substance Abuse Treatment Services, the New Mexico Department of Corrections, and the University of New Mexico. This program uses an integrated primary care and social services treatment model to assist with the reentry of homeless individuals released in the past 90 days who have opiate dependency. The treatment model includes the Housing First approach, care coordination, opiate replacement therapy, and other components. According to the reviewers, REC has produced positive outcomes, including decreased drug use, associated risky/unhealthy behaviors and number of arrests.[332]

These and similar programs demonstrate that supportive housing provided immediately upon release may be an effective approach to preventing former inmates from becoming homeless and reducing chances of future arrests and reincarcerations.

In the past decade, new housing opportunities and promising policies and practices have emerged. The Second Chance Act of 2005, signed into law on April 9, 2008, was designed to improve outcomes for people returning to communities from prison, jails, and juvenile facilities. It reauthorized the Department of Justice grants to government agencies and nonprofit organizations intended to provide support services to formerly incarcerated individuals with the purpose of facilitating their smooth reentry into the community and reducing recidivism. Activities permissible under the grant program include housing, jobs, mental health and substance abuse treatment, and services for families and children of incarcerated parents. Referencing studies that have shown that between 15 percent and 27 percent of prisoners expect to go to homeless shelters upon release from prison, the Second Chance Act highlighted the need for comprehensive reentry services including housing and identified increased housing opportunities as one of the desirable performance outcomes.[333]

Several states created new programs aimed at streamlining reentry, and housing assistance as part of the reentry process in particular, with the goal of achieving consistency and improving outcomes statewide. In 2001, the Florida legislature established a new Bureau of Transition Services within the Florida Department of Corrections (FDOC) and required that FDOC designate 400 beds in nonsecure community-based facilities for transitional assistance for inmates nearing their date of release.[334] In 2003, the Massachusetts Department of Corrections (MDOC) created the Reentry Housing Program to serve all seventeen MDOC institutions throughout Massachusetts. A notable feature of the program is that it uses five mobile housing specialists to serve soon-to-be-released inmates who are at risk of being homeless. These housing specialists "complement the work of correctional case managers within the prisons, creating a two-tiered system, and work

[331] Ibid.
[332] Ibid.
[333] 42 U.S.C.A. §§ 17501, 3797w, 3797w-2.
[334] Roman, Caterina Gouvis and Jeremy Travis. "Where Will I Sleep Tomorrow? Housing, Homelessness, and the Returning Prisoner." *Housing Policy Debate*. 2006. Vol. 17. Issue 2. P. 406.

with DOC counselors to identify housing needs and help with securing housing before an inmate's release."[335] The Rhode Island Department of Corrections and the Tennessee Department of Corrections also "implemented reentry transition planning services that include linking released prisoners to transitional housing through pre- and postrelease case management."[336] In addition to housing, all the above-mentioned reentry programs are designed to increase a returning prisoner's access to other services, such as job placement, education, mental health and substance abuse treatment.

"Taking Stock: Housing, Homelessness, and Prisoner Reentry"

In 2003, the Urban Institute convened a national forum of experts "to chart a course for housing organizations and criminal justice organizations to work together to improve housing outcomes for individuals leaving prison, their families, and the communities to which they return."[337] The report "Taking Stock: Housing, Homelessness, and Prisoner Reentry" contains a synthesis of recommendations made by prominent practitioners, researchers, and community leaders who participated in the roundtable discussion. The following list includes proposed critical steps for policy, practice, and research:

Next Steps for Policy

- Encourage high-level political endorsement in reentry planning.
- Set goals and standards for discharge planning from correctional facilities. Create standards at both the state and national level.
- Modify one-strike housing regulations so discretion is not used to target ex-offenders with minor offenses, or offenses that occurred far in the past.
- Legislate reforms in corrections. Revise the "get tough" statutes and related policies to take into account the need for supervised release.
- Educate the community about the problems facing returning prisoners. Encourage input from the community. Community forums and informal discussions with community residents can establish trust and lead to appropriate types of services that fit particular needs of communities. Encourage the development of partnerships between government agencies and community organizations.
- Mandate specific performance measures and evaluation with government and private funding of programs.

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[335] Roman, Caterina Gouvis and Jeremy Travis. "Where Will I Sleep Tomorrow? Housing, Homelessness, and the Returning Prisoner." *Housing Policy Debate*. 2006. Vol. 17. Issue 2. P. 407.
[336] Ibid.
[337] Roman, Caterina Gouvis and Jeremy Travis. *Taking Stock: Housing, Homelessness, and Prisoner Reentry*: Final Report. Washington, D.C.: Urban Institute Justice Policy Center, March 2004, available at http://www.urban.org/Uploadedpdf/411096_taking_stock.pdf (accessed August 5, 2015).

Next Steps for Practice

- Encourage investment from private donors, and bring together partners. Partnership programs can bridge fragmented services systems. Private funders are good sources of funding to address systems change. When systems change is successful, replicate.
- Reentry partnerships should not only include government agencies, but also the faith community and business community.
- Utilize nongovernmental organizations as intermediaries in reentry partnerships.
- Dispel myths about restrictions to public and Section 8 housing and provide incentives (e.g., rent vouchers or tax credits) to landlords who house returning prisoners or ex-offenders.
- Build evaluation into program implementation and maintenance.
- Develop tools and curriculum around training for multiple systems that are supporting the common interest of serving returning prisoners. Train parole officers to work with community organizations and to be knowledgeable about the services community organizations can provide. Parole officers should utilize graduated sanctions that incorporate supervision needs.
- Convene siting commissions or community boards that work together with government to determine the best sites for halfway houses and community reentry centers.

Next Steps for Research

- Catalog the policy obstacles and clarify what is myth. Disaggregate obstacles into categories: which are federal obstacles, state, local government, or community obstacles.
- Examine partnership successes and document successful strategies to implement and maintain strong partnerships. Research that utilized case studies of promising programs could provide insight on what works and why, and what could be replicated in other communities.
- Document funding streams. By understanding how the different systems fund housing-related services, communities can benefit. Document who is successful with the various funding streams.
- New studies could examine the nature and extent of housing services being utilized at pre-release facilities and halfway houses and identify promising models along a continuum of services. Similarly, research could quantify the costs and benefits associated with these facilities as compared to direct release.
- Research could also begin to focus on the promising practices for specialized populations. For instance, are there successful housing opportunities for violent offenders or sex offenders? [338]

These recommendations cover a wide range of issues, some of them going beyond the limits of the present report, with its focus on homelessness in Pennsylvania. They all, however, are important for the successful resolution of this problem and deserve the attention of legislators, executives, practitioners, and researchers seeking comprehensive solutions.

[338] Ibid.

Pennsylvania

The Commonwealth has been facing difficulties with successful housing of former inmates that are similar to those in other states, and it has been trying out various strategies to tackle this problem, which remains significant for many individuals upon their release from a state correctional institution or a county jail.

Pennsylvania Department of Corrections

The Subcommittee on the Causes, Occurrence, and Effects of Homelessness devoted one of its meetings to a detailed analysis of former inmates and their often precarious housing situation and of efforts by the Pennsylvania Department of Corrections (DOC) to combat the risk of homelessness upon their reentry into the general population. The DOC representatives on the advisory committee, Ms. Diana Woodside and Ms. Carrie Anne Amann, led the discussion. Mr. James B. Williams shared his perspective on behalf of the Pennsylvania Board of Probation and Parole (PBPP).

Ms. Amann's presentation contained key data and observations regarding the housing aspect of reentry for individuals released from the Pennsylvania state prisons. According to the information she provided, approximately 20,000 offenders are released from the state prison system annually, mostly in the Southeastern part of the state.[339] There are two distinctions when referring to the release of the state inmate population: 1) those individuals who have served out their maximum sentence and leave the system without parole supervision; and 2) those individuals who are released to the community by the Pennsylvania Board of Probation and Parole and remain under supervision of PBPP. The entire offender population is at risk of homelessness upon reentry into the community; however, special subsets of the offender population remain at higher risk. These include sex offenders, individuals with chronic medical and physical disability issues, and those with significant mental health problems.

In order to address this significant issue, DOC created a Community Orientation and Reintegration (COR) Program in May 2008. About 6-9 months prior to an inmate's anticipated release date, there is preparation for community reentry, which includes housing considerations. State Correctional Institution (SCI) Waymark houses the Forensic Treatment Center (FTC), which provides supervision and treatment of all psychiatric inmates within the DOC. At SCI Waymark, there is an Enhanced Reentry Committee, which is tasked with planning for community reintegration for individuals with serious mental health diagnoses. This process includes outreach to local housing representatives in the community in order to facilitate transition planning from prison to an appropriate living arrangement. Priority is given to assisting the inmate with obtaining Medical Assistance; however, a barrier is the varying eligibility criteria across the 67 counties in the Commonwealth. In an effort to meet the needs of this subgroup more efficiently, DOC increased the number of social workers working with this population prior to release.

[339] Information provided by Ms. Carrie Anne Amann in her presentation at the subcommittee meeting on March 11, 2015.

Additionally, DOC has collaborated with the Veterans Affairs (VA) Office in order to create the Veterans Justice Outreach (VJO) program. This program operates in both SCI Dallas and SCI Pittsburgh and focuses on providing wraparound services for veteran offenders in the community for up to 90 days following release from prison. At the conclusion of this timeframe, it is anticipated that the VA will pick up the ongoing cost of services. DOC identifies veterans among its inmates and informs the VA Office about the anticipated release ahead of time. Wraparound services include a VJO liaison who assists the veteran with all details of reintegration, including housing.

DOC provides Community Correction Centers (CCCs), also referred to as "halfway houses" or "transitional housing units," for those individuals who are approved to transition from prison to parole supervision. Inmates are eligible for placement into a center after they have served at least nine months in state prison without any major misconduct violations, or following approval of parole by the Pennsylvania Board of Probation and Parole. These centers provide programming that includes renter's preparation workshops, drug and alcohol treatment, educational and vocational training, et cetera. The centers also contract with non-residential reentry services in the community to further assist offenders with subsequent needs, including housing.

In 2012, DOC established a Housing Voucher Program that provides security deposits and rental assistance to low-risk offenders who would otherwise be placed in a CCC. These offenders have to meet requirements for approval and remain under the supervision of the Pennsylvania Board of Probation and Parole. A barrier to this program is that these vouchers are not always accepted by landlords, rendering them without value for some offenders. Engagement with the local housing authority and community housing coordinators could combat landlord perceptions and potentially increase housing options for former inmates.

The DOC representatives emphasized that their department believes it is important not to set up an individual for failure. An ability to secure and maintain housing involves employment, mental health care for those who need it, and other factors. Housing assistance alone will not guarantee success in all cases.

Not every inmate placed in the CCCs is considered "homeless"; however, those who identify as homeless may be placed in these units while completing their sentence. It is very difficult to determine the number of inmates who enter the prison system without housing, as there are approximately 16,000 admissions to the state system annually and currently no intake procedure in place to capture or verify this information.

According to the information provided by DOC, the average length of stay at a residential CCC for an inmate is between 60-90 days, with approximately 1,000 individuals maxing out at 120 days or more. The total number of inmates staying in these units is approximately between four and five thousand people.[340]

In regards to the male versus female inmate populations, the available programs vary. Women are currently placed at SCI Muncy and SCI Cambridge Springs, which both provide reentry programming prior to release; however, neither currently has a VA unit. There are VA

[340] Ibid.

facilitators made available to women inmates who are veterans so that they can be connected to the outreach program. Statistics show that female veterans make up about five percent of the veteran inmate population in Pennsylvania.[341]

In an effort to better meet the needs of the female population, DOC is currently building SCI Phoenix, which will be located outside of Philadelphia and house up to 200 female inmates.[342] The intention of this prison is to provide placement closer to the Philadelphia area so that inmates can be more efficiently and effectively connected to resources closer to where they previously resided. This philosophy is aligned with the notion that offenders may have more successful reentry if housed closer to their home and/or family, as these are where they will be most connected to resources and supports. This attitude illustrates a paradigm shift in offender placement, as it was previously believed to be best to move the offender as far away from home as possible. Some prisons are contracting with local providers in an attempt to combat this barrier; however, additional planning conflicts arise if the inmate does not have a specific release date or if the service intake cannot be completed in person due to the offender still being in prison. If inmates were placed closer to their point of origin, this barrier could be more easily overcome.

DOC makes consistent effort at outreach, trying to establish collaboration with local agencies in the community where an inmate is about to be released. Inreach, which would involve proactive contact with DOC on the part of local communities, would also be helpful in achieving the goal of smooth and successful reentry.

Homeless services providers believe there is a group of former inmates who should be specifically targeted and prioritized: those are inmates with serious medical needs, for example, those who are wheelchair-bound. Such individuals face additional challenges and require serious transition planning. These people need quick access to the Medical Assistance program and often, additional services. Different counties approach this problem in different ways. It would be beneficial for the Commonwealth to develop a unified approach.

It is important to remember that any inmates who serve out their maximum sentence within the formal prison cannot be legally detained beyond this date whether there is a safe place for them to go or not. They leave the prison system without any of the above-listed resources or supervision through the Pennsylvania Board of Probation and Parole. They are given a bus ticket and maybe an address to the local shelter or housing facility.

DOC continues to search for better ways to facilitate access to housing for former inmates, which reduces risks of recidivism and enhances their chances for successful reentry in to the community. In 2014, DOC engaged a local housing and community development consulting firm, Diana T. Myers and Associates, Inc. (DMA), to evaluate the housing assistance program for ex-offenders it had initiated in 2013 with the goal of reducing the number of individuals maxing-out of state correctional institutions without a viable home plan. DMA was charged with identifying the barriers to successfully housing ex-offenders; assessing the current DOC housing assistance program; researching other reentry housing models and approaches being implemented throughout the nation; identifying potential state and local reentry housing partners; and making

[341] Ibid.
[342] Ibid.

recommendations for surmounting housing barriers, improving the effectiveness of the current program and creating new housing options for ex-offenders in Pennsylvania.[343]

The authors state that their study and their recommendations were guided by two principles: first, the philosophy that most ex-offenders will be best served in existing housing scattered throughout the community with access to services as needed, with only certain individuals and subpopulations requiring site-based and/or specialized housing options; and second, that a comprehensive community-based approach directed by local agencies can produce real integration of ex-offenders and has the best chance for long-term success.[344] The authors felt that their extensive outreach with criminal justice, housing and human services agencies as well as current housing vendors and offenders seeking or preparing to seek housing confirmed the validity of these principles.[345]

The analysis performed by DMA led to the conclusion that "DOC's current housing assistance program appears to be successful for individuals with fewer barriers to reentry."[346] DMA offered several modifications that would, in its view, increase success with these individuals as well as expand the program to serve persons with greater barriers to reentry and specifically to obtaining and maintaining housing.

Key recommendations made in the report include the following:

- Increasing coordination with the Social Security Administration and employment initiatives;
- Working with Public Housing Authorities to create a family reunification pilot program;
- Providing housing training, including the application and appeal process for applying to PHAs and other subsidized housing providers;
- Providing funding to create Housing Locators, who would be responsible for developing relationships with landlords and housing providers;
- Providing landlords and housing providers with special incentives for making housing available to ex-offenders.[347]

Recommendations for creating more new housing include the following measures:

- Increasing education about local residency restrictions for sex offenders;
- Strategies for supporting the creation of peer-supported group homes by reusing existing vacant or under-utilized structures with proper zoning;

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[343] Pennsylvania Department of Corrections. DMA. *DOC Final Report: Recommendations for Expanding DOC Housing Services.* January 7, 2015. A copy of the report was submitted to the Joint State Government Commission by Ms. Leigh Howard, DMA President.
[344] Ibid.
[345] Ibid.
[346] Ibid.
[347] Ibid.

- Opportunities for DOC partnerships with the Pennsylvania Housing Finance Agency, Department of Community and Economic Development, and private landlords.[348]

The report addresses specific barriers to housing ex-offenders, describes existing initiatives throughout the Commonwealth, and proposes pilot projects to test promising new approaches.

The report also contains the description of several housing models for individuals with criminal justice involvement:

1. Tenant-based rental assistance
2. Site-based rental assistance
3. Flexible admissions and other policies
4. Private market incentives
5. Housing services
6. Residential models
7. Peer support[349]

DOC is presently reviewing the report's findings and recommendations.

Pennsylvania Board of Probation and Parole

Individuals who have served their prison term and are placed under the supervision of the Pennsylvania Board of Probation and Parole (PBPP) get certain assistance in obtaining suitable housing. However, they face serious obstacles. Mr. James B. Williams, a representative of PBPP, identified several of those.[350]

The first is victim contact, as offenders are prohibited from having contact with the victims of their crimes while on parole or probation. Since many victims are related to their offenders, this significantly limits the offender's access to resources and supports. For example, if the offender victimized a member of his own household, then he cannot return to his former home. If the victim is not a family member, he or she still has the option to request that the offender not return to the local area. If approved, PBPP can make this a stipulation of probation, cutting off the offender from his local community. The second barrier is landlord perceptions of offenders and their reluctance to rent to this population. The third issue highlighted the federal stipulations for eligibility for Section 8 Housing Vouchers or other HUD-funded housing programs. Any individual who is subject to a lifetime sex offender registration or who has been convicted of producing methamphetamine on public housing grounds can be barred from public housing or receiving Section 8 housing assistance. Other violations are subject to the discretion of the local authorities that often go far beyond the federal requirements; as a result, many offenders find themselves unable to qualify for housing assistance. Additionally, if an offender reunifies with his or her family already residing in HUD-funded housing, the entire family may be evicted and unable

[348] Ibid.
[349] Ibid.
[350] Information provided by Mr. James B. Williams in his presentation at the subcommittee meeting on March 11, 2015.

to receive housing assistance. The fourth barrier pointed out by Mr. Williams is the financial burden of obtaining housing. Many rental properties require a security deposit and first and last month's rent to be provided up front, with the total amount reaching as high as $1,500-$2,000; many offenders do not have the financial means to meet this requirement upon leaving prison.

Though there may be housing assistance programs within their communities, ex-offenders are considered risky investments of support, and with so many financially strapped individuals and families who are non-offenders, these programs can easily overlook or deny offender housing assistance. Another barrier for offenders in the community is related to their unrealistic expectations upon their return home. Offenders often encounter issues within the home setting, as their family has had to struggle in their absence or move forward without them. There also may be family dysfunction that existed prior to their incarceration that remains when they return. These issues can lead to domestic dispute, which results in loss of housing and family support.

From the PBPP's perspective, there are two groups of offenders who are in need of housing immediately upon being released from the prison system: 1) individuals who have lost their housing due to domestic abuse issues prior to incarceration and 2) individuals whose home has been significantly damaged or condemned due to fire, flood, or other disaster. It was suggested that DOC can assist offenders who are identified to be without housing upon release by connecting them to landlords and providing rental payments for a few months.[351]

The subset of the offender population who present with drug and alcohol issues most often transition to CCCs or work release programs so that they can receive treatment for their addictions and earn income while doing so. Offenders who take advantage of these programs have the opportunity to save money that will be available to them upon their release. Pennsylvania has resources available to be used in such circumstances, coming from the VA, the Emergency Solutions Grant, and homelessness prevention funds. Closer collaboration between PBPP and the local Communities of Care may optimize the use of these funds.

In regards to the NIMBY factor and landlords' apprehensions, there are certain approaches where landlord outreach and education and third-party support for housing assistance to offenders may open up housing opportunities to this population though concerns were voiced regarding personal responsibility and motivation among the offender population to maintain housing at a standard preferred by landlords if they are receiving third-party subsidies. It is worth noting that these concerns are tied to general behaviors associated with lower socio-economic populations, not exclusively the offender population. An increase in access to workshops and trainings in prison that link behavior changes to housing sustainability could benefit the inmate population over time.

Local Initiatives

An example of a promising program providing employment opportunities to ex-offenders is Work Pittsburgh, which is a subsidiary of Nello Development. Work Pittsburgh employs a number of former inmates to build pre-fabricated Micro Homes. Nello Vice President of Business Development Dan Bull, himself an ex-offender and a believer in second chances, says that "the

[351] Ibid.

company is poised to address three of Pittsburgh's problems simultaneously: affordable housing, unemployed veterans and former inmates."[352] Micro Homes built by Work Pittsburgh are about 700-square-feet single bedroom homes and can cost as little as $65,000 though they are custom-made and the price can go up if the buyer wants additional features. In addition to reasonable wages, with quarterly raises and opportunities for promotion, at the end of two years, an employee can get one of the houses he built if he wishes to do so. He will also be offered the opportunity to take an ownership stake in the company. The founders of the Work Pittsburgh warehouse have ambitious goals of making their company an incubator for ex-offender entrepreneurs, opening even broader prospects for former prisoners.[353] Bull's description of the warehouse site offers a hopeful and optimistic vision of the ex-offenders' future: "It's a straight line from the (county) jail, to our facility, to the building site up there on the hill," he said. "So the guys can see where they've been, where they are, and where they are going."[354]

It is probably not by serendipity that the program offering employment opportunities to former inmates described above has found a place in Pittsburgh. Allegheny County has implemented several progressive jail-related initiatives in the past several years. It is one of the few jurisdictions nationwide that supports case managers with a jail reentry caseload. In 2000, the Allegheny County Bureau of Corrections, Department of Human Services, and Health Department established the Allegheny County Jail Collaborative. The agencies joined their efforts with the purpose to enhance public safety and successful reintegration of former inmates into the community by coordinating services and reducing duplication. The Collaborative focuses on comprehensive reentry planning that includes family reunification, housing, substance abuse and mental health treatment as well as employment and community engagement. Upon release, most inmates go to a treatment center, alternative housing in the Collaborative's three-quarter way house, transitional housing, or their own home. Within the framework of the Allegheny County Jail Collaborative, "intensive case managers from the Department of Human Services begin working with inmates in the Allegheny County Jail to develop comprehensive and dynamic release plans 60-120 days before release and meet with community providers to coordinate post-release services. This same case manager follows individuals up to one year after their release, providing assistance with family reunification and access to housing, jobs, and treatment."[355]

Reentry programs launched by Allegheny County in 2010 and 2011 were implemented under the auspices of the Bureau of Justice Assistance Second Chance Act Adult Offender Reentry Demonstration programs initiative. They were designed to reduce recidivism and improve inmates' transition to the community. One of them (Reentry1) linked sentenced Allegheny County jails inmates to reentry specialists who coordinated reentry services and programming both in jail and upon release, in the community. The second one (Reentry2) connected inmates to reentry probation officers before release, and those designated officers worked with inmates on prerelease planning and later supervised them in the community once they were released. The first program was voluntary; participation in the second was a mandatory condition of post-release supervision.

[352] Morrow, Christian. "Work Pittsburgh Building Futures for Ex-offenders." *The Pittsburgh Courier*. September 30, 2015, available at http://newpittsburghcourieronline.com/2015/09/30/work-pittsburgh-building-futures-for-ex-offenders (accessed October 7, 2015).
[353] Ibid.
[354] Ibid.
[355] Solomon, Amy et al. *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, D.C.: Urban Institute, 2008, available at https://www.ncjrs.gov/pdffiles1/bja/220095.pdf (accessed October 7, 2015).

Both programs "attempted to reduce reoffending through the use of risk/needs assessment, coordinated reentry planning, and delivery of evidence-based programs and practices." [356] In their evaluation of both programs' performance and effectiveness, researchers from the Urban Institute's Justice Policy Center found strong implementation fidelity and positive outcomes. They concluded that "both Reeentry1 and Reentry2 reduce rearrest among participants and prolong time to rearrest, particularly after the first 90 days post-release, indicating that initial and continued program efforts to stabilize clients are effective."[357] The evaluators stated: "There is strong and credible evidence that Allegheny County's Second Chance Act reentry programs reduce recidivism as measured by rearrest."[358]

Enhancing housing opportunities and housing stability post-release is an important component of reentry programs in Allegheny County. For employment and housing resources, Reentry1 partnered with Goodwill Industries. Goodwill's HARBOR Project, a 40-unit HUD-sponsored resource, provides eligible ex-offenders with housing and supporting services. Clients typically stay there for six to nine months, but they may remain as long as two years. Housing could also be obtained through one of the three homeless shelters and several recovery homes.[359] In their interviews of the reentry programs' participants, the Urban Institute researchers found that many clients credited Reentry1 and Reentry2 programs for connecting them to housing. Many clients cited housing resources as a critical reentry need. Some clients reported having to go through lengthy processes to access housing, while others complained of the lack of housing options. In response to these comments, the Allegheny County Jail Collaborative and its partners "have prioritized development of alternative housing options under the reentry program redesign as stakeholders recognize the critical stabilizing effect that access to safe and drug-free housing affords clients returning from the community to jail."[360]

Other Pennsylvania counties should consider similar programs as although the research is limited, some studies have demonstrated the importance of case management in improving reentry outcomes.[361] The recent evaluation of the Allegheny County programs confirms that.

Another model to address housing challenges of ex-offenders is a housing program operated by a public housing authority and targeted to individuals discharged from either jail or prison. An example of this kind of a program is the Justice Bridge Housing Program (JBHP) in Union County that was launched in 2012. In addition to former involvement with the criminal justice system, eligibility requirements include a connection to Union County (typically former residence), non-violent behavior, and a mental health diagnosis and/or substance abuse disorder. There is particular emphasis on persons with high risk of recidivism. County and state departments of probation and parole refer and supervise program participants. Community supportive services

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[356] Willison, Janeen Buck, Sam G. Bieler and KiDeuk Kim. *Evaluation of the Allegheny County Jail Collaborative Reentry Programs: Findings and Recommendations.* Washington, D.C. Urban Institute, October 2014, available at http://www.urban.org/research/publication/evaluation-allegheny-county-jail-collaborative-reentry-programs (accessed October 28, 2015).
[357] Ibid.
[358] Ibid.
[359] Ibid.
[360] Ibid.
[361] See Solomon, Amy et al. *Life After Lockup: Improving Reentry from Jail to the Community*. Washington, D.C.: Urban Institute, 2008, available at https://www.ncjrs.gov/pdffiles1/bja/220095.pdf (accessed October 7, 2015).

are provided externally to the public housing authority by local providers.[362] In a program like JBHP, housing is delivered through tenant-based rental assistance.[363] JBHP is a "bridge" program: it does not offer permanent housing; instead, it provides a rental subsidy during participants' time on parole or probation, reducing risks of homelessness or housing instability, and this reducing the risk of recidivism. In their analysis of the program, Diana T. Myers and Associates, Inc. (DMA) found it successful and concluded that JBHP reduces the risk of recidivism: "By providing housing that is safe, affordable, and secure, the Justice Bridge Housing Program helps create a living situation in which participants can build social capital and meet their criminogenic needs, this reducing their risk of recidivism."[364] DMA established that JBHP had been implemented in accordance with what is currently perceived as best practices, most notably, cross-system collaboration (in this case, collaboration among housing providers, providers of supportive services, and the criminal justice system, especially departments of probation and parole); having housing as it its center piece (reentry programs need to be "housing-centered" as residential stability is critical for former inmates' engaging with community services or treatment and building social capital); and successful design and implementation.

According to DMA, "Union County was a particularly hospitable environment in which to develop and implement the Justice Bridge Housing Program" due to a number of favorable factors such as its collaborative public culture and orientation on best practices and cost-effective services for all county practices, in addition to prior positive experience with less-traditional interventions within the local criminal justice system.[365] The willingness and competence of the county public housing authority also played a big part. Though not all of these beneficial factors may be present in other counties, key components of JBHP can probably be replicated in a number of them. In fact, DMA's research identified four other Pennsylvania counties that also run reentry housing programs involving the public housing authority in various ways: Beaver, Clarion, Columbia, and York. Each of these four programs combines housing assistance and supportive services, "and by stabilizing housing for reentry participants, reduces their risk of recidivism." [366] Based on both Pennsylvania and national experience, reentry housing programs with a public housing authority collaboration appear to present a viable option for providing housing stability for ex-offenders and reducing the risk of recidivism.

Recommendations

- Strengthen the partnerships between the DOC Bureau of Reentry, the Pennsylvania Board of Probation and Parole, county probation and parole, and housing providers throughout the Commonwealth.
- Expand the number of effective Reentry Management Organizations throughout the Commonwealth that bring together government agencies, faith community, and

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[362] Union County Housing Authority, Pennsylvania. Justice Bridge Housing Program. *Housing Authority Reentry: Reducing the Risk of Recidivism through Housing Stability in Union County, Pennsylvania*: Report Prepared by Diana T. Myers and Associates, Inc. March, 2015. A copy of the report was submitted to the Joint State Government Commission by Ms. Leigh Howard, DMA President.
[363] Ibid.
[364] Ibid.
[365] Ibid.
[366] Ibid.

business representatives with criminal justice, mental health, housing and human service agencies to address reentry on the local level.

- Legislate reforms in criminal justice systems, including the revision of the "get tough" statutes and related policies to take into account the need for supervised release.
- Increase pre-release activities to facilitate obtaining and maintaining stable housing, including the following:
  - Encourage DOC and county jails to provide pre-release housing training that would include the application and appeal process for applying to PHAs and other subsidized housing providers;
  - Enhance collaboration between PBPP and local CoCs in order to optimize the use of funds available for reentry housing;
  - Facilitate access to public benefits at the county level immediately upon release.
- Make housing a key component of streamlined reentry. Facilitate the availability of various housing options to ex-offenders by:
  - Providing education to dispel myths about restrictions to public and Section 8 housing;
  - Providing incentives such as increased administrative fees for PHAs that flex their policies with regard to admission of individuals with criminal histories, including unification with families living in public housing and other assisted units;
  - Providing incentives (for example, rent vouchers or tax credits) to landlords who house formerly incarcerated or ex-offenders;
  - Combining housing with supportive services when necessary;
  - Modifying one-strike housing regulations so discretion is not used to target ex-offenders with minor offenses or offenses that occurred far in the past.
- Focus on a limited group of persons who demonstrate a history of unstable housing and/or are frequent users of public services including jails, emergency shelters, state hospitals, and community hospital emergency rooms.
- Increase DOC and county jail coordination with the Social Security Administration and employment initiatives.

MENTAL HEALTH
AND SUBSTANCE USE DISORDERS

Prevalence and Heightened Risks

A significant segment of people who end up homeless suffer from mental health problems or substance use disorders. They represent a majority among those defined as "chronically homeless" – those "who have either been continuously homeless for a year or more or have experienced at least four episodes of homelessness in the last three years."[367] According to various estimates, 20 to 25 percent of the homeless population in the United States suffers from some form of severe mental illness. The Substance Abuse and Mental Health Services Administration (SAMHSA) states that "in January 2014, one in five people experiencing homelessness had a serious mental illness, and a similar percentage had a chronic substance use disorder."[368] Exact estimates differ but are consistently high. A longitudinal study of single men and women admitted to New York shelters found that 51 percent had a lifetime diagnosis of DSM-IV Axis I disorder and 53 percent had a lifetime diagnosis of substance use disorder.[369] Among people experiencing chronic homelessness, approximately 30 percent suffer from a serious mental illness, and about two-thirds have a primary substance use disorder or other chronic health condition.[370]

High prevalence of homelessness among mentally ill people can be explained by a number of reasons. The publication on mental health and homelessness by the National Coalition for the Homeless points out two main factors that put mentally ill at an increased risk of homelessness compared to the general population: "Serious mental illnesses disrupt people's ability to carry out essential aspects of daily life, such as self-care and household management. Mental illnesses may prevent people from forming and maintaining stable relationships or cause people to misinterpret others' guidance and react irrationally. This often results in pushing away caregivers, family, and friends who may be the force keeping that person from becoming homeless."[371] Poor mental health may affect physical health, precluding people from taking necessary precautions against disease or seeking appropriate treatment. Some mentally ill individuals resort to self-medication using street drugs or alcohol, which exacerbates their condition. The dangerous combination of mental illness and stresses associated with it, substance abuse often co-occurring with it, and inferior

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[367] U.S. Department of Housing and Urban Development Office of Community Planning and Development. *The 2015 Annual Homeless Assessment report (AHAR) to Congress. Part 1: Point-in-Time Estimates of Homelessness*. Washington, D.C., November 2015, available at https:/www.hudexchange.info/resources/documents/2015-AHAR-Part -1. pdf (accessed January 12, 2016).

[368] SAMHSA. *Homelessness and Housing,* available at http://www.samhsa.gov/homelessness-housing (accessed January 12, 2015).

[369] Caton C.L. et al. "Risk Factors for Long-Term Homelessness: Findings from a Longitudinal Study of First-Time Homeless Single Adults." *American Journal of Public Health*. October 2005. Vol. 95. No. 10, available at http://www.ncbi.nlm.gov/pubmed/16131638 (accessed January 19, 2016).

[370] SAMHSA. *Homelessness and Housing,* available at http://www.samhsa.gov/homelessness-housing (accessed January 12, 2015).

[371] National Coalition for the Homeless. *Mental Health and Homelessness*. July 2009, available at http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf (accessed December 15, 2015).

physical health "makes it very difficult for people to obtain employment and residential stability."[372]

Mentally ill people on the streets have the quality of life that an advocacy organization founded in 2011, Mental Illness Policy Org., defines as "abysmal."[373] Many of them, suffering from untreated severe mental illness like schizophrenia or manic-depressive illness, forage through garbage cans and dumpsters for their food. They are even more likely than other homeless individuals to become victims of violence, sexual assault, and other crimes. The latter risks are even higher for women. A study that assessed three aspects of physical and sexual assault in the histories of episodically homeless, seriously mentally ill women - lifetime prevalence, severity, and co-occurrence - led to a distressing conclusion that "the life-time risk for violent victimization was so high (97%) as to amount to normative experiences for this population."[374] There is evidence that people who are homeless and suffering from a psychiatric illness "have a markedly elevated death rate from a variety of causes."[375] Impaired judgment makes them more likely victims of fatal accidents and freezing to death compared to other homeless individuals, who in general have a three times higher risk of death than the general population.

People who are homeless and have co-occurring mental health and substance use disorders often cycle through the criminal justice system, moving from the street, to the shelter, to jail or prison, and back. A SAMHSA branch specializing in this area identified several risk factors for increased criminal justice involvement faced by this population group, including criminalization of homelessness, the lack of appropriate housing, and high rates of trauma.[376] "The problem has gotten worse in recent years, according to mental health and criminal justice experts, as state and local governments have cut back on mental health services for financial reasons."[377] Once incarcerated, mentally ill people who are homeless spend more time in prison or jail than individuals with housing, and they serve their maximum terms more often because individuals lacking housing are commonly not eligible for parole or probation. Telling numbers illustrating this trend were revealed by a Pennsylvania study performed by Diana Myers and Associates, Inc., for the Montgomery County Office of Behavioral Health/Developmental Disabilities. The consultants analyzed data on persons with mental illness in the Montgomery County Correctional Facility. They found that "individuals who identified themselves as homeless spent on the average 246 more days in prison than those who were housed. Homeless individuals also experienced

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[372] Ibid.

[373] Mental Illness Policy Org. *250,000 Mentally Ill Are Homeless. The Number Is Increasing*, available at http://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html (accessed May 28, 2015).

[374] Goodman, Lisa A., Dutton, Mary Ann and Maxine Harris. "Episodically Homeless Women with Serious Mental Illness: Prevalence of Physical and Sexual Assault." *American Journal of Orthopsychiatry*. 1995. Vol. 65. No. 4 (October), available at http://www.ncbi.nlm.nih.gov/pubmed/8561181(accessed February 2, 2016).

[375] Mental Illness Policy Org. *250,000 Mentally Ill Are Homeless. The Number Is Increasing*, available at http://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html (accessed May 28, 2015).

[376] "The Intersection of Co-occurring Disorders, Homelessness, and the Criminal Justice System." *News & Views.* August 2008. Vol. 1. No. 2, available at www.floridatac.com/files/document/CHAB%20CJ%20newsletter.doc (accessed February 2, 2016).

[377] Santos, Fernanda and Erica Goode. "Police Confront Rising Numbers of Mentally Ill Suspects." *The New York Times*. April 1, 2014, available at http://www.newyorktimes.com/2014/04/02/us/police-shootings-of-mentally-ill-suspects-are-on-the-upswing (accessed April 2, 2014).

higher numbers of commitments, percentage of max outs, and probation/parole violations."[378] Differences were significant: "72% of homeless individuals have served their maximum terms compared to only 14% of those with housing."[379] A number of homeless persons with mental illness who are "frequent users of the justice system" on the average spent over 1,100 days in jail, "more than *twice* the number of days than the average inmate."[380] This is not only devastating to those individuals but also costly for the county. Realizing this, Montgomery County developed a housing program in order to provide housing stability for individuals with mental illness for the purpose of reducing justice involvement and recidivism. Pennsylvania counties that do not have similar programs yet should consider implementing one.

When a person suffering from a mental illness is released from prison or jail, history of incarceration often becomes an additional obstacle to secure housing. Clinical interventions at various points may interrupt this vicious circle.[381] Better police training in recognizing mental illness and proper procedures, specialized judicial treatment for mentally ill homeless offenders, adequate access to treatment at correctional facilities and carefully prepared reentry, with a special emphasis on housing and continued treatment, may also be helpful.

Homelessness among those suffering from severe mental illness is also associated with fewer psychiatric hospital beds. A variety of factors contributed to a radical decrease in the number of public psychiatric beds: from changes in psychiatry, to the availability of new drugs, to the emphasis on patients' civil rights and new public policies. As a result, over the past few decades, the number of public psychiatric beds has decreased dramatically: according to the Treatment Advocacy Center, "95 percent of the beds available in 1955 were no longer available in 2005."[382] While there are significant advantages in providing treatment to mentally ill people outside of the hospital setting, some researchers believe that the radical decrease in available psychiatric beds, without adequate treatment and support programs in the community, has also led to unintended negative consequences. "The consequences of the severe shortage of public psychiatric beds include increased homelessness; the incarceration of mentally ill individuals in jails and prisons; emergency rooms being overrun with patients waiting for a psychiatric bed; and an increase in violent behavior, including homicides, in communities across the nation."[383] An extensive study based on the data from 81 U.S. cities examined the relationships between psychiatric hospital capacity, homelessness, and crime and arrest rates. The author found direct correlations, and more specifically, he concluded that "hospital capacity affects crime and arrest rates in part, through its

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[378] Diana T. Myers and Associates, Inc. *Report on Individuals with Justice Involvement and Mental Illness for the Montgomery County Office of Behavioral Health/Developmental Disabilities.* January 2010. P. 3. A copy of the report was made available to the Joint State Government Commission by Ms. Leigh Howard, DMA President, on September 18, 2015.
[379] Ibid.
[380] Ibid.
[381] "The Intersection of Co-occurring Disorders, Homelessness, and the Criminal Justice System." *News & Views.* August 2008. Vol. 1. No. 2, available at www.floridatac.com/files/document/CHAB%20CJ%20newsletter.doc (accessed February 2, 2016).
[382] Fuller Torrey, E. et al. *The Shortage of Public Hospital Beds for Mentally Ill Persons: A Report of the Treatment Advocacy Center*, available at http://www.treatmentadvocacycenter.org/storage/documents/the _shortage_of_publichospital_beds.pdf (accessed January 13, 2016).
[383] Ibid.

impact on homelessness."[384] There is no consensus among researchers on the causal relationship between mental hospital closures and increased number of mentally ill homeless people. It is undeniable, however, that individuals suffering from serious mental illness are at a much higher risk of becoming homelessness, often chronically homeless, than the general population. Studies from Massachusetts, Ohio, and New York confirm that over one-third of patients discharged from state mental hospitals become homeless within six months.[385]

Most psychiatrists and mental health advocates believe that "deinstitutionalization" is the right approach; however, it is critical that the elimination of hospital beds go hand-in-hand with the development of community-based services, with the utilization of programs like assisted outpatient treatment (AOT), and most importantly, with making sure that people suffering from mental illness have a place to live. Housing stability has been proven a key to long-term recovery.

Barriers to Housing

Securing housing for individuals with mental illness may present additional challenges compared to the general population. Along with the rest of those experiencing homelessness or at-risk of homelessness, people suffering from mental illness are negatively affected by long waiting lists for public housing; by the insufficient number of vouchers to meet the need; by the lack of affordable private housing that can be found on limited income such as SSI; by the lack of funding for security deposits and utilities, especially if a person is already in arrears; and by the lack of jobs that pay a living wage for individuals without college degrees to maintain their housing. With persons who are mentally ill, there are additional concerns to consider. Private housing is often inappropriate as people with mental illness or developmental disabilities often become victimized and available housing is usually in unsafe neighborhoods. Some public shelter programs are reluctant to take people with mental illness, especially if the mental illness is untreated, and on the other hand, some people with mental illness are reluctant to go to public shelters for a variety of reasons. Lack of crisis housing services has a major impact on the mentally ill. If consumers suffering from a mental illness are unable to afford their medications and their illness remains untreated, their behaviors escalate, and they lose their housing. Many clients who have a mental illness or developmental disability, especially youth and young adults, need life skills instruction and information about budgeting. [386]

Permanent Supportive Housing as an Effective Approach

Experts and providers agree that housing alone is not enough, that support services must be provided along with housing. Permanent supportive housing (PSH) – permanent housing coupled with supportive services as needed – has been increasingly recognized as an effective

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[384] Markowitz, F. E. "Psychiatric Hospital Capacity, Homelessness, and Crime and Arrest Rates." *Criminology*. Vol. 44. No. 1. February 2006 available at
http://www.altmetric.com/details.php?domain=onlinelibrary.wiley.com&doi=10.1111/j.1745-9125.2006.00042.x (accessed January 13, 2016).

[385] Mental Illness Policy Org. *250,000 Mentally Ill Are Homeless. The Number Is Increasing*, available at http://mentalillnesspolicy.org/consequences/homeless-mentally-ill.html (accessed May 28, 2015).

[386] Some of these concerns were shared with the advisory committee by Ms. Sheila Bressler, Berks County CASSP Coordinator, Berks County MH/DD Program, in a personal e-mail to the Joint State Government Commission received on October 14, 2015.

strategy to assist people suffering from mental illness and experiencing homelessness. Some counties in the Commonwealth have seen it from their own experience. Berks County, in particular, has seen success with several practices and programs that combine housing, support, and treatment services, such as Shelter + Care, transitional housing and permanent supportive housing through HUD funding, and Project Transition funded by Medical Assistance (HealthChoices). Berks County is a good example of effective communication and collaboration between county personnel and the CoC agencies (Mental Health/Developmental Disabilities, County Redevelopment authorities, Berks Coalition to End Homelessness, and others).[387]

The term "permanent supported housing" (or "permanent supportive housing") does not imply one specific program model, but rather a number of program types and housing arrangements. Permanent supported housing is broadly defined as "subsidized housing matched with accompanying supportive services."[388] "Underlying the permanent supported housing approach is the determination that permanent housing, with the residential stability it provides, is essential to the success of clients in all dimensions of their lives."[389] In contrast to the older residential "linear continuum model" which views substance abuse, mental health disorder or other serious difficulties as obstacles that need to be addressed before a person can be deemed "housing ready," permanent supported housing programs, instead, view "residential stability as crucial, even primary, in order that clients be able to benefit from the treatment services. In fact, a foremost emphasis in permanent supported housing programs is helping persons become good tenants who can remain stably housed, as opposed to requiring *a priori* compliance with a treatment regime."[390] Permanent supportive housing projects use a Housing First approach, in which housing is offered to people experiencing homelessness without preconditions such as sobriety, mental health treatment, or participation in services.[391] HUD requires that CoCs prioritize permanent supportive housing for homeless individuals and families with the longest history of homelessness and with the most severe service needs, which means those with the history of high utilization of crisis services, including, but not limited to, emergency rooms, jails, and psychiatric facilities, or those who have significant health or behavioral challenges or functional impairments which require a significant level of support in order to maintain permanent housing.[392] Providing this category of clients with permanent supportive housing will not only satisfy their dire need for residential stability and services but also, according to emerging research, bring most likely cost savings to taxpayers as utilization of acute care services such emergency room visits, medical or psychiatric hospitalizations, detoxification services, and incarceration are extremely expensive.

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[387] Ibid.
[388] Culhane, Dennis P. and Thomas Byrne. *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration*, March 2010, available at http://works.bepress.com/dennis_culhane/94 (accessed March 19, 2015).
[389] Ibid.
[390] Ibid.
[391] United States Department of Housing and Urban development, Office of Community Planning and Development *Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status.* July 2014, available at http://portal.hud.gov/hudprtal/documents/huddoc?id=14-12cpdn.pdf (accessed January 29, 2016).
[392] Ibid.

As the elimination of chronic homelessness has been perceived as a primary goal at the federal level, there has been more research done regarding this group of people, many of whom suffer from mental health and/or substance use disorders. Eminent researchers recommend expanding the availability of permanent supported housing for chronically homeless persons and establishing practices that would make appropriate, needed and effective Medicaid services available for highly selected and targeted populations. Dr. Dennis P. Culhane and Dr. Thomas Byrne from the University of Pennsylvania prepared a White Paper in which they reviewed "evidence that provides compelling justification for permanent supported housing as a strategy that can realistically end chronic homelessness and generate substantial cost reductions (at the individual client level) and offsets (at an identified population level), if not cost-savings."[393] The researchers contend that Medicaid, the VA and other public payers of health services, "by collaborating in providing the supportive services for specifically targeted, high need, high cost individuals, can reduce the overall costs and burden of this population by pairing services with the housing necessary to their medical recovery."[394] In light of recent changes in federal regulations, several states, including Pennsylvania, are investigating the possibility of using Medicaid expansion to cover a wider range of supportive services to homeless people suffering from a mental illness and/or substance use disorder. In June 2015, the Centers for Medicare and Medicaid Services (CMS) informed Medicaid offices around the country that Medicaid funds can be used to assist chronically homeless people and other individuals with long-term disabilities to find and maintain permanent housing. Advocates for the homeless have welcomed the CMS policy statement and perceive it as an excellent opportunity to enhance services to this population.

Permanent supportive housing has been proven effective at promoting residential stability among people with mental illness and/or substance use disorder. When provided with the necessary supports along with housing assistance, a significant majority of those individuals and families are able to retain housing for extended periods of time. For example, a rigorous, controlled study that examined the effectiveness of the Pathways to Housing, a supportive housing program in New York City that provides immediate access to independent scatter-site apartments for individuals with psychiatric disabilities who are homeless and living on the street, found that over a five-year period, 88 percent of the Pathways' tenants remained housed, whereas only 47 percent of the residents of the city's linear residential treatment system were able to do the same.[395] Other evaluations have also found "housing retention rates of more than 80 percent of those placed in permanent supported housing. Moreover, tenants report satisfaction with their housing arrangements."[396]

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[393] Culhane, Dennis P. and Thomas Byrne. *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration*, March 2010, available at http://works.bepress.com/dennis_culhane/94 (accessed March 19, 2015).
[394] Ibid.
[395] Tsemberis, S. and R. F. Eisenberg. "Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities." *Psychiatric Services*. 2000. Vol. 51. No. 4 (April), available at http://www.ncbi.nlm.nih.gov/pubmed/10737824 (accessed January 29, 2016).
[396] Culhane, Dennis P. and Thomas Byrne. *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration*, March 2010, available at http://works.bepress.com/dennis_culhane/94 (accessed March 19, 2015).

Cost Factor

Permanent supportive housing programs require considerable investments, to fund both housing subsidies and support services. At the same time, their successful implementation results in "demonstrated reductions in inpatient hospitalizations, emergency room visits and utilization of other expensive acute care services," which allows leading experts to argue that "the costs of supported housing for chronically homeless persons can be offset, either partially or totally, by acute care service reductions in this targeted population."[397]

Substantial cost reductions in expensive health care and criminal justice system interventions have been demonstrated in studies dedicated to both mentally ill individuals and those with substance use disorders. Pioneering studies were conducted by Dennis Culhane and his colleagues in New York City and later, Philadelphia. Their analysis of the impact of public investment in supportive housing for homeless persons with severe mental illness in New York City in the 1990s revealed that placement was associated with a reduction in services use of $16,281 per housing unit per year, for a net cost of $995 per unit per year over the first two years.[398] A similar study in Philadelphia also indicated that "supportive housing models for people with serious mental illness who experience chronic homelessness may be associated with substantial cost offsets, because the use of acute care services diminishes in an environment of housing stability and access to ongoing support services."[399] The authors noted that "because persons with substance use issues and no recent history of mental health treatment used relatively fewer and less costly services, cost neutrality for these persons may require less service-intensive programs and smaller subsidies."[400] These findings underscore the importance of tailoring programs to participants' needs and offering varying levels of support.

A 2009 study focused on chronically homeless individuals with severe alcohol problems in Seattle, Washington, measured use and cost of services such as shelter and sobering center use, jail bookings, days incarcerated, hospital-based medical services, publicly funded alcohol and drug detoxification and treatment, emergency medical services, and Medicaid-funded services for Housing First participants in comparison with a control group. The authors established that a Housing First intervention led to a decrease in median monthly costs after six and twelve months in housing, with the total cost reduction of 53 percent for housed participants relative to wait-list controls and with total cost offsets for Housing First participants relative to controls averaging almost $2,500 per person per month after accounting for housing program costs.[401]

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[397] Ibid.
[398] Culhane, Dennis P., Metraux, Stephen and Trevor Hadley. "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing." *Housing Policy Debate.* Vol. 13. No. 1, available at http://repository.upenn.edu/spp_papers/65 (accessed December 5, 2014).
[399] Poulin, Stephen R., Maguire, Marcella, Metraux, Stephen and Dennis P. Culhane. "Service Use and Costs for Persons Experiencing Chronic Homelessness in Philadelphia: A Population-Based Study." *Psychiatric Services*. 2010. Vol. 61. No. 11 (November), available at http://works.bepress.com/dennis_culhane/99 (accessed December 5, 2014).
[400] Ibid.
[401] Larimer, Mary E. et al. "Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *JAMA*. April 1, 2009. Vol. 301. No. 13, available at http://jama.jamanetwork.com/article.aspx?articleid=183666 (accessed February 1, 2016).

A two-year study of mental health service utilization and costs associated with the Housing First program in San Diego County, California, Reaching Out and Engaging to Achieve Consumer Health (REACH), indicated that participation in this program for persons with serious mental illness "was associated with substantial increases in outpatient services as well as cost offsets in inpatient and emergency services and criminal justice system services," with the result that "the net cost of services, $417 over two years, was substantially lower than the total cost of services ($20,241)."[402]

An efficient system of housing persons with mental illness created in San Antonio, Texas, over the four-year period, "has saved the city an average of $10 million a year in emergency room and jail visits, according to the Center for Health Care Services, a non-profit mental health system that services San Antonio and Bexar County and oversees the network."[403] In San Antonio, homeless people picked up on the street are taken to the Restoration Center that offers medical treatment, psychological analysis, Wings of Sobriety, and information on apartments – all under one roof.[404] San Antonio Police are trained to bring homeless individuals showing signs of mental instability directly to the center where they get prompt help.

Based on their own research and a review of multiple studies, leading experts in the field Dennis P. Culhane and Thomas Byrne strongly assert: "The collective evidence from academic research as well as practice-based studies demonstrates that placing selected, heaviest service using, and therefore most costly, chronically homeless individuals in permanent housing can yield cost savings, as service reductions more than offset housing costs."[405] Contemplating practical implementation, the authors emphasize two important points: "First, to the extent that cost neutrality is required, there must be a reliable mechanism to ensure that only those who are eligible and will benefit most from supported housing are placed in such programs. Second, it is of great importance to provide housing and services to persons in accordance with their needs. The most extensive packages of housing and services should only be offered to persons with the highest levels of service utilization and the greatest service needs."[406] Providing permanent supportive housing to homeless individuals with less extensive and costly services needs can still lead to net savings or relative cost neutrality in the aggregate, especially with the use of new service models such as critical time intervention, which is intensive but time limited and thus, less costly.[407]

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[402] Gilmer, T.P., Manning, W.G. and S.L. Ettner. "A Cost Analysis of San Diego County's REACH Program for Homeless Persons." *Psychiatric Services*. 2009. Vol. 60. No. 4 (April). doi: 10.1176/appi.ps 60.4.445, available at http://www.ncbi.nlm.nih.gov/pubmed/19339318 (accessed February 1, 2016).

[403] Jervis, Rick. "Mental Disorders Keep Thousands of Homeless on Streets." *USA Today*. August 27, 2014, available at http://www.usatoday.com/story/news/nation/2014/08/27/mental-health-homeless-series/14255283/ (accessed August 29, 2014).

[404] Ibid.

[405] Culhane, Dennis P. and Thomas Byrne. *Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration*, March 2010, available at http://works.bepress.com/dennis_culhane/94 (accessed March 19, 2015).

[406] Ibid.

[407] Ibid.

Key Strategies for Practitioners

A recent literature review offered practitioners a framework and strategies for helping homeless individuals with co-occurring disorders (CODs) of severe mental illness and substance use disorder. The article listed four key components:

1) ensuring an effective transition for individuals with CODs from an institution (such as a hospital, foster care, prison, or residential program) into the community, a particularly important component for clients who were previously homeless, impoverished, or at risk of homelessness;
2) increasing the resources of homeless individuals with CODs by helping them apply for government entitlements or supported employment;
3) linking homeless individuals to supportive housing, including housing first options as opposed to only treatment first options, and being flexible in meeting their housing needs; and
4) engaging homeless individuals in COD treatment, incorporating modified assertive community treatment, motivational interviewing, cognitive-behavioral therapy, contingency management, and COD specialized self-help groups. [408]

SOAR

For people with mental illness or substance use disorder who have limited or no ability to work, the first and critical step to avoid homelessness is to secure SSI/SSDI benefits. A program that has been very successful in helping them to reach this goal, both in Pennsylvania and nationwide, is SOAR – SAMHSA's SSI/SSDI Outreach, Access, and Recovery Program. Based on SAMHSA's assertion that "to recover, people need a safe stable place to live," SOAR seeks to end homelessness by increasing access to SSI/SSDI income supports while also encouraging employment when feasible. SOAR is "a national program designed to increase access to disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or co-occurring substance use disorder."[409] SAMHSA SOAR Technical Assistance Center offers guidelines on the SOAR process and specifies best practices for assisting SSI/SSDI applicants experiencing homelessness. The SOAR project emphasizes close collaboration with the SSA and the Disability Determination Services (DDS).

The SOAR model is designed to address many of the challenges that SSA and DDS face when serving people who are experiencing homelessness. SOAR providers

- maintain ongoing communication with the applicant;
- serve as the applicant's appointed representative;
- provide transportation and accompany the applicant to appointments;

[408] Sun, An-Pyng. "Helping Homeless Individuals with Co-occurring Disorders: The Four Components." Social Work. 2012. Vol. 57. No. 1 (January), available at https://www.researchgate.net/publication/228437832_Helping_Homeless_Individuals_With_Co-occuring_Disorders_The_Four_Components (accessed January 29, 2016).
[409] *SOAR Works*!, available at http://soarworks.prainc.com (accessed September 11, 2015).

- complete the online Social Security Disability application and Disability Report;
- provide complete documentation and signed paperwork, medical records, and a detailed medical summary report; and
- provide timely follow-up to SSA and DDS's requests for additional information.

All of this helps shorten the application processing time; focusing on "getting it right the first time" avoids re-applications and appeals, which put additional burdens on the system.[410] From the applicant's perspective, it provides him or her with timely access to essential benefits, which he or she might otherwise be unable to receive. When successful (and it has proven so in many cases nationwide), "SOAR can be instrumental in ending the cycle of homelessness by establishing a consistent source of income and health insurance with which the claimant can secure housing, treatment, and other supports."[411]

In the Commonwealth, SOAR has been effectively used since 2007. The first SOAR project in Pennsylvania was developed and implemented in the City of Philadelphia by the Homeless Advocacy Project (HAP), which remains one of the leading SOAR providers. The history of HAP's SOAR project can be considered a model for success. Since filing its first SSI disability application under HAP's SOAR project, HAP has successfully represented more than 1,600 disabled individuals, either homeless or at-risk of homelessness, on their claims for federal SSI benefits. Remarkably, HAP maintains a 98 percent success rate with an average processing time less of than fifty days from application filing. This contrasts sharply to claims filed without the assistance of HAP, which are denied a majority of the time and can take up to two years from application until administrative hearing decision with a reduced likelihood of success.[412]

One way for clients to get engaged with HAP's SOAR project is through legal clinics that HAP holds monthly or bi-monthly at twenty-five different shelters, transitional housing programs, soup kitchens, and programs serving veterans throughout Philadelphia. Another way is referral by hospitals, outreach teams, shelter and behavioral health system case managers, and other agencies. HAP's Managing Attorney proudly highlights an important aspect of their work: "HAP's SOAR clients are sleeping on the streets, receiving inpatient psychiatric treatment, spending time in overnight cafes, or sleeping in shelters, safe havens, recovery houses and other emergency housing sites. HAP staff attorneys are accustomed to meeting clients where they eat, sleep, receive services or otherwise spend their time."[413]

Receiving SSI/SSDI benefits dramatically improves the claimants' financial status and opens up opportunities to procure housing. As HAP points out, upon approval for SSI, participants in their SOAR Project "secure more dependable federally funded medical insurance coverage and find themselves eligible for a greater variety of housing options ranging from supportive housing

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[410] Lupfer, Kristin. *Collaboration with SSA and DDS: Something for Everyone.* SAMHSA, April 2014, available at http://soarworks.prainc.com/sites/soarworks.prainc.com/files/SSA_DDS_Collaboration041114.pdf (accessed January 14, 2016.

[411] Ibid.

[412] Information provided to the advisory committee by Ms. Michele Levy, Managing Attorney of the Homeless Advocacy Project, in a personal e-mail to the Joint State Government Commission received on January 12, 2016.

[413] Levy, Michele. Personal e-mail to the Joint State Government Commission received on January 12, 2016.

programs to rented rooms to moving in with family members willing to accept a now financially stable relative."[414]

HAP initiated its SOAR Project in conjunction with Philadelphia's Office of Supportive Housing (OSH). As the project has been so successful, HAP subsequently formed new partnerships with other agencies which enabled it to expand SOAR's scope in Philadelphia. Some of the most notable projects are HAP's TANF-SOAR Project, run in partnership with Pennsylvania Department of Human Services (DHS), and "Peer AHEAD," a result of partnering with the Mental Health Association of Southeastern Pennsylvania (MHA), funded by SAMHSA. The former opened the SOAR Project to potentially disabled parents receiving TANF benefits in excess of five years who had, at some time in their recent past, been prescribed a serious psychiatric medication. Many of these families had a history of homelessness and were at risk of becoming homeless again. Between January 2009 and May 2012, "HAP's TANF-SOAR Project enabled 602 families – headed by persons too psychiatrically impaired to work – to maintain stability and avoid homelessness through significantly increased stable income."[415] "Peer AHEAD," in three years of its existence, secured SSI benefits for approximately fifty chronically street homeless men and women who had been resistant to shelter and suffered from serious and persistent mental illness.

Another important SOAR project, pursued in partnership with the Philadelphia Department of Human Services, is targeted to disabled dependent and delinquent youth aging out of DHS care, specifically from residential treatment facilities, so that benefits can be activated immediately upon discharge and homelessness averted.[416] This is an important preventive measure designed to protect an extremely fragile population group.

HAP also participates in a collaborative Support Services for Veteran Families (SSVF) grant funded by the VA. Through SOAR, HAP assists homeless individuals eligible for SSVF benefits in obtaining SSI/SSDI.[417]

In partnership with Pennsylvania's Department of Drug and Alcohol Programs (DDAP), HAP used additional SAMHSA funding to enable more than 120 chronically homeless individuals in substance use recovery programs to secure SSI through SOAR.[418]

Homeless 2 Home (H2H-PA)

After SAMHSA endorsed permanent supportive housing as an evidence-based best practice for chronically homeless persons suffering from a mental health disorder, it has been offering grants to provide critically needed service resources that can be paired with existing local infrastructure. Pennsylvania successfully applied for one of such grants called Cooperative Agreements to Benefit Homeless Individuals-States (CABHI-States). In 2013, DDAP was awarded a three-year CABHI-States grant in the amount of $2,135,454, and in 2014, it received a

[414] Ibid.
[415] Information provided to the advisory committee by Ms. Michele Levy, Managing Attorney of the Homeless Advocacy Project, in a personal e-mail to the Joint State Government Commission received on January 12, 2016.
[416] Ibid.
[417] Ibid.
[418] Ibid.

two-year CABHI-States Supplemental grant to benefit veterans in the amount of $998,702. The main CABHI-States grant runs from September 30, 2013 through September 29, 2016, and the supplement is in operation from September 30, 2014 through September 29, 2016.[419] These grants allow DDAP to finance the Homeless 2 Home Behavioral Health Project for Pennsylvania (H2H-PA).

H2H-PA can serve an individual or family residing in a place not meant for human habitation for at least one year or having experienced homelessness four times in the last three years if the head of household has a diagnosable substance use disorder, serious mental illness, developmental disability, PTSD, cognitive impairments or chronic physical illness or disability, including the co-occurrence of two or more of those conditions. Additionally, it can serve a person who resides in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital or other similar facility, and has resided there for fewer than ninety days; such a person shall also be considered chronically homeless for the purposes of this program if he or she met all of the requirements described above prior to entering that facility.[420] The latter provision is very important as the first hours and days after release from a facility like those mentioned above constitute a high-risk period when relapse is most likely and lack of immediately available housing arrangements may become a critical factor.

The program operates in Philadelphia and is based on the partnership of the Mental Health Association of Southeastern Pennsylvania, the Homeless Advocacy Project, The City of Philadelphia, Temple University, and DDAP. DDAP is the Single State Authority (SSA) and provides overall coordination for the project, including quarterly progress reporting to SAMHSA. The MHASP provides outreach and case management staffing for the project, including peer specialists and peer navigators, training managers, nurses, representative payees, and other administrators. HAP offers SSI/SDI SOAR services to participants. The City of Philadelphia Housing Authority is responsible for the placements of participants who successfully complete programming into its stock of permanent supporting housing through housing vouchers. Temple University collects, evaluates and reports project data.[421] The supplemental grant allowed DDAP to expand the H2H-PA project to the same population demographic in Bucks and Delaware counties, with adjustments in services dictated by regional differences.

The H2H-PA project is designed to connect individuals experiencing chronic homelessness and co-occurring mental health and substance use disorders to mainstream benefits and affordable and stable housing in the community. To achieve this goal, the program relies on three evidence-based practices: SOAR, critical time intervention (CTI), and peer support.

Critical time intervention is conducted during the critical time of transition from "institutional" to community-based life. This time-limited case management model ensures that the client is promptly connected with the necessary services offered in the community. It involves providing temporary support to the individual as he or she rebuilds community living skills and develops a stable network of community assets that will support long-term recovery and

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[419] Information provided to the Joint State Government Commission and the advisory committee by Mr. Steven Seitchik, Director of the Division of Treatment of the Pennsylvania Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, in his presentation to the subcommittee on July 1, 2015.
[420] Ibid.
[421] Ibid.

community reintegration. The timing of intervention and the relationship between the caseworker and the service recipient are key ingredients. Originally, CTI was introduced to prevent chronic homelessness and other negative outcomes for people transitioning from homeless shelters to community-based housing programs. Since then, it has been adapted for community reentry from prisons, psychiatric hospitals, and other institutional and social settings. CTI is an empirically supported model listed in the SAMHSA National Registry of Evidence-Based Programs and Practices. It is being applied and tested in multiple sites in the United States, the United Kingdom and other countries. The growing volume of studies have demonstrated that CTI is effective in producing an enduring reduction in the risk of homelessness for individuals with severe mental illness upon discharge from inpatient psychiatric treatment facilities. The results of a recent randomized trial of "a carefully specified intervention designed to produce a lasting reduction in the risk of recurrent homelessness among persons with severe mental illness following discharge from inpatient psychiatric treatment" supported the findings of prior studies suggesting that "CTI is an effective strategy for assisting formerly homeless individuals during the period of transition from institutional to community living."[422] The researchers observed that "the magnitude of the protective effect was substantial, ranging from a five-fold reduction in homelessness risk in the intent-to-treat analysis to a tenfold reduction in homelessness risk in the as-treated analysis."[423] The authors were able to show through randomized trials that "CTI had a substantial, lasting impact on reducing the risk of recurrent homelessness in persons with severe mental illness following re-entry to community living."[424]

One group that can benefit from CTI is people (especially young people) with substance abuse disorders who are exiting detoxification centers or inpatient treatment and who are confronting homelessness. This group includes young adults with opioid addiction, who have been lately contributing to the homeless population and homeless deaths. CTI could be a vital resource for helping these young adults in their recovery and in avoiding homelessness.

Peer-delivered outreach and engagement is another evidence-based model of care for assisting individuals with their recovery from mental health and substance use disorders. Peer engagement features a relationship where the peer support specialist assists the participant using particular expertise that includes but is not limited to his or her own experience in recovery. The personal recovery experience of staff in itself offers hope that everyone can recover from their condition. Instead of relying on this factor alone, all peer support specialists undergo special training. Peer navigators conduct outreach; for several months, they work with program participants to help them understand the principle of self-directed care, assist them with linkage to services, and act as liaison between the participant and the service network.[425]

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[422] Herman, D. et al. "A Randomized Trial of Critical Time Intervention to Prevent Homelessness in Persons with Severe Mental Illness Following Institutional Discharge." *Psychiatric Services*. 2011. Vol. 62. No. 7 (July), available at http://www.ncbi.nlm.nih.gov/pubmed/21724782 (accessed January 28, 2016).
[423] Ibid.
[424] Ibid.
[425] Information provided to the Joint State Government Commission by Ms. June Cairns, Vice President of Operations of the Mental Health Association of Southeastern Pennsylvania, in a personal e-mail received on January 20, 2016.

Current experience with the CABHI program has allowed DDAP to identify crucial lessons and best practices such as the importance of Critical Time Intervention (CTI) as an appropriate engagement/ treatment strategy. Intergovernmental and inter-organizational coordination and collaboration are critical for the holistic integration of comprehensive services to participants as homeless assistance to this category of clients requires the coordination of many types of social services: physical healthcare, food assistance, benefits navigation, mental health and/or substance use treatment, peer support, education and workforce development. Program supervisors also highlight the importance of community integration after institutional treatment and making workforce development an integral component of any homelessness assistance program.[426]

People who suffered from substance use disorders themselves sometimes start successfully as volunteers at recovery centers. A program of the Southeast Council of Pennsylvania in Philadelphia was one of the first five organizations in the nation to receive accreditation from the Council on Accreditation of Peer Recovery Support Services (CAPRSS), the only accrediting body in the United States for recovery community organizations and other programs offering addiction peer recovery support services.[427]

Examples of Successful Supportive Housing Programs for the Mentally Ill in Pennsylvania

The Lodge

Successful supportive housing programs for the mentally ill include the Mental Health Recovery Lodge of Northampton County (The Lodge). When Allentown State Hospital closed at the end of 2010, the need for mental health services in Lehigh Valley increased greatly. A national human services nonprofit company, Resources for Human Development, Inc. (RHD) contracted with Northampton County to provide a supportive housing program for adults with mental illness. The Lodge secured rental properties within walking distance to its main building. It offers supported housing, gainful employment opportunities at Café the Lodge, and an array of recreational and education programs. The Lodge supports its members in "establishing independent living arrangements, a productive and meaningful existence, and a wholesome lifestyle."[428]

A similar successful supportive housing program for people with psychiatric disabilities operates in Erie County. It uses the nationally recognized model of the Fairweather Lodge, which focuses upon peer governance, peer support and empowerment. Partners in the program include Stairways Behavioral Health, Erie Housing Options Team, Erie County Department of Human Services, and the Erie Housing Authority. The Fairweather Lodge is a research-driven recovery-oriented housing model for persons with mental illness. The model consists of shared housing and shared employment; "its goal is to provide emotional support, a place to live, and employment for

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[426] Information provided to the Joint State Government Commission and the advisory committee by Mr. Steven Seitchik, Director of the Division of Treatment of the Pennsylvania Department of Drug and Alcohol Programs, Bureau of Treatment, Prevention and Intervention, in his presentation to the subcommittee on July 1, 2015.

[427] *Congratulations to the First Five Organizations to Receive CAPRSS Accreditation!*, available at http://www.facesandvoicesofrecovery.org/blog/2014/02/congratulations-first-five-organizations-receive-caprss-accreditation (accessed February 3, 2016).

[428] *The Lodge*, available at http://www.thelodge-rhd.org/about.html (accessed December 1, 2015).

its members."[429] The program was established in California in 1963 as a result of extensive experimental research, and it was named after its founder, Dr. George Fairweather. Dr. Fairweather's research indicated that people with serious mental illness are less likely to return to the hospital when they live and work together as a group, rather than live and work individually.[430] People who benefit most from the program are individuals with mental illness who are active members of society and wish to live independently but are unable to afford rent, food, transportation, and utilities on their own but could do so with the help of house mates.[431] Stairways Behavioral Health, the company that operates the Lodge in Erie and is designated by the Commonwealth of Pennsylvania to train other counties in establishing Fairweather Lodge programs in their communities, lists the following benefits of living in a Fairweather Lodge:

- The Lodge provides very affordable group living while respecting one's personal freedom.
- The Lodge creates a supportive environment in which residents live, grow and learn from others.
- The Lodge encourages residents to take part in healthy, decision-making processes.
- The Lodge offers support at home and on the job as members live and work together.
- The Lodge ensures members receive adequate mental health services including medication.
- The Lodge enhances members' employability by developing social and work-related skills.[432]

Dr. Fairweather's approach, with its emphasis on shared living and shared employment, may deserve additional attention in light of recent research of other housing and treatment interventions targeted to homeless people with mental illness. In 2015, an extensive study conducted in four Canadian cities examined the impact of scattered-site housing using rent supplements combined with off-site intensive case management (ICM). The findings indicated that "scattered site housing with ICM services compared with usual access to existing housing and community services resulted in increased housing stability over 24 months, but did not improve generic quality of life."[433]

LHOTs

The Fairweather Lodge in Erie County was spearheaded by the Erie County Housing Option Team. Local Housing Options Teams (LHOTs) appeared in the early 2000s. LHOTs are "coalitions that bring together the key stakeholders on the county or multi-county level in order to identify local housing needs for people with disabilities; to expand housing options; and to seek

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[429] Pennsylvania Housing Choices. *Fairweather Lodge*, available at http://www.pahousingchoices.org/housing-options/fairweather-lodge/ (accessed February 9, 2016).
[430] Ibid.
[431] Stairways Behavioral Health. *Fairweather Lodge*, available at http://www.stairwaysbh.org/programs_for_adults/skills-based_programs/fairweather_lodge/ (accessed February 9, 2016).
[432] Ibid.
[433] Stergiopoulos. Vicky et al. "Effect of Scattered-Site Housing Using Rent Subsidies and Intensive Care Management on Housing Stability Among Homeless Adults With Mental Illness." *JAMA*. March 3. 2015. Vol. 313. No. 9, available at http://jama.jamanetwork.com/article.aspx?articleid=2174029 (accessed February 1, 2016).

long-term solutions to the housing needs of people with disabilities."[434] Pennsylvania's Office of Mental Health and Substance Abuse Services (OMHSAS) offers technical assistance and training to the county offices through its staff and through a private consultant that specializes in planning and developing housing for people with disabilities. At present, LHOTs or other local housing coalitions exist in many Pennsylvania counties.

While LHOTs vary in their mission, representation, and priorities dependent on the county or counties involved, their main purpose is to bring together the stakeholders in their community to identify the housing needs of people with disabilities and to take action to meet their needs. LHOTs engage in networking among local agencies and in landlord outreach, conduct needs assessments, develop housing strategies, apply for supportive housing grants, and create partnerships to address problems. They plan and finance specific housing programs or projects like the Lodge in Erie County; Concepts for Housing With Care in Dauphin County; and Shelter Plus Care Program in Clearfield, Jefferson, Cameron, Elk and McKean Counties. LHOTs have demonstrated how successful collaboration on the local level can be in meeting housing and other needs of people with mental health and developmental disabilities.

<u>ACT</u>

Individuals with serious mental illness are believed to benefit from Assertive Community Treatment (ACT), a team-based model of providing comprehensive treatment and support to those who have not been helped by other services and have the greatest needs such as people who suffer from schizophrenia, other psychotic disorders or bipolar disorder and have experienced homelessness, substance abuse, or criminal justice involvement. SAMHSA has identified ACT as an evidence-based practice that consistently demonstrates positive outcomes and is considered by experts as an essential treatment option for these patients.[435] The Center for Evidence-Based Practices (CEBP) also listed assertive community treatment as an evidence-based practice that improves outcomes for people with severe mental illness who are most at-risk of homelessness, psychiatric hospitalization, and institutional recidivism."[436] To bring good outcomes and be cost-effective, ACT programs must be applied with fidelity. Compared to traditional case management programs, "high-fidelity ACT programs result in fewer hospitalizations, increased housing stability, and improved quality of life for individuals experiencing serious impairment from mental illness."[437]

ACT teams include peer support specialists and practitioners with expertise in psychiatry, social work, substance abuse treatment, and employment. They provide a variety of services including supported housing and assistance in accessing benefits, along with illness management

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[434] Pennsylvania Housing Choices. *Local Housing Teams (LHOT),* available at http://www.pahousingchoices.org/housing-resources/local-housing-options-teams/ (accessed November 16, 2015).
[435] National Alliance on Mental Illness. *Assertive Community Treatment: Investment Yields Outcomes*. September 2007, available at https://www2.nami.org/Template.cfm?Section=act-ta_center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382 (accessed June 23, 2015).
[436] Center for Evidence-Based Practices. *Assertive Community Treatment*, available at https://www.centerforebp.case.edu/practices/act (accessed June 23, 2015).
[437] National Alliance on Mental Illness. *Assertive Community Treatment: Investment Yields Outcomes*. September 2007, available at https://www2.nami.org/Template.cfm?Section=act-ta_center&template=/ContentManagement/ContentDisplay.cfm&ContentID=52382 (accessed June 23, 2015).

and recovery skills, crisis intervention, individual supportive therapy, assistance with daily living activities, and medication prescribing, administration, and monitoring. Assertive Community Treatment has been proven to be a flexible model that can be adaptable to a wide range of mental health systems and to various high-risk populations in urban and rural areas. Some ACT teams "have targeted their programs to serve homeless persons, some to serve individuals entering or leaving criminal justice systems," others focused on veterans diagnosed with a severe mental illness.[438] The United States Interagency Council on Homelessness underscored that "the combination of ACT and housing assistance is more effective than ACT alone or other models of case management."[439]

ACT teams working with people who have severe and persistent mental illness and experience homelessness include linkages to housing assistance, which is often provided through vouchers or tenant-based rental assistance that can be used for scattered-site supportive housing. ACT teams may cultivate relationships with landlords and property managers to develop a pool of housing options and work with clients to identify their housing needs and preferences. ACT teams often include a housing specialist who helps clients with the housing application process, may assist in negotiating rental agreements and communicating with landlords and neighbors to solve problems and avoid situations that could lead to the loss of housing.[440] A meta-analysis of several randomized control and observational studies, totaling 5,775 subjects, convincingly demonstrated that "assertive community treatment offers significant advantages over standard care management models in reducing homelessness and symptom severity in homeless persons with severe mental illness."[441] This study was focused specifically on persons with mental illness. ACT subjects demonstrated dramatic reductions in homelessness and notable improvement in psychiatric symptom severity compared to comparison subjects.[442] On the basis of their findings, the authors of the meta-analysis recommended "policy makers and community program directors to institute assertive community treatment as a best available practice to improve outcomes for the homeless mentally ill."[443]

In Pennsylvania, ACT and ACT-like programs have been in existence since 1990s though there were no statewide standards for ACT then. In 2008, the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) issued an ACT bulletin stipulating the standards and procedures for developing, administering, and monitoring Assertive Community Treatment programs in the Commonwealth. Currently, Pennsylvania has over forty ACT and ACT-like teams that serve more than 3,000 consumers.[444] OMHSAS has provided training and monitoring for ACTs and CTTs (Community Treatment Teams) and in the past few years, has assisted them in

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[438] Ibid.
[439] United States Interagency Council on Homelessness. *Assertive Community Treatment*, available at http://usich.gov/usich_resources/solutions/explore/assertive_community_treatment (accessed June 23, 2015).
[440] Ibid.
[441] Coldwell, Craig M. and William S. Bender. "The Effectiveness of Assertive Community Treatment for Homeless Populations with Severe Mental Illness: A Meta-Analysis." *American Journal of Psychiatry*. 2007. Vol. 164. No. 3 (March), available at http://ajp.psychiatryonline.org/doi/pdf/10.1176/ajp.2007.164.3.393 (accessed February 10, 2016).
[442] Ibid.
[443] Ibid.
[444] *Pennsylvania Recovery and Resiliency – Behavioral Health for the New Century*, available at http://www.parecovery.org/services_act.shtml (accessed February 8, 2016).

transitioning to high-fidelity levels as high-fidelity teams have demonstrated better outcomes and have proven to be more cost-effective.[445]

The Commonwealth is presently looking at expanding access to Assertive Community Treatment programs for Pennsylvanians who may benefit from them. Several bills related to this issue are currently under consideration of the General Assembly. Pennsylvania Senate Bill 21 is focused on an assisted outpatient treatment program. If implemented, this bill would change the outpatient standard to enable court-mandated treatment based on clear and convincing evidence that an individual has a high risk for homelessness, arrest, incarceration, or death due to his or her mental illness.[446] A two-bill package designed to expand ACT programs was introduced in the Pennsylvania House of Representatives. The first bill, House Bill 1629, amends the Insurance Company Law of 1921. Under the proposed bill, health insurance companies would be required to provide health insurance coverage for Assertive Community Treatment for individuals with serious and persistent mental illness.[447] The second bill, House Bill 1630, amends Mental Health Procedures Act and establishes an Assertive Community Treatment program in the DHS. If enacted, HB 1630 would require OMHSAS to expand ACT services throughout the entire state.[448]

Most people who have mental illness do not require as substantial a level of supports and services as ACT. Housing assistance and support services to individuals with mental illness and substance use disorder should vary dependent on the level of their needs and specific circumstances.

Recommendations

- Expand cross training of staff in the behavioral health, housing, and criminal justice systems.
- Promote housing stability as it is a key to long-term recovery.
- Expand permanent supportive housing for individuals who need it utilizing all available resources including Health Choices reinvestment funds.
- Provide housing with access to treatment and recovery support services to reduce relapse and improve outcomes.
- Facilitate access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are homeless or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.

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[445] Commonwealth of Pennsylvania Office of Mental Health and Substance Abuse Services. Mercer. *Assertive Community Treatment and Community Treatment Teams in Pennsylvania*. April 2009, available at http://www.parecovery.org/documents/ACT_CTT_Report_042009.pdf (accessed February 8, 2016).
[446] Senate Bill 21, Printer's No. 6 (2015).
[447] House Bill 1629, Printer's No. 2364 (2015).
[448] House Bill 1630, Printer's No. 2365 (2015).

- Enhance employment training and employment opportunities for individuals with serious mental illness and co-occurring disorders.
- Utilize certified peer specialists and other peer supports and peer navigation to assist persons who experience homelessness with substance use disorders or co-occurring substance use and mental health disorders.
- Implement evidence-based models of providing comprehensive and flexible treatment and support to individuals who live with serious mental illness such as Assertive Community Treatment (ACT).
- Increase collaboration and coordination between providers of mental health/substance abuse services, housing authorities, the DHS Office of Mental Health and Substance Abuse Services, CoCs, and homeless advocacy projects under the leadership of the Department of Drug and Alcohol Programs.
- At the county level, increase collaboration between county behavioral health personnel and CoCs in various areas, including the use of funds.
- Develop a network of Recovery Community Centers, ensuring a proper accreditation system and supervision.

RURAL HOMELESSNESS

Characteristics of Homelessness in Rural Areas

Homelessness was traditionally conceptualized as an urban issue. In the past few years, however, there has been a growing understanding that "homelessness is pervasive in rural communities due to high rates of poverty, unemployment or underemployment, lack of affordable housing, and geographic isolation."[449] The United States Interagency Council on Homelessness (USICH) noted that "people living in rural communities are 1.2 and 2.3 times more likely to be poor than people living in metropolitan areas, and poor rural communities have some of the highest rates of homelessness in the country."[450]

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 directed the United States Government Accountability Office (GAO) to conduct a broad study of homelessness in rural areas. In the ensuing report, GAO addressed the questions regarding the characteristics of homelessness in rural areas, assistance available to affected families, and barriers that persons experiencing homelessness in rural areas and homeless service providers encounter when seeking assistance or funding to provide assistance.[451] GAO findings confirmed that persons experiencing homelessness in rural areas could be living in one of a limited number of shelters, in extremely overcrowded situations, in severely substandard housing, or outdoors. Based on their visits to six states and their conversations with state and local officials and with persons experiencing homelessness, GAO identified several barriers to accessing and providing homeless services in rural areas: limited access to services, large service areas, dispersed populations, and a lack of transportation and affordable housing. For instance, "many rural areas have few shelters or shelters with few beds serving very large areas."[452] The lack of transportation can become a more significant barrier in rural areas than in big cities. It has hindered homeless individuals in accessing services as well as securing employment. Rural areas can be "isolating due to the combination of expansive land size and sparse population. Persons experiencing homelessness might be geographically cut-off from the limited homeless service providers available in their areas, and would need to travel long distances to receive needed services."[453] Lack of affordable housing is a major cause of homelessness anywhere, but in rural areas it may be even keener, especially in regions where a newly developed high-paying industry like gas or oil exploration has recently set in. Shortage of affordable housing in rural areas is often combined with the poor quality of housing, with some buildings lacking complete plumbing or heat. In some rural areas, "deteriorating housing conditions for private market units may be more severe due to

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[449] National Health Care for the Homeless Council. "Rural Homelessness: Identifying and Understanding the 'Hidden Homeless.'" *In Focus: A Quarterly Research Review of the National HCH Council.* Vol. I. No. 4. June 2013, available at http://www.nhchc.org/wp-content/uploads/2013/06/InFocus_June2013.pdf (accessed February 12, 2015).
[450] United States Interagency Council on Homelessness. *Rural Homelessness*, available at http://usich.gov/issue/rural_homelessness (accessed November 16, 2015).
[451] United State Government Accountability Office. *Rural Homelessness: Better Collaboration by HHS and HUD Could Improve Delivery of Services in Rural Areas.* Washington, D.C. July 2010, available at http://www.gao.gov/assets/310/307448.pdf (accessed February 10, 2016).
[452] Ibid.
[453] Ibid.

the absence of building code enforcement."[454] Another obstacle is the resistance in some local communities to the building of shelters and other low-income housing for the homeless motivated by fears that undesirable persons might then move to their communities.

It has been established that "rural homelessness is most pronounced in rural regions that are primarily agricultural; regions whose economies are based on declining extractive industries such as mining, timber, or fishing; and regions experiencing economic growth – for example, areas with industrial plants that attract more workers than jobs available, and areas near urban centers that attract new businesses and higher income residents, thereby driving up taxes and living expenses."[455] All the above-mentioned kinds of rural areas exist in Pennsylvania, most conspicuously in counties within the Marcellus Shale zone of impact.

Studies at both national and state levels have indicated that an even bigger share of the rural homelessness population have a mental health or a substance use disorder compared to homeless people in general. According to the National Survey of Homeless Assistance Providers and Clients, two-thirds of the rural homeless population reported having a mental health or substance abuse problem and might require specialized services such as psychiatric treatment.[456] The study "Homelessness in Rural Pennsylvania," commissioned by the Center for Rural Pennsylvania and conducted by Heather S. Feldhaus and Avi Slone from Bloomsburg University, also showed that the rural homeless exhibit high rates of health and substance use problems. The researchers surveyed professionals who work with the homeless. The survey results "indicated slightly higher rates of mental health and substance use issues among rural clients."[457] At the same time, access to mental health providers, as well as health care providers in general, is more limited in rural areas, and so is access to substance abuse services. Lack of transportation precludes people from getting to services they need.

Local providers in rural areas often struggle with additional administrative burdens and challenges in applying for various grants partly due to their limited staff, and partly due to the difficulty of providing data to demonstrate resource needs that are required by many grant programs: "Especially in rural areas with no shelters or visible points of entry for services, counts of the homeless are not documented, and without data it is hard to prove that the services are needed."[458]

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[454] Ibid.

[455] National Coalition for the Homeless. *Rural Homelessness*, available at http://www.nationalhomeless.org/factsheets/Rural.pdf (accessed November 16, 2015).

[456] Bart, M.R. et al. *Homelessness: Programs and the People They Serve, Findings of the National Survey of Homeless Assistance Providers and Clients.* Washington D.C.: Urban Institute, 1999, available at https://www.huduser.gov/portal//publications/pdf/HUD-8774.pdf (accessed February 16, 2016).

[457] Feldhaus, Heather S. and Avi Slone. *Homelessness in Rural Pennsylvania*. Harrisburg, PA: The Center for Rural Pennsylvania, March 2015, available at http://www.rural.palegislature.us/publications_reports.html (accessed July 10, 2015).

[458] United State Government Accountability Office. *Rural Homelessness: Better Collaboration by HHS and HUD Could Improve Delivery of Services in Rural Areas.* Washington, D.C. July 2010, available at http://www.gao.gov/assets/310/307448.pdf (accessed February 10, 2016).

GAO's main recommendation consisted in strengthening formal collaboration between the Departments of Housing and Urban Development (HUD) and Health and Human Services (HHS) on linking housing and supportive services to address homelessness, with specific consideration for how such collaboration can minimize barriers to service provision in rural areas.[459]

Dr. Tom Simpatico of Pathways to Housing Vermont and the University of Vermont, in his interview with USICH, identified some of the subpopulations of people experiencing homelessness in rural and frontier areas:

- The Traditional Homeless – people living unsheltered on the street; the characteristics are similar to people experiencing chronic homelessness in urban areas. They often suffer from substance abuse, personal tragedy, or mental or physical disabilities. They generally have had little recent attachment to the labor force and have trouble maintaining a permanent address or securing employment.
- The Working Poor – often driven by financial hardship, this group has been growing in recent years. They are often one- and two-parent families with children. They often double-up with friends/friendly acquaintances and/or move frequently in search of work.
- Displaced Farmers and Farm Workers – farm foreclosures cause displacement for many who rely on farms for work and livelihood. Since it is often difficult to resell property after foreclosure, farmers are often permitted to stay on the land. There is often despondency involved as farms have been in a family's possession for generations; there is a sudden loss of personal identity as well as financial security.
- Veterans – veterans are more likely to live in rural areas than other households, and veterans in rural areas tend to be older and in worse health than veterans in urban areas. Because rural veterans experiencing homelessness are not easily identifiable and are not engaged in services, it is difficult to capture an accurate picture of the number of veterans experiencing homelessness in rural communities.[460]

A review of recent literature on rural homelessness performed by the National Health Care for the Homeless (HCH) Council enumerated a number of factors that have contributed to rural poverty homelessness, including "a lack of affordable housing, especially in proximity to employment opportunities; prevalence of low-wage service occupations; lack of infrastructure to support employment (e.g. child care and public transportation); inadequate treatment opportunities for medical and behavioral health problems; natural disasters; and domestic violence."[461]

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[459] Ibid.

[460] United States Interagency Council on Homelessness. *Ending Rural Homelessness: Advice from Experts in the Field*, available at http://usich/gov/issue/rural_homlessness/ending_rural_homelessness_advice_from_experts_in_the_field (accessed November 16, 2015).

[461] National Health Care for the Homeless Council. "Rural Homelessness: Identifying and Understanding the 'Hidden Homeless.'" *In Focus: A Quarterly Research Review of the National HCH Council.* Vol. I. No. 4. June 2013, available at http://www.nhchc.org/wp-content/uploads/2013/06/InFocus_June2013.pdf (accessed February 12, 2015).

Challenges of Data Collection

All experts agree that a major challenge in the study of rural homelessness is "the inability to accurately identify and quantify the population."[462] It can be attributed to a number of factors, including inconsistent and, at times, competing definitions of "rural" and "homeless"; insufficiency of the urban methodology when applied to rural populations; and lack of awareness or recognition of homelessness. Individuals experiencing homelessness in rural areas are also believed to be more transient, which makes it much less likely to encounter them unless you know exactly where they are.[463]

The rural homeless are sometimes called the "unseen," "hidden," or "invisible" population. Recognition of rural homelessness is limited for several reasons: "rural landscapes camouflage homelessness through expansive geography with low population density, unstably housed individuals reside in less visible locations than in urban areas (wilderness, substandard housing, doubling up, etc.), and cultural norms deny that homelessness can exist in the idealized rural setting and aim to rid communities of this "social problem.""[464] Another kind of cultural norm in some rural communities, based on the belief in self-sufficiency and the desire for privacy, may explain why some individuals are reluctant to seek outside assistance even when they need it.

Methods traditionally used to quantify the urban homeless are not as suitable for rural areas and commonly lead to significant undercounts. Urban counts are often based upon the record of homeless service users in an area, but this method "likely undercounts the homeless population in rural communities due to the lack of service sites."[465] The Point-in-Time counts are bound to miss significant numbers of individuals who are experiencing homelessness in sparsely populated rural areas and may be finding shelter in a dilapidated cabin in the woods or in a tent set up on land owned by a friend or a family member.

It is believed that chronic homelessness is not widely spread in rural areas. A more common situation is that a family falls on hard times due to an unexpected expense or a job loss and is suddenly unable to make the ends meet anymore. In this case, people often end up temporarily living with friends or family – either out of preference or simply because no shelters exist in their area. This is one of the reasons for the undercount of the rural homeless, and the undercount is probably quite significant. As the school system uses a more comprehensive definition of homelessness, school counts can serve as a gauge of the level of undercounting. For example, in Cambria County, two-thirds of the students identified as homeless are "doubled-up," or temporarily living with friends or relatives, according to Andrea Sheesley, who coordinates the Pennsylvania Department of Education's homeless student support efforts in that part of the

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[462] Ibid.

[463] United States Interagency Council on Homelessness. *Ending Rural Homelessness: Advice from Experts in the Field*, available at http://usich/gov/issue/rural_homlessness/ending_rural_homelessness_advice_from_experts_in_the_field (accessed November 16, 2015).

[464] National Health Care for the Homeless Council. "Rural Homelessness: Identifying and Understanding the 'Hidden Homeless.'" *In Focus: A Quarterly Research Review of the National HCH Council.* Vol. I. No. 4. June 2013, available at http://www.nhchc.org/wp-content/uploads/2013/06/InFocus_June2013.pdf (accessed February 12, 2015).

[465] Ibid.

state.[466] This means none of these students or their parents will be captured by Point-in-Time counts, and they may not be using any services.

Homeless providers in rural communities often feel they have fewer resources to help their clients than their urban counterparts. Wendy Kinnear, regional coordinator for the state of Pennsylvania's Education for Children and Youth Experiencing Homelessness program (ECYEH), who works with ten rural counties in northwestern Pennsylvania, was quoted in a Stateline article as saying, "We don't get the same funding and support. People are being undercounted – which means they're not getting the services and funding that they can be tapping into."[467]

The Need for Tailored Approaches

Growing awareness of the incidence and prevalence of homelessness in rural areas has led to the realization that "the patterns in which homelessness unfolds in rural areas differ from urban settings, necessitating tailored approaches in public policy and service design."[468] New methodology to effectively identify and enumerate the rural homeless population should be developed and applied, and subsequently, service infrastructures should be "evaluated and redesigned to more effectively match rural settings, taking into consideration geography, culture, and organizational environment."[469]

It is evident that effectively addressing rural homelessness requires special approaches in the outreach, service structure, and service delivery areas.

Based on its literature review, the National HCH Council offered a list of promising practices (many of those are not exceptional for rural settings but gain particular importance there):

- Behavioral health and primary care integration
- Transportation assistance
- Continuity of care across community providers
- Increased outreach in remote areas
- Use of community networks/peer navigators for outreach
- Promotion of cultural competence among staff
- Development of community coalitions/rural service teams
- Regionalized services
- Housing-plus-services model

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[466] Finnerty, John. "Hidden Homeless: Defining 'homeless' a Key Issue." *The Daily Item*. February 27, 2016, available at http://www.dailyitem.com/news/hidden_homeless/hidden-homeless-defining-homeless-a-key-issue/article_dc36c30a-dcdd-11e5-8fa7-1fb8b835075b.html (accessed March 1, 2016).
[467] Wiltz, Teresa. *States Struggle with 'Hidden' Rural Homelessness,* available at http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/6/26/states-struggle-with-hidden-rural-homelessness (accessed June 29, 2015).
[468] National Health Care for the Homeless Council. "Rural Homelessness: Identifying and Understanding the 'Hidden Homeless.'" *In Focus: A Quarterly Research Review of the National HCH Council.* Vol. I. No. 4. June 2013, available at http://www.nhchc.org/wp-content/uploads/2013/06/InFocus_June2013.pdf (accessed February 12, 2015).
[469] Ibid.

- Employment initiatives to train local workforce.[470]

Healthcare is one of the critical areas where service delivery to the homeless is often even a bigger problem in distant rural communities than in large urban centers with thriving public hospitals, university research centers, and numerous private medical practices. Telemedicine and regional conglomerates are two of the ways to enhance access to crucial medical services for those experiencing homelessness in rural areas. Another way might be allowing volunteers from other states to come and provide the necessary services. One organization that does it nationally is Remote Area Medical (RAM). RAM offers "free dental, vision and medical care to isolated, impoverished, or underserved communities."[471] RAM's mobile medical centers are set up quickly in remote locations and deliver basic medical aid, including preventative care, to underserved areas. RAM has helped many people around the country and the world. In many states, however, various laws and regulations require dentists and doctors to register and be credentialed in advance in order to be able to offer their services. Tennessee was the first state to enact legislation allowing any licensed doctor to practice in the state as long as this doctor is providing medical services to the poor at no cost.[472] Virginia allows various medical professionals, from dentists to doctors of medicine, to nurses and optometrists, to apply for registration for volunteer practice. The licensure exemption sought through this application is valid only during the limited period that free healthcare is made available through the specific volunteer, nonprofit organization on the dates and at the location specified in the application. Some homeless advocates encourage other states to enact similar legislation that would provide a waiver from the applicable licensing laws to a physician who is not licensed in a particular state but would like to provide services to indigent individuals there as long as he or she does not impose any charges for these services.

In their study "Homelessness in Rural Pennsylvania," sponsored by a grant from the Center for Rural Pennsylvania, Heather S. Feldhaus and Avi Stone analyzed existing data on rural homelessness, surveyed professionals who work with the homeless, and summarized information gathered at two homelessness summits held at Bloomsburg University in Columbia County. In their conclusions, the researchers highlighted important differences in rural and urban areas. They noted greater rates of increase in homelessness in rural areas than in urbans areas within a five-year period, with most dramatic increases for the unsheltered homeless, individuals who are homeless, and homeless veterans.[473] Service providers from rural areas responding to their survey "were more likely than their urban counterparts to have encountered the homeless living in non-residential structures."[474] A lack of transportation was perceived as a major problem in rural areas, with geographically dispersed employment opportunities, healthcare providers, and social services. The authors believe that their comparison of different data sources suggested "a potentially dramatic undercount of the homeless."[475] They recommended developing a standard

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[470] National Health Care for the Homeless Council. "Rural Homelessness: Identifying and Understanding the 'Hidden Homeless.'" *In Focus: A Quarterly Research Review of the National HCH Council.* Vol. I. No. 4. June 2013, available at http://www.nhchc.org/wp-content/uploads/2013/06/InFocus_June2013.pdf (accessed February 12, 2015).
[471] *Free Medical Clinics*, available at http://ramusa.org/ (accessed August 15, 2015).
[472] Volunteer Health Care Services Act: Tenn. Code Ann. §§ 63-6-701 to -6-710.
[473] Feldhaus, Heather S. and Avi Slone. *Homelessness in Rural Pennsylvania*. Harrisburg, PA: The Center for Rural Pennsylvania, March 2015, available at http://www.rural.palegislature.us/publications_reports.html (accessed July 10, 2015).
[474] Ibid.
[475] Ibid.

definition of homelessness that includes those who are doubled up, consolidating state-level data collection under one methodology and Homeless Management Information System, and developing data collection strategies specifically designed for rural areas.[476]

One of the observations the researchers made based on the homelessness summits was that "increasing dialogue between service providers at the regional and local levels is an effective means of identifying models, refining existing programs, identifying and troubleshooting gaps in services, encouraging innovation and tailoring services to the specific communities in which they operate."[477]

A Successful Model of Outreach and Service Delivery: Lessons from one Pennsylvania County

Their observation is confirmed by the successful experience of some of the Commonwealth counties. An innovative and highly successful model of providing services to people experiencing homelessness has emerged in Monroe County. The Monroe County Homeless Initiative was based on thoughtful utilization of community resources, including colleges, veterans' groups, and faith-based organizations. As other rural counties, Monroe County has few shelter programs. Only seven small shelters (Salvation Army Emergency Shelter, Women's Resources, Pocono Area Transitional Housing, Stroudsburg Wesleyan Cold Weather Shelter, Valor Foundation Clinic, Shepherd's Maternity House, and Family Promise) exist in Monroe County. There are only ten units of emergency shelter for two-parent families with children. The various shelters have eligibility criteria, some of them very specific, such as veteran PTSD outreach and domestic violence. Open slots are rare, and each agency has a waiting list.[478] Finding affordable housing is a significant challenge in this rural county; it is exacerbated by a number of factors.

Realizing that rural areas require special outreach and homeless identification efforts, Monroe County prepared carefully for an effective Point-in-Time count. Necessary steps include training volunteers, creating care packages, and alerting police about the count. The homeless in rural areas are often spread out in remote locations that are not easy to reach. On the other hand, some of the homeless individuals identified by the Point-in-Time count in Monroe County were found hidden within a mile of resources.[479]

Upon completion of a thorough PIT count in 2013, Monroe County proceeded from recognition of the problem (dissonance between observed reality, formal reports, and data; a lack of networking among providers toward a common goal); to defining the challenge; to building a network of collaborators (including government officials, the diverse faith-based community, committed community members, medical providers, university and community college, media, business leaders and making the members of the homeless community a vital part of all the conversations and formal committees).[480] The county organized eight task forces based on the

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[476] Ibid.
[477] Ibid.
[478] Information provided to the Joint State Government Commission and the advisory committee by Ms. Faith Water-Kimes and Ms. Leslie Perryman in their presentation to the subcommittee on July 22, 2015.
[479] Information provided to the Joint State Government Commission and the advisory committee by Ms. Faith Water-Kimes and Ms. Leslie Perryman in their presentation to the subcommittee on July 22, 2015.
[480] Ibid.

needs determined from data; a veterans' task force was added later. The first achievements included creation of a Day Center in the downtown retail area, expansion of the emergency cold weather center, launching a partnership with the State Public Health office and Pocono Medical Center to ensure access to medical prevention and treatment, and adding food and clothing pantries in various parts of the county. The Day Center started to provide critical services such as case management, basic needs support, job search help, medical support, a postal address, a subsidized cell phone, and assistance with obtaining a state identification card or license and applying for housing and benefits.

In order to achieve sustainability, the Monroe County Commissioners established an interim advisory board for homelessness, and subsequently, an ongoing, formal board, with one commissioner responsible for overseeing its work. The Monroe County Housing Advisory Board (MCHAB) has become a focal point for homeless prevention and intervention efforts in the county. The Street2Feet Day Center responds to basic needs and serves as an entry point to an array of services. The Pocono Medical Center On-Site Health Clinic, thanks to a partnership with the local community hospital, offers primary medical care at the Day Center and at the Salvation Army shelter on a regular basis. Referrals to specialists, vision and basic dental care are also available. Designated agencies and case managers work together to utilize the tools of hotel vouchers, utility and rental assistance in the most effective way. Street outreach efforts remain ongoing in Monroe County; they are led by a case manager who has a background in camping and survival skills. The Monroe County Housing Advisory Board asserts a collaborative approach to all elements of its program. It also emphasizes community outreach and education, looking for multiple, easy and diverse ways for people to know what key resources exist to help the unsheltered. The local paper, *Pocono Record*, won an award for its homelessness coverage.

Monroe County presents an excellent example of an effective approach to homelessness. A key to its success appears to be thoughtful identification of existing challenges and resources and taking advantage of being a rural community, where it is easier to make connections and to bring people together to address a local problem.

Recommendations

- Improve the methodology for the identification of homeless families and individuals in rural areas, and increase the ability to accurately identify and quantify the population.
- Create a unified, comprehensive system that addresses the needs of the unsheltered and those in danger of losing their homes. Combine funding and programming under one roof to allow for a more comprehensive, preventative approach.
- Recognize and address the special problems of addressing homelessness in rural communities such as low population density, levels of perceived visibility, unique local dynamics, limited availability of resources, and lack of public transportation.

- Examine the special relationship between health and homelessness in rural areas; explore various ways of broadening access to physical and mental health care, including via telemedicine and regional conglomerates.
- Provide funding for advanced dental care realizing that oral health has a significant impact on the ability to secure housing and employment.
- Develop a comprehensive employment program for homeless in rural areas that would include training, physical and behavioral health supports, and transportation.
- Introduce financial incentives for communities that want to bring the services together that address the needs of the identified population, for example, tax incentives to purchase abandoned, foreclosed, or economically feasible buildings to retrofit for homeless services such as agencies, emergency shelter, job training, et cetera, under one roof or on one campus.

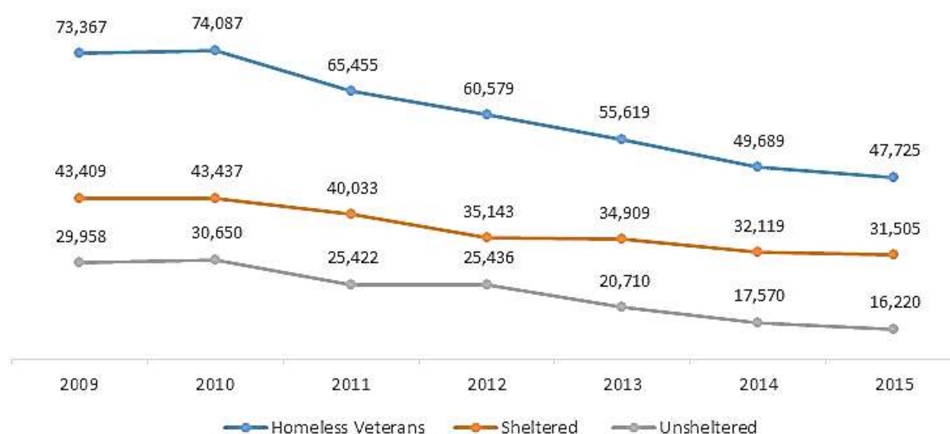
VETERANS

Occurrence and Trends

There are many factors contributing to veteran homelessness, some of which are shared with non-veterans. These factors include socioeconomic status, mental health disorders, history of substance abuse, and a lack of affordable housing. However, there are disproportionately higher levels of homeless veterans compared to both general and low-income populations.[481] Some veterans can become homeless through sudden adverse events which place them under financial strain while others experience difficulty transitioning to civilian life.[482]

When deployed, veterans may face numerous physical or psychological injuries including post-traumatic stress disorder, traumatic brain injuries, and military sexual trauma. These conditions can erode a veteran's tie to family and other supports and can become obstacles to maintaining employment and stable housing if untreated. Across the country, communities have discovered that strong outreach, veteran support by peers, and employment assistance emphasizing a transition of military experience to civilian skills are all useful strategies to putting veterans on a path to stable housing.

National PIT Estimates of Homeless Veterans by Sheltered Status, 2009-2015[483]



[481] U.S. Interagency Council on Homelessness. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* Washington, D.C.: June 2015. P. 27, available at https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf (accessed March 21, 2016).

[482] Cunningham, Mary et al. *Veterans Homelessness Prevention Demonstration Evaluation: Final Report*. Washington, D.C.: U.S. Department of Housing and Urban Development, November 2015, available at https://www.huduser.gov/portal/publications/homeless/veterans-homelessness-prevention-report.html (accessed December 27, 2015).

[483] Henry, Meghan et al. *The 2015 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 – PIT Estimates of Homelessness in the U.S*. Washington, D.C.: U.S. Department of Housing and Urban Development, November 2015, P 50, available at https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf (accessed December 27, 2015).

Along with other types of individuals experiencing homelessness, HUD's Annual Homeless Assessment Report (AHAR) tracks and records the number of veterans counted in communities or those who receive housing services. AHAR defines a veteran as any person who served on active duty in the Armed Forces of the United States, including military reserves and National Guard who were called up to active duty.[484] During the January 2015 PIT count, there were a total of 47,725 homeless veterans throughout the country, making up 11 percent of all homeless adults.[485] Since 2009, veteran homelessness has fallen by 35 percent, with 25,642 fewer homeless veterans in 2015.[486] This decline includes both large decreases in the number of veterans found in unsheltered locations, and in veterans experiencing homelessness in shelters and transitional housing. Despite the progress made, the rapid decreases in homelessness shown in prior years have slowed starting in 2014.

Demographics

While data specific to Pennsylvanian's veterans could not be located, HUD has constructed a nation-wide profile for homeless veterans using Homeless Management Information System (HMIS) shelter data. In its report, HUD found that the majority of homeless veterans who used housing services were male, single, and live in urban areas.[487] It is possible that geographical statistics may be misleading since there are fewer housing services existing outside of major cities. Overall, the age of sheltered veterans is increasing, as fewer middle-aged veterans use housing services. Currently adults age 51 to 61 comprised the single largest age group who used housing services at close to 44 percent, and the number of homeless veterans over 60 has been increasing.[488] This trend poses a potential problem to service providers because older homeless individuals often need more intensive health services.

The share of sheltered veterans with a disability was 56 percent, nearly double the percent of U.S. veterans with disabilities and 14 percent higher than adults in the general homeless population.[489] Approximately half of veterans experiencing homelessness have serious mental illness; 70 percent have substance use problems; over half have other health problems.[490] Homelessness exacerbates poor health and behavioral health and increases an individual's contact with the criminal justice system. Close to half of veterans experiencing homelessness have histories of involvement with criminal justice system after leaving military service.[491]

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[484] Ibid. P. 2.
[485] Ibid. P. 50.
[486] Ibid. P. 51.
[487] Solari, Claudia D. et al. *The 2014 Annual Homeless Assessment Report (AHAR) to Congress: Part 2 – Estimates of Homelessness in the United States*. Washington, D.C.: U.S. Department of Housing and Urban Development, December 2015. Section 5. P. 6, available at https://www.hudexchange.info/onecpd/assets/File/2014-AHAR-Part-2.pdf (accessed January 7, 2016).
[488] Ibid. Section 5. P. 9.
[489] Ibid. Section 5. P. 11.
[490] Ibid.
[491] U.S. Interagency Council on Homelessness. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* Washington, D.C.: June 2015. P. 27, available at https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf (accessed March 21, 2016).

The race and ethnicity of veterans experiencing homelessness has also been recorded by HUD. In 2014, white veterans comprised close to half of all sheltered veterans.[492] Over a five-year period, the number of sheltered veterans in minority groups declined by 5,669, a seven-percent decrease.[493] Of particular note are Hispanic veterans, whose number has decreased by a third, or 5,891 veterans, over a five-year period, despite a growing number of Hispanic veterans in the overall population.[494] The exception to this trend are black veterans, who comprised 39 percent of the total homeless veteran population but only 11 percent of the total veteran population.[495] Since 2009, the number of black veterans using shelter has increased by 6.7 percent, or 3,354 more veterans.[496]

Programs

Due to their service history, there are more programs and benefits available to homeless veterans than the general population; however, the veteran population also has greater physical and mental health needs than the general homeless population. In addition to mainstream housing programs, there are many programs created specifically to aid veterans who are experiencing or at risk of homelessness. Universal screenings offered at VA healthcare services can help veterans be quickly linked to the services and supports they need.[497] VA Medical Centers are actively working in partnerships with local community-based organizations and public housing authorities to identify and engage veterans who are experiencing chronic homelessness and helping them connect to the assistance available through VA homeless programs. Under the current federal administration, many of these programs were expanded or received additional funding. In 2016 VA allocated 1.4 billion dollars towards programs that would end veteran homelessness.[498] A list of these programs is detailed in the Resources section of this report.

For some veterans, their military discharge status may make them ineligible to receive VA assistance. In these cases local communities, Continuum of Care programs and mainstream systems can provide aid. HUD has collected data on the veteran use of housing programs. Of the veterans who used shelter programs in the 2014 reporting year, almost two-thirds used only emergency shelter.[499] The rest used only transitional housing programs or more rarely accessed

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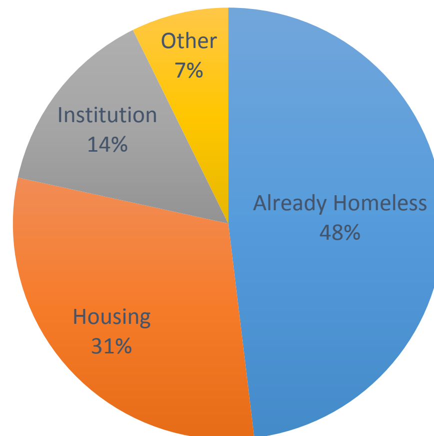
[492] Solari, Claudia D. et al. *The 2014 Annual Homeless Assessment Report (AHAR) to Congress: Part 2 – Estimates of Homelessness in The United States*. Washington, D.C.: U.S. Department of Housing and Urban Development, December 2015. Section 5. P. 9, available at https://www.hudexchange.info/onecpd/assets/File/2014-AHAR-Part-2.pdf (accessed January 7, 2016).
[493] Ibid.
[494] Ibid.
[495] Ibid.
[496] Ibid.
[17] U.S. Interagency Council on Homelessness. U.S. Interagency Council on Homelessness. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* Washington, D.C.: June 2015. P. 26, available at https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf (accessed March 21, 2016).
[498] Office of the First Lady. *Fact Sheet: Preventing and Ending Veteran Homelessness*. April 2015, available at https://www.whitehouse.gov/the-press-office/2015/04/20/fact-sheet-preventing-and-ending-veteran-homelessness (accessed March 21, 2016).
[499] Solari, Claudia D. et al. *The 2014 Annual Homeless Assessment Report (AHAR) to Congress: Part 2 – Estimates of Homelessness in the United States*. Washington, D.C.: U.S. Department of Housing and Urban Development, December 2015. Section 5. P. 14, available at https://www.hudexchange.info/onecpd/assets/File/2014-AHAR-Part-2.pdf (accessed January 7, 2016).

both shelter programs during the year. The average length of stay in emergency shelter was 49 nights, and it was 145 nights, or about 5 months, in transitional housing programs.[500] Compared to previous years, there has been a slight increase in time spent at emergency shelter, along with a slight decrease in the number of nights spent in transitional housing.[501]

Housing Status Before Entering Shelter Program[502]



Before entering a housing program, close to half of the veterans were already homeless. Of those veterans who had housing, close to two-thirds were staying with friends and family, while 30 percent rented an apartment. Very few veterans had previously owned a home or were enrolled in a permanent supportive housing program. Of the veterans who were living in institutional settings prior to homelessness, thirty-five percent were in in substance abuse treatment centers, while over a quarter came from correctional facilities. The remaining forty percent of veterans from institutional settings were split between hospitals and psychiatric facilities. The remaining veterans had found housing in motels or other locations.

Ending Veteran Homelessness in Pennsylvania

In Pennsylvania, there were 1,375 veterans experiencing homelessness recorded during the January 2015 PIT count, a number which represents 2.8 percent of the national's total population of homeless veterans.[503] While the Commonwealth has not experienced the same drastic reduction in homeless veterans compared to the country as a whole, Pennsylvania has shrunk its number of homeless veterans by nearly a quarter since 2007. In recent years, this decrease has been driven by a substantial reduction in unsheltered veterans experiencing homelessness. Over ninety-four percent of homeless veterans in Pennsylvania were found in emergency shelters, transitional

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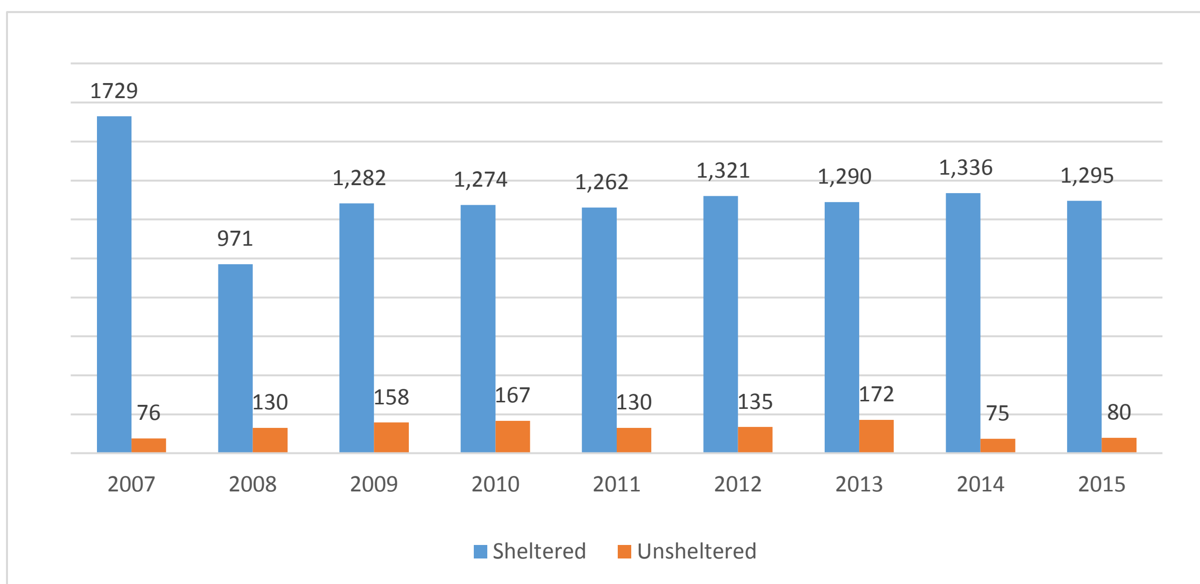
[500] Ibid.
[501] Ibid.
[502] Ibid.
[503] Henry, Meghan et al. *The 2015 Annual Homeless Assessment Report (AHAR) to Congress: Part 1 – PIT Estimates of Homelessness in the U.S*. Washington, D.C.: U.S. Department of Housing and Urban Development, November 2015, P. 52, available at https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf (accessed December 27, 2015).

housing programs, or safe havens. Only 5.8 percent of homeless veterans were found in unsheltered locations in Pennsylvania compared to 34 percent across the nation.[504]

Pennsylvania has shown a thorough commitment to ending veteran homelessness. In early 2015, Pennsylvania CoCs identified 1,375 homeless veterans throughout the state, and since that time much progress has been made to permanently end veteran homelessness in the state. In September of 2015, Governor Tom Wolf announced Pennsylvania's participation in a 100-day challenge to serve 550 homeless veterans throughout the end of 2015. Pennsylvania exceeded its goal and has permanently housed over 900 homeless veterans from the end of September until the end of January.[505] Numerous Pennsylvania cities have taken up the Mayors' Challenge to end homelessness in their communities. Participating cities include Philadelphia, Pittsburgh, Lancaster, Reading, Erie, Allentown, York, Westchester, and Downingtown.[506]

PIT Count of Homeless Veterans in Pennsylvania by Shelter Status[507]



Pennsylvanian cities have found success combining the efforts of county VA offices with federal supportive housing vouchers. Increased outreach to homeless veterans and working with community programs to combine resources are frequently cited as central components to ending veteran homelessness. Some communities have used volunteers to distribute program information to shelters and locations frequented by homeless veterans. Then a master list of all homeless veterans in the community is created, along with an inventory of available housing stock.

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[504] Ibid.
[505] Pennsylvania Governor's Office. *Governor Wolf Provides Update on Pennsylvania Efforts to End Veterans Homelessness.* March 3, 2016, available at https://www.governor.pa.gov/governor-wolf-provides-update-on-pennsylvania-efforts-to-end-veterans-homelessness/ (accessed March 21, 2016).
[506] Ibid.
[507] U. S. Department of Housing and Urban Development. *2007 – 2015 PIT Data by State*. 2015, available at https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/ (accessed February 22, 2016).

Communities also work with landlords to house veterans and provide vouchers to move veterans into more secure housing. By moving from person to person, the community tries to place each veteran in housing and check up with them periodically.

A growing number of Pennsylvania cities and counties have already declared an end to veteran homelessness. To date, Berks County, City of Reading, Lancaster City, Lancaster County, Montgomery County, and Philadelphia have all reached functional zero, while Pittsburgh has made significant progress.[508] While there will be veterans in these areas that will experience housing crises in the future, reaching functional zero means there is the capacity and infrastructure in place to house more people than are currently in the system. The goal achieved is an important landmark. It is, however, necessary to realize that success will continue only with sustainability of efforts and resources. Sustained success with veteran homelessness requires continued permanent housing options like VASH, flexibility services to help people retain their homes, an ability to use aspects of the representatives payee model to help veterans keep up rent payments, and continued close collaboration among various agencies. It is hoped that the successful process used to end veteran homelessness can act as a guide for housing other groups of individuals and families experiencing homelessness statewide.

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[508] U.S. Department of Housing and Urban Development. *Mayors' Challenge*, available at http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/veteran_information/mayors_challenge (accessed February 22, 2016).

HOMELESS SURVEY RESULTS AND ANALYSIS

Purpose of the Study

The purpose of the survey conducted by the Advisory Committee was to determine the characteristics of adults who are experiencing homelessness in Pennsylvania, to enhance insight regarding the complex issues associated with individual and family homelessness in the Commonwealth. This study was important because it provided a random, brief, snapshot, qualitative analysis of the current landscape of homelessness in the state. The way it was conducted ensured broad-based and geographically diverse representation.

Data was obtained from individual interviews and focus group sessions organized by housing providers in sixteen counties. Surveys were conducted in a manner determined by each provider; all participants of the survey acted voluntarily and without compensation. Surveys were offered randomly to consumers, with no personally identifying information documented. Information reported by all providers was aggregated and analyzed for the purpose of answering the following research questions:

1) What are characteristics of those experiencing homelessness in the Commonwealth?
2) What are long-term and short-term causes of homelessness?
3) What could have prevented an individual from becoming homelessness?

Research Design

The Advisory Committee of HR 550 and the Joint State Government Commission developed the survey parameters to ensure voluntary participation and maintain confidentiality of participants. With those structures in mind, the Joint State Government Commission conducted an exploratory research study with a qualitative design in order to delineate characteristics of individuals and families experiencing homelessness, as well as to identify issues and factors leading to homelessness. This study was cross-sectional and utilized an availability sampling method, also referred to as convenience or accidental sampling. The research design allowed for both individual interview and focus group survey methods. This design was chosen so that housing providers could use discretion in conducting the surveys to best fit their consumers and complete the research in the limited timeframe available.

The research instrument was a paper survey comprised of demographic information, quantitative information, and qualitative information (Appendix B). The demographic information collected included current age, age at time of first becoming homeless, employment status, and SSDI status. Quantitative information gathered included yes/no questions regarding causes of homelessness, utilization of housing or service assistance, and service satisfaction. Qualitative information gathered included details of issues leading to homelessness, barriers to obtaining housing, and suggestions for how state and local agencies could help to prevent or end homelessness in the state.

Participants

The target population included any adult consumer who was actively attending a housing provider agency in the Commonwealth for services to address issues of homelessness.

Data Collection

Members of the Advisory Committee volunteered to reach out to their local constituents who provide services to the homeless and invite them to participate in the survey. As a result, 29 agencies representing 19 different counties expressed interest in conducting the survey. The survey was provided to all interested agencies, and a two-month window of completion was established, ranging from January through March 2015. The Joint State Government Commission received 213 individually completed surveys and six focus group responses, with 42 people participating in focus group discussions. That means the total of respondents was 255. Completed survey data was received from 27 agencies representing 16 counties.

Limitations and Strengths of Study

A survey is just one part of the comprehensive study of homelessness in Pennsylvania performed by the Joint State Government Commission with the assistance from the task force and the advisory committee. Within a two-year period, in addition to interviewing those experiencing homelessness, the JSGC was tasked to review current data and literature from across the country, examine successful homeless reduction practices utilized by other states, conduct analysis of the cost factors of homelessness, and assess Pennsylvania's current efforts to address this problem. The timeframe for completion of the final report to the legislature was two years, putting restrictions on the interval for survey creation, distribution, aggregation, and outcomes analysis. The survey was not intended as the main source of information but as a complimentary tool to better understand homelessness problems in the Commonwealth. As a result, there are limitations to this study.

The survey was not tested for validity or reliability, as it was intended to be a preliminary, exploratory snapshot of the current characteristics of the homeless population in Pennsylvania. Therefore, this report is not an exhaustive representation of the characteristics of homelessness across the Commonwealth. The number of participants is but a small percentage of the current homeless population. Additionally, the sample of participants represent only 16 of the 67 counties in Pennsylvania.

To elaborate on the issue of reliability, as with any survey or focus group, there is no guarantee that responses are entirely truthful. In this particular case, certain respondents might have been hesitant, for example, to admit to having children for fear of having them taken away by the children and youth services, or to make critical remarks about the program they participate in. We must also realize that people may not always realistically assess the level of their problems and possibilities. A person may, for example, honestly believe that one-time assistance with paying back rent or security deposit would be sufficient and there would no problems in the future, but this prognosis may be too optimistic.

The fact that all respondents were current participants of housing assistance programs, most likely, predetermines a certain bias in responses to several questions, for example those regarding a place where individuals spend the night if homeless, whether they have accepted housing assistance in the past, and what other benefits they are using. One can presume that the share of positive responses to these and similar questions would be higher among our survey participants in comparison with those in similar circumstances who are still on the street or doubled-up due to their reluctance to apply for services, lack of knowledge of services available, or their inability to get those services.

Strengths of this research include participant diversity in their experience with homelessness, including age at the time of first experiencing homelessness, current age, and length of time participants have been homeless in their lifetime. In addition, there was diversity in participants' self-identified characteristics, including household status, employment and income status, parental status, and whether they were rural or urban inhabitants. An array of different kinds of agencies conducting the survey and focus groups in itself ensured that the survey was broad-based and geographically diverse, and represented a cross-section of various homeless population subgroups. Among the agencies that conducted the survey and focus groups were county social and emergency services, YWCA, Valley Youth House/Supportive Housing, faith-based residential programs, a specialized division of the Pennsylvania Board of Probation and Parole, Women Against Abuse, Ruth's Place Women's Shelter, Mercy Community Health, and others. The number of participants is impressive given the short timeframe for the research study and the limited period allowed for quantifiably gathering and analyzing data.

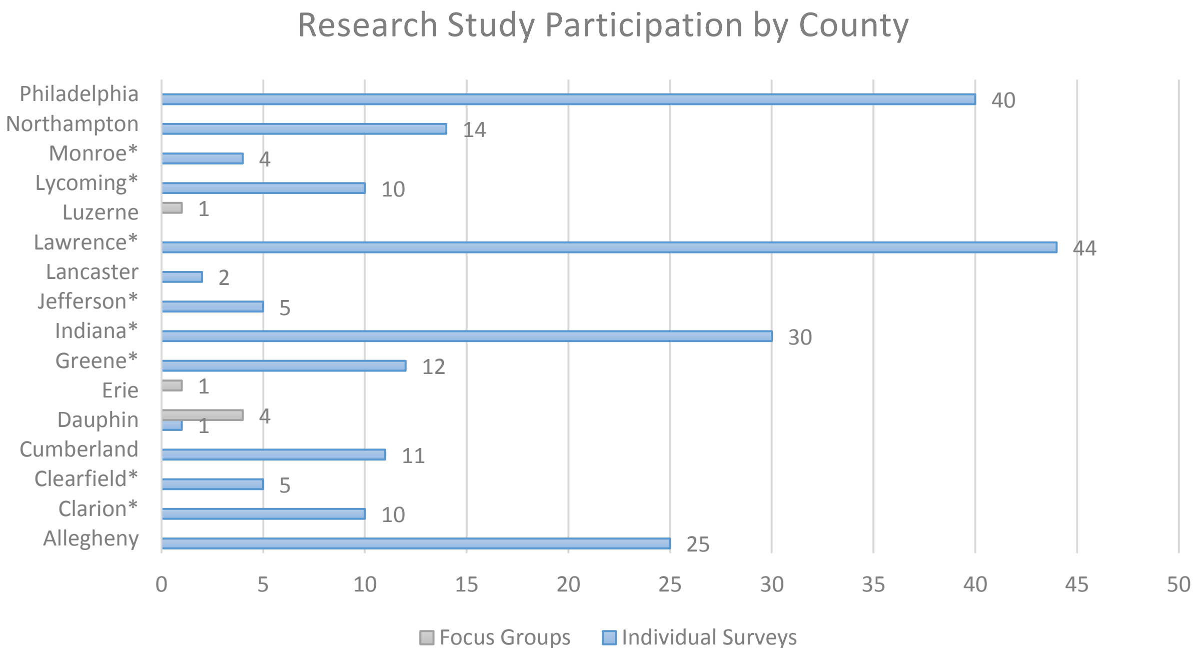
While it would be imprudent to extrapolate generalizations from the admittedly limited data received from this survey, it has given us the opportunity to receive direct input from people currently experiencing homelessness, and the opportunity to hear from them directly is extremely valuable. One of the HR 550 guidelines was to interview individuals and families, to contact communities, and a consumer survey and focus groups proved to be an effective method to do that. It provided people who are currently homeless an opportunity to be heard. Many of them appreciated this opportunity. A compelling indicator of the survey's value was the wish expressed by a number of participants that similar surveys be conducted on a regular basis.

Findings

The presentation of the data collected includes tables that list the variable counts and percentages. This plan best represents the data by providing aggregated numbers from the reporting sources.

Of the 213 individual participants, a majority of respondents (56%, n=120) were consumers in rural county or private agencies serving the homeless, while all focus group participants represented urban county consumers. The Center for Rural Pennsylvania defines rural and urban based on population density. On its website, the Center for Rural Pennsylvania (2015) explains that population density is calculated by dividing the total population of a specific area by the total number of square land miles of that area. According to the 2010 United States Census, the population of Pennsylvania is 12,702,379 and the number of square miles of land in Pennsylvania is 44,743. Therefore, the population density is 284 persons per square mile[509]. To illustrate county population, an asterisk is marked beside each rural county in Table 1.

Table 1. County Breakdown of Survey Participants



Descriptive Statistics of Individual Interview Surveys

In fourteen counties, 213 surveys were completed by adult individuals who currently are experiencing, or have in the past experienced, homelessness. Of these respondents, 139 (65.6%) identified as single, with 48 (22.6%) identifying as part of a household, and 24 (11.3%) not providing an answer to this question.

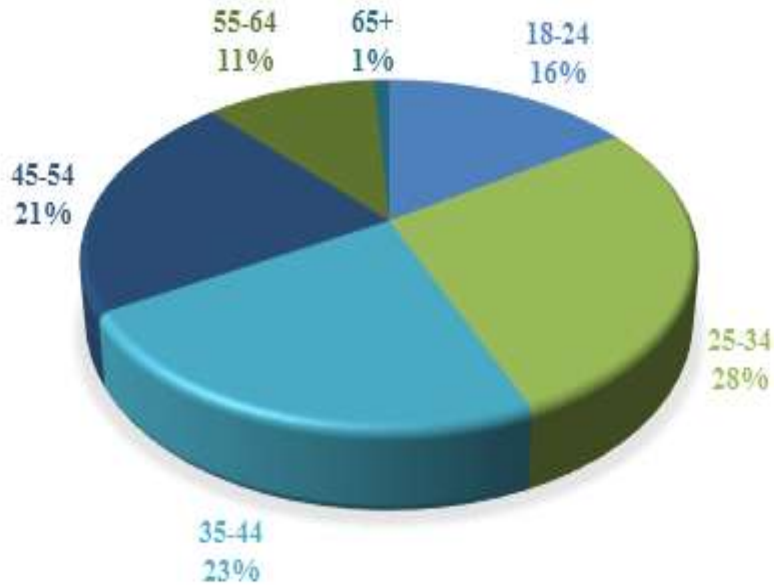
[509] The Center for Rural Pennsylvania. *Demographics: Rural Urban Definitions, available at* http://www.rural.palegislature.us/demographics_rural_urban.html (accessed May 1, 2015).

Table 2. Household Composition of Homelessness Survey Respondents

In addition, respondents were asked to provide their current age. Of the 205 participants who provided an answer to this question, 32 reported to be between the ages of 18-24 (16%), 57 reported to be between the ages of 25-34 (28%), 46 reported to be between the ages of 35-44 (23%), 44 reported to be between the ages of 45-54 (21%), 22 reported to be between the ages 55 and 64 (11%), and two reported to be 65 years or older (1%). Comparatively, survey participants were also asked about their age at the time of first experiencing homelessness. Of the 193 participants who responded to this question, 11 reported that they were under the age of 18 (6%), 50 reported that they were between the ages of 18-24 (26%), 43 were between the ages of 25-34 (22%), 41 were between the ages of 35-44 (21%), 36 were in 45-54 age range (19%), 11 were in the 55-64 age range (6%), and one reported to be 65 years or older at the time they first became homeless (1%).

Age variety of the respondents is remarkable. Even a comparatively small, random survey like this encompassed people in their twenties, thirties, forties, fifties, and sixties. Likewise, the age of the children whose parents were homeless at the time of the survey ranged from several months to eighteen years, including every single year in-between. A disconcerting observation here is that the largest age group was also the youngest: babies 0 to 1 constituted 6.1 percent, more than any other age group. Obviously, children are most vulnerable at this stage. Additionally, it has been demonstrated how critical early brain development is for the entire future life of an individual. The longer a child remains homeless, the more pronounced adverse effects are.

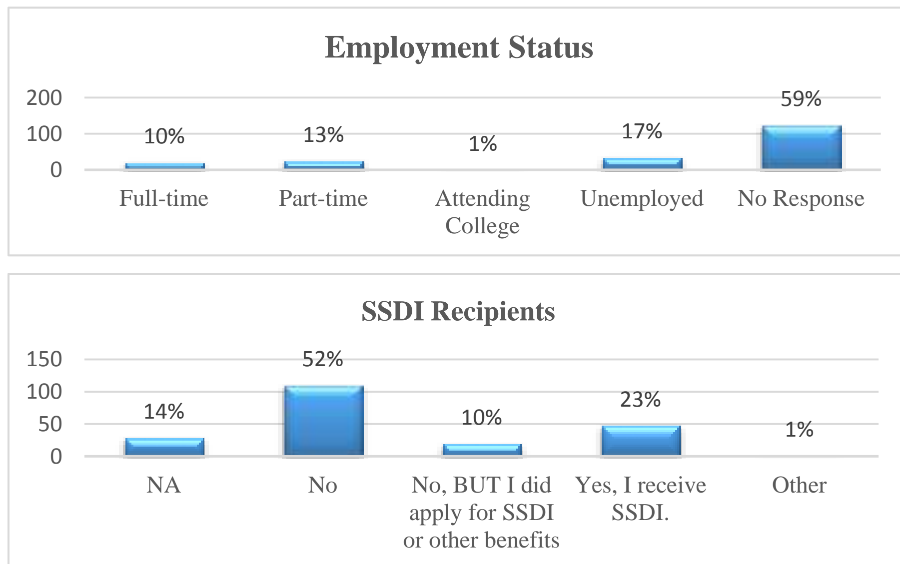
Table 3. Current Age of Survey Respondents



Participants were also asked about their employment status and if they receive SSDI benefits. Of the 213 survey participants, 36 reported that they are unemployed (17%), 22 reported that they are employed full time (10%), 27 reported that they are employed part time (13%), two are college students (1%), and 126 did not provide an answer to the employment question (59%).

Additionally, the majority of respondents reported that they do not receive SSDI benefits (52%, n=111), with only 49 of the 213 participants reporting that they do receive SSDI (23%). A small percentage of survey participants (10%, n=21) reported that they have applied for SSDI or another benefit but do not receive this assistance currently.

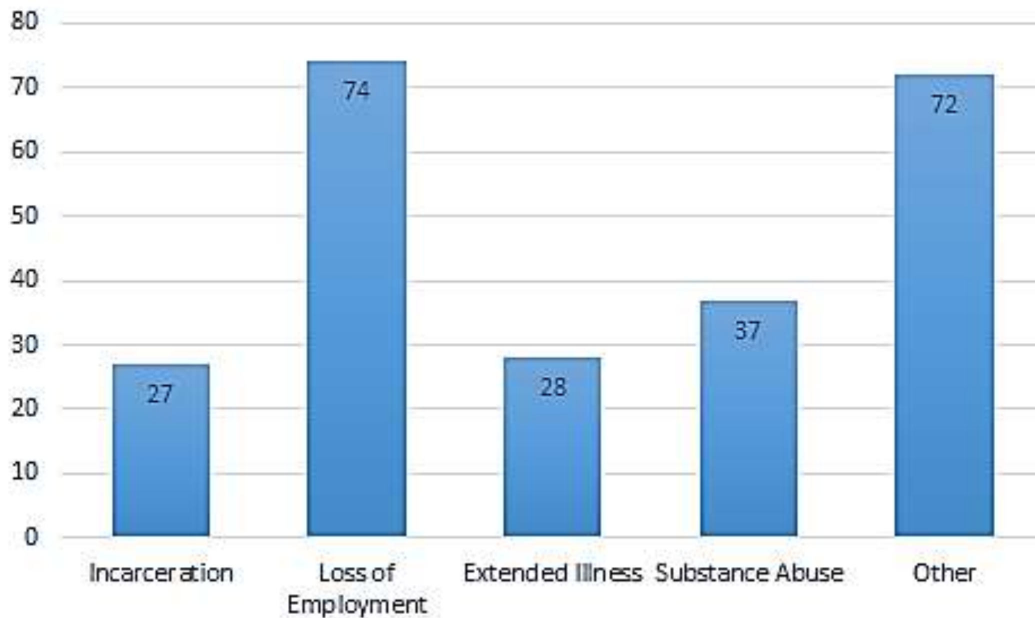
Table 4. Employment Status and SSDI Recipients of Survey Respondents



Individual Survey Analysis

As part of the individual survey, participants were questioned about the long-term issues leading to homelessness. Of those who responded, 35% reported that they lost their job, 17% cited substance abuse issues, 13% reported that they or a household member had previously been incarcerated, and 13% reported issues related to an extended illness, citing both physical and/or mental health illnesses.

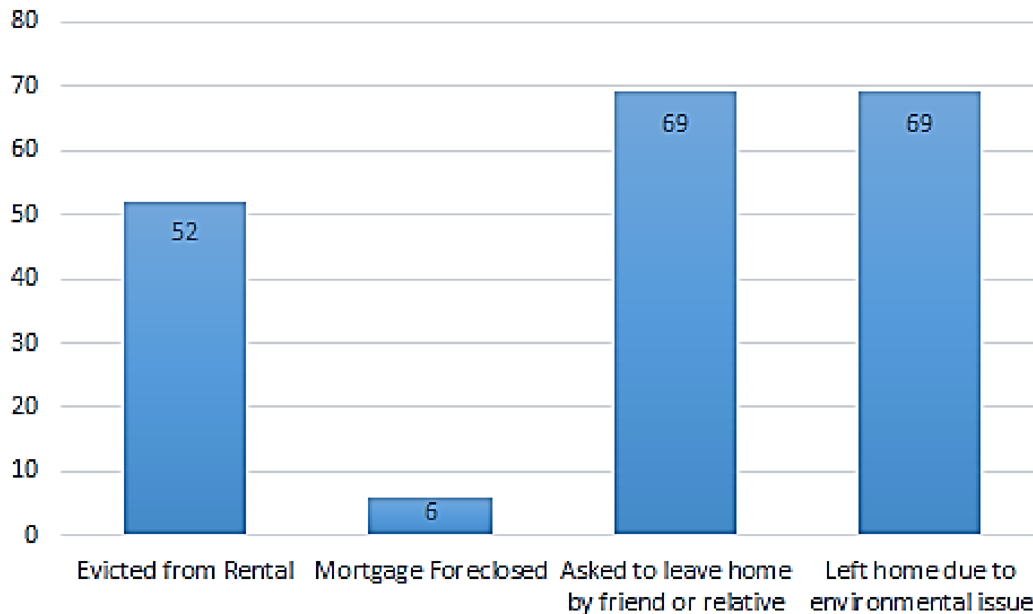
Table 5. Reported Long Term Issues Leading to Homelessness



1. Counts based on those participants that answered the question (n=213).
2. Some respondents answered "yes" to more than one factor, or provided "other" response in addition.

Additionally, survey participants were asked about specific housing issues leading to their homelessness status. As a result, 32% of participants reported that they were asked to leave their home by a friend or relative, 32% left their residence due to environmental issues, 24% were evicted from their rental property, and 3% reported that their mortgage was foreclosed. In addition to the factors listed, respondents were given an option to write in supplementary information regarding housing issues leading to homelessness, and those who indicated that they vacated their housing due to environmental issues cited a range of reasons, including fire damage to their residence, carbon monoxide leaking, neighborhood crime rate, and domestic violence within the home.

Table 6. Reported Housing Issues Leading to Homelessness



1. Counts based on participants that answered the question (n=213).
2. Some respondents answered "yes" to more than one factor.

Analysis of Family Homelessness

In addition to obtaining information regarding the characteristics and factors related to individual homelessness, the survey also asked questions related to the impact of family homelessness. For the purposes of this study, the term "family" has been characterized as any individual or household who has one or more children under the age of 18 years. Of the 213 individual survey respondents, only 77 reported that they have children under the age of 18 years. Of the 77 respondents, 69 participants (90%) reported that their children were unable to remain in the home at the time of their parent becoming homeless. Of these same participants, 33 reported that one or more of their children were under the age of six (48%), 34 reported to have one or more children between the ages of 6-12 years (49%), and 15 reported to have at least one child between the ages of 13-17 years (22%). Of the 69 respondents with children under the age of 18 years at the time of being homeless, 34 reported having more than one child with them at the time (49%), which resulted in multiple answers to the age range question.

Of the 33 parents surveyed whose children are currently under the age of six and homeless, 21 reported that their child(ren) are enrolled in a preschool or child care program (64%). Additionally, the same number reported that their child(ren) under the age of six have also been screened for eligibility of Early Intervention services.

Of the 77 parents surveyed who have children under the age of 18 years, 61 reported that their children are enrolled in school (79%), and 11 reported that their children had to change schools during the time period that they were homeless (14%).

Table 7: Survey Participants with Children Experiencing Homelessness

Homeless Children under the age of 18	Count	Percentage
Yes	**77**	**36%**
No	136	64%
Total	213	100%
Children Able to Stay in Their Home		
Yes	8	10%
No	**69**	**90%**
Total	77	
Ages of Children Experiencing Homelessness		
0-5 years	33	48%**
6-12 years	34	49%**
13-17 years	15	22%**
Total*	82*	
Preschool or Child Care Enrollment for Children < 6		
Yes	21	64%
No	12	36%
Total	33	
Screened for Early Intervention Services		
Yes	21	
No	12	
Total	33	
Children Enrolled in School		
Yes	61	79%
No	10	13%
NA	6	
Total	**77**	
Children Who Changed Schools		
Yes	11	14%
No	28	36%
NA	38	
Total	77	
*Some respondents marked more than one answer to reflect having more than one child		
**Percentage of total children reported (N=77)		

In addition to questions about the characteristics of those experiencing homelessness, the survey also asked for suggestions on how to address the issue of homelessness. Respondents' answers varied; however, there were central themes throughout, which included the following:

- Educational housing and budgeting programs should be offered, with a low- income housing incentive provided for successful completion of the program. Subsidized housing can then be offered for six months to a year while the individual or family regains financial stability. Additional assistance options could include 3-6 months of rent, utility payments, and child care to also allow for families to regain financial stability.
- In addition to low-income or subsidized housing options, applicants should also be able to provide volunteer time and work in exchange for housing.
- Many participants suggested that abandoned buildings be remodeled and made available as affordable housing.
- It should be taken into account how criminal fines impact an individual's ability to afford basic needs and pay monthly bills.
- We should create more employment and housing programs that focus on enhancing the status of ex-offenders (including sexual offenders) and reevaluate the impact of criminal background restrictions on housing options.
- Child care within the shelter settings is a necessity, as single parents are unable to engage in job search or to attend appointments for housing without free child care options. In general there exists the need for affordable childcare for low- or middle-class parents, as the cost of child care is a great financial burden.
- The minimum wage should be increased to a livable wage so that individuals and families could afford basic needs, including housing.
- Those experiencing homelessness should be offered increased transportation options, to include gas cards and/or free, daily runs from shelters to grocery stores, assistance office, employment office, etc.
- There should be programming for individuals without substance abuse or mental health issues. Many programs require a diagnosis for participant eligibility.
- The process for obtaining SSDI and SSI needs to be examined and expedited, as the long period for approval puts a heavy financial burden on individuals who cannot obtain employment due to medical issue(s).
- Victims of domestic violence must be empowered to stay away from their abuser by providing housing programs with intensive support and resources for gaining independence.
- Regular surveys of homeless service consumers should be conducted in order to continuously be aware of issues/barriers and provide volunteer opportunities through homeless programs/shelters in exchange for affordable housing. This not only provides experience and practice wisdom to the service delivery, but also gives more options for consumers to obtain housing if they do not have income.

Focus Group Analysis

Between January and March 2015, a total of six focus group surveys were held by shelter and transitional housing agencies, with a total of 42 participants from four different agencies in three separate counties: Dauphin, Luzerne, and Erie. The responses from each focus group were formatted differently; therefore, participant responses are detailed by agency.

The YWCA of Greater Harrisburg Focus Group Outcomes. The YWCA of Greater Harrisburg conducted three focus groups over the course of the month of March. Initially, the focus groups were intended to contain a representative from each client population, i.e. Emergency Shelter and Winter Overnight Shelter, Transitional Housing and Permanent Supportive Housing; however, only one shelter resident accepted the invitation to participate. As a result, the subsequent two focus groups offered were not limited to the type of service delivery the client was receiving, and more participation resulted.

The first focus group contained only one participant. Participant #1 was a young adult female who reported that she was adopted after being a part of the foster care system. She reported that she was placed in a group home at the age of 15-16 after experiencing mental health issues that included anger, depression, and suicidal thoughts. At 18, Participant #1 attempted to move back in with her parents; however, they refused her reunification due to her mental health. In September 2014, Participant #1 was accepted into the Transitional Program through the YWCA, and she is currently on the Dauphin County Housing Authority list.

The second focus group had five participants, all adult females, with the oldest participant reporting to be in her late fifties. These participants attributed their homelessness to incarceration, memory loss, abuse, and "not being able to pay rent". When asked what services or assistance may have prevented them from becoming homeless, respondents mentioned more cooperation between the county and local agencies and more programs available for ex-offenders. During the discussion, participants detailed frustrations about the inability to access services without valid identification or obtain employment with a criminal background. Participant 5 shared her disappointment at being repeatedly turned away by service providers: "it's very discouraging when the agency shuts its door on you".

Though all of the women expressed satisfaction with the services they have received through the YWCA, they also offered suggestions for improvement, which included increased privacy, longer periods of shelter stay, and the option to cook whatever they want and in the manner that they want. Participants also suggested that abandoned homes in the area be repaired to provide additional housing options for the homeless, and that housing deposits be covered or waived, as "it takes time to save that kind of money". Participant 3 suggested that there be separate programs that focus on ex-offenders and provide them with the tools and resources to make a fresh start.

The third focus group conducted by the YWCA of Greater Harrisburg included nine participants. All participants were adult females who reported that the immediate causes leading to homelessness involved economic problems, not paying rent, domestic violence, death of a spouse, having an undiagnosed mental illness, and incarceration.

Participants of the third focus group offered many suggestions for improvement of service to the homeless community. All participants agreed that there should be a Women's Mission—similar to the Men's Mission that is currently operating in Harrisburg. This program would provide women with access to multiple services in one location, including drug and alcohol counseling, prenatal care, ex-offender assistance, and a residential shelter. The women cited Downtown Daily Bread in Harrisburg as a successful example of this kind of service programming.

Additional suggestions included change machines in the shelter facilities so that women could pull change to clean their laundry or access public transportation, as well as group transportation available for shelter residents that make routine runs for grocery shopping and other necessary living activities.

The women also suggested that homeless individuals should provide networking and advocacy groups for others who are experiencing homelessness, so as to acclimate consumers to available programs and resources. They suggested that regular focus groups be conducted at homeless service agencies in order to generate improvement and advocacy on their behalf. Further, participants suggested that service providers who work with the homeless community make more effort to educate the surrounding communities and raise awareness.

Throughout all three focus groups conducted at the YWCA of Greater Harrisburg, the following themes recurred:

- Participants did not have family support or any strong community network prior to becoming homeless.
- Many participants suffered from mental illness, substance abuse, and domestic violence.
- All residents seemed fairly pleased by the services they were receiving from the YWCA and other local service agencies.
- Many of the women believed that state legislatures could put funds into renovating abandoned and condemned housing in Harrisburg to help provide more housing options for the homeless persons.
- Many participants would like advocates who have been in their shoes and can talk to them and assist them from experience.
- Participants expressed a wish to have more options for transportation to necessary appointments other than medical transport provided by some social service agencies.

Additional observations from all three focus groups included the need for more:

- centralized service delivery so that needs could be met in one place
- housing services available to women who have been previously incarcerated
- services available to those homeless individuals who are not from the local area

Brethren Housing Association (BHA), Transitions Program. Transitions is a transitional housing program in Harrisburg for homeless women with children. Families reside in BHA housing for up to two years while they receive intensive case management services to work on goals such as employment, budgeting, education, parenting, housing, etc. Five female, adult residents of the BHA program participated in the focus group. The group facilitator provided no demographic information on participants.

During this focus group, participants detailed issues that led to homelessness, which included lack of support system, self-doubt, poor decisions at a young age, lack of independent living skills, lack of money management skills, loss of employment, and mental health issues. Participants expressed their opinion that basic living skills such as budgeting, household management, credit building, knowledge of available services, and public system navigation should be taught in school, starting at a young age. Some participants said that family members had previously put utility bills in their names without their permission or knowledge, leaving them responsible for large amounts of debt and poor credit before they became independent.

Participants, all of whom are mothers, shared fear of accessing services due to the possibility of Children and Youth Services becoming involved and removing their children from their custody. One participant in particular expressed fear that each of her children would be sent to live with different relatives, and she did not want her children to grow up separately from each other. Furthermore, participants reported the increased anxiety of not knowing when the family would be reunified once separated. A barrier to receiving services as a family is the common restriction that families cannot access shelter services if they have more than two children. Families that utilize BHA can consist of five to six children, and shelters cannot accommodate these large families.

The focus group discussed other barriers to accessing services. Low-income housing is most often available far away or on the outskirts of an area where an individual works, causing employment issues and/or loss. Service delivery, for example access to the HELP Ministry in Harrisburg, which is the central location for emergency shelter placements, is only available during normal business hours, requiring for working individuals to take off work to seek out assistance, which negatively impacts their employment status. There were other complaints against the HELP Ministries, including their inability or unwillingness to help people with criminal backgrounds or to provide local rental assistance, which, according to some of the participants, could have averted their ending up in shelters altogether. Some participants felt they had received false hope from the HELP Ministry and did not get services they had expected. Women in the focus group also cited workplace discrimination as a barrier to maintaining stability, as they felt that they were discriminated against for having children and having to take time off to care for their children when sick.

Several participants stated that rental assistance could have prevented them from becoming homeless. One participant reported that she was denied assistance because she was told that she makes too much money; however, she felt that the assessment did not take into account the expenses of maintaining her family’s basic needs. Other participants related that they have had to settle for housing options that they would not ideally choose for their children, as affordable

housing is often in neighborhoods that are unsafe, consists of housing with poor conditions (roof falling in, mold, etc.), and is often coupled with poor landlord relationships.

Central themes during this focus group included effective service delivery, increased need for services to homeless individuals without children, and the persistent desire to obtain self-sufficiency. One participant recounted how when she was homeless prior to having any children, the level of available resources was dramatically lower than after she had children. She posited that if there had been more opportunities for her when she was a single adult, she may have been independently stable by the time she had children. Additionally, the focus group addressed the stigma associated with receiving assistance and service. The moderator described it in the following way:

There is the negative stereotype in society that makes people who are using certain social services seem 'lazy' or just 'using the system'. These stereotypes often negatively impact our families' abilities to further strengthen their future. Many of our families and participants have expressed a great interest in being able to get off of services, like welfare, in the future and not having to depend on them for the rest of their lives.

The BHA staff at BHA incorporated in the focus group report consumer suggestions for changing the current systems and policies to better meet the needs of the homeless population:

- Reevaluating the way criminal and credit background checks are analyzed for public housing and employment applications, considering the current homeless population and increasing opportunities for these individuals and families. Participants complained that their criminal background made them ineligible for public housing, illustrating how their past mistakes made it difficult for them to become stable and independent.
- Providing education regarding landlord and tenant rights so that everyone is aware of their rights and responsibilities in the rental process.
- Developing a system that increases wage opportunity and personal growth so that people are better able to meet their needs through employment.
- Participants shared a preference for Section 8 vouchers over public housing options so that they have the ability to choose the location in which they live and raise their family.
- Requiring a more thorough screening process for low-income housing applicants to ensure that those in the most need receive expedited services (for example, those who are homeless or in a housing program could receive priority).

In addition, the BHA staff offered some of their own feedback. Based on their daily experiences, they strongly support the need to reevaluate the way we analyze and judge criminal and credit background related to public housing and employment and to reconsider the low-income housing restrictions based on such backgrounds. They also highlighted the need to "develop a system to encourage people to increase their income but also be able to meet their needs so that they are not worse off working than when they were receiving assistance." Notably, the BHA staff expressed interest in being educated on the Housing First model and learning how it can be used more in their community.

Ruth's Place Women's Shelter, a program of Volunteers of America. Fifteen adult residents of Ruth's Place Women's Shelter program in Wilkes-Barre, Luzerne County, participated in a consumer focus group regarding homelessness. Participants ranged in age from 20 to 58 years, with the average age of the group being 41 years old. Twelve women indicated that they were single, and three part of a household. Of the 15 participants, two reported to be employed full time, four employed part time, and seven in the process of actively seeking employment. Additionally, two of the participants reported to receive SSD/SSI, and three were engaged in some phase of the application process.

When asked where they were previously living, seven women reported that they had been temporarily staying with friends or family, two were incarcerated, two had been inpatients at a psychiatric facility, one was evicted from permanent housing, one had been recently discharged from a substance abuse treatment program, one woman had been staying in a hotel, and one woman was sleeping on the street. When asked about the timeframe of homelessness, the women reported a range of two weeks to thirteen months. The average length of homelessness was three months, with eight out of the fifteen women reporting to have been homeless more than once during their lifetime.

When asked if there were any services that may have prevented them from becoming homeless, the women responded overwhelmingly that assistance with past-due rent and utilities, security deposit, and first and last months' rent would have been most beneficial. Additionally, the women reported that in order to maintain self-sufficiency, they needed assistance dealing with a landlord, help from family and friends, budgeting skills training, help with finding employment, counseling and case management services, and mental health and substance abuse treatment.

The women were questioned about any fears or barriers surrounding accessing services, and participants reported an initial fear of entering a shelter, fear of being looked down upon or treated poorly by service providers, and a fear of losing custody of their children. Study participants also cited the distance to service locations and lack of familiarity with available service providers as barriers to accessing services.

When asked about suggestions or solutions, participants requested more affordable housing options, income-based housing, and jobs with higher wages and better benefits. The women also suggested that the number of beds in emergency shelters be increased, with longer time limits on how long a person can stay in the shelter while getting on her feet. There was an expressed need for more transitional housing, more subsidized housing, and more options for housing that provided independent living programs.

Homeless Consumer Focus Group, Erie County. There were seven participants, with two females ranging in age from 36 to 50 years, and five males ranging in age from 41 to 61 years. All participants identified as single with no children currently under the age of 18. Of the seven participants, two reported to be employed full time, one employed part time, and four unemployed. One participant reported to receive SSDI, and three reported to receive SSI.

In regards to issues leading to their homeless status, five respondents reported that they were previously incarcerated, two respondents admitted to struggles with substance abuse, one respondent had an extended illness, and one respondent reported loss of employment. Length of homelessness varied from five months up to ten years, with up to five repeated occurrences of homelessness reported by one participant. One participant reported becoming homeless as early as at the age of 16, with another participant reporting the first experience with homelessness at the age of 56 years old.

When questioned about preferences concerning housing assistance, participants prioritized subsidized housing, permanent housing, permanent housing with supports, and independent housing as the most preferred. Additional assistance preferred included dental services, transportation, employment, and car repair. Of the seven participants, everyone reported utilizing the services of a community mental health agency, with five participants also utilizing food services and SNAP benefits, and four participants having utilized transportation assistance and public health services.

Participants were also asked to openly provide feedback regarding issues of homelessness and possible solutions, and responses varied. Participants believe that their background history should not be held against them when considering housing options, that housing eligibility restrictions should be decreased. Other participants suggested that more employment opportunities be made available, proposing that those who have experienced homelessness could be employed to work with those individuals and families who are currently experiencing homelessness. Additional suggestions included increased workforce training and increased funding to services for the homeless population.

Implications for Future Research

It is often inferred that effective research elicits more research. While conducting this preliminary study and reviewing subsequent data, we have identified several areas requiring further inquiry. Though current literature has explored the relationships of early childhood experiences and education on success later in life, continued investigation of the specific impacts of homelessness on children could be beneficial. Another area of additional scholarship that might bring illuminating results involves the diversity of family structures, including single-parent families, same-sex families, and children raised by adults other than their biological parents. Considerations could also be made for diversity among families of varying race and ethnicity, and additional studies could explore the relationships between specific cultures and the incidence and impact of homelessness in Pennsylvania.

Additionally, longitudinal studies could provide a wealth of information regarding the factors leading to homelessness as well as assess service availability and delivery once a person becomes homeless.

Concluding Thoughts

Though the survey does not purport to be exhaustive, as has been mentioned above, it offers an intimate look at the circumstances that have led some people to homelessness and reveals their perspective on causes of homelessness and possible solutions. As could be expected, most of the findings reinforce what has already been known from other sources. The survey results illustrate significant diversity of the homeless population. They also reveal several notable facts that deserve further discussion and should be considered in policymaking.

It is worthy of notice that almost a quarter (23 percent) of survey respondents were employed full or part time. This number may be even higher as more than a half of respondents did not provide any answer to the question regarding their employment. Similarly, over half of the women participating in a focus group at Ruth's Place Women Shelter in Luzerne County were either working or actively seeking employment.

The same percentage of individual survey respondents as those employed (23 percent) receive SSDI, and 10 percent have applied for either SSDI or other benefits.

As we are interested in finding solutions to the problem of homelessness in Pennsylvania, it is very important to identify immediate and long-term causes of homelessness, and the survey results contain salient information on that. For example, speaking of the immediate causes that left them without a place to live, almost one quarter of respondents said they became homeless as a result of being evicted from their rental property. We have to ask if there are concrete steps that can be taken to prevent similar evictions and thus, forestall homelessness.

Among the long-term issues that led to their homeless status, loss of employment was indicated by the largest share of respondents – 35 percent. Substance abuse, former incarceration and extended illness were perceived as the main cause of their homelessness by 13-17 percent of respondents. Domestic abuse appears to play a significant part as well.

When the survey participants were asked whether they felt that a particular kind of assistance might have helped to prevent them from becoming homeless, the answer that was given most often (somewhat surprisingly) was assistance with security deposit, first or last month's rent. Over 30 percent of respondents felt such assistance could have averted their homelessness situation. As mentioned earlier, we have to remember that the survey respondents' assessment of their circumstances may not always be reliable even when honest; nevertheless, this answer requires serious attention. If indeed such a limited, one-time, comparatively easy intervention could have prevented an individual or a family from ending up homeless, it appears to be clearly worthwhile for the state: not only would it save a person, maybe along with her children, from the trauma of homelessness and a host of problems associated with it, but it would cost the state or the county much less money and effort than providing care for her at any facility for the homeless.

The second kind of assistance that, in view of the people currently experiencing homelessness, could have prevented them from getting into this situation is assistance with employment (26.4 percent). The importance of this kind of help is self-evident and, arguably, most effective in the long run.

Financial assistance with past-due rent or utilities comes close third (24.1 percent). If you combine the first and the third group of answers and assume that most of them accurately reflect the real circumstances, it means that more than half of the people who were homeless at the time of the survey could have avoided that painful experience if they had received a single, limited, timely intervention. This clearly deserves attention.

When asked what type of housing assistance they would prefer, over one half of the survey participants selected subsidized housing (with rent generally no more than 30 percent of their income) and permanent housing (with a lease). A little less than one-third would like to have an independent apartment. A supervised apartment (housing with on-site staff) was the least popular choice.

Over 60 percent of respondents received case management services, and almost all received either SNAP (food stamps) or other assistance with meals (54.2 percent and 43.4 percent combined). 60 percent said they were satisfied with the services they received from the community agency. When asked what other types of assistance they would prefer, the largest number of participants (almost 28 percent) indicated transportation and employment. Case management was the next choice (over 20 percent).

Responses to an open-ended question regarding suggestions about the possible ways state or local agencies could help to prevent or end homelessness in Pennsylvania were summarized earlier in the report. In this concluding section, we would like to emphasize diversity of these suggestions. They vary from very general thoughts about the need for robust economic development, enhanced employment opportunities and affordable housing, to proper application of the existing criminal law or desirable changes in law and regulations, to very specific measures that can be taken by housing facilities such as offering transportation and child care services at the shelter. Studying these specific proposals could be helpful to providers.

Housing service agencies and their supervising authorities should also note specific assessments revealed by the survey. For example, if the HELP Ministry in Harrisburg received a number of negative comments and Downtown Daily Bread earned enthusiastic praise, concrete steps should be taken to make improvements to the practices of the former and to support and disseminate the activities of the latter.

Survey and focus group feedback evinces a clear emphasis on “helping more people who are actually trying to move forward in life,” as one of the respondents phrased it, on weeding out individuals who are abusing the system and on focusing instead on those who are willing and able to move ahead on the road to self-sufficiency. While there are numerous requests for permanent supportive housing for those who need it, many responses underline the wish to move to self-sufficiency as soon as possible. It is worth noting that several survey participants expressed concern that it is easier for some to stay in the system than to start working and secure their own housing, that there are, actually, disincentives to do that or factors that make it hard to achieve.

In this strive for self-sufficiency achieved through employment, people encounter different obstacles. Many feel they require additional training, and they are willing to accept it. However, participants complained that even upon completion of educational programs and obtaining a necessary certificate or degree, they still cannot obtain the employment they seek due to a problematic background. The survey feedback clearly indicates the need for reevaluation of the impact of criminal background upon employment and housing opportunities.

Many respondents pointed out the glaring paradox of scores of abandoned and continuously deteriorating buildings on the streets of Harrisburg and other cities while numerous families lose their residence every day. They urge the state leaders to come up with a program that would salvage these buildings, reinvigorate the neighborhoods they are in, and provide housing to those in need. This idea also deserves further scrutiny.

The feedback provided by individuals who are currently experiencing homelessness and who agreed to fill out a survey or participate in a focus group discussion offers a unique and illuminating perspective on the problem of homelessness and merits serious consideration by decision-makers.

CHILDREN AND YOUTH EXPERIENCING HOMELESSNESS: PREVALENCE, IMPACTS, AND MITIGATING STRATEGIES

OCCURRENCE AND TRENDS

In 2009, the National Center on Family Homelessness (NCFH) issued "America's Youngest Outcasts: State Report Card on Child Homelessness," to provide a comprehensive snapshot of child homelessness in the United States. In this update of its original study, NCFH concludes that compared to the situation a decade ago, "the problem of child homelessness is worsening."[510]

In the past few years, the number of children and youth experiencing homelessness has reached historic highs. According to new federal data published in the fall of 2015, the number of homeless children in public schools exceeded 1.3 million in the 2013-2014 school year.[511] This is a record national total, and it means the number of homeless students has doubled since before the recession. The number of students identified as homeless and enrolled in school has increased over the last three years, with a change of almost 15 percent.[512] The greatest growth was seen in preschool-aged children and ninth-grade students. Commenting on the data, the National Center on Homeless Education notes that the change seen in preschool-aged children is especially likely to represent efforts to improve data quality for this category or recording of students as enrolled in school instead of served.[513]

In Pennsylvania, 24,504 children and youth who experienced homelessness were reported as being served during the 2013-14 program year (directly or indirectly), of which 20,785 were also identified as being enrolled in school. The 24,504 children and youth represent 96 percent of school districts.[514]

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[510] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).
[511] The National Center for Homeless Education. *Federal Data Summary School Years 2011-12 to 2013-14.* November 2015, available at http://www2.ed.gov/programs/homeless/data-comp-sy13-14.pdf (accessed February 23, 2016).
[512] Ibid.
[513] Ibid. The McKinney-Vento Act defines "enrolled" as "attending classes and participating fully in school activities" [42 U.S.C.A. § 11434(a) (1)] and "served" as those who have been served directly or indirectly through McKinney-Vento funds regardless of their enrollment in school or preschool [42 U.S.C.A. § 11433].
[514] Pennsylvania Department of Education. *Education for Children and Youth Experiencing Homelessness Program 2013-14 Stathttp://www.education.pa.gov/K-12/Homeless%20Education/Pages/default.aspx#.VstnyfMo6poe Evaluation Report*. January 2015, available at http://www.education.pa.gov/Documents/K-12/Homeless%20Education/PA%20Education%20for%20Children%20and%20Youth%20Experiencing%20Homelessness%20Program%202013-14%20State%20Evaluation%20Report.pdf (accessed February 22, 2016).

Recently, the People's Emergency Center (PEC) in Philadelphia that has consistently regarded helping families and children who are experiencing homelessness as a priority, issued a policy brief based on the national data, the Pennsylvania state evaluation report, and PEC's own earlier summaries. It includes the following graphs illustrating the dynamics of children and youth homelessness in Pennsylvania in the past few years:

Number of Children and Youth Who Are Homeless, Pennsylvania:

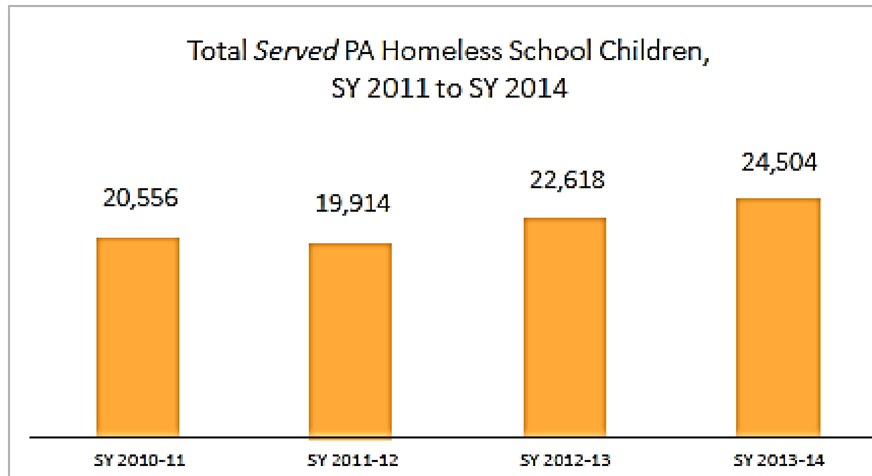

Figure 2. SY 2013-14 data from PDE 2015; SY 2010-13 data from previous PEC summaries

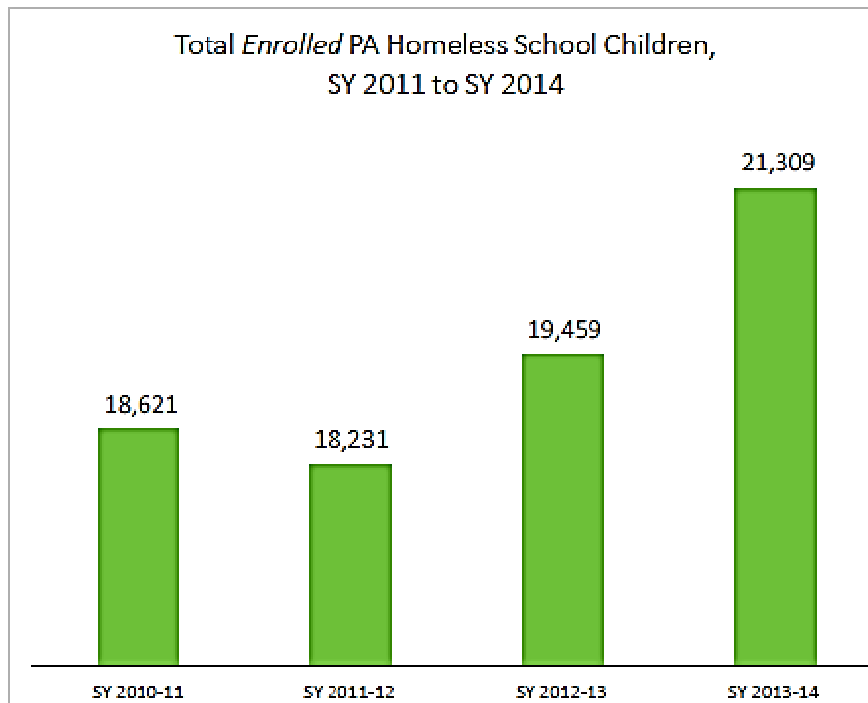

Figure 3. SY 2013-14 data from PDE 2015; SY 2010-13 data from previous PEC summaries

In its commentary, PEC emphasizes that "youth homelessness is increasing and vastly under-reported" and "the need to increase attention on children and youth grows."[515] PEC also points out two troubling issues made clear by the comparison of Pennsylvania homeless students data with national indicators. One of them is that a larger segment of homeless children and youth are living in shelters in Pennsylvania than in the United States in general (29 percent versus 15 percent – almost double).[516] Both in the Commonwealth and nationally, the majority of homeless children and youth are living doubled-up, but in in Pennsylvania, the number is smaller: 63 percent of homeless children and youth are living doubled-up compared to 76 percent - more than three quarters - nationally.[517] Another worrisome area highlighted by PEC is the homeless students' academic achievement. The percentage of students in grades three to eight meeting or exceeding state proficiency in reading and maths declined between the school years 2010-11 and 2013-14, and PEC regards this as an ominous signal for Pennsylvania's homeless students' academic future.[518]

There are certainly valid concerns about the growing numbers of children and youth reported as homeless; however, while interpreting the data, it is important to realize that part of the registered growth is the result of better efforts at identifying and serving these children, which is, in fact, a positive phenomenon. It is equally important to remember that a number of students experiencing homelessness may still remain unknown and thus, not be receiving any services they are entitled to. This number is likely to be more significant for certain subgroups such as unaccompanied youth and children of preschool age, especially the youngest and the most transient.

A thoughtful analysis of childhood homelessness in Pennsylvania was performed by Dr. Staci Perlman and Mr. Joe Willard from the PEC. Their report relied mostly on data submitted by the Pennsylvania CoCs and allowed to create an illuminating general picture of childhood homelessness in the Commonwealth as well as, importantly, significant regional differences. The study examined children and youth using emergency housing and transitional housing programs, and the authors repeatedly underscored that the actual number of homeless children in Pennsylvania was higher because those who were not served by those programs remained unidentified and often unserved.[519] That would include children who were living doubled-up with family or friends, in domestic violence shelters, in cars or public places. Children experiencing homelessness in rural areas tend to be undercounted to an even higher degree than those in urban settings. Noting that approximately a quarter of people served in the emergency housing system

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[515] People's Emergency Center. *Historic Increases in the Number of Children and Youth Experiencing Homelessness in United State and Pennsylvania*, available at http://www.pec-cares.org/clientfolders/pdf/PEC%20EHCY%202015%20Summary-2016%201%2021%20FINAL.pdf (accessed February 17, 2016).
[516] Ibid.
[517] Ibid. See also The National Center for Homeless Education. *Federal Data Summary School Years 2011-12 to 2013-14.* November 2015, available at http://www2.ed.gov/programs/homeless/data-comp-sy13-14.pdf (accessed February 23, 2016).
[518] Ibid.
[519] Perlman, Staci and Joe Willard. *Childhood Homelessness in Pennsylvania*. Philadelphia, PA: People's Emergency Center, October 2013, available at http://www.pec-cares.org/clientfolders/pdf/Childhood%20Homelessness%20in%20Pennsylvania%20Full%20Report.pdf (accessed January 26, 2015).

are under the age of eighteen and that very young children are disproportionately more likely than older children and youth to have spent at least one night in the emergency/transitional housing, the researchers opined that "this population's needs could be addressed earlier in their lives rather than later, which would certainly affect programmatic effectiveness and cost."[520]

Pennsylvania has made clear progress in the past few years. In its latest "State Report Card on Child Homelessness," the National Center on Family Homelessness ranked Pennsylvania 8th out of 50 states for the year 2013.[521] It was ranked 14th in the 2009 NCFH report.[522] Each state is assigned a rank of 1 (best) to 50 (worst) based on a state composite score that reflects each state's overall performance across four domains:

1) extent of child homelessness
2) child well-being
3) risk for child homelessness
4) state policy and planning efforts.

Not only has Pennsylvania moved upwards from 14 to 8 in overall ranking, but it has shown notable improvement in specific categories directly related to homelessness surging from rank 34 to 5 in the extent of child homelessness in a five-year period and from rank 27 to 11 in the risk for child homelessness category.[523] This significant progress indicates that the efforts the Commonwealth has been making to reduce children's risk of homelessness have brought positive results and should continue as no child should be homeless in Pennsylvania.

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[520] Ibid.
[521] The National Center on Family Homelessness. America's Youngest Outcasts: State Report Card on Child Homelessness. Newton, MA, 2014, available at http://www.homelesschildrenamerica.org/mediadocs/276.pdf (accessed March 9, 2016).
[522] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).
[523] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).
The National Center on Family Homelessness. America's Youngest Outcasts: State Report Card on Child Homelessness. Newton, MA, 2014, available at http://www.homelesschildrenamerica.org/mediadocs/276.pdf (accessed March 9, 2016).

HEALTH

General Health

Homelessness affects children in many ways. One of the critically important negative impacts is on the child's general health. Since family and child homelessness has become a growing and increasingly recognized problem in the 1980s, researchers engaged in the analysis of medical consequences of homelessness. These studies have clearly established that homelessness can cause illness and aggravate existing medical problems; homeless children tend to be in poorer health than their housed counterparts.[524]

The first national study performed by NCFH in 1999, "Homeless Children: America's New Outcasts," identified several health problems homeless children are beset by to a significantly higher degree than the rest of their peers. NCFH researchers concluded that homeless children

- Are in fair or poor health twice as often as other children and four times as often as children whose families earn more than $35,000 a year.
- Have higher rates of low birth weight and need special care right after birth four times as often as other children.
- Have very high rates of acute illness, with half suffering from two or more symptoms during a single month.
- Have twice as many ear infections, five times more diarrhea and stomach problems, and six times as many speech and stammering problems.
- Are four times more likely to be asthmatic.
- Go hungry at more than twice the rate of other children.[525]

An updated NCFH report, summarizing the growing body of research, reasserts:

- Poor health for homeless children begins at birth. They have lower birth weights and more often need specialty care immediately after birth as compared with housed children.
- From infancy through childhood, homeless children have significantly higher levels of acute and chronic illness.
- Predictably, homeless children have poorer access to both medical and dental care.[526]

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[524] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).
[525] The National Center on Family Homelessness. *Homeless Children: America's New Outcasts.* Newton, MA, 1999, available at http:/www.colorado.edu/cye/sites/default/files/attached-files/outcasts.pdf (accessed May 15, 2015).
[526] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).

While poverty in general presents health risks to children (those from low-income families have consistently been found to have more medical problems and poorer health outcomes than those from high-income families), homelessness in itself is a serious aggravating factor. Carefully designed, case-control studies that compared health status of homeless and low-income housed children attested to significant differences. One of such studies performed in Massachusetts, using a variety of outcome measures including health status, acute illness morbidity, emergency department and outpatient medical visits, established that mothers of homeless children were more likely to report their children as being in poor or fair health compared to their housed counterparts.[527] The fair/poor health metric is widely used by the medical community nationally and internationally. Fair/poor health status based on this measure is acknowledged to be highly predictive of health services utilization, including hospitalizations and outpatient visits. Other findings of the Massachusetts study were that homeless children experienced a higher number of acute illness symptoms such as fever, ear infection, diarrhea, and asthma; emergency room and ambulatory visits were higher among the homeless group.[528] The researchers concluded that "homelessness is an independent predictor of poor health status and high service use among children" and that "the present findings highlight the importance of preventive interventions and efforts to increase access to primary care among homeless children."[529]

Homelessness creates and compounds health risks for children in several ways. It is broadly recognized that "the impact of homelessness begins well before a child is born."[530] Summarizing existing research, the authors of the recent report on the effects of homelessness on children's health point to a growing body of evidence that "a child's health and development are critically dependent on his mother's mental and physical well-being during pregnancy."[531] Homeless women's health has often been compromised by their difficult life circumstances. Many of these women have experienced homelessness themselves when they were children. Many of them have also experienced physical and sexual abuse and the cumulative stress of persistent poverty. They are likely to be suffering from depression and acute stress caused by their homelessness status or the circumstances that led to it such as domestic violence.

Pregnancy rates among homeless women are high: "Nationally, 35 percent of women coming into shelters are pregnant versus 6 percent of the general population, and 26 percent have given birth within a year of seeking shelter."[532] Prevalence of pregnancy in certain groups of homeless youth is even higher. A comparative study of the prevalence of pregnancy among runaway and homeless youth between the ages of 14 and 17 years in various settings versus their

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[527] Weinreb, Linda et al. "Determinants of Health and Service Use Patterns in Homeless and Low-income Housed Children" *Pediatrics*. Vol. 102. No. 3 September 1, 1998 (doi: 10.1542/ped.102.3.554).
[528] Ibid.
[529] Ibid.
[530] Hart-Shegos, Ellen. *Homelessness and its Effects on Children: A Report Prepared for the Family Housing Fund*. Family Housing Fund: Minneapolis, MN, December 1999, available at http://www.fhfund.org/wp-content/uploads/2014/10/Homelessness_Effects_Children.pdf (accessed May 28, 2015).
[531] Sandel, Megan, Richard Sheward and Lisa Sturtevant. *Compounding Stress: The Timing and Duration Effects of Homelessness on Children's Health.* Center for Housing Policy and Children's Health Watch, available at http://www.childrenshealthwatch.org/wp-content/uploads/Compounding-Stress_2015.pdf?utm_source=Compounding+Stress+-+ALL+-+June+15&utm_campaign=Compounding+Stress+-+ALL+-+June+15&utm_campaign=Compounding+Stress+-+ALL+June+15&utm_medium=email (accessed June 12, 2015).
[532] Hart-Shegos, Ellen. Op. cit.

peers in the general population revealed significantly higher pregnancy rates among homeless adolescents, especially those living on the streets. The authors of that study used three surveys of youth: the first nationally representative study of runaway and homeless youth residing in federally and nonfederally funded shelters, a multiple survey of street youth, and a nationally representative household survey of youth with and without recent runaway and homeless experiences. The findings evinced that "youth living on the streets had the highest lifetime rates of pregnancy (48%), followed by youth residing in shelters (33%) and household youth (< 10%)."[533] The researchers concluded that street and shelter adolescents were at much greater risk of having ever been pregnant than were youth in households and consequently, "such youth need comprehensive services, including pregnancy prevention, family planning, and prenatal and parenting services."[534]

Once pregnant, homeless women face various obstacles to healthy pregnancies, including substance abuse, chronic and acute health problems that can affect the prenatal development of the offspring, and lack of prenatal care.[535] Approximately one-fifth of homeless women disclosed drug and alcohol use during pregnancy, which is alarming in light of the "overwhelming evidence that chemical abuse harms prenatal development and later cognitive and behavioral development of their children."[536] Though homeless women's often compromised health makes prenatal care even more essential to them than to healthy women, they are much less likely to get it: "Fifty percent of homeless women versus 15 percent of the general population had not had a prenatal visit in the first trimester of pregnancy. Forty-eight percent of homeless women had not received medical assessment of their pregnancy before being admitted to the shelter."[537]

An important indicator of the child's future health is his or her birth weight. "Children born into homelessness are more likely to have low birth weights. A child with a low birth weight and whose mother did not receive prenatal care is nine times more likely to die in the first 12 months of life."[538]

Homelessness exposes babies and infants to numerous environmental factors that can endanger their health, including overcrowded conditions at a shelter or a home of a family member that increase babies' exposure to disease and illness, lack of sanitation, lack of refrigeration and sterilization for formula.[539] Maternal stress is a portentous factor in itself. Later on, the above-mentioned environmental factors continue to raise the risks of diarrhea and various infections.

Homeless children are at high risk of infectious disease. They suffer from respiratory infections at twice the rate of housed children, and even more ominously, they are twice as likely to have a positive skin test showing exposure to tuberculosis.[540]

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[533] Green J.M., Ringwalt C.L "Pregnancy Among Three National Samples of Runaway and Homeless Youth." *Journal of Adolescent Health.* Vol. 23. No. 6. December 1998. Pp.370-377.
[534] Ibid.
[535] Hart-Shegos, Ellen. Op. cit.
[536] Ibid.
[537] Ibid.
[538] Ibid.
[539] Ibid.
[540] Hart-Shegos, Ellen. Op. cit.

Poor nutrition contributes to homeless children's poor health. They are six times more likely than other children to have stunted growth and seven times more likely to experience iron deficiency leading to anemia. Moreover, when found anemic, homeless children's iron deficiency is 50 percent worse than anemia among housed poor children."[541]

Limited access to health care increases health risks and exacerbates existing medical problems. An illuminative indicator is that, according to research, "at least one-third of all homeless infants lack essential immunizations."[542] It is widely acknowledged that homeless children are far more likely to receive poor preventative care and excessive emergency treatment. An influential national study divulged that 60 percent of homeless families surveyed stated they had visited the hospital emergency room at least once within the past twelve months and 37 percent two or more times in the past year. More than 10 percent of those surveyed said that they or their children had been hospitalized in the past year. Nearly a third of the homeless children have never visited a dentist.[543] Based on the study submitted by the Kaiser Commission on Medicaid and the Uninsured, "America's Youngest Outcasts" report states that "although homeless children are likely to have more dental caries (e.g., tooth decay, cavities) as well as more severe decay at any age, they are twice as likely to have untreated caries in their primary teeth."[544] Lack of routine medical care and excessive emergency room treatment is not only detrimental to children's health, but it is also significantly costlier for taxpayers.

A good example to illustrate the cumulative nature of adverse factors impacting homeless children's health is prevalence and treatment of asthma. Asthma is a serious medical condition in itself and also a risk factor for other problems. Socioeconomic and racial disparities related to diagnosis and treatment of asthma are well known to the medical community. Low-income, racial minority children, especially in underserved communities, are more likely to be diagnosed with asthma, more likely to suffer from more severe forms of asthma, less likely to have their asthma controlled through medication use, and more likely to require emergency room treatment for asthma. They have higher overnight hospitalization rates and higher asthma-related mortality rates.[545] Homeless children are "hospitalized for symptoms at three times the rate of the average asthma patient."[546] Several studies have shown that homeless children have elevated rates of asthma; in fact, "across these studies, asthma rates for children living in a shelter were consistently two to three times the national prevalence."[547] A pioneering cross-sectional study in New York led the researchers to a grave conclusion that "the prevalence of asthma among a random sample of

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[541] Ibid.
[542] Ibid.
[543] The National Center on Family Homelessness. *Homeless Children: America's New Outcasts.* Newton, MA, 1999, available at http:/www.colorado.edu/cye/sites/default/files/attached-files/outcasts.pdf (accessed May 15, 2015).
[544] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).
[545] See Cutuli, J.J. "Asthma and Adaptive Functioning among Homeless Kindergarten-Aged Children in Emergency Housing." *Journal of Health Care for the Poor and Undeserved*. Vol. 25. No. 2, May 2014. Pp. 717-730. McLean, Diane E. et al. "Asthma Among Homeless Children: Undercounting and Undertreating the Undeserved." *Archives* of *Pediatrics and Adolescent Medicine*. Vol. 158. No. 3. Pp. 244-249. March 2004. Doi:10.1001/archpedi.158.3.244, available at http://archpedi.jamanetwork.com/article.aspx?articleid=485640 (accessed June 16, 2015).
[546] Hart-Shegos, Ellen. Op. cit.
[547] Cutuli, J.J. "Asthma and Adaptive Functioning among Homeless Kindergarten-Aged Children in Emergency Housing." *Journal of Health Care for the Poor and Undeserved*. Vol. 25. No. 2, May 2014. Pp. 717-730.

homeless children in New York City is likely to be 39.8% - more than 6 times the national rate for children. Asthma in homeless children is also likely to be severe and substantially undertreated."[548] The authors noted with concern that "12.9% of children reported significant levels of symptoms that were undiagnosed" and that "of homeless children with asthma, 43.0% have symptoms likely to be moderate or severe, in contrast to the approximately 30% of children with asthma who are commonly described as having moderate to severe symptoms."[549] A Minnesota study based on the assessments of kindergarten-aged children and their caregivers in shelters found that "asthma diagnosis was reported for 21% of 4-to-6-year-old children, about twice the national and state prevalences."[550]

Hypotheses regarding the main contributors of increased asthma prevalence among homeless children range from increased rate of exposure to risk factors in the physical environment such as pollution, mold, moisture, rodent and insect droppings, tobacco smoke; to the possibility of increased rates of respiratory infections in early childhood; to altered functioning of physiological systems due to chronic stress early in life.[551] Most likely, it is a concatenation of circumstances. There is also growing evidence that adverse psychosocial factors may serve as triggers for asthma attacks. Children of any socioeconomic status may encounter psychological stressors. However, "high levels of exposure to adverse psychosocial factors may play a critical role in determining the high levels of severity and undertreatment found among homeless children."[552]

Severity and prognosis of asthma are highly dependent on its management. Accordingly, its undertreatment in homeless children is a serious problem. The authors of the above-mentioned New York study assert that for this population subgroup, "the level of appropriate treatment is far below the level of usual care in primary care settings," and they go on to explain that "the high rate of undertreatment among these children is of grave concern, given evidence that the chronic inflammation associated with untreated asthma can lead to irreversible and detrimental thickening of the alveolar basement membrane and permanent lung damage."[553] Additional results of this study corroborate the authors' conclusion that asthma in homeless children is often not treated adequately and efficiently: "Few children with persistent asthma received any anti-inflammatory treatment. Almost 50% (48.6%) of children with severe asthma had at least 1 emergency department visit in the past year; 24.8% of children with symptoms of mild intermittent asthma had at least 1 visit. This percentage was even higher for children with a prior physician diagnosis of asthma. Between 54.9% and 68.0% of children, depending on level of severity, who had been previously identified by a physician as having asthma reported at least 1 visit to an emergency department in the past year."[554] These latter numbers are worth noting because they indicate that

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[548] . McLean, Diane E. et al. "Asthma Among Homeless Children: Undercounting and Undertreating the Undeserved." *Archives* of *Pediatrics and Adolescent Medicine*. Vol. 158. No. 3. Pp. 244-249. March 2004. Doi:10.1001/archpedi.158.3.244, available at http://archpedi.jamanetwork.com/article.aspx?articleid=485640 (accessed June 16, 2015).

[549] Ibid.

[550] Cutuli, J.J. "Asthma and Adaptive Functioning among Homeless Kindergarten-Aged Children in Emergency Housing." *Journal of Health Care for the Poor and Undeserved*. Vol. 25. No. 2, May 2014. Pp. 717-730.

[551] Ibid.

[552] McLean, Diane E. et al. Op. cit.

[553] Ibid.

[554] McLean, Diane E. et al. Op. cit.

even a prior contact with the healthcare system and a correct diagnosis do not guarantee proper follow-up treatment for this category of patients.

J.J. Cutuli and his colleagues have also observed that “children with asthma had health care service utilization and medication rates that suggest challenges in managing their condition.”[555] The researchers contend that “the experience of homelessness may present multiple challenges to asthma management,” including disconnection from the family’s usual primary care physician and other means of renewing prescription medication; increased exposure to environmental triggers outside of the family’s control in the shelter (for example, allergens and irritants such as cigarette smoke); and multiple psychosocial stressors associated with homeless episodes.[556]

The growing body of research demonstrating the extent of asthma prevalence, severity, undertreatment, and frequent asthma-related emergency department visits has clear policy implications. As the researchers underline, “speculation on factors likely to contribute to the high rates of asthma prevalence, severity, undertreatment, and emergency department use among homeless children is useful, because it may point to routes of intervention.”[557] For example, “lack of access to a medical home and to continuity of care is likely to contribute strongly to severity, lack of appropriate treatment, and heavy emergency department use.”[558] Consequently, this issue needs to be addressed. As the high rates of asthma among homeless children have now been established, “systematic screening for current asthma symptoms and asthma history is recommended for all families entering a homeless shelter system to identify high-risk children in need of appropriate medical care.”[559] Speedy rehousing to a safe environment, with adequate and consistent medical care, would most likely improve asthma management and prognosis for these children.

Recently, Children’s HealthWatch, a highly respected nonpartisan network of pediatricians, public health researchers, and children’s health and policy experts, published a study entitled “Compounding Stress: The Timing and Duration Effects of Homelessness on Children’s Health.” Researchers from Children’s HealthWatch interviewed over 20,000 caregivers of low-income children under the age of four in five U.S. cities from 2009 through 2014. The collected data were analyzed to assess children’s health and to compare outcomes for children who experienced homelessness at some point in their lives with those for children who were never homeless. New findings indicated a significant compounding impact of homelessness on children’s health, also known as “dose-response” effect.[560] While pre-natal and post-natal child

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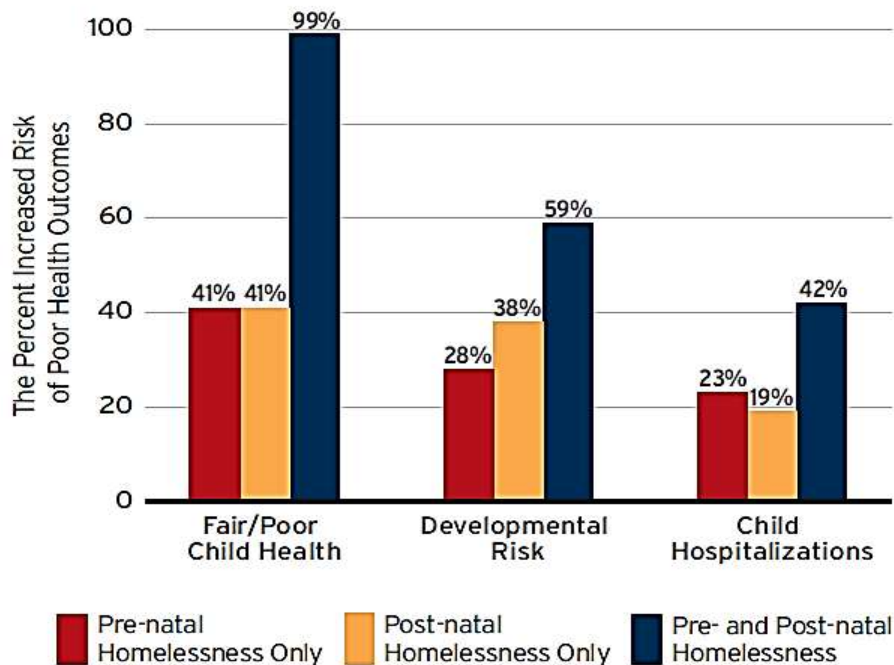
[555] Cutuli, J.J. “Asthma and Adaptive Functioning among Homeless Kindergarten-Aged Children in Emergency Housing.” *Journal of Health Care for the Poor and Undeserved*. Vol. 25. No. 2, May 2014. Pp. 717-730.
[556] Ibid.
[557] McLean, Diane E. et al. Op. cit.
[558] McLean, Diane E. et al. Op. cit.
[559] Ibid.
[560] Sandel, Megan, Richard Sheward and Lisa Sturtevant. *Compounding Stress: The Timing and Duration Effects of Homelessness on Children’s Health.* Center for Housing Policy and Children’s Health Watch, available at http://www.childrenshealthwatch.org/wp-content/uploads/Compounding-Stress_2015.pdf?utm_source=Compounding+Stress+-+ALL+-+June+15&utm_campaign=Compounding+Stress+-+ALL+-+June+15&utm_campaign=Compounding+Stress+-+ALL+June+15&utm_medium=email (accessed June 12, 2015).

homelessness were each separately associated with poor health outcomes for children, the combination of both significantly increased health risks.[561]



Longer periods of homelessness were also associated with worse health outcomes, along with other detrimental effects. The researchers observed that "young children (especially infants) who experience homelessness for greater than six months were significantly more likely to be at risk for developmental delays, fair or poor health, hospitalizations and overweight, compared to children who were never homeless or only homeless for less than six months."[562]

The authors came to a clear conclusion: "The younger and longer a child experiences homelessness, the greater the cumulative toll of negative health outcomes, which can have lifelong effects on the child, the family, and the community."[563]

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[561] Sandel, Megan, Richard Sheward, and Lisa Sturtevant. Op. cit.
[562] Ibid.
[563] Ibid.

Poor health outcomes mean greater health care utilization, which in its turn, involves significant financial costs, most of which are born by public health insurance. In 2012, the average costs of non-birth-related pediatric hospital stays amounted to $14,266 for infants and $8,901 for toddlers; 52 percent of such stays were covered by Medicaid.[564] Curtailing or avoiding such stays would mean considerable savings to the state.

One of the conclusions ensuing from new research is that "interventions that focus on preventing child and family homelessness can be especially effective before birth."[565] The authors of the "Compounding Stress" study contend that "rapid response to the needs of pregnant women at-risk of homelessness has the potential to reduce the likelihood of negative health outcomes, help support a child's trajectory towards healthy development, and reduce public health expenditures."[566] Specific policy tools they recommend to prevent the compounding health stresses and negative health outcomes created by prenatal, post-natal, and persistent homelessness are rapid rehousing and wraparound case management.[567]

A good example of combining housing with wraparound services to improve outcomes for children and families is Healthy Start in Housing (HSiH), a collaborative initiative of the Boston Public Health Commission and the Boston Housing Authority. It is "the nation's first contemporary program to use housing as a strategy to promote healthy birth outcomes."[568]

The conceptual framework for this initiative is the life course theory. The program is targeted to homeless or housing-insecure, high-risk pregnant women and/or parenting families with a child under the age of five who has a complex medical condition requiring specialty care. HSiH helps such women to secure and retain housing and offers intensive care management. HSiH visits expectant and new mothers at their homes weekly.

With the growing realization of the social determinants of health, "stable housing has emerged as a critical factor in the lives of women at risk for poor health outcomes."[569] In fact, an extensive retrospective study of homeless women who had given birth in the previous three years, demonstrated that severity of homelessness (measured in terms of homelessness during the first trimester and longer duration or repeated instances of homelessness) "significantly predicted low birth weight and preterm births beyond its relationship with prenatal care and other risk factors."[570] Later studies confirmed that "the unique effects of homelessness on birth outcomes matched or outweighed those of any other adverse circumstance."[571]

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[564]Sandel, Megan, Richard Sheward, and Lisa Sturtevant. Op. cit.
[565] Ibid.
[566] Ibid.
[567] Ibid.
[568] Feinberg, Emily et al. "Healthy Start in Housing: A Case Study of a Public Health and Housing Partnership To Improve Birth Outcomes." *Cityscape: A Journal of Policy Development and Research*. Vol. 16, No. 1, 2014, available at http://www.huduser.org/portal/periodicals/cityscpe/vol16num1/ch6.pdf (accessed July 6, 2015).
[569] Ibid.
[570] Stein, Judith A., Michael C. Lu, and Lillian Gelberg. "Severity of Homelessness and Adverse Birth Outcomes." *Health Psychology*. Vol. 19. No. 6. 2000. DOI: 10.1037//0278-6133.19.6.524.
[571] Feinberg, Emily et al. Op. cit.

In addition, analysis of the demographic characteristics and patterns of housing instability led researchers to consider pregnancy itself as a factor that increases the risk of homelessness.[572] For a typical homeless family, which is a young mother with children less than six years old and an income below the federal poverty level, or a pregnant woman without children, "homelessness is usually preceded by periods of housing instability characterized by frequent moves and "doubling up" with friends and relatives… The increased need for space and the disruption of normal routines that accompany the birth of an infant may be the critical factors that make a previously unstable living situation untenable."[573]

The above-mentioned factors provide sufficient grounds for allotting priority access to housing to pregnant women who have existing medical risks associated with poor health outcomes. There are reasons to believe that provision of supported housing and case management may prevent long-term negative health outcomes for both women and their children and bring cost savings to the states by eliminating the need for extensive healthcare later.

As the Healthy Start in Housing program in Boston is new, its outcomes for pregnant women and their children are yet to be assessed. Nonetheless, as an example of successful collaboration between a local public health agency and a public housing authority in providing services to a vulnerable group of people experiencing homelessness, this initiative has already elicited significant amount of interest. It illustrates a new approach in policymaking and program development, based on the new opportunities to strengthen housing and health collaborations offered by the Affordable Care Act and the newly adopted National Prevention Strategy.

Emotional and Behavioral Development

In addition to multiple adverse impacts on children's physical health, homelessness negatively affects their emotional and behavioral development. "America's Youngest Outcasts" report declares them "the most vulnerable of all to mental health problems."[574] According to the earlier NCFH study, by age eight, one out of three homeless children will have a diagnosable mental disorder that interferes with daily activity; almost half suffer from anxiety and depression, or withdrawal; and one-third express their distress through aggressive or violent outbursts.[575] Regrettably, in a comparative assessment of mental health disturbances in homeless and middle-income children, Pennsylvania is among the bottom ten states. The National Center on Family Homelessness puts it in the forty-eighth place, ahead of only Indiana and Nebraska, with 25 percent of homeless children in Pennsylvania reporting emotional disturbances versus 6.5 percent of middle-income children.[576]

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[572] Feinberg, Emily et al. Op. cit.
[573] Ibid.
[574] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).
[575] The National Center on Family Homelessness. *Homeless Children: America's New Outcasts.* Op. cit.
[576] The National Center on Family Homelessness. *America's Youngest Outcasts: State Report Card on Child Homelessness*. Newton, MA, 2009, available at http://www.homelesschildrenamerica.org/pdf/rc_full_report.pdf (accessed May 14, 2015).

When children are homeless, they are confronted with stressful and traumatic events, which causes severe emotional distress. When this distress and the child's fears are unmitigated by a caring parental interference because the parent, most commonly the mother, is incapable of offering it as she is herself depressed or traumatized, it can lead to "toxic stress", which can induce long-term deleterious consequences. Recent neuroscience research discovered the foundations for brain architecture are formed prenatally and in early childhood. The developing brain is shaped by both genes and experience. Chronic or extreme adversity can disrupt normal brain development, which in turn can have a life-long negative impact on the child's physical and mental health. To describe the detrimental effect of chronic stress, scientists use the term "toxic stress." A certain amount of adversity is unavoidable in even a most nurturing environment, and learning how to cope with it is a natural part of healthy child development. Unlike "positive stress response," characterized by a brief increase in heart rate and hormone levels, or "tolerable stress response," activating the body's systems to a greater degree as a result of more severe, longer-lasting difficulties, "toxic stress response" can occur when a child experiences "strong, frequent, and/or prolonged adversity, and does not have adult support."[577] Homelessness presents exactly this kind of harmful, prolonged adversity, with the availability of parental support often diminished by the already compromised mental health of the parent. As the researchers found out, "prolonged activation of stress response systems can disrupt the development of brain architecture and other organ systems, and increase the risk for stress-related disease and cognitive impairment, well into adult years."[578] Early childhood toxic stress has been linked with disruptions of the developing nervous, cardiovascular, immune, and metabolic systems. Such disruptions can eventually lead to lifelong impairments in physical and mental health, behavior, and learning. Research also indicates that "supportive, responsive relationships with caring adults as early in life as possible can prevent or reverse the damaging effects of toxic stress response."[579]

New developments in neuroscience help understand the impacts of timing and duration of homelessness on the child's physical and mental health. They should also guide policy and practice: families with young children and pregnant women should be prioritized for housing placement; trauma-informed approach should be recommended for both children and their homeless mothers; and parental support and training should be offered to parents so that they, in turn, could be emotionally responsive and supportive of their children in spite of the adversity. As positive parenting could protect children from the stress of homelessness and conditions that often coexist with it and as several studies of evidence-based parenting programs indicated, albeit tentatively, changes in parenting and child functioning, some experts recommend further inquiry aimed at determination of evidence-based programs that could be implemented with fidelity in emergency and transitional housing settings. They also recommend building the evidence base for existing and new interventions implemented in such settings.[580]

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[577] Center on Developing Child, Harvard University. *Key Concepts*: *Toxic Stress*, available at http://developingchild.harvard.edu/ (accessed July 9, 2015).
[578] Ibid.
[579] Ibid.
[580] Perlman, Staci and Joe Willard. *Childhood Homelessness in Pennsylvania*. Philadelphia, PA: People's Emergency Center, October 2013, available at http://www.pec-cares.org/clientfolders/pdf/Childhood%20Homelessness%20in%20Pennsylvania%20Full%20Report.pdf (accessed January 26, 2015). Haskett, Mary E., Jessica Loehman, and Kimberly Burkhart. "Parenting Interventions in Shelter Settings: A Qualitative Systematic Review of Literature." *Child & Family Social Work*, 2014, available at http://onlinelibrary.wiley.com/doi/10.1111/cfs.12147/full (accessed February 10, 2015).

In recent years, with the growing number of children experiencing homelessness, pediatricians have become more aware of the impact of homelessness on their patients' health and have become increasingly involved. Acknowledging that "child health and housing security are closely intertwined, and children without homes are more likely to suffer from chronic disease, hunger, and malnutrition than are children with homes," the American Academy of Pediatrics issued a special policy statement "Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity." The statement proclaims: "Given the overall effects that homelessness can have on a child's health and potential, it is important for pediatricians to recognize the factors that lead to homelessness, understand the ways that homelessness and its causes can lead to poor health outcomes, and when possible, help children and families mitigate some of the effects of homelessness."[581] The American Academy of Pediatrics encourages its members to "help optimize the health and well-being of children affected by homelessness" thorough practice change, partnership with community resources, and advocacy.[582]

A good example of effective pediatricians' involvement in Pennsylvania is the Homeless Health Initiative (HHI), a nationally recognized program run by the Children's Hospital of Philadelphia (CHOP). The initiative began in 1988, when a small group of volunteers began offering free medical care several times a year in three West Philadelphia shelters a few blocks from the hospital. Today, hundreds of dedicated volunteers from the HHI, including doctors, nurses, dentists, social workers and students, work to improve the health of families in urban homeless shelters by

- Providing high-quality, acute medical and dental care
- Connecting families with health insurance as well as primary and specialty care providers
- Providing health education on topics such as nutrition and fitness to shelter residents and staff members
- Collaborating with local and national partners to effectively advocate for the healthcare of children in shelters
- Assisting others in replicating the HHI model of collaboration, partnership and care.[583]

While volunteer initiatives like the one run by CHOP cannot resolve the problem of child homelessness, they do help thousands of people experiencing homelessness and deserve public acclaim and emulation.

[581] The American Academy of Pediatrics. *Providing Care for Children and Adolescents Facing Homelessness and Housing Insecurity*, available at http://pediatrics.aapublications.org/content/131/6/1206.abstract (accessed June 3, 2015).
[582] Ibid.
[583] *About the Homeless Health Initiative*, available at http://www.chop.edu/centers-program/homeless-health-intitative-about (accessed June 1, 2015).

EDUCATION

Homelessness has a major influence on children's education. The stress of homelessness, frequent disruptions, and school change may all jeopardize homeless students' academic success. Many of the negative impacts of homelessness can, however, be mitigated or even eliminated by specially designed policies and interventions.

The legal groundwork for providing access to education and the assistance that may be necessary to children experiencing homelessness has been laid by the Stewart B. McKinney Homeless Assistance Act signed into law in 1987 and amended later. The latest revision occurred in 2002, when McKinney Act was reauthorized as the McKinney-Vento Homeless Assistance Act (Title X, Part C of ESEA), strengthening legislative requirements and directing all school districts to appoint a local liaison to ensure effective implementation of the law at the local level.

The McKinney-Vento Act uses a broader definition of homelessness than HUD; it includes the so-called "doubled-up." For the purposes of the key federal education program targeted to homeless children and youth, the term "homeless children and youths" means "individuals who lack a fixed, regular, and adequate nighttime residence."[584] This includes children who

- are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; are abandoned in hospitals; or are awaiting foster care placement;
- children and youth who have a primary residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings;
- children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and
- migratory children who qualify as homeless because the children are living in circumstances described in the previous clauses.[585]

The Pennsylvania Department of Education (PDE) developed a state plan outlining Pennsylvania's implementation of the McKinney-Vento Homeless Assistance Improvements Act and issued a *Basic Education Circular* on homeless youth to offer guidance to local education agencies (LEAs) regarding the implementation. The current *State Plan and Basic Education Circular*, as well as other relevant documents are available on PDE's website at www.education.state.pa.us.

[584] 42 U.S.C.A. § 11434a (2) (A).
[585] 42 U.S.C.A. § 11434a (2) (B).

The Pennsylvania State Plan

- Informs school districts of their responsibility to homeless children and youth;
- Provides policies that bring the state into compliance with federal law; and
- Outlines assurances that homeless students have equal access to a quality education.[586]

In Pennsylvania, the Education for Children and Youth Experiencing Homelessness (ECYEH) Program was developed "to ensure that each child of an individual experiencing homelessness and each youth experiencing homelessness have equal access to the same free and appropriate public education, including public preschool education, as provided to other children and youth."[587] PDE describes the goals and objectives of its education program for homeless children in the following way:

The goals of Pennsylvania's ECYEH Program are to:

- Ensure that all children and youth experiencing homelessness enroll, participate, and have the opportunity to succeed in school;
- Ensure children and youth experiencing homelessness receive a free and appropriate public education on an equal basis with all other children in the state; and
- Eliminate and/or reduce educational barriers through the use of local best practices and the authorized activities of the McKinney-Vento Act.

The main objectives of Pennsylvania's ECYEH Program are to:

- Reduce the disruption in the educational lives of children and youth experiencing homelessness;
- Increase awareness about the nature and extent of the problems children and youth experiencing homelessness have enrolling in and gaining access to educational programs and services;
- Explain laws and policies already in place that help students overcome these barriers to education;
- Build the capacity of others to assist in identifying, enrolling, and ensuring the educational success of children and youth experiencing homelessness; and
- Provide opportunities to collaborate with other statewide initiatives to improve academic achievement of students experiencing homelessness.[588]

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[586] Pennsylvania Department of Education. *Homeless Education*, available at http://www.education.pa.gov/K-12/Homeless%20Education/Pages/default.aspx#.VstnyfMo6po (accessed February 22, 2016).
[587] Pennsylvania Department of Education. *Education for Children and Youth Experiencing Homelessness Program 2013-14 Stathttp://www.education.pa.gov/K-12/Homeless%20Education/Pages/default.aspx#.VstnyfMo6poe Evaluation Report*. January 2015, available at http://www.education.pa.gov/Documents/K-12/Homeless%20Education/PA%20Education%20for%20Children%20and%20Youth%20Experiencing%20Homelessness%20Program%202013-14%20State%20Evaluation%20Report.pdf (accessed February 22, 2016).
[588] Ibid.

These objectives have been selected thoughtfully; they pinpoint the critical issues related to educational experiences of children who happen to be homeless at a particular time in their lives such as the negative impact the disruption itself can play in a child's education, the frequent lack of awareness on the part of teachers and social workers regarding specific homeless-related problems their students may experience, and the parents' and youths' insufficient knowledge of the rights and opportunities they may already have according to the existing laws and policies.

The program was designed so that every child or youth identified as experiencing homelessness could receive support and services he or she needs. Pennsylvania is divided into eight regions, each with a regional coordinator. The regional coordinators and their subcontracted site coordinators provide outreach, training, and technical assistance to LEAs and "work to link children, youth, families, and LEAs to additional support services or resources specializing in serving individuals experiencing homelessness."[589] The Center for Schools and Communities, a subsidiary of the Central Susquehanna Intermediate Unit, provides statewide technical assistance to regions and LEAs. The state coordinator, based at PDE, is responsible for program coordination and collaboration at the state level.

PDE performs annual evaluation of the program with the purpose to

- Examine the extent to which regions provide support to LEAs to meet the goals and objectives of the ECYEH Program;
- Examine the extent to which children and youth identified as experiencing homelessness receive services and support;
- Identify the types of services and supports children and youth received;
- Build capacity within each region to examine results and make improvements based on data; and
- Provide recommendations for overall program improvement.[590]

The ECYEH Program staff make presentations to community or school groups in order to increase awareness about the McKinney-Vento Act and its implementation in the Commonwealth; serve on the board of local community agencies or groups; collaborate with other agencies that serve the homeless population; facilitate student access to or LEA provision of transportation to and from school; offer referrals for families and children to other community or government agencies; provide training and technical assistance to LEA homeless liaisons; develop and maintain informational websites; organize summer programs and activities for children; and facilitate donations of goods and money to serve the needs of children and youth experiencing homelessness.[591] The regional programs find unique ways to implement the typical activities, and their innovative programs or events are also highlighted in the ECYEH evaluation report.

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[589] Ibid.
[590] Ibid.
[591] Ibid.

Pennsylvania ECYEH Program State Plan, as amended in 2013, listed ten educational barriers to address through the program implementation:

1. Residency and Guardianship Requirements and Other School Enrollment/Attendance Practices
2. Lack of Coordination, Collaboration and Cooperation
3. Lack of Program Continuity and Delays in Educational Evaluation and Placement
4. Lack of Transportation to Stay in School of Origin When It is in the Best Interest of the Student
5. Delays in Academic and Health Records
6. Lack of Awareness Among School Personnel
7. Inadequate Parental Response
8. Social Embarrassment
9. Transiency Among Families With Preschool Children
10. Lack of Access and Knowledge of Available Services for Runaway and Chronically Homeless.[592]

In the academic year 2013-14, the most common barriers were transportation, followed closely by determining if a student was eligible for homeless services, and then school selection.[593] The first two have been in the top three reported barriers since the inception of the program evaluation. According to the report, transportation issues continue to grow, and the evaluators attribute it to LEA financial constraints and logistical challenges in arranging transportation.[594]

The most notable decline was made in barriers related to obtaining immunization, and other medical and school records. The evaluators believe the substantial decrease in these once-formidable barriers reflects ongoing training and technical assistance of the ECYEH Program with LEAs.[595]

The most prevalent service children/youth received through the ECYEH Program was tutoring or other instructional support: 77 percent of all children and youth served by the program were documented as receiving it.[596] Other services involved coordination between schools and agencies, transportation, school supplies, and clothing to meet a school requirement.

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[592] Pennsylvania Department of Education. *Pennsylvania's Education for Children and Youth Experiencing Homelessness Program –State Plan (Amended)*. October 2013, available at http://www.education.pa.gov/Documents/K-12/Homeless%20Education/ECYEH%20State%20Plan%202013%20FINAL.pdf (accessed February 23, 2016).

[593] Pennsylvania Department of Education. *Education for Children and Youth Experiencing Homelessness Program 2013-14 Stathttp://www.education.pa.gov/K-12/Homeless%20Education/Pages/default.aspx#.VstnyfMo6poe Evaluation Report*. January 2015, available at http://www.education.pa.gov/Documents/K-12/Homeless%20Education/PA%20Education%20for%20Children%20and%20Youth%20Experiencing%20Homelessness%20Program%202013-14%20State%20Evaluation%20Report.pdf (accessed February 22, 2016).

[594] Ibid.

[595] Ibid.

[596] Ibid.

PDE is constantly working on optimizing the program implementation and monitoring at the regional and local levels. In enhancing its monitoring practices, PDE is acting in accordance with federal guidelines. In its review of the education of homeless students program, GAO recommended improved oversight at all levels.[597] The ECYEH Program in Pennsylvania has demonstrated some good outcomes. Reporting and follow-up have improved each year for the enrolled population.[598] Overall, more than 80 percent of the 24,504 children and youth are documented as receiving service at the individual level, with some regions (Philadelphia and northwestern counties) showing even higher percentages – around 95 percent.[599] As the ultimate result of the homeless education program is its impact on children's and youth's lives, several success stories related in the program evaluation report are very illuminating. They include a story of a 17-year-old in Berks County who was kicked out of his home and had nowhere to go. Within 24 hours, the ECYEH site coordinator connected the student with the local Family Promise program to secure housing and with the school district's transportation department to find a way for him to get to school. She made sure the student had everything he needed, and there was no disruption in his education. Other success stories showcase a student who lived in her car during her junior and senior years but later graduated from a local university, an 18-year-old student who had to leave home due to domestic violence but managed to stay in the school of origin after the ECYEH Program office helped her to find a family she could stay with until graduation and also assisted her with her other needs, and other equally impressive cases demonstrating a life-changing positive impact of the homeless education program when implemented in the optimal way.

Some of the recommendations made in the evaluation report pertained to further exploring transportation issues and creating solutions, and also to collaborating and finding options that offer additional instructional support to students experiencing homelessness such as tutoring in shelters by college students, priority for service in LEA or community after-school or summer programs, or inclusion in other state or federally funded programs such as Migrant Education, English as a Second Language, or 21st Century Community Learning Centers.[600]

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[597] United States Government Accountability Office. *Education of Homeless Students: Improved Program Oversight Needed*. Washington, D.C. July 2014, available at http://www.gao.gov/assets/670/665185.pdf (accessed October 8, 2015).

[598] Pennsylvania Department of Education. *Education for Children and Youth Experiencing Homelessness Program 2013-14 Stathttp://www.education.pa.gov/K-12/Homeless%20Education/Pages/default.aspx#.VstnyfMo6poe Evaluation Report*. January 2015, available at http://www.education.pa.gov/Documents/K-12/Homeless%20Education/PA%20Education%20for%20Children%20and%20Youth%20Experiencing%20Homelessness%20Program%202013-14%20State%20Evaluation%20Report.pdf (accessed February 22, 2016).

[599] Ibid.

[600] Ibid.

PRESCHOOL-AGE CHILDREN AND EARLY LEARNING

Most people realize the importance of providing school-age children the opportunity to keep attending schools when they are experiencing homelessness. The general public and sometimes even policymakers are less aware of the prevalence of homelessness among younger children and of their needs. In fact, approximately half of children living in federally funded emergency and transitional housing programs are age five or younger. It may come as a shock to some to find out that the age at which a person in the United States is most likely to stay in a homeless shelter is in infancy.[601] In addition to homelessness, these very young children are more likely than their stably housed peers to be subjected to other risk factors such as malnutrition and maltreatment. The cumulative effect of homelessness and other risks is associated with poor early development and educational well-being.[602] Research shows the association of early childhood homelessness with higher likelihood of developmental delays.

To mitigate negative impacts of homelessness and provide individuals experiencing it in early childhood a chance at academic success, interventions often need to start early. Programs like Head Start, Early Head Start, Child Care Works and other similar programs may play a big part in the life of these children and should be made accessible to them.

In 2013, the National Association for the Education of Homeless Children and Youth (NAEHCY) administered a survey to school district liaisons, homeless housing providers, and early care/education providers including Early Head Start/Head Start (EHS/HS), child care, preschool, Early Intervention (Individuals with Disabilities Education Act Part C), and Preschool Special Education providers (Individuals with Disabilities Education Act Part B). The survey had three objectives:

1. To understand the barriers families with young children experiencing homelessness face when trying to access early childhood services.
2. To identify successful strategies for addressing those barriers.
3. To assess the decree of the collaboration among early care and education programs.[603]

The survey was completed by close to a thousand responders. The barriers identified by the survey included transportation issues, insufficient number of slots, eligibility, enrollment requirements, and lack of awareness of how to find homeless families. Challenges in maintaining contact with families were most prohibitive in rural areas. The issue of communication/mobility was particularly salient with regard to services that include home visiting – such as Early Head Start and Early Intervention.[604] Competing demands families have when they are experiencing

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[601] Perlman, Staci. *Access to Early Childhood Programs for Young Children Experiencing Homelessness: A Survey Report*. National Association for the Education of Homeless Children and Youth, available at http://www.naehcy.org/sites/default/files/pdf/naehcy-survey-report.pdf (accessed February 25, 2016).
[602] Ibid.
[603] Ibid.
[604] Ibid.

homelessness can also become a barrier for accessing early childhood services: putting food on the table, finding shelter and clothing, and job search can, understandably, take precedence over a young child's early education.

The survey also attempted to identify strategies that were successful at helping homeless families access early education services. These strategies appear to involve working both with families and with other agencies to navigate the process of accessing services. Transportation and variants of cross-system collaboration were cited as the most successful strategies for increasing access.[605]

Based on its analysis of the survey results, the NAEHCY came up with five policy and practice recommendations that could improve access to early care and education for young children experiencing homelessness:

1. Increase awareness of the impact of homelessness on young children among early childhood providers, homeless service providers, and the general public.
2. Provide regular training for McKinney-Vento Liaisons, homeless service providers, and early childhood providers to support their ability to collaborate to meet the needs of young children experiencing homelessness.
3. Implement strategies to increase connections to families experiencing homelessness and support effective cross-sector collaboration.
4. Advocate for policies and funding to increase access to early childhood programs and services for young children experiencing homelessness.
5. Increase representation of young children who experience homelessness in local and state homelessness and early education planning efforts.[606]

In the Commonwealth, positive changes have been made in this area lately thanks to Act 143 of 2014. Act 143 amends the Act 212 of 1990, known as the Early Intervention Services System Act. Act 143 added homeless children to several other categories eligible for at-risk tracking.[607] This is a very important achievement that should vastly increase access to early education programs for homeless children. However, as a dedicated child advocate and one of the most prominent national experts on early childhood education Dr. Staci Perlman reminded, while young homeless children who are homeless are now prioritized for access to these services, "prioritization does not guarantee service utilization."[608] She recommended that future inquiry "address systemic factors that both facilitate and deter access to early childhood education."[609] Act 143 needs to be applied consistently by providers throughout the state as regards homeless children as well as other at-risk categories.

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[605] Ibid.
[606] Ibid.
[607] Act of Dec. 19, 1990 (P.L. 1372, No.212), § 305(b); 11 P.S. § 875-305(b).
[608] Perlman, Staci and Joe Willard. *Childhood Homelessness in Pennsylvania*. Philadelphia, PA: People's Emergency Center, October 2013, available at http://www.pec-cares.org/clientfolders/pdf/Childhood%20Homelessness%20in%20Pennsylvania%20Full%20Report.pdf (accessed January 26, 2015).
[609] Ibid.

Early education programs in Pennsylvania are administered by the Office of Child Development and Early Learning (OCDEL). OCDEL has guidelines regarding homeless children for all the programs under its management, including Early Intervention, Head Start, Early Head Start, Child Care Works, Child Care and Nurse-Family Partnership. The programs are instructed to contact and provide outreach activities as appropriate to their school district homeless liaisons, site and regional site coordinators, local shelters, bridge or temporary housing services, county Office of Children, Youth, and Families, homeless coalitions, the federal Department of Housing and Urban Development, and other local resources in their area; ensure that the appropriate staff know which children are considered homeless and are aware of the services and resources available; and develop collaborative strategies across early childhood programs and appropriate agencies to support continuity of services for families who experience frequent moves due to homelessness. When Act 143 of 2014 was signed by the Governor, OCDEL issued an additional announcement requiring local early education programs to revise their tracking procedures accordingly; review and revise child fund, screening, and evaluation procedures as required; and disseminate information regarding Act 143 and other resources regarding children and families experiencing homelessness to the Local Interagency Coordinating Council, shelters and other agencies addressing homelessness, and other community stakeholders. OCDEL and PDE work closely on issues related to early education programs for homeless children. OCDEL and ECYEH conduct joint trainings statewide. Representatives from both agencies are members of the Pennsylvania State Interagency Coordinating Council (SICC) that is responsible for early intervention in Pennsylvania.[610]

Trainings on early childhood education and other related topics are also offered to emergency and transitional housing programs by the Children's Work Group (CWG) of the City of Philadelphia. CWG is a collaboration of nonprofit, public and private agencies serving children experiencing homelessness or housing insecurity across Philadelphia. It was founded in 2009 and has been very active in achieving its goal of unifying the efforts to effectively serve children through cross-systems collaborations and trainings and to identify evidence-based practices that can be replicated in the city.[611]

The experience of two such promising practices in the area of early childhood education for children experiencing homelessness, implemented in Massachusetts and Oregon, indicate that the following strategies can lead to success:

- Building relationships between homeless service agencies and early care and learning agencies at the state and local levels;

- Integrating direct feedback of parents of children experiencing homelessness into their early care and learning system's efforts;

[610] Information provided to the Joint State Government Commission by Mr. Sheldon Winnick from the Pennsylvania Department of Education in his personal e-mail of June 23, 2015, and by Mr. Jonathan McVey and Ms. Andrea Algatt from the Pennsylvania Department of Human Services in their personal e-mails of January 7, 2016.

[611] Children's Work Group. *Philadelphia Children's Workgroup Recommendations To Expand Access to Quality Early Learning for Young Children Experiencing Homelessness*, available at http://www.elc-pa.org/wp-content/uploads/2015/11/ELC-and-Childrens-Workgroup-Recommendations-for-OCDELRevised2014.pdf (accessed 3/29/16).

- Providing cross-training for the staff of homeless service agencies and early childhood agencies;

- Expanding on past efforts and lessons learned to connect children experiencing homelessness to early childhood development services; and

- Sharing data among agencies that serve families with children age 0-5 who are experiencing homelessness.[612]

Pennsylvania has been utilizing some of these promising strategies and should continue to do so and to expand their implementation.

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[612] Office of the Deputy Assistant Secretary for Early Childhood Development, Administration for Children and Families, U.S. Department of Health & Human Services. *Promising Practices for Children Experiencing Homelessness: A Look at Two States*. July 2014, available at https://www.acf.hhs.gov/sites/default/files/ecd/final_promising_practice.pdf (accessed 01/23/2015).

UNACCOMPANIED YOUTH

While over a million and a half children experience homelessness with their families, an equal or even higher number are estimated to be without home on their own.[613] The most commonly quoted number of homeless youth under the age of eighteen, slightly below 1.7 million, comes from the National Studies of Missing, Abducted, Runaway and Throwaway Children (NISMART).[614] A study conducted by HHS'S Substance Abuse and Mental Health Services Administration (SAMHSA) found that 1.6 million youth ages 12 to 17 ran away from home and slept on the street in the year 2002.[615] The lack of reliable statistics is due partly to varying definitions, and partly due to the fact that this population is especially difficult to find and count. Many researchers, government officials, and providers suggest that unaccompanied youth are under-identified to a higher degree than the rest of youth experiencing homelessness for a number of reasons.[616] Unaccompanied youth use services more rarely than youth experiencing homelessness with their family. Often they avoid seeking services and, in fact, make a special effort to remain invisible, to avoid being identified as homeless, for fear of being returned to the household where they might have been victimized or being sent to foster care.

In its review of homeless and runaway youth studies, the National Conference of State Legislatures listed several troubling numbers:

- Youth age 12 to 17 are more at risk of homelessness than adults
- 75 percent of runaways are female
- Estimates of the number of pregnant homeless girls are between 6 and 22 percent
- Estimates of homeless youth who identify as gay, lesbian, bisexual, transgender, or questioning (LGBTQ) are 20 to 40 percent
- 46 percent of runaway and homeless youth reported being physically abused, 38 percent reported being emotionally abused, and 17 percent reported being forced into unwanted sexual activity by a family or household member

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613 Burt, Martha R. *Understanding Homeless Youth: Numbers. Characteristics, Multisystem Involvement, and Intervention Options*: Testimony before the U. S. House Committee on Ways and Means Subcommittee on Income Security and Family Support on June 19, 2007, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/901087-Understanding-Homeless-Youth-Numbers-Characteristics-Multisystem-Involvement-and-Intervention-Options.PDF (accessed March 2, 2016).

614 National Alliance to End Homelessness. *An Emerging Framework for Ending Unaccompanied Youth Homelessness,* available at http://www.endhomelessness.org/page/-/files/4486_file_An_Emerging_Framework_for_Ending_Unaccompanied_Youth_Homelessness.pdf (accessed March 1, 2016).

615 U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Statistics. National Survey on Drug Use and Health, *Substance Abuse Among Youth Who Had Run Away From Home,* available at http://www.oas.samhsa.gov/2k4/runAways/runAways.htm (accessed December 11, 2014).

616 United States Government Accountability Office. *Education of Homeless Students: Improved Program Oversight Needed*. Washington, D.C. July 2014, available at http://www.gao.gov/assets/670/665185.pdf (accessed October 8, 2015).

- 75 percent of homeless or runaway youth have dropped out or will drop out of school.[617]

One recent study on the lifetime prevalence of running away from home established that many runaways are very young adolescents: "In fact, half of all youth who ran away had their first runaway episode before the age of 14, with males starting at younger ages than females."[618] The study highlighted the importance of taking into account the entire history in tailoring services to meet those teens' needs and the role of prevention.

The group identified as unaccompanied youth is commonly categorized into subgroups:

1) runaway-homeless youths, who stayed away at least overnight without parents' or guardians' permission;
2) so-called 'throwaway' youths, who left home because parents encouraged them to leave or locked them out of the home;
3) independent youths who feel they have no home to return to due to irreconcilable familial conflict or have lost contact with their families.[619]

A related term is 'street youth,' sometimes used synonymously with 'runaway youth.' The term 'street youth' usually highlights the fact that this individual "spends a significant amount of time on the street or in other areas that increase the risk to such youth for sexual abuse, sexual exploitation, prostitution, or drug use."[620]

Evidently, there are no clear boundaries between these categories. The determination can be subjective, dependent on the perspective. For example, the youths themselves tend to emphasize the 'throwaway' aspect while the parents or guardians tend to focus on the 'runaway' side of it. The essential fact is that youths are no longer home with their families, that they feel home is no longer a safe or possible place for them to stay, and an expert intervention is needed to assess the existing situation and find a solution.

Factors that propel youth towards homelessness fall into three main areas: family problems, economic problems, and transitions from foster care and other public systems.[621] Children and youth may run away because of physical and sexual abuse, mental health or substance use disorder

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[617] National Conference of State Legislatures. *Homeless and Runaway Youth.* October 2013, available at http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx (accessed February 25, 2016).

[618] Pergamit, Michael R. *On the Lifetime Prevalence of Running Away from Home.* Washington, D.C.: Urban Institute, April 2010, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412087-On-the-Prevalence-of-Running-Away-from-Home.PDF (accessed February 25, 2016).

[619] Aratani, Yumiko. *Homeless Children and Youth: Causes and Consequences*. National Center for Children in Poverty (NCCP). September 2009, available at http://scholar.google.com/scholar_url?url=http://academiccommons.columbia.edu/download/fedora_content/download/ac:126258/CONTENT/text_888.pdf&hl=en&sa=X&scisig=AAGBfm1ZtKecfwhjYXcQh-SzOsunOdnR8A&nossl=1&oi=scholarr (accessed February 23, 2016).

[620] United States Department of Health and Human Services, Family and Youth Services Bureau. *Runaway and Homeless Youth Program Authorizing Legislation*. April 2012, available at http://www.acf.hhs.gov/programs/fysb/resource/rhy-act (accessed February 26, 2016).

[621] National Conference of State Legislatures. *Homeless and Runaway Youth.* October 2013, available at http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx (accessed February 25, 2016).

of a family member. Religious and sexual orientation differences constitute a common reason for youth being kicked out of the house. Researchers agree that “sexual minority status is a powerful risk factor for youth homelessness, as disclosure to a parent or a parent’s discovery of that status may lead to being thrown out or running away.”[622] It is widely acknowledged that gay, lesbian, bisexual, transgender, or questioning (LGBTQ) youth tend to be overrepresented in the homeless youth population.[623] In addition to family rejection, harassment in schools continues to drive elevated rates of homelessness among LGBTQ youths and needs to be addressed effectively.[624]

Sometimes parents cannot afford to take care of their children due to difficult financial situations. Some youth who first become homeless with their families may end up separated for them and living on the streets alone due to shelter or child welfare policies.

Youth aging out of the foster care system “often have little or no income support and limited housing options and are at high risk to end up on the streets.”[625] It has been observed that youth who have been involved in the foster care system are more likely to become homeless at an earlier age and remain homeless for a longer period of time.[626] According to the National Survey of Homeless Assistance Providers and Clients (NSHAPC), 61 percent of 18- to 19-year-old young adults had been in out-of-home placements – a rate more than two and a half times that reported by homeless adults 25 years and older.[627] According to a longitudinal study of the young adults who had been in the care of a welfare agency in one of three Midwestern states, 15 percent of the 26-year-olds reported being homeless for at least one night in the past three years, and one-quarter reported that they had couch-surfed.[628] Thirty-one percent of the Midwest Study participants reported having couch-surfed or been homeless, including seven percent who had experienced both. Almost half of the study participants experienced homelessness repeatedly, including nearly one-quarter who had been homeless four or more times.[629] Repeated episodes of couch-surfing were even more common: “Over 60 percent of the young adults who had couch surfed since their

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[622] Burt, Martha R. *Understanding Homeless Youth: Numbers. Characteristics, Multisystem Involvement, and Intervention Options*: Testimony before the U. S. House Committee on Ways and Means Subcommittee on Income Security and Family Support on June 19, 2007, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/901087-Understanding-Homeless-Youth-Numbers-Characteristics-Multisystem-Involvement-and-Intervention-Options.PDF (accessed March 2, 2016).
[623] Cray, Andrew, Katie Miller, and Laura E. Durso. *Seeking Shelter: The Experiences and Unmet Needs of LGBT Homeless Youth*. Washington, D.C.: Center for American Progress, September 2013, available at https://www.americanprogress.org/wp-content/uploads/2013/09/LGBTHomelessYouth.pdf (accessed February 25, 2016).
[624] Ibid.
[625] National Conference of State Legislatures. *Homeless and Runaway Youth.* October 2013, available at http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx (accessed February 25, 2016).
[626] Ibid.
[627] Burt, Martha R. *Understanding Homeless Youth: Numbers. Characteristics, Multisystem Involvement, and Intervention Options*: Testimony before the U. S. House Committee on Ways and Means Subcommittee on Income Security and Family Support on June 19, 2007, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/901087-Understanding-Homeless-Youth-Numbers-Characteristics-Multisystem-Involvement-and-Intervention-Options.PDF (accessed March 2, 2016).
[628] Courtney, Mark E. et al. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 26.* Chicago: Chapin Hall Canter for Children at the University of Chicago, 2011, available at https://www.chapinhall.org/sites/default/files/Midwest%20Evaluation_Report_4_10_12.pdf (accessed March 3, 2016).
[629] Ibid.

most recent interview had done so more than once, including 35 percent who reported at least four episodes."[630] The researchers found equally troubling the amount of time some Midwest Study participants spent homeless or couch surfing. One-third of those among them who had been homeless "reported an episode of homelessness that lasted at least one month and nearly 40 percent of those who had couch surfed reported an episode of couch surfing that lasted a month or more."[631]

One existing resource for youth aging out of foster care and leaving the child welfare system is the Family Unification Program (FUP). A recent analysis prepared for HUD revealed that the FUP can be helpful to such youth, but for various reasons it is not widely used for them.[632] The researchers concluded that higher awareness of the risk of homelessness in this population and better cross-agency collaboration could increase the potential of FUP for serving eligible youth; this small, resource-constrained program is, however, "unlikely to be a major resource for youth aging out of care," and additional policy innovations to meet the housing needs of former foster youth should be explored.[633]

Youth who have lived in residential or institutional facilities often become homeless upon discharge. Some leading experts believe that the periods surrounding institutional release are the intervention points that are likely to yield maximum payoff as youth who turn 18 while in foster care and youth who leave juvenile or corrections facilities are "those among the general youth population who have the highest risk of becoming homeless and of staying homeless or reentering institutions if nothing is done to intervene."[634]

Children and youth who find themselves on the streets alone face a daunting range of risks and dangers. Consequences of life on the street include not only poor health and nutrition, greater risk of severe anxiety and depression, and difficulty attending school, but also increased likelihood of high-risk behaviors such as participating in intravenous drug use and engaging in unprotected sex, often with multiple partners. Unaccompanied homeless youth often become victims or perpetrators of crime. Youth may be driven to "survival sex," exchanging sex for food, clothing, or a place to spend the night. Sometimes they start dealing drugs to meet their basic needs. Unaccompanied youth can easily become victims of human trafficking. Homeless providers that serve this population should comprehensively screen for human trafficking and should understand the resources and options for trafficking victims.

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[630] Ibid.

[631] Ibid.

[632] Dion, M. Robin et al. *The Family Unification Program: A Housing Resource for Youth Aging Out of Foster Care*. Washington, D.C.: U.S. Department of Housing and Urban Development, May 2014, available at http://www.urban.org/publications/1001375.html (accessed February 25, 2016).

[633] Ibid.

[634] Burt, Martha R. *Understanding Homeless Youth: Numbers. Characteristics, Multisystem Involvement, and Intervention Options*: Testimony before the U. S. House Committee on Ways and Means Subcommittee on Income Security and Family Support on June 19, 2007, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/901087-Understanding-Homeless-Youth-Numbers-Characteristics-Multisystem-Involvement-and-Intervention-Options.PDF (accessed March 2, 2016).

Homeless gay, lesbian, bisexual, transgender or questioning youth are more likely to exchange sex for housing, are abused more often at homeless shelters (especially adult shelters), and experience more violence on the streets than homeless heterosexual youth.[635] LGBTQ homeless youth report higher rates of suicidal ideation and attempt than their heterosexual peers who are also homeless.[636] In surveys, LGBTQ youth report higher rates than the general homeless population of being unable to find services when they needed assistance with both short- and long-term housing, and they were found twice as likely as the general population of homeless youth to have been unable to receive medical care for both chronic and acute illness.[637]

The longer a young individual has been homeless, the more likely he or she is to be in many kinds of trouble. Furthermore, "the longer the period of youth homelessness is and the more barriers a youth faces, the higher risk that the youth will end up as a chronically homeless adult."[638]

The main funding source and coordinating entity for services to unaccompanied youth is the Runaway and Homeless Youth Program (RHYP) created by the Runaway and Homeless Youth Act of 1974 that has been expanded and reauthorized every five years since the 1970s.[639] RHYP currently authorizes funding for three programs: the Basic Center Program, Transitional Living Program, and Street Outreach Program.[640] The Basic Center Program provides temporary shelter, counseling, and after-care services to runaway and homeless youth under age 18 and their families. The Transitional Living Program is targeted to older youth ages 16 through 22 (and sometimes even older); it offers longer term housing with supportive services. The Street Outreach Program provides treatment, education, counseling, and referrals for runaway, homeless, and street youth who have been subjected to or at risk of being subjected to sexual abuse and exploitation. The Runaway and Homeless Youth Act also authorizes several important related services including a national communication system to facilitate communication between service providers, runaway youths and their families; training and technical support for grantees; and evaluations of the programs.[641] Other federal programs that support runaway and homeless youth are the Education for Homeless Children and Youth program, discretionary grants for family violence prevention, and the Chafee Foster Care Independent Living program for foster youth.

Realizing the obvious lack of reliable statistics and the importance of accurate count as well as a clearer picture of the characteristics and subgroups of unaccompanied homeless youth, four federal agencies (the U.S. Interagency Council on Homelessness, the Department of

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[635] National Conference of State Legislatures. *Homeless and Runaway Youth.* October 2013, available at http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx (accessed February 25, 2016).
[636] Cray, Andrew et al. Op. cit.
[637] Ibid.
[638] Burt, Martha R. *Understanding Homeless Youth: Numbers. Characteristics, Multisystem Involvement, and Intervention Options*: Testimony before the U. S. House Committee on Ways and Means Subcommittee on Income Security and Family Support on June 19, 2007, available at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/901087-Understanding-Homeless-Youth-Numbers-Characteristics-Multisystem-Involvement-and-Intervention-Options.PDF (accessed March 2, 2016).
[639] 42 U.S.C.A. § 4701 et seq.
[640] Fernandes-Alcantara, Adrienne L. *Runaway and Homeless Youth: Demographics and Programs*. CRS Report for Congress. Washington, D.C.: Congressional Research Service. January 2013, available at http://www.nchcw.org/uploads/7/5/3/3/7533556/crs_2013_rhya_history_and_lit_review.pdf (accessed February 25, 2016).
[641] Ibid.

Education, the Department of Housing and Urban Development, and the Department of Health and Human Services) launched the Youth Count! Initiative in 2012. As methods typically used for counting homeless adults do not "accurately capture survival strategies common to youth, such as being mobile and transient, latching onto friends and staying in groups, or trying to hide in plain sight," along with the desire many of them have not to be found, the Youth Count! process study experimented with innovative ways to expand coverage and identify more homeless youth.

Several promising practices have emerged:

- Engage youth service providers.
- Engage LGBTQ partners.
- Involve youth.
- Hold magnet events.
- Use social media to raise awareness and outreach.
- Measure housing instability, not homelessness.[642]

In Pennsylvania, Staci Perlman and Joe Willard, in collaboration with others, effectively used the Youth Risk Behavior Study (YRBS) as an innovative tool to measure homelessness among school-age youth, some of them unaccompanied and some living with their families.[643] Designed by the Centers for Disease Control and Prevention (CDC) in the early 1990s, the YRBS has been conducted biennially at the national, state, and local levels. It targets high-school youth and addresses a range of behaviors related to physical safety, mental health, substance use, and sexual risk-taking. The YRBS has good reliability. Dr. Perlman believed that the YRBS represented a unique methodology for addressing limitations associated with the estimates of youth homelessness obtained through the PIT and Department of Education counts. In 2009, the county and school district of Philadelphia collaborated to add three housing questions to the municipality's YRBS. The answers to those questions provided valuable information on the students' housing status and the prevalence of youth homelessness; on various characteristics of youth experiencing homelessness; and on their mental health symptoms. The authors acknowledged certain limitations of the YRBS counts, most notably the fact that it relies solely on youth self-reports and is limited to youth attending public school. Consequently, "even though estimates of youth homelessness generated from the YRBS are higher than those garnered from other traditional methods of counting, YRBS estimates are still limited by both the youth's interpretation of questions and their responses to the YRBS housing questions as well as the reality that youth experiencing homelessness are disproportionately more likely to have dropped out of school."[644] In spite of these and other limitations, adding housing questions to the YRBS appears to be an innovative and cost-effective method to better assess the prevalence of youth homelessness and to gain insight into their experiences. "The capacity to gain this information represents a first step towards identifying

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[642] Pergamit, Michael et al. *Youth Count! Process Study*. Washington, D.C.: Urban Institute, July 2013, available at http://www.urban.org/UploadedPDF/412872-youth--count-process-study-2.pdf (accessed July 10, 2015).
[643] Perlman, Staci et al. "Youth Homelessness: Prevalence and Mental Health Correlates." *Journal of the Society for Social Work & Research.* Vol. 5. No. 3. October 2014, available at http://works.com/staci_perlman/16 (accessed September 2, 2014).
[644] Ibid.

and meeting the needs of this vulnerable population," with the final goal of developing and strategically targeting the required services to youth experiencing homelessness.[645]

To eradicate unaccompanied youth homelessness, the National Alliance to End Homelessness (NAEH) recommended an approach based on the premise that "when working to end homelessness for a particular population it has proven effective to define a framework by enumerating the population, establishing a typology to assist with scaling of resources, and then to measure progress."[646] In its enumeration of unaccompanied homeless youth under the age of eighteen, NAEH relied on the number coming from the National Studies of Missing, Abducted, Runaway and Throwaway Children (NISMART) - slightly below 1.7 million. Of that number, 1.3 million, according to the NISMART, return home quickly, within one week, often even within a day, with little or no outside assistance.[647] NAEH believes that the main focus should be on approximately half a million unaccompanied, single youth and young adults up to the age of 24 who experience a homeless episode of longer than one week.[648]

The NAEH proposed a framework for ending unaccompanied youth homelessness based on a promising typology developed by Dr. Paul Toro and his co-researchers. This typology used the data from his Detroit study and was based on the youths' behavior while homeless. Dr. Toro and his colleagues identified three subpopulations of homeless youth:

- "Low-risk" youth who tend to be younger, maintain more stable relationships with their families and school, and experience the least amount of homelessness over time;
- "Transient" youth have less stable connections with school and housing as they moved in and out of homelessness repeatedly, but still did not have prominent mental health or substance abuse problems and retained relationships with their families; and
- "High-risk" youth who are more likely to have dropped out of school, have unstable relationships with their families, struggle with mental health and substance abuse issues, and experience long stretches of homelessness.[649]

Assisting these three different subcategories of youth, along with the so-called transitional population – young adults ages 18 to 24 – requires different approaches. Based on available research and outcome data from the Runaway and Homeless Youth Act programs, NAEH concludes that the solution for most homeless youth of all ages, particularly for youth under the age of 18 in the temporarily disconnected and unstably connected subpopulations, is reunification with their families, when it is safe.[650] Even when youth are unable to return to live with their families, family finding and family connection activities have proven valuable to all youth. Youth under the age of 18 who are unable to return home most likely fall into the chronically disconnected and the unstably connected categories. For them, "transitional living programs and transitional

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[645] Ibid.
[646] National Alliance to End Homelessness. *An Emerging Framework for Ending Unaccompanied Youth Homelessness,* available at http://www.endhomelessness.org/page/-/files/4486_file_An_Emerging_Framework_for_Ending_Unaccompanied_Youth_Homelessness.pdf (accessed March 1, 2016).
[647] Ibid.
[648] Ibid.
[649] Ibid.
[650] Ibid.

housing programs provide a platform from which youth can become independent adults."[651] Transitional living/housing programs are especially important for youth with disabilities, NAEH pointedly underscores that these programs must have limited barriers to entry and minimal number of rules that could potentially result in ejecting youth from the programs, as it is most important to keep these youths off the streets.[652] Homeless young adults ages 18 to 24 appear to benefit from Rapid Rehousing, transitional housing, and, when appropriate, permanent supportive housing.

Ultimately, NAEH emphasizes that more resources are clearly needed to respond adequately to youth homelessness as currently only 50,000 youth per year are served by homeless youth programs, which falls far short of demand.[653] To improve the current response to youth homelessness, NAEC offers the following recommendations:

- *Improve the crisis response.* There are too few shelter programs to meet the existing need and, as a result, youth are regularly turned away without a place to sleep. A larger investment is needed here. In addition, there should be alternative models to house youth in crisis to prevent them from remaining unsheltered such as a safe and supervised home host option.
- *Prioritize family reunification or support as the initial intervention.* All programs should support this process when safe and appropriate. Ongoing support may be required upon the reunification. Prevention efforts at an earlier stage should also be increased to avoid a youth separating from his family altogether.
- *Expand the reach and effectiveness of transitional living programs.* When family reunification is not an option, youth need to be provided with longer-term housing options.
- *Improve data collection and performance measurement.* Better data on both the number of homeless youth and the effectiveness of interventions is critical.[654]

With respect to all programs serving homeless youth, NAEH specifically points out the need to ensure they are "accepting and inviting" to lesbian, gay, bisexual, transgendered, and questioning (LGBTQ) youths as they may be at particular risk for family separation because of a lack of acceptance. In addition, LGBTQ youth who are forced to stay on the street may be at heightened risk for sexual exploitation and violence. All this makes them "a population for whom accepting housing models become particularly important."[655]

An informative report on youth homelessness was prepared by the Allegheny County Department of Human Services. Based on interviews with homeless youth and service providers as well as the providers' written documentation and independent research, the report looked at the services provided and identified gaps in availability of services and other issues making access to services more difficult for young people, such as "the need for more shelter beds for this age group, the difficulty young people have in navigating a system that is so decentralized, and the fact that

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[651] Ibid.
[652] Ibid.
[653] Ibid.
[654] Ibid.
[655] Ibid.

the system is designed for adults, rather than youth, who are less trusting of authority and less savvy about resources."[656]

The Allegheny County DHS report offers a set of very specific policy and practice recommendations for local leaders and funders of the housing and homelessness system:

1. Expand the eligibility window for existing youth services to extend through age 24. This matches the HUD definition of "youth."
2. Plan services for this age group.
3. Open a drop-in center in or near downtown; or open shelters during the day to serve drop-ins.
4. Increase shelter options for youth.
5. Review quality assurance and provide training across the entire continuum of housing and homelessness services and to people at key intervention points where they might encounter homeless youth.
6. Planning and coordination to address the issues that result from multiple funding sources with varying policies and requirements.[657]

The National Association of State Legislatures recommends that states consider state policy options in three domains:

- Early intervention and prevention programs, such as a homelessness prevention program that includes counseling, family reunification services, and rent assistance.
- Intervention with already-homeless youth that would include providing access to services that would help them regain stability in their lives through obtaining a job and affordable housing; access to educational outreach and job training programs, transitional living programs, services for mental health and life skills training.
- Independent housing options, with the emphasis on expanding long-term housing options and supportive services and creating a variety of youth housing programs to respond to the diverse needs of homeless youth (these would include group homes, residential treatment, host homes, shared homes, youth shelters, and community-based transitional programs).
- Enhance services provided by juvenile corrections and foster care programs, to offer youth some resources when they are leaving foster care or juvenile correctional facilities.[658]

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[656] McCauley, Kathy. *I'll Never Get Used to It: Young People Living on the Street*. Pittsburgh, PA: the Allegheny County Department of Human Services, May 2014, available at http://www.housingalliancepa.org/sites/default/files/resources/REPORTYoung%20People%20Living%20on%20the%20Street.pdf (accessed March 4, 2016).

[657] Ibid.

[658] National Conference of State Legislatures. *Homeless and Runaway Youth.* October 2013, available at http://www.ncsl.org/research/human-services/homeless-and-runaway-youth.aspx (accessed February 25, 2016).

Key recommendations for policy action charted by the National Center for Children in Poverty include the following:

- ❖ Increase housing subsidies to provide permanent housing for children living in homeless families, and unaccompanied youth.
- ❖ Increase school-based and community-based health and mental health services, including assessment and screening for homeless children and youth. Focus on a trauma-informed approach.
- ❖ Target and increase programs that better identify and serve children living in homeless families and unaccompanied youth with developmental delays or at-risk developmental delays and disabilities.
- ❖ Increase funding for transitional and independent living programs for youth who are aging of foster care.
- ❖ Provide nutritiously adequate food and nutrition outreach to shelters and other temporary housing.
- ❖ Provide educational services to facilitate high school completion for unaccompanied youth to achieve economic self-sufficiency.
- ❖ Provide funding to collect data for a national longitudinal sample of children and youth who experienced homelessness as current research is largely based on selected samples from metropolitan areas and often do not include those who experience homelessness in non-urban areas.[659]

In its recent report, based on emerging research evidence, field experience, and providers' perspectives, the Bassuk Center on Homelessness and Vulnerable Children and Youth delineates the essential components of a comprehensive response to family homelessness. The report was endorsed by community-based providers from all fifty states. Many of the components listed in the report are already being implemented in promising programs around the country:

1. Permanent affordable housing.
2. Education, job training and income support.
3. Assessment of the needs of parents and children.
4. Trauma-informed care.
5. Recognition and treatment of depression in mothers.
6. Family preservation.
7. Parenting supports.
8. Addressing children's developmental and mental health needs.[660]

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[659] Aratani, Yumiko. *Homeless Children and Youth: Causes and Consequences*. National Center for Children in Poverty (NCCP). September 2009, available at http://scholar.google.com/scholar_url?url=http://academiccommons.columbia.edu/download/fedora_content/download/ac:126258/CONTENT/text_888.pdf&hl=en&sa=X&scisig=AAGBfm1ZtKecfwhjYXcQh-SzOsunOdnR8A&nossl=1&oi=scholarr (accessed February 23, 2016).

[660] Bassuk, Ellen L., Carmela J. Decandia, and Molly K. Richard. Services Matter: How Housing & Services Can End Family Homelessness. Needham, MA: The Bassuk Center on Homeless and Vulnerable Children & Youth, 2015, available at http://www.bassukcenter.org/wp-content/uploads/2015/11/Services-Matter.pdf (accessed March 7, 2016).

Summarizing its outlook on programs and policy issues related to homelessness among young people, the National Coalition for the Homeless (NCH) concludes that "homeless youth benefit from programs that meet immediate needs first and then help them address other aspects of their lives."[661] Based on existing research, NCH recommends programs that minimize institutional demands and offer a range of services as they have had success in helping homeless youth regain stability. It also enjoins educational outreach programs, assistance in locating job training and employment, transitional living programs, and "health care especially designed for and directed at homeless youth."[662] Ultimately, NCH comes to an indisputable conclusion that "in the long term, homeless youth would benefit from many of the same measures that are needed to fight poverty and homelessness in the adult population, including the provision of affordable housing and employment that pays a living wage. In addition to these basic supports, the child welfare system must make every effort to prevent children from ending up on the streets."[663]

RECOMMENDATIONS

Families

- Take steps to reduce overall risk levels for children who face homelessness, in addition to boosting resources and adaptive capacity.
- Emphasize family preservation. Prevent children's placement into foster care due solely to homelessness or unstable housing by providing housing assistance to families, in addition to intensive wraparound services such as income supports, job training, health care, trauma-specific services, parental supports, and programs for children.
- Prioritize families with young children and pregnant women for housing placement as it has been shown that the younger and longer a child experiences homelessness, the greater the cumulative toll of negative health outcomes, which can have lifelong effects on the child, the family and the community.
- Ensure that pregnant women experiencing homelessness have access to early and consistent prenatal care.
- Explore and pursue various ways of increasing access to physical and mental health care for children experiencing homelessness.
- Expand cross-training opportunities for homeless service providers and early childhood agencies/providers.
- Increase support for children in supported housing.
- Offer parental support and training to homeless parents so that they could be emotionally responsive and supportive of their children even in the midst of adversity and/or transient and stressful living environments.
- As shelter and street youth are at much higher risk of having been pregnant than housed youth, provide them with comprehensive services, including pregnancy prevention, family planning, and prenatal and parenting services.

[661] National Coalition for the Homeless. *Homeless Youth*, available at http://www.nationalhomeless.org/publications/facts/youth.pdf (accessed March 4, 2016).
[662] Ibid.
[663] Ibid.

- Connect all infants and toddlers experiencing homelessness to evidence-based early childhood home visiting programs and parenting interventions that promote positive early parent-child relationships, such as those funded through the Maternal, Infant, and Early Childhood Home Visiting Program.
- Ensure that all HUD-funded family shelters are safe environments for young children, that they provide appropriate play spaces designed specifically for young children, and that they fully implement the new *Early Childhood Self-Assessment Tool for Family Shelters.*
- Ensure that all HUD-funded family shelters meet HUD prohibition against family separation, keeping children below eighteen years of age with their families.
- Continuously assess all programs' outcomes for both parents and children.

Education

- Continue and improve the Educating Children and Youth Experiencing Homelessness (ECYEH) program, with specific attention to identification and outreach as well as to academic achievement.
- Educate teachers about the signs of homelessness and homeless students' rights and instruct them to refer homeless students to the ECYEH office for services.
- Prioritize access and increase outreach to expand the high-quality early learning opportunities available to young children experiencing homelessness.
- Head Start, Early Head Start and Pre-K Counts should "save slots" for children who are homeless and should not be penalized when a child moves out of the program.
- Consistently apply Act 143 requirements that children who are homeless be automatically screened and, if appropriate, evaluated for Early Intervention (EI) services. Homelessness has been added to the list of "automatic qualifiers" for screening.
- Quality early learning programs should be strategically located to serve at-risk children and offer expanded hours and transportation. Not only should high-quality learning centers be located in close proximity to shelters and transitional housing, but shelters themselves and transitional housing programs should offer learning opportunities on site.
- In order to expand access to early education programs, allow the mother's GED training as well as working to be considered a qualifying criterion.
- Offer resources to encourage Head Start grantees and housing service providers to work together to expand services for children experiencing homelessness or at-risk for homelessness.
- Provide cross-training opportunities for homeless service providers and early childhood agencies/providers.
- Connect all infants and toddlers with the national universal developmental screening system and ensure all infants and toddlers with identified needs receive services according to the federal Individuals with Disabilities Education Act (IDEA), Part C system.
- Encourage secondary schools to explore opportunities for teaching financial literacy.

Child Care

- Modify Child Care Information Services (CCIS) eligibility criteria for homeless families, including waiver of child care co-payments and other expenses for those families.
- Prioritize homeless families' access to subsidized child care.
- Eliminate bureaucratic barriers in part by designating a CCIS representative at TANF offices to assist families applying for CCIS subsidies.
- Offer higher reimbursement rates to providers who serve homeless children.
- Train child care staff on the impact of trauma and trauma-informed care to improve outcomes for children.

Unaccompanied Youth

- Use special, innovative practices to facilitate identification and engagement of homeless youth:
  - Engage youth service providers
  - Engage LGBTQ partners
  - Involve youth as outreach workers, as advisers on the survey design, and as guides to find homeless youth
  - Hold magnet events
  - Use social media to raise awareness and outreach
- Explore the feasibility of opening a drop-in center for youth in/near downtown, or open shelters during the day to serve as drop-in centers. A drop-in center for youth would combine many of the services and supports that youth need, under one roof, including
  - a service coordinator who knows about resources and can help young people access them;
  - a place where a young person who is without a home can come to take a shower, have some food, use a phone or a computer with Internet access, receive mail, do his or her laundry, get bus tickets to key destinations, et cetera;
  - It could also serve as a house base where nurses, employers, schools and job training agencies can come to engage young people.
- Initiate a pilot project with CoCs collaborating with federal, state and local governments, private agencies, and with homeless and formerly homeless youth. The lead agency could be the Department of Human Services Office of Children, Youth and Families, with project activities consisting of
  - Identification and engagement of homeless youth
  - Homeless prevention, including:
    - Transition and life skills
    - Discharge planning from child welfare and juvenile justice institutions
    - Counseling for family and "kin" reunification
  - Services for homeless youth including
    - Emergency/short term interventions
    - Models for longer-term housing and supports
    - Public education and awareness

PRIOR PRINTER'S NO. 2640 PRINTER'S NO. 3110

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 550 Session of 2013

INTRODUCED BY HARHAI, GILLESPIE, SCHLOSSBERG, R. MILLER, COHEN, KOTIK, KIRKLAND, HAGGERTY, LUCAS, B. BOYLE, KINSEY, V. BROWN, BROWNLEE, CALTAGIRONE, JAMES, YOUNGBLOOD, BOBACK, BIZZARRO, SCHREIBER, READSHAW, HENNESSEY, SWANGER, DAVIS, MAHONEY, GODSHALL, WHITE, KORTZ, PARKER, GINGRICH, ROSS, MURT, FARINA, REED, CLYMER, MAJOR, GRELL, FLECK, GOODMAN, THOMAS, MCNEILL, DELISSIO, WATSON, SABATINA, SCAVELLO, MCCARTER AND DONATUCCI, NOVEMBER 13, 2013

AS REPORTED FROM COMMITTEE ON URBAN AFFAIRS, HOUSE OF REPRESENTATIVES, AS AMENDED, MARCH 11, 2014

A RESOLUTION

1 Directing the Joint State Government Commission to establish a
2 bipartisan legislative task force and an advisory committee
3 to conduct a study of the occurrence, effects and trends of
4 homelessness in Pennsylvania and to report its findings and
5 recommendations to the House of Representatives.

6 WHEREAS, Shelter is a basic human need; and

7 WHEREAS, A stable, quality, affordable home promotes family
8 stability, physical and mental health and enhances both adults'
9 and children's ability to be productive. Conversely, the lack of
10 a stable, quality, affordable home increases the risk of
11 illness, failure at school, inability to find or hold a job,
12 incarceration and nursing home placement, often at public
13 expense; and

14 WHEREAS, In 2011, more than 34,000 Pennsylvanians spent at
15 least one night in an emergency or transitional housing program,
16 not including those individuals living on the street, under

1 bridges, in parks or sleeping in someone else's house
2 temporarily; and
3 WHEREAS, The National Alliance to End Homelessness reported
4 an estimated 235,000 Pennsylvanians as living doubled up in
5 someone else's house temporarily in 2011; and
6 WHEREAS, In Pennsylvania, statistics show that family,
7 veteran and chronic homelessness have all risen between 2011 and
8 2012; and
9 WHEREAS, Homeless pregnant mothers are less likely to have
10 received adequate prenatal care and more likely to be young and
11 without a high school education; and
12 WHEREAS, Children born to homeless mothers are more likely to
13 be born prematurely and at a low birth weight. These children
14 have higher than average rates of chronic health conditions such
15 as asthma, evidence high rates of chronic ear infections and are
16 at increased risk for iron-deficiency anemia and lead toxicity;
17 and
18 WHEREAS, In Pennsylvania, more than 9,400 children spent at
19 least one night in emergency or transitional housing in 2011,
20 nearly 60% of whom are less than six years of age; and
21 WHEREAS, Pennsylvania school districts provided services to
22 20,556 homeless children and youth in 2010-2011; and
23 WHEREAS, For many children, homelessness represents many
24 risks, including the likelihood of experiencing an array of
25 health challenges; and
26 WHEREAS, In addition to health-related risks, research
27 demonstrates that children experiencing homelessness are more
28 likely to have been exposed to family violence; and
29 WHEREAS, Almost 40% of children served by emergency housing
30 programs experienced substantiated abuse or neglect and more

1 than 20% had been placed in out-of-home care by the end of the
2 second grade; and
3 WHEREAS, The effects of childhood homelessness do not end
4 with childhood. Homeless children experience higher rates of
5 physical and sexual risk behaviors and are more likely to
6 partake in illegal substances; and
7 WHEREAS, Homeless children show higher rates of poor mental
8 health, are less likely to graduate from high school and are
9 more likely to end up incarcerated; and
10 WHEREAS, The adverse influence of childhood homelessness on
11 children's health, development and well-being is associated with
12 short-term and long-term societal costs that far exceed the cost
13 of providing shelter alone and creates a costly toll on society;
14 and
15 ~~WHEREAS, Funding for the Homeless Assistance Program in~~ <--
16 ~~Pennsylvania has decreased by $8,000,000 since 2008; and~~
17 WHEREAS, The high demand for housing and other causative
18 factors of homelessness compelled counties in Pennsylvania to
19 increase their emergency housing units for families by 12% from
20 2009-2011; therefore be it
21 RESOLVED, That the Joint State Government Commission be
22 directed to establish a bipartisan legislative task force OF <--
23 FOUR MEMBERS OF THE HOUSE OF REPRESENTATIVES to investigate,
24 review and make recommendations of the causes and impacts of
25 homelessness in Pennsylvania; and be it further
26 RESOLVED, THAT THE SPEAKER OF THE HOUSE OF REPRESENTATIVES <--
27 AND THE MINORITY LEADER OF THE HOUSE OF REPRESENTATIVES EACH
28 APPOINT TWO MEMBERS OF THE TASK FORCE; AND BE IT FURTHER
29 RESOLVED, That the task force be authorized to hold ~~public~~ <--
30 ~~hearings~~ INFORMATION SESSIONS, take testimony and conduct site <--

1 visits; and be it further

2 RESOLVED, That the Joint State Government Commission oversee

3 the creation of an advisory committee of no fewer than 13

4 members to assist the task force in its study and

5 recommendations; and be it further

6 RESOLVED, That the advisory committee be a bipartisan, broad-

7 based and geographically diverse representation THAT MAY INCLUDE <--

8 INDIVIDUALS FROM among the business, faith, community, labor,

9 local government and human services communities and individuals

10 affected by poverty; and be it further

11 RESOLVED, That the advisory committee ~~be comprised of at~~ <--

12 ~~least:~~ SHALL INCLUDE ALL OF THE FOLLOWING AS MEMBERS: <--

13 (1) SECRETARY OF COMMUNITY AND ECONOMIC DEVELOPMENT, OR

14 HIS OR HER DESIGNEE;

15 (2) SECRETARY OF CORRECTIONS, OR HIS OR HER DESIGNEE;

16 (3) SECRETARY OF DRUG AND ALCOHOL PROGRAMS, OR HIS OR

17 HER DESIGNEE;

18 (4) SECRETARY OF EDUCATION, OR HIS OR HER DESIGNEE;

19 (5) SECRETARY OF LABOR AND INDUSTRY, OR HIS OR HER

20 DESIGNEE;

21 (6) SECRETARY OF PUBLIC WELFARE, OR HIS OR HER DESIGNEE;

22 (7) CHAIRMAN OF THE GOVERNOR'S COMMISSION FOR CHILDREN

23 AND FAMILIES, OR HIS OR HER DESIGNEE;

24 (8) EXECUTIVE DIRECTOR AND CHIEF EXECUTIVE OFFICER OF

25 THE PENNSYLVANIA HOUSING FINANCE AGENCY, OR HIS OR HER

26 DESIGNEE;

27 ~~(1)~~ (9) one representative from the executive branch; <--

28 ~~(2)~~ (10) four representatives of agencies that work with <--

29 homeless Pennsylvanians, with every reasonable effort made to

30 include diverse homeless populations, such as veterans,

1 people with disabilities, families with children, single
2 individuals, senior citizens and victims of domestic
3 violence;
4 ~~(3)~~ (11) individuals from the general public WHO WERE <--
5 FORMERLY HOMELESS; and
6 ~~(4)~~ (12) two individuals from each of the Southeastern, <--
7 Northeastern, Central and Western geographic regions of this
8 Commonwealth;
9 and be it further
10 RESOLVED, That the TASK FORCE, WITH THE ASSISTANCE OF THE <--
11 advisory committee, examine data, interview individuals and <--
12 families, ~~survey~~ CONTACT communities through methods decided by <--
13 the committee and examine successful strategies used in other
14 states' poverty reduction efforts; and be it further
15 RESOLVED, That additional assistance in this endeavor be
16 provided by the Urban Affairs Committee of the House of
17 Representatives; and be it further
18 RESOLVED, That the ~~task force~~ JOINT STATE GOVERNMENT <--
19 COMMISSION, with the assistance of the advisory committee:
20 (1) Review other recent studies of homelessness from
21 around the country.
22 (2) Research and review the cost factor of homelessness
23 that shall include health care costs, education, mental
24 health, incarceration rates and other factors.
25 (3) Undertake a comprehensive analysis of Pennsylvania's
26 homelessness problem to determine what policy
27 recommendations, if any, would move the Commonwealth toward
28 permanently reducing and eliminating homelessness.
29 (4) Examine other matters that it deems important;
30 and be it further

1 RESOLVED, That the task force propose new legislation, if
2 necessary and appropriate; and be it further
3 ~~RESOLVED, That the task force and advisory committee choose a~~ <--
4 ~~chairperson from among its members; and be it further~~
5 ~~RESOLVED, That members of the task force and advisory~~
6 ~~committee serve without compensation, but be reimbursed for~~
7 ~~necessary expenses incurred in the performance of their duties,~~
8 ~~within the limits of funds appropriated or otherwise made~~
9 ~~available to the task force and advisory committee for their~~
10 ~~purposes. All members of the task force or advisory committee~~
11 ~~who are duly elected members of the General Assembly shall~~
12 ~~remain members of the task force or advisory committee until~~
13 ~~they report their findings and recommendations to the House of~~
14 ~~Representatives; and be it further~~
15 RESOLVED, THAT THE TASK FORCE SELECT A CHAIRMAN AND SUCH <--
16 OTHER OFFICERS AS THE TASK FORCE MAY DEEM NECESSARY FROM AMONG
17 ITS MEMBERSHIP; AND BE IT FURTHER
18 RESOLVED, THAT THE ADVISORY COMMITTEE CHOOSE A CHAIRPERSON
19 FROM AMONG ITS MEMBERS; AND BE IT FURTHER
20 RESOLVED, That all State, county and municipal agencies,
21 departments, boards, bureaus and commissions cooperate fully
22 with the task force and advisory committee; and be it further
23 RESOLVED, That the task force ~~and advisory committee~~ report <--
24 ~~their~~ ITS findings and recommendations to the House of <--
25 Representatives no later than two years after the adoption of
26 this resolution.

APPENDIX B
SURVEY QUESTIONNAIRE

QUESTIONS FOR HOMELESS CONSUMER FOCUS GROUPS

Note to Focus Group Facilitators: if you are facilitating a focus group, the prompts are primarily to give you ideas in order to stimulate the conversation in the event that no one is responding. They are not to be read as part of the question.

Introduction: The State Legislature has directed the Joint State Government Commission to establish a two-year task force to determine the causes, effects, and solutions to homelessness in Pennsylvania. As part of this effort, we are seeking input from families and individuals throughout the state who are homeless or have experienced homelessness. I will be posing a series of questions about why you became homeless, what housing and services you have received, and what you think should be done to improve homeless housing and services for people experiencing homelessness. Your responses will be extremely important in assisting the Legislature to truly understand homelessness and to determine their best course of action in addressing homelessness in the future. The results of our work will be reflected in the report that will be available to the public. Please note that your answers will be totally confidential, so your honest answers are much appreciated!

Question	Prompts:
1. Please introduce yourself and describe the immediate circumstances that resulted in loss of your housing.	☐ How old are you? ☐ Are you single or part of a household? If a household, how many members? ☐ Are you employed? Full-time or part-time? ☐ Do you receive SSDI? Have you applied for SSDI or other benefits? ☐ Where were you last living? ☐ Were you evicted from a home you were renting? ☐ Was your mortgage foreclosed? ☐ Were you asked to leave the home of a friend or family member? ☐ Did you leave due to health or environmental concerns about your housing?
2. Were there longer term causes that led up to your becoming homeless?	☐ Was it the result of a family dispute, domestic or child abuse, or separation? ☐ Were you or a family member incarcerated? ☐ Loss of employment/income? ☐ Extended illness? ☐ Substance abuse? ☐ Other?____________________________________

3. How long have you been homeless? __________

If you have been homeless more than once, how many different times have you been homeless? __________

At what age did you first become homeless? __________ What age are you now? __________

4. Where do you generally spend the night when you are homeless? (There may be multiple answers)	Prompts: ☐ On the street? ☐ In your car? ☐ In a shelter? ☐ In a hotel/motel? ☐ In a cabin, tent, other temporary place? ☐ Moving from family member to family member or friend to friend? ☐ Other ____
5. Was there any kind of assistance that might have helped to *prevent* you from becoming homeless? *If so, please describe that assistance.*	Prompts: ☐ Financial assistance with past due rent or utilities? ☐ Security deposit, first or last months rent? ☐ Assistance in dealing with the landlord? ☐ Assistance from a friend or family member? ☐ Counseling or case management services? ☐ Help with budgeting skills? ☐ Mental health or substance abuse treatment? ☐ Employment assistance? ☐ Help from a well-publicized official or agency? ☐ Other ______________________________
6. Have you ever refused housing or service assistance that were offered to you? *If so, what did you refuse and why?*	Prompts: ☐ Fear of entering shelter? ☐ Fear of location of housing offered? ☐ Fear of losing custody of children ☐ Not familiar with people offering services? ☐ Housing/services offered were not what you needed? ☐ Restrictions of the housing program (eg. No pets, curfew)? ☐ Because you would have had to leave the area? ☐ Other ______________
7. Since becoming homeless have you accepted housing services from a community agency? *If so, what type of housing assistance have you received?*	Prompts: ☐ Emergency Shelter? ☐ Transitional housing? ☐ Assistance finding housing? ☐ Negotiating rent with landlord? ☐ Security deposit/first month's rent? ☐ Short term rental assistance (3-6 months)? ☐ Long term rental assistance (more than 6 months)? ☐ Permanent supportive housing? ☐ Subsidized housing (section 8, public housing)? ☐ Utility assistance? ☐ Moving assistance? ☐ Other______________________________

<table>
<tr><td colspan="2">8. If you have children and received housing assistance, were you able to stay in your home? __________
Was your family able to stay together? __________
Are your children enrolled in school? __________
Were they able to stay in the same school they attended before becoming homeless? __________
Did they attend a different school during that period? __________
What ages are your children? __________
If under six, are they enrolled in a preschool or child care program (e.g., Head Start)? __________
If not, what is preventing their enrollment? __________
Has your child been screened for eligibility for early intervention services? __________</td></tr>
<tr><td>9. Were you satisfied with the housing assistance you (and your family) received?

If not, why not?</td><td><u>Prompts:</u>
☐ Too far from school, family, employment?
☐ Too much money?
☐ Too small?
☐ No privacy?
☐ Too many rules?
☐ Didn't like other residents?
☐ Other ____________________</td></tr>
<tr><td>10. What type of housing assistance would you prefer?</td><td><u>Prompts:</u>
☐ Assistance with paying back rent, utilities or other housing related expenses?
☐ Emergency shelter? (short term)
☐ Transitional housing (up to 24 months with services)?
☐ Subsidized housing (rent generally no more than 30% of your income)?
☐ Permanent housing? (with a lease)
☐ Permanent housing with supports (for people with disabilities–a lease and access to behavioral health and other supports)?
☐ An independent apartment?
☐ Sharing an apartment with a friend or relative with your own bedroom and shared kitchen and living areas)?
☐ A supervised apartment (housing with on-site staff)?
☐ Other ____________________</td></tr>
<tr><td>11. Since becoming homeless have you accepted any other services from a community agency?

If so, what type of services have you received?</td><td><u>Prompts:</u>
☐ Food or meals?
☐ SNAP (food stamps)?
☐ Health services?
☐ Transportation?
☐ Case management?
☐ Mental Health?
☐ Substance use treatment?
☐ Employment?
☐ Life Skills?
☐ Child care?
☐ Other __________</td></tr>
<tr><td>12. Were you satisfied with the assistance you (and your family) received?

If not, why not?</td><td><u>Prompts:</u>
☐ Were services received in a timely fashion?
☐ Were they services that you needed?
☐ Were you treated with respect?
☐ Were there too many requirements/restrictions on receiving service?
☐ Were services accessible?
☐ Other?</td></tr>
</table>

13. What other types of assistance would you prefer?	Prompts: ☐ Food or meals? ☐ SNAP (food stamps)? ☐ Health services? ☐ Dental services? ☐ Transportation? ☐ Case management? ☐ Car repair assistance?	☐ Mental Health? ☐ Substance use treatment? ☐ Employment? ☐ Life Skills? ☐ Child care? ☐ Other __________
14. Do you have any other thoughts about how state or local agencies could help to prevent or end homelessness in Pennsylvania?		

>>>>>>>>>>TO BE FILLED OUT BY THE FACILITATOR<<<<<<<<<<

Please Print Date: ____________________ Your Name: ____________________ Agency: ____________________ Telephone: ____________________ Email: ____________________	Number of Participants: __________ Type of facility/group: (e.g., shelter, transitional housing, PSH, meal program, etc.) ________________________

Geographic Area	Counties/Cities Served ____________________	☐ Urban ☐ Rural ☐ Suburban
Participant Characteristics: (check all that apply)	☐ Families ☐ Individuals ☐ Youth (18-24) ☐ Veterans	☐ Chronic Homeless ☐ With Disabilities ☐ Other

Survey Deadline: March 31, 2015	Please return the survey to Joint State Government Commission by scanning and emailing wbaker@legis.state.pa.us or by fax 717-787-7020 *Thank you.*

APPENDIX C
PROPOSED AMENDMENTS TO 53 Pa.C.S.

53 Pa.C.S.

SUBCHAPTER A

PRELIMINARY PROVISIONS

§ 6001. Scope of chapter.

This chapter deals with optional affordable housing funding.

§ 6002. Legislative purpose.

The General Assembly intends to provide a method for counties and cities of the first class to raise revenues at the local level to enable residents to purchase, rent or maintain quality residential housing.

§ 6003. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Agency." The Pennsylvania Housing Finance Agency.

"County." A county of the second, second A, third, fourth, fifth, sixth, seventh or eighth class. The term does not include any county of the first class.

"National Affordable Housing Act of 1990." The Cranston-Gonzalez National Affordable Housing Act (Public Law 101-625, 42 U.S.C. § 12701 et seq.), as amended.

§ 6004. Reporting.

Each city of the first class that adopts an affordable housing program fee under this chapter shall report annually to the agency the following information:

(1) the amount of funds collected;

(2) the amount of funds distributed;

(3) the name of the entity receiving the funds; and

(4) the name and a description of the program or project.

The agency shall compile the information received from the various counties and make it available to the public, including posting it on the agency's website.

SUBCHAPTER B

AFFORDABLE HOUSING PROGRAMS AND FUNDING IN COUNTIES

§ 6011. Affordable housing programs fee in counties.

(a) General rule.--The governing body of each county may, by ordinance, increase the fees charged by the recorder of deeds for recording deeds, ~~and~~ mortgages, and related mortgage documents under the act of June 12, 1919 (P.L.476, No.240), referred to as the Second Class County Recorder of Deeds Fee Law, or the act of April 8, 1982 (P.L.310, No.87), referred to as the Recorder of Deeds Fee Law.

(b) Limitation.--The additional fees levied by a governing body of a county under subsection (a) shall not exceed 100% of the amounts charged ~~on February 12, 1993~~. for recording deeds, mortgages, and other related mortgage documents.

§ 6012. Disposition of proceeds in counties.

(a) Deposit.--Money collected as a result of the fee imposed under section 6011(a) (relating to affordable housing programs fee in counties) shall be deposited in the general fund of the county.

(b) Allocation.--Money collected as a result of the fee imposed under section 6011(a) shall be allocated as follows:

(1) At least 85% of the money collected shall be set aside in a separate account to be used to fund affordable housing efforts in the county.

(2) Not more than 15% of the money collected may be used by the county for the administrative costs associated with the affordable housing efforts.

§ 6013. Affordable housing efforts in counties.

"Affordable housing effort" as used in this subchapter is any program or project approved by the governing body of the county which increases the availability of quality housing, either sales or rental, to any county resident whose annual income is less than the median income of the county and includes:

(1) Providing local matching funds to secure National Affordable Housing Act of 1990 HOME funds.

(2) Assisting or supporting housing efforts by the Pennsylvania Housing Finance Agency and by commercial banks and thrift institutions.

(3) Supporting soft second mortgage programs.

(4) A program or project which prevents or reduces homelessness.

(5) A program or project which increases the accessibility of new and existing housing to visitors or occupants who are physically disabled.

(6) A program or project which provides grants for repair of basic systems or improvement of owner-occupied housing.

(7) A program or project which increases the production of housing for sale or rent.

SUBCHAPTER C

AFFORDABLE HOUSING PROGRAMS

AND FUNDING IN CITIES OF FIRST CLASS

§ 6021. Affordable housing programs fee in cities of first class.

(a) General rule.--The governing body of a city of the first class may, by ordinance, charge an affordable housing program fee for recording deeds and mortgages and other related mortgage documents.

(b) Limitation.--The fee levied by a governing body of a city of the first class under subsection (a) shall not exceed 100% of the amounts charged by a city of the first class for recording deeds and mortgages and other related documents.

(c) Construction.--Subsection (a) shall not limit or otherwise impact the authority of a city of the first class to alter the fees charged by a city of the first class as of the effective date of this chapter for recording deeds and mortgages and other related mortgage documents.

§ 6022. Disposition of proceeds in cities of the first class.

(a) Deposit.--Money collected as a result of the fee imposed under section 6021(a) (relating to affordable housing programs fee in cities of the first class) shall be deposited in a special fund established by a city of the first class.

(b) Allocation.--Money collected as a result of the fee imposed under section 6021(a) shall be allocated as follows:

(1) At least 85% of the money collected shall be used to fund affordable housing efforts in a city of the first class. The following apply:

(i) A city of the first class may by ordinance dedicate a portion of the funds allocated under this subsection to benefit households whose annual income adjusted for household size is

equal to or less than 30% of the median income of the metropolitan statistical area including that city of the first class.

(ii) A city of the first class may by ordinance dedicate a portion of the funds allocated under this subsection to programs described in section 6023(1) (relating to affordable housing efforts in cities of first class).

(iii) A city of the first class may by ordinance define criteria for accessibility of new and existing housing for visitors or occupants who are physically disabled and establish the percentage of new construction units produced as a result of the affordable housing efforts of the city funded under this subsection that must meet the criteria.

(iv) A city of the first class may by ordinance restrict expenditure of money raised under this subchapter to those programs and projects described in section 6023.

(v) A city of the first class may by ordinance require that housing produced or rehabilitated through affordable housing efforts be priced or rented at an amount such that the purchase or rental will require the expenditure of no more than a certain maximum percentage of the gross income of the household of the purchaser or renter.

(2) Not more than 15% of the money collected may be used for the administrative costs of a city of the first class associated with the affordable housing efforts.

§ 6023. Affordable housing efforts in cities of first class.

"Affordable housing effort" as used in this subchapter is a program or project which increases the availability of quality housing, either sales or rental, to any resident of a city of the first class whose annual income adjusted for household size is less than 115% of the median income of the metropolitan statistical area including that city of the first class and includes:

(1) A program or project which increases the production of housing for sale or rent.

(2) A program or project which increases the accessibility of new and existing housing to visitors or occupants who are physically disabled.

(3) A program or project which provides grants for repair of basic systems or improvement of owner-occupied housing.

(4) A program or project which provides for the improvement of facades for owner-occupied housing.

(5) A program or project which prevents or reduces homelessness.